

TRENDS IN LONG-TERM CARE

HEARINGS
BEFORE THE
SUBCOMMITTEE ON LONG-TERM CARE
OF THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
NINETY-SECOND CONGRESS
FIRST SESSION

PART 18—WASHINGTON, D.C.

OCTOBER 28, 1971



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- Part 1. Trends in Long-Term Care, Washington, D.C., July 30, 1969
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 - Part 3. Trends in Long-Term Care, Hartford, Conn., January 15, 1970
 - Part 4. Trends in Long-Term Care, Washington, D.C., February 9, 1970 (Marietta Fire)
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 - Part 15. Trends in Long-Term Care, Chicago, Ill., September 14, 1971
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 - Part 17. Trends in Long-Term Care, Washington, D.C., October 14, 1971
 - Part 18. Trends in Long-Term Care, Washington, D.C., October 28, 1971
 - Part 19. Trends in Long-Term Care, Minneapolis-St. Paul, Minn., November 29, 1971

¹ Senator Winston Prouty, Vermont, served as ranking minority member of the committee from September 1969, until his death September 10, 1971. Senator Robert T. Stafford, Vermont, was appointed to fill the vacancy on September 17, 1971.

² Assigned to subcommittee, Nov. 2, 1971.

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TRENDS IN LONG-TERM CARE

THURSDAY, OCTOBER 28, 1971

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

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 1202, New Senate Office Building, Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss, Gurney, and Percy.

Staff members present: William E. Oriol, staff director; Val Halamandaris, professional staff member; John Guy Miller, minority staff director; and Janet Neigh, clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The subcommittee will come to order.

This is a hearing of the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging to hear from the Department of Health, Education, and Welfare about their progress in carrying out Mr. Nixon's plan to improve our system of long-term care.

Despite some reservations most of us who have been students of nursing home problems for these many years applauded the President's forthright stand. In hearing the Department of Health, Education, and Welfare today we intend to assess just how serious to take the Government's new "get tough" policy.

The last time HEW witnesses were before my subcommittee was May of last year. At that time I lamented HEW's failure to promulgate acceptable standards in implementation of the so-called Moss amendments of 1967 designed to improve the quality of care in our skilled nursing homes and to provide uniformity of standards throughout the United States.

Three years passed since these amendments were enacted and they were finally implemented in regulation form by the Department. While I very much regret this delay, I am for the most part pleased with the regulations which have been announced. This is not to say that the regulations could not have been improved and I am still waiting for the Department to issue the long promised ratios of staff to patients.

At this point we do have an acceptable body of law upon the books but to quote Sir Robert Peele and the positive school of jurisprudence, "Law is not law unless it is enforced."

There is no doubt that the so-called Nixon nursing home initiatives with the welcomed exception of training programs for nursing home

inspectors and personnel can be listed under the category of "policing" or enforcement. What this tells me if I can generalize, and I hope not unfairly, is that the administration and HEW are just getting around to enforcing the amendments which I steered through the Congress nearly 4 years ago. Again one has to wonder about the delay.

I guess my attitude even before hearing today's witnesses has to be "better late than never" but I want some assurances today. I want assurances that HEW has embarked on a positive program and that it will play a more aggressive role in seeing that States meet minimum standards. I am sure the witnesses know our hearings in Chicago, Ill., where the Health Department testified that over 50 percent of that State's nursing homes did not meet minimum standards and of the General Accounting Office audit of May 28 of this year that confirmed this same trend in three more States.

I also want assurances that the new 150 positions requested by the President for enforcement of nursing home standards will be devoted to this work and not to other HEW projects.

I might comment for the edification of those present that this is the 18th hearing we have held in the current series. My staff was somewhat amused by the September 24 call from an unidentified Department of Health, Education, and Welfare employee asking if we have held any nursing home hearings since 1965.

I anticipate a meaningful hearing today and I am pleased to welcome Under Secretary of the Department of Health, Education, and Welfare, John Veneman along with Dr. Merlin K. DuVal, Jr., Assistant Secretary for Health and Scientific Affairs, Mr. Stephen Kurzman, Assistant Secretary for Legislation; Mr. Arthur E. Hess, Deputy Commissioner, Social Security Administration; and Mr. Howard N. Newman, Commissioner, Medical Services Administration, Social and Rehabilitation Services; and other appropriate departmental officials.

We have called this hearing for the purpose of getting the testimony of the Department and with this array of talent I am sure that we can get on the record what we are seeking in trying to determine whether the regulations on nursing homes are now complete or nearly complete and what degree of enforcement we may expect to have of the regulations that have been issued.

I do appreciate the appearance of all of you gentlemen who have come this morning. We look forward very much to hearing from you.

I don't know whether my colleague, Senator Gurney, has a statement to make.

Senator GURNEY. I am not a member of the subcommittee. I appreciate your courtesy in asking me to sit in on this hearing.

Everybody knows in Florida we have a large portion of the retired and elderly and a goodly portion of the nursing home problems so I am intensely interested in the subject and I will listen with interest.

Senator MOSS. Thank you, we are pleased to have you here. Indeed you do have a good population of the elderly in your State, larger than other States.

We have had some fine hearings down there attempting to define the problem and find appropriate solutions for problems that exist.

We will be pleased to hear you, Mr. Secretary and if you have any of your assistants or others here that you want to give a statement, you may call on them at the appropriate time.

STATEMENT OF HON. JOHN G. VENEMAN, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE: ACCOMPANIED BY MERLIN K. DuVAL, M.D., ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS; ARTHUR E. HESS, DEPUTY COMMISSIONER, SOCIAL SECURITY ADMINISTRATION; HOWARD N. NEWMAN, COMMISSIONER, MEDICAL SERVICE ADMINISTRATION, SOCIAL AND REHABILITATION SERVICE; JOHN TWINAME, ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE; AND JAMES EDWARDS, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION

Mr. VENEMAN. Thank you, Mr. Chairman. What I would like to do is present a statement and then we do have these other gentlemen to respond to any questions the members of the committee may have. We have had a change in lineup since those printed in your opening statement. If I may I will identify those persons at the table.

To my far left is the Deputy Assistant Secretary for Legislation, Jim Edwards, who has the responsibility for the welfare. To my immediate left, the Deputy Commissioner of the Social Security Administration, Mr. Art Hess. On my immediate right, Dr. DuVal, Assistant Secretary for Health and Scientific Affairs; and next to him, John Twiname, Administrator of Social and Rehabilitation Service, and next to Mr. Twiname is Howard Newman, the Commissioner of the Medical Service Administration, which handles the Medicaid problems.

Mr. Chairman, if it is your desire, I will read my statement, following which we will have the questions. I point out, Mr. Chairman, that this subcommittee meets in the wake of still another tragic nursing home fire. The blaze that claimed the lives of 15 aged, helpless Americans in Honesdale, Pa., 10 days ago is but the latest in a litany of similar tragedies.

Twenty-one months ago, 32 aging persons perished in a nursing home fire in Marietta, Ohio.

And just over a month ago, in your own State of Utah, six persons died in another such fire.

Honesdale was not certified to care for Medicare or Medicaid patients. It fell far short of meeting the standards required by either of these programs.

So the answers we seek clearly transcend the problem of nursing homes governed by Medicare and Medicaid eligibility standards.

What I want to do first is give your subcommittee a brief status report on enforcement of the Medicaid and Medicare programs, then describe what will be done with the initiatives in nursing home action that the President articulated on August 6.

Since Medicare began, almost 100 extended care facilities have had their Medicare approval terminated because they failed to meet Medicare's health and safety standards. Another 43 facilities are now on notice that their Medicare approval will be terminated. Hundreds among the approximately 2,000 facilities that have withdrawn from the program voluntarily did so rather than face termination action because they were unable to remain in compliance with the standards.

While many substandard facilities have been terminated or withdrawn from Medicare, a large number have significantly improved the

way they deliver services. Much of this has come about through the thousands of visits to Medicare facilities by State inspectors paid from Federal funds. Over the last 12 months about 4,000 surveys of nursing homes have been made to determine whether these homes meet Medicare's standards and about 8,000 visits have been made to nursing homes to assist them to correct deficiencies and improve services. As a result hundreds of nursing homes have made some very significant improvements in the way they deliver services; for example, hiring more trained nurses, improving their food service, establishing better procedures for administering drugs and removing fire and other safety hazards. Additionally, the very threat of terminating facilities from the Medicare program has produced good results—58 homes have come up to standard after being notified that they would be faced with termination proceedings.

Medicaid enforcement, in contrast to Medicare, must be accomplished within the constraints of a State administered Federal-State program. Medicaid relies on State certification of skilled nursing homes and State enforcement of Federal standards. Reliance on the State enforcement machinery has led to widespread nonenforcement of Federal nursing home standards. Many States have simply relied on their licensure activity and have made no provision for applying the special requirements of Medicaid. Obviously, a more visible and effective Federal presence is needed to assure compliance. The administration's program is our response to this need.

Clearly, it is not acceptable to continue the existing situation. If we did, deficiencies in enforcement, violations of standards, inadequate care and neglect of thousands of helpless aged citizens would continue, and in the absence of more positive enforcement efforts, grow. Since the advent of Medicare and Medicaid in the mid-1960's, massive sums of Federal, State, and local funds have been spent for institutional care of our aged. In spite of the large expenditure of funds, however, not enough attention has been given to supervising the quality of care given to our aging.

DUAL PROGRAMS FURTHER COMPLICATE PROBLEMS

The problem is complicated further by the presence of two different categorical programs enacted by Congress, Medicare and Medicaid, each with its own regulations, its own funding base, and its own administrative direction.

Our current efforts to improve enforcement of standards are being directed primarily at the skilled nursing homes participating in the Medicaid program. The State inspection and enforcement programs have been only as good as each State wants them to be and have varied widely from State to State.

The administration is committed to changing this situation. In his speech on August 6, the President outlined the steps he feels are necessary to improve nursing home care.* As an immediate first step, he directed that HEW consolidate all activities relating to nursing home standards into one effective program, and that a single official be designated who will be accountable for success or failure.

That official has been designated, and he is here this morning; Dr. Merlin K. DuVal, Assistant Secretary for Health and Scientific Affairs.

* See statement, p. 2015.

To assist Dr. DuVal in this urgent undertaking, the Secretary in this past week has selected one of the Nation's most knowledgeable experts in the nursing home field. She is Mrs. Marie Callender who has been serving as assistant professor of the Department of Clinical Medicine and Health Care at the University of Connecticut School of Medicine.

One of her first tasks will be to take a highly critical look at the existing regulatory activity in the nursing home field, and from this, develop concrete recommendations to unify and coordinate the overall effort. In pursuit of that goal, Mrs. Callender will seek close consultation with this subcommittee. We recognize that you and the members of this committee know many of the problems we face in upgrading the standards of nursing home care and we want to work closely with you and your staff in the months ahead.

I might inject here, Mr. Chairman, that there may have been one person in the Department of Health, Education, and Welfare that was unaware of your hearings since 1965 but there are those that were not responsible for that call who are aware of the committee's hearings.

Senator Moss. You can understand the politician's sensitiveness to that.

Mr. VENEMAN. I think the lack of adequate enforcement of nursing home standards by the States was brought to the attention of Congress last May by the General Accounting Office. In a report on the enforcement of Medicaid and Medicare standards in 90 nursing homes located in Michigan, New York, and Oklahoma, deficiencies were found in over half of these homes; 44 of them did not even meet fire safety standards.

Another more detailed study of Medicaid enforcement conducted by HEW among 15 States showed that in most of them Medicaid standards were not being used to certify nursing homes. Instead, contrary to law, State licensure standards were being used.

This month, we began a crash effort to assess the performance of State Medicaid certification efforts. Using teams of Federal personnel, 34 State programs have already been visited and 16 more are scheduled to be visited before November 15.*

As part of these visits, the 100 Federal personnel involved in these State surveys have already inspected 110 homes. The results of their evaluation will be available before the end of November and will be used to help the States improve their performance.

However, no matter what these surveys show we cannot place all of the blame for any deficiencies at the doorsteps of State capitals. State governments face towering fiscal problems today.

The President has recognized the dilemma faced by the States. That's why the second of his eight action directives requests Congress to authorize the Federal Government to pick up 100 percent of the cost of State nursing home inspection programs.

Unless this authorization is forthcoming, the next vital step to better nursing homes for our aged cannot be taken.

ADDITIONAL 2,000 STATE NURSING HOME INSPECTORS

To further accelerate the effort by States, the President has also

* See State survey reports, appendix 1, p. 2023.

directed that an additional 2,000 State nursing home inspectors be trained over the next 18 months at Federal expense.

And I report to you today that this effort is already well underway. With this increased effort, over half of these State inspectors will be trained within the next year and all 2,000 will be trained within 18 months.

To enhance State efforts even further, and strengthen the Federal presence in the field, the President has asked the Congress to appropriate funds that will finance 150 additional Federal positions for nursing home enforcement.

When the funds become available to hire these additional personnel, most of them will be assigned to our regional offices to monitor State enforcement efforts under the Medicaid and Medicare programs.

The President has also recognized the need for the Department to :

Institute a new program of short-term courses for physicians, nurses, dietitians, social workers, and others who are regularly involved in furnishing services to nursing home patients.

Many otherwise competent professionals, he noted :

Have not been adequately trained to meet the special needs of the elderly.

The Department has supported some of this type of training for several years. As a result of this administration's new initiative, we will now expand this activity in a program planned to offer short-term courses to more than 20,000 health professionals, paraprofessionals, and other nursing home workers during the coming 18 months at a budgeted cost of \$2.4 million.

Over the past year we have been working to enact common safety standards for nursing homes and other medical care facilities that serve Medicare and Medicaid patients.

Today, final fire and safety regulations for Medicare are being published in the Federal Register. The new regulations provide that extended care facilities and hospitals shall comply with the Life Safety Code. This will make the Medicare fire safety standards the same as Medicaid's where, as a result of the Moss amendment, the Life Safety Code became applicable January 1, 1970, for nursing homes.

Other immediate steps have been taken. Not long ago, Secretary Richardson wrote the Governors of every State, asking their help and cooperation in improving nursing home standards.

I can report to you this morning that we have taken an additional step to assist Governors in this effort. Staff members of the Department are developing a plan to provide a means by which State governments can respond to complaints by nursing home patients or their relatives.

It is time that the consumer is heard in nursing home concerns and the establishment of these "ombudsman" units will give voice to those concerns.

However, it will take time to establish these units, and time is running out.

So in order to encourage an immediate consumer voice and in accord with the President's August 6 initiative, Secretary Richardson has directed that each of the 885 Social Security district and branch office managers act on an ad hoc basis as contact points to receive and refer complaints on behalf of the patients.

The President has also directed that a comprehensive review be

launched by HEW looking toward recommendations for fundamental improvements in standards and practices in nursing homes.

Your subcommittee has had more experience in this field than any other legislative unit of Government.

We will therefore expect to draw freely from the insight and perspectives of your subcommittee as this study proceeds.

Among the subjects that this study will include are such things as:

The need for uniform terms and classifications of nursing homes;
Ways to protect the personal and property rights of aged persons in institutions;

A study of utilization practices and the relationships between benefits covered and reimbursement levels;

A review of the compatibility of standards for long-term care facilities, including new approaches to assuring quality of care;

Use of new kinds of personnel in long-term care facilities, including physician assistants, nurse practitioners, and others;

Finally, we also plan to explore fully ways of providing alternatives to the institutional care of the aged.

LONG-TERM CARE INSTITUTIONS ARE NOT ALWAYS NECESSARY

I have a strong feeling that far too many of our aged who have physical infirmities are being railroaded into long-term care institutions today. There is money to pay for institutional care, but there are not enough community programs that offer the alternative of letting older persons live in their own homes.

Sometimes all older persons need are hot meals brought into their home, some housekeeping help and perhaps a regular visit from a nurse or a physical therapist. These services can be provided at a fraction of what it costs to put an older person into a long-term care facility. In their own familiar surroundings, they are happier and healthier and less likely to lapse into a senile state.

Growing old in a young Nation has become for all too many older persons a painful and lonely experience. And one of the worst of those experiences for an older American is to be shunted off to a home somewhere, away from familiar faces and friendly surroundings. If it isn't necessary, it just should not be tolerated.

I believe that in many ways the aged in this country are being discriminated against. One place to begin combating that discrimination is by recognizing the needs of older Americans as individuals, not as part of a homogeneous mass whose only common reference point is that they all survived a 65th birthday.

The older Americans that we are talking about are our own fathers and mothers. They survived two world wars and a depression, and despite it all, they still managed to build the America we know. Now they have handed it over to use to build some more.

It seems to me that the place where we ought to take up that task is by assuring that their years with us have some life, some love, some warmth, some dignity, and some honor.

Thank you very much, Mr. Chairman. That concluded my opening statement.

As I indicated I have all the experts from Health Service Administration, from the Social Security Administration, from the Medical Service Administration, who will be very happy to respond to any questions of the committee.

Senator Moss. Thank you very much. This is a good statement. I particularly applaud your summation there where you talk about the goals that we should have in providing for our elderly citizens and not allow them to be shunted aside and grow old in a lonely and isolated situation.

As those of us who spent time working on the problems realize—and I am sure most people would realize if they thought about it—that our elderly ought to be honored and cherished in our society. They ought to be recognized fully as individuals with aspirations and opportunities the same as a person of any age, and to treat them differently and discriminate against them simply because of the passage of years is certainly something which shames our society.

Our objective is to eliminate this discrimination.

I am very glad to have so many distinguished members present on the panel sitting here. I have a few questions that I would like to ask to help fill out the record.

I can say again that I am encouraged by the fact that we seem to be coming to grips now with some of the more severe problems, there is much which needs to be done.

I wonder, in order to put this question into appropriate reference, if you can tell me a little about the size of the problem we are facing. You referred to the fact that about 50 percent of the State nursing homes did not meet minimum standards and based on the GAO audit, my question is how big of a problem are we facing, how many substandard nursing homes are there? What percentage of our total would you estimate there are?

Mr. VENEMAN. The question is difficult to respond to. The sample taken by GAO indicated roughly a 50-percent figure in Medicaid institutions they investigated were not complying with the standard established by the Medicaid program.

As I pointed out in the testimony, it will vary from State to State. You will find some States where the ratio would be higher.

Mr. Hess, I think, can respond more accurately but, as you know the Social Security Administration will qualify a home to receive Medicare recipients when it is substantially in compliance.

Now there might be some deficiency, for example, a lack of a dietitian on certain hours or some other minor incidents that may make them substantially in compliance but would have no impact on the level of care to any degree that the patient receives.

So, if you took a hard, fast rule, I don't know whether the GAO's 50 percent would hold up or not. The intermediate care facilities have not been looked at since the Federal Government has no authority to establish standards and survey those facilities. One of the amendments in H.R. 1 is that we would be given standard setting authority for intermediate care facilities. We hope this will give us some control over these facilities. It will be 5,000 or 6,000 more facilities that do have patients that are receiving Federal funds through the titles I, X, XIV, and XVI programs.

Mr. HESS. Mr. Chairman, when we received the GAO report it indicated that 35 of the 90 homes were also Medicare approved. Although the GAO did not turn over to us specific deficiencies, since the report we had the State agencies visit all the facilities and conduct a resurvey. Seven of those withdrew from the Medicare program. Of the remaining 26, 21 were reported by the State Health Departments to be in substantial compliance with the correctable deficiencies.

As the Under Secretary explained, that means that these are areas

where there is room for improvement, but in the State Health Department's judgment the care provided is adequate and without hazard to the health and safety of the patients. Interestingly enough when the State officials got there they found there were no longer deficiencies. Presumably in the meantime the problems identified by the GAO had been corrected.

We have identified, of course, a number of participating ECF's which have to do more upgrading—for example, make some physical plant improvements to meet all of the Life Safety Code fire provisions or acceptable equivalent alternatives. We have been going through the process this past year of setting up procedures so that facilities that still fall short of meeting the code provisions can be identified for followup action.

DAY-TO-DAY FLUCTUATION OF CONDITIONS

Senator Moss. What you are really saying then is that facilities fluctuate a great deal from day to day, so evaluation is difficult.

Mr. HESS. And each one has to be looked at as an individual case and worked with. The State agencies receive 100-percent reimbursement from Medicare for survey activities and for technical assistance.

As the Secretary indicated we have had in the past year 8,000 visits to over 4,000 ECF's that are indicated as being in substantial compliance advising nursing and other medical and technical personnel how to correct deficiencies. It has been our experience that the only way that you can get enforcement is to have a cadre of State people explicitly financed and put on this operation, doing this 100 percent of the time, following up on identified deficiencies, providing technical assistance, reporting back and keeping the pressure on.

Senator Moss. Taking into account that some of the deficiencies are greater than others, would you still say that less than half of the nursing homes meet all of the standards required at this time?

Mr. HESS. While I could not speak for nursing homes generally, I would certainly say in the ECF area we have here a more precise method of classification. We have about 1,100 ECF's in which there are no deficiencies of any significance recorded. Then there are about 3,160 DCN's in which there are one or more deficiencies that are correctable and in the stage of being corrected.

As the Secretary indicated these can be ones that have to do with—I would not call them minor—less consequential matters as far as the safety and health of the patient is concerned. For example one of the major deficiencies we have in the smaller ECF's, the largest single deficiency is the absence of adequate social work consultation or a social worker on the staff.

As you know, that happens to be a matter that is in controversy now between the Ways and Means Committee and the Senate Finance Committee on H.R. 1.

Mr. VENEMAN. Dr. DuVal pointed out we have something here prepared September 1971, by the Social Security Administration which we can submit which is a breakdown of the conditions where the deficiencies exist. I think it is significant that there are 1,584 of those extended care facilities that are not complying with the Social Service provision. That is the highest.

We would be happy to submit this for the record.

Senator Moss. We would be pleased to have you submit that for the record. It will be printed in our transcript.

(The document referred to follows:)

U.S. EXTENDED CARE FACILITIES CERTIFIED UNDER TITLE VIII—WITH MAJOR DEFICIENCIES IN SPECIFIED CONDITIONS OF PARTICIPATION, SEPTEMBER 1967, SEPTEMBER 1968, JANUARY 1969, JUNE 1970, AND MARCH 1971

Section 405	Conditions of participation	September 1967			September 1968			January 1969			June 1970			March 1971		
		Number of ECF	Percent of total ¹	Rank order	Number of ECF	Percent of total ¹	Rank order	Number of ECF	Percent of total ¹	Rank order	Number of ECF	Percent of total ¹	Rank order	Number of ECF	Percent of total ¹	Rank order
.1120	Compliance? State and local laws.....	39	1	18	27	1	18	36	1	18	378	11	8	420	13	6
.1121	Administrative management.....	487	14	10	311	9	11	304	9	10	227	7	11	198	6	12
.1122	Patient care policies.....	412	12	13	269	8	12	269	8	12	175	5	14	153	5	13
.1123	Physician services.....	502	15	9	467	14	7	467	14	7	397	12	6	324	10	9
.1124	Nursing services.....	1,188	35	3	895	27	3	863	26	3	773	23	3	662	21	4
.1125	Dietary services.....	1,040	31	4	782	23	4	780	23	4	650	19	5	557	17	5
.1126	Restorative services.....	454	13	12	354	11	9	330	10	9	269	8	10	249	8	10
.1127	Pharmaceutical services.....	941	28	5	516	15	6	480	14	6	386	11	7	400	12	7
.1128	Diagnostic services.....	52	2	17	44	1	17	44	1	17	25	1	18	17	1	18
.1129	Dental services.....	120	4	15	104	3	15	96	3	15	59	2	17	93	3	15
.1130	Social services.....	1,400	41	2	1,782	53	1	1,829	54	1	1,776	53	1	1,584	50	1
.1131	Patient activities.....	109	3	16	101	3	16	95	3	16	78	2	16	86	3	16
.1132	Clinical records.....	599	18	7	633	19	5	626	19	5	721	21	4	891	28	3
.1133	Transfer agreement.....	503	15	8	195	6	14	162	5	14	108	3	15	57	2	17
.1134	Physical environment.....	1,868	55	1	1,696	51	2	1,660	49	2	1,149	34	2	931	29	2
.1135	Housekeeping services.....	191	6	14	201	6	13	203	6	13	183	5	13	150	5	14
.1136	Disaster plan.....	477	14	11	322	10	10	288	9	11	216	6	12	220	7	11
.1137	Utilization review plan.....	842	25	6	377	11	8	337	10	8	330	10	9	358	11	8
Total ²		11,224			9,076			8,869			7,900			7,350		
ECF's with major deficiencies.....		3,400	82		3,356	70		3,365	71		3,382	73		3,198	74	
ECF's without major deficiencies.....		738	18		1,402	30		1,441	29		1,274	27		1,141	26	
Total ECF's.....		4,138	100		4,758	100		4,806	100		4,656	100		4,339	100	

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¹ Based on total extended care facilities with deficiencies.
² Total number of times every condition of participation was reported with major deficiencies (each extended care facility is multiplied by the number of conditions in which it has major deficiencies).

Source: Social Security Administration, Form SSA-1539, section 11. Prepared by Community Health Service, Division of Health Resources, and Community Profile Data Center Staff.

Senator GURNEY. It seems to me we have two problems. One is the establishment of high quality care as far as Medicare and Medicaid nursing homes are concerned. We have been talking about an adequate means of inspecting these homes. However, it seems to me that the problem is much broader than that. We have not touched on all homes.

I think the chairman's question was also directed to that. How many nursing homes do we have in this country? Does the Department of Health, Education, and Welfare have those figures?

Mr. VENEMAN. We have about 20,000 facilities that are called nursing homes. Something between 60 and 70 percent are identified as extended care facilities, skilled nursing homes, or intermediate care facilities.

Senator GURNEY. How many do we have under Medicare and Medicaid?

Mr. VENEMAN. There are about 7,000, Senator Gurney.

Senator GURNEY. So there are about 13,000 outside of those covered by Medicare and Medicaid?

Mr. VENEMAN. There would be slightly more than that, that is right; 13,000 outside the scope of the Medicaid-Medicare program. If we are to get the amendment that would permit us to set standards for intermediate care facilities, we would cover another 4,000 or 5,000.

Senator GURNEY. Under the President's proposal that you mentioned in the last part of your statement, are you going to make studies and come up with recommendations as far as these 13,000 nursing homes that are not covered by Medicare and Medicaid?

Mr. VENEMAN. Yes, I will hope we don't have many more studies without recommendations. We have enough of those.

Senator GURNEY. That is my next question. Haven't we studied the thing to death and can we come up with some recommendations based on present facts and figures?

Mr. VENEMAN. As a result of this study you have been given the focus of this problem by the President, by the committee, by Members of Congress. With Mrs. Callender coming aboard and Dr. DuVal having responsibility for this study, we will come up with the kinds of recommendations that will recognize not only the problem areas but how we can get some kind of leverage on these other homes such as the Honesdale situation.

Senator GURNEY. I congratulate you on your acquiring Mrs. Callender because, as we all know, she has been a leader in this business and she certainly ought to know the situation well. I am sure she will be helpful to you.

Senator Moss. Thank you.

You talked about the program of the 150 different positions to aid in enforcement of nursing home standards. I wonder if you could give me unequivocal assurance that these 150 positions will be used in MSA central office and field offices to enforce nursing home standards. Some \$1.3 million has been requested for this purpose and I would like to be sure that these people won't be used for some other purpose.

Mr. VENEMAN. We will give you that assurance, Mr. Chairman, because that is the sole purpose for these additional personnel; 142 of those will be assigned to the Medical Service Administration which will be the Medicaid portion. Out of those 142 I would personally

hope that more than 100 of those will be out in the field. They would not be Washington based personnel. So they would be out there providing the kind of Federal presence within the States that is going to be necessary. We are still going to have to lean for the most part on the State, on the State Public Health Departments or their agencies that are responsible for most of the inspection. We will pay the cost but in so doing we are going to have to have a Federal presence there, a Federal person available. That is the purpose of these 150 trained personnel.

Senator Moss. That is the assurance I wanted.

I am hoping we would not get them diverted off to some other place because of the great need we have for them in this enforcement of standards.

The President has asked you to help the States develop investigative units to help check up on nursing home complaints. My question is, Where will these ombudsman units be located?

You spoke of the ad hoc situation to take care of the situation immediately but will they be independent or will they be located in the Health Department or what do you have in mind?

Mr. VENEMAN. We are going to have to leave some of that to the discretion of the States. It has been recommended that they be in the executive branch reporting to the government but I think there should be sufficient flexibility that they could be, if they established an effective system, reporting to the single State agency. It would depend upon how a State government executive branch was structured. In some States you have a Department of Human Resources, for example, who has a secretary reporting directly to the Governor, who concerns himself with more than just the nursing home problem. I don't think we should be so rigid as to say each of these has to be established in the Governor's office. Presumably that is where it would fall, but we are attempting to use the Social Security district managers as an interim measure.

It is simply a means of having a contact point where these complaints can be taken until these State programs are established. It is my understanding that two or three States have already moved.

Dr. DUVAL. We have some inquiries developing already, three specifically as of today, Senator.

Senator Moss. In different States?

Dr. DUVAL. Yes, sir; that expressed an interest in coming in early to establish such a consumer complaint type machinery.

Mr. VENEMAN. I have the letters, Mr. Chairman, sent to the Governors asking for their cooperation, which I would be happy to submit for the record. This would give you more insight into what the intentions are.

Senator Moss. That will be printed in the record at this point.

(The documents referred to follow:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., October 1, 1971.

DEAR GOVERNOR: The President has called for increased Federal attention to the problems of aged citizens confined to nursing homes. This attention will be focused on stronger enforcement activities designed to assure high quality care in these homes. A copy of the President's August 6 statement which outlines his plan of action is enclosed.*

* See "Statement by the President," p. 2015.

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Your personal support, cooperation and help in this important undertaking is needed. Our Federal efforts will place greater demands upon your State personnel, and we hope that you can give them the administrative support and encouragement they will need to respond quickly and effectively.

Through new programs instituted by the Department as a result of the President's mandate, we will be able to provide additional assistance to your State enforcement officials. This will include training materials and courses for your nursing home surveyors and inspectors, as well as a request for Congressional authorization to pay for 100 percent of these costs in the Medicaid program. As you know these costs are already fully reimbursed for the Medicare program.

These Federal initiatives, however, cannot alone prove successful. Substantially increased State efforts are requested to insure that acceptable standards of care are provided in nursing homes in your State. I have asked Dr. Merlin K. DuVal, Assistant Secretary for Health and Scientific Affairs, to be responsible for insuring rigorous enforcement of the Department's guidelines and regulations. He will be contacting you further about additional steps to insure effective State action.

It would help greatly if you would appoint one individual with whom you would like Dr. DuVal to work to insure coordinated and effective enforcement of regulations governing all levels of care in the nursing homes in your State.

Thank you for your cooperation in this important task.

With kindest regards.

Sincerely,

ELLIOT L. RICHARDSON, *Secretary.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., October 20, 1971.

DEAR GOVERNOR: In early August the President announced a major new Federal effort to improve the quality of nursing home care. Secretary Richardson has already told you about some of our plans, but I would like to take this opportunity to give you some further details and enlist your support of our activities.

A major thrust of the new effort is enforcement of existing standards for nursing homes. This includes full enforcement of the Federal and State standards for extended care facilities under Medicare and for skilled nursing homes and intermediate care facilities under Medicaid. The effort will necessitate the termination of payments to substandard facilities under both of these programs in as expeditious a manner as possible unless standards of care are raised to meet the minimum requirements. To accomplish this, your State inspectors—both those who inspect for Medicare under full Federal reimbursement by that program, and those who inspect for Medicaid on behalf of your State Medicaid agency—must be encouraged to enforce the standards stringently through complete inspection of all homes, documentation of deficiencies, and consultation with providers to help them improve their facilities.

We are fully aware that this enforcement program may place even greater strains upon your State's personnel and financial resources. Consequently, we have asked Congress to amend Title XIX of the Social Security Act so that we can pay 100 percent of the costs of inspection for the Medicaid program. In the meantime, we will provide you with as much short term help as possible in the form of teams of Federal personnel who are qualified to do inspections and who can provide technical assistance, advice, and supplementation to your staff on an ad hoc basis. Arrangements for these teams will be made with your State agency through our HEW Regional Office.

Many of the nursing homes in your State participate in both Medicare and Medicaid. Since the standards for Medicare extended care facilities and Medicaid skilled nursing homes are nearly identical, the inspections and decisions made for one will often apply to the other. I would expect, therefore, that if a Federal decision to terminate Medicare payments is made, Medicaid payments are also apt to be terminated by your State agency, unless adequate justification is presented for continuing the home in the Medicaid program. If any homes in your State have been decertified from participation in the Medicare program this year, a list of those homes is enclosed. I assume that you will want to inspect these homes as soon as possible for compliance with Medicaid standards, and I would appreciate a report from your designated representative on these homes as soon as inspections are completed, hopefully no later than December 1. Such a report

may be sent to the Regional Director in the HEW Region serving your State. Should any home fail to take the necessary steps to comply with Federal and State regulations, and Medicaid payment termination is in order, we will, of course, work with your staff to assure that any patients in facilities terminated are placed in other facilities.

To enhance the capability of your staff to enforce standards, we will provide training for State nursing home surveyors under contracts we have with university training centers. Within 18 months, we hope that all of your staff conducting surveys and inspections under Medicare and Medicaid and your State licensure programs will have received this training. Although this training will take inspectors away from their jobs for 3-4 weeks, I solicit your complete support in encouraging their participation in this training because it represents a critical part of our joint enforcement activity. If your policies currently restrict out-of-State travel, or otherwise deter the possibility of staff participation, I would hope that you could reexamine these policies and support us in this effort.

Another element of the President's proposal envisions the establishment of investigative or "ombudsman" units in the State to review and followup complaints made by, or on behalf of, nursing home patients. I would appreciate your having plans developed for establishing such a unit in your office. Some modification of Federal regulations and some Federal support may be necessary in this area, and I look forward to working with you on this.

Finally, there are other actions we will be taking to improve nursing home care. A study of long-term care is under way through which we hope to reexamine our national policy. Also being developed are short-term training programs for health workers—both professional and paraprofessional—who work with nursing home patients.

We are most anxious to assist you, as well as to receive assistance from you and your staff in a joint effort to improve the performance of Federal and State responsibilities. Please let me know if you have specific problems or suggestions. I look forward to hearing from you or your designee.

Sincerely yours,

MERLIN K. DUVAL, M.D.,
Assistant Secretary for
Health and Scientific Affairs.

Mr. VENEMAN. Also a memo from the Secretary to the regional directors which also directs their role in the nursing home issues. These have already gone out. These are October letters.

