

TRENDS IN LONG-TERM CARE

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

PART 7—SALT LAKE CITY, UTAH

FEBRUARY 13, 1970



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TRENDS IN LONG-TERM CARE

(Salt Lake City, Utah)

FRIDAY, FEBRUARY 13, 1970

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE OF THE
SPECIAL COMMITTEE ON AGING,
Salt Lake City, Utah.

The subcommittee met, pursuant to call, at 9:30 a.m., in the State Capitol Building Auditorium, Senator Frank E. Moss (chairman) presiding.

Present: Senator Moss.

Also present: Val Halamandaris, professional staff member; John Guy Miller, minority staff director; and Margaret Wright, clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The subcommittee will come to order.

We are delighted to be here in Salt Lake City this morning, welcomed by a fresh snowfall overnight. The committee was sitting in San Francisco yesterday having a hearing on the same problems that we are going to hear this morning in Salt Lake City.

We welcome all of you here today. This is the Subcommittee on Long-Term Care of the U.S. Senate, and the Special Committee on Aging. We are continuing our study of the vital issues confronting our citizens who carry the compound burdens of illness and advanced age.

Your presence here today indicates your concern with the most unrepresented minority group of our society.

We are in Utah today to help complete a record that we are building on several nationally important questions. Inevitably, we must deal with problems; unfortunately, we sometimes give the impression that there is nothing positive in the nursing home industry. That is far from true, and I want to underline that. We have made great strides.

Some of the issues that have been considered by the subcommittee are the problems relating to the shortage of personnel, inadequate State welfare payments to nursing homes, the relationship between the nursing home and the hospital, the access of minority groups to the nursing home, and the problems which we have with present Medicare payments to nursing homes.

The Finance Committee of the Senate has recently issued a report which is highly critical of the operation of the Medicare program. Part of this subcommittee's function is to determine ways in which the Medicare program can be made more efficient. Even in the face of

the substantial criticism that it has received, Medicare is still the most significant program for the elderly adopted by the Congress at any time. We must strive to insure that it does not become another broken promise. As the title of this subcommittee indicates, we are primarily concerned with nursing homes. We seek to emphasize the positive today, to focus on the nursing home of the future. We have questions that we would pose, such as, how can we best care for our increasing number of elderly now and in the future.

Perhaps the question would be better phrased in terms of what future generations will do with us.

That these questions are important is obvious from the statistics as well as logic. There are presently 20 million people over 65 in this country. Someone has indicated that in 15 years the over-65 population will comprise 33 percent of the population of the United States and a much higher percentage of the voting population.

Of our 20 million elderly, almost 1 million are currently housed in some 23,000 nursing homes. As these figures indicate, only one of our elderly out of 20 is presently housed in a nursing home. Therefore, we must recognize that nursing homes are not the only problems facing our senior citizens. The primary problem is inadequate income and in this regard the 15 percent social security increase recently granted to our elderly is far from adequate. We must do more and much more.

It does seem that as far as income is concerned, the elderly will continue to constitute the floor of our economy. For this reason, I have suggested a program of rewards and incentives to supplement the central need to increase incomes. What I have in mind, for example, is my program for reduced fares for senior citizens on airlines. Chicago, New York, and San Francisco presently allow their senior citizens to ride on their subways and buses at half price. Many progressive cities have made arrangements which allow our elderly to attend movies and ball games at half price. Right here in Salt Lake City we have a drug-store chain that sells drugs at half price to senior citizens. But we must do still more.

Having considered the health and economic needs, we should mention briefly the psychological needs of our elderly. Everyone needs to feel useful. Certainly we must adjust our present attitudes. Our senior citizens in the future will increase in number and in average age and we cannot afford to waste this valuable source of energy, experience, and intelligence.

I underline that it is our attitude that counts. Thankfully, the State of Utah still has great respect for those of advanced age. There is no place in the United States where age is more venerated than here in Utah. For this our citizens should be proud.

We have a full witness list today and considerations of time require me to comment before we begin that the statements of witnesses will be printed in full in the record. Those who submitted a prepared text are assured it will be printed in full in the record. Accordingly, if it is possible and desirable to the witness, each witness could summarize or highlight significant parts of his testimony for oral presentation. That will enable us to move along and to hear the many fine witnesses we have scheduled for the hearing this morning. The purpose of this hearing and other public hearings is to compile written record. Obviously, although I am the chairman of the subcommittee, I am just one of several who serve on the subcommittee and then on the full

committee. Other than oral impressions that I can give them, they are going to depend on what is written on the record in determining what actions, if any, should be taken on the problems that we will discuss.

I also ought to explain that this hearing is a little bit different from some others that you may have attended. Very frequently we have before us a given piece of legislation, a bill that has been introduced in the public hearing, for people to talk to the particular terms of that bill. This is not that sort of hearing. It is what we call an oversight hearing. We are examining the whole field here, the law that we do have on the books now, and asking for recommendations or suggestions. Out of this may grow some proposed legislation, but we do not have a specific bill before us that we are talking about this morning. I want to get the opinions and the information that I can for the committee on the general subject that I have outlined. We are talking about "Trends in Long-Term Care".

I have seated with me at the table here two members of the staff, Mr. Val Halamandaris, who is a native of our State, and Mr. John Guy Miller, minority staff director of the Senate Committee on Aging.

Before we call the first witness, I am going to ask Robert J. Utzinger, who is regional representative of the National Retired Teachers Association, if he would come forward and make some general remarks of greeting.

We will ask those who are called to come and sit at this table over here (indicating) where the mikes are set up. That way everybody in the room will be able to hear and the reporter will be able to record the testimony.

We are very glad to have you, Mr. Utzinger, and we appreciate your coming here this morning.

STATEMENT OF ROBERT J. UTZINGER, REGIONAL REPRESENTATIVE, AREA VIII, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. UTZINGER. I am Bob Utzinger, regional representative for the National Retired Teachers Association and the American Association of Retired Persons, with Regional Headquarters here in Salt Lake City. We serve five Rocky Mountain States.

We are very pleased to welcome the Senate Subcommittee on Long-Term Care of the Special Committee on Aging of the U.S. Senate. We are pleased particularly to welcome you, Mr. Chairman, Senator Moss.

We are interested to note that you mentioned the 20-million older Americans as being the most unrepresented group in the United States today. We certainly concur in that comment. However, we do represent a large number of this group, over 2 million people. Our associations are quite interested in all aspects of long-term care.

We do have a prepared statement, Mr. Chairman, which we will not read. We do want to say that we certainly subscribe to your philosophy that we want to accentuate the positive. We are interested in those programs which lead toward the preventive aspects of chronic illnesses and I think this all relates to long-term care. The more older people we can keep independent in their action as long as possible and keep them out of long-term care facilities the happier we are.

We will leave the statement with the committee, Senator Moss. Thank you.

Senator Moss. Thank you very much, Mr. Utzinger. The statement, of course, will appear in full in the record. We do appreciate your coming here to make those remarks at the beginning of our hearing. You represent a most important group in our society and we appreciate your interest and concern with the problems that we are surveying on these hearings we are holding in various parts of the country.

(The statement follows:)

Honorable Senator Moss, distinguished members and guests of the committee: my name is Robert J. Utzinger. I am regional representative for the National Retired Teachers Association and the American Association of Retired Persons serving Area VIII composed of Colorado, Idaho, Montana, Utah, and Wyoming. Our associations have a combined membership of over two million. I have a master of public health degree from the University of Michigan and 20 years experience in public health, 10 years in the field of chronic illnesses.

We are all well acquainted with the economics of prevention in reducing the cost of care for the chronically ill.

Our associations are vitally concerned with this area of prevention of illness for all older persons, so they may enjoy retirement and the aging process with some degree of independence.

Unfortunately, with our present non-system of medical care, we are not always completely successful in helping our older persons achieve this goal of independence in later life.

Too often, older persons are struck down with a catastrophic illness requiring lengthy hospitalization, which depletes their resources both financially and physically. This sometimes forces them into a nursing home for a period of convalescence. Many older people could forego or shorten this stay if certain community personal services were more readily available—some of these personal services are:

- Home health services.
- Meals on wheels.
- Home makers service.
- Telephone reassurance.
- Friendly visitors.
- Neighborhood lunch programs.
- Transportation systems.

To enable our older persons to maintain a positive health status, our federal, state, and local health and welfare agencies must place more attention and funds in these community based preventive type programs.

Currently in the Rocky Mountain west, the majority of these few personal care service programs exists only through the shaky financing of the Older American Acts, Title III grants. I might add here, our associations were distressed that in the revised budget request for FY 1970 funds for programs established under the amended OAA were so low—less than half of what was authorized. Particularly distressing to us, is that the budget for FY 71 does not seem to be any more encouraging. This means many Title III projects will be threatened. Three years is not enough time to muster local budgets for these programs. More federal funds are needed to carry on and expand these programs that are just in their infancy.

One program bombed by this budget cut, of particular interest to our associations is the Title VI, R.S.V.P. (Retired Service Volunteer Program). This was tailor-made to get maximum support from volunteer organizations such as ours. Now it appears this fine modest program designed to pay older volunteers "out of pocket" expense money will not be funded.

Adult foster care programs present a special need—currently here in Utah, the Veterans Administration operates such an activity. This provides care for an adult who needs minimal care in a natural family setting. This service is quite limited even for the V.A. here in Utah, since state law limits the program to only one adult per home. If a foster home family wishes to have two persons to care for they are required to be licensed as a nursing home.

The adult foster home care program serves many purposes—

- It provides a family home atmosphere for persons requiring minimum care.
- It provides additional needed income for an older person or couple.
- It provides needed companionship for both parties.

It is possible that the adult foster home care program can become as important in our society as the child foster home care program, which has made an anachronism of our orphanages. We are basically a family society, and people do better in family settings than in artificially created institutions.

Another level of care needed for older folks, is that of low cost group housing. Here is a real need—our associations have on file many letters testifying to the fact of older people paying more than 50% of their total income for housing. I received a recent one from a lady in Denver, whose income is \$120.00 per month, but who pays \$65.00 a month for rent. Mr. Burtram A. Weight, Executive Vice President of the Salt Lake Board of Realtors told me earlier this week that he doesn't like to see folks pay more than 25% of their income for housing. Can anyone in this room find decent housing in Salt Lake City for \$30.00 a month?

Low cost group housing is described as something between a residential retirement center and a nursing home—it provides an older person with a protective environment so that he can be relieved of such simple tasks as paying utility bills, household maintenance, yard work, worrying over the security problems, or break-ins from vandals.

Many of these seemingly small tasks loom great to an older person facing life alone after the loss of a mate. This low cost group housing program which should be accessible to health facilities, would provide the very minimal services necessary to help the older persons maintain his independence of action, without which, life soon loses all purpose.

Our associations are vitally interested in seeing less attention given to the institutional aspects of the long term care programs, which emphasize fixed clinical and medical facilities and more attention given to low cost housing programs and community service activities aimed at preventing chronic illnesses. We feel preventive type programs will reduce the crush for chronic illness beds, plus helping more older Americans maintain purposeful and independent living as long as possible.

Senator Moss. I will now call on Dr. Victor Kassel, who was formerly chief of the geriatrics division of the veterans' hospital here in Salt Lake City. We look forward to hearing from Dr. Kassel, a man of great reputation and background in the field he is going to talk about this morning.

Welcome, Doctor.

**STATEMENT OF VICTOR KASSEL, M.D., PRACTICING GERIATRICIAN,
FORMERLY CHIEF OF GERIATRICS, VETERANS' HOSPITAL, SALT
LAKE CITY, UTAH**

Dr. KASSEL. Good morning, sir.

It is a pleasure being here. I have a prepared statement and I wish to point out that it is a summary. I just hope I didn't summarize it too much.

Senator Moss. If you feel it is too much, you may expand a little on the summary.

Dr. KASSEL. You know, with no disrespect to the committee, I have heard some of my more conservative medical colleagues describe this committee as the "Subcommittee on Long-Term Care of the U.S. Senate."

Senator Moss. We are all moving that way.

Dr. KASSEL. In the consideration of long-term care, and I understand the concern for the nursing home, we all must recognize that, as a physician, I don't see the patient only in the nursing home, but, through the hospital, courses in the office, at home, in nursing homes. I cannot focus my attention singularly on the nursing home, because my hope is that, although a patient may need nursing home care, eventually they should get out of the nursing home. The nursing home serves a purpose, but this is not the normal place for the older individual.

Earlier mention was made, and I think we should reinforce the idea, that unfortunately most of the senile aged—and by senile I mean confused, and disoriented—the senile aged who live in nursing homes today are there. And, frankly, there is very little we can do for them. Realistically they are a lost group. We are investing a lot of money, time, and energy in their care. But, more important, I am convinced that senility is preventable. And, more of our energies, techniques, and attitudes should be turned toward the prevention of the state of senility.

Senility is becoming more and more an American disease, because people are expected to become senile as part of our culture. Too many sociologists define senility as a normal phase of life following senescence. In the practice of geriatrics I cannot agree. All I have to do is refer you to Lord Moran's diary of Churchill during his last years, and Churchill's return from senility whenever he was needed in Parliament. Also, you nursing home operators are aware of many elderly patients who are senile one day and clear the next. I feel that more and more stress should be placed on the prevention.

In my paper I have divided the problem into four areas: Government, nursing home, patient, and physician.

I have been horrified at some of the attitudes of the Medicare law in relationship to the patient, because the law has fragmented the patient. All elderly patients suffer from three major difficulties. In the classes I have given to the nursing home operators I have tried to stress this. The aged are impaired by medical and surgical difficulties, and Medicare seems to have recognized this. All elderly individuals are impaired by psychiatric and psychological difficulties and, in a way, Medicare has come to recognize this. But, unfortunately, the major problem of the aged today, as it has been for a long time, are the social disabilities, and Medicare has completely ignored this.

Prior to the Medicare law, we were confronted with a variety of unhealthy, unhappy elderly individuals; now with the Medicare law we are confronted with a variety of healthy, unhappy elderly individuals. Because we have not been fully aware of the social problems of the aged.

In fact, accompanying my written testimony, there is a letter that I sent to the Utilization Review Committee of the Utah State Medical Association resigning from the committee, because I could not continue in the destruction of a patient. For example, one patient I had was a lady who was disabled with a severe case of Parkinson's disease. She was admitted in the hospital with pneumonia, then discharged from the hospital to a nursing home. She was found not to be entitled to nursing home care because she was primarily custodial. She went home to live with her husband who was not interested in her; and she developed pneumonia again, went back to the hospital, then to the nursing home, and finally back home. This was the cycle until finally the patient became impaired enough where nursing home care was continued on the basis of medical necessity. Staying with her husband, she further deteriorated. But Medicare was not concerned with these social needs.

This (indicating) is the specific concept that came out of Denver to me, when I was on the Utilization Review Committee. In the practice of geriatrics, I will not destroy patients on the basis of a law

that does not fully recognize a total patient. A total person who incidentally happens to have an interesting abnormal kidney, or an interesting abnormal heart.

There is another problem that I have encountered with the Government in relationship to Medicare, and that is in its deficiency in educating the public. Educating as to what they are entitled to. The problem continues in the various ECF areas with the persistent and continued difficulty in evaluating custodial care versus skilled nursing care.

We are now beginning to see the problem of how much of a physical examination is a patient entitled to, on the basis of a particular illness. We are getting letters from the Medicare office stating that perhaps an electrocardiogram is not necessary in the care of the patient who happened to have diabetes.

We continue to fragment the patient and it seems that, rather than a realistic decision on the patient, a computer is making a decision as to the actual necessary care of the patient.

Incidentally, with the Medicaid program (I don't know whether the Utah Welfare Commissioners are here) but they lie to the welfare recipients. I find this most distasteful. They will tell welfare recipients that the recipient is entitled to select the physician of his own choice, and they also tell the recipient that Medicaid or welfare will pay for the services. Unfortunately, the welfare commission will pay only for those services they deem necessary, and they will pay according to that fee schedule which happens to tickle their fancy at the time. So the nursing home loses out; the patient loses out; the physician loses out; the family loses out; but welfare maintains its position in the community as being an agency which is trying to help individuals. In reality, they are not.

Incidentally and unfortunately, too often decisions about the patients' needs are made by obstetricians, pediatricians; general surgeons; and not by those of us who are experts in the needs of the total patient.

Medicare doesn't seem to have come to recognize that there is a difference in time and energy spent in doing a complete physical examination on a 27-year-old man, in contrast to doing a complete physical examination on a 72-year-old, uncooperative, confused, incontinent man. It is insisted that a physical examination is a physical examination, and the needs of a patient is taken from computer statistics, to the detriment of the patient.

That is all for the Government.

As far as the nursing homes are concerned, they attempt to do a very fine job. Unfortunately, the flow of personnel in nursing homes continues. We have trained individuals who remain for a while and leave. I have a license as a nursing home operator, and I can assure you that I would never work as a nursing home operator. It is the most difficult job available today, and I have to hand it to the nursing home operators who continue, taking the burden of guilt, projection of guilt and hostility that families have to offer, while the nursing home operators attempt to carry on the care of the patient.

Unfortunately, the education of personnel in the nursing home is not continuing to the depth that it should. We still have nursing personnel reporting to me that a patient is ill, and never bothering to

take the patient's temperature with a thermometer. They use the back of their hand as the thermometer. Too many are not able to intelligently describe difficulties to the physician on the telephone. There seems to be a lack of professionalism in too many areas.

In addition are the problems of terminal illnesses. All too often a physician is called, and asked to drop everything to come out and see an elderly patient, 93 years of age and suffering from her fourth stroke, because the elderly patient is about to pass away. This is unrealistic. It would be nice to be able to examine the patient every hour during her demise, but we can't do it. There aren't enough physicians to go around. Too often nursing home personnel have the idea that you have to do something in an illness, and even if nothing is to be done, they want you to do something. You have to give the patient a shot, and so forth. If you ask them, "A shot of what?" they will say, "I don't know, just give the patient a shot." "For what?" And it goes on.

There is an old medical saying that I think we all should learn when it comes to taking care of elderly individuals, or any individual for that matter: *Primum non nocere*. First, do no harm. We must all recognize that adage.

In general, I find that nursing homes do a fine job. In my mind I have categorized them in the following classifications:

They should offer terminal care to patients. Second, care of the seriously ill patient who requires continued expert nursing in order to maintain optimal health. Third, convalescent care after an acute illness. Fourth, rehabilitation. Fifth, intensive chronic care not necessarily requiring the expertise of an acute hospital. And finally the one most lacking in America is that type of care offered by the programs developed by Lionel Cosin in England. He offers day care; night care; weekend care; vacation-time care; and care when the family gets sick and tired of the elderly person and wants to get them off their back for a week or two. Many of the patients we see in nursing homes could be at home, if periodically they could be taken to the nursing home so that the family taking care of them at home could have some freedom.

Then, of course, the problems of the terminal patient and our inability in America to come to grips with some very important problems. As you know, with transplantation of organs, we are now redefining death. What about the dying patient? I have a letter here, and it is part of my written testimony of a patient who had cancer spread throughout his body. He made a request in writing to me that I should do away with him. He knew he had cancer, and he wanted to die. It was Sophocles who said: "Death is not the greatest of ills: it is worse to want to die and not be able to."

What about the question of euthanasia, active or passive? What about suicide? What about the chronically ill, terminal patient who must depend upon the nurse to bring him a syringe, containing a narcotic, every 3 or 4 hours, also dependent upon the whims, the caprices, the desires, the attitudes of the nurse?

Perhaps we have become unrealistic in the care of the terminal patient. I feel that in those nursing homes which carry terminal patients, there should be an area where tormented souls might relax, lounge, and in complete reverie smoke opium. We don't object to giving them a shot of morphine every 3 to 4 hours. Why not allow the

patient to make his own selection, at his own time, at his own discomfort? Of course, now that we are concerned about cigarette smoking, we may object to smoking opium. Then allow the patient to have a cocktail of the juice of the poppy, as he, the patient, desires.

These are some of the things that we must consider. The question of life and death is becoming political in America. In ancient Greece it was always a matter of the individual with his gods. We persist in trying to legislate morality and we are becoming more barbaric.

I have difficulties with patients because they have not been educated. Included in my written testimony there is a copy of a bulletin that I have made up for my patients. It directs them to recognize that the Medicare contract is a contract between the Federal Government and the patient. It is not a contract between the Federal Government and the physician. Nursing homes and other agencies can charge for the completion of forms and for the duplication of paperwork. Physicians can rest, and it has become a tremendous burden for the physician. Where you have families of two, three, or four children, why these children cannot assume the responsibility of carrying through the routine paperwork for their parents I have yet to understand. These people must recognize that this is a health contract between the patient and the Federal Government.

In addition, I think it is a responsibility of Medicare to have social workers available to whom the patients can come and get the paper problems worked out. When a patient goes down to the Medicare offices and attempts to seek solutions to any one of the billing processes, the entitlements, these patients will tell you that it is just impossible. Trying to get adequate information from the Medicare office, ends in a feeling of the lack of cooperation. These patients must be able to go someplace.

I am always horrified to find a patient walking into the office with the little green envelope sticking out of his pocket, because I know what is going to happen. The elderly patients of today are individuals who have felt responsibility for their debts, and want to pay their debts. So they feel guilty; they become agitated; they become anxious and upset when a bill is unpaid. I find more of them spending time with me in my office discussing Medicare forms, discussing Medicaid procedures, discussing the costs, discussing the proper mailing and ignoring their illnesses.

These patients should have a place to go, where in some way they might be able to get proper information and help in working through the various rules and regulations of the Medicare law. They should not have to depend upon either the social security office or the Medicare office where, I am sorry to say, inadequate information is usually given.

Then, there is the obligation of the patient to have some understanding about their bodies, some ability to describe symptoms; some understanding of their own physiologies; so that so much time and money is not wasted. Remember, before the Medicare law, the sick individual had the responsibility of himself and had to bear the cost himself. Today with the Medicare law, we all invest in his care. The patient now has the responsibility to the citizenry to be somewhat intelligent and knowledgeable about himself and his illnesses.

Finally, we have the problems the physicians are having with Medicare and Medicaid. We have all become labeled as dishonest, thieves, robbers, by the newspapers all over the country. I don't want to go

into this too deeply, but I do feel that it is about time the medical profession stood up and specifically stated what they feel should be an adequate net income for a physician based on the 40-hour week, remembering the amount of training, the cost to go to medical school, the fact that it took 5 years to bring money home. But, not only on the 40-hour week, what about those of us who work an 80-hour week? What about time and a half for overtime, and double time for holidays?

You see, Senator Moss, it doesn't require very much education, and this is not an attempt to demean but it doesn't require much education to become a Senator, Congressman, even President, we all have this opportunity. But how many of you here can practice medicine? It takes a long period of education and training.

With the Medicare law a new concept developed. Laissez faire government began to recede with Teddy Roosevelt. We now find ourselves in a position where as citizens and residents of the United States we are entitled to good medical care, to fine medical care. No longer is charity acceptable with medical care.

Not only that, but the concept of equal but separate no longer exists in medicine. The indigent and the nonindigent are entitled to the same quality of medical care. The physician is told he is not expected to give charity, that he will be paid for this service, but, unfortunately, too many physicians are taxed sixfold for so-called noncharitable care.

I can end this particular portion with a definition of the physician by Ambrose Bierce from the "Devil's Dictionary." He said, "A physician, one upon whom we set our hopes when ill and our dogs when well."

Senator Moss. Thank you, Dr. Kassel, for your very eloquent testimony. Incidentally, the different documents that you submitted and referred to will be printed following your remarks, so that we have them in the record, too.

I don't know when I have had a more lucid bit of testimony before the committee. Although I must agree with you that anybody can become a Senator, he doesn't get a 40-hour week, let me assure you that. This is supposed to be a holiday right now for the Senate and you can see what is going on, and I am not the only one.

I appreciate your testimony because it comes directly from experience, long experience which you have had in this field of geriatrics and in dealing with the Medicare law and the general problems of the older citizens and nursing homes.

I was very interested in several of your observations. One has caused me, as a layman, to want to ask further questions: your assertion that senility is preventable. Just how far can you now take that?

Dr. KASSEL. I can take it to its not ridiculous extreme.

The sociologists try to define the stages of life as infancy, childhood, the teenage years, and adulthood. Then they sort of tack on a thing called senescence, which is supposed to be beginning decrepitude, and then, of course, senility.

The definition basically of senility is mental decline with old age, the individual becomes confused, disoriented, and has intellectual deterioration. We pretty well can accept physical deterioration but need not accept intellectual deterioration. The problem of the aged today is that they have no activities or satisfactions in depth. The

successful adult in our time is an individual who is able to work for a living and indulge in physical recreation. We become impaired physically as we grow older, so that the opportunity for physical recreation declines. We all become retired eventually, and so there is this void of time. It is expected in our culture that the aged become senile. They have nothing that has any meaning. They are totally bored. They have no reason to get out of bed in the morning. So we see their gradual withdrawal.

The sociologists also talk about this in terms of disengagement. The problem is that the aged must develop satisfying activities that offer the depth of satisfaction that work and physical recreation offered. From my point of view, the great opportunity, is the opportunity of the mind. This idea is not original with me. Cicero wrote about it in his essays; the essay called "De Senectute" (Concerning Old Age). In my practice of geriatrics, those individuals who are alert, bright, and enjoying the later years, and find this the best time of life, are those who are able to turn to intellectual activities. The ability to learn at age 80 is as good as it is at age 18. We are at our peak at 23, and then we go downhill. So that the capability is there, the only difficulty is that the aged will not accept it. We are not an intellectual nation, the "egghead" is looked down upon. The aged must recognize this or they are lost. I think it has to become a part of our culture, that during our adulthood after we have gone to school to learn some trade that will enable us to earn a living, then we must spend our time developing a taste for the life of the mind. When we arrive at age 60 or 65, we will then be able to turn to these activities.

There is no better example than what we see in the leadership of the LDS Church in Salt Lake City. In those cultures where the aged are very revered and found to be important, the aged do well. It is a matter of developing a social awareness, an attitude, that this is the way of life. We have to begin to prepare for it in our earlier years. One need not become senile.

Senator Moss. That is most encouraging.

Dr. KASSEL. You can go to any nursing home where you see senile elderly individuals. Every nursing home operator will tell you, they are senile one day and not the next. Why the variation? On examination of the brain after the death of a patient, the pathologist cannot tell you the intellectual capacity of the patient merely on the basis of brain changes.

Of course, we talk about hardening of the arteries. Hardening of the arteries is becoming an excuse for the aged, a way out. You know, unfortunately, with the fight of the American Medical Association and the Democratic Party, the aged became important because they were sick. They have learned a good lesson, it is good to be sick. If I am sick, I gain attention. If I am sick, I am able to direct my family. If I am sick, people feel sorry for me. If I am the squeaky wheel sick, more attention is paid to me. So many of the aged have used their illnesses to control the people around them.

In this type of culture for the aged, it is good to be sick. It is good to become senile, because the family will come and visit. The family will come, and pay attention to me. Senility is becoming culturally accepted as a way of life.

Senator Moss. Does an older person quit because his physical functions decline and he can't do as much, is that the reason he gives up these intellectual efforts that you are talking about?

Dr. KASSEL. No. He has never developed a taste for them. You can read if you have arthritis; you can write; you can think. No, it is just that we are a physical nation. It is important to be physically oriented; it is important to ski; "Ski Utah." It is important to bowl. What are we glamorizing at the University of Utah, the basketball team, the baseball team, the football team. Do we glamorize the kid who has won a scholarship? You see, we have become too physically oriented. What happened to Adlai Stevenson? What was the main criticism when he ran for president? He was an "egghead." People were afraid of his intelligence. Hoffstader has written very nicely about the climate of anti-intellectualism. We have to direct the attention of the citizenry to the fact that it is important to keep bright, sharp, intellectually competent as we grow older. The only thing that is supposed to happen as you grow older is that you grow smarter, nothing else.

Senator Moss. I appreciate hearing that and there is much I can accept in what you say. It is good to have this discussion.

You said in your testimony that turnover of personnel at nursing homes was great and that there was a lack of professionalism generally. Is that because of the low-income factor or is there something else that discourages personnel?

Dr. KASSEL. Personnel are not paid well and it is just a miserable job. I hate to go to a nursing home. It has not been unusual for me to sit on a chair that is covered with urine. You just don't want to sit down. You are afraid to touch things. Patients are confused, and they will wipe stool on a doorknob. The taking care of many of these patients in nursing homes is a difficult job and you have to be very dedicated.

Senator Moss. How can you get that motivation into our people to work there?

Dr. KASSEL. Make good Christians out of them.

I really don't know. One of the motivating factors is to pay them a good salary.

Senator Moss. That is one factor.

Dr. KASSEL. You may even pay them a good salary yet you will have nurses, who have been nurses in the hospital, and then they will take a job at a nursing home. Somebody will say, "Why are you in a nursing home, where did you foul up? Why do you find yourself having to accept a nursing home position?"

The nursing home is the low rung on the ladder. It still has the aura of "poor farm". In some way we have to get Madison Avenue involved. Maybe we can get a television series, "Gerty of the Nursing Home", or something. This is an avenue open to public relations that in some way must be filled in order to raise the status and prestige of the personnel in nursing homes. It is a rough job, it is a rough job! I would not do it! Of course, I have difficulty enough being a geriatrician, but I wouldn't do nursing home care.

The past history of nursing homes, the position they had in the past as the poor houses in England, has impaired the ability of the nursing home operator to get competent help.

I teach at the Technical Trade School where we train L.P.N.'s. We give them classes in geriatrics and where do they go on graduation?

The hospitals grab them. The hospitals have an obligation not to steal competent help from the nursing home.

Schools of Nursing have to educate that nursing homes are important.

Senator Moss. Is this image of the nursing home improving any?

Dr. KASSEL. Somewhat, but not rapidly enough.

Senator Moss. I think that we need to give some attention to this, despite the joking about it, we do need some kind of status or an acceptance of some kind by society generally for those who would be qualified to work in nursing homes so they can feel that they are really making a contribution in the work they are doing.

Dr. KASSEL. Many of them do not feel that they are making a contribution because we are youth-oriented. Why spend so much time and money on old people? They are finished! Why not invest this time in youth?

Senator Moss. Bob Finch made an unfortunate remark like that, and I am sure he is sorry he made it.

This is so fascinating I would like to spend all morning talking with you, doctor. It has been an excellent presentation. I liked your suggestion that we ought to consider the whole patient and the whole problem that we have tended to fragment the kind of care that we extend.

Dr. KASSEL. This is really destructive. Many of the physicians are discouraged because of the definition that a social need is not part of the concern of Medicare. This is wrong!

Senator Moss. Yes. This came through very strongly in the hearing that we had in San Francisco. Unfortunately governmental administration generally means regulations that are written by people sitting in offices and deciding how they can get the job done within the means they have. Government workers seem to sort of lose sight of the whole object, care for the patient, the whole person, and certainly his social needs, his psychic needs are of great importance.

Dr. KASSEL. The social need of the aged today is the No. 1 problem. You, know, I wrote a paper once, "Polygamy After Sixty"——

Senator Moss (interrupting). I was going to ask you about that.

Dr. KASSEL. The point of the paper was that people have to prepare themselves for their later years and find a place for themselves. Polygamy after 60 was tongue-in-cheek. If it is important for a woman to be married and have a husband, then she had better go out and find a husband for herself. The average wife can expect to outlive her husband 5 to 15 years. We see so many widows who are terribly depressed, have withdrawn completely, and they will say that the only way they would be happy is if their husbands were alive. I am not in a position to resurrect husbands, and we're not running a matrimonial service. If it is so important for her to be married, then she is going to have to find a husband. At the age of 60, for every 100 men there are 125 women, so the women are going to have to share the good available men.

Senator Moss. This has been most helpful and it really is a great contribution to be made in the record that we are trying to fashion here, Dr. Kassel. We appreciate your coming very much.

John Guy, did you have some questions?

Mr. MILLER. No.

Senator Moss. Thank you. We appreciate it greatly.

Dr. KASSEL. It has been a pleasure.

(The statement follows:)

I wish to thank Senator Frank E. Moss for the opportunity of appearing before this Committee. Since 1951, I have directed most of my professional attention to the care of the Aged. The last twenty years has seen attitudes change regarding the Aged, and more people have developed an optimistic feeling about the future of this age group. Unfortunately, too large a segment of the American Society continue naively youth-oriented. On a practical level, I have grown more pessimistic in working with the "senile" Aged, for in most cases here the future is bleak. (Incidentally, I am convinced that most senility is preventable.) Rather than invest most of our energies in correcting unassailable decrepitude, a greater portion of our attention must be turned toward prevention. The only thing that should happen as we grow older, is that we get smarter!

The reality of today is that many aged infirm exist. This Hearing is concerned with the present programs on the level of Medicare and Medicaid working with the infirm. My own experience as a practicing Geriatrician has caused me to react in a variety of ways to some of the facets of the available programs. I will present my remarks concisely, outlined under the following headings: Government, Nursing Home, Patient, and Physician.

GOVERNMENT

Under the Medicare law, the patient is fragmented. Rather than a person, who incidentally has a variety of disabilities, he has become a pathological heart, a pathological kidney, or a pathological brain. Geriatricians know that aged patients have a variety of Medical-Surgical disabilities. Here Medicare coverage is adequate. In addition, the Aged have a variety of Psychiatric-Psychological disabilities. Here Medicare has given some coverage. The major pathological difficulties of the Aged today, the Social disabilities are ignored by Medicare. By this fragmentation, realistic care is withheld. Please refer to the copy, enclosed, of a letter sent to Joseph R. Evans, M.D., when I resigned from the Utilization Review Committee.

The Federal Government has been unexcusable deficient in educating the public relative to Medicare coverage. I need only point out the continued confusion of Custodial Care versus Skilled Nursing Care. The physician has become the villain.

Now there also is the question of coverage for that part of an illness dealt with during a complete physical examination. The time shortly upon us will be that of a decision made by the computer as to how much of a physical examination was necessary for a specific illness.

Medicaid coverage in Utah is presented untruthfully to the Welfare recipient. These patients are told that they may select any private physician, and that Medicaid will pay for the service. Medicaid pays for the service that Medicaid deems necessary, at the fee schedule that tickles Medicaid's fancy.

What Government employee determines the validity of the physician's service? Sometimes clerks; sometimes general surgeons; sometimes obstetricians. A point that seems to have slipped the awareness is that there exists a difference between the complete physical examination accomplished on a cooperative twenty-seven year old male, and a complete physical examination accomplished on a uncooperative, confused, incontinent seventy-two year old male.

NURSING HOME

In many instances, Nursing Homes rightfully complain about the lack of physician cooperation particularly in following his patients in the Nursing Home.