Senator Moss. Very good, we are glad to have those documents.
(The document referred to follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
October 28, 1971.

Memorandum to: All Regional Directors

From: The Secretary.

Subject: Your Role in Departmental Nursing Home Initiatives.

On August 6 the President announced an action plan designed to upgrade the quality of care given to the Nation's elderly who are confined to nursing homes. We have been working since that time to design a broad departmental effort which is responsive to the President's plan. Many of the elements of our new initiatives have begun, and most of you are generally aware of some of these. The regional offices must play a key role in the execution of all of our initiatives in this area.

Because of the importance of obtaining prompt and effective results in this multi-agency effort, I would like you personally to assume the regional responsibility for its timely execution. You should make sure that there is full cooperation and coordination among the participants and act as a regional point of authority and accountability. I suggest that you appoint immediately a regional coordinating committee composed of yourself, your ARD for Health and Scientific Affairs (where one exists), and the relevant Commissioners of SRS, SSA and the Regional Health Directors.

I have named Dr. Merlin K. DuVal, Assistant Secretary for Health and Scientific Affairs to direct all activities in the Department which relate to enforcement of nursing home standards. Dr. DuVal is thus the "focal point" which the President ordered in his August 6 statement. He is, as the President said, the

single individual who is "accountable for success or failure in this endeavor." Thus, all overall direction and final decisions in our activities relating to nursing homes will come from Dr. DuVal, and you will report directly to him for this special effort. He will be communicating with you directly from time to time to give you details of new or expanded program efforts, and if you have problems which cannot be worked out at the regional level, he should be contacted. Dr. DuVal will of course coordinate very closely with Mrs. Hitt on all his contacts with you.

Agency plans have already been developed under Dr. DuVal's supervision. These, specifically, include:

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

HSMHA's regional staff, particularly staff from CHS and NIMH, have been made available to the SRS Regional Commissioner in support of the immediate enforcement activities related to Medicaid standards improvement. In addition to serving on the teams which are now beginning to visit the State Medicaid and survey agencies, HSMHA's staff would be available to be assigned on a short-term full-time basis to State agencies, provided certain criteria are met. The RHD has authority to assign these staff persons and will discuss the criteria with you. The purpose of the assignment would be to provide immediate support to a State which was found to have serious program deficiencies which it could not overcome with its own resources.

In addition, HSMHA has the lead agency responsibility in two efforts which will rely heavily on regional inputs. These include: (1) The training of 2,000 State surveyors in the next 18 months. Regional staff of HSMHA will take the lead in working with the States to recruit the participation of State personnel in the training programs and to follow-up on the training. Your assistance in working with the Governors of some States which have policies that impede surveyor participation in the training may be requested. A coordinator for surveyor training has been named by your RHD. (2) The provision of short-term training for professional and paraprofessional staff who work with nursing home patients. The curriculum development aspect of the professional training will be handled by HSMHA's central office. However, national professional organizations will develop regional prototype seminars which can be then carried out through the State affiliates of the national organizations. Regional staff of HSMHA will be expected to carry out this work with regional and State organizations.

Finally, HSMHA has the responsibility centrally to develop the basis for the State investigative units which would handle complaints made by or on behalf of nursing home patients. The immediate plan will be to develop five demonstrations of how this might be accomplished. Therefore, some regions may become involved in this effort either through encouraging States to bid on the demonstration contracts or through monitoring of the contracts once awarded.

SOCIAL AND REHABILITATION SERVICE

SRS Regional Offices will execute a number of immediate steps as the first phase of enforcement activities regarding skilled nursing homes participating in the Medicaid program. SRS Regional Office teams, supplemented by Regional personnel from HSMHA and SSA, began visiting each State in the Region on October 18 to assess Title XIX agency compliance with SRS regulations governing the skilled nursing home certification process in three key areas: (1) formal arrangements with the survey agencies for application of standards and for reporting; (2) evidence of Title XIX agency action on survey findings; and (3) use of time-limited provider contracts with proper documentation. Records and procedures of the survey agency will be examined, and site visits will be made to sample participating facilities for purposes of supplementing State agency compliance information. Reports on compliance status and follow-up steps will be submitted to the Administrator, SRS, by November 15, 1971. Established SRS compliance procedures will be instituted with those States when evidence of non-compliance is identified. SRS would be prepared to move toward conformity hearings where negotiations with the State fail to resolve the issues.

SOCIAL SECURITY ADMINISTRATION

As its part of the departmental effort to implement the President's initiatives on improving nursing homes, the SSA is taking the following actions: (1) through

budgeted increases in regional office and central office personnel SSA will expand its program review and end-of-line effort significantly. This will enable the agency to maintain a tighter control on the activities of State agency certifications of providers of service; (2) significantly strengthen the ECF conditions of participation to place greater emphasis on the actual care being rendered to patients; (3) institute a system for assuring that the State agency is following through on a timely basis with a nursing home which fails to meet one or more important Medicare health and safety requirement to determine whether the facility has taken corrective action; (4) provide increased financial support to the State survey agencies to assure that they are adequately staffed to carry out the Medicare survey responsibilities; (5) step up significantly the number of direct surveys of nursing homes by Federal surveyors operating out of the central office and the regional offices; and (6) make available trained personnel to SRS for the regional teams assessing Title XIX agency compliance with SRS skilled nursing home survey requirements.

All of these individual agency plans and your overall regional direction should impact substantially on the quality of nursing home care in this country. I believe that this program is of the highest priority and I hope that you will regard it similarly in the coming months.

Senator Moss. Senator Gurney was pointing out that that comprehensive review of nursing home utilization standards is a study of a long line of studies. Don't you think we have enough data already?

Mr. VENEMAN. I think it is narrowing down, Mr. Chairman. As a result of the activity that has been going on in the past we have been able to, or we have narrowed down some of the problem areas. In fact the Medicare fire and safety standards which were just published in the Register indicate another area that has been narrowed down. I don't think we can just turn our back on the whole field of institutional care for the aged and say that we have solved the problem.

I do think there is a need for continuous study but I think it has to be the kind of study Senator Gurney pointed out, that keeps up with some recommendations.

Senator Moss. In any studies that you make I would suggest return on investment profit and costs in depth be ascertained. I don't know whether you have seen the Connecticut study which asserts that the average return on investment for nursing homes in that State is 44 percent.

Do you have any comment on that?

Mr. VENEMAN. I think it is too high. That would be my comment. I am not familiar with the study but I think we have attempted to take care of that problem. If I can find it, one of the provisions in H.R. 1 simply requires that any institution is to provide in advance their budget for the coming year. Am I fairly close on that?

Mr. HESS. There are a couple of provisions in H.R. 1 that address themselves to this. One was a provision that was introduced by the Senate last year that attempts to set guidelines for Medicare reimbursement in relation to Medicaid reimbursement and addresses itself to the question of the assumption that there ought not be such large differentials between the cost of providing care under two types of programs or between the costs of providing care from one institution to the next when the level of service is approximately the same.

Senator Moss. I think we all agree if that percentage is accurate, that this certainly requires some careful scrutiny.

Second, 207 of H.R. 1, that is the Federal matching grant goes to patients and State mental institutions by 33 percent after a patient has been in there for 90 days. After the patient has been in the State

mental institution for 365 days in his lifetime he is no longer eligible for Federal matching grants. By this proposal the States, it seems to me, are on notice that once a patient has been in a State mental hospital for 365 days he becomes totally a State responsibility.

Under these circumstances, isn't it likely that the States will accelerate the present programs to get patients out of mental hospitals and into nursing homes that they could take advantage of the Federal matching?

Isn't it likely to increase the State nursing home problems and result in less service for patients since very few nursing homes have psychiatric services at the present time? What precautions does the Department anticipate on this, or have you taken it up?

MR. VENEMAN. We have taken this into consideration. There are two sides to this. First, I think there has been a trend and I will speak from personal experience, if I may.

I was involved when I was a member of the legislature in California during the period when title XIX was implemented. Two things occurred during that period of time. One was a trend to move mental hospital patients into other kinds of facilities because, as I refer to in my opening remarks, there has been a tendency to warehouse. There is evidence that with new medication and new procedures many of the patients in mental institutions could be adequately cared for in the nursing home in many cases in the home itself.

In reality the population in State mental institutions could decrease rapidly.

On the other side of the coin, many of the patients that remain in the institution—the State took advantage of the fact there was some matching money out. I think what we are saying by this amendment of section 207 is that, yes, we will agree that we do have some responsibility for mental patients admitted to a mental institution but only for a given period of time and we also say that after the 60 days if they can show that it is necessary to keep a person in there to have effective therapeutic treatment, that this can be extended. There is a limitation on the total lifetime of that patient. What we are saying is we pick up the first part and then the State goes back and pays 100 percent as they did prior to enactment of Medicaid and Medicare at which time these people were 100 percent the responsibility of the States.

I think we have done two things. One, encourage the movement of patients outside of mental institutions who belong outside of this kind of institution. The second thing is with regard to an unwarranted movement of these people in nursing homes. I think the limitation there on nursing home care is 60 days. So there is no advantage.

Senator Moss. But what about this business of gravitation? Are you saying that because they are limited in the nursing home entitlement to 60 days there would not be this gravitation?

Mr. VENEMAN. What I am saying is that in either case it becomes—

Senator Moss. The Kennedy amendment of 1967 requires the licensure of nursing home administration. The statute calls for these licensure boards to be representative of all health professionals. Nursing home administrators presently dominate the licensure boards in more than 20 States.

Because of what I regard as erroneous interpretation of the statute, there have been some rumors that HEW has recognized this responsibility and will revise the regulation of domination of the boards by nursing home operations.

Is this about to take place? How long should we wait for a regulation?

Mr. VENEMAN. It is my impression it has taken place. I remember the regulation coming across my desk but I will let Mr. Twiname respond.

Mr. TWINAME. This regulation, Mr. Chairman, has been published in the Federal Register as a proposed regulation, just as you cited it.

Senator Moss. The time is running now then.

Mr. TWINAME. Yes, sir; we are getting responses to that.

Senator Moss. I am glad to hear that. That updates one of our problems.

ENLARGE TRAINING PROGRAMS IN CARE OF NURSING HOME PATIENTS

One of the major problems we have in the nursing home field is absence of a physician from the nursing home setting. One of the recommendations of the interagency committee of Secretary Richardson was a proposal to pressure medical facilities, or medical schools to enlarge training of doctors in care of nursing home patients. I understand this proposal is being held up within HEW for further study. Can you tell me about that?

Mr. VENEMAN. I don't know whether it is being held up. I will let Dr. DuVal respond.

Dr. DUVAL. I don't know of this but we may be able to develop that answer for you.

In part the short-term training courses that we will be mounting are going to be given in the field in order to educate all persons who work in and around nursing homes. These will be 3- to 5-day courses mounted in the field jointly with the effort of the local chapters of professional organizations, academic medical centers and medical schools to help train physicians, nurses, nurse aides, dietitians, anybody who works in a nursing home environment so they will have a greater comprehension and understanding of the needs of a person in such home. We think as you do that this is an area where we have not perhaps brought forward all the information that could be useful to persons in such nursing home settings.

Senator Moss. My question arose from an article that appeared in the Senior Citizen News which quotes Mr. Newman as saying, that it is being held up pending further study. That is the reason I was asking about it.

Mr. NEWMAN. Mr. Chairman, as you indicated, an interagency group was formed a year ago to look at some of the problems. The group's response to the problems is reflected in a series of initiatives which have already been presented. These include the recommendation with regard to physician training in the context of short-term training efforts. It is my understanding that this is receiving consideration in the Health Services and Mental Health Administration as part of the general effort to train professionals who deal with nursing home patients.

Senator Moss. One of the biggest problems in the nursing home field is getting physicians to see nursing home patients. For this reason we wrote into the Medicaid law the requirement that Medicaid patients must be seen by a physician at least once a month. This was recommended as a minimum because we know physicians should see patients more often than that. This being true, one has to wonder about the perversion of this requirement by Medicare. Medicare regulations presently tells physicians they will not be paid for more than one visit for nursing home patients or if the physician wants to be paid for more than one visit he must justify the visit in writing. I wonder about the logic of this kind of regulation.

UNNECESSARY VISITS TO PATIENTS

Mr. Hess. I don't believe they are inconsistent. We have the Medicare regulation which requires that extended care facilities must have each patient under the care of a physician so that the patient will be seen at least once a month. The guidelines that were issued to carriers, that have to do with justifying more frequent visits have to do with domiciliary and institutional visits generally. We found out in some places physicians were making what seemed to be an excessive number of home visits and institutional visits to one or more patients and we felt that where such a pattern existed the carrier should make certain they were medically justified. There has been some misunderstanding as to the flexibility of that policy which we issued but it was not meant to qualify or cancel out the basic requirement.

Senator Moss. Doesn't it place an extra burden on the physician if he must justify his visiting more frequently?

Mr. Hess. It places a burden on the physician insofar as having to produce, in connection with his bill, some very brief statement that indicates the nature of the patient's condition. This would really have an important cost control on the policy as I said, was generated after considerable medical advice that it had to be instituted. It places the responsibility on the carrier to make sure that we don't get gang visits and excessive frequency of visits by physicians who are simply visiting people in custodial situations.

In determining whether to request additional information from a physician the carrier can generally assume that an ECF admission is keyed to having had an acute situation from which the individual is recovering or perhaps a terminal situation where the individual has been in the hospital and then is moved to an ECF.

The carriers are not disposed to apply the criteria of justification in the same way where they are dealing with a postacute hospital situation as where they are dealing with a physician who claims repeatedly, maybe once a week, billings for somebody who has been residential in a custodial situation for a long period of time.

Senator Moss. You testified, Mr. Secretary, about the President's proposal for training 2,000 new nursing home inspectors in the next 18 months. Am I correct that the present training facilities only exist in three universities with a 4-week course and have trained a total of only 255 inspectors in the year the program has been in operation?

Mr. VENEMAN. I think your figures are correct, Mr. Chairman. We would propose these courses would continue. We would propose three

additional universities be involved in these training courses initially.

As I remember these would be selected on a geographic basis. Consideration is being given to the University of Maryland, University of California and the University of Chicago, who meet the criteria for this type of training which would give us six.

Dr. DuVal, would you elaborate?

Dr. DuVAL. The figures are correct as you have both quoted, give or take a few. We are expanding very substantially the course enrollment of the three existing universities as well as doubling that by adding three additional universities, such that by the end of this year we would have trained 1,225 and by the end of June an additional 750 to reach at least 2,000 by next February.

Senator Moss. Have you given consideration to the alternative of taking the course into each State, perhaps with some Federal instruction, rather than transporting these people across the country to universities?

Dr. DuVAL. We have considered that as one of the alternatives before selecting the route that we have selected because we have experience with the one we are now using and we felt we could get there more rapidly by this route. But I think anytime we are able to show that we could do it more rapidly and more effectively that way, we would do that as well or in substitution of the route we have chosen.

Senator Moss. Thank you. I am happy to have my colleague on this committee, the Senator from Illinois who has taken quite a leadership part of this problem of long-term care and other problems affecting the elderly. I would like to give him an opportunity to ask some questions or make any comment he would like to make.

Senator Percy?

Senator PERCY. Mr. Chairman, since you and I have visited some of the nursing homes in Chicago together, both good and bad, I have continued those visitations on an unannounced basis, and I have found the same conditions continue to exist, some good and some bad. I feel that this legislation and request for money by the administration is urgently needed. I did sit at the appropriations subcommittee meeting when Dr. DuVal made his presentation, and I can say before this committee that I feel the administration has addressed this problem in a very forthright manner and I fully support its efforts. I was impressed by the intensity of feeling the President conveyed to me and to Dr. Arthur Flemming when we were in Chicago making an address to a senior citizen's group, the AARP-NRTA.

I commend this effort on the part of the President to upgrade nursing homes, and I will support the appropriation request fully in the appropriations committee. These hearings that we are holding this morning will be extremely helpful to me in putting together arguments that will help support that appropriation request now pending before the committee.

I do have some questions, just to clarify and to further strengthen our hand as we request funds and support what the administration now intends to do.

REGULATORY CHANGES

Dr. DuVal, in recent testimony before the Senate Appropriations Committee, mentioned that, in addition to helping States set up in-

vestigative "ombudsman"-like units, the administration would also make "regulatory changes under Medicare and Medicaid to help assure patient rights."

What specific "regulatory changes" under Medicare and Medicaid does the administration have in mind?

Mr. VENEMAN. I think I will let Mr. Hess respond to that. I cannot specifically say what administrative options are available at the present time.

Mr. HESS. Senator Percy, we have a process that is going now of updating all of the health and safety requirements for participation in Medicare. We have two things in mind. One is to get greater consistency to the extent that this is feasible between the various conditions that apply to hospitals and extended care facilities and home health agencies so both surveyors and providers will have less confusion by the fact that there may be small nuances for requirements that are essentially all geared to the same objective.

Secondly, we had very much in mind attempting to conform to the fullest extent possible to Medicare and Medicaid regulations.

For example, we are now moving to have the same provision under Medicaid that have to do with disclosure of ownership. We also recently published a regulation that requires that physician owners of hospitals and nursing homes cannot serve on the committees that review long-stay cases and patterns of use—so-called utilization review committees.

We would expect under our new regulation to conform Medicare disclosure of ownership requirement with the one that is Medicaid. Similarly we have a set of conditions that has to do with licensing of administrators with utilization review, infection control. Social Service, and the requirement that there be a physician identified as the principal physician for the facility.

As I say, our objective here is to try to give the State surveyors and the providers, to the extent possible, a common set of standards and then we support the provision in H.R. 1 which will require that a single agency in the State, probably the health agency, the one that is designated to make the Medicare certifications, also will be the instrument that is used for the title XIX certification.

We can accomplish all of those things notwithstanding the fact we are dealing with two different pieces of legislation. We will have come fairly close together.

Mr. NEWMAN. Could I amplify for a moment?

My understanding was that you were asking somewhat narrower questions which had to do with the establishment of investigative units and the possibilities within the Department for developing regulatory efforts to carry through.

The President's statement in August was:

I have also directed the Department of Health, Education, and Welfare to assist the States in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual nursing home patients.

That statement is elaborated upon. Dr. DuVal, I think, has indicated there are demonstration efforts underway in several States. It would be our expectation that with regard to Medicaid programs, depending on the results of those demonstration efforts, we could

require through the issuance of regulations, that each State's Medicaid plan include provision for such an investigative unit. This would be the specific method by which investigative units could be established through regulation in Medicaid.

Senator PERCY. Dr. DuVal also mentioned at that time in his testimony that the administration would be working with consumer groups. That is a rather broad term. I think the Senior Citizens groups would be particularly reassured if it were perfectly clear that they were to be included in the consumer groups the administration intends to work with in connection with these investigative units.

Mr. VENEMAN. They would definitely be one of the major consumer groups that we would want to work with in any efforts in this direction, Senator Percy.

Senator PERCY. As part of its eight point program for improving nursing homes, the administration plans to begin :

A comprehensive review of how long-term care facilities are used, and standards and reimbursement mechanisms and practices of nursing homes.

For the record when will the study get underway and who will lead the study.

Mr. VENEMAN. Pieces of the study are coming into view now because it has been started in the absence of setting up a full-time chairman. The full-time director would be Mrs. Mary Callender who will be arriving at work with me in my office from the University of Connecticut within the next 2 weeks and whose appointment was announced.

Senator PERCY. It will be under your direction ?

Dr. DUVAL. Under my direction and she is a very experienced nationally known figure in this field who completed a major study of the same kind for the State of New York. She will chair the study.

DESIRED TARGET DATE

Senator PERCY. What is the target date for completion of the study ?

Dr. DUVAL. As rapidly as we can assemble the data. We believe the material that will come forth is going to be useful and should be translated into appropriate action and, where necessary, legislation.

Senator PERCY. Could we be more specific as to what might be a reasonable target date ?

Dr. DUVAL. Within a year.

Mr. VENEMAN. I think it is fair to say, Senator Percy, a year or so ago when we gave the charge to Medicaid task force, we asked that they provide us with interim reports and, if they did come up with some recommendation that could be made and concurred in by the Secretary either administratively or as an amendment to a piece of legislation or new legislation, we asked that that be done. I would presume—and perhaps Dr. DuVal may respond to this—by saying it will happen. I would presume that this task force would also perhaps come up with obvious modifications that should be made during the interim prior to the submission of the final report.

Senator PERCY. I should think that would be helpful. I know from our standpoint we would be most anxious to cooperate.

Does the administration anticipate it will be necessary for Con-

gress to pass any new standards for nursing homes, or have we reached the point where we have enough standards and it is just a matter of finding ways to enforce those existing standards?

Mr. VENEMAN. There are some new modifications that would be required and changes that have been suggested under H.R. 1.

I would like to have Mr. Hess respond but I don't think it is a static thing, Senator Percy. That would be my judgment.

Mr. HESS. If I can hark back to a comment that the Secretary made earlier with respect to intermediate care facilities, Senator, the provision of H.R. 1 would make it possible to not establish new types of standards but rather to apply the Medicare-Medicaid type of requirement to an entire set of institutions which do not now come under Federal standards.

Maybe Mr. Newman would want to comment on that. This is with respect to possibly as many as 5,000 to 7,000 or more so-called nursing homes or homes that call themselves nursing homes that do not now come under Federal standards.

Mr. NEWMAN. I would add one other legislative request: The amendment to H.R. 1 which would provide 100-percent financing by the Federal Government of the State inspection costs relating to surveying nursing homes for Medicaid. That has been mentioned and is being put forth as an amendment in H.R. 1.

As to whether the need is primarily for stronger standards or for stronger enforcement of existing standards, I would, in general, subscribe to the latter alternative. We feel with regard to Medicaid that there is an adequate body of law and regulations. Adequately and meaningfully enforced, this body of law and regulations, can bring significant improvements in the nursing home field.

Senator PERCY. In this study and review that is to be made—it is to be a comprehensive review—I certainly concur with the need for looking at those aspects of it that I know will be underway, standards, reimbursement mechanisms, and practices of homes.

I would like to just mention a few things that grew out of our hearings in Chicago, to see whether you can tell me for certain that these aspects and these problems will also be studied. With respect to the alleged misuse of drugs on nursing home patients, you know we had a GAO report. We asked to see how much was being spent on drugs, on sedatives for instance, and there seems to be no question but that there is a common practice among certain nursing homes to use drugs in such a way as to make the patient almost immobile, tied to the bed. If the patients develop bed sores the homes get extra money because the former are confined to bed. Presumably they require extra care but they don't get extra care if constantly kept under sedatives. That inhumane practice, I think, must really be exposed and blown out of existence.

Will the comprehensive study include a review of the evidence we have already accumulated and take it into account?

Mr. VENEMAN. I think it would go beyond just the study. I think what we get into here are two other things; that is, what I was speaking to partially in the testimony. One, is making sure that we have appropriate utilization and guidance in the institutional care facilities regardless of which one they are, nursing home or extended care

facilities or whether they are the hospitals themselves. One of the most difficult problems we encounter in any kind of health program is adequate means of utilization and review. There have been suggestions and amendments put into H.R. 17550, Social Security Amendments enacted by the Senate last year as well as H.R. 1.

We are making recommendations for additional utilization review controls in the existing bill but these are the kind of things you run into when you have a very, very small percentage of practitioners and providers who take advantage of the system. And that is really what they are doing.

Now, I think that by having more of a presence in the field you are able to find out what is going on, both from the standpoint of standards and meeting Federal requirements and from the standpoint of utilization review, how they treat patients, how they prescribe drugs, and to what extent prescriptions are being handled properly. I would say that these would also be included as a significant part of any study that is being made with regard to the provisions of care in skilled nursing homes or extended care facilities.

Mr. TWINAME. I think I should add to what was said that from the medical review, included in Senator Moss' amendments, we have now developed a comprehensive set of guidelines which are under final review. Next year with the issuance of those guidelines, the presence of our people in the field to set up teams to see that they actually get into nursing homes on a minimum of once a year basis to review this kind of practice will be a significant step forward for us. We welcome that opportunity.

ALTERNATIVES TO NURSING HOMES

Senator PERCY. I want to emphasize the importance I attach to the administration's intention to study alternatives to nursing homes. As we know, nursing homes are very costly, and once a person is committed to a nursing home he frequently does not move out. In any case we must try to improve the quality of homes, of course. But taking steps to find other, more humane, better socially adapted alternatives I think would be exceedingly important.

I would like to ask whether you attach importance to such relatively low-cost programs as supplementary feeding programs? We have a nutrition for the elderly program which, as you know, we almost lost. We came within a couple of days of losing it for lack of \$1.7 million. The Secretary of HEW, Elliot Richardson, made the decision: "We are going to save that program."

We got the money and with a good deal of cooperation from the floor of the Senate we saved the program. I have visited a number of these nutrition centers for senior citizens around the country, particularly in Chicago. But I asked Dr. Arthur Flemming to visit some with me in Washington, D.C., and to see first hand what these programs are doing.

The participants in these programs pay about 25 cents for their meal, and this meal can cost around \$1.67. The cost to the Government is less than a dollar and one-half a day. People found what they missed and what they sometimes finally turned to nursing homes for, was companionship, the ability to be with other people, the desire

not to be left alone, or abandoned in a backroom some place feeling left out of the whole mainstream of human activity.

There is a great therapeutic value on participants in this group feeding program. In the center I visited here in Washington there were 25 to 30 people there—one woman explained if her friend was missing, they would get Jessie on the phone or go see her: “Why aren’t you down here?”

“I don’t feel well today.”

“Come on down. You will feel better down here with us.”

And soon Jessie would feel better about her ailment when she got a hot meal and some companionship.

I wonder if we should take another look at S. 1163, which has been opposed, and which is designed to set up nutrition programs on a more permanent basis. We have had 4 years of study. Every single person I have ever gone with to visit these programs comes away impressed with the low-cost and the high-value of the program.

To think this Nation does not have the money to just give one meal to elderly people who otherwise simply would not get that kind of meal, to me is a wrong sense of priority. So, again, as part of this comprehensive study, I think we should take another look and really see if we cannot find the justification for this as a higher priority item than we have to date.

Mr. VENEMAN. I think the concept you have described I concur in as I have expressed in the closing part of my statement this morning. I feel very strongly that we have to find alternative ways of taking care of the aged people other than institutional care and particularly those that lack resources or family.

Now, to speak specifically to the bill that you mentioned, I am not familiar with it but I can say that the principles that you have described, they are the kind of things that can be provided under the Social Security Amendments of the Social Security Act, I think at the present time. H.R. 1 specifically cites these kinds of services. I really feel that one of the big challenges we have is to identify the level of need of the people in this country and put them in the appropriate institution or facility for the kind of care that they need.

TOO MUCH WAREHOUSING OF AGED PEOPLE

I think, as I mentioned in my statement, I think we have seen too much warehousing of aged people. I really feel, based upon some of the discussions that I have had with Dr. Arthur Flemming and his staff, that this will be a major consideration during the White House Conference on Aging discussion in December. This whole idea of what do we do, what are the alternatives to institutional care. I think that will be one of the major considerations of the Conference.

Senator PERCY. Although I will mention additional areas of need, I want you to know I am delighted with your response, Mr. Secretary. I want it clearly on the record that the year’s commitment you gave to get this comprehensive study finished was made prior to adding anything to it. So, if we add additional subject, some leeway may be required. It would be unreasonable for us to have a promise from you to finish the study within a year and then start adding a lot of things,

unless you are able to add some staff. But I think that would be very helpful to have information on these other areas.

Now, again, I am impressed as I visit university campuses with the concept of student center. I have not found a university yet that could not justify a student center and feel that it does a tremendous amount for the social well-being of young people to have a place to get together, to socialize, visit, eat together, whatever it may be. This is why some people go to St. Petersburg, because they can be with older people. They have facilities for older people. They cater to them. Of course, not everyone wants this kind of set-up. Nor can everyone do that. The concept of senior centers, I think, is not a revolutionary or radical idea. Every place we have them they are bulging to the walls and providing ways to help people, giving people in their later years a greater sense of enjoyment and taking away their loneliness.

Can we try in this study to develop a real commitment that the Nation might make over a period of years, to develop the same kind of physical facilities for senior citizens that we have found so helpful for our younger people?

Mr. VENEMAN. We can but I think it is fair to point out that this is already under consideration. Secretary Richardson is chairman of a subcommittee of the Domestic Council on the problems of aging. Much of his work in the Domestic Council Subcommittee is trying to gear itself up for the White House Conference and for legislation next year. One of the studies they have underway is this question of developing programs for conglomerate housing and living situations for the elderly people. Secretary Romney is a member of the committee as is Secretary Hardin. So it will be looked at from a perspective of interdepartmental interest and concern. I think most of this would be in Housing and Urban Development but it is something that is presently being taken under consideration by the Domestic Council.

Senator PERCY. Would the study embrace better housing alternatives for the elderly than we now have? For instance, a study of the FHA-202 programs?

Mr. VENEMAN. I cannot respond specifically to that. I do not know to what extent they are going into the optional housing. I assume it would.

Senator PERCY. Housing being very poor?

Mr. VENEMAN. Yes, sir. I can go this far, they recognize housing as a major component of an area need for the aged. What provision they get into, I don't know.

PROBLEMS OF MOBILITY

Senator PERCY. I find transportation among older people a grave problem. Local transportation. Older people lose their driver's licenses and public transportation fails them. They do not have the money for taxicabs always.

Can we include in the study the problem of transportation for elderly people and ways to bring the cost down for them?

Mr. VENEMAN. These are factors, housing, the possibility of some kind of conglomerate living situation, the problems of transportation—to what extent they should be dealt with in the study that will

be handled by Dr. Callender and Dr. DuVal. I have some apprehensions about making that study quite as comprehensive but I can assure you each of these points you have raised will be studied by both the subcommittee and Domestic Council and I failed to mention Secretary Volpe is also a member and this is one of the areas they are reviewing. I feel very safe in assuring you that these will all be studied by the White House Conference on Aging and, undoubtedly, recommendations along all of these areas will be forthcoming in time for legislative action during the next session of Congress.

What the administration's position will be on the recommendations is a little premature to say because we do not have them yet. But I do know they are all areas of interest.

Senator PERCY. I have a bill in, S. 1587 and I am trying to figure out how to eliminate it. We only put legislation in if we do not see any other recourse and, S. 1581 would be offered as an amendment to H.R. 1. The purpose of that bill is to provide and to eliminate the duplicative instruction processes that we have found in local, State governments and so forth.

Everyone was passing the buck in Chicago to everyone else. No one really seemed truly responsible. So this bill simply provides for the Secretary of HEW to make a feasibility study requiring as a standard for eligibility that one State agency have a responsibility for administering Medicaid programs, for licensing and inspecting long-term-care facilities.

I could eliminate the bill if we had assurance from you that we could include this as a part of comprehensive study.

Mr. VENEMAN. I think what you are trying to do is a provision in H.R. 1. I think we would require under H.R. 1 that a single State agency have the responsibility for both title XVIII and title XIX recipients.

Mr. TWINAME. That is correct and it would be the health agency so named in that amendment to H.R. 1, so the inspection for both Medicare and Medicaid would be accomplished in one inspection process. And moreover, as this committee has cited before, the need is to get Medicare and Medicaid regulations as internally consistent as possible under the law in these two titles of the act.

I feel we made real progress on that. With this accomplishment in H.R. 1, it should clear up the confusion. One of the regulations provides for a utilization review for Medicare and Medicaid at the same time, so we avoid what I think you are getting at, a nursing home administrator being called on twice in the same month by different people. We have made progress in cleaning that up.

Mr. VENEMAN. I think H.R. 1 does more than reform welfare assistance. So any assistance we can receive from this committee expediting reporting of H.R. 1 will be greatly appreciated.

JOINT SURVEY FORMS

Mr. NEWMAN. May I add as a postscript that we are currently developing joint survey forms so that the inspection for both Medicare and Medicaid could be done by the same inspector at the same time with the same form. In addition to that we have currently underway, as Mr. Veneman mentioned in his opening statement, an in-

tensive effort at the State level to clarify the responsibilities of specific agencies for inspection and certification. Certification is by law the responsibility of the single State agency regardless of delegation to another agency of the responsibility for inspection and inspection reports.

So I think in response to your question that there is identified within the State a specific focus of responsibility.

Senator PERCY. Senator Moss mentioned the problem of uniform standards and definition of levels of care. I would like to reinforce what he had to say and fully support the position he has taken. I introduced a bill, S. 1586, to have a study to see if we could establish such uniform standards.

I much prefer that, rather than legislation we have the administration adopt the necessary regulations. I am delighted that there is an indication from the Secretary that the administration will move ahead on this proposal and through executive order, as part of its comprehensive review, see if we could not have uniform standards adopted by as early as next spring.

Mr. VENEMAN. I think we can to a certain degree, Senator Percy. As I mentioned earlier I think one large gap that we do have in the institutional facilities that is not covered is the intermediate care facilities. In order to establish some uniform standard for that kind of facility we will have to have legislation which is also incorporated in the Social Security Amendments. But as far as the others are concerned we can and have been moving toward uniform standards.

As far as time frame is concerned I would not want to commit Dr. DuVal or Mr. Twiname. Mr. Hess has as much involvement as anybody to determine whether or not that can be done by spring.

Mr. HESS. I think it is ready to go to the extent it can be done under existing legislation. As we indicated there are quite a few points we have already made considerable progress on.

Mr. NEWMAN. I would like to add a caveat to that. There are many aspects to the question of levels of care, including as far as I am concerned, the problem of treatment of patients with regard to drugs that you mentioned earlier. We must think in terms of a cluster of related problems, it seems to me. A regulation or guideline defining a level of care should take cognizance of the fact that adequate alternative facilities are crucial to the solution of the problem. We have reports, GAO reports and other reports, which indicate that substantial numbers of patients who are in nursing homes appear not to need skilled nursing home care. The response when one investigates is that there are no alternative facilities available. I would urge that we proceed cautiously although it is clearly an important problem that has to be dealt with.

I think that the issuance or the commitment to a date of issuance of a regulation without recognizing the related problems would raise other difficulties.

A QUESTION OF STANDARDS

Mr. VENEMAN. I am not quite as negative as Mr. Newman. I think it can be done. But I think one of the problems we have is in the public's eyes. We can have uniform standards and reach some conclusion and what should be the uniform certification procedures for skilled nursing homes and extended care facilities. But I cite again the

Honesdale, Penn., situation that occurred where this fire was. By Pennsylvania standards that was identified as a skilled nursing home. It was not eligible for Medicare or Medicaid recipients, but to the people in Pennsylvania that was a skilled nursing home.

That is where we are going to have our problems. We are going to have to somehow or other change the identity among the States. We cannot do it all on this level. This will have to be an educational process among people and among legislators within the State so that they identify their facilities according to our standards.