I sympathize with the Nursing Home Operator; but I also recognize the limitations set by a twenty-four hour day. The concept of better trained nursing personnel is a valid one. Not too great a depth of professionalism is necessary to determine fever with a thermometer, not with a hand; to pass on intelligent information about an ill patient to the afternoon shift; to know the patients' rooms, and thereby adequately direct thereto; to update correctly patients' names and room numbers on charts; to reasonably describe a patient's complaints in a reasonably understandable language; etc.

We can all expect to die, this as the result of a terminal illness. Although it might be ideal to examine a patient every hour during his demise, it is unreasonable to expect it. It is unrealistic to ask the physician to drop everything because Mrs. . . . , aged 93, after her fourth stroke, is about to pass away. Too many nurses persist in: "You've got to do something!" They forget: *Primum non nocere*.

In general, Nursing Homes could offer the following care:

1. Terminal care.
2. Care of the seriously ill patient who requires continued expert nursing in order to maintain optimal health.
3. Convalescent care after an acute illness where further improvement can be expected.
4. Rehabilitation.
5. Intensive chronic care not requiring the expertise of the acute hospital.
6. The care programs developed by Lionel Cozin in England consisting of night care, day care, week-end care, care while the family is on vacation, and care when the family needs to get away from the patient for the family's good.

Patients with long-term illnesses in Nursing Homes find themselves completely dependent upon the whims, caprices, idiosyncrasies, moods, and desires of the nursing personnel. Can we the healthy, independent, understand? For us there is a tomorrow. For the chronically ill, further dependency. For the terminal cancer patient, further pain; further pain, and the hope that the nurses will have the shot soon enough. Note the appended letter asking me, the physician, to take his life. He knew his cancer had spread to the bones.

What about euthanasia, active or passive?

What about the availability of suicide?

Was it not Sophocles who said: "Death is not the greatest of ills; it is worse to want to die and not be able to."

His, a life revolving around the hope that the nurse gets there with the narcotic soon enough.

I think less barbaric would be an area where these tormented souls might relax, lounge, and in complete reverie smoke opium. For the non-smoker, sipping the juice of the poppy.

PATIENT

Social Workers must be incorporated into the Medicare Program. These elderly patients are confused about the forms, the bills, the entitlements, the payments, the rules, the regulations, etc. Too much of my time is spent explaining the technical aspects of Medicare with less time available for the patients' illnesses. The patients are showing greater concern for their Medicare correspondence than for the details of their treatment. Seeking help from the Medicare Office I am told, is more than useless.

The Medicare recipient and his family have not been able to comprehend their own individual relationship and responsibility relative to Medicare. Medicaid is even worse. I have found it necessary to issue to my patients and their families a copy of the appended Patient Information Bulletin—2.

In medical practice three factors are involved: the patient, the doctor, and the disease. The following story succinctly makes the point.

A sick man called a doctor. After the doctor had examined him, he said, "My friend—you, I, and your disease—are three. If you will take my side the two of us will easily be able to overcome your illness which is only one. However, should you forsake me and not cooperate with me but hold on to your disease, then I, being alone, won't be able to overcome both of you."

Patients must come to know their responsibility in the treatment of disease. This should include the ability to intelligently describe a symptom, some basic idea of body anatomy, some basic idea of human physiology, the intelligently following of the physician's orders, etc. No longer is it the patient alone who invests in his care. Rather, now his health is shared by many.

PHYSICIAN

The private practitioner too is involved in Medicare-Medicaid. How does the L.M.D. (local medical doctor) stand in relation to the modern political philosophies, health concepts, and new trends engendered by Medicare-Medicaid? What means the adverse publicity appearing in the scattered newspapers? Has any responsible individual come forth yet to suggest a reasonable net income for the physician based on a forty-hour week? Further yet, for those working an eighty-hour week? Time and a-half for overtime? Double-time for holidays? There are no formal study requirements to become a U.S. Senator; there are to practice medicine. Anyone can become a Senator; not anyone can practice medicine.

With President Theodore Roosevelt, *laissez faire* began to recede. We have advanced to the proposition that the people of our country are entitled to medical care; fine medical care. No longer need they hold their hands out for the charitable

medical care. Even further, the concept of "equal but separate" does not hold for medicine; no separation shall exist for indigent and the nonindigent. So be it! Do not tax the physician sixfold for so called noncharitable care.

I end these few remarks with the cynicism of Ambrose Bierce when he defined "PHYSICIAN, n. One upon whom we set our hopes when ill and our dogs when well.

SALT LAKE CITY, UTAH, June 20, 1968.

JOSEPH R. EVANS, M.D.,
508 East South Temple
Salt Lake City, Utah

DEAR DR. EVANS: This letter is sent to you following my experience in doing a utilization review at the Bonneville Extended Care Facility. I tried to use the standard that Social Need is *not* a reason for continuance in the Medicare program established during our meeting at the Salt Lake County Medical Society Building on June 12, 1968. In the past, I have been known as one of the doctors who is more "lenient" when determining the patient's need for skilled nursing care in contrast to non-covered services. I can conclude only that the approach outlined contradicts all of my philosophy in the private practice of Geriatrics.

My leniency in the past was due to the recognition that all elderly individuals have social problems. Now, Medicare is specific in saying that the program is not to include payment for difficulties in the social realm. This is fragmentation of the patient! For many years, those who were concerned with patient care have tried to teach that the care of a patient involves the care of an *individual* who incidentally may have heart disease, liver disease, psychiatric disease, bone disease, etc. The concept that one is treating a sick liver, a sick heart, or a sick brain is outmoded. For the past seventeen years, I have specialized in the care of the aged. During this time, each patient had reemphasized the fact that elderly people are individuals who incidentally are impaired by a variety of medical-surgical, psychiatric-psychological, and social disabilities. Each major pathological category is interrelated; each major pathological category has an influence on the other two. It is only with this concept in mind that one can care adequately for an aged individual.

The new bulletins from the Medicare people are trying to split the patient. To insist that an elderly person, who is in an Extended Care Facility receiving the necessary care, should be refused this service because the necessary care can be obtained at home is one thing. But, to deny the service saying that the necessary care should be obtained at home when it is not available at home because of *social problems* is another thing. Social problems as for example: an incompetent spouse, a hostile child, uninterested neighbors, outmoded ideas in the neighborhood, economic limitation, inadequate housing structure, etc. Too often during the past seventeen years, I have seen an elderly lady with arthritis return to an inadequate social environment at home with a hostile milieu. Upon arrival, the patient becomes depressed, and with the depression, further limitation in physical activity. Increased impairment from the arthritis results. A plain example of social pathology increasing organicity. I need not remind you that psychological dysfunction can produce organic changes, as for example a peptic ulcer; nor need I remind you that organic disease can produce functional difficulty, an acute myocardial infarction resulting in anxiety and depression. Widening our perspective of patients' needs to include the needs produced by social pathology enables us to realize that the third factor too is important. Social pathology produces further organic impairment; social pathology produces further psychiatric impairment; and in a vicious cycle, all three pathological categories destroy the patient.

As I have said so often: prior to Medicare we were confronted with unhealthy, socially impoverished aged; with the Medicare program, we are confronted with healthy, socially impoverished aged. The major problem of the aged today still consists of their social problems. I cannot increase the physical impairment found in the aged, and I cannot increase the psychiatric impairment found in the aged by ignoring the harmful effects of the related social problems.

At this time, I see Medicare aiding a patient to overcome an acute physical or mental disability, at least during the acute phase; and then plunging the patient back into an inadequate environment which rekindles the entire process. The concept that the decision rests on the need for "Skilled Nursing Care" rather than the needs of the patient is inadequate. What we are doing is carrying the patient through the trials of treatment of an acute illness enabling him to heal partially, and then thrusting him into an inadequate treatment program so that the patient must again be taken through the trials of an acute treatment program.

I came to recognize this limitation when a patient of mine was rejected from the Medicare program in an Extended Care Facility. An elderly lady was totally impaired by Parkinson's Disease. Following her acute hospitalization, she was referred to an Extended Care Facility to be included in the Medicare program. By full definition, she did not need total services supplied by skilled nursing care. The point that was missed was that the patient's husband was hostile, and he would not give her the necessary care at home because he lacked the interest, he was not willing to be bothered by the burden, and he felt himself imposed upon. Unfortunately, a married daughter was overburdened by her own family affairs. The patient's finances were limited, and she could not afford good posthospital care. Her rejection by the Utilization Committee was correct by definition. It wasn't long thereafter, when she was returned to the hospital to retrace her former trials of treatment during an acute illness precipitated by a pneumonia. And now what? By strict definition, she is not entitled to Extended Care. Does she again return home to a disinterested husband who will allow the development of a third acute illness with repeat acute hospitalization? Eventually, with home neglect she should arrive at a point where she requires skilled nursing care around the clock. How can one divorce social need, from medical need, from psychiatric need? It seems all we are doing is merely dangling health in front of many of the aged.

Concisely the problem is: A patient requires care, but not, as defined, "Skilled Nursing Services." He is unable to obtain the necessary care at home, because of social problems existing there. If discharged home, the patient will relapse requiring rehospitalization. By regulation, we are bound to cater to the latter.

This letter is to inform you of my resignation from the Salt Lake County Medical Society's Utilization Review Committee. I cannot in good conscience participate in a program which in a way is harmful to the aged. I learned this as I attempted to do a utilization review "by the book."

I do want you to know that my feelings in this matter do not end with this letter. I intend to inform other involved members of our Society concerning the above. More specifically, I shall be writing a letter to Dr. Wilbur Cohn, the new head of the Department of Health, Education and Welfare. The Medicare program and the philosophy above described originated under him. He was instrumental in developing the Medicare program, but unfortunately has not come to recognize these limitations therein. As I mentioned in our meeting, I am concerned about academicians who have spent most of their lives in an ivory tower and feel inclined to set up social programs. Despite what the politicians and the American Medical Association have said in the past, the prime problem of the aged today represents difficulties in the social field. One comes to recognize this only after he has been involved with aged people on a one-to-one level, and he attempts to help them solve their problems.

Very sincerely yours,

VICTOR KASSEL, M.D.

PATIENT INFORMATION BULLETIN—2

The Federal Government and the Social Security Office have neglected to make clear to Medicare recipients and their families the following information:

The Medicare Program is a health insurance program contracted *between the Federal Government and the patient*. It is *not* an arrangement between the Federal Government and the physician. This concept is important for patients to understand. *The contract is between the patient and the Government, not between the physician and the Government.*

Patients and their families do not seem to understand this very important point. The responsibility of the contract is *between the patient and the Federal Government!* The physician is purely incidental.

Patients must recognize that when the physician:

1. Completes Medicare forms,
2. Arranges for Medicare payments,
3. Mails forms,
4. Contacts the Medicare Office,
5. Or, anything else related to Medicare and the patient;

that all of these represent a *courtesy* on the part of the physician. None of these courtesies does "he have to do," as so many patients and their families seem to believe.

Thus, when a patient is ill and receives the necessary care from his physician; Medicare for some vague reason may refuse to accept the diagnosis and the treatment. When this happens, it is *the patient's responsibility to settle the difficulty*

with Medicare. It is *not* the physician's responsibility! As a courtesy to the patient, the physician will help the patient in resolving Medicare's error.

The patient comes to the physician for help, and the patient agrees to pay the physician for this service. Should Medicare not assume its responsibility to pay their portion of the financial arrangement, Medicare has abandoned the patient—not the physician. For as pointed out above, the Medicare contract is *between the Federal Government and the patient*; not between the Federal Government and the physician.

I would suggest that patients read the back of the Medicare Form No. SSA-1490(2) or the booklet received from the Medicare Office.

Your courtesy, cooperation, and understanding will be appreciated. The above was established by the United States Congress and it is The Law.

Incidentally, the above discussion also pertains to any health insurance: Blue Cross, Blue Shield; Mutual of Omaha; Travelers; etc.

Senator Moss. Our next witness will be Mr. Oscar W. Walch, former administrator of the Eldred Hospital in Provo.

We are pleased to have you, sir. It looks as though you came armed.

STATEMENT OF OSCAR W. WALCH, FORMER ADMINISTRATOR OF THE ELDRED HOSPITAL, PROVO, UTAH

Mr. WALCH. Senator Moss, members of your committee, distinguished representatives of the Committee on Aging, and representatives of the health industry. I appreciate the opportunity to present my point of view regarding some of the successes and failures in the health industry.

One modification possibly I should make on my statement of qualifications. At the present time I'm unemployed, so I have no one to fear. My boss can't retaliate, others can't retaliate in any way, so I can speak pretty freely.

There are some major areas of improvement that I feel are critical. The greatest area for improvement of health care for the aging and those with long-term ailments is not the arts, skills, and sciences of medical care, it is the areas of obtaining initiative, creativity, innovation, persistence, and huge doses of enthusiasm at the scene where the science of health care is applied to the patient to overcome the massive inertia of "can't-itis." The core of the challenge is to structure the situation in such a way that the zest for living and enthusiasm for going places and doing things are allowed to generate spontaneously in an environment filled with good examples by patients and those who serve the patients. Although this philosophy can be found written between the lines of the act passed by Congress, the structure of the processes are such that they are falling far short of this goal.

We of the Eldred Hospital achieved this goal on several occasions and sustained it for extended periods of time. It can be achieved.

When I first arrived at the facility, the most obvious thing that I observed was that the patients were sitting in a corner with their eyes glued to the corner and no attempt made in any way to socialize, to participate in any of the activities. This was not just isolated patients, one or two, but the majority of the patients had been conditioned in this way.

We evaluated the conditions carefully and decided that several of various activities should be provided to try to overcome this conditioning. One of the things we structured was to obtain an old bus. Part of the procedure was to allow the patients to make some of these decisions. A little old lady whose hands were so arthritic that she had to hold the

needles between her thumb and finger (indicating) in a reverse direction so that she could make a quilt, but she made a quilt and helped—I am sorry I can't control my emotions. Through her efforts she helped buy a pipe organ for church services and made a major contribution toward the bus. It took quite an extended period of time to get the patients so that they would enjoy the activities after their thorough conditioning of inactivity.

We later took one of the patients and tricked him into going on a bus ride. I went to his room and said, "Now, look, you have been sitting in your room, you have avoided every opportunity to participate. It is time you came out and joined us. I am going to have a party and I want you to come." The patient at first refused but later said that he would, so the employees got him dressed up and prepared. In our hospital we had an elevator with a front door and back door. In taking him up the elevator, instead of opening the front, the door to the rest of the building, we opened up the back door and before he could effectively prevent his boarding the bus we had him in the bus and shut the door. The air turned a slight haze of blue as he expressed himself fluently and he didn't run out of vocabulary for the 3 hours that we were on the ride. We saw the Christmas sights in Orem, Provo, and Springfield, and I never heard such a vocabulary before, nor since.

When we returned he was causing a serious disturbance, so we quickly took him out of the bus, put him in his room and one of the personnel helped him to bed and arranged for his medication. Before the medication and sleeping pill could be given he had fallen asleep. It was the first time in years he had had any exercise.

The next morning the hue was still a violent purple, but by 10 or 11 o'clock he began to calm down a little bit and by 3 o'clock in the afternoon he was beginning to change quite noticeably. One of the employees came in and talked to him briefly and he said, "You know, I really enjoyed it last night. I will never miss another bus ride as long as I am here," and he didn't.

To begin with, he couldn't walk a step, but we insisted that he try. Part of his procedure was to struggle to get himself upright so that others could assist him onto the bus. We told him that when he could walk the full length of the bus and take the front seat, he could tell us to go anywhere and we would go, and he did. He learned to walk the full length of that bus without assistance.

Some people have criticized us for this. They said the cost is prohibitive, but this man then learned to walk from his bed to a wheelchair, to the bathroom and get into the tub to take a bath. The cost of getting a glass of water for that man was 10 cents a glass, a minimum of 10 cents a glass, for just the labor. Over a period of his expected lifetime it could have cost \$300 a year or more just to keep him from being thirsty. If you calculate the cost of the bus, it was well paid for.

The thing that we tried to accomplish was enthusiasm. We sent the patients on trips anywhere that they would like to go. On one of these trips we came to Salt Lake and as we were going off the fifth north overpass heading west, a car came speeding up, passed us on the wrong side of the road and took off over the overpass. We immediately got back on the road after being somewhat disturbed, and here came a police car. It passed us on the wrong side of the road

and took off over the overpass. Not knowing what else to do, we followed them over the overpass. Then we thought, well, it might be fun to see what happens. So we went along with that group and after a short distance, another squad car, two motorcycle units, and a private detective passed us. In a few minutes, the patients were very thrilled to see and participate in cops and robbers for real. The police apprehended the thief, and the Eldred Hospital bus participated in the chase. When they got back they refused to go to sleep. They had seen something exciting. They went up and down the halls and told every other patient and visitor their experience.

The personnel at the hospital did not find it a distasteful job. They found their work enjoyable because they gave the kind of care that the patients needed.

I would like to refer to another situation. The bruises on the body of a patient in a nursing home in Ogden shocked and amazed the public. Such a report is evidence of the fact that all is not well in the care of patients in some of the nursing homes in Utah; not all, but in many. A painless death by a sudden blow would be the most humane in comparison to some of the deaths that could have been reported. I would like to tell you about the patient we received. I refer to it as "Case History of Mr. V."

Mr. V came to our facility on an emergency basis. The doctor taking care of his case had followed through with him. To begin with, he was not handicapped but kind of a nuisance in the area where he lived, so a fine caseworker and others arranged for his admission to a nursing home. It wasn't very long until he didn't have any reason to get out of bed. He became a chair patient. A little later he didn't have any reason to even get up to get in a wheelchair, so he became a bed patient.

Now, the care and prevention of bedsores can be accomplished by frequently moving the patient and maintaining clean and sanitary conditions. When this patient came to the Eldred Hospital we wore out three nurses. We didn't keep track of the washcloths and the towels and the gallons of water that were used. The dirt had accumulated in the hair to the point where it would be soaked and then scraped into lumps with the fingers. Then the lumps would be crushed and that way could be removed without pulling the hair. The rest of the body was in an equal condition of filth. The bedsores on this patient, the dark area could not be covered by my hand extended (indicating). The open area was larger than my palm. The excrement from the patient, not just one, but several days' accumulation, had worked its way into the bandage. What a beautiful sight, psychedelic colors that you could never imagine, the green from the gangrene, excrement, blood from broken capillaries, which I am sure caused a most excruciatingly painful situation. This did not happen frequently, but it happened many times in the 10 years that I was there.

This patient was treated at a general hospital, given plastic surgery to try and correct the situation, but surgery was of little value due to the deteriorated condition of the tissues. Needless to say, the patient died in an emergency hemorrhage as a result of the bedsores.

The findings of my research indicate that there were over 26 patients in nursing homes in Utah who died most painful deaths as the result of bedsores during the last 12 months.

The greatest problem is that the physicians don't like to check on physicians, nursing home operators don't like to check on nursing home operators, hospitals do not like the responsibility of policing their staff. No one is willing—apparently, no one is able to accomplish this objective. In checking the situation in Utah County, even though there have been major problems in nursing homes, not one license has been revoked except that of the Eldred Hospital, and not one physician has lost his license.

If you have some questions I will try to answer them.

Senator Moss. Thank you, Mr. Walch.

I notice you have a very extensive statement. This will all be in the record. We are glad to have that, and we do appreciate your coming to testify. You needn't apologize at all because of the fact that your emotions are high on this. I can understand your involvement.

I am particularly, of course, stuck with your very beginning, that the real thing we need for elderly people is some incentive, some interest, some involvement. The bus story about running down and following the police car is a very dramatic illustration of how these people were stimulated by something; that they felt they could reach out and be a part of what is going on in the community around them, even though it is a rather sordid experience to have, in a way, but I can understand the excitement that ran through them.

I think what you have tried to tell us is much of what Dr. Kassel was saying, that we tend to fragment care and to think of needs of the elderly almost entirely in the physical and not in the psychological sense, when perhaps the latter is more important than the physical. You did talk about some areas of neglect that certainly are shocking, indeed, that would indicate one need for careful, impartial but firm supervision and inspection in the operation of nursing homes and the operation of personnel therein. I have felt for a long time that we need to find a way that we can do it.

Mr. WALCH. There is a way available, sir, I think, by carefully organizing a good inspection team and arranging that the facilities and the employees in the facilities where outstanding achievement is attained are given additional remuneration. If we find blatant abuses, not just one case, I don't believe any punishment should be based on one case, but if there is a series of blatant abuses of patients, or dirt, or any of these other things, that that institution should lose its license without consideration. Until you hit their pocketbook they don't feel it. This has not been done.

There was, in all of our activities, at the Eldred Hospital no provision made for any of these things by the Federal Government, the State government, or the county. These were raised through funds of philanthropists and the employees and occasionally the patients' relatives.

Senator Moss. Well, I like your idea of some incentive to try to excel in service given. We need to find that if we can.

Mr. WALCH. In my first experiences I had major opposition from all of the employees. They thought I was a crackpot of some kind because I wanted them to emphasize the psychological and social environment so that the physical care would produce results. Some of them resisted right up to the point where our evaluation system was modified. I told them specifically the things that I was going to be

observing and that if I didn't observe these things they would not receive an increase in pay and if I continued to find these aspects missing they would have a reduction in pay. Within a matter of 3 months our patient participation increased 100 percent over its previous level.

Senator Moss. Well, that is a heartening experience and one that indicates what can be done if we get the right kind of motivation and understanding of the needs of elderly people. Obviously, one of the great crimes committed against the elderly is simply to warehouse them in a home and, where as you said in the beginning of your statement, the majority of the patients are found just sitting around in a corner doing nothing. I can't think of anything more depressing, or more cruel, than that.

We thank you very much, Mr. Walch, and we do appreciate your coming to give us this testimony. We will try to draw some lessons from what you have told us this morning. Thank you, sir.

Mr. WALCH. Thank you.

Senator Moss. Mr. Walch's statement will be made a part of this record.

(The statement follows:)

The Eldred Hospital needed and had improvements under consideration which might have obtained the optimum independence for more of the patients who had potentials for rehabilitation. I am sure there were many services where improvements could be made, rehabilitation accelerated, and economies obtained. Continual evaluations were also made of the patients with irreversible damage to prevent additional handicaps and to fill days with interesting and useful activities.

The ideas found to be successful at the Eldred Hospital came from employees, volunteers, members of the medical staff, patients, relatives, members of the board, and from many other sources. We encouraged the "try" method with every suggestion—even when failure appeared inevitable. The number of successes surprised us. The vitalization of patient interest and activity was most gratifying and the "esprit de corps" of the patients and employees far exceeded our expectations.

Please do not consider this report as a blanket condemnation of the whole health industry. It is an attempt to review the weaknesses I have observed. It is the basis for the recommendation that other methods of evaluating the accomplishments in patient care be developed.

I encourage the elimination of bed-sore-factories by every legal means available. I request increased opportunities and financial assistance for those who have original ideas on methods of care, provision of physical exercises, and stimulation of social and psychological activities which will reduce the occurrence of preventable handicaps for the chronically ill.

I also point out that the present inspection system of Utah looks for the secondary factors contributing toward good care but ignores the direct results of the care or lack of care on patient conditions—withholds or revokes the license of one institution for not meeting the letter of the law while in another nearby institution allows a patient to die of bed sores, and allows another patient to be held prisoner as he watches death creep up his body.

CHARACTERISTICS OF THE PATIENT WITH A LONG-TERM ILLNESS OR AILMENT

1. The individual with chronic ailments exhausts his cash reserves and liquid assets very rapidly while seeking relief from pain and hoping for the establishment or recovery of skills which will allow independent living. At the other extreme is the individual which will live with his ailments and seek no help or care.

2. After the patient exhausts his financial resources, interested relatives assist but establish limits on their assistance leaving the patient to care provided by some support program. Frequently the relatives reject any control or responsibility for the patient or for the arrangements made for the patient.

3. The patient lacks mobility and the finances to obtain supplies and care for his conditions. He gets lost in the paper-work when seeking help. After all of the discouragement of loss of health and independence it takes little opposition to

destroy any desire to seek more help. Too often the help desired is given and then refused at the point when progress is a realistic objective—the welfare agency issues the directive that no funds are available for the piece of equipment needed for the patient to reach the next plateau of independence. If this happens to the same patient two or three times the patient refuses to try for any further improvement—his optimism is destroyed.

4. The patient is then left at the mercy of any interested party that will assume responsibility for some aspect of the patient's needs. A combination of relatives, friends, case workers of the welfare agency, employees of the facility where he stays, etc. provide services which are whimsical, uncoordinated, unpredictable, unreliable and omit elements essential to progress toward optimum independence. Such interest is often accompanied by pity and words of advice—"You've had a long hard life, you just lay still and make them do everything for you—you don't have to do a thing now!"

5. Patients with chronic ailments exhibit feelings of guilt, a self-image of inferiority and withdrawal symptoms. They want to be allowed to stay in their room, spend hours facing a corner, avoid social contacts of any form, and if possible they would vanish from all people. The behavior elicited is frequently in the form of verbal or physical attack on others.

6. New patients with intense fear of the employees of the hospital were frequently admitted. Those were patients who had had retaliation for speaking out against the nursing home, for doing some displeasing act, or for not doing the things requested by the person giving care. These patients would dodge, put up their arm, look frightened and some would shake in fear when an employee approached them. It would take two or three weeks to overcome their fears and get rid of their fear reactions.

PROBLEMS FACING PATIENTS WITH CHRONIC AILMENTS

1. Pain and decreased ability are observed by the patient.
2. Fear of pain, helplessness, doctors, and institutions is increased when the patient realizes he must seek help.
3. Uncertainty and confusion develop when ailments persist after treatment.
4. Loneliness for familiar faces, things, and the "good old days" increase when the patient is isolated in an institution and has little else to think about.
5. Boredom soon becomes a problem when there is nothing to do, little to anticipate, monotonous menus are anticipated, and the institutional routine is habitual.
6. Despair deepens when deteriorating conditions become obvious and resist correction.
7. Dominating hopelessness shadows optimism when the patient sees other patients deteriorate and die—he thinks "here they are—I am here—they get worse—what hope have I".
8. Irreversible helplessness—physical, psychological, and social—result from inactivity in a barren and impotent environment.
9. Some patients have "willed" their death, become critical and died.

MEDICARE—MEDICAID

The greatest area for improvement of health care for the aging and those with long term ailments is not the arts, skills, and sciences of medical care. It is in the areas of obtaining initiative, creativity, innovation, persistence and huge doses of enthusiasm at the scene where the science of health care is applied to the patient to overcome the massive inertia of "can't-itis". The core of the challenge is to structure the situation in such a way that the zest for living and enthusiasm for going places and doing things are allowed to generate spontaneously in an environment filled with good examples—by patients and by those who serve the patients. Although this philosophy can be found written between the lines in the act passed by the congress, the structure of the processes are such that they are failing far short of this goal. (We at the Eldred Hospital achieved this goal on several occasions and sustained it for extended periods of time—it can be achieved!)

Medicare and Medicaid have increased the funds available for care of eligible patients in Utah. However, from my point of view, those who were giving good care and tried to provide a good balance of environmental conditions before the introduction of these programs are still giving good care and providing a stimulating environment.

I have not seen improvements proportionate to the increase in funds in those institutions which were giving marginal and inferior care before these programs provided increases in available funds. They are still giving poor care.

Another observation is that the local political organizations have reduced or eliminated their former support of health care programs. Utah county commissioners have eliminated all support of Medicaid patients past care in the general hospitals as provided by Medicare and Medicaid. This transfer of responsibility has provided no increase in funds for the care of patients. In the case of the Eldred Hospital, the Board of Directors of the Eldred Sunset Manor Foundation withdrew completely from the health industry rather than affiliate with an institution giving the inferior services forced by the reduction in financial support caused by county action. No other funds could be arranged to fill in the gap to allow continued operation at acceptable levels.

Those responsible for providing the care needed by the patient are ineffective in obtaining desired results. Those responsible for evaluating the results obtained by the providers of care are very ineffective. As one responsible party put it—"poor care is better than no care at all!"

NURSING HOMES

The bruises on the body of the patient in the nursing home in Ogden, Utah shocked and amazed the public. Such a report is mute evidence of the fact that all is not well in the care of patients in some of the nursing homes in Utah. Painless death by a sudden blow would be most humane in comparison to some of the deaths that could have been reported.

1. Evaluation of patients—The most serious shortcoming of the nursing home is the inability to determine or the refusal to recognize that a patient needs technical care and/or activities which the home is not providing. Too frequently the admission to a nursing home is a one-way street. Even when invited, instructed and encouraged to send a patient back if patient conditions changed, most operators resisted or refused to allow a patient to return to the Eldred Hospital for re-evaluation and changes in therapy. As one operator put it in arranging the transfer of a stabilized diabetic patient—"Anything the Eldred Hospital can do, I can do better!" (The patient died of diabetic complications soon after transfer.)

2. Nutrition—Some operators have bragged that adequate nutrition can be provided for a patient at the cost of \$20.55 a month. I have been assured that others require less. 67% of the patients at the Eldred Hospital required special diets. If a high protein menu is maintained and special diet requirements are met the cost of food service will require much more than this. The cost of milk alone for 3 glasses a day at wholesale prices will cost \$8.10 a month. Any reasoning person can imagine the amount and the quality of food the patient receives.

3. Physical exercise—Patients in nursing homes become increasingly dependent due to restrictions on activities. The patients are encouraged and required to become inactive. They are prevented from walking or other physical conditioning. The routine in many homes is to get the patient up and set him in his chair where he stays except for toileting until bed time. It was heartbreaking to spend several weeks teaching a patient to walk and build up physical endurance for complete independence and then find that the first thing done when the patient was transferred to another facility was to permit the patient to return to a wheel chair and later become a bed patient.

4. Cleanliness—Self respect is destroyed when a patient is restricted to a regimen of a bath *once* a week—whether the patient *needs* it or not—*IF* it is convenient. Some of the patients who came to the Eldred Hospital had dirt accumulated in the hair so that the scalp had to be soaked to soften the dirt and then the dirt would be scraped and crumbled by the fingers so that it could be removed without pulling the hair out by the roots. Putrid excreta would be so matted into the pubic hair and between the buttocks that it would have to be soaked repeatedly in soap and water before it could be dislodged with wash cloths and scrubbing brushes. Care had to be taken to prevent damage to the corroded flesh.

The patient is ashamed of his inability to maintain bowel and bladder control. His feelings of guilt and self-disrespect are increased when soiled clothing and bedding must be endured for long periods of time. Employees of the facility frequently scold and ridicule patients when accidents occur but do little toward scheduling training and control. When visitors come, their reactions to the strong odors are obvious to the patient. This barrier to enjoyable social experiences exists for long periods of time for both patient and visitors.

5. Maintaining psychological skills—Nursing homes and hospitals provide the least challenging environment of any segment of the American society. The patients make few decisions, have very limited opportunity to apply initiative resulting in significant rewards to the patient, and attempts to improve their social or physical environment are fruitless and frequently lead to varying degrees of punishment. After a few days of such intellectually sterile surroundings, the patient's reaction is to become seclusive and isolate himself from any further embarrassment, ridicule, or punishment. This reaction accompanied by former fear, loneliness, self-criticism, guilt, and boredom leads the patient to an irreversible syndrome of despair as he sees the progress of others who are in the institution. He then evaluates his future as hopeless.

6. Social skills—With few exceptions, the environment in the nursing home is void of activities designed to enable the patient to maintain a zest for life and social activities. Little effort is made to overcome the boredom, alleviate the loneliness, or to combat the despair which accompanies every long term illness. In such situations, the patients invariably lose their social skills. Their initiative is destroyed when repeated attempts to attain improved social environment are thwarted and frequently end in continued use of physical and psychological restraints. Such restraints increase frustrations and impose confusion which further reduces the patient's ability to make satisfactory social contacts with other patients or with visiting friends and relatives.

7. Diagnostic services—A reputable accountant's report on the services in one of the "better nursing homes in Utah" indicates that very little diagnostic and evaluative laboratory work to prevent and correct chemical and biological problems developing among the nursing home patients. An average of less than \$4.00 a month for all medical supplies will provide few laboratory tests. Blood-sugar levels and other complications can soar without detection for extended periods of time and even lead to death with little or no effort to adjust insulin, balance diet, or detect causes of significant changes in patients' conditions.

8. Motivational field for the patient—At the Eldred Hospital patients who were in the last stages of terminal illness were busy and interested in going places and doing things. The patient who was totally disoriented looked out of the bus window and reacted to the passing scenes of home, former neighborhood and familiar sights. The drugs required for the terminally ill were reduced and the mental acuity of the disoriented was restored to nearly normal through experimentation, carefully planned activities and environmental manipulations which were designed to capitalize on the motivational forces uniquely applicable for the patient to be served.

In the nursing homes I have visited or discussed with relatives the procedure is to have the patient "sit down now and be a good patient"! Little concern was given toward the structure of a motivational field aimed at the optimum independence and achievement by the patient. The patient could easily see that everyone had given up—no laboratory work was being done, no evaluation of progress was being made, visits from relatives were becoming shorter and less often, the employees displaying great "disthusiasm" for any changes in the status quo or for suggestions for activities to break the monotony.

9. Statistical studies of patients from nursing homes—The Eldred Hospital records indicate that the situation in Utah is not good. Recent articles in the papers and magazines describe the situation with greater accuracy than those who play ostrich have been willing to admit. Many case histories stand out in my memory which describe the helpless and despondent future of the nursing home patient—particularly in some of the "reputable" nursing homes in Utah County. The sights and smells of these patients have resulted in more than one night-mare, in spite of my conditioning in 17 years of hospital work. The national statistics reported in national journals and periodicals are in close agreement with those obtained in my studies. The following evaluations are supplementary to national studies:

(a) Patients were received at the Eldred Hospital with very serious problems resulting from negligent care on the average of one every two months. This does not include putrid feces in the pubic and perianal areas, scald, rash, small bed sores, etc. These were problems that needed additional special care to prevent pain and effect a cure.

(b) Serious bed sores were received at the rate of one each 3.8 months—of these one patient died on the average of 10.6 months as a direct result of the bed sores and from complications resulting from the bed sores. How many more in Utah County have died in this way is not known.

(c) Fecal impactions were received at the rate of one each 9 months.

(d) Patients with severe problems due to drug addiction were admitted at the rate of one every 8 months.

(e) The Eldred Hospital had patients which developed symptoms indicating negligent care at the rate of one every 6.9 months. Of these none were listed as a contributing cause of death—2 lasted until death. Employees were supervised closely to correct the problems found by a continuing review of patient conditions and medical records. If improvements were not observed, the employee was disciplined or terminated.

(f) During the last 4 months in Utah county, two patients in nursing homes died as a direct result of bed sores. No record of investigation was found. This has happened since my letter to Governor Rampton and Senator Moss dated November 17, 1969. Apparently, my letter did very little to improve the situation.

The following histories are not unique—they are quite usual. They are not the result of an over-active imagination. Each one can be varified by medical and social histories.