A lot of people are being mislead and left with an impression that they are getting "skilled nursing home care," when it is nothing more than a rest home of some kind that subjects them to the kind of problems that we have been discussing here today.

Senator PERCY. There has been a lot of emphasis on hiring veterans and we all want to do that. Does the administration see any way of hiring veterans with experience as medics in the field of long-term care? Either as "medical assistants," physician's associates, or as State inspectors?

Mr. VENEMAN. Very definitely. As a matter of fact Dr. DuVal handed me a paper on that very subject and I will let him talk to it. But I would point out that we do have a couple of programs going on right now which train returning veterans who have skills as pharmacists mates and the medics for transition into civilian occupations.

We feel that the paraprofessional, utilization of paraprofessionals in this resource—if you look at it, it was a lost source after World War II and the Korean war—we feel it could be very appropriately used as a means of filling the manpower needs in the nursing home and extended-care facilities.

Dr. DUVAL. It has been said too well by the Secretary but the point is we are very eager to increase very substantially the outreaching capability of the health profession and clearly the way to do this is to begin to tap the resources of persons who have some training in the field and continue to upgrade them.

Senator PERCY. I would like to ask another question, and I do so knowing we will agree on the answer, but I do so because the chairman and I, and members of the staff, have so many times emphasized that it is not just bodies that we need in nursing homes; it is a sense of commitment on the part of nursing home personnel that this is an important responsibility that they carry.

I would like to quote what the Senate Finance Committee staff had to say in a report issued February 1970:

While the Medical Services Administration probably requires additional personnel if effective Federal supervision of Medicaid is to be realized, it appears vital that any additional personnel—including officials—operate with a greater sense of responsibility and direct involvement than has been manifested heretofore. The MSA needs dynamic, concerned and qualified leadership and staff if a complex, costly and important program such as Medicaid is to be soundly administered.

This goes then all the way from the people in the immediate contact with the patients on the nursing home level straight up through the top level. I offer the comment and offer the forum to indicate your own deep concern and dedication to the selection of personnel for this field.

Mr. VENEMAN. I think it is essential that those who are responsible

for the supervision, development, enforcement and placement, of people who are going to be in these kind of institutions—that has to be one that consists of dedication to a single purpose. One of the problems we have is a problem of human nature, the fact that we do find those that get involved in virtually every field though allow this kind of dedication to be overridden by greed for one reason or another.

Now as far as appointees that we are responsible for, and I really will not accept an indictment of those people that are serving on the Federal level or on a State level that I have worked with, and I have worked with several who are involved in this area of taking care of patients in institutions, whether aged or any age, particularly those that come under public assistance programs.

I think for the most part, again, with few exceptions, they are very dedicated to solving the problem. I think one of the things that has to be recognized when it comes to medical service administration is the fact that in 1965 when Congress passed title XIX, you passed a massive program which said to States:

Come in fellows. You take care of all your poor and we will pay, essentially we will put up half the money. You come up with a program.

If my memory serves me right when title XIX became effective there was something like 35 people on the Washington level working in that program. It now extends to billions of dollars. Even now I don't think Mr. Newman has much more than 167 people that are involved in a program that expends billions of dollars for health care for the lower income people of this Nation.

Why did this happen? Because the intent of Congress was to work out a system where the direction was not coming from Washington or the Federal Government but where the direction was coming from the States. So what we ended up with is not one health program for the poor of this country but 48 programs for the poor of this country.

Two States still do not have any despite the fact that that statute does require it.

I think for what resources the Federal Government had I think they were extended further than anybody could responsibly ask them to extend themselves. I think there is room for improvement and I hope—the kind of dedication you talk about—that we can find a means of having that prevail.

“SUBSTANTIAL COMPLIANCE”

Senator PERCY. Regulations call for inspections of all homes every year and inspections of those in “substantial compliance” every 9 months. It has been recommended that this category of substantial compliance be eliminated. Could you give us an idea as to the status now of such homes which are in substantial compliance? How many are only in substantial compliance, and if any are not in full compliance, how do we make this fact available to the public so that someone is not duped into thinking he is going into a home that is in full compliance?

Mr. VENEMAN. We have submitted a table for the record earlier in the day. But I would like to simply comment about the general question that you raised. We are dealing first of all with a group of facil-

ities which are one of the best in the country. The fact that we have out of some 4,200 about 3,100 of them are said to be only in substantial compliance does not really mean that these are seriously deficient homes in terms of the health and safety of patients or the standard of good nursing care.

Approximately 1,100 of them are fully certified so that the surveyors in the State Health Department and Social Security felt that there was nothing that was even worth commenting on that could be improved or upgraded. Those that are in substantial compliance but that have deficiencies received comments on those deficiencies because we inspect with regard to a checksheet that has approximately 400 items that can be looked into.

These are sometimes items on which the surveyor makes an observation. He thinks there is room for further improvement. We don't like to give an institution a bill of health that suggests that there are not things that can be done better. We adopted this technique of substantial compliance in tabulation of these and now we have to live with the fact that we have an unsophisticated tabulation of checklists, unevaluated raw data that come in that indicate some deficiency ranging all the way from very incidental ones to ones that they really have to do something about within a period of 90 days or 6 months or else.

We are refining and improving the reporting system by developing a system that indicates deficiencies that are significant enough that people ought to know about them. But we also need to build into the system a way of avoiding the creation of a public relations problem for the institution in terms of people feeling that their loved ones are safe and they are in good care in the institution.

In connection with this revision and restructuring of the whole process of reporting we are getting ready again for a provision which we have been working out with the Senate Finance Committee which will make it possible to have on record in the regional offices and available to the public on request a current up-to-date list that not only says what the deficiencies are, if any, but indicates the time frame within which they have to be acted upon and has a followup to it.

One of the concerns we have had—and I express this concern now with the tabulation that we have put in the record with the statement that there are over 3,000 institutions that are in substantial compliance—is the fact that these are just tabulations of what appear on the inspector's checklist. We did not have the kind of system that enables us to continuously update. This is a very fluid situation. Something that appears on the checklist as a deficiency now may have been checked and corrected within a matter of a few months and yet it still can remain on the checklist as indicating a current deficiency.

So as soon as we restructure this, I think we will have a basis for the thing you expressed about making available to the consumer and the public a true picture of the conditions under which the nursing service and the other service are provided.

FALSE ADVERTISING

Senator PERCY. There is one other aspect of this problem which I think we should include in this study. A woman testified before our subcommittee in Chicago that her father had died after severe mis-

treatment in a nursing home and the nursing home even tried to charge her a fee for several days after her father had died.

When asked how she happened to select the nursing home, she said she did so by looking through the Yellow Pages and she picked out one that had a statement in its ad, "Medicare approved." Our study shows it never had been and was not at the time of the hearing, "Medicare Approved" as such. This of course is misleading. Can we take a look at this practice in the comprehensive review so the public will not be misled by this type of advertising?

We will be happy to furnish you a copy of that testimony. I do not know whether the nursing home still uses the "Medicare Approval" or not.

Mr. HESS. We would like to have that. I am sure there are not many of them but to the extent there are misrepresentations we can take action on them.

Mr. VENEMAN. Would that fall within the deceptive advertising—would that fall within the jurisdiction of the Federal Trade Commission?

Senator MOSS. Very likely; yes.

Senator PERCY. We will furnish this to you.

Earlier this year, in May, GAO published its audit report of nursing homes in Michigan, Oklahoma and in New York. GAO's conclusion was many of the homes its investigators visited are not providing proper care and treatment of Medicare/Medicaid patients. Many patients receiving the improper level of care should have been in different types of institutions or at home, and there was failure to meet basic Federal standards. There are weaknesses in State procedures, and ineffective State and HEW enforcement of Federal requirements—as well as inadequate attention from physicians, inadequate nursing attention and inadequate fire protection.

What followup action was taken by the Department after it received this report? What is the procedure here? Are we making good use of these GAO reports? Does HEW respond to the report but take no action?

Mr. VENEMAN. I think the followup action has been the substance of today's hearing. Not only of this report but a subsequent report that we initiated ourselves following the GAO report where we went to 15 States under Medicaid and we have moved in to 34 States that have been visited since October. In 1 month 34 visits were completed. We have 16 to go. We are moving really as far as I mentioned in my initial testimony, as far as Medicaid programs are concerned, we depend to a great degree upon State certification and the State inspections.

This is where we really have to move in and find out if in fact they are certifying according to Medicaid standards or whether certifying according to State license standards which makes quite a difference.

Secondly, I think out of that GAO report 44 of those were deficient in fire and safety standards. I think the action taken by the Social Security Administration moving toward life safety standards recognizes this kind of a problem. I think the initiatives that have been taken in trying to get more presence in the field, either Federal or State, is trying to combat the problem brought out in the GAO report.

Senator PERCY. I would like to say I consider the GAO reports quite valuable. I think there is a value in prompt follow-up action. I think as swift an action as possible would increase the value of these reports a great deal.

Mr. Chairman, I have found the administration's testimony this morning extremely helpful and very reassuring, and I deeply appreciate our witnesses being here this morning.

I would like to comment briefly on a rehabilitation center being built in Chicago, as the work of this center relates to the hearing. It is a magnificent facility for the physically handicapped. We went out to dedicate it the other day and HEW gave assurance that the funding would continue at the present level and would not be subject to a \$4.7 million budget cut. I think this center is a proper use of priorities.

Mr. VENEMAN. I hope you got that assurance out of OMB too.

Senator PERCY. I would tend to think they would agree that this area is one that is exceedingly important. We simply cannot afford to cut back. HEW has done a magnificent job in this area.

Thank you, Mr. Chairman.

Senator MOSS. Thank you, Senator Percy. You have by your questions enabled us to fill out our record and get before us a lot of information that we want to have as we consider this problem. I am going to ask if either of the staff members here have any points that they think we have overlooked that they might like to ask. We seldom get a battery of witnesses as knowledgeable and important as we have before us today and we don't want to overlook any opportunity to fill out any things in the record that have not been touched upon up until this point.

Mr. HALAMANDARIS. I have several questions.

Mr. Secretary, in your testimony you refer to 2,000 facilities that have withdrawn from Medicare program voluntarily rather than face termination actions. I wonder if perhaps that 2,000 figure does reflect, at least in part, the effect of retroactive denials and the industry's dissatisfaction with the program.

Mr. VENEMAN. I think the retroactive denial problem may have contributed. To what degree I don't know.

Mr. HESS. May I first put the 2,000 figure in the context of the total number of ECF's that we have had in the program. The certification of ECF is a dynamic process. We have new ones coming in and others dropping out or being terminated. I think the highest number that we ever reached was about 4,800. We now have 4,200 facilities so that there has been a net over time of approximately 500 to 600 facilities.

Many of those that dropped out were quite small institutions that came in the beginning of the program and that came in with deficiencies but with an initial opportunity to be considered in substantial compliance providing they took steps to up-grade. Some of them admittedly were disappointed by the numbers of Medicare patients or the circumstances under which they took Medicare patients. The problem of retroactive denials has concerned us and worried us just as much as it worried you and members of this committee and the public.

This came about as you may know from the fact that in the earlier

years of the administration program, intermediaries accepted and paid for bills of persons who were admitted to ECF care sometimes for extensive periods of time but that did not meet the criteria of the law, who did not need skilled nursing service for a condition under which these people had been hospitalized.

The ECF benefit under Medicare is a post-hospital, short-term benefit, not a general nursing home benefit, what we have tried to do in addition to a whole host of administrative steps to contain and minimize the problem of retroactive denials is to develop—we seem to keep coming back to H.R. 1 as the panacea for all our problems—but we have tried to develop a provision which is in H.R. 1. There was a difference between the House and Senate version last year but we hope that whichever version prevails we will be able to get over pretty nearly all of the circumstances that caused retroactive denial by having a statutory authority to provide physician certification that the individual needs to be in an institution which have available services of skilled nursing care.

Mr. HALAMANDARIS. Doesn't this come under the category of locking the barn door after the horse is gone?

Mr. HESS. I think what we have to remember is that while retroactive denials are a very troublesome problem and with respect to any individual a very painful situation, that the ECF benefit is working well as it was intended to work.

We have paid for, over the last 5 years or so, 100 million days of extended care. Although there has been some decline in the last 2 fiscal years I believe we have hit a point where it is stabilized. At any given day of the week, any given week of the year we are paying ECF benefits with respect to approximately 70,000 aged persons who are in a post-hospital state and we are paying these benefits in the neighborhood of \$250 billion a year.

From 1968 through 1969 and 1970 to the present it has dropped from about \$350 million to about \$250. But it is steady now and the intermediaries and the nursing homes have got a pretty good fix on what is extended care and what are the circumstances under which an individual can receive this care under Medicare.

And, now that we have a more extensive use of procedure that is a voluntary procedure—and that is the assurance of payment procedure, this has leveled out at the rate of 70,000 persons occupying these beds on any day.

Mr. HALAMANDARIS. I would like to request at this point a copy of the study which has been issued by your Department and referred to in your testimony. I would like to also request, Mr. Secretary, a copy of a document prepared by BHI, Social Security entitled "ECF by type and deficiency."

Mr. VENEMAN. We will be glad to submit that for the record.*

Mr. HALAMANDARIS. Let me ask you now, Mr. Secretary, if you would not mind giving us some sort of documentation on what is the total budgetary impact of the nursing home program beyond revenues, what is the Federal Government's total commitment to nursing homes in any year in the broadest meaning of the words?

* See appendix 5, p. 2055.

Mr. VENEMAN. How much does the Federal Government spend for nursing home facilities? Is that what you want?

Mr. HALAMANDARIS. Yes, sir.

Mr. VENEMAN. I can give that to you. For 1971, the Federal Government spent in total for all our HEW programs approximately \$1.4 billion out of a total of \$2.4 billion, so the State and local government spent \$1 billion.

Mr. HALAMANDARIS. Have we now included these Hill-Burton construction loans, SBA loans, et cetera?

Mr. VENEMAN. We have Hill-Burton construction grants but as far as FHA is concerned of course we recognize this is not appropriated money. These are guaranteed loans as in the case with the Hill-Burton loan. FHA nursing home guarantees for 1970, \$157.8 million into loan guarantees through FHA.

Mr. HALAMANDARIS. I have totaled up the Federal Government's commitment to nursing homes adding in such items as you just referred to, FHA insurance, and I came to a staggering amount representing our commitment to the nursing homes industry as far as we could identify it. We came up with a ballpark figure of almost \$2.5 billion in fiscal year 1970. I know of no other industry which is so wedded to the Federal Government.

Another question, Mr. Secretary.

How does the administration answer the arguments that these vigorous enforcement programs which are now being promulgated will seriously limit the number of nursing home beds and in the end, result in increased costs to the Government.

Mr. VENEMAN. We would hope that the result of the enforcement practices would not necessarily follow that you are going to limit the total number of nursing home beds. I think that can be assumed appropriately that there will be some that can not come into compliance, but again, I am not sure that you can anticipate whether or not there will be additional beds constructed to offset the number that we would lose by refusal to comply.

It seems to me that the net result of compliance is better care for the people and better facilities out in the field. We have to recognize also that in some communities—and I would say this is the situation throughout the United States—but in some communities we presently have a surplus of nursing home beds. Maybe some of those new ones will be put to use as the old ones that are found that have refused to comply are taken out.

Mr. HALAMANDARIS. Mr. Secretary, five out of six Medicare nursing homes terminated on October 5 have been in the program since January, 1967; since the beginning of the program.

I wonder why it took so long for these nursing homes to be thrown out of the program. What were the deficiencies and why has it taken so long to identify these particular nursing homes and what assurances do we have that the patients were moved to another facility which is conforming with minimum standards. Is HEW taking steps to take care of the people that were discharged from these facilities?

Mr. VENEMAN. I think the ones in Ohio had been put into certified care. There was one in California. I am not sure they did anything

about that. Why has it taken so long? I think that first of all you try again to get back to what Mr. Hess has pointed out with regard to Medicare. You try to bring the men to reasonable compliance.

I am not sure just how long these particular facilities had Medicare recipients, but the other problems we are confronted with are the split in jurisdiction between Federal and State government when it comes to title XIX patients.

As I recall, we have had response from two of the Governors who took the initiative to decertify these homes for Medicaid recipients. I will let Mr. Hess and Mr. Newman speak to the balance of this.

Mr. NEWMAN. The homes in question were participating in Medicaid. In Medicaid certification is the responsibility of the State. The Governors were informed by the Secretary that this Social Security Administration action had been taken the day before. In Ohio the two homes were put on notice that effective November 3 they would be decertified from participation in Medicaid.

Two homes in Michigan are appealing the decertification action and it is my understanding that State administrative law permits the continuation of the benefit during the process of appeal. In California as of yesterday, the report indicates that the State initially felt that the home met title XIX standards. However, the State Department of Public Health was yesterday resurveying, and as of this moment no action has been taken that I am aware of. That is the situation with regard to Medicaid. However, that was not, it seems to me, what the question was.

Mr. VENEMAN. I think that partially answers your question as to why it took so much time: if you go to the Department of Health and State agencies saying "We disagree—They do meet the Medicaid certification." These things in themselves are time consuming.

Mr. HALAMANDARIS. The President has asked Congress to assume 100 percent of the cost of State inspections. I understand that we are now going to have joint Medicare-Medicaid survey forms. My concern is: What assurance do we have that these inspectors that we are going to train will look at patient care as well as the physical environment?

In most States, the preponderance of concern in inspection reports is with the physical plant. Is the Department thinking about making sure inspections emphasize the proper care in nursing homes?

Mr. VENEMAN. Yes, sir; I think the kind of inspectors that we are talking about would go through the training program that was described earlier. I think this answers your questions, Mr. Chairman, when you asked why this was not done in each State.

I think what we have to do is develop the kind of training programs so when these people do go out into the field they are all approaching the problem with the same basic training, the same basic understanding of what to look for, and doing it in the university setting as we propose to do, gives them the opportunity to receive the kind of training that will give them an opportunity for some determination as to whether or not they are meeting the medical standard, as well as the physical standards.

But the real question is whether or not they are getting adequate treatment or appropriate level treatment or whether or not there is or is not over or under utilization in a particular facility.

WHAT IS MEDICAL REVIEW?

What do we mean by medical review? One thing doctors resent is for laymen to come in and say, "You are telling me how to practice medicine." It is a tough defense on the part of the layman. We can have basic criteria, obvious criteria, but when it comes to whether or not an appropriate drug has been prescribed, whether or not the patient should or should not be in the facility because of the purported illness, these are going to have to be done by utilization, medical utilization review.

Mr. HESS. I have one more point to mention on the survey process. It is true in some States that a surveyor may go on and attempt to cover the whole range of matters but in many instances we are really talking about a survey team. We are talking about specialists on the team which may include nurse consultants and dietary personnel who can come in either on call or who are concerned with the finalization of one aspect of the survey. Additionally the report of the onsite survey group is reviewed in both the State agency and by Federal staff at the regional level with respect to Medicare facilities to make sure that the survey reports contain evaluations that go beyond the physical facilities to the type of patient-care rendered.

Mr. HALAMANDARIS. This is one of the comments we hear from conscientious operators. That Federal people come in, they sit in the office and look through forms for 3 or 4 hours and leave the facility without inspecting the condition of the patients.

The question, Mr. Secretary, on location of ombudsman units that we have been talking about—I would like to see if you agree with me here that these ombudsman units would be more informative if they were independent rather than within the Health Department.

I think the agency would be more effective if it was independent. Would you agree?

Mr. VENEMAN. I would agree. I think a letter that the Secretary sent to the Governor recommended that this person be in the Governor's office as independent as he could be of the health agencies.

But the letter did not mandate, nor do I think we are in a position to mandate where this goes. I think we can make strong recommendations. I would agree that you do run the possibility of either real or unreal accusation that they are pawns of the Health Department. I think we do have to recognize that in some States with their executive branch organization plans you do have someone essentially that would be the equivalent of Secretary over prisons, welfare programs, institutional care or medical facilities and licensing and other responsibilities.

If a Governor were to detail it to this kind of individual I don't think it would.

Mr. HALAMANDARIS. My next question deals with disclosure provided to the committee from the General Accounting Office in their inspection of the Maryland nursing home system. They found out in December of last year that the State of Maryland, although it reimburses on a reasonable cost system under Medicaid, from the fiscal period 1967 to 1969 only two audits were made of nursing homes under the Medicaid program.

These were at the same nursing home in conjunction with audits of

the Medicare program. I wonder how many States are not making so-called audits and what is the Department's policy on that?

Mr. VENEMAN. The States are required to audit as we well know by the statute. I would also point out we mentioned 150 additional employees for the purpose of enforcement. I should also add we are recommending approximately in the neighborhood of 100 or so additional auditors for HEW, 34 in the supplemental request.

Now, this is the area where we really have been able to identify some of the problems we have had with title XIX programs within the States. We have a series of audit reports that have been forthcoming recently which gives us some idea of what is going on out in the real world, which will be most helpful.

That is the kind of identification we need in order to move in and make determinations first as to whether or not Federal funds should be withheld from a particular facility, additional facilities, and in extreme cases whether or not we should find the entire State out of compliance.

Mr. HALAMANDARIS. One of the suggestions that was made by the Nader Task Force and by others has been that HEW publish a rating system for nursing homes, or beyond that, that HEW and Federal Government should in some way make public State inspection of records and the ownership lists called for by the Moss Amendments of 1967.

In other words I am asking a disclosure question here. Is it your opinion that these lists should be made public? Should the public have access to inspection records, ownership lists and other documents?

Mr. VENEMAN. I have no objection but the question is, under what circumstances. When it comes to the question of deficiencies, I think there should be a period, when the State enforcement agency is working with the nursing home to get it corrected and the nursing home is cooperating, when the finding should not be made public. But after a reasonable period if the nursing home has not taken corrective action, then the deficiencies could be made a matter of record.

Mr. HALAMANDARIS. Your provision is essentially that expressed in H.R. 1, is that correct?

Mr. VENEMAN. What we say in H.R. 1 is essentially anybody that has an interest of over 10 percent has to be identified.

Mr. HALAMANDARIS. Yes, sir; in part.

Mr. VENEMAN. We are suggesting that the same apply to homes that provided Medicare coverage. If that does pass, if that information is available to the Federal Government then I think it should be a matter of public record.

Mr. HALAMANDARIS. I heartily agree with you. I would like to talk with you on a question you answered for the chairman. That is the specific provision of H.R. 1 No. 207(C) which in effect says after 365 days in a mental institution, an individual becomes no longer eligible for Federal matching funds.

Your comment was, mental health is essentially the States' responsibility.

Mr. VENEMAN. I say this without too much equivocation. I do feel that there is a limitation to just how long you go on with institutional care out of a Medicaid-Medicare title program. If we move into health insurance, that is a different matter.

But I don't think when we pass these kinds of programs that we are saying we are going to bail out State and local governments of all the responsibility for the care of the people in our institutions and they set the rules. That is really what happens.

As I pointed out earlier, I was involved in transition that took place in the State of California. My last figure that I recall the population in mental institutions in the State of California had gone down from nearly 30,000 people to somewhere around 18,000 people a couple of year ago, about the time I left.

Now, just from that it becomes obvious with a concentrated program a lot of people that are now confined in mental institutions do not have to be there. They can be home. They can be in nursing homes or a lesser kind of facility.

California has 20 million people—if my latest figures are correct, there are approximately 8 million people in Washington, D.C.—there are nearly 5,000 people in St. Elizabeth's Hospital; one third of the people institutionalized.

I say that progress can be made in moving people out of institutional type care. So when this amendment came forth I looked at it from a fiscal standpoint. I looked at it from the standpoint of providing motivation for States to start moving some of these people out of mental institutions. If you leave them there more than a year, it is your ball game.

Mr. HALAMANDARIS. Are you satisfied then, in your own mind these people that are increasingly going to be transferred from State institutions to nursing homes are going to have appropriate psychiatric services?

Mr. VENEMAN. I am satisfied that I have no reason to believe they would not have more appropriate care than they are getting in some of the warehouse institutions that we see in some States in this country.

Mr. NEWMAN. I'd like to add that the statute, title 19, section 1902(A) 20, subparagraph C, requires that if services to people over 65 in mental institutions are included in a State medical assistance plan, the plan must provide for development of alternate plans of care making maximum utilization of available resources.

Mr. HALAMANDARIS. Still talking about H.R. 1, does the administration still oppose the provision in the Senate version of H.R. 1 which provides for Office of Inspector General within HEW?

Mr. VENEMAN. Yes, sir.

Mr. HALAMANDARIS. The question is, Why do you find this inconsistent with the new departmental structure?

Mr. VENEMAN. Of course that is not in H.R. 1. That was in 17550 last year, the Senate version that went to the floor. That was Senator Williams. I think it was patterned after a provision that was required by the AID programs.

I think it is not necessary to set up within HEW an autonomous person who has the authority and the power to second-guess and prejudice the actions of the Secretary.

Mr. HALAMANDARIS. The new office would be sort of a big brother and big brothers are not necessary or welcome?

Mr. VENEMAN. I would not really look at him that way. I am not trying to be facetious. I think there is the necessity for department

oversight but I don't think it has to be done by giving a person, an individual within any part of the Government that kind of autonomous power described. I don't think it is necessary or desirable.

Mr. HALAMANDARIS. A few comments about the Moss amendments. Commissioner Newman knows my dissatisfaction with the way those amendments were implemented and the lack of haste or urgency on the part of the administration. Of course the previous administration shares part of the blame.

I want to commend HEW for its new game-plan; these are very constructive steps. I have been reading the background of Dr. DuVal and Dr. Calendar I have been very impressed. I also think HEW has a much better attitude today and hopefully we can now have progress in getting these standards enforced. As the chairman pointed out, 4 years ago the Moss amendments were enacted and only now are we getting around to enforcing them. I am pleased but, I too, keep wondering why it has taken us so long.

The Secretary's presentation here today leads me to wonder if perhaps I have not been overly concerned without good reason. You have convinced me we are going to move in a positive direction.

Maybe I have worried about a lot of things I need not worry about. Before I came to this hearing I was of the opinion that we are in the 9th inning with two outs and the bases loaded and the President of the United States had called HEW, a .150 hitter, to the plate. One can reach that conclusion in following the haphazard way that the Moss amendments have been implemented.

Mr. VENEMAN. There have been a lot of changes. I appreciate your complimentary comment with regard to the staff. We feel both from the standpoint of what Secretary Finch attempted to do, and Secretary Richardson has continued on, that we can produce effective programs and we can comply with the intent and the requirements set forth by congressional action in the statutes if we have people. We do feel that we have brought on board some top flight people who can perhaps relieve you of some of the apprehensions that you have with regard to whether or not we are serious.

Mr. HALAMANDARIS. I do wonder, for example, why the provision of the Moss amendment which placed an affirmative duty on the Secretary to insure that each nursing home fully meet the State standards before any Federal money was issued has not been implemented.

It seems to me HEW has had the authority to withhold funds since the Moss amendments were passed in 1967. I guess your answer for the delay was lack of personnel in HEW for implementation?

Mr. VENEMAN. That would be a factor. I think the other thing you do is lean upon the information made available to you by the States. I think we have a tendency to read the statutes to say "The Secretary shall. . . ." I think none of us are so naive as to think Elliot Richardson will walk around the United States and look at every nursing home before he puts money in.

I think we do have to place a great deal of responsibility on the States and place a great deal of confidence in the information we receive from them. This is probably where the breakdown was. It was not that we did not want to comply with the Moss amendments in 1967. It is just that the personnel and structuring was not there.

We hope with the initiatives that the President has set forth, and we are moving forward, that we will have the personnel.

Mr. HALAMANDARIS. Now that you are applying these amendments, I would like to point out that this particular section, Public Law 90-248, 28(C), also applies to title 1, title 10, title 14 and title 16 and it poses an affirmative duty on the Secretary to make sure that facilities are in compliance with the statutes before releasing Federal funds.

Mr. VENEMAN. Sections 14 and 16 are the same kinds of programs as you recall. That is where the authority, eligible determination, degree of programs, amount of payments, are all determinations made by the State, and again we have the same problem, depending upon them for reliable information.

Mr. HALAMANDARIS. I believe John Twiname was speaking about the Kennedy amendment and what has been done in issuing regulations in line with congressional intent. He indicated a proposed regulation has been issued and you were now receiving comments on the Kennedy amendment.

I am wondering what has been the nature of those comments and whether there is danger that the proposed regulation may be withdrawn at some date in the future. I wonder when it will be amended in final regulation form.

Mr. TWINAME. I appreciate your comments about that. In any proposed regulation provisions are made for the public to respond. On the basis of those responses we can make a final judgment about what is appropriate. In this case, I have been written to by a number of groups and special nursing home administrators who point out that, first, the statute does not prohibit a majority on the boards being nursing home administrators and secondly, that all other boards which license professional people in the States generally are dominated by the profession which is being licensed, and thirdly, that this is so because those conscientious administrators want to upgrade this field.

And they say that those who administer nursing homes are in the best position to put the pressure on to see that the standards for administration are clean; and fourth that this is an area of State domain and a State administered program which should be left to the States for them to organize their licensing arrangements.

These then are some of the objections: namely, if you put on those boards other people who do not know as much about the requirements for good nursing home administration you may get an opposite effect. I would say that has been the majority opinion received so far to this regulation. I would appreciate your comments and what your thoughts would be about those.

Mr. HALAMANDARIS. I would simply refer back to the hearing that we held May 7 in which Commissioner Newman appeared before us and we asked this specific question and attempted to develop congressional intent at the time the legislation was introduced.

In my mind it is clear that congressional intent was that the Board should not be dominated by the nursing home industry or by any other factions.

I am sure that the chairman can speak for himself but I would like to have Mr. Twiname keep us posted by letter, as to the nature of the

comments received and the projected time for the final regulations. Is that possible?

Mr. VENEMAN. I think we can provide you with any information we may have at that particular point in time.

Mr. HALAMANDARIS. The new standards which have been issued today applying the Life Safety code to Medicare facilities and there are approximately 100 or 200 extended-care facilities, unprotected wood-frame buildings, in other words, classic fire traps in the ECF program. Under the new regulations which have been issued today, are they going to be expelled from the program?

Mr. VENEMAN. My personal reaction is that the mere fact they are wood-frame would not necessarily determine whether or not they would be exempted at the time these went into effect.

Mr. HESS. If there are unprotected wood-frames, they are eventually going to have to have sprinklers unless the State fire authorities are able to find that under the equivalency standard that we are working out with them, that the total environment is such as to warrant a finding that an equivalency protection exists.

Mr. VENEMAN. To say all 200 of them would be dropped—the question will be to what extent are they willing to make additional investment in their facilities.

Mr. MILLER. Mr. Secretary, you have made reference to the very commendable decertification of institutions which have offered less than adequate quality care. There has been concern expressed about the voluntary withdrawal from Medicare by a number of institutions, a higher percentage of which are fully qualified to provide care.

I am sure it is of concern to you and you might want to comment on what might be expected to correct this problem since it tends to deny quality care to many potential patients.

Mr. VENEMAN. There are a series of factors that would cause an institution to decide not to accept Medicare recipients. But I don't know how much of a problem it is if they met all the quality standards and the certification requirements, how many would really drop out of the program unless it was strictly fiscal and since it is reimbursed on a reasonable basis that would hardly be the motivation.

Mr. MILLER. Are there developments within the reimbursement pattern that tend to mitigate against institutions that have a mix of different kinds of patients and services?

Mr. VENEMAN. There could be. If you had a very high quality plush-type facility in an area where there was a demand for that kind of facility, perhaps they would say, "No, I won't on any of the public programs because I have a waiting list of all paid patients." I suppose that could happen.

Mr. MILLER. My second question, Mr. Secretary, relates again to the observation you made with reference to substantial compliance statistics. You made reference to the fact that there might be absence of some specialists. Social workers or physiotherapists, for example, might be involved.

I think it is evident that sometimes for nothing other than reasons of geography some institutions may have serious problems in providing such services. My question relates to whether you have given thought to or whether you are proceeding with programs which might

in effect be a kind of outreach program to provide a number of institutions with this kind of service in a way that would permit them to provide the quality care?

Mr. VENEMAN. Definitely. Mr. Hess has affirmed my statement that we are in position. We are trying to get that kind of professional help to spread its resources around to more than one institution plus the fact we have occasions to receive care outside the institution if they are capable of being moved.

Senator Moss. Thank you very much, gentlemen. This was a good informal hearing. You have responded to our questions. I am sure you supplied us with a great deal of information we have been seeking.

I concur with what both of the staff members said during the course of their questioning, that it is most heartening to see the mood now. It looks as though we are finally getting on the track—we have been waiting so long for some progress in this field.

My feeling is that you are now attacking those problems, with discretion but with vigor. I appreciate having all of you here this morning and having your response.

We have asked you to supply certain things. You agreed to do that. We appreciate it. We want to work in close cooperation with you because our concerns are the same and this committee, having spent so much time trying to fashion appropriate legislation, wants to keep fully informed so that if there are further requirements from us we can address ourselves to them and try to get appropriate legislation. H.R. 1 is high on the list and we therefore assure you that we will do the best we can to move that along.

Thank you very much.

Mr. VENEMAN. May I make one last request? During the course of this morning discussion we made several references to the President's statement and with your permission I would like to request that it be submitted as part of the record following my statement so we will have the entire thing in context.

Senator Moss. That is an excellent suggestion. That will be the order. If you will supply a copy, it will be placed in the record.

(The document referred to follows:)

THE WHITE HOUSE

AUGUST 6, 1971.

STATEMENT BY THE PRESIDENT

The vast majority of Americans over 65 years of age are eager and able to play a continuing role as active, independent participants in the life of our country. Encouraging them to play this role—and providing greater opportunities for them to do so—is a cornerstone of this administration's policy concerning older Americans.

For almost one million of our 20 million senior citizens, however, a dignified and humane existence requires a degree of care from others that can usually be found only in a nursing home or extended care facility. For those who need them, the nursing homes of America should be shining symbols of comfort and concern.

Many of our nursing homes meet this standard most admirably. Day after day and year after year they demonstrate the capacity of our society to care for even the most dependent of its elderly citizens in a decent and compassionate manner. It is the goal of this administration to see that all of our nursing homes provide care of this same high quality.

Unfortunately, many facilities now fall woefully short of this standard. Unsanitary and unsafe, overcrowded and understaffed, the substandard nursing

home can be a terribly depressing institution. To live one's later years in such a place is to live in an atmosphere of neglect and degradation.