1. The case of Mr. V.—Mr. V. was having difficulty convincing his neighbors and friends that he was able to continue to take care of himself. Arrangements were made for his admission into a nursing home so that his care would be "complete." The nursing home selected provided custody but little else. In a short time, he was no longer able to find a good reason to get up in the morning so his hour of rising grew later. Eventually, he became a full-time bed patient. The home didn't mind too much. They received an increase in the rate paid for his care because he was now a bed patient—how rewarding!!!

The usual care to prevent a bed sore is the change of position of the patient at frequent intervals, day and night. Keeping the patient clean and changing dressings every day and more often when they become soiled is mandatory to prevent infection of small lesions and assure continued improvement of any damaged tissues. In a few weeks. Mr. V. was in very serious trouble due to bed-sores. When his physician was finally made aware of the advanced complications resulting from the bed sores, the patient was moved to the Eldred Hospital.

Mr. V. had no interested relatives. His physician, the Director of Nursing and I had conferences on his condition at least once each day. I insisted that the officials of the State Welfare Department visit and check this patient in person.

The nurse obliged the guests from the welfare office by lifting the tissues around the sore so that the sinuses could be easily seen. The gangrenous green jelly-like ooze was wiped away to provide clear vision of the depth of the sore. On occasion, the bone could be easily seen but by this time the faces of the guests grew pale and it was decided enough had been seen. One of the guests confided later that she had to go home because it had made her too sick to work.

Inadequate action was taken by the officials notified to prevent the recurrences for other patients in the area.

Complications developed beyond our regular services so arrangements were made for Mr. V. to go to the general hospital for evaluation and plastic surgery. After a short recovery, Mr. V. was returned to the Eldred Hospital. The tissues were so deteriorated that stitches would not hold and healing was extremely slow. Blood transfusions were frequent. An urgent call from the nurses on the floor set emergency procedures into operation. A clot had dislodged and Mr. V. was bleeding critically. Death was announced shortly after re-admission to the hospital and emergency surgery failed to stop the bleeding. This was a case of a sentence to a most painful death by monotony, boredom, neglect and bed sores!!!

2. The case of Mr. L.—Mr. L. is alive to tell his own story—but who will listen?—who will do something to assure that there will be no others who will have a comparable story to tell?

Mr. L. was an independent man accustomed to hard work. He had several chips on his shoulders as a result of hard experiences. The tender spot in his heart could be seen occasionally but it was usually shielded by a tough shell and a good vocabulary which was used with great precision when the situation was appropriate.

After a clean surgery and dismissal from a hospital, he was transferred to a nursing home for rehabilitation. Recovery should have been complete in a few days so that training for ambulation could begin. Mr. L. recognized that things were not going well and complained to his relatives. His relatives were assured by the nursing home that little more could be done "in view of his condition."

Mr. L. became constipated quite frequently. Instead of receiving proper softening and controlling drugs, one of the men stuck a finger up his rectum and pulled the hard lumps out causing extreme pain.

Dressings were not changed regularly. The odors from his incisions accompanied by increased pain told him that his condition was growing worse. He was told that this was normal for his condition. Medicines were changed and the pain was lessened but the discoloration of his limbs continued. Mr. L. watched the dark area of his limbs grow each day. In spite of the drugged condition of his mind, he realized that he was watching death creep up his body.

Pleas to his relatives finally brought a visit from his physician in spite of the objections of the operator. That same afternoon, Mr. L. was transferred to the Eldred Hospital.

Gallons of water, many wash cloths and towels, and three exhausted nurses later, he looked almost clean.

Once more, officials were notified. Once more visits were made and conditions were seen. Once more, nothing was done.

Many painful and discouraging months later, Mr. L. waved good-bye and walked out of the door of the Hospital. His parting comments included the statement, "I will die before they ever trap me in another one of those (censored) nursing homes."

HOSPITALS

Outstanding achievements have been made by hospitals in the areas of chemical, bacteriological, radiological and cardiovascular laboratory evaluations for chronically ill patients. Surgical procedures, anesthesiological techniques, and intensive care facilities have improved the prognosis for many patients who have difficulty recovering from long term ailments. In spite of the skill and achievements in the above areas, hospitals should make improvements in relation to the following problems which effect the progress of patient achievements and independence. Frequently the problems facing nursing homes start in the hospital.

1. Inadequate psychological support—The hospital provides inadequate psychological support for the patient with long term illness in terms of the quality and the length of time. Such support is not needed during the period when short term illness is given care. The patient sees others recovering and going home. During this period his hopes are high and motivation is easy. The support of the family and friends becomes more difficult as they realize that the hospital stay is long and growing longer with little results seen from the therapies provided.

2. Social support—Reductions in the social support by friends and relatives are made by the quarantine imposed by the hospital to prevent contamination of the hospital environment. Some effort should be made to supplement and reinforce social experiences to maintain skills and improve them in new dimensions as time passes and the quality and quantity of social experiences relating to friends and family reduces.

3. Physical skills—Coordination and endurance are destroyed by the inactivity imposed by the hospital situation—no place to go and nothing to do for exercise. Physical therapy is ineffective in maintaining strength in more than limited sets of muscles.

4. Motivational field—The hospital scene is adequate for motivating short term patients of 5 to 10 days of rapid recovery. The efforts to provide a motivating environment for patients with long term problems are exhausted when they should become most effective. The following weaknesses have been observed.

(a) All of the short term patients leave after an average of 6 days. The patient with chronic ailments sees their departure and the fact that he must still have more care destroys his hopes for recovery. He becomes discouraged with his progress making it very difficult to maintain motivation.

(b) Long term patients who have achieved improvements and independence are not available to encourage and set an example of successful rehabilitation.

(c) Hospital employees are not instructed and experienced in the activities and patient relations suited to the needs of long term patients.

(d) Hospitals do not provide a variety of activities which will maintain the interest and participation of the long term patients emphasizing physical fitness, psychological skills and social opportunities.

5. Hospitals keep patients clean the first 5 or 6 days but standards of care allow an accumulation of dirt in hair and on personal parts of the body when the patient cannot clean themselves adequately.

6. Communications from nursing homes—A former hospital administrator and official of the Utah Hospital Association expressed a strong but common resentment against the "high and mighty attitude" of hospital administrators, hospital personnel and the Utah Hospital Association toward nursing homes. Even though hospital personnel have similar problems and have much to offer nursing homes,

major pressures will have to be applied to overcome resentment and hostility so that the flow of information available in nursing homes will find its way to hospitals.

7. Communications to nursing homes—Hospitals have been most cooperative with the Eldred Hospital when information regarding patients or procedures was requested. Some of the hospital personnel feel that the information sent to nursing homes is ignored and not utilized in providing continuous levels of care to the patient. I am certain that much of the information sent to nursing homes by the the Eldred Hospital was not followed.

8. Statistical studies of patients from hospitals—The Eldred Hospital records indicate that hospitals have several areas for improvements. Suggestions to some of the hospitals have been fruitless as far as I can determine as no effective action was observed in terms of instructions to nursing personnel of the hospitals involved. Patients with problems continued to arrive after the suggestions were made.

(a) Moderate problems which appeared to be the result of inadequate care were received by the Eldred Hospital at the rate of one each 1.7 months.

(b) Bed sores was the most frequent problem received. One patient with a bed sore requiring extra time and costs for patient recovery was received at an average of 2.5 months. None of these died as a result of bed sores but some were several weeks in healing.

(c) A fecal impaction was received on the average of every 6.2 months.

(One case of resistant staff infection was received in the 36 months studied for the above statistics.)

(One patient was received during this period that had been in a hospital for several days that was positively filthy. I was very disappointed that the blame for the situation fell upon a student L. P. N. who left the training program because she felt that she had been unjustly accused when many others had equal or greater responsibility for the situation.)

WHO IS TO BLAME?

How can such conditions exist? Why hasn't someone done something to correct this type of situation? When will the next patient be sentenced to "death by bedsores"? The Ogden story has been modified and altered to protect the guilty and the responsible disinterested. Who will be the "goat"—the next patient! And who is to blame???

The patient and the patient's relatives—Unless the patient and his relatives are actively involved in providing health care, they are not well enough informed to make comparisons and determine when poor health care is given. It is impossible to sample the care given by several facilities to determine the standards in each. Once the patient is in a nursing home, he finds himself trapped and can find no way to tell of the conditions and change the situation when it is not right. There is no prison like a nursing home when the patient is unable to act on his own. The advice of a "specialist" counters any statement a patient may make giving reasons which explain "that's to be expected". The word of the patient is of no great value. If the truth is known, where can the patient or the family find improved arrangements?

The State Welfare Department—Personnel of the State Welfare Department make more visits to nursing homes than any other group. The welfare case worker is frequently the only outside agent for the patient. Many of these people are amazingly gullible and naive in relation to quality of care. Besides, I have been informed that "as long as the nursing home has its license from the State Department of Health, the State Welfare Department cannot refuse payment or relocate a patient even if it is known that care is sub-standard". In my opinion, this is a pinnacle of success in governmental irresponsibility. In addition to this, the State Welfare Department rewards those facilities who can make patients the most helpless the fastest with higher rates of remuneration.

The State Health Department—This department has the responsibility of licensing the nursing home. They can do a good job of checking the facilities and the secondary factors needed for good patient care. But when discussing the problems of abuse and neglect, they have firmly and plainly explained that the County Health Department is responsible for such problems. The State Health Department cannot assure that good care is given to every patient every day during every shift when they visit only once or twice a year for licensing inspections.

The Utah County Health Department—When one patient was admitted whose condition indicated poor health care, the Utah County Health Department officials were notified and asked to investigate. They called back and stated that

due to the "problems" between the county and the Eldred Hospital, they could not come. No visit was made. No action was taken. They informed me later that they had neither the authority nor the personnel to assume such responsibilities.

Physicians and the Medical Association—Few physicians are willing to care for nursing home patients due to the amount of time required, the poor prognosis for the patients and the poor care the patients receive. The medical association finds the inertia of the status-quo and public apathy too difficult to move and of no great interest to their members. Physicians are frequently among the last to know that their nursing home patient has serious complications. They rely on the personnel of the nursing home to report changes in condition. When they know of the patient's conditions, they have little confidence in the personnel of the nursing home and have little hope for more than "a delay in the inevitable" after serious complications are allowed to develop. Little evaluation is made of a physician's standards of care in a home. Unless a dedicated and skilled nursing staff follow each patient and provide needed care and follow through, the symptoms of complications go without attention. Another problem is that most physicians do not have the time or lack the experimental approach using a variety of inter-related therapies, physical exercises, psychological variables, social structures, or drugs for patients after standard routines have been exhausted.

The District Attorney—When the problem of death by bed sores was called to his attention, he stated that he was concerned, sympathetic and very interested. Then he referred the problem to the Utah County Attorney as he didn't have jurisdiction over such problems.

The Utah County Attorney—Our blunderful county attorney informed me that "negligent homicide" was of interest to him but that there had to be witnesses. The subject changed when asked if bed sores on the body of the deceased were not "prima facie" evidence of negligent homicide when medical records varified the causes of death.

Utah County Commissioners—Our unconscientious county commissioners have turned their back on the problem stating that no problem exists for them—neither moral, financial nor for care standards.

Morticians—Major sources of income would be lost if a mortician hints abuse of a patient or negligent care. By then, it is too late to effect changes needed for the people they serve.

Courts of law—Relatives have informed me that attorneys are very hesitant about starting legal action for nursing home patients. By the time turtle-paced legal procedures can be accomplished, the patient frequently dies closing the case and leaving them with inadequate reimbursement for their time and efforts. Even with good health, the abused patient can't hope for any action for months.

News media—The news media have hesitated or refused to publish stories which would enlighten the public on deficiencies in care by local nursing homes or others providing health care. A local news paper withheld publication of the story when a significant portion of the patients in a nearby nursing home died as the result of epidemic infection for over 7 months. The story was then quite well hidden in an inconspicuous place.

Zoning Commissions—The nursing home is to be tolerated as the garbage dump is to be tolerated. The nursing home is to be isolated from the residential areas where patients have a better chance of maintaining dignity, cultivating social contacts and capitalizing on their initiative to improve their situation. They zone the nursing home to industrial areas if they can.

Private philanthropists—The cost of adequate care would deplete the assets of those who are willing to contribute toward improving the situation. A greater problem was that after the Eldred Hospital tried to raise funds the political agencies and other welfare agencies would reduce their assistance making our accomplishments ineffective in providing funds for desired equipment, services and experimentation in modifying services. The attitude of some was that they had no confidence in nursing homes as a recipient of funds and the use of contributions for the benefit of patients.

State Legislature—The writing of the state code for nursing homes and hospitals was the responsibility of a council dominated by the State Health Department. The state code is well written and fairly complete. They act on the advice of the State Welfare Department for determining the budget for payment for care of indigent nursing home patients. They have not required a supplementary evaluation to determine that the state funds are producing the kind of care which they determine as adequate. Nor have they required a method of encouraging better care by a difference in payment for good care designed to maintain optimum independence of the patient.

The Governor—After my letter, the problem was turned over to the Director of Health and Welfare for study and a report. A radio report the next week stated that the Director found the health care in Utah to be very good. No one contacted me for further information. I have found that nursing home employees nor operators have received any instructions for improvements. I have also found that in the weeks since my letter 2 patients in nursing homes in Utah County died as a direct result of bed sores—my sources of information were quite limited so there may have been more. The Governor is too busy to be concerned with death by bed sores.

Senator Moss. I am now going to call on Dr. Bruce A. Walter, director of the Bureau of Medical Care Services in the State of Utah, and Miss Charline Birkins, director of the Colorado State Department of Public Welfare.

Dr. Walter and Miss Birkins, if you will come and sit together at the table, we will hear from both of you.

We are pleased to welcome you. Miss Birkins is here from Colorado.

We are very glad you came to our hearing.

Dr. Walter, will you proceed, sir.

STATEMENT OF BRUCE A. WALTER, DIRECTOR, BUREAU OF MEDICAL CARE SERVICES, STATE OF UTAH DIVISION OF HEALTH

Dr. WALTER. Senator Moss, members of the committee, and guests, thank you for the opportunity of coming here and giving you our views.

I thought before I started I would give you a capsular view of the health facilities that we have in the State of Utah which might give some background as to our problems and difficulties.

We have 42 hospitals and two Federal Government hospitals, making a total of 44, which contain 3,500 general hospital beds and a little over a thousand special hospital beds. There are at present 138 nursing homes with 5,001 beds.

We have a great deal of change in our nursing home operation. We have closed four nursing homes in the last month, which would give you some idea of the changes that are going on in that particular field.

In general, however, our bed total remains approximately the same because we are constantly adding on and improving other facilities. We have about 11,500 people employed in our hospitals and probably something around 3,000 employed in nursing homes in the State of Utah. We have a few somewhat unique situations in Utah, one of interest to minority groups. We have one nursing home run by blacks. We do have minority groups in our other nursing homes as well. We also have one hospital which is also an interesting conglomerate, if I may use the term, which was developed by the Bureau of Indian Affairs, the LDS Church, and Duchesne County, who put up funds to match with the Hill-Burton grant. They built a center to service all people who are located in that particular area. This hospital has just opened and is a very fine one. It also has a clinic built right on the grounds which houses three young doctors. This is something rather unique in our rural areas today. We have new and different kinds of projects in Utah.

You may wonder why I mention a hospital when we are talking about long-term care. Some of our stays in hospitals are strictly long term, and this is one of the problems I will touch on later and one of the areas that I hope we can improve upon and perhaps slow the rising spiral of costs.

I have a number of details in my writeup which I will only refer to briefly but which pertain to each of the laws we are concerned with. The first is Medicaid, not only title 19, but the other titles as well. Of the nursing home population in Utah, approximately half of the beds in nursing homes are supported by the various titles, including 19. This brings to light an important factor. We have to make title 19 work and work well, therefore, we have to have standards. I am asking and I am hoping that eventually we will have title 18 standards for title 19 facilities where possible. However, there must be adequate reimbursement for these nursing homes if this is to be expected. I also believe it would be worthwhile the Federal agency administering title 19 and the other titles to support a State agency administrative group, such as found in title 18 for certification of nursing homes. I believe this is primarily an educational program, and not a police process, which could be most helpful in upgrading our nursing homes.

I am also concerned to some degree about title 19 provider fees. We have a particular problem about title 19 provider fees because we have in Utah central city problems and rural problems. We are interested in encouraging all types of providers to service these two areas. The best way to do that is to pay them the going rate wherever possible. Some of our providers are dependent upon title 19 fees to exist. I believe it would be important to review fee schedules for these particular areas and make sure they are adequate and will cover the overhead for the provision of these services.

Next I am interested in developing some flexibility in the Medicaid System. I believe there is already a great deal of flexibility and I hope it is not taken away. In general, this particular program in Utah recognizes the individual. There may be critics of this particular situation, but I believe the Utah administrators of title 19 do think of the people and make every effort to bring the services to them within the scope of the budget.

Under Medicare there are some other items. In Medicare is the flexibility problem. We are running and operating a national program. In the United States there are 50 States, and all of them are different. We have regions which have different problems. Unfortunately, not all of these problems are recognized on Social Security Boulevard in Baltimore. In many cases Baltimore seems to be oriented toward the thousand-bed hospital. We don't have any thousand-bed hospitals in Utah. They operate differently; they take care of people in a different manner. We must have the regionalization. I am advocating that a regional board be set up, perhaps composed of State agency representatives, Federal representatives, and consumer representatives to actually advise the social security regional representatives in decision-making, and that decisionmaking powers be delegated to the regional office the central office in Baltimore.

Sometimes a number of the small items will have more impact on the saving of money than some grand and great change. Here is one of the small items which may save money, and probably will bring about better patient care and less condemnation of nursing homes. I don't believe nursing homes should have this condemnation—that is the responsibility of transferring of patients from hospitals to nursing homes. I am requesting the insertion within the Medicare rules and regulations of a provision for discharge planning, which

clearly states that the hospital is required to plan for the discharge from the hospital of nursing home patients. There should be stipulations and standards for the admissions department, which handles discharges in most hospitals, as to staffing and their manner of operation.

At the present time the hospital has little reason to be concerned, as far as the rules and regulations are concerned, about the patient after he leaves its doors.

I am further requesting that this be enforced. An example of the problem is as follows: A patient is admitted to the hospital from a nursing home, a personal care home, with a stroke. When the patient is finally ready to go home, or back to the nursing home, the patient has a different medical condition. He may be incontinent, the stroke has changed him, yet poor discharge planning may send this patient back to a personal care home where adequate care is not available. Therefore discharge planning is important.

Next I will discuss reimbursement. Adequate reimbursement is essential. You cannot have good care, the type of care that Mr. Walch mentioned without adequate reimbursement. Now I have come to one of these small items, an item that perhaps, Senator Moss, you could correct and the saving might be considerable. This is in the area of what we call the "Madison Avenue Oversell."

In this nice red, white, and blue jacketed pamphlet may be many millions of dollars of loss. All that it amounts to is a very simple situation. When Medicare started out it was necessary to acquaint the people with the program and what their benefits were. However, that time is long gone. This book says, "Your benefits are up to 90 days in the hospital, 100 days ECF." The people interpret that literally. Contrary to general belief, the patient still exerts considerable pressure on the physician to remain in the facility. In many cases they like to remain in the hospital or the ECF, and this is a major factor. If you continue to educate them with this, you will thwart your Utilization Review program, which is a program to cut down on the overuse of the medical facilities.

In one instance in this State a patient was warned that they would probably not be covered by Medicare. The patient stayed on over 80 days in the hospital. Later the Utilization Review Committee denied the case as covered care and you can imagine how much money was involved in the controversy.

I feel that much of our overuse is tied to the red, white, and blue pamphlets. For those of us who work in developing utilization review, it is frustrating to look at the box when these come tumbling out. You can almost imagine that martial music playing as the pamphlets go out to destroy your efforts. A change in wording is important to inform the people that there are controls. We, in the region VIII meeting, set up a suggestion that should have this particular wording before the benefits were explained. The wording should be in large, bold print, with the number of days in smaller print. It should be stated that the list's benefits under title 18, or Medicare, are based on medical necessity and subject to review by a committee.

The next major problem which causes difficulty and additional administrative costs in our Medicare program is the deductible. This is a problem which is not well understood by the beneficiary. It frequently makes him very unhappy. The deductible, of course, is the amount of

money that is collected before benefits start. I am advocating that we have a clear-cut coinsurance program, which means that the patient pays some money for each service rendered. The administrative costs incurred by our health facilities when handling this deductible is a major item.

Next I come to another difficult problem which has plagued hospitals and nursing homes. It is called the distinct part. It has been a problem all the way. It has been a typical big hospital, big nursing home type of approach. In Utah we don't have these large facilities. This kind of problem can be changed. A distinct part is a section of beds zoned from other parts of the facility. Cost accounting must be performed for each part. One of our facilities has a distinct part of two beds. It is almost necessary for the administrator to count the number of swipes of the mop in those two rooms to adequately cover the cost accounting. In another town we have a hospital that is running at 30 to 40 percent capacity. We have recently been approached to build a separate nursing home because of the need. The problem is that the hospital cannot develop all of the cost accounting, nor does it have the will to set up a distinct part. They did set up a distinct part for a short time and gave it up. Here would be a saving of construction funds if we could establish a different kind of system where we would not have to build a nursing home using Hill-Burton funds or other funds, and merely use the empty beds for ECF and long-term care. We have a number of other hospitals in these areas where there are no nursing home beds available or where the beds are filled, yet the hospital beds are empty. The distinct part is not helping our situation. The distinct part, again, is a product of the large institutions. We have made an attempt to set up a program to change this, but we have not had active help from social security so we are trying again.

I would like to say a few words about nursing homes. They are not perfect in the State of Utah, but we have a number of good nursing homes. They have many problems, as Dr. Kassel pointed out. I believe that the answers to these problems are the Federal support at 100 percent for a State agency team, and support for master programs nursing home administration set up in Association of University Programs in Hospital Administration courses. These have been attempted in the past and have been unsuccessful. I believe that new national nursing home administration licensing rules will be of help, but it will require Federal grants to stimulate these programs. I also believe there should be generous support wherever possible to support the continued education centers such as we have in this area for continuing education, which would bring to the area continuing education for nursing home administrators. We also hope that programs such as Hill-Burton and the very excellent program called the Four Corners program continue. The Four Corners program, though not directed at health facilities, has been a major benefit to us and has provided assistance where it would have been impossible to develop services in any other way.

I would also like to mention residential care. As you know, we have progressive patient care, where there are hospitals, extended care facilities, nursing homes, home care, and then residential care, the people who can more or less take care of themselves. I am sure Dr. White will cover and mention these, but I want to put my bid in for support of residential care facilities, not only for better care for

senior citizens in a boarding home situation, but more agreeable care, perhaps, in another type of facility. This would be a residential care facility where they take care of themselves and may even prepare their own meals. As an adjunct to this kind of facility there may either be local kitchens to provide food, or there may be arrangements with restaurants, such as in San Francisco.

I have a few general points. One of my areas of concern is our present malpractice insurance problem for physicians, the lack of policies and the high cost. We are probably reaching a zenith in this situation, where in some areas the actual cost of premiums is visibly reflected in the cost of the visit by the patient.

It brings about an increased number of tests, longer stays in facilities, and so forth. I am asking for a major study to be done in this area. It will have to be a State oriented type study in each State that will lead to a medical review board which, I hope, would function something like our quite successful industrial accident commissions. Perhaps if the gentlemen on Capitol Hill deem it wise, Medicare and Medicaid recipients might be required to go through this process. I believe that some cooling off of this particular area will benefit in cost and wear and tear not only for physicians but for physical therapists, nurses, and other people who must be wary of malpractice claims.

The next point I wish to make concerns the dissemination of raw computer data by Federal Government agencies. I have been somewhat distressed at nonreviewed data being released without a complete review by a statistician and by people in the field who are knowledgeable, before it is issued to the news media. I hope that the data on hospitals will be reviewed by statisticians and, by people from hospital administration as to its validity before it is released so that the public will not be misled.

The last concerns the education of the patient. The patient is still the key to a good health program. We have health education on how to take care of themselves, let us have health education on how to use health facilities and health personnel. The house call, is a major problem when dealing with our older citizens. They were brought up in an age where the house call was Medicare, the doctor came to the house. The diagnostic house call is gone, its usefulness is very limited. A house call on a home care program is an entirely different thing, but a diagnostic or initial house call can actually be poor medical care. Education of the public will probably save many unhappy comments, unhappy patients, and perhaps a lot of unhappy physicians as well.

Perhaps this story might give you an idea of some of the physicians' feelings about it. I believe this came in the Wall Street Journal. A lady called a doctor's office for a house call. There was a pause and then the nurse said, "When will you be at the doctor's home?"

I would also like to say one word about the people with whom I work in the regional office in Denver.

I have been very pleased with the quality of the help that these people give us. I believe for some reason, the Denver Regional Office collected a group of very first-class people who have thrown away their bureaucratic badges and work with us.

Thank you.

Senator Moss. Thank you, Dr. Walter, for a very excellent discussion of a very fine paper, which, of course, will be in the record in full. It is even more complete than the summary that you gave us and, naturally, it will be most helpful to us.

(The statement follows:)

Gentlemen: Thank you for giving me this opportunity to present a few points which I believe will be helpful in the medical care of our citizens in Utah. I've taken the liberty of dividing my points under the headings Medicaid, Medicare, Nursing Homes, Residential Care, and general points.

My first area of concern is Title XIX, or the Medicaid program. Medicaid in Utah has perhaps had fewer problems than a number of the other states. Medicaid has been implemented in the State of Utah since July 1, 1966. Title XIX, along with Titles I, X, and XIV, covers approximately 22,368 persons in the State of Utah. Approximately 2,600 of these are in nursing homes.

1. My first point is to urge you to adopt Medicare standards for Title XIX facilities. I believe this would benefit the patients and eventually the administrators of these facilities, providing adequate reimbursement is forthcoming.

2. I further request that the federal government fund the state certification program, or state agency program, for Title XIX at 100% instead of using matching funds. In other words, this would be similar to the 100% administrative funding of Title XVIII. I would also wish that this particular organization assume the same certification process and responsibilities covering those nursing homes used under Titles I, X, and XIV. Utah does not operate Title XVI.

3. I urge an examination and thorough review of the fee program under Medicaid. This would include fees for physicians, hospitals, and all other services. I caution you, too, that a lower fee schedule than the going rate tends to make second class citizens of the recipients of these programs. It also places hardships on those personnel, physicians, and other paramedical personnel who primarily service our central cities and our rural areas. In many cases these people are largely dependent upon these programs, and should therefore be entitled to receive the same or similar fees as the going rate.

4. I am particularly concerned that when a reorganization of the Medicaid program is undertaken, the present flexibility of administration by the state agency will be reduced. Flexibility in the provision of services is essential. There has been a definite and distinct recognition of the individual in Utah with genuine concern and flexibility in providing needed benefits.

5. Further, I request that there also be 100% federal support of administrative funds for the utilization review program for Title XIX and also for Titles I, X, and XIV. This is similar to the Title XVIII program.

6. In addition, the establishment of administrative standards for this program should be undertaken. If this program is to merge with Title XVIII in some areas as rumors would have it, then some of my concern will be modified.

My next area of concern is Medicare, or Title XVIII of the Social Security Act. Under Medicare there are a number of areas which I believe would be of assistance to the citizens of the country and of Utah if adopted.

1. First, I believe it is time to increase the flexibility of Medicare's administration. Efforts are now in the works to regionalize Medicare. I fear, however, that increased regionalization in this situation will not be enough. I believe the Bureau of Health Insurance in Baltimore suffers from one major malady, and that is size. It may also suffer from some problems in the area of flexibility, which may not be Social Security's fault, but the problem of design of the original law. For example, the various rules, regulations, and interpretations that have followed the law have been largely oriented to very large hospitals, and probably for the most part, eastern hospitals. For the smaller hospital, of which we have 23 under 50 beds in size in Utah, or 53% of our hospitals, some of the requirements of paperwork, including the reimbursement formula, are inappropriate for their operations. I advocate a delegation of decision making authority to the regional offices, which would be advised by regional boards made up of state agency personnel, federal personnel, and consumers. The problems of Manhattan Island and Monticello, Utah are simply not the same in most areas of administration.

2. The second concern pertains to the hospital's responsibility in transferring patients. To enhance the medical care, and particularly the continuity of care of patients, I request that discharge planning and staffing standards for this function be established for the hospital. The admissions department, which handles the discharges in many hospitals, along with the social service department, must be

required to meet specific standards so they may provide proper discharge planning in the transferring of patients to appropriate facilities outside the hospital. In a number of cases we have had in the State of Utah, the transferring of patients to the facility which was not appropriate for the medical care needed, has led to longer care, occasionally to early hospitalization, and increased costs.

3. Reimbursement. Because of the importance of this particular area, I would encourage the development of a realistic reimbursement formula based on actual cost, and providing the needed funds for proper and continued operation of the hospital. At present, in many facilities, private patients are actually subsidizing other patients in the facility. The key to lower costs, or shall we say a slowing of the increasing costs in hospitalization, is found in the efficiency of good administrative practices, not in placing ceilings on reimbursement, which can only lead to poor care and inadequate development in maintenance of hospitals.

4. Benefit Information. The present program of providing information to Social Security recipients may be one of the major factors in the increased cost of the Medicare program. The simple solution to this problem may go a long way to prevent the projected deficits in the Social Security trust fund.

The "Madison Avenue" approach of selling the beneficiary on the benefits may have been important in the very beginning of the program; however, it has now developed into a major contributor to over-utilization. We have, on several occasions, requested that Social Security rewrite the red, white and blue pamphlets they pass out to beneficiaries which now read: "Your Part A benefits are: up to 90 hospital days for each benefit period and up to 100 extended care days for each benefit period." The beneficiary rightly interprets this as meaning that he is entitled to stay that length of time in these facilities. In conjunction with other agencies in our region, we asked the Social Security Administration to change the wording to the following: "Benefits under Title XVIII Program are based upon medical necessity and are subject to review by a committee of physicians." I believe that a change in format should be made to inform the beneficiaries that their benefits are determined by medical need and by a utilization review committee in consultation with their physician. A change in this wording would also benefit physicians who are pressed by patients to remain in the hospital or remain in extended care facilities for a longer period than is needed. Remember that insurance has largely removed the patient's restraints on health care expenditures, and has actually made him a factor in extending the length of stay in the hospital and nursing home.

5. An important problem that confronts most providers in the Medicare program is the deductible. This particular situation is not understood by many of our senior citizens, nor is it easily administered by our hospitals and other providers. It has been a major factor causing unrest and unhappiness with the Medicare program. It also has major administrative problems, including difficulty in collecting and increase in administrative costs. Though I am well aware of the need for such a restraint, I believe that a modification of this stand can be made. A conversion to a co-insurance program, which means that the patient pays a portion, as he does now, of each of the costs, can be developed. It must be studied and field tested prior to its adoption. I expect there would be considerable opposition from insurance-oriented individuals regarding this change, but the good outweighs the bad points. I believe that a co-insurance program, along with a well established utilization review program set up by a medical society with state agency assistance, could be a much more palatable and workable answer to this dilemma.

6. The distinct part problem. It has become increasingly apparent that the current system of distinct parts for extended care units in small hospitals is becoming uneconomic, unworkable, and an added administrative expense to both Medicare and the operation of the facility. Though we are aware of the needs for controls over such organizations for both fiscal and other reasons, the present program seems to be defeating the general purpose of providing extended care in all possible areas due to its restrictive covenants and administrative difficulties.

We have discussed the matter with many of our small hospital administrators, plus made a number of on-site visits in an effort to solve this dilemma in these small hospitals. We believe that a less complicated, workable program should be worked out; one that would reduce much of the administrative difficulty and the financial complexities. We need a program to enhance the care given to the patient, reduce the costs of care and, in many cases, enhance the financial stability of the institution involved.

Because of the great difficulty in establishing a cost center in a small hospital which has neither the personnel nor the inclination to establish a sophisticated cost control system, I am proposing a simplified system which may turn out to be a

better evaluation of costs than a highly-sophisticated system developed on questionable data and questionable costing procedures. The program I will outline is an effort to reduce the amount of administrative detail and yet accomplish the objectives I have mentioned above.

AUDIT CONSIDERATIONS

(a) The reimbursable costs for the institution in question shall be determined by the existing reimbursement formula, or by a revised equitable system which hopefully will be developed in the near future.

(b) The extended care rate will then be computed as a percentage of the going reimbursable rate for hospital patients. The rate will be set by one or any combination of the following:

1. Regional costs for extended care patients;
2. Projected costs by the administrator;
3. Negotiation between the administrator and the auditor representing the fiscal intermediary, with consultation with the state agency;
4. Actual cost studies performed.

(c) A percentage of the hospital rate will then be established. The facility will then bill the fiscal intermediary on the basis of this percentage for each Medicare patient within the facility. Changes in the general reimbursable rate for the hospital patient will automatically be reflected in the rate paid for the extended care patient. The discrepancy in costing for two general levels of patients will be adjusted in the negotiated percentage. Since nursing care needs for individual hospital patients vary widely, I see acceptance of this solution.

(d) The objectives of the study are:

1. General objective:

(a) To extend appropriate extended care facility Medicare services to outlying areas where none exist in an effort to improve the quality of medical care at the same or reduced cost.

2. Specific objectives:

(a) To provide extended care facility services in selected outlying areas;

(b) To provide extended care facility services where only hospital services exist;

(c) To reduce the administrative paperwork where cost accounting expertise is not generally available;

(d) To increase the effectiveness of the hospital utilization review process;

(e) To reduce the transportation costs of patients to available facilities in distant areas;

(f) To better utilize existing hospital beds now empty;

(g) To provide a better economic base for small rural hospitals;

(h) To reduce the fiscal intermediary audit costs;

(i) To keep the patient in the patient's home area;

(j) To provide more efficient continuity of care by retaining the patient in the area under the same physician;

(k) To prevent the construction of new beds in areas where empty hospital beds now exist.

(l) To improve the image of Medicare program to the beneficiaries and providers alike.

7. General comment: I have been very pleased with the flexibility of the Region VIII office of the Bureau of Health Insurance, Social Security Administration, in Denver, Colorado. They have been of considerable help and have shown great understanding in our many dilemmas.

NURSING HOMES

The nursing homes in Utah have made progress in recent years in the improvement of their physical plant, as well as the services they are now delivering. There are, however, many problems yet to be overcome. In Utah, as in other states, we are experiencing the closure of small nursing homes and the enlargement of existing ones or the development of larger facilities. We expect only a small increase in the number of beds in the year 1970, though there has been closure of four homes in the month of January alone. Structural and patient care problems remain as challenges to nursing homes. Services would be greatly enhanced with the previously discussed certification program for Titles I, X, XIV, and XIX.