In my speech to the regional convention of the National Retired Teachers Association and the American Association of Retired Persons in Chicago on June 25th, I pledged action to meet this challenge. Members of my administration have been vigorous in their development of specific plans to carry out that pledge. Today I am announcing certain decisions which we have already made in this important area.

A plan for action

Nursing homes presently receive over \$1 billion or 40 percent of their total income from the Federal Government—most of it through Medicare and Medicaid payments. (An additional \$700 million comes from the States and localities and \$900 million comes from private sources.) As I emphasized in my Chicago speech, "I do not believe that Medicaid and Medicare funds should go to substandard nursing homes in this country and subsidize them." This is not only a matter of personal belief, it is also the law of the land—and has been since 1965.

The reason that many substandard facilities have often continued to receive such payments are many and complex. It has been difficult to enforce the law that requires participant homes to meet certain standards. In the final analysis, however, there can be no excuse for lax law enforcement—and I therefore am taking a number of steps to improve enforcement efforts.

1. I am ordering that the Federal program for training State nursing home inspectors be expanded so that an additional 2,000 inspectors will be trained over the next 18-month period. The major responsibility for surveillance and regulation in the field is now carried out by State governments and this action will enable them to increase their effectiveness most significantly.

One of three places in the country where such training is now provided is the W. K. Kellogg Center for Continuing Education at the University of New Hampshire in Durham. This program trains people not only to inspect nursing homes, but also to provide technical assistance and consultative services which can help improve these facilities. This New Hampshire program is funded through a grant from Department of Health, Education and Welfare and it is our intention to establish similar programs in other areas of the country. This expansion effort will cost approximately \$3 million.

2. Toward this same end, I am asking the Congress to authorize the Federal Government to assume 100% of the necessary costs of these State inspection teams under the Medicaid program. This will bring the Medicaid law, which now requires the States to pay from 25 to 50 percent of these costs, into line with the Medicare law, under which the Federal Government pays the entire cost for such inspections. Again, State enforcement efforts would be significantly enhanced by this procedure.

3. I am ordering that all activities relating to the enforcement of such standards—activities which are now scattered in various branches of the Department of Health, Education and Welfare—be consolidated within the Department into a single, highly efficient program. This means that all enforcement responsibility will be focused at a single point—that a single official will be accountable for success or failure in this endeavor. I am confident that this step alone will enormously improve the efficiency and the consistency of our enforcement activities.

4. I am requesting funds to enlarge our Federal enforcement program by creating 150 additional positions. This will enable the Federal Government more effectively to meet its own responsibilities under the law and to support State-enforcement efforts.

5. I have directed the Department of Health, Education and Welfare to institute a new program of short-term courses for physicians, nurses, dieticians, social workers and others who are regularly involved in furnishing services to nursing home patients. Appropriate professional organizations will be involved in developing plans and course materials for this program and the latest research findings in this complex field will also be utilized. In too many cases, those who provide nursing home care—though they be generally well prepared for their profession—have not been adequately trained to meet the special needs of the elderly. Our new program will help correct this deficiency.

6. I have also directed the Department of Health, Education and Welfare to assist the States in establishing investigative units which will respond in a

responsible and constructive way to complaints made by or on behalf of individual patients. The individual who is confined to an institution and dependent upon it is often powerless to make his voice heard. This new program will help him deal with concerns such as accounting for his funds and other personal property, protecting himself against involuntary transfers from one nursing home to another or to a mental hospital, and gaining a fair hearing for reports of physical and psychological abuse.

7. I am also directing the Secretary of Health, Education and Welfare to undertake a comprehensive review of the use of long-term care facilities as well as the standards and practices of nursing homes and to recommend any further remedial measures that may be appropriate. Such a review is badly needed. Study after study tells us—compellingly—that many things are wrong with certain nursing home facilities, but there is not yet a clear enough understanding of all the steps that must be taken to correct this picture.

Of course, I am also looking to the White House Conference on Aging, which meets this December, to offer specific recommendations regarding this same difficult question.

8. Finally, I would emphasize my earnest hope that all these efforts will bring about the improvement of existing substandard homes rather than their abolition. The interests of the elderly are far better served when a home is reformed and renewed than when a home is eliminated. But let there be no mistaking the fact that when facilities fail to meet reasonable standards, we will not hesitate to cut off their Medicare and Medicaid funds.

We are particularly hopeful that our efforts will bring reform, since any reasonable expenses incurred as a result of improving care can often be financed under the existing Medicare and Medicaid programs. We are fully prepared to budget the necessary funds to meet reasonable cost increases which result from such improvements.

The Federal Government stands ready to help in this great reform effort in other ways as well. Under the Hill Burton Act, for example, we are able to provide loan guarantees and direct loans for the modernization of old nursing home facilities and the construction of new ones. The Federal Housing Administration also provides help in this field by insuring mortgages to finance construction or rehabilitation of nursing homes and intermediate care facilities. And the Small Business Administration also guarantees loans and makes direct loans to assist proprietary nursing homes in constructing, expanding or converting their facilities, in purchasing equipment or materials, and in assembling working capital.

In addition to all of these efforts, the administration is working in a number of other ways to improve the life of all older Americans—whatever their place of residence. Some of our strongest initiatives to help older people—including major reforms in both the welfare and social security systems—are contained in the legislation designated H.R. 1 which is now pending in the Senate. I would emphasize again the passage of this legislation could make a major impact for good in the lives of older Americans, including those who need to live in nursing homes and extended care facilities.

As we work to improve the quality of life for the elderly—and especially for those who must rely on the care provided in the nursing homes of our country—we should not expect overnight miracles. The problems we face have developed in too many places over too long a time. But we can expect that our efforts will result in significant and continuing progress. With the cooperation of the Congress, the State governments, and the nursing home industry, we can truly transform substandard nursing homes so that the very best nursing homes of today will be the typical nursing homes of tomorrow.

WHITE HOUSE FACT SHEET

BACKGROUND

In Chicago on June 25, 1971, in remarks at a Joint Conference of the National Retired Teachers Association and the American Association of Retired Persons, the President referred to the "depressing" nature of some nursing homes and said:

"I think we should take notice of this problem. I am confident that our Federal, State and local governments, working together with the private sector,

can do much to transform the nursing home—for those who need it or want it—transform it into an inspiring symbol of comfort and hope.

"I have asked the White House Conference to give particular attention to it. One thing you can be sure, I do not believe that Medicaid and Medicare funds should go to substandard nursing homes in this country and subsidize them."

PRESIDENT'S PLAN FOR ACTION

Although the President continues to expect to receive recommendations from the White House Conference on Aging when it meets in December, he has today:

1. Ordered that the Federal program for training State nursing home inspectors be expanded so that an additional 2,000 inspectors will be trained over the next 18-month period. (One of three places in the country where such training is now provided is at the University of New Hampshire in Durham.)

2. Announced his intention to ask the Congress to authorize the Federal Government to assume 100 percent of the cost of State inspection of nursing homes to significantly enhance enforcement efforts.

3. Ordered that all activities relating to the enforcement of nursing home standards now scattered in various branches of the Department of Health, Education, and Welfare be consolidated within the Department into a single, highly efficient program. This action will place all enforcement responsibility at a single point so that a single official will be accountable for success or failure in this endeavor.

4. Announced intention to request funds to enlarge the Federal enforcement program by creating 150 additional positions to enable the Federal Government to more effectively support State efforts to enforce the law and to upgrade nursing homes.

5. Directed the Department of Health, Education, and Welfare to institute short-term training of health workers who are regularly involved in furnishing services to nursing home patients so that they can meet the specific needs of the elderly.

6. Directed the Department of Health, Education, and Welfare to assist the States in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual nursing home patients.

7. Directed the Secretary of Health, Education, and Welfare to undertake a comprehensive review of the use of long-term care facilities as well as standards and practices of nursing homes and to recommend further measures that may be needed.

8. Has restated his intention that Medicare and Medicaid funds will be cut off to those nursing homes that fail to meet reasonable standards.

Some facts on nursing homes

Number of institutions for the aged.....	23, 000
Type of ownership (percent):	
Proprietary for profit.....	77
Private nonprofit.....	15
Governmental (State and local).....	8
Number of discharges.....	661, 089
Number of employees (total).....	505, 031
Number of employees (per 100 residents).....	68
Average monthly charge per resident:	
In nursing homes.....	\$295
In personal care homes.....	\$210
Number of persons 65 and over, percentage of population.....	20, 000, 000
In New Hampshire 11.2 percent of population is over 65.....	9
Number of persons 65 and over in nursing homes.....	900, 000
Federal support of nursing home patient care, 1970 (more than).....	\$1, 000, 000, 000
State and local governments spend.....	\$700, 000, 000
Private sources spend over.....	\$900, 000, 000
Nursing home "industry" is close to.....	\$2, 600, 000, 000

TYPES OF NURSING HOMES PRESENTLY RECEIVING FEDERAL FUNDS

	Extended care facilities (receive Medicare payments)	Skilled nursing homes, title XIX (receive Medicaid payments)	Intermediate care facility (State option) (receive welfare payments)
Types of facilities involved.....	Extended care facilities, extended care wings of hospitals, skilled nursing homes.	Skilled nursing homes, infirmary sections of homes for the aged, skilled nursing home wings of hospitals.	As defined by the State plan: Homes for the aged, rest homes, personal care homes, other homes for those not requiring skilled nursing care.
Minimum facility standards for Federal financial participation.	Facility must have State license; meet Federal standards for staffing, safety, and quality of patient care.	Facility must meet State licensing requirements; meet Federal standards.	State licensing, sanitation, and safety standards applicable to State nursing home licensure and any other standards set by State.
Review of patient's needs.....	Visit by physician at least once every 30 days.....	Monthly visit by physician. Independent medical review and evaluation of care and services received in relation to patient's needs at least annually.	Independent review and evaluation by physician and case worker of care and services received in relation to patient's needs at least annually.
Eligibility in Federal or Federal-State programs.	Those eligible for Medicare under title XVIII of the Social Security Act.	Those eligible for medical assistance under title XIX of the Social Security Act.	In the 32 States including intermediate care in their assistance plans, those eligible for financial assistance under federally-supported programs for old age assistance, aid to the blind, aid to the disabled.
Estimated number of facilities.....	4,200.....	7,000.....	12,000.....
Estimated expenditures, fiscal year 1970.....	\$320,000,000.....	\$1,300,000 (State and Federal).....	\$307,000,000.....
Estimated number of people served, fiscal year 1970.....	472,500 admissions.....	450,000.....	146,000.....
Focus.....	Post-hospital skilled nursing care in an institutional setting.	Long-term skilled care and services as defined by Federal regulations in an institutional setting.	Long-term supportive care in an institutional setting.
Typical patients and services.....	Those able to leave acute care wings in a hospital but not yet ready to go home; continues and completes course of hospital treatment prior to complete discharge.	Those requiring skilled nursing services on a continuous basis; long-term patients with little potential of rehabilitation to the point of discharge.	Those needing more care than is available at home but not requiring skilled nursing services.

REMARKS OF THE PRESIDENT AT GREENBRIAR NURSING HOME, NASHUA,
NEW HAMPSHIRE

Governor Peterson, Senator Cotton, Senator McIntyre, Congressman Cleveland, Congressman Wyman, and Ladies and Gentlemen:

I have just had the opportunity to visit a number of the patients in this nursing home, and also, just as important, to meet a great many members of the staff. You see representatives of both groups here with the members of the staff behind.

In my brief remarks I would like to tell you why, first, we came to this, of all of the thousands of institutions of this type around the country that we could have selected. This institution has been selected as among the top 10 percent in all of America in terms of quality, in terms, also, of the services that are provided for the funds that are provided by those who are the patients.

We selected one of the best to come to because, by selecting the best, we want it to be an example for others throughout the Nation. Some of you may recall that in Chicago, in speaking to the American Association of Retired Persons a few weeks ago, I referred to the fact that there were many institutions of this type for older people and disabled people that were a disgrace, and that it was absolutely essential that the Federal Government do everything that it could through its programs to upgrade them—upgrade them so that people in the last years of their lives who live in places like this, institutions like this, could have a good life, and not a life of hopelessness and desperation.

We have that program now initiated. I have issued a major statement here today in Nashua concerning the new initiatives that the Administration is taking to use the power of the Federal Government, through inspection and through the programs where we provide financial assistance, to see to it that these institutions throughout the country have a higher standard than they presently have.

So we have come to one of the best to show what can be done, not only with money, but also, particularly, what can be done with regard to the personnel.

As I went through this building, and as Mrs. Nixon went through it, we were very inspired to meet those who are the patients here. Here are some of them back here. They are in wheelchairs. You would think that they would have a hopeless, despairing attitude about life, but as a matter of fact, I went in to cheer them up and they cheered me up, because they feel that they have good care, and also they have an optimistic attitude about life.

There is a reason for that. One, because of their own character, which comes from this New England soil in which most of them have grown up, but also the other reason is because the nurses and all the others who work in this institution are proud to work here, and because they do not treat these patients as a burden. As they go from one to the other, they try to make each day a happier day for them.

Accompanying me on this trip today in addition to the distinguished members of the Senate and the House of Representatives, and the Governor who is here, is the wife of one of the most powerful men in Washington, the Director of the Office of Budget and Management, Mrs. George Shultz. She is from New Hampshire. She was a nurse. She set an example in her own life of what nursing can mean and what it can do.

In speaking today about what the Federal Government will do to upgrade our nursing homes for the elderly, upgrade them so that, as near as possible, they can be as fine as this one, let me say, we can build finer buildings, we can provide more money; but what really counts are the people who work here, the nurses, the supervisors and people up and down the line, because the fine buildings, and the good view and the good weather that we have today would mean nothing if you had a sourpuss coming in that room every day to say good morning to you.

I simply want to pay tribute to the wonderful nurses, thousands of them—thousands I will never meet—who dedicate their lives to this profession and who make me the people they work with a little happier because they are there.

Let me say, finally, I speak with somewhat a personal feeling here because my mother, in the last year of her life, had had a disabling stroke, and she was in a rest home during that period. When I went to see her, I couldn't tell whether she recognized me or not. I always rather thought she did. But I am always grateful and will always be grateful for the fact that the nurses that were in

that home treated her with such love and such attention. I will never forget it.

So today I think all of us who are fortunate enough to be well, and walking, and who have our mothers or our grandmothers or, as the case might be, some other relative who may be in a home like this, all of us want to extend our appreciation and our thanks to those who maintain such institutions as this, to those who, in addition to simply providing the food, sometimes the clothing, sometimes the rooms, all these material things, provide something that money cannot buy: affection, caring, really wanting to see that the individuals who are here have a better day and a better life by reason of what they are able to provide in raising their spirits.

Thank you very much.

Senator Moss. We thank you. We look forward in working with you and your staff as we pursue this common objective.

We are adjourned.

(Whereupon, at 12:25, the subcommittee adjourned, to reconvene subject to call of the Chair.)

APPENDIXES

Appendix 1

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1. NEWS RELEASE, OFFICE OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE, NOVEMBER 30, 1971

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
OFFICE OF PUBLIC AFFAIRS,
Washington, D.C., November 30, 1971.

HEW Secretary Elliot L. Richardson told the White House Conference on Aging today that 38 States have "substantial deficiencies" in their nursing home certification process under Medicaid and called for rapid corrections.

The Secretary said that "appropriate officials in all 38 of these States are being notified today" of the results of a recent survey of certification procedures "and advised that they have until February 1 to significantly improve their Medicaid processes."

Under the Federal-State Medicaid program, Federal regulations require States to certify that nursing homes meet Federal, State and local standards covering fire, sanitation, and safety, and for medical, nursing and general care services for patients.

In his address to conference delegates meeting here through December 8, Secretary Richardson said "the States also have been informed that HEW stands ready to assist them, in any way the Department can, in upgrading their procedures.

"And they have been further informed," he said, "that unless such improvements are validated by the February 1 target date, HEW intends to initiate a non-compliance procedure that could ultimately result in withholding *all Federal Medicaid funds* from any or every one of the 38 States."

Secretary Richardson said, "Finally, all States and territories receiving Federal Medicaid funds have been given until July 1 of next year to inspect every participating skilled nursing home to insure that such homes are in compliance or in substantial compliance with the Medicaid certification procedure that the State must have in place by February 1."

The deficiencies in certification procedures in the 38 States were found during a special survey of State Medicaid inspection and enforcement efforts undertaken at President Nixon's request and completed November 15.

Secretary Richardson told the conference that "I am sure we can expect that some will accuse the Federal Government of exhibiting too much muscle in this matter .

"But I am hopeful," he said, "that strong Federal action will, in the end, prove unnecessary. I believe that none of the 38 States face insurmountable difficulties in meeting the February 1 target date.

"But let there be no mistake about it," he said, "the President has said Federal funds will no longer be used to subsidize nursing homes that are little more than 'warehouses for the elderly . . . dumping grounds for the dying'—and I mean to enforce that Presidential directive."

In letters sent Monday to State officials responsible for the Medicaid program in the 38 States, John D. Twiname, Administrator of HEW's Social and Rehabilitation Service, outlined steps States must take if they are to avoid loss of Medicaid funds.

By December 15, all States with deficiencies must submit to HEW Regional Offices written plans and timetables for correcting deficiencies.

Mr. Twiname emphasized that if the target dates announced by Secretary Richardson to the Conference delegates are not met, he would "have no alternative but to initiate" the non-compliance hearings process.

HEW acted to carry out the Presidential directive to upgrade nursing homes by developing plans to train 2000 additional State nursing home inspectors over the next 18 months, planning short-term courses for those who regularly furnish services to patients, and helping States set up "ombudsman" units to check complaints by patients.

The Department has asked Congress to amend the Social Security Act so that the Federal Government can pay 100 percent of the cost of Medicaid inspections, and has asked for funds to add 150 Federal positions for enforcement of nursing home standards.

To expedite the job, Secretary Richardson mobilized task forces in each HEW region which, on October 18, began the survey of Medicaid certification standards in each State.

List of 38 States, copy of the letter to State officials, and a background sheet are attached.

[Enclosure]

SELECTED AREAS REQUIRING SIGNIFICANT IMPROVEMENT IN THE CERTIFICATION OF SKILLED NURSING HOMES FOR PARTICIPATION IN THE TITLE XIX PROGRAM

States	Failure of States to—				
	Have agreements for facility surveys (A)	Use Medicaid standards in surveys (B)	Have written agreements with skilled nursing homes (C)	Place required time limits on agreements (D)	Have other required survey procedures (E)
Total	11	19	13	24	38
Arkansas				X	X
California				X	X
Connecticut	X	X	X		X
District of Columbia				X	X
Delaware	X	X	X	X	X
Georgia			X		X
Hawaii	X	X		X	X
Idaho	X		X		X
Illinois				X	X
Indiana				X	X
Iowa	X			X	X
Kansas		X	X		X
Kentucky		X	X		X
Louisiana		X		X	X
Maine		X		X	X
Maryland	X	X	X	X	X
Michigan		X	X		X
Minnesota			X		X
Mississippi		X			X
Montana				X	X
Nevada	X	X	X		X
North Carolina		X	X		X
North Dakota		X			X
New Mexico				X	X
New York		X			X
Ohio				X	X
Oklahoma		X		X	X
Oregon		X			X
Pennsylvania	X	X			X
South Carolina		X			X
South Dakota					X
Tennessee	X				X
Utah				X	X
Vermont		X	X		X
Washington				X	X
Wisconsin			X		X
West Virginia	X	X	X		X
Wyoming		X			X

Explanation of columns:

(A) Agreements for facility surveys—Written agreement or memorandum of understanding between the State Medicaid agency and the survey agency (which performs on-site reviews of skilled nursing homes). The agreement should delineate the responsibilities of each agency and provide for the exchange of pertinent information. 45 CFR 205.190(a)(3) and 45 CFR 249.33(a)(2)(i).

(B) Medicaid standards in surveys—The application by the survey agency of Federal Medicaid standards relating to: (1) health, (2) sanitation, (3) construction, (4) physical plant including fire safety, (5) patient records, (6) admission

policies and procedures, and (7) administrative and fiscal records as prescribed by regulations 45 CFR 249.10(b)(4)(i) and 45 CFR 249.33.

(C) Written agreements with skilled nursing homes—Formal written agreement between the State Medicaid agency and the skilled nursing homes which receive Medicaid payments. These agreements should conform with the applicable requirements of Federal regulations. 45 CFR 249.10(b)(4)(h); 45 CFR 249.33; and 45 CFR 250.21.

(D) Time limits on agreements—1-year agreements with skilled nursing homes which meet all Medicaid requirements. 6-month agreements with skilled nursing homes which have correctable deficiencies, or deficiencies which the Medicaid agency can waive in accordance with regulations. 45 CFR 249.33(a)(2)(iv).

(E) Other required survey procedures—These include review of survey agency reports by the Medicaid agency to determine whether a facility meets Medicaid standards; appropriate follow-up with facilities which have correctable deficiencies; obtaining and reviewing staffing reports on a quarterly basis; and ascertaining that facilities are licensed by the State licensing authority. 45 CFR 249.10(b)(4)(i) and 45 CFR 249.33.

Note: The information in this chart is based on recent findings by the regional office survey teams and is not necessarily complete. The States have been advised of the deficiencies and have been asked to submit plans for correction. The degree of deficiency in each area varies from State to State.

ARKANSAS

Time-Limited Agreements

The Single State Agency does maintain provider agreements with skilled nursing homes. Time-limited agreements, however, are not being utilized in accordance with Federal regulations. The Regional office has recommended that agreements be modified to reflect requirements that they do not exceed a period of one year, that they contain an effective date and a termination date, and that they do not exceed a period of six-months for those facilities with deficiencies.

Other Survey Procedures

It is unclear precisely what action the title XIX agency takes on survey reports and findings at present; the Regional office has recommended that the agency reorganize its procedures to conform with all the requirements of 45 CFR 249.33.

CALIFORNIA

Required Time Limits on Agreements

The State's provider agreements with skilled nursing home facilities are not limited to one year or six months as required by 45 CFR 249.33.

Other Required Survey Procedures

(1) The State does not obtain or review required quarterly staffing reports. (2) The State title XIX agency does not review survey information to determine compliance with title XIX standards. (3) The State agency has no assurance that facilities are complying with fire and safety standards (in respect to licensing of facilities).

CONNECTICUT

Agreement for Facility Surveys

There is no interagency agreement. As of October 1971, the survey agency's responsibilities were being executed on an informal arrangement with the title XIX agency. An agreement has been prepared and signed by the Welfare Commissioner. There is no indication when the Health Department (survey agency) is expected to sign.

Use of Medicaid Standards in Surveys

A modified Medicare survey form is being used to survey nursing homes for compliance with title XIX standards. However, not all Medicaid standards are being surveyed.

Written Agreements with Nursing Homes

The title XIX agency has not executed provider agreements with all nursing homes participating in the Connecticut title XIX program. As of October 1971: (1) 230 nursing homes were participating in title XIX; (2) 56 nursing homes had been surveyed; and (3) the title XIX agency had executed only 7 provider agreements.

Other Required Survey Procedures

1. The title XIX agency has no assurance that nursing homes are implementing action to correct deficiencies.

2. Nursing homes are submitting quarterly staffing reports to the survey agency. Information with reference to such reports are not sent to the title XIX agency.

3. The documentation sent by the survey agency to the title XIX agency with reference to deficiencies in nursing homes is inadequate.

4. Ownership information obtained but content does not meet Federal requirements.

5. Procedures exist for performing surveys and/or resurveys. There is no assurance that this is being carried out in practice due to the survey agency's understanding that Medicaid surveys were to be conducted annually.

DISTRICT OF COLUMBIA

Agreement for Facility Survey

There exists no written agreement or memorandum of understanding between the survey agency and the Medicaid agency.

Time-Limited Provider Agreements

Nursing homes are certified for a period of nine months or for one year, not for the federally required six or twelve months.

Other Required Survey Procedures

Quarterly staffing report forms have been designed but are not in use. A head count of staff on duty is made at the time of the unannounced inspection visit.

DELAWARE

Agreement for Facility Surveys

The State title XIX agency has no interagency agreement or written memorandum of understanding with the State Agency responsible for surveying nursing home facilities.

Use of Medicaid Standards in Surveys

The State has not implemented a skilled nursing home service for title XIX patients.

Written Agreements With Skilled Nursing Homes

The State has not instituted provider agreements with skilled nursing home facilities.

Place Required Time Limits on Agreements

As mentioned above, the State has no written agreements with skilled nursing homes.

Other Required Survey Procedures

Again, the State has no skilled nursing home program for title XIX recipients.

GEORGIA

Written Agreements With Providers

Provider agreements are routinely issued for a 12 month period (except when a provisional license is granted) irrespective of the deficiencies. The agreements are not based on survey findings. Most of the agreements had expired on June 30, 1971.

The agreement is in the form of an "application to participate" because of an apparent conflict with the "State Administrative Procedure Act."

Medicaid Standards in Surveys

The State does not enforce the Life Safety Code of 1967, thus many facilities do not meet these requirements.

HAWAII

Agreement for Facility Survey

The Medicaid agency does not have a written agreement with the survey agency. Medicare standards have been used to certify facilities for Medicaid. Steps are currently being taken by the Medicaid agency to enter into an agreement with the survey agency. It is expected that such agreement will be completed and signed by December 1, 1971.

Use of Medicaid Standards in Surveys

As noted above, Medicare standards are being used to certify facilities for participation in Medicaid. Although Medicare and Medicaid standards are for

the most part similar, facilities have to meet some additional standards to qualify for Medicaid. As soon as the agreement between the Medicaid agency and the survey agency is implemented, all skilled nursing homes participating in the Medicaid program will be surveyed using Medicaid standards.

Time Limits on Agreements

The Medicaid agency routinely issues annual agreements which are reviewed at the beginning of each fiscal year (July 1). Because the Medicaid agency has not identified deficiencies, it has not issued six month agreements. When current agreements expire, facilities with correctable deficiencies or deficiencies which can be waived will be issued six months agreements.

Other Required Survey Procedures

The Medicaid agency does not review the reports of the survey agency nor does it review quarterly staffing reports. In addition, deficiencies are not identified nor followed-up.

IDAHO

Agreement for Facility Surveys

The State title XIX agency, the Department of Public Assistance, has no agreement with the State Department of Health, the licensure and standard-setting authority.

Written Agreements with Skilled Nursing Homes

The State has not executed individual provider agreements with skilled nursing homes consistent with requirements in 45 CFR 249.33. The only agreement used by the State is a statement on the provider invoice covering maintenance of necessary records and providing the State agency with information as requested.

Other Required Survey Procedures

The State has not enforced its life safety code and has only recently begun to survey facilities in respect to compliance with the code (in respect to licensing of facilities) and thus has no assurance that facilities are meeting requirements.

ILLINOIS

Required Time Limits on Provider Agreements

The provider agreements the title XIX agency executes with nursing homes participating in the Illinois title XIX program are not limited to: (1) one year for nursing homes determined not to have any deficiencies; or (2) six months for nursing homes determined to have deficiencies that can be corrected.

Other Required Survey Procedures

1. The title XIX agency has no assurance that nursing homes are implementing action to correct licensure deficiencies.
2. The title XIX agency receives no reports from the survey agency with reference to deficiencies in nursing homes. Therefore, there is no review of a nursing home's level of compliance with title XIX standards, by the title XIX agency, before being certified to participate in the Illinois title XIX program.

INDIANA

Require Time Limits on Provider Agreements

The title XIX agency does not execute time-limited (6 month or 12 month) provider agreements with all nursing homes participating in the Indiana title XIX program. The report notes that some agreements do not make reference to the effective dates.

Other Required Survey Procedures

1. Inadequate and infrequent nursing home licensure surveys are being conducted. As a result, the title XIX agency has no assurance that nursing homes are implementing action to correct licensure deficiencies.
2. Prior to certifying nursing homes to participate in the Indiana title XIX program, the title XIX agency does not receive adequate information from the survey agency to be assured that nursing homes: (1) have deficiencies that *can be corrected*, or reasonable progress *can be made toward correction*; (2) *have*

corrected the deficiencies, or *have made* reasonable progress toward correction; and (3) in which there are deficiencies, such deficiencies have been determined not to be a hazard to the health and safety of the patients.

IOWA

Agreement for Facility Surveys

The title XIX agency and the survey agency have not executed an interagency agreement.

Required Time-Limits on Provider Agreements

Time-limited (6 month, or 12 month) provider agreements are not executed with nursing homes. The title XIX agency interprets provider agreements to be in effect as long as the facility is certified to participate in the Iowa title program.

Other Required Survey Procedures

The report indicates that the title XIX agency does not receive sufficient information from the survey agency to assure itself that nursing homes are in compliance with title XIX standards.

KANSAS

Medicaid Standards in Survey

The State has been applying its licensure standards for participation in Title XIX rather than the requirements set forth in 45 CFR 249.33.

Written Agreements with Providers

The State does not have provider agreements, pending legal action brought against the State Agency by the Nursing Home Association.

Other Required Survey Procedures

The Medicaid Agency doesn't review survey finding.

KENTUCKY

Medicaid Survey Standards

Current practice is to survey by title XVIII standards. Title XIX requirements, which are in addition to those of title XVIII, are not incorporated into the survey.

Written Agreements with Skilled Nursing Homes

The Medicaid program has a form which it considers both an application form and an agreement. However, this form does not contain the signature of any representative of the Medicaid agency and cannot be considered a "contract".

Time-Limited Agreements

The State agency does not issue time-limited agreements in accordance with CFR 249.33.

Other Survey Procedures

The title XIX agency does not maintain documentation of the certification process and controls as required. There is no evidence that it acts on quarterly staffing reports, reports of deficiencies, etc. It accepts the recommendations of the survey agency and issues a form letter of participation on these recommendations.

LOUISIANA

Medicaid Standards in Surveys

The Regional office reports that not all of the title XIX standards against which the survey is to be made are covered in the survey activity.

Time-Limited Agreements

The Regional office finds that provider agreements have been negotiated for periods ranging from one month to twelve months and that six-month agreements, necessitated by deficiencies in the nursing homes, are not being justified in writing. Further, twelve-month agreements are being entered into with nursing homes which have significant deficiencies. The present provider agreement does not contain an effective date.

Other Survey Procedures

The Single State Agency is acting on the decision made by the Department

of Hospitals as to whether Federal standards for skilled nursing homes are met rather than receiving and evaluating survey data and making the judgment.

MAINE

Use of Medicaid Standards in Surveys

The title XIX agency has not instituted effective arrangements for the survey of "distinct part" SNH units in institutions for the mentally retarded. Waivers of requirements were granted to these distinct part units without documentation and for requirements not subject to the waiver provision.

Required Time Limits on Agreements

Current provider agreements were in effect with roughly only half of the 22 participating facilities. Provider agreements are not executed with "distinct parts" of institutions for the mentally retarded. The State has not implemented procedures for the execution of provider agreements which meet the requirements or conditions of Federal regulations.

Other Required Survey Procedures

There is no separate and identifiable survey and certification process for title XIX. Only certified ECF's are providers of SNH services under title XIX. There is no adequate documentation to assure that SNH meet title XIX standards in addition to title XVIII or that the conditions for certification with deficiencies were being applied.

MARYLAND

Agreement for Facility Survey

There is no agreement between the Medicaid agency and the survey agency. Maryland has not instituted a program for certifying nursing homes in accordance with Medicaid requirements.

Use of Medicaid Standards in Surveys

Medicaid standards are not used. Nursing homes which are licensed in accordance with State regulations have the right to participate as providers of skilled nursing home care under the Medicaid program.

Written Agreements with Skilled Nursing Homes

There are no agreements between the Medicaid agency and the skilled nursing homes which receive Medicaid payments. As mentioned above, those nursing homes which are licensed under State regulations are eligible to receive payment for skilled nursing home services rendered to Medicaid patients.

Other Required Survey Procedures

Maryland does not apply Medicaid requirements in surveying nursing homes. Surveyors inspect homes which apply for licensure to determine whether they meet State standards for licensure. Based on surveyors' recommendations, the licensing agency can issue or deny a license. None of the required Medicaid survey procedures is followed.

MICHIGAN

Written Agreements with Skilled Nursing Homes

The State has failed to implement Federal requirements with respect to provider agreements.

Other Required Survey Procedures

Standards are not being fully complied with by the State. Homes are being certified before a fire safety inspection. Some facilities are being certified for participation without a valid State license and the deficiency reports on file in the survey agency are not always shared with the title XIX agency. Homes are being certified despite survey agency reports of questionable compliance.

MINNESOTA

Written Agreements with Skilled Nursing Homes

There are no agreements between the Medicaid agency and skilled nursing homes receiving Medicaid payments.

Other Required Survey Procedures

The Medicaid agency does not follow-up on deficiencies found in skilled nursing

homes. Five of twelve homes reviewed by the Regional Office team were licensed with deficiencies.

MISSISSIPPI

Use Medicaid Standards in Surveys

The survey agency is hampered by insufficient staff in its efforts to conduct adequate surveys. Local fire protection agencies inspect facilities in accordance with State laws and regulations rather than with Federal standards.

Other Required Survey Procedures

- (a) Survey results are not transmitted to the title XIX agency.
- (b) Quarterly staffing reports are not submitted to the survey agency and are not reviewed by the title XIX agency.

MONTANA

Use of Medicaid Standards in Surveys

There is no indication that the survey agency has been provided with Medicaid standards to use as a guide in surveying Medicaid facilities.

Required Time Limits on Provider Agreements

The agreement is an annual agreement.

Other Required Survey Procedures

(a) Gaps of time noted between the expiration date of the State license and the issuance of a renewal.

(b) Letters of deficiencies to facilities allow 15 days for response with plan of correction. In 30% of the cases, facilities are not responding within this time period—in at least one case, 7 months had elapsed before a response was received from the facility.

NEVADA

Agreements for Facility Survey

There has not been an agreement between the Medicaid agency and the survey agency. However, an agreement is currently being negotiated and should be completed and signed by 12/1/71.

Use of Medicaid Standards in Surveys

The Medicaid agency has depended upon the Medicare survey and certification for certifying skilled nursing homes. Although Medicare standards are similar to those of Medicaid, there is no assurance that the additional Medicaid standards are being met by skilled nursing homes receiving Medicaid payments. This should be corrected when the agreement for facility survey is signed.

Written Agreements with Skilled Nursing Homes

Agreements with skilled nursing homes do not stipulate a termination date. Agreements are renewed at least annually when payment rates are renegotiated. No six month agreements have been issued because the Medicaid agency has not identified deficiencies and has not considered the waiver of certain requirements.

Other Required Survey Procedures

The Medicaid agency does not review survey reports nor does it obtain and review quarterly staffing reports.

NORTH CAROLINA

Use Medicaid Standards in Surveys

Surveyors use the Medicare survey form and do not incorporate the additional requirements for title XIX. Life Safety Code or equivalent standards are not being applied.