1. Masters in Nursing Home Administration. My first proposal in this area concerns the establishment and assistance of a masters level program in nursing home administration. Though these programs were unsuccessful in the past, I believe it is now the time to develop such a program, due to the oncoming licensure for nursing home administrators. I would hope that you would use caution in funding these programs, and that you seek approval of curriculum and standards from an organization such as the Association of University Programs in Hospital Administration.

2. Continuing Education. Positive support for continuing education programs in nursing home administration and nursing home personnel is indicated. Programs developed under the national and state nursing home organization and the Kellogg supported regional centers are generally excellent. Utah is serviced by the Kellogg-founded Western Center for Continuing Education in Health facilities, based at the University of California, with headquarters in Los Angeles. Organizations such as this can provide the quality control necessary.

3. Facilities. The Hill-Burton (Hill-Harris) Program is most helpful in this state in the provision of long-term care facilities. I should also like to commend the Four-Corners Program. This admittedly covers a very wide range of activities, but where it has affected health care, it has been beneficial. This is a well administered, beneficial program.

RESIDENTIAL CARE

I see a need in the care of our senior citizens in the area of residential care. This can be divided into two somewhat distinct parts:

1. First is the boarding home type where the individual receives some supervision, room, meals, and other types of assistance. I believe this particular category can assist us in relieving some of our personal care nursing homes of certain patients, following the progressive patient care concept.

2. The second type is truly residential care facilities where individuals may come and go as they please and live in a specific area which is near the various services they desire. I believe location and construction of inexpensive facilities would be most beneficial in some of our central cities, as well as some of our smaller towns. Services would be available to them by virtue of locating near business areas. Meals could be provided either by central kitchens or by utilizing local restaurants on special arrangements. I believe there is considerable need for this type of residential program, providing quality standards are established. Since the great need for these facilities is in the lower income group, it may be necessary to either subsidize or provide low interest loans for these facilities. I also believe that a number of activity programs, either operated through Senior Citizens Groups or by special facility arrangements, are also necessary and should be part of the development of these facilities.

GENERAL POINTS

There are three other points of importance to medical care in the State of Utah.

1. Malpractice insurance problem. Complaints against physicians, nurses, therapists, and others have not reached the high level experienced in several other states. However, we have experienced a problem of procurement of insurance protection against complaints from patients, which are all included under the name "malpractice." The current wave of patient complaints is now a factor in cost of medical care. To some extent it is reflected in the cost or premium of obtaining insurance, but also it concerns the extra hospitalization, the extra X-rays, and laboratory procedures that physicians feel they must order in an effort to protect themselves. There is no actual way of measuring the cost of this concern on the physician's part, but it is thought to be considerable. Since many of the claims by patients are based on misunderstanding and other closely related concerns, I believe a major study should be undertaken to find a solution.

Due to the many legal implications, this would have to be undertaken within each state, but I believe expression nationally or an inclusion in any changes of the Medicare and Medicaid laws could recommend or require the referral to a medical review commission or committee similar to those found in the industrial commission area. It is my belief that this will reduce the number of patient complaints, physician concern, and costs to the consumer.

2. My next area of concern involves the issuance of statistical information by the federal government. We have seen the development of a truth in lending law. Perhaps we are now in need of a truth in information law. The issuance of computer output or raw data without interpretation usually leads to misinterpretation

or misleading stories in the various news media. Due to the probability of the further issuance of raw data concerning other health activities, I request that a review board composed of statisticians, experts in the field of health, and perhaps some persons who may be concerned with the data release review the statistics before they are released to the news media. It is my belief that information that can be misinterpreted is damaging to the image of our facilities and personnel in the health care field, and can hinder our recruitment of good personnel. We are presently diligently working to attract competent people into the many health professions. Please help us do this, and issue only properly interpreted information. If there are legal problems, they should be reported following appropriate investigation and indictment.

3. Education of the patient. The patient remains a major factor in the use of medical care services. He influences the physician and other providers of care to a very great extent. In past years when the patient paid his own bill, he acted as the brake on utilization of these services, whereas now he is less concerned due to insurance and governmental programs. I believe it is important that the patient be made aware of the use of drugs, the utilization of medical services, the time to use services, especially outpatient services in many of our facilities, the times to call physicians, and the declining importance of the diagnostic or initial house call. I suggest encouragement of studies or programs to acquaint the patient with proper use of medical care services.

Senator Moss. Do we have a ceiling of the amount here under Medicaid in Utah that is set statewide as to how much reimbursement there may be?

Dr. WALTER. Yes.

Senator Moss. How much is that now?

Dr. WALTER. As far as the actual total dollars?

Senator Moss. Yes; I mean per patient, if we can break it down.

Dr. WALTER. We have 10 levels in nursing homes that we pay.

Senator Moss. Is there a scale?

Dr. WALTER. It is roughly \$320 a month, down to \$146.

Senator Moss. But \$320 would be the high figure?

Dr. WALTER. Yes.

Senator Moss. Which is, of course, quite inadequate, isn't it?

Dr. WALTER. We believe that there are patients who require so much that this particular amount probably does not cover the cost of care. We have other patients, of course, that it will. We have 10 levels of payments.

Senator Moss. This contrasts with Medicare where the standard is reasonable cost of reimbursement?

Dr. WALTER. Yes.

Senator Moss. If we brought those two together, so that both systems reimbursed for reasonable costs, would that improve the situation greatly?

Dr. WALTER. Yes.

Senator Moss. I am very interested in what you had to say about the Medical Handbook; and I agree with what you have to say.

By stressing the maximum number of days, then the recipient gets the idea that he is just entitled to that many days, 80 in the hospital and 100 in the extended care facility. This is, of course, not true, he is entitled only to such care as he needs. There is an evaluation board to determine how many of those days he needs and the figures in the handbook represent absolute maximums.

Dr. WALTER. Yes.

Senator Moss. That is a very good recommendation, that we see if we can get the HEW to correct this misrepresentation of benefits.

Your recommendations, your suggestions, were all very helpful, the "distinct part," requirements I can see are a great frustration for smaller facilities that have difficulty trying to parcel off a distinct part of their facility and keep accurate cost accounting, often spending more in the cost accounting than running the distinct part.

Dr. WALTER. That is right.

Senator MOSS. This is unfortunate. Well, again I appreciate your comments.

We want to hear from Miss Birkins, Director of the Division of Welfare, Department of Social Services. If you would like to remain there, doctor, we will hear Miss Birkins.

We certainly appreciate your being here, and you proceed in whatever way you would like, Miss Birkins.

**STATEMENT OF CHARLINE J. BIRKINS, DEPUTY DIRECTOR,
COLORADO DEPARTMENT OF SOCIAL SERVICES**

Miss BIRKINS. I appreciate the privilege of having been invited. Particularly did I enjoy the ride this morning. Last weekend I was on the ground in the mountains, and today I got to fly over them, and with all the snow, it was beautiful.

Senator MOSS. Snow is pretty when you look down from the air.

Miss BIRKINS. Right.

I thought today I might approach this with some generalities. As you know, I am a State administrator of welfare. I likewise am on the Secretary's National Advisory Council on Nursing Home Administration and the Secretary's Task Force on Medicaid. So mine will be a little bit of a combination of certain things as I see them, speaking basically, I think, from the welfare standpoint.

I think we cannot talk about long-term care without first defining why are we in business, and this is people. We too often get all mixed up in controls and costs and methods and somewhere the people get lost. We have people who end up in long-term care facilities of one kind or another who have conditions where their relatives can no longer take care of them from a physical standpoint, or who can no longer take care of them from a physical or financial standpoint, and then there are those with no relatives at all, so we have a combination set of responsibilities.

We further complicate these people's frustrations, and I think Dr. Kassel mentioned this, in various ways by playing musical chairs with them, by moving them away from their home, away from the town, from floor to floor, from room to room, by trying to categorize or classify their needs, when many times it is the care they need and not necessarily the type of room they are in, or where they are, or where they have to move that should be considered.

Likewise, as has been mentioned before, these patients' conditions fluctuate from day to day. They might be ambulatory and considered more or less a basic type patient today and for the next 3 days they are downhill. They have conditions that go up and down, if that is the proper term, and it is not as easy as some people may think to try and properly classify a patient and have him where from day to day or week to week he gets the care that he needs.

Too many times I think we forget the broad term of rehabilitation. Too often, we expect nursing homes to take patients, get them better, move them out and on toward some other situation. But we should accept that there are many, many of our patients whose home for life will be a nursing home or some type of medical facility. The more that we can rehabilitate them in the broad sense to where, if nothing else, they can clothe themselves or feed themselves or walk down the hall or be able to hold a book up and read again, whatever the situation is, in my mind this is rehabilitation. It helps them reach a point where each day can be a little more pleasant, where the time goes by more effectively. So I stress, to start off with, let's not forget we are talking about and for people.

We stress quality of care, but we cannot have quality without appreciating the fact that this costs money. We have many States with nursing home care or other types of care that still pay flat fees. Our experience with this has been that the poor home is the one which makes the money and the good home loses money when you pay on a flat fee basis.

Colorado for some time has had an audit cost formula, but because of appropriations we have had to impose a ceiling. We do pay audit costs plus 3 percent for fluctuating cost between audit periods because we do not adjust retroactively. We pay a 65 cent a day profit allowance per patient. This is in accordance with our law where we are instructed to pay reasonable cost plus a profit to the homes for their endeavors for our people.

As I say, we have had to have a ceiling because of appropriations. We have had many homes which in accordance with their audit costs do get full payment. We have some homes where the ceiling is working a hardship. We adjust that audit cost at the present time, if possible, semiannually, but try at least annually to bring it in line with the cost of living.

We would recommend that some similar plan be used in other places. We have found that this results in better planning, can result in better administration because the administrators know what range they are going to fall within. They know where they can plan for improvements, they know what is going to happen as they go ahead with their administration. This likewise, we feel, has been fair to the State and to the nursing home administrators rather than just a flat rate where they had no room to know what was going to happen to them. The audit also, of course, gives us a much better chance in connection with appropriations to anticipate what our future costs or budget requirements might be.

I would like, Senator Moss, to express one item of real concern to me at this time. I understand that the Bureau of the Budget has suggested or requested that HEW cut \$135 million from its budget for Medicaid. This \$135 million would go back on the States who are now at their budget limit or who are in the middle of annual appropriations or semi- or biannual appropriations which I can see will result in nothing but reduced medical care programs and services to people across the country. At the same time, I understand that HEW is considering a new policy wherein individuals who have no earned income can exclude one-half of it in arriving at the amount of their needs.

I certainly can't quarrel with this as a principle, but I think we are looking at priorities right now. If a State like ours had to exempt half of all the social security payments and other types of revenue these people have, this could be quite costly to us. I have been told that the ticket for this, so to speak, from the Federal Government is \$400 million. I would rather see this spent to hold this \$135 million for medical care, where we are meeting, for the most part, at present, emergency, acute, current medical need for people. If this amount is cut off, and reimbursements to States, I think it could be very drastic, particularly in its repercussions as far as the people are concerned.

We have talked about classification of patients. I think it is very essential that there be careful evaluations of the patient in classification, and that following this there be proper placement, proper facilities in which to place these people after classifying them. At the present time, frankly, physicians are criticized, but in many areas they have no recourse. There is either just the hospital or there is a hospital and a nursing home, and these are the only services this physician has available or knows to refer to the patients.

So as we review the classification of the patients, and find their needs, we must have developed the proper alternate care facilities available. There is no real necessity for all leaving the hospital to go to an ECF. Some of them could go directly to nursing home care. Some of them could go directly to a good board and room residential social care facility, whatever you want to call it, under proper supervision and standards. Some of them with home health care could go directly home. But again, some of these alternate types of care are not available.

I think this is particularly pertinent in the area here in Utah and Colorado where we have, at least in Colorado, many rural areas with no adequate facilities at all. We have some counties without doctors, we have counties with no medical facilities and, therefore, you have to uproot people to take them somewhere where medical care might be available. If you have a county with just a doctor, to me, this is second-rate medical care because he doesn't have the auxiliary facilities and services that he can call on to round out the proper service for his patient. Likewise, in these same areas, this doctor lacks properly trained auxiliary associate paramedical, whatever you want to call it, types of personnel to be of assistance to him.

As we look at the manpower problems, and I would like to recommend that we develop some of the nontraditional training systems or methods, not doing away with the excellent medical school, the nursing school, et cetera, that we have, but on top of this devise methods to go out into these rural areas and teach some people who now live in these areas to become the medical assistants to all types or titles, whatever the case might be.

One of the biggest problems in medical education in the past has been we bring the people from the rural area. They then like the city and the situation where there is more available equipment and facilities around them and they don't go back to where they came from. I think we need to teach people to operate in conjunction with centers where, in a given rural area, you may have a good facility that is geared for extensive, comprehensive type of medical care. From this, going to either traveling clinics or satellites or teams of doctors or teams of a variety of medical care providers, with training in local areas, so that if a man has a sudden heart attack there are people there

who know what to do first for him to keep him alive, and then by helicopter, ambulance, or whatever, get him to the center where all the pertinent and necessary equipment is. This is the only way we can adequately afford medical care in some of our isolated rural areas.

The same thing, of course, is necessary in that those of us who are in the business of trying to administer medical programs must see that the planning agencies and planning committees out of various areas not only plan the way they are doing now, basically by gathering data, but take the responsibility to really say we do not need this type of facility here, but we need more adult foster homes, a residential care home, a combination nursing home, whatever the case might be, and try to stimulate them into the development of this in a given community in accordance with its needs.

This brings me, in connection with the delivery of services, to another point that has been mentioned this morning which I think is most important and has been too long neglected in general in medical programs across the country, and this is the word prevention. Too many of our medical care programs are geared to the acute, the emergent, to handle a situation when somebody is sick and not for prevention. It is only as we start developing screening, diagnostic services, treatment at the point minor ailments develop that could lead to more emergent or intensive illnesses later, that we can come down the line a few years from now and find that people are able to remain out of medical facilities longer or do not have to go into quite such skilled types of facilities.

I can say this, Colorado is a glaring example of this. Our basic program covers me when I get sick today but not for screening to try and find what might make me sick 2 years from now.

In regard to Medicare, we hear rumors, we read in the papers about the thrust and the recommendations toward national insurance. I personally do not feel that we are ready for this. If we can't afford Medicare and Medicaid now, I think a health insurance program on a national basis is going to be much more expensive. I would like to see us take what we have and try to make some improvements. I think there are some very worthwhile elements in both Medicare and Medicaid. We should see what we can do to improve these and get more experience before we try to embark on national health insurance. I am speaking purely from my personal opinion on this.

Since I am in the situation of administering title 19 or Medicaid, my personal feeling is that we get criticized by the legislature, by the public for the high cost of our care, when out of a \$52 million plus appropriation for Medicaid in Colorado, \$36,700,000 of it is spent to supplement Medicare coverage and for people over 65. I, therefore, am inclined to state that if we are to claim we have an insurance program to cover the medical needs of the aged, we should take a look at Medicare and decide do we expand into nursing home care for these people, do we pay for drugs on an outpatient basis where we are willing to pay for the doctor but not the medicine that he prescribes, and it is the medicine which, I am informed, is supposed to keep the patient stable or make him improve. This is poor practice.

We begin in Medicare, Medicaid, to fragment the patient. We run him around. He can go one place to get hospitalization, he has to go somewhere else to obtain these other services.

Likewise, I would like to recommend that since you have social security disability beneficiaries, that those people who draw social security disability benefits should also be covered by Medicare. These are people who are a beneficiary because of a disability, and it is known at the beginning they have a medical problem of some type that needs care and treatment. These beneficiaries should be covered by Medicare.

A couple of remarks in connection with Medicaid. As you know, Medicaid itself covers skilled nursing home care. At the same time, through the Department of Health, Education, and Welfare, we receive reimbursement on the same formula for intermediate care but chargeable to the assistance programs. Now, this is, in my opinion, kind of a glorified bookkeeping system, where if we are to receive reimbursement for this, some types of our intermediate care, depending on how a State has defined and broken it down, it is still medical care and medical service. In Colorado, we charge it all to one State appropriation code. Then we have to break it down in various ways to charge it for Government reporting, to various categories. Therefore, I would recommend for the portion of intermediate care that is medically related, this type of care be a part of title 19 or Medicaid.

I had also written down an item before Dr. Walter got in ahead of me, about irresponsible releases from Federal reports. I spent one solid day and a half after the medical releases came out of Washington concerning this study where one physician got \$326,000 in Colorado. This turned out not only to be the wrong provider code number that was released, but this \$326,000 went to a hospital where it covered physicians services for around 127 doctors. The headline in the paper that one physician, provider code so and so, received \$326,000 in a 12-month period created, as you can see, a real ruckus. The newspapers, the television, the radio, the medical associations, the doctors, everybody else gets very excited about this type of release out of Washington. This likewise reflects on patient care, because certain providers are not going to continue giving us care and accepting our patients if they are subject to this kind of harassment. So I think I plead with the doctor here that somehow, when these things come out; they be accurate and not be so sensational.

One other comment and then I will close for any questions. I can't compliment, from my personal knowledge, what the nursing home industry has done in the last 10, 15 years, I just can't compliment them enough. I, as you can probably tell, have been in this business a long time. I can remember the nursing homes that I went into in the 1930's, 1940's, 1950's, and I see the ones we go into today. I am certainly not saying that all of them have pulled themselves up by their bootstraps and have improved, but at least in my own State, by far a majority of the beds are new beds, new surroundings, much better and more trained staff, pleasant surroundings in which a patient will spend the rest of his life. This industry itself is striving, I think, in every way to improve itself and become an added asset to any community or State. They do suffer from the old stereotyped reputation that was gained in the past.