Other Required Survey Procedures

Quarterly staffing reports are not forwarded to the Medicaid agency although they are documented, reviewed, and on file in the licensing agency.

NORTH DAKOTA

Documentation is insufficient to show that nursing homes have been surveyed according to Medicaid standards.

Time-Limited Provider Agreements

Provider agreements are not limited to one year for homes in full compliance or to six months for homes with correctable deficiencies.

Other Required Survey Procedures

(a) Survey reports reviewed by title XIX are insufficient to show that nursing homes have been surveyed by title XIX standards or that homes are in full compliance.

(b) Survey findings are reviewed after the provider agreement has been renewed.

NEW MEXICO

Time-Limited Agreements

Regional office has recommended that present agreements with providers be revised to include Federal requirements that such agreements do not exceed one year, that agreements include an effective date and a termination date, and that agreements with facilities found to have deficiencies do not exceed a six-month period.

Survey Procedures

Regional office has recommended that the title XIX agency review the findings of surveys before certification of skilled nursing homes, and that the survey information contain, among other requirements, information concerning quarterly staffing patterns, deficiencies, and documented evidence that deficiencies do not endanger the health or safety of the patients.

NEW YORK

Failure of State to:

Use Medicaid Standards in Surveys

Due to local operation of program in New York some jurisdictions use title XIX standards while some do not.

Have Other Required Survey Procedures

The title XIX agency does not review information based on evidence derived through surveys of facilities prior to entering into agreements with those facilities to provide skilled nursing services under the program.

OHIO

Time Limited Provider Agreements

Provider agreements have no termination dates and there are no six month agreements for homes with correctable deficiencies.

Other Required Survey Procedures

(a) Survey reports reviewed by the Medicaid agency report only deficiencies in building code, fire and safety requirements, and contain no information on correction of deficiencies.

(b) Quarterly staffing reports are not reviewed by the Medicaid agency.

OKLAHOMA

Use Medicaid Standards in Surveys

All Federal standards are not covered by the forms now in use.

Place Required Time Limits on Agreements (with provider facilities)

A 12-month agreement and a supplemental 6-month agreement are currently given to skilled nursing homes found to be in substantial compliance with skilled nursing home standards. In some instances, the 6-month agreement runs beyond the 12-month agreement and in others, the 6-month agreement terminates prior to the termination of the 12-month agreement. This results in second 6-month agreements being negotiated without a resurvey, 12-month agreements being renegotiated without a survey, and results in creating a situation which has made the timely planning of surveys impossible. Successive 6-month agreements were noted based on identical deficiencies without indication of progress in correcting the deficiencies during the term of the first 6-month contract.

Have Other Required Survey Certification Procedures

(a) Inadequate survey data received from State Health Department. All deficiencies are not being identified to the title XIX agency.

(b) Many agreements being negotiated with skilled nursing homes prior to an evaluation to determine that the facility is in compliance with title VI of the Civil Rights Act.

(c) The Life Safety Code is not being enforced.

(d) Inadequate surveys of facilities. In two facilities visited, only one representative from the survey agency appeared and the survey lasted a maximum of 2-3 hours. The title XVIII program in the State allows 3 man-days for an ECF survey.

OREGON

Required Time Limits in Agreements

The State title XIX agency has failed to meet requirements with its provider agreements with skilled nursing home facilities in that it does not execute agreements limited to 12 months or six months.

Other Required Survey Procedures

The State agency has no procedures to assure that facilities comply with Federal life safety regulations prior to the execution of provider agreements.

PENNSYLVANIA

Agreement for Facility Survey

The Medicaid Agency has not entered into an agreement with the survey agency. The State contends that there is no need for an agreement, because the survey agency is a bureau within the Medicaid agency, and there is a written document which assigns functions to each bureau. However, the State was not able to produce such document at the time of the Regional Office inspection.

Use of Medicaid Standards in Surveys

The Regional Office reported that Medicaid Standards are not being applied when nursing homes are surveyed for participation in the Medicaid program.

Time Limits on Agreements

At the time the Regional Office reviewed the Medicaid Agency, it was found that 440 nursing homes had returned signed agreements, however, none had been countersigned and returned to the homes.

Other Required Survey Procedures

The Medicaid Agency does not review the report of the survey agency, but it receives a copy of the survey agency's findings. There is no follow-up on deficiencies by the Medicaid Agency.

SOUTH CAROLINA

Required Time Limits on Agreements

The State has not instituted procedures to meet Federal requirements or conditions with respect to the execution of provider agreements. The period of time covered on the contract with each facility is not based upon the requirements of 45 CFR 249.33(a)(2).

Other Required Survey Procedures

The deficiencies found by the Survey Agency are not routinely documented to the title XIX agency so that the agency can assure itself that a facility is eligible to participate and under what conditions. Reports of quarterly staffing are not being received or reviewed.

SOUTH DAKOTA

Time Limits on Agreements

The Regional Office has recommended to the Medicaid agency that one year agreements be issued only to skilled nursing homes which fully meet Medicaid requirements, and that six month agreements be issued to nursing homes which have correctable deficiencies or deficiencies which can be waived.

Other Required Survey Procedures

The Medicaid agency does not review survey reports and has no assurance that skilled nursing homes participating in the Medicaid program meet Federal requirements.

TENNESSEE

Failure of State to:

1. *Have Agreements for Facility Surveys*: No agreement or memorandum of understanding exists.

2. *Place Required Time Limits on Agreements* (with provider facilities): Agreements have been executed between the single State agency and each participating skilled nursing home but they are not of time-limited duration.

3. *Have Other Required Survey Procedures*:

a. The survey agency does not provide the title XIX agency with lists of deficiencies found to exist in provider facilities or plans of correction.

b. Survey agency presumes from the fact that providers are licensed that title XIX requirements relative to disclosure of ownership and the Life Safety Code are met.

c. Transfer agreements which satisfy Medicare requirements are accepted in lieu of hospital agreements required by Medicaid regulations.

UTAH

Failure of State to:

Place Required Time Limits on Agreements (with provider facilities): The overall agreement with facilities appears adequate with the exception of three items. One item is that the agreement does not indicate whether the facility is granted full 12 months certification, 6 months or less with deficiencies or 12 months certification with waivers.

Have Other Required Survey Procedures:

A. Deficiencies noted in survey reports not always included in letter of deficiencies to facility.

B. Although the letter of deficiencies instructs facilities as to the State's expectations on a response with a plan of correction, some responses are ambiguous.

VERMONT

Use of Medicaid Standards in Survey Process

The State has just begun to make the survey personnel aware of the Medicaid requirements. As of report date, the State had surveyed six facilities using the Medicaid standards.

Written Agreements with Providers

Vermont has not had provider agreements. A draft has been prepared, but to date no agreements have been signed.

Other Required Survey Procedures

The Survey agency has been told to obtain quarterly staffing reports and to report the adequacy of staffing to the Medicaid agency.

The Medicaid agency has failed to obtain sufficient evidence that a facility meets the requirements to participate in the Medicaid program.

WASHINGTON

Failure of State to:

Place Required Time Limits on Agreements (with provider facilities)

At report writing, all agreements were 12 months. State has prepared (but not yet sent out) a formal notice that all existing 12 month agreements will be withdrawn as of 12/31/71.

Have Other Required Survey Procedures

Facilities participating with 12 months agreements which are not eligible for 12 month agreements.

WISCONSIN

Written Agreements with Skilled Nursing Homes

There is no provider agreement in existence between the State title XIX agency and each skilled nursing home participating in Medicaid as required by CFR 249.33(a)(2).

Other Survey Procedures

It is unclear precisely what action the title XIX agency takes on survey reports

and findings at present; the Regional office has recommended that the agency reorganize its procedures to conform with all the requirements of 45 CFR 249.33.

WEST VIRGINIA

Agreement for Facility Surveys

The State has not implemented an interagency agreement nor made any other arrangements for the survey of title XIX facilities.

Use of Medicaid Standards in Surveys

There is no title XIX certification or survey process.

Written Agreements with Skilled Nursing Homes

The State has not implemented Federal requirements with respect to the execution of provider agreements.

Other Required Survey Procedures

There is no title XIX certification program. Only title XVIII ECF's are permitted to receive XIX payments. State is out of compliance with all aspects of 249.33; staffing reports, standards, provider agreements, etc.

WYOMING

Use Medicaid Standards in Surveys

As of November 10, 1971, none of the approximate 18 skilled nursing homes receiving title XIX payments have been properly certified in accord with title XIX standards.

About 4 of the 18 facilities do not meet one or more provisions of the Life Safety Code. These 4 homes have not been certified to participate with waivers.

Have Other Required Survey Certification Procedures

(a) Survey reports to title XIX agency reflect only those areas of total non-compliance.

(b) Instances of failing to execute the required on-site annual inspections within a 12 month cycle.

(c) Excessive lags (3 to 5 months) were noted in the survey agency procedure of submitting written reports of deficiencies, and in receiving written corrective plans of action from skilled nursing homes.

(d) The procedures in effect for reporting survey findings to the title XIX program are very informal and range in transmittal method from "word of mouth" to occasional memoranda.

LETTER FROM THE ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE, HEW, TO THE DIRECTORS OF TITLE XIX AGENCIES IN THE 38 STATES WHERE NEED FOR SIGNIFICANT IMPROVEMENT IN THE SKILLED NURSING HOME CERTIFICATION PROCESS HAS BEEN IDENTIFIED

Staff from the Department of Health, Education, and Welfare Regional Office have recently visited your State to survey the skilled nursing home certification process. The information they gathered has been transmitted to me by the Regional Office and has been subjected to an analysis by the staff of the Medical Services Administration in Washington. Review of this report indicates that there are substantial deficiencies in your skilled nursing home certification process which require significant corrective action. Thus, there is a question of compliance.

Social and Rehabilitation Service staff will assist any State where the need for significant improvement has been identified in upgrading its procedures. We hope and anticipate that it will not be necessary to institute compliance proceedings that would result in the withholding of Federal funds.

Where the Regional Office has not already received a written plan and timetable for correction of deficiencies from the State, the State must submit this by December 15, 1971. Where insufficient information has been obtained by the survey team regarding the certification process, they will be in touch with you to obtain this further information by December 6, 1971.

I am anxious to have all States come into compliance with the title XIX regulations for certification of skilled nursing homes without the necessity of calling a conformity hearing.

To accomplish the certification goal, we have set the following target date for full compliance in all States:

February 1, 1972.—All States must have in place and ready to operate a mechanism (including organization, procedures, and staff) for surveying and certifying skilled nursing home providers. Beginning on that date, each State will be expected to process all new provider applicants through that mechanism.

July 1, 1972.—All States will be expected to have examined *all* participating skilled nursing homes and to have established that they have valid provider agreements and that they are in compliance or substantial compliance with Federal standards.

As stated above, the Regional Commissioner is available to assist you in any way that he can to meet these deadlines. If, however, the target dates listed in the immediately preceding paragraph are not met, I will have no alternative but to initiate the conformity hearing process. Under Section 1904(a) of the Social Security Act, the Secretary of Health, Education, and Welfare is required to provide opportunity to a State for a hearing to determine if there is failure to comply with Federal requirements. If the State is found to be out of compliance, all or part of the Federal funding for the title XIX program in the State must be withheld.

The above procedures and deadlines relate only to the certification process. We will shortly plan for the review of other aspects of the skilled nursing home program in your State that will cover utilization review, medical review, and other requirements of title XIX.

Sincerely yours,

JOHN D. TWINAME, *Administrator.*

NOVEMBER 30, 1971.

BACKGROUND PAPER CERTIFICATION OF SKILLED NURSING HOMES

A skilled nursing home qualified to care for Medicaid patients and receive Medicaid payments is a facility, or distinct part of a facility, that has been *surveyed and certified* as meeting the conditions and standards set forth under Federal, State and local regulations. These regulations define standards for the physical attributes of the institution (fire, sanitation and safety rules) and for the medical, nursing, and general care and services to be provided for patients.

Since Medicaid is a Federal grant-in-aid program administered by the States in accordance with Federal regulations, State Medicaid agencies are responsible to the Department of Health, Education, and Welfare (SRS) for making sure that State programs operate in accordance with all Federal regulations as well as with State and local rules.

A State can give the Department of HEW assurance that this is so only if it demonstrates that homes are inspected, that standards are enforced, and that only homes that meet Federal, State, and local standards are "certified" to participate in the Medicaid program and receive Medicaid funds.

How does a State do this? The staff of a State Medicaid agency has neither the personnel or expertise to survey homes to find out whether they meet the standards for fire safety, or nursing care, or dietary planning. The Medicaid agency therefore arranges for the "survey" or inspection function to be done, usually employing the State licensing authority or the State authority designated to survey for the Medicare program. This is accomplished thru an "inter-agency agreement." The agency responsible for surveying inspects homes, notes deficiencies, makes recommendations, and forwards its report to the Medicaid agency.

The next step is up to the Medicaid agency which must review the survey findings, inform the home of deficiencies, discuss the possibility of prompt remedial action, and decide whether or not the home meets all requirements for certification. If the home meets standards the Medicaid agency may enter into a "provider agreement" with it. The provider agreement will be in effect for a maximum of a year, and will specify the services to be made available to Medicaid patients and the rate at which the home will be reimbursed for these services.

If the Medicaid agency decides that the home is in substantial compliance with requirements except for some deficiencies which individually or collectively do not jeopardize patients' health and safety, the State agency may enter into

a provider agreement with it for a maximum of six months, providing it is reasonable to believe that the deficiencies can be corrected within that period and the nursing home provides a written plan indicating how it will do so. No more than two successive 6-month agreements may be executed with any nursing home having deficiencies. The second agreement may be signed only if the home can document its remedial effort and progress.

The reports of the regional survey teams that recently inspected State efforts to enforce nursing home standards noted deficiencies relating to interagency agreements, certification procedures, and provider agreements—deficiencies serious enough to have made us inform 38 States that “significant improvements are needed” in their enforcement programs.

Interagency agreements may have been ambiguous about the respective responsibilities of the agencies involved, or they may have failed to set standards for the professional qualifications of surveyors, or may have failed to call for recommendations for the correction of the deficiencies found, or may have been totally nonexistent.

Certification procedures were deficient in that they permitted the certification of homes which did not meet Federal standards. For example, in some cases States did not use Medicaid standards in surveying homes or the Medicaid agency did not review the survey agency's findings before approving Medicaid payments to a home.

Provider agreements were sometimes signed with homes although they did not meet the conditions for such agreements. Some agreements were issued for an indefinite period. Twelve-month agreements were sometimes signed when six-month agreements were called for. Or successive six-month agreements were signed when they could not be justified.

ITEM 2.—MEMORANDUM—DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, SOCIAL AND REHABILITATION SERVICE, MEDICAL SERVICES ADMINISTRATION

August 20, 1971.

To : Mr. Howard N. Newman, Commissioner.

From : Warren R. Whitted, Confidential Assistant to the Commissioner.

Subject : Report on the Skilled Nursing Home Certification Project.

We are pleased to transmit our report on the skilled nursing home certification project. It responds to your request of February 1971, for guidance on how to develop comprehensive procedures for State agencies to follow in certifying skilled nursing homes for participation in title XIX.

The report summarizes the fact-finding surveys made in fifteen States and recommends procedures for correcting some of the problem areas defined.

We believe that if the recommendations are accepted and programs structured to implement them, it can help the Medical Services Administration meet the challenge of making available quality care for title XIX recipients in skilled nursing homes throughout the country.

WARREN R. WHITTED.

PROJECT PARTICIPANTS

Administrative Coordinator of Project : Mr. Warren Whitted.

Director of Certification Project : Mr. Darold Taylor

Staff : Richard C. Davison, Ria M. Finch, Sandra E. Haynes, Edward L. Padler, Ilse C. Sandmann.

Acknowledgement is made of the excellent cooperation the project received from Regional MSA staff in arranging the fact-finding visits. Without this cooperation it would not have been possible to achieve the project objectives.

BACKGROUND STATEMENT

The Medical Assistance Program (Medicaid) operating under title XIX of the Social Security Act is a Federal grant-in-aid program to help States finance medical care for certain low-income groups. Skilled nursing home care is one of the institutional services available under a State's title XIX (Medicaid) program.

Skilled nursing home care under title XIX has been defined as those items and services furnished by a skilled nursing home maintained primarily for the care

and treatment of inpatients with disorders, other than tuberculosis or mental disease. These services are provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law. A title XIX "skilled nursing home" is a facility, or distinct part of a facility, which has been surveyed and certified as meeting the conditions and standards set forth under Federal Regulations (45 CFR 249.33 and 249.10(b)(4)(i)).

Medicaid or title XIX is a Federal grant-in-aid program, administered by the State within Federal guidelines, and financed by Federal, State, and sometimes local contribution. The line of responsibility under the title XIX program goes from the Federal Government to the single State title XIX agency which is responsible to the Social and Rehabilitation Service for assuring that the State program operates in accord with all Federal regulations. The designated State survey agency, usually the health department, is responsible to the single State title XIX agency for surveying facilities participating in the title XIX program.

Medicare or title XVIII is a Federal insurance program federally financed and federally administered. It covers designated benefits for designated periods of time. The purpose of the Medicare program is to help all eligible people in a selected group (i.e., over 65 years of age) by paying part or all of the costs of post-hospital extended care services. A title XVIII extended care facility is a facility, or distinct part of a facility, which meets the conditions and standards set forth under Federal Regulations (20 CFR 405). To insure that these standards are met, there are straight lines of authority and responsibility from the designated State Survey Agency to the Social Security Administration of the Department of Health, Education, and Welfare.

While Federal regulations applicable to standards of care in Medicare extended care facilities and Medicaid skilled nursing homes are essentially the same, there are significant differences in requirements relating to homes' participation in the two programs. The differences in Federal requirements relate to disclosure of ownership, State licensure, hospital agreements, life safety, waivers, and conditions for participation with deficiencies. Because the line of responsibility for Medicaid runs from the Department of Health, Education, and Welfare to the single State title XIX agency, that agency is charged with specific responsibilities to assure that participating facilities meet the minimum standards set forth by Federal regulations.

Prior to entering into an agreement with a facility to participate as a skilled nursing home under title XIX, the single State agency must obtain evidence that the facility meets all applicable Federal, State, and local requirements. This evidence may be obtained through survey arrangements (interagency agreements) with the State licensing authority or with the agency of the State designated pursuant to Section 1864 of the Social Security Act. The single State agency's agreement with a facility (provider agreement) regarding payments under the plan may not cover a period of more than one year. Execution of a new agreement shall be contingent upon a determination that the home is in compliance with regulations.

If a skilled nursing home is determined or certified to be in compliance except for deficiencies which individually or collectively do not jeopardize patients' health and safety, the single State agency may enter into an agreement with it for a period not to exceed 6 months provided that the single State agency can document evidence that:

(a) There is a reasonable prospect that the deficiencies can be corrected within 6 months; and

(b) the skilled nursing home provided a written plan acceptable to the single State agency for so doing; and

(c) a written justification that the deficiencies do not jeopardize health and safety on file with the appropriate State agency.

The single State agency, may accept a home's certification as an extended care facility as certification under title XIX provided that a determination has been made that the facility meets, in addition, title XIX requirements with respect to:

(a) full compliance with State requirements for licensing as a nursing home; (45 CFR 249.10(b)(4)(i)(1));

(b) information regarding ownership of the facility (45 CFR 249.33(a)(1)(i));

(c) arrangements with hospitals (45 CFR 249.33(a)(1)(v)); and

(d) the health and safety requirements (45 CFR 249.33(a)(1)(vii)).

No more than two successive 6-month agreements may be executed with any skilled nursing home having deficiencies. A second 6-month agreement may be

executed only if there is documented evidence that the facility has made substantial effort and progress in correcting the deficiencies.

Under specified circumstances, certain requirements may be waived. The single State agency may waive the application to a skilled nursing home of one or more of the specific provisions relating to environment and sanitation; hospital agreements; or one or more specific provisions of the fire and safety code applied pursuant to Section 1902(a) (28) (F) of the Act if:

(i) it finds on the basis of documented evidence derived from a survey that:

(a) such provision(s), if rigidly applied, would result in unreasonable hardship upon the skilled nursing home; and

(b) the waiver of the specific provision(s) does not adversely affect the health and safety of the patients in the facility and a written justification of such a finding is maintained on file; and where

(c) structural changes in the facility are necessary to meet a provision, the change is of such magnitude as to be infeasible, or economically impracticable; delay in making such changes would not adversely affect the health and safety of patients; and an explanation of this finding is maintained on file; and

(ii) it has assurance that the conditions of waiver are redetermined at the time of each survey and written evidence of such redetermination is maintained on file; and

(iii) any of the conditions found no longer apply, the waiver requirement is rescinded.

INTRODUCTION

The skilled nursing home certification project was initiated in response to recommendations made by the Interagency Committee on Long-Term Care comprised of representatives from HSMHA; SSA; AOA; MSA; CSA; and APA. The Interagency Committee was established in October 1970. The immediate focus of the Interagency Committee was on those long-term care problems which could be identified as short range. It was here that action programs could be initiated within the present authority and administrative framework of the Department.

The first recommendation of the Committee and the one most frequently discussed was that there be "inaugurated a program for reviewing the performance of State agencies in implementing and enforcing standards and certification requirements for skilled nursing homes."

The skilled nursing home certification project was established in response to the Committee recommendation. The project which was initiated March 1, 1971, had as its prime objective the development of a comprehensive procedure that State agencies could follow in certifying skilled nursing homes for participation in the title XIX program. The project was developed in a three phase operation: planning and organization; fact-finding; and reporting and systems development. During the fact-finding phase of the project, State title XIX skilled nursing home certification programs were surveyed and evaluated to provide a base-line from which a comprehensive, nation-wide certification program could be developed. From the State programs reviewed, the project has been able to determine those areas where emphasis must be given in making sound recommendations for implementing a nation-wide certification and enforcement program to meet the intent and provisions of Federal regulations (45 CFR 249.33).

Fifteen States were visited during the fact-finding phase of the project, April 5 through July 13, 1971:

Colorado, Georgia, Idaho, Kansas, Louisiana, Minnesota, Nebraska, Nevada, New York, Ohio, South Carolina, Utah, Vermont, Washington, and West Virginia.

Data are reported as found at the time of the visits but some States have changed their procedure and are currently using other systems. The project has identified many areas where the Federal and State agencies have misinterpreted their responsibilities to enforce standards and to certify skilled nursing homes. In some of the States, attempts are being made to develop programs that would carry out the intent of the title XIX requirements. However, leadership in developing meaningful programs is lacking on the part of the Federal agency.

Most of the State agencies visited (title XIX agencies and licensure and/or survey agencies) want to improve their procedures and programs but need in-

struction on how to go about it. Regional MSA personnel is willing to assist the States if uniform national program guides are made available.

The project findings clearly indicate the need for implementing an immediate and affirmative enforcement program if the Federal and State agencies are to meet their responsibilities in making quality care available to patients in skilled nursing homes. The observations expressed in the report are intended to provide background against which the recommendations made can be seen more clearly.

PART I

SUMMARY OF PROJECT FINDINGS AND RECOMMENDATIONS

Summary

1. In the fifteen States included in the project fact-finding survey, more than half of the 5,109 licensed facilities were participating only in title XIX. Most of these facilities were caring for patients requiring skilled nursing care authorized under title XIX. There were clear signs that facilities were withdrawing from the title XVIII program to participate only in XIX. This creates an even greater and more urgent need for tighter and more effective application of title XIX standards for participation in Medicaid.

2. In the majority of States, title XIX standards were not being effectively applied or enforced for title XIX certification. State licensure standards and decisions were being used as the criteria for certification of title XIX facilities. In homes participating in both titles XVIII and XIX, title XVIII standards alone were being applied to determine certification under title XIX. What was acceptable for title XVIII became the basis for acceptance under title XIX.

3. For the most part, surveyors paid by title XIX had not attended Health Care Facility Surveyor Training Institutes sponsored by HSMHA. The majority of surveyors were professionals in their own right but needed instruction in the techniques of surveying and applying title XIX standards.

4. All States that were visited by the project teams were utilizing local fire safety and/or health department personnel in varying degrees for survey purposes. Most often, local personnel were not familiar with title XIX standards.

5. In most of the States visited, the same agency was used to survey both title XVII and title XIX activities. Facilities participating only in the title XIX program received only token attention; emphasis was placed on facilities participating in the title XVIII program since most of the surveyors were being paid by that program and had received better guidance and supervision.

6. States had not gone much beyond the exact language of Federal regulations that there be "arrangements" with the survey agency. Where agreements did exist they served no real purpose; nor did they meet the intent of Federal regulations. The responsibilities of the title XIX agency to the survey agency were not defined. Services purchased by the title XIX agency including procedures for reporting survey results were not delineated.

7. Communications between survey agencies and the title XIX agencies were very poor. In all States, survey agencies established their own title XIX survey programs and interpreted standards. The State title XIX agencies and the Federal agencies had been of little help in this regard. No uniformity in applying Federal standards existed since each survey agency conducted its own title XIX survey program as it best understood it. Consequently, it is rather difficult for HEW regional offices and the central office to criticize whatever effort the survey agency has been making.

8. The intent of the provisions for waivers and for time-limited provider agreements were not understood or implemented to full advantage by the State agencies. These two provisions are excellent enforcement tools and when properly applied can assist a facility in meeting title XIX standards. The procedure of limiting provider agreements to six months in homes with deficiencies had not been enforced. States that attempted to carry out the intent of the standards had difficulties because Federal agencies had not provided guidance.

9. Twice the flow of information between agencies was very poor; statistics were not available. Facilities that were visited were not familiar with all aspects of the title XIX program, nor did they or the State control agencies have adequate or sound statistics on any aspect of the program. Unless the State and Federal agencies have adequate and sound reporting procedures, title XIX programs cannot be structured to give facilities maximum help in providing quality care to patients.

RECOMMENDATIONS

It is recommended that:

1. An organized program for policy development, training and evaluation be structured and implemented by the Medical Services Administration to provide guidance and leadership to State agencies whose function it is to carry out the intent of the title XIX skilled nursing home certification program.
2. Adequate personnel be made available to the regions to enable them to help the States fulfill their roles in the program, and to the central office to enable it to carry on the functions of policy development, training and evaluation.
3. A communication system linking facilities, States, regions, and the central office be developed and implemented by the central and regional offices to permit development of programs that are meaningful and beneficial to State agencies and title XIX facilities.
4. Regional personnel conduct regular on-site visits to assess progress being made by State title XIX agencies in implementing and enforcing Federal standards and by facilities in meeting standards and providing quality care.
5. Uniform and coordinated titles XVII and XIX survey forms and procedures be developed to better utilize manpower and minimize the number of facility visits needed.
6. Only qualified, trained State surveyor personnel who can help providers "program for improvement" be employed to survey facilities for participation in the title XIX program.

PART II

ISSUES AND RECOMMENDATIONS

A. Nursing Homes Participating in the Federal Programs

In the fifteen States visited by the project survey teams, a total of 5,109 licensed nursing homes and health related facilities were reported. These licensed facilities included Extended Care Facilities (ECF) under the title XVIII program; Skilled Nursing Facilities (SNF) under the title XIX program; Intermediate Care Facilities (ICF) under the title XIX program and all other personal care homes licensed by the States.

1.078 or 21% of these licensed facilities were participating as combination title XVIII and title XIX facilities and 1,509 or 29% were participating in the title XIX program only.

Of the total number of facilities licensed by the fifteen States, 2,587 or 50% were receiving vendor payments under the title XIX program.

In one State, there were no title XIX certified facilities at all. It was found that title XIX payments were being made for care in ECF's only. It became apparent after discussing the title XIX program with some nursing home administrators (licensed homes as well as ECF's) that they did not know the difference between a title XIX recipient and a public assistance cash grant recipient. It was the latter group that everyone considered "Medicaid" recipients.

In reviewing the number of nursing homes participating in the two Federally sponsored programs (titles XVIII and XIX) it became apparent that there was a definite trend for "combination facilities" caring for title XVIII and title XIX patients to withdraw from the title XVIII program. Reasons given for this withdrawal were:

1. The increased number of retroactive payment denials being made by BHI; and
2. Inability to meet title XVIII standards.

Many administrators felt that although they might be unable to meet title XVIII standards, they could meet title XIX standards. In most States, nursing homes believed that eligibility for Medicaid participation was synonymous with licensure.

An attempt was made to determine whether facilities were fully meeting all State licensure requirements before being accepted in the title XIX program. In seven States, licenses were issued without inspection when a facility filed an application. After licensure the facility was inspected at some time during the year. A review of records in every State revealed that homes with licensure deficiencies were "certified" and receiving payments under the title XIX program.

It became apparent early in the project that title XIX was making vendor payments to nursing homes that did not comply with Medicaid standards.

RECOMMENDATIONS

It is recommended that:

1. MSA structure and implement an enforcement and certification program that will assure skilled nursing home compliance with existing title XIX standards.

B. Interagency Agreements and/or Contracts

In six States, no written interagency agreement, contract, or memorandum of understanding was negotiated between the title XIX agency and the survey agency. In nine States written documents were found. However, they did *not* satisfactorily set out all the functions expected of the survey agency.

In only three States was any attempt made to keep interagency agreements current with changes in Federal regulations. Many of the agreements that were reviewed were dated as far back as 1966 and contain only general provisions. Other States prepared their first interagency agreements just prior to the project visit. In only six States did the agreements mention anything about surveying facilities for participation in the title XIX program. One of the largest cities in the country was not included in its State's interagency agreement. In this case, the single State agency had no contractual agreement with the city and surveys of 97 proprietary title XIX homes were made without guidance or supervision from anyone at the State level. The title XIX agency could give no assurance that these homes were in compliance with standards. In none of the interagency agreements were the specific duties and responsibilities of the survey agency or the title XIX agency adequately established.

RECOMMENDATIONS

It is recommended that:

1. When a title XIX agency purchases services from a survey agency an interagency agreement be negotiated that delineates responsibilities and specific duties for both agencies.

2. The interagency agreement incorporate funding procedures for supporting surveying and consultative services.

3. The interagency agreement provide that surveying activities be performed exclusively by the State survey agency.

4. The agreement be reviewed periodically to keep it up to date with changes in title XIX regulations.

5. In a State whose administrative organization or law precludes an interagency agreement, the two organizational units charged with responsibility for surveying and executing provider agreements exchange a "memorandum of understanding" setting forth the specific duties and responsibilities of each.

C. Qualifications of Surveyors Participating in the Title XIX Program

In nine of the fifteen States title XIX and survey agencies signed agreements that did not mention the number, types, or qualifications of personnel needed to survey facilities for participation in the title XIX program.

In the fifteen States that were visited, 303 people were employed as surveyors at the State level. Of this number, 274 were conducting surveys for both title XVIII and title XIX and 29 were conducting surveys for title XIX only. The majority of the surveyors were professionals in their own right (nurses, sanitarians, hospital administrators, etc.) and employed under State merit systems. Thus, they met State employment requirements for their professional categories. However, very few surveyors had received instruction or guidance in the techniques of surveying or in the applicable standards for the title XIX program. In two States separate job descriptions for "Health Care Facility Surveyors" had been developed and were being used when new surveyors were hired.

Of the 303 surveyors surveying for the two Federal programs, only 43 had attended the University Health Care Facility Surveyors Institutes sponsored by HSMHS. The Institutes were designed to improve survey and inspection techniques of surveyors and to acquaint them with requirements of the title XIX and title XVIII programs.

Three States had not sent any surveyors to the training institutes. If quality surveys are to be made and programs instituted to improve facilities, all surveyors must receive instruction in the techniques of surveying, documentation, consultation, and working with facilities to "program for improvement." If quality surveys are to be made and programs instituted to improve facilities, all sur-

veyors must receive instruction in the techniques of surveying, documentation, consultation, and working with facilities to "program for improvement."

Most of the surveyors who had attended a Surveyor Training Institute were surveying for the title XVIII program because their training had been funded by title XVIII. In only one State had title XIX funds been used to send surveyors to a Surveyor Training Institute.

RECOMMENDATIONS

It is recommended that:

1. All State interagency agreements be amended to require that surveys be made by personnel qualified by special training.
2. Federal funds be made available to pay 100% of the cost of training title XIX surveyors at Surveyor Training Institutes.

D. State Agencies Surveying for Participation in the Title XIX Program

In all fifteen States, the title XIX agency delegated all survey responsibilities to the State Health Department. In two States, title XIX surveys were combined with licensure procedures.

In three States there was no title XIX survey activity at all. In two of these States, the survey agency merely transmitted periodically to the title XIX agency a list of homes that had been licensed. In the other State, the title XIX program had no title XIX certified homes. In one State, title XIX skilled nursing home payments were restricted to certified ECF's. In the remaining ten States, the same State agency surveyed for title XVIII and title XIX. To the extent that only six States were providing very modest funds for the title XIX surveys, the reviews revealed that title XIX survey activities were being carried by title XVIII or licensure survey activities.

Combination title XVIII-XIX facilities were being surveyed more comprehensively than title XIX—only facilities since the former were surveyed against the Medicare survey report form. Most survey units recognized no different or additional requirements for title XIX. In those States that had identified additional title XIX requirements, the interpretations of the requirements were either incomplete or incorrect.

Because title XVIII was paying survey unit costs, the tendency was for title XIX-only facilities to receive token attention. In most cases they were merely "certified" to the title XIX agency on the basis of verification of the last State licensure survey and not on a separate title XIX survey. In many States, title XIX certification was so closely related to licensure, that title XIX de-certification paralleled the State's licensure revocation process.

Only five States had developed with varying degrees of success, a survey form for title XIX. It was significant, however, that in every State, regardless of the survey process or the forms used, nursing home administrators were unable to distinguish title XIX survey activity from licensure or in the case of facilities also participating in title XVIII from Medicare surveys.

In none of the States had the title XIX agency provided the survey agency with procedures, guide material, or operating instructions for use in surveying for title XIX. Most of the State survey agencies had, on their own, interpreted the standards as best they could and structured survey activities accordingly. Consequently, some States had done a better job than others in developing survey activities. Uniformity among States in implementing this activity and interpreting title XIX standards was completely lacking.

RECOMMENDATIONS

It is recommended that:

1. A combination title XVIII and title XIX survey form be developed and made available to the States for use in certifying *all* title XIX facilities. This will assure that all facilities participating in title XIX are certified under the same standard.
2. State title XIX staff receive adequate training in the administrative aspects of the title XIX program and staff concerned with certification attend the surveyor training course.
3. Measures be instituted to assure adequate State title XIX funding for survey activities.
4. A uniform system be developed and implemented for keeping the title XIX agency advised about facility compliance with standards to enable the agency to make better judgments on the issuance of six month or twelve month provider agreements.

E. Survey Responsibilities and Reporting Survey Findings

In addition to State level personnel surveying for the title XIX program, it was found that State and local fire marshals and local health department personnel also assisted in the survey process. Most of the fire safety surveys were made by local fire marshals. But local fire inspection personnel were never fully acquainted with Life Safety Code requirements. Most facility survey files reviewed did not list specific fire safety deficiencies. The files merely contained a brief statement or certificate to indicate that the facility had been inspected for fire safety.

It was evident that Life Safety Code requirements for title XIX were not being enforced. It was also found, in every program reviewed, that local health department personnel were surveying for title XIX without adequate instruction in title XIX requirements. Local health department sanitarians inspected the physical plant, sanitation, etc. Nurses surveyed nursing, dietary, medical records, etc. In three States the health department had re-delegated survey responsibilities to city or county health agencies that carried out the complete survey.

In only five States were survey findings reported to the title XIX agency. In only four of these were these findings being reported in any detail. In the other ten States the title XIX agency received only a list of facilities inspected by the survey agency. On this limited basis the title XIX agencies determined whether facilities should participate in the title XIX program.

In all States the survey agency files contained copies of facility survey reports rating numerous deficiencies of various kinds. Most frequently these deficiencies related to fire safety, sanitation, housekeeping, dietary, nursing, and medical records. Most files indicated that facilities had been notified about the deficiencies found. In all but three States, plans for correcting deficiencies were also found in the files kept by survey agencies. However, the corresponding files kept by title XIX agency files (when they existed) contained few if any of the deficiencies noted in the survey agency files. One of these States considered unnecessary and did not require facilities to file plans for correcting deficiencies.

RECOMMENDATIONS

It is recommended that:

1. All State interagency agreements specify the number of qualified personnel the survey agency needs and should have to survey for title XIX.
2. The agreement between the title XIX agency and the survey agency specifies that the latter will employ only qualified personnel to survey for fire safety.
3. Surveyors receive adequate training in the administrative aspects of the title XIX program and attend a surveyor training institute.
4. Guidelines be developed to help State title XIX agencies establish operating procedures that assure that title XIX facilities meet all Federal and State requirements.

F. Issuance of Waiver

The title XIX program permits facilities that are deficient in ways that do not jeopardize the health and safety of patients to remain in the program under a "waiver." This enforcement technique was not generally used. Only three States were considering the proper use of this option. One of these was establishing a board to review all waivers recommended by the survey agency. The review board would make recommendations to the title XIX agency on the issuance of waivers.

RECOMMENDATION

It is recommended that:

1. Detailed guidelines be developed to help State agencies use the waiver option advantageously in an enforcement program.

G. Provider Agreements

None of the States employed adequate mechanisms to assure that provider agreements took survey findings into account. In fact, five States had no provider agreements at all. In States that did issue provider agreements, they were neither comprehensive or adequate in specifying terms, conditions, and responsibilities.

Three States issued six-month provider agreements. The remaining States issued only annual agreements. A study of survey files indicated that most facilities should have been granted only 6-month provider agreements because of the number of deficiencies noted. In three States, a provider agreement remained in effect until it was revoked.

One State included a clause in its printed provider agreement blanketing in for six-month facilities operating under a provisional licensure permit.

In five States the survey agency made the initial determination of a facility's certification and advised the facility of its status. In seven States the title XIX agency made the determination on certification. In all cases, however, this determination was made on the survey agency's recommendation and in most cases without substantiating information.

Three States had no program at all for certifying facilities. In only three States was any attempt made by the title XIX agency to review survey agency findings before certification.

RECOMMENDATIONS

It is recommended that:

1. A uniform procedure be established and implemented to guide title XIX agencies in granting provider agreements, with special emphasis on procedures for assuring that provider agreements be related to the title XIX agency's evaluation and review of survey data.

H. Facility Operators' Understanding of the Title XIX Program

Project members tried to find out to what extent facility administrators understood the title XIX program. In conversations with the administrators and their staff, it was found that confusion rather than understanding existed.

In one State, facility management believed the title program was synonymous with cash grants of public assistance titles. All facility administrators and staff sought interpretation of standards and consultation services from the survey agency. Because the survey agency emphasized the title XVIII program, it gave little consultation relative to standards for title XIX. Facility operators seemed to know where to turn for financial matters. Many facilities relied heavily on the State Nursing Home Association and other professional organizations for information on title XIX. Since they learned about the program piecemeal, there was no uniformity of understanding on the application of title XIX standards.

In general very little facility-directed information about the title XIX program was available in title XIX agencies, except in relation to patient placement and payment.

Unless an organized and uniform system is developed to provide facilities with basic information about the title XIX program, there is little chance for facilities throughout the country to receive proper interpretation of standards and enforcement policies.

RECOMMENDATIONS

It is recommended that:

1. The State title XIX agency assert more leadership with regard to facility certification and compliance with all title XIX standards.
2. The Federal agency through regional offices provide guidelines for State agencies relative to their responsibilities.
3. Adequate personnel be made available in each region to help the States carry out their responsibilities for interpreting and enforcing standards.
4. Adequate personnel be made available to the central office to help the regions implement policy standards.

IMPLEMENTATION OF RECOMMENDATIONS

President Nixon on August 6, stated that:

1. One hundred and fifty new staff positions will be made available to enforce nursing home standards.
2. One hundred percent Federal funding will be provided to pay for surveying nursing homes.
3. Two thousand surveyors will receive training.
4. The present program to train surveyors at university training courses will be expanded.

Phase II of the Skilled Nursing Home Certification Project was to develop systems to implement the certification process at the Regional, State, and local levels. Such a system has been developed and will affect the recommendation in part II of this report.

An enforcement and certification program has been structured and implementation in the form of training State staff will begin in October 1971.

PART II

Page 9—*Recommendations 1-5*

A. Sample interagency agreement has been devised. Its clauses provide for:

- (a) funding procedures for surveying and consultative services
- (b) clear delineation of duties and responsibilities of both the single State and the survey agency
- (c) surveying to be done exclusively by the State survey agency
- (d) periodic review of the agreement to keep it current with Federal regulations.

The training courses for HEW Regional Staff to begin in September 1971 will include a section on a "Memorandum of understanding" for those States in which such form of agreement is applicable in lieu of an interagency agreement.

Page 14—*Recommendation 1*.—The sample, interagency agreement provides that only qualified surveyors may survey title XIX homes.

Recommendation 2.—The President's message indicated that such funds will be made available.

Page 16—*Recommendation 1*.—A permanent interagency committee has been formed to develop a joint survey form for titles XVIII and XIX.

Recommendation 2.—A training course for MSA staff has been authorized to begin September 14, 1971 to teach the administrative aspects of the title XIX certification program.

Recommendation 3.—The President's message stated that Federal funding for surveying title XIX homes would be at 100%.

Page 17—*Recommendation 4*.—MSA has developed a system for keeping the State title XIX agency apprised of compliance with standards. The training of State staff in this system is to begin in October 1971.

Page 18—*Recommendation 1*.—A suggested ratio of one full-time equivalent surveyor to 20-25 facilities is being recommended for incorporation in the interagency agreement.

Page 19—*Recommendation 2*.—The sample interagency agreement has incorporated a clause requiring that only qualified surveyors inspect title XIX homes. The criteria for qualified surveyors are being issued by MSA.

Recommendation 3.—University surveyor training courses after September 1971 will provide at least 8 hours for title XIX orientation.

Recommendation 1.—A sample waiver form has been developed for use by States to determine whether waivers are to be granted.

Page 21—*Recommendation 1*.—A sample provider agreement has been devised to incorporate all aspects of the certification process. Training in its use will begin in September 1971.

Page 22—*Recommendation 2*.—The new MSA "Certification Process Course" will provide steps and guidelines for regions and States to assist them in implementing the requirements of the law and the regulations.

Pages 22, 23.—*Recommendations 3 and 4*.—The President's message has promised 150 more people to carry out the enforcement of standards for skilled nursing homes.

Appendix 2

SKILLED NURSING HOME CERTIFICATION PROJECT

(Mr. Warren Whitted, Administrative Coordinator of Project; Mr. Darold W. Taylor, Director, Certification Project)

OBJECTIVE

The object of the project is to develop comprehensive procedures that State agencies can follow in certifying skilled nursing homes for participation in title XIX.

Federal law and regulations prescribe standards which must be met by skilled nursing homes to participate in title XIX. The project will: (1) survey and evaluate operating State programs to determine the existing practices in States operating title XIX programs and (2) develop recommended guidelines and manuals or procedure that will interpret standards so that meaningful evaluation and judgments can be made in certifying skilled nursing homes.

The project will be developed in a three phase operation as follows:

PHASE I—PLANNING

(a) *Communication development.*—Communications will be developed with the regional offices to advise of the project and solicit cooperation in the surveying phase. Contact will not only be made with the regional SRS/MSA personnel but also with the regional CHS personnel.

(b) *Review State plans.*—A very cursory review will be made of existing State plans to determine the extent State plans now in effect incorporate comprehensive certification procedures.

(c) *Select areas to be surveyed.*—Title XIX standards will be reviewed to determine areas to be covered by the sampling survey and develop survey procedure.

(d) *Develop survey forms.*—Survey forms and/or guidelines will be developed to reflect subject areas selected for coverage during the survey and determinations made as to the depth of coverage on each subject area.

(e) *Determine time need for each State survey.*—Time frames will then be developed for the surveys in order to give the survey teams ample time to interview State agency personnel and review necessary records.

(f) *Orientation and training.*—Orientation training will be given the survey staff on procedures and techniques to be followed in obtaining information during the survey. Uniform procedures for recording the information will be outlined in order to expedite tabulation procedures. At this time determinations will be made as to survey team structure, i.e. How many should be represented on the team from headquarters; the region, etc.?

(g) *Select State for survey coverage.*—In coordination with the regions, select States to be covered by the survey. At least two States in each region should be visited. States with both large and small programs will be scheduled. States with de-centralized welfare programs will also be included in the survey study.

(h) *Develop schedule for survey visits to States.*—Team survey visits to the States will be scheduled and coordinated through the regions so that the regions can make the necessary arrangements for the visits.

PHASE II—SURVEY

(a) *Major area to be covered.*—The survey will focus on two areas: (1) the procedures in effect in the single State agency for obtaining information on the compliance of skilled nursing homes with title XIX standards in accordance with 45 CFR 249.33 and (2) a sample review of survey reports on skilled nursing homes currently participating as providers under the title XIX program.

(b) *Record review and personnel review.*—Complete information will be obtained through interviews with the single State agency personnel and examination of pertinent records on how the State agency is carrying out the certification process as set forth in sub-paragraph (a) (2) of 45 CFR 249.33. A list shall be obtained from the single State agency of all skilled nursing homes paid under title XIX program and survey reports will be obtained from the survey agency for a sampling of these homes. The survey agency files will be reviewed to obtain the following information :

1. Is the date of the latest survey sufficiently recent for a valid certification?
2. Do the survey reports cover all of the requirements for participation in title XIX?
3. Where significant deficiencies are noted, what actions have been taken to obtain correction of the deficiencies?
4. Is the contract with the facility limited in accordance with regulations?
5. Where deficiencies with respect to environment, sanitation, and fire safety standards are noted, has compliance been formally waived by the single State agency and are the waivers on file supported by the findings required under (c) (2) of CFR 249.33.

(c) *Visits to skilled nursing homes.*—Where at all possible sample visits will be made to the homes whose records have been reviewed in order to assess the completeness and accuracy of the data contained in the files. As a result of these visits, an estimate of the total amount of payments made to the homes which are not properly certified will be made.

(d) *Possible audit followup.*—After the above information has been obtained and visits made to the homes, a decision will be made by the headquarter's office as to whether or not a complete audit should be made to further substantiate payments to unqualified facilities in the State.

(e) *Tabulation of survey findings.*—Survey findings will be tabulated in a form that can be used to develop a comprehensive report and to structure recommended guidelines and/or manuals that can be used so that meaningful evaluations and judgments can be made in certifying skilled nursing homes.

PHASE III—REPORTING AND DEVELOPING GUIDELINES

(a) *Developing report.*—A comprehensive report will be developed to summarize the survey findings. The report will reflect the strong and weak points of certification activities as they were surveyed and suggested actions to structure a national certification program for skilled nursing homes.

(b) *Development of guidelines.*—Recommended guidelines and/or manuals will be developed that will assist the regions and the State agencies in interpreting title XIX standards in determining agency and facility compliance for certification.

(c) *Recommendations.*—Recommendations will be made as to the future role, organization, and personnel needed to fill the role of MSA in the certification of skilled nursing homes.

Appendix 3

PREPARED STATEMENT

ITEM 1.—PREPARED STATEMENT OF BERNARD E. NASH, EXECUTIVE DIRECTOR, NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS*

My name is Bernard E. Nash. I am Executive Director of the 3.4 million member National Retired Teachers Association and American Association of Retired Persons.

Over one year ago, I discussed the serious deficiencies which existed in many of our nation's nursing homes in an article in our Associations' magazines, *Modern Maturity* and the *NRTA Journal*. That account carried the title, "The Nursing Home Scandal." In the ensuing months, our Associations have been in the forefront of a campaign to correct this major blight in our nation's social system. In an editorial in this month's *Association News Bulletins*, we note the recent actions by the Administration to tighten up inspection programs and strengthen training programs for nursing home personnel. It expresses our hope that finally the nation may be willing to substitute action for rhetoric in dealing with this cruel social situation. But much action is still needed.

There has been no lack of publicity and public awareness of documented instances of neglect and disregard for personal dignity, non-professional and untrained administrators and personnel, federal funds illegally flowing to substandard homes, physicians with inadequate geriatric training, and the absence of compassionate treatment, necessary services and normal activities for the institutionalized elderly.

And there has been an abundance of investigations and recommendations by Congressional committees and subcommittees, Executive Branch task forces, inter-agency committees and study groups, and public interest organizations.

Among our Associations' Legislative Objectives for 1971, no less than 6 are concerned in one way or another with long and intermediate-term non-hospital care. Arkansas Congressman David Pryor, whose nursing home crusade is well known to each of you, conducted special hearings on the subject of three of our Associations' area conferences in 1971. President Nixon selected our Chicago area conference in June to disclose that the federal government was moving to cut off Medicare and Medicaid funds in substandard nursing homes.

We are heartened by the President's eight-point nursing home program set forth in New Hampshire and the new Areawide Model Projects initiatives, several bearing on nursing home activities, to be operated by the Administration on Aging. While we are optimistic, our experience warns us to be cautious. We will be watching to see whether performance matches promise and commitment overcomes obstacles.

I hope it is apparent from the foregoing remarks that we believe recommendations for betterment of nursing homes exist in plentiful supply. What has not been evident is effective action.

Mr. Chairman, in November our Associations, in our continued fight to improve the nursing home situation in this country, sponsored last November, in cooperation with Duke University, a symposium, "The Nursing Home: Critical Issues in a National Policy," and while you probably read or heard little about the meeting, it was one of the most hopeful developments in decades in solving what I have described as one of our society's most cruel social concerns.

If the needed changes are to be made to improve the quality of nursing home care in America, the group which assembled for this forum must do it. For they are the agents of change. And the fact that you read or heard little about the meeting is no measure of its impact or success. It was planned that way. Our hope was to end the sniping and headline-grabbing charges being hurled through

*Statement submitted subsequent to the hearing.

the media at various segments of the nursing home industry and bring together the people most directly involved in designing, delivering and financing nursing home care.

From a list of more than 3,000 leaders, we selected 80 persons, including the presidents of 8 organizations involved in nursing home care. Present were the leaders of private and public facilities, profit and non-profit homes, experts in the financing and delivery of care, nurses, doctors and government officials. Program participants included HEW Secretary Elliot Richardson, the White House Conference on Aging chairman, Dr. Arthur Flemming, Rep. David Pryor, Senator Frank Moss and consumer advocate Ralph Nader. Appropriately enough, Val Halamandaris, your staff specialist in the Nursing Home area, gave the keynote speech—and set the stage for the conference in a commendable manner.

At the opening session, I—and our co-chairman Dr. Carl Eisdorfer, director of the Duke Center—urged “an open and frank discussion of the whole problem of long-term and extended health care. There will be no headlines coming out of this conference,” we said, “and no press releases will be issued.”

Certainly the objective of a free and candid discussion was achieved. And I believe that progress was made in achieving the more important goal of solving the problems. Too much generalization, emotion and despair has dominated the issue in the past. Forum participants agreed, I think, that the problems are solvable and that nursing homes must be viewed less as mere medical facilities and more as human institutions.

They acknowledged the fact that in our nation today there are many good—and many bad—nursing homes. And they agreed that excellence must be the goal for all.

Preliminary results and recommendation of the forum were made available to the White House Conference Section charged with dealing with the nursing home crisis.

At this point Mr. Chairman, I should like to summarize for you the major recommendations from that Forum.

THE NEED FOR COMPREHENSIVE QUALITY CARE

The absence of comprehensive health services for the impaired aged and younger persons with chronic conditions underscores the need for a reexamination of our goals and the development of a new national policy for the infirm. In the shaping of this policy, the government should play an expanded role in encouraging and assisting professions in setting uniform standards, enforcing them and ensuring increased accountability.

Such a national policy should derive from such essential values concerning comprehensive health care as continuity of service, the affirmation of the inseparable link between the medical and psycho-social or emotional aspects of long-term care, and the need for a full range of support and remedial services (e.g., home services and day care) provided by qualified, well-trained staff. This would eliminate artificial distinctions between “skilled nursing care” and “custodial care.” The nursing home is an essential aspect of a continuum of comprehensive health care—a setting in which an infirm person can be treated effectively instead of being “warehoused.”

Since the meeting of medical needs and the meeting of psycho-social needs are known to be mutually reinforcing, the Federal government should develop and support pilot projects that would provide cost estimates for “social care” systems and test the hypothesis that such systems might reduce the cost of medical services. These experimental efforts should build on preliminary data emerging from similar studies now underway.

The evidence of discriminatory treatment of the mentally ill requires special consideration. Particular caution must be exercised to avoid the “dumping syndrome”—moving the patient from a state hospital to the community, for example, without investigating whether his home environment is adequate. Such indiscriminate transfers can also be a serious problem in the treatment of other infirm persons.

Physicians should play a more vigorous role than they now do in institutional long-term care. Every skilled nursing home and extended care facility should have a full-time or part-time medical director, and at least one full-time or part-time registered nurse, depending on the number of patients served. The team responsible for the patient's care should also include a mental health consultant. Careful screening programs by teams representing relevant disciplines should be

established to prevent long-term institutionalization of persons who do not need such placement.

The Federal government should finance short-term training programs as well as continuing inservice training for the staffs now employed in nursing homes. In addition, it should provide the funds required to stimulate the university-centered training of geriatrics experts in medicine, nursing, social work and mental health. An immediate specific goal is the creation of departments of geriatrics and special programs of health care for the aged in at least six to ten medical centers throughout the country. By developing a broad awareness of the need for such training, professional associations can plan a useful public educational role in support of the Federal government.

Training of paramedical personnel should be accelerated, their pay scales upgraded and a built-in career "ladder" provided. A government-sponsored conference of experts in the major professional disciplines of geriatric care should help determine the types of training needs, giving consideration to the kinds of work to be performed, pay scales, career incentives, upward mobility through further training, status, job satisfactions and the nature of dissatisfactions among personnel currently employed in nursing homes. Estimates of current personnel shortages, reasons for shortages and sources of recruitment should be taken into account. Implementation of recommendations from such a conference should be the responsibility of HEW.

Future legislative measures should improve—not lower—the quality of care and professional standards in nursing homes. (Sections 265, 267 and 269 of H.R. 1, now before Congress, for example, would constitute a retreat from present standards of care.)

SETTING RELEVANT STANDARDS AND ENSURING PUBLIC ACCOUNTABILITY AND ENFORCEMENT

In the current absence of uniform standards that deal with actual performance, and in the interests of a coordinated national policy, a system should be devised to grade and label the many existing long-term facilities according to the type and quality of the services they offer. Compensation should then be scaled to the range and quality of the services the facilities actually provide, as distinct from the mere fact of their availability.

Existing regulations on long-term care facilities should be vigorously enforced.

Section 1106 of the Social Security Act should be amended to permit full public disclosure of all institutional deficiencies, with appropriate mechanisms established to permit interested persons to review reported deficiencies.

To handle instances of noncompliance, and to ensure an effective national monitoring program, a system should be developed under which the Federal government contacts the Governor of a particular state to advise him of the deficiencies, to provide time for voluntary correction and to withhold funds if the State fails to comply.

The enforcement system should encourage such voluntary associations in the aging field as NRTA-AARP and the NCSO to accept the role of monitoring institutional performance and assisting local institutions in efforts to enrich the lives of patients and improve the quality of patient care. Local citizen groups could play an important advocate role in helping provide increased financial and moral support.

When nursing homes have valid reasons for requesting assistance to bring their facilities and services up to standard, the Federal government should make short-term loans available.

IMPROVING FINANCIAL MECHANISMS

To support the changes required for moving toward a comprehensive system, the use of trust funds and other monetary sources must be greatly augmented by general funds from Federal tax revenues.

The Federal financial incentives provided for good care should relate not merely to the maintenance of an institution's physical plant but to the quality of the care and the services the physical envelope contains.

Section 207 of H.R. 1 should be eliminated because it reduces Federal participation in Medicaid by one-third after 60 days. Similarly, Section 225 should be deleted because it arbitrarily limits cost increases to 105 percent of the prior year's expenses.

In addition to the above recommendations, I should like to include also several recommendations which did not reach the floor for discussion, they are :

COMPREHENSIVE QUALITY CARE

Develop voluntary action programs that would permit the elderly to remain in their homes or other places of residence. These programs, however, must be additions to and not substitutes for swift action to improve institutional care.

Create a federally-funded Personal Achievement Liaison Service whose representatives would perform the following functions: help residents of long-term facilities to adjust to their changing physical and social environment without relinquishing the old interests and values that characterized their life styles; participate with the patient and other professional staff in the planning of all social and leisure activities; support and encourage achievement in the direction of personal and social autonomy, thereby integrating the social health needs of the patient with his medical physical care program.

Create an awards program to recognize excellence in the nursing home field.

STANDARDS, ACCOUNTABILITY AND ENFORCEMENT

Periodic review by a citizen review board of every long-term facility receiving payments from the Federal government. Each citizen review board should consist of at least three consumers who are not members of the community health care system and one resident from each nursing home.

The Commission on Malpractice of the Department of Health, Education and Welfare should address itself to problems in the nursing home field and the Commission should include representation of long-term care providers.

FINANCING

End the practice of making retroactive denials of payments to Medicare facilities, and implement regulations designed to assure payments to such institutions.

MEDICAL REVIEW

The processes of periodic medical review of physician, nursing, personal, and social care and planning for medical assistance patients in skilled nursing homes and mental hospitals, as these are set forth in Regulation 250.23 of the Social Security Amendments of 1967, should be assiduously followed and aggressively implemented by all Title XIX Single State Agencies.

Appendix 4

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER WITH ENCLOSURE FROM SENATOR CLIFFORD P. HANSEN TO SENATOR FRANK E. MOSS, NOVEMBER 9, 1971

NOVEMBER 9, 1971.

HON. FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care, Special Committee on Aging, New Senate Building, Washington, D.C.

DEAR TED: I regretted that I was unable to attend the October 28 hearing you conducted on Trends in Long-Term Care. I was, however, represented at the hearing and advised of your very excellent statement and conduct of the hearing.

I have received a letter from Dr. A. L. Lichtman, Director of the De Witt Nursing Home in New York City which seems to be most appropriate to the subject of that particular hearing. I would appreciate having the enclosed correspondence entered in the record of the hearing.

With kind regards,
Sincerely,

CLIFFORD P. HANSEN,
U.S. Senate.

[Enclosure.]

DEWITT NURSING HOME,
New York, N.Y., October 14, 1971.

HON. CLIFFORD P. HANSEN,
Senator From Wyoming, New Senate Office Building, Washington, D.C.

DEAR SENATOR HANSEN: At the suggestion of Mr. C. C. Kuehn, I am taking the liberty of writing to you on some present problems in the care of the aged in this country.

Since 1964 there have been many articles attacking conditions in the homes of the country, but few constructive articles have appeared. Other than insisting upon better care, few suggestions as to how to improve care have been offered. Suggesting new plans and allocating money offers little in the way of eliminating existing condition.

There are substandard facilities and the demand for space in these are a result of a shortage of beds for the care of the aged. The personnel working in these substandard homes have to work harder to maintain cleanliness and a satisfactory appearance in the rooms. It is harder to move the patients, and they lack recreational, occupational and rehabilitative facilities. It is more difficult to free them of odors. In the near future these must be replaced. Regardless of the method, eventually the cost is borne by the public.

The new legislation on Health Care being studied, of which there appears to be 45 varieties, in most cases carefully omits plans for the care of the aged in nursing homes. This apparently is a result of what is considered in many circles to be a fiasco resulting from the Medicare Bill.

As interpreted by the intermediaries and the Bureau of Health Insurance, Medicare, with reference to nursing home care, is practically non-existent. The interpretation of the skilled nursing care requirement has been so constricted and garbled that there is no possibility of predicting what few cases would be eligible and for how long. From the viewpoint of the nursing home personnel who are close to the problem, a horrible and wasteful state exists. As a result of the original application of the plan, large staffs survive in the intermediaries and the Bureau of Health Insurance whose sole nursing home function is the rejection of the required application of all eligible cases. What is needed is more education and less inspection and more research in this neglected subject.

It is the opinion of the present nursing home operators that the bulk of funds allotted to nursing homes is spent on the rejection and retroactive denial phenomenon. The Medicare Bill that was written by Congress was actually a well intended attempt to help care for the sick, aged person, but some people

abused the act. This has occurred during the early phase in all nations in which this type of legislation has been introduced. But the pendulum was pushed too far back. At present, the nursing home care of the aged has become dependent on Medicaid plans which are more realistic.

Much of the criticism of the nursing homes is actually a result of the nature of the care of elderly sick people. Incontinence, aphasia, agitation, brain syndrome and loss of elasticity of the skin, which all are due to the aging process, lead to many of the situations that have led to calling nursing homes "snake pits" and "warehouses of the dying." This care is a difficult problem requiring complete dedication of the attendants who render it and who receive few compliments and many complaints. Elderly people often become belligerent as part of their illness and the role of the attendant is not an easy one. Today's youth oriented society tends to relegate the Senior Citizen group to the nonentity classification. Present day attitudes of the young make it difficult to find people who are willing to give the tender loving care that is needed. To counteract this, the primary requisite is intensive training of those personnel who are willing to accept the thankless job. In planning for ways and means of remedying existing conditions this intensive training of personnel should be given as high a priority as the training of more inspectors to visit the homes and weed out the substandard facilities.

By its very nature the care of the aged is difficult. People have certain hang-ups about the elderly that they must overcome in order to relate to the aged. Personnel must undergo reality training and prepare themselves for the necessary remotivation. Devoted dedicated workers are hard to find. Aged individuals with paralysis due to strokes, incontinence of urine and feces, agitated states due to brain damage, disorientation and constant complaints can try anyone's patience. Loss of speech, the inability to swallow, and aggressiveness are often found in the same person. Added to this, in Metropolitan areas there is the variety of languages that have to be adjusted to. The Paul de Krief of the geriatric nurse has not yet been born. Attendants are often struck with chairs, canes and crutches. All they hear are complaints of relatives and receive few thanks. These disgruntled relatives are the very children who are often too busy to care for their own parents. Furthermore, personnel are subject to continuous harassment by families and friends who vent all their pentup guilt feelings on them. They fail to remember that these staff members have to deal with a multiplicity of problems that they were unable to cope with even while taking care of just one parent. Two parents can bring up ten children, but ten children do not seem to be able to care for one parent. In the past five years, legislation has released children from the responsibility of their parents, producing a group of wealthy individuals who pauperize their parents, placing them in nursing homes under Medicaid and then visit as infrequently as once every two or three months to complain in the loud voices of very important people about the general care. Persons in the high income bracket should be required to pay something toward the care of their parents.

I wish to stress that the greatest need in the care of the aged is educators in the areas of reality training, remotivation and the basic fundamentals. In view of the fact that medical schools and nursing schools have largely ignored this field (a field which involves care of one third of the sick population) the nursing homes themselves must set up more extensive educational facilities to train Medical and paramedical personnel for these purposes. Until such training is available, improvement in the care of the aged will not become a reality.

Thanking you for your kind consideration and the interest you have shown in upgrading Nursing Home care, I remain,

Yours very truly,

A. LEE LICHTMAN, M.D.,
Director.

ITEM 2. LETTER FROM JEAN K. FILER, ADMINISTRATOR, CYPRESS ACRES NURSING HOME AND CONVALESCENT HOSPITAL TO SENATOR FRANK E. MOSS, NOVEMBER 8, 1971

PARADISE, CALIF.,
November 8, 1971.

Senator FRANK MOSS,
*Chairman, Subcommittee on Long-Term Care, New Senate Office Building,
Washington, D.C.*

DEAR SENATOR MOSS: It has been brought to my attention by Marshal Horsman

that it is possible to have further testimony read into the record on long-term care.

Since 1945 I have been in a position to provide care to the chronically ill and aged. Every effort has been made to develop programs in my nursing home to give meaning to the everyday life of our patients and staff. Emphasis has been placed on community involvement through volunteers in the home and my activities in the community with service clubs, church groups, senior citizens organizations and the California Association of Nursing Homes Sanitarium, Rest Homes and Homes for the Aged, Inc.

Understanding the needs of individuals and developing programs to fulfill these needs are a challenge to any administrator. Overcoming the concept of the keeping a patient in bed and waited on for their every need has been accomplished in our facility through a *strong* policy to educate and train staff to provide rehabilitative nursing procedures—which will allow the patient to be up—dress and ambulated when at all possible—this is the primary goal established by our staff and the attending physician in most cases.

Going for a two hour auto trip to points of interest has been the delight of many of our long term (non-ambulatory) patient—lunch at a hamburger stand with directions from the dietitian as to what would be allowed, planned in advance. With a sing-a-long on the way home to the accompaniment of a patient on the harmonica.

A monthly Pancake Breakfast with patients cooking the pancakes complete with Chef's hat and apron—with volunteers from the community assisting. Halloween parties with apple cider, pumpkin pie, costumes and decorations. All planned and participated in by patients, families and staff—again "volunteers in costume, music and participation of patients and staff make this a fun time for all."

Every month there is a big birthday party for all who have a birthday—cake, candles, ice cream, plus punch or coffee.

We have had fashion shows—hat shows with all participating—the models go into the rooms if the patients can't leave them.

The biggest event of the year is for each patient to send a written invitation to a friend or a relative (limit two) to be their guest for Thanksgiving. This means that a maximum of guests must be worked out by the Activities Director and the Administrator. Turkey and all the trimmings are served—Buffet Style with tables set up all through the nursing home for individual groups. Gay thanksgiving appointments are on each table.

Magazines, daily papers, radio and T.V. are all part of the daily program. Crafts or hobbies are encouraged for all—depending on the patient capacity.

We have had Open House to celebrate 50th Wedding Anniversaries and up. The wedding ceremony has been performed on some occasions and patients have all responded to this atmosphere of reality. This is life even in an institution.

Yours sincerely,

(Mrs.) JEAN K. FILER,
Administrator.

Appendix 5

EXTENDED CARE FACILITIES BY TYPE OF DEFICIENCIES

July 15, 1971.

Mr. TOM VAIL,
Chief Counsel, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR TOM: This is in response to your letter of June 1, 1971, requesting information about deficiencies in hospitals and extended care facilities participating in the Medicare program. You requested information about the numbers of participating hospitals and extended care facilities that are in full compliance, substantial compliance, or (in the case of hospitals) conditionally approved. You also requested for the latter two categories the numbers of facilities with deficiencies by area of deficiency and type within each area. The information which you requested is enclosed.

In furnishing the information about the number of participating facilities by participation category, I would want to point out that under the Medicare regulations, all hospitals and extended care facilities are certified as being in "substantial compliance." Additionally, an "access" certification category was established for certain hospitals that experienced some real problems in meeting certain of the Medicare requirements; generally, these are smaller hospitals located in rural areas where there are no nearby hospitals that are in substantial compliance with the Medicare requirements.

As indicated in section 405.1005 of the hospital regulations, to be in "substantial compliance," a hospital must: (1) be accredited by the Joint Commission on Accreditation of Hospitals or accredited by the American Osteopathic Association, and have in effect a utilization review plan meeting the statutory requirements of section 1861(k); or (2) meet the specific statutory requirements of section 1861(c) and be operating in accordance with all of the conditions of participation with no significant deficiencies (there would be hospitals approved in this category with deficiencies but the nature of the deficiencies are such that they are not considered as adversely influencing the facilities' ability to provide patient care; e.g., the content of medical staff bylaws may not cover all appropriate areas); or (3) meet the specific statutory requirements of section 1861(e), and if it has deficiencies with respect to one or more of the conditions of participation, be making reasonable plans and efforts to correct these, and notwithstanding the deficiencies, be rendering adequate care without hazard to the health and safety of individuals. Similarly, in accordance with section 405.1105 of the extended care facility regulations, an extended care facility would be certified in substantial compliance where: (1) it meets each of the specific statutory requirements of section 1861(j) and is operating in accordance with all other conditions of participation with no significant deficiencies; or (2) meets each of the section 1861(j) requirements but has deficiencies with respect to one or more conditions of participation which it is making reasonable plans and efforts to correct and notwithstanding the deficiencies is rendering adequate care without hazard, etc.

In the context of these certification categories, we have interpreted your request for information about the numbers of facilities in full compliance as covering these hospitals approved as being in substantial compliance in categories (1) and (2) above; i.e., accredited or nonaccredited but meeting all statutory requirements or operating in accordance with all of the conditions with no significant deficiencies. We have also interpreted the request for the number of extended care facilities in full compliance as being consonant with those facilities certified as being in substantial compliance by virtue of meeting all of the conditions of participation with no significant deficiencies. We have further interpreted that part of your request for information about deficiencies in hospitals and extended care facilities certified in substantial compliance as covering the remaining cate-

gory of facilities certified under sections 405.1005 and 405.1105 of the hospital and extended care facility regulations as being in substantial compliance, viz., by meeting the statutory requirements of 1861(e) or (j), as appropriate, but containing deficiencies in one or more conditions which they are planning to correct and are rendering adequate care without hazard, taking into account special precautions taken. Finally, we are interpreting your request for hospitals conditionally approved as being consonant with the hospitals given certification under the so-called "access" provision.

While I realize all of this constitutes a rather lengthy preliminary before getting to the information you requested, I would certainly wish to avoid any misunderstanding of the Medicare approval categories for hospitals and extended care facilities and of the data we are furnishing. As of May 1, 1971, there were 6,772 hospitals and 4,332 extended care facilities participating in Medicare. Of these 4,484 hospitals and 1,138 extended care facilities were certified as being in substantial compliance by virtue of being accredited by JCAH or AOA and having an operative utilization review plan (hospitals only) or meeting all of the statutory requirements in section 1861(e) or (j) as applicable and operating in accordance with all of the conditions of participation with no significant deficiencies; 2,014 hospitals and 3,162 extended care facilities were approved as being in substantial compliance under the concept of meeting all of the specific statutory requirements but with deficiencies in one or more conditions of participation, which, however, they had plans to correct and notwithstanding the deficiencies, they were rendering adequate care without hazard to patients; 269 hospitals were approved under the so-called "access" provisions.

The enclosures contain for hospitals and extended care facilities the number of facilities with deficiencies by area of deficiency and type of deficiency within each area. There follows an explanation of how the data were derived as well as certain limitations you may wish to consider in your evaluation of these data.

The data were computer produced from information taken from the latest survey report forms received from the State agencies through May 1, 1971. During a Medicare survey of a health facility, the surveyor responds to 481 items on the hospital survey report form and 392 items on the extended care facility report. The data storage and retrieval process which produced the information contained in the enclosures essentially involves recording each instance where the surveyor indicates in his response to these items on the survey report form that a Medicare requirement was not met and producing this via printout. There are inherent limitations in such a large data recording process which involves the ongoing recording of responses for several thousand hospitals and extended care facilities.

1. Since the data are derived from the survey report forms, there is always a lag due to the administrative process itself. Hospitals may be surveyed at intervals of up to two years depending, of course, on the general quality level of the hospital at the time of the latest survey. (New regulations currently being prepared for issuance would provide for all hospitals to be surveyed on an annual basis.) The survey interval for extended care facilities can be up to one year. Thus, some of the data may reflect situations as they existed up to two years ago for hospitals or one year ago for extended care facilities since information from a number of survey report forms of recently surveyed institutions; i.e., in the last couple of months, have not yet entered into the storage and retrieval process.

2. Instructions to State agencies require that where there are deficiencies but the facility agrees to correct them and in the State health department's judgment adequate care without hazard would be provided pending the correction, the survey report form is to be completed and forwarded to the Social Security Administration, showing the deficiencies at the time of the survey, together with a description of the facility's plan of correction and target dates for completion. This procedure is followed since many deficiencies require reasonable periods of time to correct or to verify that correction has actually occurred. For instance, a commitment on the part of a facility to record all required information on medical records could not be confirmed until after several months have elapsed and a surveyor, through a retrospective sampling of records, has verified that adequate records have been maintained. In some instances, a facility will agree to take immediate corrective action and may even have been able to correct the deficiency while the surveyor is in the facility. Even in those circumstances, we ask that the surveyor record the existence of the deficiency but furnish on the survey report form an explanation of correction. This technique is followed as a reminder of the existence of possible weak spots that should be given careful con-

sideration during future contacts with the facility. But here, too, the limitations inherent in establishing a large-scale coding and punching operation make it impractical at this time to attempt to adjust the operation to reflect these situations. Thus, the information on deficiencies captured by our computer does not reflect the corrective actions taken by facilities either during the survey or following the survey. Incidentally, our instructions to the State health departments also require them to work with each facility with reported deficiencies to facilitate correction within the time frame for correction agreed to at the time of the survey. Frequently this "working with" may involve providing specialized consultation by various specialists; e.g., medical record librarians, dietitians, pathologists, etc.

3. For the reasons cited in item 2 above, and for other reasons I will describe next, I would suggest that in your consideration of the reported existence of numbers of deficiencies in a given universe of facilities, that I know that you are, of course, aware that our general practice to date has been to delegate the function of facility surveys to the State agencies (normally the State health departments) throughout the country and to conduct a continuing appraisal of the effectiveness of their performance. This appraisal takes the form of on-site visits to the State agencies themselves and more recently on-site surveys of individual facilities by program validation personnel from our central and regional offices. In the overall it is our feeling that the State agencies have generally performed their functions well, but it is virtually impossible on any given date to be fully assured about the compliance status of all of the participating providers throughout the nation. The data which is tabulated in the enclosed reports provides some gross indicators, but since they attempt to involve not only the statutory requirements but the conditions of participation and then the detailed factors which are specified in our regulations, they do not give a sufficient pinpoint focus on the status of each institution. We are working on further computer programs which we believe will provide a better and more current perspective in this regard.

After you have reviewed the enclosed material, I would like the opportunity to meet with you to discuss certain aspects of our certification operations as they relate to this information.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

[Enclosures]

ADDENDUM

In order to illustrate the "episodic" nature of various deficiencies shown on this report, we selected several categories of what we would consider "major" deficiencies to determine if they had been subsequently corrected or if there were qualifying circumstances that would negate the significance of the deficiency. In this sampling, we reviewed the entire provider file and in several instances requested further clarification from our regional offices. The findings are as follows:

1. *Hospitals*.—Condition I, Standard (a)—Licensure of Hospital:

The facility at the time of survey was in the process of being issued a 3-month "provisional" license pending acquisition of a sprinkler system. The hospital is now fully licensed.

2. *Hospitals*.—Condition II, Standard (h)—All Patients Under Physicians Care:

All four of the hospitals instituted immediate arrangements to assure that all patients were under the care of a physician and this deficiency is currently corrected.

3. *Hospitals*.—Condition X, Standard (b)—Radiology Dept., Hazards for Patients and Personnel:

Of the 20 deficiencies noted, all were in the process of being corrected at the time of survey. There were several facilities in which new equipment had been installed and inspections were scheduled. Other deficiencies related to minor functional defects in operating equipment in which the service representative of the machine companies had been contacted to make minor adjustments. Several of the other deficiencies consisted of a failure of some x-ray technicians to wear radiation badges and the absence of "no smoking" signs in certain areas.

4. Condition I, Standard (c)—Conformity with State and Local Laws:

Of the 383 facilities with deficiencies in this area, 361 were located in California. The California ECF licensure laws are very comprehensive and defi-

iciencies are noted in areas such as failure to have a qualified social worker, dietary consultant, etc. The majority of the deficiencies have now been corrected.

5. Condition V, Standard (a)—Full Time Nurse:

Of the five deficiencies noted, four have subsequently hired a full-time RN and one facility withdrew from the program.

6. Condition XVIII, Standard (e)—Composition of UR Committee:

Of the 12 facilities with deficiencies, six have withdrawn from the program; four were new facilities that were in the process of organizing that now have corrected the deficiency and the other two facilities have alleged correction.

7. Condition XVIII, Standard (g)—Reviews of Cases of Continuance Extended Duration:

Of the 17 deficiencies, seven facilities have subsequently withdrawn from the program and the other 10 have corrected the deficiency.

EXTENDED CARE FACILITIES BY TYPE OF DEFICIENCIES

*Does not
meet this
requirement*

I. Compliance With State and Local Laws.—405.1120:

The extended care facility is in conformity with all applicable Federal, State, and local laws, regulations and similar requirements.

(a) *Standard: Licensing of Institution.*—In any State in which State or applicable local law provides for the licensing of extended care facilities, the institution (1) is licensed pursuant to such law, or (2) is approved by the agency of the State locality responsible for licensing such institutions, as meeting the standards established for such licensing.----- 0

(b) *Standard: Licensing of Staff.*—Staff of the extended care facility is currently licensed or registered in accordance with applicable laws ----- 8

(c) *Standard: Conformity With Laws.*—The extended care facility is in conformity with laws relating to fire and safety, communicable and reportable diseases, and other relevant matters.----- 1 333

II. Condition of Participation—Administrative Management.—405.1121:

The extended care facility has an effective governing body legally responsible for the conduct of the facility, which designates an administrator and establishes administrative policies. However, if the extended care facility does not have an organized governing body, the persons legally responsible for the conduct of extended care facility carry out or have carried out the functions herein pertaining to the governing body.

(a) *Standard: Governing Body.*—There is a governing body which assumes full legal responsibility for the overall conduct of the facility. The factors explaining the standard are as follows.----- 4

(1) The ownership of the facility is fully disclosed to the State agency. In the case of corporations, the corporate officers are made known.----- 5

(2) The governing body is responsible for compliance with the applicable laws and regulations of legally authorized agencies.--- 4

(b) *Standards: Full-Time Administrator.*—The governing body appoints a full-time administrator who is qualified by training and experience and delegates to him the internal operation of the facility in accordance with established policies. The factors explaining the standard are as follows.----- 13

(1) The administrator is at least 21 years old, is capable of making mature judgments, and has no physical or mental disabilities or personality disturbances which interfere with carrying out his responsibilities.----- 4

(2) It is desirable for the administrator to have a minimum of a high school education, to have completed courses in administration or management and to have had at least 1 year of work experience including some administrative experience with a health program.

(3) The administrator's responsibilities for procurement and direction of competent personnel are clearly defined.----- 29

¹ See Addendum, p. 2057, item 4.

	<i>Does not meet this requirement</i>
II. Condition of Participation—Administrative Management—Con.	
(b) <i>Standards: Full-time Administrator—Continued</i>	
(4) An individual competent and authorized to act in the absence of the administrator is designated-----	19
(5) The administrator may be a member of the governing body.	
(c) <i>Standard: Personnel Policies.</i> —There are written personnel policies, practices, and procedures that adequately support sound patient care. The factors explaining the standard are as follows----	38
(1) Current employee records are maintained and include a resume of each employee's training and experience-----	30
(2) Files contain evidence of adequate health supervision such as results of preemployment and periodic physical examination, including chest X-rays, and records of all illnesses and accidents occurring on duty-----	354
(3) Work assignments are consistent with qualifications-----	25
(d) <i>Standard: Notification of Changes in Patient Status.</i> —There are appropriate written policies and procedures relating to notification of responsible persons in the event of significant change in patient status, patient charges, billings, and other related administrative matters. The factors explaining the standard are as follows-----	32
(1) Patients are not transferred or discharged without prior notification of next of kin or sponsor-----	48
(2) Information describing the care and services provided by the facility is accurate and not misleading-----	14
III. Condition of Participation—Patient Care Policies.—405.1122:	
There are policies to govern the skilled nursing care and related medical or other services provided, which are developed with the advice of professional personnel, including one or more physicians and one or more registered professional nurses. A physician, a registered professional nurse, or a medical staff is responsible for the execution of these policies.	
(a) <i>Standard: Policies Regarding Nursing and Medical Care.</i> —The extended care facility has written policies which are developed with the advice of (and with provision for review of such policy from time to time by) a group of professional personnel, including at least one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides. Policies reflect awareness of and provision for meeting the total needs of patients. (1) These are reviewed at least annually and cover at least the following-----	21
(i) Admission, transfer, and discharge policies including categories of patients accepted and not accepted by extended care facility-----	22
(ii) Physician services-----	16
(iii) Nursing services-----	20
(iv) Dietary services-----	21
(v) Restorative services-----	35
(vi) Pharmaceutical services-----	24
(vii) Diagnostic services-----	25
(viii) Care of patients in an emergency, during a communicable disease episode, and when critically ill or mentally disturbed-----	154
(ix) Dental services-----	41
(x) Social services-----	71
(xi) Patient activities-----	39
(xii) Clinical records-----	33
(xiii) Transfer agreement-----	31
(xiv) Utilization review-----	35
(2) The factors explaining the standard are as follows:	
(i) It is desirable that the group of professional personnel responsible for patient care policies includes health personnel such as social workers, dietitians, pharmacists, speech pathologists and audiologists, physical and occupational therapists, and mental health personnel. Pharmacy policies and procedures are preferably developed with the advice of a subgroup of physicians and pharmacists serving as a pharmacy and therapeutics committee-----	203

III. Condition of Participation—Patient Care Policies—Continued	<i>Does not meet this requirement</i>
(2) The factors explaining the standards are as follows—Con.	
(ii) Some members of this group are neither owners nor employees of the facility-----	66
(iii) The group meets at regularly scheduled intervals and minutes of each meeting are recorded-----	283
(iv) The group may serve one or more facilities.	
(b) <i>Standard: Responsibilities; Execution of Patient Care Policies.</i> —The extended care facility has a physician, a registered professional nurse, or a medical staff responsible for the execution of patient care policies established by the professional group referred to in paragraph (a) (1) of this section. The factors explaining the standard are as follows:-----	8
(1) If the organized medical staff is responsible, an individual physician is designated to maintain compliance with overall patient care policies-----	254
(2) If a registered professional nurse is responsible, the facility makes available an advisory physician from whom she receives medical guidance-----	25
IV. Condition of Participation—Physician Services.—405.1123.	
Patients in need of skilled nursing care are admitted only upon the recommendation of a physician; their health care continues under the supervision of a physician; and the facility has a physician available to furnish necessary medical care in case of emergency.	
(a) <i>Standard: Medical Findings and Physicians' Orders.</i> —There is made available to the facility, prior to or at the time of admission, patient information which includes current medical findings, diagnoses, rehabilitation potential, a summary of the course of treatment followed in the hospital, and orders from a physician for the immediate care of the patient. The factors explaining the standard are as follows:-----	60
(1) If the above information is not available in the facility upon admission of the patient, it is obtained by the facility within 48 hours after admission-----	187
(2) If medical orders for the immediate care of a patient are unobtainable at the time of admission, the physician with responsibility for emergency care gives temporary orders-----	14
(3) A current hospital discharge summary containing the above information is acceptable.	
(b) <i>Standard: Supervision by Physician.</i> —The facility has a requirement that the health care of every patient is under the supervision of a physician who, based on an evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of medical care which covers indicated medications, treatments, restorative services, diet, special procedures recommended for the health and safety of the patient, plans for continuing care and discharge. The factors explaining the standard are as follows:-----	39
(1) The medical evaluation of the patient is based on a physical examination done within 48 hours of admission unless such examination was performed within 5 days prior to admission-----	288
(2) The charge nurse and other appropriate personnel involved in the care of the patient assist in planning his total program care-----	28
(3) The patient's total program of care is reviewed and revised at intervals appropriate to his needs. Attention is given to special needs of patients such as foot, sight, speech, and hearing problems-----	78
(4) Orders concerning medications and treatments are in effect for the specified number of days indicated by the physician but in no case exceed a period of 30 days unless recorded in writing by the physician-----	340
(5) Telephone orders are accepted only when necessary and only by licensed nurses. Telephone orders are written into the appropriate clinical record by the nurse receiving them and are countersigned by the physician within 48 hours-----	374
(6) Patients are seen by a physician at least once every 30 days. There is evidence in the clinical record of the physician's visits to the patient at appropriate intervals-----	297

	<i>Does not meet this requirement</i>
IV. Condition of Participation—Physician Services—Continued	
(b) <i>Standard: Supervision by Physician—Continued</i>	
(7) There is evidence in the clinical record that the physician has made arrangements for the medical care of the patient in the physician's absence-----	217
(8) To the extent feasible, each patient or his sponsor designates a personal physician-----	14
(c) <i>Standards Availability of Physicians for Emergency Care.</i> —The extended care facility provides for having one or more physicians available to furnish necessary medical care in case of emergency if the physician responsible for the care of the patient is not immediately available-----	9
(1) A schedule listing the names and telephone numbers of these physicians and the specific days each is on call is posted in each nursing station-----	77
(2) There are established procedures to be followed in an emergency, which cover immediate care of the patient, persons to be notified, and reports to be prepared-----	46
V. Condition of Participation—Nursing Services.—405.1124:	
The extended care facility provides 24-hour nursing service which is sufficient to meet the nursing needs of all patients. There is at least one registered professional nurse employed full time and responsible for the total nursing service. There is a registered professional nurse who is a graduate of a State approved school of practical nursing in charge of nursing activities during each tour of duty. The terms "licensed practical nurse(s)" and "practical nursing" as used in this section are synonymous with "licensed vocational nurse(s)" and "vocational nursing."	
(a) <i>Standard: Full-Time Nurse.</i> —There is at least one registered professional nurse employed full time-----	15
(1) If there is one registered professional nurse, she serves as director of the nursing service, works full time during the day, and devotes full time to the nursing service of the facility-----	21
(2) If the director of nursing has administrative responsibility for facility, she has a professional nurse assistant so that there is the equivalent of a full time director of nursing service-----	59
(3) The director of nursing service is trained or experienced in areas such as nursing service administration, rehabilitation psychiatric or geriatric nursing-----	21
(b) <i>Standard: Director of Nursing Service.</i> —The director of the nursing service is responsible for:-----	18
(1) Developing and/or maintaining nursing service objectives, standards of nursing practice, nursing procedure manuals, and written job descriptions for each level of nursing personnel----	49
(2) Recommending to the administrator the number and levels of nursing personnel to be employed, participating in their recruitment and selection, and recommending termination of employment when necessary-----	28
(3) Assigning and supervising all levels of nursing personnel----	13
(4) Participating in planning and budgeting for nursing care----	92
(5) Participating in the development and implementation of patient care policies and bringing patient care problems requiring changes in policy to the attention of the professional policy advisory groups-----	41
(6) Coordinating nursing services with other patient care services such as physician, physical therapy, occupational therapy, and dietary-----	15
(7) Planning and conducting orientation programs for new nursing personnel, and continuing inservice education for all nursing personnel-----	88
(8) Participating in the selection of prospective patients in terms of nursing services they need and nursing competencies available-----	65
(9) Assuring that a nursing care plan is reviewed and modified as necessary-----	101

² See Addendum, p. 2057, Item 5.

V. Condition of Participation—Nursing Services—Continued

- (c) *Standard: Supervising Nurse.*—Nursing care is provided by or under the supervision of a full-time registered professional nurse currently licensed to practice in the State. The factors explaining the standard are as follows:----- 19
- (1) The supervising nurse is trained or experienced in areas such as nursing administration and supervision, rehabilitation nursing, psychiatric or geriatric nursing.----- 23
- (2) The supervising nurse makes daily rounds to all nursing units performing such functions as visiting each patient, reviewing clinical records, medication cards, patient care plans and staff assignments, and to the greatest degree possible accompanying physicians when visiting patients.----- 36
- (d) *Standard: Charge Nurse.*—There is at least one registered professional nurse or qualified licensed practical nurse who is a graduate of a State-approved school of practical nursing on duty at all times and in charge of the nursing activities during each tour of duty. The factors explaining the standard are as follows:----- 40
- (1) A State-operated school of practical nursing is one whose standards of education meet those set by the appropriate State nurse licensing authority.----- 25
- (2) Some State laws grant practical nurse licensure (nonwaivered) to certain individuals who have an educational background considered to be equivalent to graduation from a State-approved school of practical nursing. Such licensure determination is made by the appropriate State nursing authority on the basis of evaluation of the individual's educational achievements, as well as on successful completion of the appropriate State licensing examination. Licensure under such conditions may be accepted as meeting the requirement of graduation from a State-approved school of practical nursing.
- (3) It is desirable that the nurse in charge of each tour of duty be trained or experienced in areas such as nursing administration and supervision, rehabilitation nursing, psychiatric or geriatric nursing.----- 48
- (4) The charge nurse has the ability to recognize significant changes in the condition of patients and to take necessary action.----- 23
- (5) The charge nurse is responsible for the total nursing care of patients during her tour of duty.----- 24
- (e) *Standard: 24-Hour Nursing Service.*—There is 24-hour nursing service with a sufficient number of nursing personnel on duty at all times to meet the total needs of patients. The factors explaining the standard are as follows:----- 32
- (1) Nursing personnel include registered professional nurses, licensed practical nurses, aides and orderlies.
- (2) The amount of nursing time available for patient care is exclusive of nonnursing duties.----- 99
- (3) Sufficient nursing time is available to assure that each patient:
- (i) Receives treatments, medications and diet as prescribed.----- 113
- (ii) Receives proper care to prevent decubiti and is kept comfortable, clean, and well-groomed.----- 58
- (iii) Is protected from accident and injury by the adoption of indicated safety measures.----- 29
- (iv) Is treated with kindness and respect.----- 16
- (4) Licensed practical nurses, nurses' aides, and orderlies are assigned duties consistent with their training and experience.----- 59
- (f) *Standard: Restorative Nursing Care.*—There is an active program of restorative nursing care directed toward assisting each patient to achieve and maintain his highest level of self care and independence. The factors explaining the standard are as follows:----- 45
- (1) Restorative nursing care initiated in the hospital is continued immediately upon admission to the extended care facility.----- 51

V. Condition of Participation—Nursing Services—Continued

*Does not
meet this
requirement*

- (f) *Standard: Restorative Nursing Care—Continued*
- (2) Nursing personnel are taught restorative nursing measures and practice them in their daily care of patients. These measures include:
- (i) Maintaining good body alignment and proper positioning of bedfast patients..... 47
 - (ii) Encouraging and assisting bedfast patients to change positions at least every 2 hours day and night to stimulate circulation, and prevent decubiti and deformities..... 46
 - (iii) Making every effort to keep patients active and out of bed for reasonable periods of time, except when contraindicated by physicians' orders, and encouraging patients to achieve independence in activities of daily living by teaching self care, transfer and ambulation activities..... 93
 - (iv) Assisting patients to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests if necessary..... 37
 - (v) Assisting patients to carry out prescribed physical therapy exercises between visits of the physical therapist... 81
- (3) Consultation and instruction in restorative nursing available from State or local agencies are utilized..... 132
- (g) *Standard: Dietary Supervision.*—Nursing personnel are aware of the dietary needs and food and fluid intake of patients. The factors explaining the standard are as follows..... 16
- (1) Nursing personnel observe that patients are served diets as prescribed..... 38
 - (2) Patients needing help in eating are assigned promptly upon receipt of meals..... 28
 - (3) Adaptive self-help devices are provided to contribute to the patient's independence in eating..... 415
 - (4) Food and fluid intake of patients is observed and deviations from normal are reported to the charge nurse. Persistent unresolved problems are reported to the physician..... 42
- (h) *Standard: Nursing Care Plan.*—There is a written nursing care plan for each patient based on the nature of illness, treatment prescribed, long and short-term goals and other pertinent information. The factors explaining the standard are as follows..... 147
- (1) The nursing care plan is a personalized, daily plan for individual patients. It indicates what nursing care is needed, how it can best be accomplished for each patient, how the patient likes things done, what methods and approaches are most successful, and what modifications are necessary to insure best results..... 287
 - (2) Nursing care plans are available for use by all nursing personnel..... 80
 - (3) Nursing care plans are revised as needed..... 239
 - (4) Relevant nursing information from the nursing care plan is included with other medical information when patients are transferred..... 93
- (i) *Standard: Inservice Educational Program.*—There is a continuing personnel in addition to a thorough job orientation for new personnel. Skill training for nonprofessional nursing personnel begins during orientation period. The factors explaining the standard are as follows..... 142
- (1) Planned inservice programs are conducted at regular intervals for all nursing personnel..... 241
 - (2) All patient care personnel are instructed and supervised in the care of emotionally disturbed and confused patients, and are helped to understand the social aspects of patient care..... 234
 - (3) Skill training includes demonstration, practice, and supervision of simple nursing procedures applicable in the individual facility. It also includes simple restorative nursing procedures... 94
 - (4) Orientation of new personnel includes a review of the procedures to be followed in emergencies..... 109
 - (5) Opportunities are provided for nursing personnel to attend training courses in restorative nursing and other educational programs related to care of long-term patients..... 156

VI. Dietary Services—405.1125—The dietary service is directed by a qualified individual and meets the daily dietary needs of patients. An extended care facility which has a contract with an outside food management company may be found to meet this condition of participation provided the company has a dietitian who serves, as required by the scope and complexity of the service, on a full-time, part-time or consultant basis to the extended care facility, and provided the company maintains standards as listed herein and provides for continuing liaison with the medical and nursing staff of the extended care facility for recommendations on dietetic policies affecting patient care.

STANDARDS AND FACTORS

(a) <i>Standard: Dietary Supervision.</i> —A person designated by the administrator is responsible for the total food service of the facility. The factors explaining the standard are as follows:-----	75
(1) The designated person is a professional dietitian, i.e., meets the American Dietetic Association's qualification standards-----	1, 796
(2) The designated person is a graduate of baccalaureate degree program with major studies in food and nutrition-----	1, 732
(3) The person in charge of the dietary service participates in regular conferences with the administrator and other supervisors of patient services-----	89
(4) The person makes recommendations concerning the quantity, quality and variety of food purchases-----	43
(5) This person is responsible for the orientation, training, and supervision of food service employees, and participates in their selection and in the formulation of pertinent personnel policies-----	133
(6) If the designated person is not a professional dietitian, frequent and regularly scheduled consultation is provided from a professional dietitian or other person with suitable training-----	107
(b) <i>Adequacy of Dietary Staff.</i> —A sufficient number of food service personnel are employed and their working hours are scheduled to meet the dietary needs of the patients. The factors explaining the standard are as follows-----	41
(1) There are food service employees on duty over a period of 12 or more hours-----	42
(2) Food service employees are trained to perform assigned duties and participate in selected inservice education programs-----	217
(3) In the event food service employees are assigned duties outside the dietary department, these duties do not interfere with the sanitation, safety, or time required for dietary work assignments-----	44
(4) Work assignments and duty schedules are posted-----	117
(c) <i>Standard: Hygiene of Dietary Staff.</i> —Food service personnel are in good health and practice hygiene food handling techniques. The factors explaining the standard are as follows-----	21
(1) Food service personnel wear clean washable garments, hairnets, or clean caps, and keep their hands and fingernails clean at all times-----	26
(2) Routine health examinations at least meet local, State, or Federal codes for food service personnel. Where food handlers' permits are required, they are current-----	148
(3) Personnel having symptoms of communicable diseases or open infected wounds are not permitted to work-----	17
(d) <i>Standard: Adequacy of Diet.</i> —The food and nutritional needs of patients are met in accordance with physicians' orders, and, to the extent medically possible, meet the dietary allowances of the Food and Nutrition Board of the National Research Council adjusted for age, sex and activity-----	20
(e) <i>Standard: Therapeutic Diets.</i> —Therapeutic diets are prepared and served as prescribed by the attending physician. The factors explaining the standard are as follows-----	86
(1) Therapeutic diet orders are planned, prepared, and served with supervision or consultation from a qualified dietitian-----	103

VI. Dietary Services—Continued

Does not
meet this
requirement

(e) <i>Standard: Therapeutic Diets</i> —Continued	
(2) A current diet manual recommended by the State licensure agency is readily available to food service personnel and supervisors of nursing service	71
(3) Persons responsible for therapeutic diets have sufficient knowledge of food values to make appropriate substitutions when necessary	140
(f) <i>Standard: Quality of Food</i> .—At least three meals or their equivalent are served daily	14
(1) The meals are served at regular times	13
(4) Not more than a 14-hour span exists between a substantial evening meal and breakfast	327
(3) Between meal or bedtime snacks of nourishing quality are offered	36
(4) If the "four or five meal a day" plan is in effect, meals and snacks provide nutritional value equivalent to the daily food guide previously described	100
(g) <i>Standard: Planning of Menus</i> .—Menus are planned in advance and food sufficient to meet the nutrition needs of patients is prepared as planned for each meal. When changes in the menu are necessary, substitutions provide equal nutritive value. The factors explaining the standard are as follows:	17
(1) Menus are written at least 1 week in advance. The current week's menu is in one or more accessible places in the dietary department for easy use by workers purchasing, preparing, and serving foods	22
(2) Menus provide a sufficient variety of foods served in adequate amounts at each meal. Menus are different for the same days of each week and are adjusted for seasonal changes	23
(3) Records of menus as served are filed and maintained for 30 days	62
(4) Supplies of staple foods for a minimum of a 1-week period and of perishable foods for a minimum of a 2-day period are maintained on the premises	32
(5) Records of food purchased for preparation are on file	15
(h) <i>Standard: Preparation of Food</i> .—Foods are prepared by methods that conserve nutritive value, flavor, and appearance, and are attractively served at the proper temperatures and in a form to meet individual needs. The factors explaining the standard are as follows:	24
(1) A file of tested recipes, adjusted to appropriate yield, is maintained	85
(2) Food is cut, chopped or ground to meet individual needs	7
(3) If a patient refuses foods served, substitutes are offered	34
(4) Effective equipment is provided and procedures established to maintain food at proper temperature during serving	148
(5) Table service is provided for all who can and will eat at a table including wheelchair patients	65
(6) Trays provided bedfast patients rest on firm supports such as overbed tables. Sturdy tray stands of proper height are provided patients able to be out of bed	12
(i) <i>Standard: Maintenance of Sanitary Conditions</i> .—Sanitary conditions are maintained in the storage, preparation and distribution of food. The factors explaining the standard are as follows:	57
(1) Effective procedures for cleaning all equipment and work areas are followed consistently	156
(2) Dishwashing procedures and techniques are well-developed, understood and carried out in compliance with the State and local health codes	158
(3) Written reports of inspections by State or local health authorities are on file at the facility with notation made of action taken by the facility to comply with any recommendations	88
(4) Waste which is not disposed of by mechanical means is kept in leak-proof nonabsorbent containers with close-fitting covers and is disposed of daily. Containers are thoroughly cleaned inside and out each time emptied	97

VI. Dietary Services—Continued

Does not
meet this
requirement

(i) <i>Standard: Maintenance of Sanitary Conditions—Con.</i>	
(5) Dry or staple food items are stored off the floor in a ventilated room not subject to sewage or waste water backflow, or contamination by condensation; leakage, rodents or vermin.	144
(6) Handwashing facilities including hot and cold water, soap, and individual towels, preferably paper towels, are provided in kitchen areas.	68
VII. Restorative Services.—405.1126: Restorative services are provided upon written order of the physician.	
(a) <i>Standard: Medical Direction.</i> —Restorative services are provided only upon written order by the physician. The factors explaining the standard are as follows:	44
(1) The physician indicates anticipated goals and is responsible for general medical direction of such services as part of the total care of the patient.	105
(2) The physician prescribes specific modalities to be used and frequency of physical and occupational therapy services.	147
(b) <i>Standard: Maintenance of Patient's Functions.</i> —At a minimum, restorative nursing care designed to maintain function or improve the patient's ability to carry out the activities of daily living is provided by the extended care facility. (See § 405.1124(f).)	33
(c) <i>Standard: Therapy Services.</i> —If restorative services beyond restorative nursing care are offered, whether directly or through cooperative arrangements with appropriate agencies such as hospitals, rehabilitation centers, State or local health departments, or independently practicing therapists, these services are given or supervised by therapists meeting the qualification set out below. When supervision is less than full time it is provided on a planned basis and is frequent enough, in relation to the staff therapist's training and experience to assure sufficient review of individual treatment plans and progress. The factors explaining the standard are as follows:	43
(1) Physical therapy is given or supervised by a qualified physical therapist	33
(2) Physical therapy includes such services as:	
(i) Assisting the physician in his evaluation of patients by applying muscle, nerve, joint, and functional ability tests.	29
(ii) Treating patients to relieve pain, develop or restore function, and maintain maximum performance, using physical means such as exercise, massage, heat, water, light, and electricity	30
(3) Speech therapy is given or supervised by a qualified therapist	165
(4) Speech therapy is service in speech, pathology or audiology, and may include:	
(i) Cooperation in the evaluation of patients with speech, hearing, or language disorders.	138
(ii) Determination and recommendation of appropriate speech and hearing services.	140
(iii) Provision of necessary rehabilitative services for patients with speech, hearing, and language disabilities.	132
(5) Occupational therapy is given or supervised by a registered therapist	280
(6) Occupational therapy includes duties such as:	
(i) Assisting the physician in his evaluation of the patient's level of function by applying diagnostic and prognostic tests	255
(ii) Guiding the patient in his use of therapeutic creative and self-care activities for improving function.	242
(7) Other personnel providing restorative services are specially trained and work under accepted professional practices. For example, an occupational therapy assistant has successfully completed a training course approved by the American Occupational Therapy Association, is certified by that body as a certified occupational therapy assistant, and receives supervision from a qualified occupational therapist.	259

VII. Restorative Services—Continued

Does not
meet this
requirement(c) *Standard: Therapy Services*—Continued

- (8) In a facility with an organized rehabilitation service using a multi-disciplinary team approach to all the needs of the patient, and where all therapists' services are administered under the direct supervision of physician qualified in physical medicine who will determine the goals and limits of therapists' work, persons with qualifications other than those described in subparagraphs (1), (3), and (5) of this paragraph could be assigned duties appropriate to their training and experience.
- (9) Therapists collaborate with the facility's medical and nursing staff in developing the patient's total plan of care.----- 99
- (10) Therapists participate in the facility's inservice education programs.

(d) *Standard: Ambulation and Therapeutic Equipment*.—Commonly used in ambulation and therapeutic equipment necessary for services offered is available for use in the facility. The factors explaining the standard are as follows.----- 12

- (1) Recommended ambulation equipment includes such items as parallel bars, hand rails, wheelchair, walkers, walkerettes, crutches and canes.----- 13
- (2) The therapists advise the administrator concerning the purchase, rental, storage, and maintenance of equipment and supplies ----- 38

VIII. Pharmaceutical Services.—405.1127 :

Whether drugs are generally procured from community or institutional pharmacists or stocked by the facility, the extended care facility has methods and procedures for its pharmaceutical services that are in accord with accepted professional practices.

(a) *Standard: Procedures for Administration of Pharmaceutical Services*.—The extended care facility provides appropriate methods and procedures for the obtaining, dispensing and administering of drugs and biologicals, developed with the advice of a staff pharmacist, a consultant pharmacist, or a pharmaceutical advisory committee which includes one or more licensed pharmacists. The factors explaining the standard are as follows.----- 16

- (1) If the extended care facility has a pharmacy department, a licensed pharmacist is employed to administer the pharmacy department ----- 254
- (2) If the facility does not have a pharmacy department, it has provision for promptly and conveniently obtaining prescribed drugs and biologicals from community or institutional pharmacists ----- 23
- (3) If the facility does not have a pharmacy department, but does maintain a supply of drugs :

- (i) The consultant pharmacist is responsible for the control of all bulk drugs and maintains records of their receipt and disposition.----- 153
- (ii) The consultant pharmacist dispenses drugs from the drug supply, properly labels them and makes them available to appropriate licensed nursing personnel. Whenever possible, the pharmacist in dispensing drugs works from the prescriber's original order or a direct copy.----- 108
- (iii) Provision is made for emergency withdrawal of medications from the drug supply.----- 85

- (4) An emergency medication kit approved by the facility's group of professional personnel is kept readily available.----- 102

- (5) The extended care facility has written policies covering pharmaceutical services which are developed with the advice of a group of professional personnel and which are reviewed at least annually. Pharmacy policies and procedures are preferably developed with the advice of a subgroup of physicians and pharmacists serving as a pharmacy and therapeutic committee ----- 90

(b) *Standard: Conformance with Physician's Orders*.—All medications administered to patients are ordered in writing by the patient's physician. Oral orders are given only to a licensed nurse, immedi-

VIII. Pharmaceutical Services—Continued

Does not
meet this
requirement

(b) <i>Standard: Conformance with Physicians', etc.</i> —Continued	
ately reduced to writing, signed by the nurse and countersigned by the physician within 48 hours. Medications not specifically limited as to time or number of doses, when ordered, are automatically stopped in accordance with written policy approved by the physician or physicians responsible for advising the facility on its medical administrative policies. The factors explaining the standard are as follows.....	94
(1) The charge nurse and the prescribing physician together review monthly each patient's medications.....	214
(2) The patient's attending physician is notified of stop order policies and contacted promptly for renewal of such orders so that continuity of the patient's therapeutic regimen is not interrupted.....	155
(3) Medications are released to patients on discharge only on the written authorization of the physician.....	43
(c) <i>Standard: Administration of Medications.</i> —All medications are administered by licensed medical or nursing personnel in accordance with the Medical and Nurse Practices Acts of each State. Each dose administered is properly recorded in the clinical record. The factors explaining the standard are as follows.....	90
(1) The nursing station has readily available items necessary for the proper administration of medication.....	2
(2) In administering medications, medication cards and other State approved systems are used and checked against the physician's orders.....	26
(3) Medications prescribed for one patient are not administered to any other patient.....	65
(4) Self-administration of medications by patients is not permitted except for emergency drugs on special order of the patient's physician or in a pre-discharged program under the supervision of a licensed nurse.....	36
(5) Medication errors and drug reactions are immediately reported to the patient's physician and an entry thereof made in the patient's clinical record as well as on an incident report.....	32
(6) Up-to-date medication reference texts and sources of information are provided, such as the American Hospital Formulary Service of the American Society of Hospital Pharmacists or other suitable references.....	45
(d) <i>Standard: Labeling and Storing Medications.</i> —Patient's medications are properly labeled and stored in a locked cabinet at the nurses' station. The factors explaining the standard are as follows:.....	65
(1) The label of each patient's individual medication container clearly indicates the patient's full name, physician's name, prescription number, name and strength of drug, date of issue, expiration date of all time-dated drugs, and name and address, and telephone number of pharmacy issuing the drug. It is advisable that the manufacturer's name and the lot or control number of the medication also appear on the label.....	159
(2) Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the issuing pharmacist or pharmacy for relabeling or disposal. Containers having no labels are destroyed in accordance with State and Federal laws.....	73
(3) The medications of each patient are kept and stored in their originally received containers and transferring between containers is forbidden.....	33
(4) Separately locked, securely fastened boxes (or drawers) within the medicine cabinet are provided for storage of narcotics, barbiturates, amphetamines and other dangerous drugs subject to the Drug Abuse Control Amendments of 1965.....	68
(5) Cabinets are well lighted and of sufficient size to permit storage without crowding.....	37
(6) Medications requiring refrigeration are kept in a separate, locked box within a refrigerator at or near the nursing station.....	132
(7) Poisons and medications for "external use only" are kept in a locked cabinet and separate from other medications.....	151

	<i>Does not meet this requirement</i>
VIII. Pharmaceutical Services—Continued	
(d) <i>Standard: Labeling and Storing Medications</i> —Continued	
(8) Medications no longer in use are disposed of or destroyed in accordance with Federal and State laws and regulations.....	136
(9) Medications having an expiration date are removed from usage and properly disposed of after such date.....	31
(e) <i>Standard: Control of Narcotics, etc.</i> —The extended care facility complies with all Federal and State laws and regulations relating to the procurement, storage, dispensing, administration and disposal of narcotics, those drugs subject to the Drug Abuse Control Amendments of 1965, and other legend drugs. The factors explaining the standard are as follows:.....	22
(1) A narcotic record is maintained which lists on separate sheets for each type and strength of narcotic the following information: date, time administered, name of patient, dose, physician's name, signature of person administering dose, and balance....	19
IX. Diagnostic Services.—405.1128:	
The extended care facility has provision for obtaining required clinical laboratory, X-ray and other diagnostic services.	
(a) <i>Standard: Provisions for Diagnostic Services.</i> —The extended care facility has provision for promptly and conveniently obtaining required clinical laboratory, X-ray and other diagnostic services. The factors explaining the standard are as follows.....	4
Such services may be obtained from a physician's office, a laboratory which is part of a hospital approved for participation in the Health Insurance for the Aged program or a laboratory which is approved to provide these services as an independent laboratory under the Supplementary Medical Insurance for the Aged program. If the facility provides its own diagnostic services, these meet the applicable conditions established for certification of hospitals that are contained in §§405.1028 and 405.1029.	
(1) All diagnostic services are provided only on the request of a physician.....	5
(2) The physician is notified promptly of the test results.....	6
(3) Arrangements are made for the transportation of patients, if necessary, to and from the source of service.....	6
(4) Simple tests, such as those customarily done by nursing personnel for diabetic patients, may be done in the facility....	4
(5) All reports are included in the clinical record.....	42
X. Dental Services.—405.1129:	
The extended care facility assists patients to obtain regular and emergency dental care. However, the services of dentists to individual patients are not included as a benefit in the basic hospital insurance program, and only certain oral surgery is included in the supplemental medical insurance program.	
(a) <i>Standard: Provision for Dental Care.</i> —Patients are assisted to obtain regular and emergency dental care. The factors explaining the standard are as follows.....	36
(1) An advisory dentist provides consultation, participates in in-service education, recommends policies concerning oral hygiene, and is available in case of emergency.....	424
(2) The extended care facility, when necessary, arranges for the patient to be transported to the dentist's office.....	38
(3) Nursing personnel assist the patient to carry out the dentist's recommendations.....	5
XI. Social Services.—405.1130:	
Services are provided to meet the medically related social needs of patients.	
(a) <i>Standard: Provision for Medically Related Social Needs.</i> —The medically related social needs of the patient are identified, and services provided to meet them, in admission of the patient, during his treatment and care in the facility, and in planning for his discharge. The factors explaining the standard are as follows.....	66
(1) As a part of the process of evaluating a patient's need for services in an extended care facility and whether the facility can offer appropriate care, emotional and social factors are considered in relation to medical and nursing requirements.....	65

XI. Social Services.—Continued

Does not
meet this
requirement

- (a) *Standard: Provisions for Medically Related, etc.—Con* -----
- (2) As soon as possible after admission, there is evaluation, based on medical, nursing, and social factors, of the probable duration of the patient's need for care and a plan is formulated and recorded for providing such care.----- 322
- (3) Where there are indications that financial help will be needed arrangements are made promptly for referral to an appropriate agency ----- 48
- (4) Social and emotional factors related to the patient's illness, to his response to treatment, and to his adjustment to care in the facility are recognized and appropriate action is taken when necessary to obtain casework services to assist in resolving problems in these areas ----- 86
- (5) Knowledge of the patient's home situation, financial resources, community resources available to assist him, and pertinent information related to his medical and nursing requirements are used in making decisions regarding his discharge from the facility ----- 68
- (b) *Standard: Staff Members Responsible for Social Services.—*There is a designated member of the staff of the facility who will take responsibility, when medically related social problems are recognized, for action necessary to solve them. The factors explaining the standard are as follows.----- 414
- (1) There is a full-time or part-time social worker employed by the facility, or there is a person on the staff who is suited by training and/or experience in related fields to find community resources to deal with the social problems.----- 170
- (2) The staff member responsible for this area of service has information promptly available on health and welfare resources in the community.----- 74
- (3) If the facility does not have a qualified social worker on its staff, there is an effective arrangement with a public or private agency, which may include the local welfare department, to provide social service consultation. (*A qualified social worker is a graduate of a school of social work accredited by the Council on Social Work Education.*) ----- 708
- (c) *Standard: Social Services Training of Staff.—*There is provision for orientation and in-service training of staff directed toward understanding emotional problems and social needs of sick and infirm aged persons, and recognition of social problems of patients and the means of taking appropriate action in relation to them. Either a qualified social worker on the staff, or one from outside the facility, participates in training programs, case conferences, and arrangements for staff orientation to community services and patient needs.----- 861
- (d) *Standard: Confidentiality of Social Data.—*Pertinent social data, and information about personal and family problems related to the patient's illness and care, are made available only to the attending physician, appropriate members of the nursing staff, and other key personnel who are directly involved in the patient's care, or to recognized health or welfare agencies. There are appropriate policies and procedures for assuring the confidentiality of such information. The factors explaining the standard are as follows.----- 259
- (1) The staff member responsible for social services participates in clinical staff conferences and/or confers with the attending physician prior to admission of the patient, at intervals during the patient's stay in the facility, and prior to discharge of the patient, and there is evidence in the record of such conferences.----- 388
- (2) The staff member and nurses responsible for the patient's care confer frequently and there is evidence of effective working relationships between them ----- 172
- (3) Records of pertinent social information, and of action taken to meet social needs, are maintained for each patient; signed social service summaries are entered promptly in the patient's clinical record for the benefit of all staff involved in the care of the patient.----- 691

XII. Patient Activities.—405.1131:

Does not
meet this
requirement(d) *Standard: Confidentiality of Social Data*—Con.

Activities suited to the needs and interests of patients are provided as an important adjunct to the active treatment program and to encourage restoration to self-care and resumption of normal activities.

- (a) *Standard: Provision for Patient Activity*.—Provision is made for purposeful activities which are suited to the needs and interests of patients. The factors explaining the standard are as follows----- 30
- (1) An individual is designated as being in charge of patient activities. This individual has experience and/or training in directing group activity, or has available consultation from a qualified recreational therapist or group activity leader----- 129
 - (2) The activity leader uses, to the fullest possible extent, community, social and recreational opportunities----- 98
 - (3) Patients are encouraged, but not forced, to participate in such activities. Suitable activities are provided for patients unable to leave their room----- 86
 - (4) Patients who are able and who wish to do so are assisted to attend religious services----- 27
 - (5) Patient's requests to see their clergymen are honored and space is provided for privacy during visits----- 3
 - (6) Visiting hours are flexible and posted to permit and encourage visiting by friends and relatives----- 28
 - (7) The facility makes available a variety of supplies and equipment adequate to satisfy the individual interests of patients. Examples of such supplies and equipment are: Books and magazines, daily newspapers, games, stationery, radio and television, and the like----- 28

XIII. Clinical Records.—405.1132:

A clinical record is maintained for each patient admitted, in accordance with accepted professional principles.

- (a) *Standard: Maintenance of Clinical Record*.—The extended care facility maintains a separate clinical record for each patient admitted with all entries kept current, dated, and signed. The factors explaining the standard are as follows----- 29
- The record includes: (1) Identification and summary sheet(s) including patient's name, social security number, marital status, age, sex, home address, and religion; names, addresses, and telephone numbers of referral agency (including hospital from which admitted), personal physician, dentist, and next of kin or other responsible person; admitting diagnosis; final diagnosis, condition on discharge, and disposition, and any other information needed to meet State requirements----- 169
- (2) Initial medical evaluation including medical history, physical examination, diagnosis, and estimation of restoration potential... 482
 - (3) Authentication of hospital diagnoses, in the form of a hospital summary discharge sheet, or a report from the physician who attended the patient in the hospital, or a transfer form used under a transfer agreement----- 73
 - (4) Physician's orders, including all medications, treatments, diet, restorative and special medical procedures required for the safety and well-being of the patient----- 135
 - (5) Physician's progress notes describing significant changes in the patient's condition, written at the time of each visit----- 230
 - (6) Nurse's notes containing observations made by the nursing personnel----- 124
 - (7) Medication and treatment record including all medications, treatments, and special procedures performed for the safety and well-being of the patient----- 94
 - (8) Laboratory and X-ray reports----- 67
 - (9) Consultation reports----- 258
 - (10) Dental reports----- 524
 - (11) Social service notes----- 711
 - (12) Patient care referral reports----- 78
- (b) *Standard: Retention of Records*.—All clinical records of discharged patients are completed promptly and are filed and retained in ac-

	<i>Does not meet this requirement</i>
XIII. Clinical Records.—Continued	
(b) <i>Standard: Retention of Records.</i> —Continued cordance with State law or for 5 years in the absence of a State statute. The factors explaining the standard are as follows.....	53
(1) The extended care facility has policies providing for the reten- tion and safekeeping of patient's clinical records by the govern- ing body for the required period of time in the event that the extended care facility discontinues operation.....	144
(2) If the patient is transferred to another health care facility, a copy of the patient's clinical record or an abstract accompanies the patient.....	45.
(c) <i>Standard: Confidentiality of Records.</i> —Information contained in the clinical records is treated as confidential and is disclosed only to authorized persons.....	6.
(d) <i>Standard: Staff Responsibility for Records.</i> —If the extended care facility does not have a full- or part-time medical record librarian, an employee of the facility is assigned the responsibility for assur- ing that records are maintained, completed and preserved. The desig- nated individual is trained by, and receives, regular consultation from a person skilled in record maintenance and preservation.....	648.
XIV. Transfer Agreement.—405.1133:	
The extended care facility has in effect a transfer agreement (meeting the requirements of section 1861(1) of the Social Security Act) with one or more hospitals which have entered into agreements with the Secretary to participate in the pro- gram. (See paragraph (e) of this section where facility at- tempted to enter into a transfer agreement.)	
(a) <i>Standard: Patient.</i> —The transfer agreement provides reasonable assurance that transfer of patients will be effected between the hos- pital and the extended care facility whenever such transfer is medi- cally appropriate as determined by the attending physician. The factors explaining the standard are as follows.....	2:
(1) The agreement is with a hospital close enough to the facility to make the transfer of patients feasible.....	5
(2) The transfer agreement facilitates continuity of patient care and expedites appropriate care for the patient.....	9.
(3) The agreement may be made on a one-to-one basis or on a community-wide basis. The latter arrangement could provide for a master agreement to be signed by each hospital and ex- tended care facility.....	19.
(4) When the transfer agreement is on a community-wide basis it reflects the mutual planning and agreement of hospitals, ex- tended care facilities and other related agencies.....	105.
(5) The institutions provide to each other information about their resources sufficient to determine whether the care needed by a patient is available.....	14.
(6) Where the transfer agreement specifies restrictions with re- spect to the types of services available in the hospital or the facility and/or the types of patients or health conditions that will not be accepted by the hospital or the facility, or includes any other criteria relating to the transfer of patients (such as priorities for persons on waiting lists), such restrictions or cri- teria are the same as those applied by the hospital or facility to all other potential inpatients of the hospital or facility.....	22.
(7) When a transfer agreement has been in effect over a period of time, a sufficient number of patient transfers between the two institutions have occurred to indicate that the transfer agree- ment is effective.....	32.
(b) <i>Standard: Interchanges of Information.</i> —The transfer agreement provides reasonable assurance that there will be interchange of medi- cal and other information necessary or useful in the care and treat- ment of individuals transferred between the institutions, or in deter- mining whether such individuals can be adequately cared for other- wise than in either of such institutions. The factors explaining the standard are as follows.....	9.
(1) The agreement establishes responsibility for the prompt ex- change of patient information to enable each institution to deter- mine whether it can adequately care for the patient and to as- sure continuity of patient care.....	12.

XIV. Transfer Agreement.—Continued

Does not
meet this
requirement

- (b) *Standard: Interchange of Information.*—Continued
- (2) Medical information transferred includes current medical findings, diagnosis, rehabilitation potential, a brief summary of the course of treatment followed in the hospital or extended care facility, nursing and dietary information useful in the care of the patient, ambulation status, and pertinent administrative and social information.----- 112
- (3) The agreement provides for the transfer of personal effects, particularly money and valuables, and for the transfer of information related to these items.----- 96
- (c) *Standard: Execution of Agreement.*—The transfer agreement is in writing and is signed by individuals authorized to execute such agreement on behalf of the institutions, or, in case the two institutions are under common control, there is a written policy or order signed by the person or body which controls them. The factors explaining the standard are as follows----- 4
- (1) When the hospital and extended care facility are not under common control, the terms of the transfer agreement are established jointly by both institutions.----- 7
- (2) Each institution participating in the agreement maintains a copy of the agreement.----- 7
- (d) *Standard: Specification of Responsibilities.*—The transfer agreement specifies the responsibilities each institution assumes in the transfer of patients and information between the hospital and the extended care facility. The agreement establishes responsibility for notifying the other institution promptly of the impending transfer of a patient; arranging for appropriate and safe transportation; and arranging for the care of patients during transfer.
- (e) *Standard: Presumed Agreement Where Necessary for Provisions of Services.*—Any facility which does not have a transfer agreement in effect but which is found by the State agency conducting the survey (or, in the case of a State in which there is no such agency, by the Secretary) to have attempted in good faith to enter into a transfer agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and medical and other information, shall be considered to have such an agreement in effect if and for so long as it is also found to do so in the public interest and essential to assuring extended care services for patients in the community eligible for benefits. The factors explaining the standard are as follows:----- 3
- (1) If there is only one hospital in the community, the extended care facility has attempted in good faith to enter into a transfer agreement with that hospital.----- 3
- (2) If there are several hospitals in the community, the extended care facility has exhausted all reasonable possibilities of entering into a transfer agreement with these hospitals.----- 2
- (3) The extended care facility has copies of letters, records of conferences, and other evidence to support its claim that it has attempted in good faith to enter into a transfer agreement.----- 3
- (4) The State agency has found that hospitals in the community have, in fact, refused to enter into a transfer agreement with the extended care facility in question.----- 5
- (5) The State agency has taken into consideration the availability of extended care facilities in the community and the expected need of such services for eligible beneficiaries under the law.----- 2
- XV. Physical Environment.—405.1134: The extended care facility is constructed, equipped, and maintained to insure the safety of patients and provides a functional, sanitary, and comfortable environment. The following standards are guidelines to help State agencies to evaluate existing structures which do not meet Hill-Burton construction regulations in effect at the time of the survey, and to evaluate in all facilities those aspects of the physical environment which are not covered by such Hill-Burton regulations. They are to be applied to existing construction with discretion and community need for service.
- (a) *Standard: Safety of Patients.*—The extended care facility is constructed, equipped, and maintained to insure the safety of patients.

XV. Physical Environment.—Continued

(a) *Standard: Safety of Patients.*—ContinuedDoes not
meet this
requirement

It is structurally sound and satisfies the following conditions-----	104
(1) The facility complies with all applicable State and local codes governing construction-----	61
(2) Fire resistance and flamespread ratings of construction, materials, and finishes comply with current State and local fire protection codes and ordinances-----	163
(3) Permanently attached automatic fire-extinguishing systems of adequate capacity are installed in all areas considered to have special fire hazards including but not limited to boiler rooms, trash rooms, and nonfire resistant areas or buildings. In an extended care facility of two or more stories fire alarm systems providing complete coverage of the building are installed and inspected regularly. Fire extinguishers are conveniently located on each floor and in special hazard areas such as boiler rooms, kitchens, laundries, and storage rooms. Fire regulations are prominently posted and carefully observed-----	395
(4) Doorways, passageways, and stairwells are wide enough for easy evacuation of patients and are kept free from obstruction at all times. Corridors are equipped with family secured hand-rails on each side. Stairwells, elevators, and all vertical shafts with openings have fire doors kept normally in closed position. Exit facilities comply with State and local codes and regulations-----	129
(5) Unless the facility is of fire resistive construction, blind and nonambulatory or physically handicapped persons are not housed above the street level floor-----	16
(6) Reports of periodic inspections of the structure by the fire control authority having jurisdiction in the area are on file in the facility-----	76
(7) The building is maintained in good repair and kept free of hazards such as those created by any damaged or defective parts of the building-----	109
(8) No occupancies or activities undesirable to the health and safety of patients are located in the building or buildings of the extended care facility-----	10
(b) <i>Standard: Favorable Environment for Patients.</i> —The extended care facility is equipped and maintained to provide a functional, sanitary and comfortable environment. Its electrical and mechanical systems (including water supply and sewage disposal) are designed, constructed, and maintained in accordance with recognized safety standards and comply with applicable State codes and regulations. The factors explaining the standard are as follows:-----	97
(1) Lighting levels in all areas of the facility are adequate and void of high brightness, glare, and reflecting surfaces that preclude discomfort. Lighting levels are in accordance with recommendations of the Illuminating Engineering Society. The use of candles, kerosene oil lanterns, and other open flame methods illumination is prohibited-----	62
(2) An emergency electrical service, which may be battery operated if effective for 4 or more hours, covers lights at nursing stations, telephone switchboard, night lights, exit and corridor lights, boiler room, and the fire alarm system-----	315
(3) The heating and air-conditioning systems are capable of maintaining adequate temperatures and providing freedom from drafts-----	26
(4) An adequate supply of hot water for patient use is available at all times. Temperature of hot water at plumbing fixtures used by patients is automatically regulated by control valves and does not exceed 110° F. (110 degrees Fahrenheit)-----	278
(5) The facility is well-ventilated through the use of windows, mechanical ventilation, or a combination of both. Rooms and areas which do not have outside windows and which are used by patients or personnel are provided with functioning mechanical ventilation to change the air on a basis commensurate with the type of occupancy-----	70

XV. Physical Environment.—Continued		<i>Does not meet this requirement</i>
(b) <i>Standard: Favorable Environment for Patients.—Con.</i>		
(6) All inside bathrooms and toilet rooms have forced ventilation to the outside.....	47	
(7) Laundry facilities (when applicable) are located in areas separate from patient units and are provided with the necessary washing, drying, and ironing equipment.....	39	
(c) <i>Standard: Elevators.—Elevators are installed in the facility if patient bedrooms are located on floors above the street level. The factors explaining the standard are as follows.....</i>		
(1) Installation of elevators and dumbwaiters complies with all applicable codes.....	41	
(2) Elevators are of sufficient size to accommodate a wheeled stretcher.....	44	
(d) <i>Standard: Nursing Unit.—Each nursing unit has at least the following basic service areas: Nurses' station, medicine storage and preparation area, space for storage of linen, equipment and supplies, and a utility room. The factors explaining the standard are as follows:.....</i>		
(1) A nurses' call system registers calls at the nurses' station from each patient bed, patient toilet room, and each bathtub or shower.....	148	
(2) Equipment necessary for charting and recordkeeping is provided.....	0	
(3) The medication preparation area is well-illuminated and is provided with hot and cold running water.....	39	
(4) The utility room is located, designed and equipped to provide areas for the separate handling of clean and soiled linen, equipment and supplies.....	89	
(5) Toilet and handwashing facilities are provided.....	17	
(e) <i>Standard: Patients' Bedrooms and Toilet Facilities.—Patients' bedrooms are designed and equipped for adequate nursing care and the comfort and privacy of patients. Each bedroom has or is conveniently located near adequate toilet and bathing facilities. Each bedroom has direct access to a corridor and outside exposure with the floor at or above grade level. The factors explaining the standard are as follows:.....</i>		
(1) Ordinarily rooms have no more than four beds with not less than 3 feet between beds.....	105	
(2) In addition to basic patient care equipment each patient unit has a nurses' call signal, an individual reading light, bedside cabinet, comfortable chair, and storage space for clothing and other possessions. In multiple bedrooms, each bed has flame-proof cubicle curtains or their equivalent.....	132	
(3) Each patient room has a lavatory with both hot and cold running water, unless provided in adjacent toilet or bathroom facilities.....	38	
(4) On floors where wheelchair patients are located, there is at least one toilet room large enough to accommodate wheelchairs.....	21	
(5) Each bathtub or shower is in a separate room or compartment which is large enough to accommodate wheelchair and attendant.....	39	
(6) At least one water closet, enclosed in a separate room or stall, is provided for each eight beds.....	11	
(7) Substantially secured grab bars are installed in all water closet and bathing fixture compartments.....	84	
(8) Doors to patient bedrooms are never locked.....	19	
(f) <i>Standard: Facilities for Isolation.—Provision is made for isolating infectious patients in well-ventilated single bedrooms having separate toilet and bathing facilities. Such facilities are also available to provide for the special care of patients who develop acute illnesses while in the facility and patients in terminal phases of illness.....</i>		
(g) <i>Standard: Examination Rooms.—A special room (or rooms) is provided for examination, treatments, and other therapeutic procedures. The factors explaining the standard are as follows.....</i>	65	
	225	

XV. Physical Environment.—Continued

Does not
meet this
requirement(g) *Standard: Examination Rooms.*—Continued

- (1) This room is of sufficient size and is equipped with a treatment table, lavatory or sink with other than hand controls, instrument sterilizer, instrument table, and necessary instruments and supplies.----- 326
- (2) If the facility provides physical therapy, areas are of sufficient size to accommodate necessary equipment and facilitate the movement of disabled patients. Lavatories and toilets designed for the use of wheelchair patients are provided in such areas.----- 173

(h) *Standard: Dayroom and Dining Area.*—The extended care facility provides one or more attractively furnished multipurpose areas of adequate size for patient dining, diversional and social activities. The factors explaining the standard are as follows.----- 29

- (1) At least one dayroom or lounge, centrally located, is provided to accommodate the diversional and social activities of the patients. In addition, several smaller dayrooms, convenient to patient bedrooms, are desirable.----- 22
- (2) Dining areas are large enough to accommodate all patients able to eat out of their rooms. These areas are well-lighted and well-ventilated.----- 70
- (3) If a multipurpose room is used for dining and diversional and social activities, there is sufficient space to accommodate all activities.----- 39

(i) *Standard: Kitchen or Dietary Area.*—The extended care facility has a kitchen or dietary area adequate to meet food service needs and arranged and equipped for the refrigeration, storage, preparation, and serving of food as well as for dish and utensil cleaning and refuse storage and removal. Dietary areas comply with the local health or food handling codes. Food preparation space is arranged for the separation of functions and is located to permit efficient service to patients and is not used for non-dietary functions.----- 34

XVI. Housekeeping Services.—405.1135:

The extended care facility provides the housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment.

- (a) *Standard: Housekeeping Services.*—The facility provides sufficient housekeeping and maintenance personnel to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. Nursing personnel are not assigned housekeeping duties. The factors explaining the standard are as follows.----- 35
- (1) Housekeeping personnel, using accepted practices and procedures, keep the facility free from offensive odors, accumulations of dirt, rubbish, dust, and safety hazards.----- 121
- (2) Floors are cleaned regularly. Polishes on floors provide a non-slip finish; throw or scatter rugs are not used except for nonslip entrance mats.----- 41
- (3) Walls and ceilings are maintained free from cracks and falling plaster, and are cleaned and painted regularly.----- 127
- (4) Deodorizers are not used to cover up odors caused by unsanitary conditions or poor housekeeping practices.----- 38
- (5) Storage areas, attics, and cellars are kept safe and free from accumulations of extraneous materials such as refuse, discarded furniture, and old newspapers. Combustibles such as cleaning rags and compounds are kept in closed metal containers.----- 61
- (6) The grounds are kept free from refuse and litter. Areas around buildings, sidewalks, gardens, and patios are kept clear of dense undergrowth.----- 29
- (b) *Standard: Pest Control.*—The facility is maintained free from insects and rodents. The factors explaining the standard are as follows.----- 19
- (1) A pest control program is in operation in the facility. Pest control services are provided by maintenance personnel of the facility or by contract with a pest control company. Care is taken to use the least toxic, and least flammable effective insecticides and rodenticides. These compounds are stored in non-

	<i>Does not meet this requirement</i>
XVI. Housekeeping Services.—Continued	
(b) <i>Standard: Pest Control.—Continued</i>	
patient areas and in nonfood preparation and storage areas.	
Poisons are under lock.....	22
(2) Windows and doors are appropriately screened during the insect breeding season.....	44
(3) Harborage and entrances for insects and rodents are elim- inated.....	35
(4) Garbage and trash are stored in areas separate from those used for the preparation and storage of food and are removed from the premises in conformity with State and local practices. Containers are cleaned regularly.....	96
(c) <i>Standard: Linen.</i> —The facility has available at all times a quan- tity of linen essential for the proper care and comfort of patients. Linen are handled, stored, and processed so as to control the spread of infection. The factors explaining the standard are as follows.....	24
(1) The linen supply is at least three times the usual occupancy....	24
(2) Clean linen and clothing are stored in clear, dry, dust-free areas easily accessible to the nurses' station.....	38
(3) Soiled linen is stored in separate well-ventilated areas, and is not permitted to accumulate in the facility. Soiled linen and clothing are stored separately in suitable bags or containers....	127
(4) Soiled linen is not sorted, laundered, rinsed, or stored in bathrooms, patient rooms, kitchens or food storage areas.....	38
XVII. Disaster Plan.—405.1136:	
The extended care facility has a written procedure to be followed in case of fire or disaster.	
(a) <i>Standard: Disaster Plan.</i> —The facility has a written procedure to be followed in case of fire, explosion or other emergency. It specifies persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating helpless patients, frequency of fire drills, and assignment of specific tasks and responsibilities to the personnel of each shift. The factors ex- plaining the standard are as follows.....	79
(1) The plan is developed with the assistance of qualified fire and safety experts.....	48
(2) All personnel are trained to perform assigned tasks.....	145
(3) Simulated drills testing the effectiveness of the plan are conducted on each shift at least three times a year.....	562
(4) The plan is posted throughout the facility.....	101
XVIII. Utilization Review (405.1137):	
<i>Condition.</i> —The facility has in effect a plan for utilization re- view which applies at least to the services furnished by the facility to inpatients who are entitled to benefits under title XVIII of the act. An acceptable utilization review plan pro- vides for: (1) the review, on a sample or other basis, of ad- missions, duration of stays, and professional services fur- nished; and (2) review of each case of continuous extended duration.	
(c) <i>Approval</i>	
<i>Approval and Operation of Plan.</i> —The operation of the utilization re- view plan is a responsibility of the medical profession. The plan in the facility has the approval of the medical staff (if any) as well as that of the governing body.....	15
(d) <i>Description</i>	
<i>Written Description of Plan.</i> —The facility has a currently applicable, written description of its utilization review plan. Such description includes.....	27
(1) The organization and composition of the committee(s) which will be responsible for the utilization review function.....	20
(2) Frequency of meetings.....	24
(3) The type of records to be kept.....	20
(4) The method to be used in selecting cases on a sample or other basis.....	86
(5) The definition of what constitutes the period or periods of extended duration.....	32
(6) The relationship of the utilization review plan to claims ad- ministration by a third party.....	118

XVIII. Utilization Review.—Continued

*Does not
meet this
requirement*

Written Description Plan.—Continued

- (7) Arrangements for committee reports and their dissemination..... 27
- (8) Responsibilities of the facility's administrative staff..... 33

(e) Committee

Statutory Requirement:

Conduct of Function By Committees.—The utilization review function is conducted by one or a combination of the following..... ² 12

(Check the type of committee sponsorship. Indicate if a combination.

If other than (i), describe:)

- (i) By a staff committee or committees of the facility, each of which is composed of two or more physicians, with or without the inclusion of other professional personnel;
- (ii) By a committee(s) or group(s) outside the facility composed as in (i) which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality;
- (iii) Where a committee(s) or group(s) as described in (i) or (ii) has not been established to carry out all the utilization review functions prescribed by title XVIII, by a committee(s) or group(s) composed as in (i), and sponsored and organized in such manner as approved by the Secretary of Health, Education, and Welfare.
 - (1) The medical care appraisal and educational aspects of review on a sample or other basis, and the review of long-stay cases need not be done by the same committee or group.
 - (2) Existing staff committees may assume the review responsibility stipulated in the plan. In smaller facilities, all of these functions may be carried out by a committee of the whole or a medical care appraisal committee.
 - (3) The committee(s) is broadly representative of the medical staff and at least one member does not have a direct financial interest in the facility.

(f) Reviews

Statutory Requirement:

Reviews are made, on a sample or other basis, of admissions, duration of stays, and professional services, furnished, with respect to the medical necessity of the services, and for the purpose of promoting the most efficient use of available health facilities and services..... 62

Such reviews emphasize identification and analysis of patterns of patient care in order to maintain consistent high quality.

- (1) Review of cases, based on diagnostic categories, include diagnoses of special relevance to the aged group..... 611
- (2) Some review functions are carried out on a continuing basis... 435
- (3) Reviews include a sample of recertifications of medical necessity, as made for purposes of the health insurance for the aged program..... 229

(g) Extended; Duration

Statutory Requirement:

Reviews are made of each health insurance beneficiary case of continuous extended duration..... ³ 17

Committee minutes or other records show that:

Statutory Requirement:

Reviews for such purpose are made no later than the seventh day following the last day of the period of extended duration specified in the plan..... 41

No physician has review responsibility for any extended stay cases in which he was professionally involved..... 46

Statutory Requirement:

If physician members of the committee decide, after opportunity for consultation is given the attending physician by the committee, and considering the availability and appropriateness of out-of-hospital

² See addendum, p. 2057, item 6.

³ See addendum, p. 2057, item 7.

XVIII. Utilization Review.—Continued
Statutory Requirement.—Continued

*Does not
meet this
requirement*

facilities and services, that further inpatient stay is not medically necessary, there is notification in writing within 48 hours to the institution, the attending physician and the patient or his representative. 30

(h) *Records*

Records are kept of the activities of the committee, and reports are regularly made by the committee to the executive committee of the medical staff, and relevant information and recommendations are reported through usual channels to the entire medical staff and the governing body of the hospital.----- 45

(1) The facility's administration studies and acts upon administrative recommendations made by the committee.----- 84

(2) A summary of the number and types of cases reviewed, and the findings, are part of the records.----- 222

(3) Minutes of each committee meeting are maintained.----- 58

(4) Committee action in extended stay cases is recorded, with cases identified only by medical case number.----- 322

(i) *Administrative Staff*

The committee(s) having responsibility for utilization review functions have the support and assistance of the facility administrative staff in assembling information, facilitating chart reviews, conducting studies, exploring ways to improve procedures, maintaining committee records, and promoting the most efficient use of available health services and facilities.----- 27

(1) With respect to each of these activities, an individual or department is designated as being responsible for the particular service.----- 38

(2) In order to encourage the most efficient use of available health services and facilities, assistance to the physician in timely planning for post-hospital care is initiated as promptly as possible, either by facility staff, or by arrangement with other agencies.----- 24

(3) For this purpose, the facility makes available to the attending physician current information on resources available for continued out-of-hospital care of patients and arranges for prompt transfer of appropriate medical and nursing information in order to assure continuity of care upon discharge of a patient.----- 47