Now, frankly, we think, through some of the new standards coming up for the licensing of nursing home administrators, that this will be another step in improving the administration, the qualifications of people who will be running these facilities. There are some training

provisions for those people who will be examined for their licenses and there are also schools across the country that are striving desperately to establish curriculum now that will be of benefit to nursing home administrators. Some of this is going in the direction that instead of turning out hospital administrators, they will have degrees in health facility administration or could function in hospitals, nursing homes, or other health facilities.

I leave Sunday to go to South Carolina where the National Advisory Council on Nursing Home Administration is having hearings with educators on the curriculum they are establishing for this purpose. We feel that in the next couple of years, as all administrators get involved in training programs and the requirements for continuing education classes or hours every year, this again will be of great benefit to the industry.

With that, I will stop, and I appreciate the privilege of being invited and hope that I can answer your questions.

Senator Moss. Thank you very much, Miss Birkins. That was a very fine statement, and a very full written statement that you have filed with us. It will be part of the record.

(The statement follows:)

I am pleased and honored for the privilege of meeting with you today and to have the opportunity to express some of my ideas regarding the problems of long-term care.

The goal of our program is people. Our goal is to provide care and treatment to *people* so they might live out their lives in dignity, in as purposeful and meaningful a way as possible. Inflation and today's economy make it increasingly difficult for older people to meet their daily living needs and to also provide their necessary medical needs. The spiralling costs of medical care and other costs create problems of family and individual living. It creates problems for governmental agencies to meet these costs.

All at once we begin to lose sight of our goal—people. Because of the constant pressures of administration and our efforts to control or hold down costs or abuse, we tend to forget Mrs. Jones who needs a special type of care for her heart problems and diabetes. We forget Mr. Brown who lives out in the country mile from town, who fears being away from his wife as much as the disease which cause his doctor to send him 100 miles away for treatment. Instead, we speak of available funds, federal reimbursement, levels of care, types of facilities.

Mr. Chairman, in my years as an administrator I have welcomed new programs, new ways to make medical facilities and staff available to all; at the same time, I have been disturbed by the mechanical way these programs shuffle and rearrange the lives of people. This has to do not only with delivery of services but the fiscal carrots which encourage states to initiate certain types of programs over others.

I would like to present the following information in the people context, to show the gaps in services and administrative problems of Medicaid and Medicare programs as they affect the people who seek to use these services.

MEDICARE-MEDICAID

Two major programs that have been established to provide medical care to patients needing long-term care are Medicare and Medicaid. Medicare is an insurance-based program which only partially meets the needs of its beneficiaries; hospital coverage, physicians' services, extended care, lab and X-ray, home health care, et cetera cover many of the medical needs; but, as hospital benefits or extended care benefits are exhausted, the long-term care patient finds that he either has no funds to meet his needs or the burden falls on Medicaid for those who qualify.

The fact that Medicare does not provide out-patient drugs or nursing home care leaves a vital gap in coverage. This also results in longer periods of hospitalization or extended care than might be utilized if nursing home care or other alternate care was available. This requires that states either pay the difference and/or the co-insurance for those eligible for Medicaid. This inflates the cost of Medicaid.

In Colorado's current Medicaid budget of \$52,223,120, \$7,884,366 supplements Medicare coverage; \$28,740,438 pays for items not covered by Medicare for patients over 65. In addition, Medicare has paid to have the claims processed; and Medicaid *again* pays to partially reprocess and make an additional payment.

In Colorado, out of 11,455 nursing home beds available, 6,186 are certified for extended care. The probable average need for these is 670 beds. The first 12 months' experience in Colorado showed only 6,800 admissions to extended care. This would confirm the need for only 600 to 700 certified extended care beds. In recent months a few nursing homes have discontinued their extended care facility certifications while a few, where the demand is greater, added beds. Some of these were reduced because the volume of referrals did not warrant the number of beds set aside. Others were because physicians referred and nursing homes accepted patients who did not properly fit the extended care facility patient classification, and nursing homes owed large recoveries. When vacancies occur in the utilization of these beds, the cost of those in use would be much higher. Many facilities that are certified are not hospital connected and are located so far from a hospital that they cannot effectively provide the service that is intended for facilities of this type. If the extended care facility part of a nursing home is not large enough to accommodate enough patients to be a proper patient load for the required skilled staff and special equipment, this results in higher costs. Skilled staff is spread into other parts of the nursing home facility where they give good care to all, including extended care facility patients, but this is especially costly care for those who do not require extended care facility skills. To be effective, the extended care facility should be a part or near to a hospital. This enables proper use of hospital equipment and ancillary services when needed, and more effective physician care. The concept of extended care is good. I am afraid that it has not been effectively utilized.

The current thinking in the Department of Health, Education, and Welfare is that the standards and rates for extended care facilities and skilled nursing homes should be the same. My own opinion is that they are different and that rates for skilled care should be less.

The extended care facility patient has left the hospital as a result of serious illness. He needs days of extended care with more intensive nursing services, but not in a setting that requires all the expensive equipment, lab and X-rays, specialty staff, et cetera which cause the high cost in a hospital. He, however, does require adequate staff and services during what I term a more acute convalescent period. This requires accessibility to a hospital for physician's services, some lab and X-ray, and therapy. The patient before referral to an extended care facility requires evaluation by the physician. Some patients following hospital care do not need a convalescent period but do need nursing home care for a period of time, or for life, and should be transferred directly to the proper alternate care plan.

I do not mean to belittle the type of care required in skilled nursing homes. People requiring placement for this type of care should be assured of adequate nursing and medical services. Many are extremely ill and need complete care. These patients, however, are of the more permanent type, need varying degrees of daily nursing services, to have a continuity of care by understanding staff with which the patient develops an on-going trust, confidence and a comfortable relationship.

There has been discussion in the Department of Health, Education, and Welfare to reduce reimbursement on skilled nursing home payments after 180 days. I disagree with this method of saving federal funds. If the cases are properly classified, the skilled nursing home patients are all in need of continued quality care. They are mostly in the high age brackets. Many are helpless and bedfast and need continued skilled care. I agree that all efforts should be made to properly classify patients and use alternate types for are wherever medically possible. However, I seriously question the thinking that federal matching should be cut for these types of patients. Most of them would not receive proper care in other types of facilities. A curtailment of reimbursement could result in patients being removed from skilled homes and proper care, or states refusing to provide skilled care after 180 days (or whatever limit is set).

Our records show that the ages for persons in Colorado nursing homes are:

- 30 percent—85 years and over.
- 42 percent—75 to 84 years.
- 18 percent—65 to 74 years.
- 10 percent—64 and under.

Most of those in skilled care are non-ambulatory or only partially ambulatory and have advanced debilitating physical conditions.

It is my understanding that the Department of Health, Education, and Welfare has been asked to reduce its Medicaid budget by \$135 million and that the reduction of federal matching to states for skilled nursing home care is one of the major items from which they hope to achieve this. States have tried to comply with Health, Education, and Welfare rules to improve Medicaid's scope of coverage and higher standards of care. This has increased our costs. States should not be penalized by having these costs thrown back to state and local funds. Since many states now find it difficult to fund Title XIX, I would predict that this could cause states to drop out of the program, or to drastically cut their scope of service and benefits which would leave many people with inadequate or no medical care coverage.

Many states do not have legislatures in session at this time and could not obtain funds to absorb the added cost because of reduced federal matching. Others who have biennial sessions could not secure funds for a long time.

I also understand that the Department of Health, Education, and Welfare is considering the requirement that states exempt 50 percent of unearned income (dividends, rentals, Social Security assistance payments, private retirement funds, support payments, et cetera). I have been told that this would increase the cost of federal matching for assistance grants approximately \$400 million. I would certainly recommend that at this time such a policy not be adopted. I would recommend these federal funds be used to counteract the \$135 million reduction in Medicaid.

Medicare at present only covers Social Security beneficiaries 65 years of age and over. In addition to my recommendation concerning more full coverage for Medicare patients, I would suggest that disability beneficiaries under Social Security also be covered by Medicare. Many of these disability beneficiaries also receive public assistance and receive their medical care from Medicaid or other state medical programs.

There have been recommendations that the United States should have a National Health Insurance Program. I believe that before we embark such a broad and expansive program, and one that surely will cost more, we should solve our problems and strengthen the program we now have.

The largest problem heretofore in our Medicare-Medicaid programs has been lack of effective planning for the Mrs. Joneses and the Mr. Browns who leave our hospitals. Where do they go for the care they require? Extended care facilities (and I have discussed some of the difficulties we have had in utilizing this type of care), skilled nursing homes, intermediate care facilities—residential or boarding homes? These create problems in proper classification, when they do not exist in all areas of a state. The answer lies in the tags attached to federal funds to encourage construction of certain types of facilities. The answer lies principally in health facilities planning—a coordinated, flexible approach to planning care for *people*, not in spending money alone.

How have we planned until now? What has been the result?

According to a 1967 survey of in-patients in long-term facilities by the Health Facilities Planning Council of Denver, a comparison of 1966 and 1967 figures shows a decrease in bedfast and wheelchair patients in the more recent year, and an increase in those who are ambulatory and ambulatory with assistance.

The survey notes that most of these long-term patients were admitted to the nursing home from their own homes, indicating the "multi-function of Long-Term facilities ranging from custodial care to bedfast patients . . ."

"One may assume," the report concludes, "that many placements to these facilities were made because of the absence of other suitable types of facilities to provide custodial and protective care for a certain number of the aged . . ."

Here is the problem stated another way: Mr. Brown enters a nursing home because he needs supervision, particularly with respect to taking his medications. These medications are the type that can be self-administered. He needs a special diet. Mr. Brown does not require nursing home care, nor want it. But in the rural area where he lives, the hospital and the nursing home are the only types of long-term care which have been developed.

Therefore, there is a great need in our planning to develop alternate methods of delivering health care. Our planning needs to concern itself with manpower, lack of adequate facilities, the role of the consumer in long-term services, and a renewed emphasis, at all levels, in preventive medicine.

Manpower is a critical issue for most of the health services—physicians, nurses, aides, therapists, home health care personnel, associate or para-medical personnel.

Manpower needs are certainly more critical in rural areas. There are counties with no medical facilities and it would be ridiculous to develop facilities without properly trained manpower to deliver the services.

Colorado nursing home patients are concentrated as follows:

Metropolitan—25 percent.

Urban-rural—32 percent.

Rural—43 percent.

At the present time, most health services training programs are geared to the traditional methods. Centers where physicians, nurses, therapists, administrators et cetera are in the usual fulltime schools for full degree achievement. We need to continue those, but also develop new training sites and curriculum for all types of "helping or associate" personnel for clinics, hospitals, doctors' offices, health centers and nursing homes. People in rural areas with an interest and aptitude for this should have training made available to them so that they can be available for employment in their own communities or areas where they reside. The time has come when auxiliary types of aides can and should be taught to carry out some types of preventive medicine, screening and delivery of all auxiliary services. There should be ways the nurses aide can graduate to Licensed Practical Nurse status; the Licensed Practical Nurse should have a chance for higher achievement.

The residents in rural areas suffer from a lack of available services. New economical methods of delivery must be developed. Sparsely populated areas cannot staff and properly support at reasonable cost full service comprehensive health facilities. Centers should be developed in central areas where there can be proper, fully-equipped clinics and hospitals. These should have satellite clinics, traveling clinics, home health services, diagnostic centers, ambulatory clinic centers, and local community trained residents to handle routine types of care, emergency care until the person can be moved to an intensive health care facility if this is medically necessary. More authority should be placed in local and state health planning agencies to stop unnecessary building of nursing home or hospital beds where they are not needed. At the same time, these planning agencies should encourage development of alternate care facilities.

One way to encourage the growth of needed facilities is to make Medicaid-Medicare capital construction funds available to facilities that are built with the approval of the health planning agency.

It is also recommended that Hill-Burton funds be limited for hospital purposes except in areas where no facility exists and others are too far away to be practical. For the next few years, the Hill-Burton funds should be used to help develop skilled nursing homes if beds are needed, intermediate care facilities, group homes, residential care facilities, neighborhood health clinics, community mental health centers, et cetera.

In the use of Hill-Burton funds for alternate care facilities, thought should be given to the type of structures necessary. Standards should not be so high that the facility cannot have reasonable charges. These patients need good, safe and comfortable surroundings, but not constructed to hospital standards.

One way to save money on nursing home costs has been the audited-cost system with a ceiling now in use in Colorado. Under this system, nursing homes receive payment only for specific services given. Besides saving money, this system has given the Colorado Department of Social Services a much more realistic basis to appraise patient needs, care and future programs. Such a system for arriving at payment rates would be more effective and realistic than where states, by arbitration, pay flat or set rates. This system also provides controls and results in better management.

At the present time, there is great emphasis being placed on nursing homes to be licensed for one type of care. This is practical in urban areas. There is still a place for good facilities in rural areas to have dual licenses so that they can accommodate skilled and intermediate care patients. Their volume would not warrant two facilities and this could be an efficient way to use manpower. Both kinds of care in one facility would provide the needs of one or two counties and would eliminate the necessity of moving patients long distances where they would not be near home, their relatives, friends and familiar surroundings. It is not conducive to good morale or health care to uproot people to strange surroundings, miles from their friends and relatives. Also, I firmly believe that ambulatory patients in a facility is good for morale of the more helpless. It inspires them to try to become ambulatory. Also, the ambulatory frequently visit other patients and help them in many ways.

EDUCATION OF MEDICAL PROVIDERS

We must have much more education and training of providers and consumers regarding the services available under Medicare and Medicaid and the proper and economical way to utilize the services.

Physicians do not understand all of the alternate methods of caring for people and too frequently only recommend hospital or nursing home care. Too often, hospitals are used for diagnostic procedures that could and should be done on an out-patient basis. Relatives insist on in-patient services when there are other methods available.

And, they are not alone. Some nursing home administrators seem to feel that patients are there for life; and, the patient and his relatives are subtly indoctrinated to this concept.

Caseworkers, too, seem to work towards nursing home placement.

We also need to work in the areas of public education so that people contemplating medical placement will have an idea of the alternatives. It will also open doors in the community to citizens who themselves might have a role to play in health care.

Insurance companies encourage higher cost medical care because they do not cover nursing home care or full utilization of all of the out-patient types of care available. Many types of minor surgery could be done in out-patient departments or physicians' offices. Patients could go home with home health care services rather than a nursing home or a "few more days in the hospital."

Hospitals and other medical facilities can cut costs and better coordinate if they would share records on a more cooperative basis. Many times hospitals repeat X-rays and lab tests that were done on an out-patient basis just a day or so by the doctor or an outside lab before hospital admission. Hospitals usually insist on running these tests again by their own staff and equipment.

PREVENTIVE MEDICINE

Preventive medicine is another aspect of health care on which there is much agreement and little accomplished. Many medical programs concentrate on current illness and emergency care (episodic medicine). Most states in establishing Title XIX, Medicaid, selected coverage for in-patient hospital services, out-patient hospital services, X-ray and laboratory services, nursing home care, and physicians (the five basic required services). Some included drugs and home health care and a few adopted all items covered by Title XIX. Diagnostic, screening, preventive and rehabilitative services have not been among the top priorities of many Medicaid programs.

Providers of health care and the general public need to know about the life-saving, cost-saving benefits of early screening and diagnosis followed by prompt treatment to prevent long-term illness.

I think if we were serious about preventive care we would begin with adequate care for the unborn. At the other end of the age spectrum you would find an increased age level of people entering nursing home and other long-term facilities.

With preventive and health maintenance programs, people could survive longer at home before institutional care would become inevitable, and due more to old age than to debilitating diseases developing at earlier ages because of the lack of adequate preventive and control measures. Effective preventive services can only be provided if some of the types of delivery of service are developed that were previously mentioned in this paper.

This is better cost-wise and people-wise.

I think as we grow in the use of medical utilization review committees, evidence of the need for early screening and diagnosis will be overwhelming. For long-term patients, much of this material will be gathered from findings of review committees in nursing homes.

I continue to hear rumors indicating that the requirement for medical review in nursing homes may be removed, because of the close similarity in what it is to achieve in comparison to utilization review. I think that strong commitment should be maintained to retain this requirement in nursing homes. It is the one level that would allay any suspicion among the taxpaying public that the utilization review process in nursing homes is not farcical. It also can give us data hopefully to indicate the illnesses which could have been ameliorated by early screening and other preventive measures.

THE ROLE OF THE CONSUMER OF LONG-TERM SERVICES

Since I started out by emphasizing the "people function" of long-term care, I would like to turn again to individuals who now find themselves bewildered by the checkerboard of medical services and costs.

Too often, patients seem to lose their rights when they become residents in nursing homes, particularly those with no relatives to maintain an interest in their well-being.

Encouragement should be given to nursing home boards and administrators to use patients on committees or councils concerning patient-care policies, recreation and religious programs.

Patients need to know, and have it re-emphasized, that they are free to move to another facility if they desire, that they can have the home call the pharmacist of their choice, and that this freedom of choice extends to physicians.

A grievance committee comprised of patients in these homes is another way to discover their points of view.

One county director is thinking about issuing cards about patients' rights in nursing homes. He thinks this will be reassuring to patients and their relatives who oftentimes have no idea of what to expect from nursing home care.

Services are developed for the consumer. Certainly he should have a voice and not be left to feel that he has reached the end of the road.

The nursing homes in Colorado participating in Medicaid all have been informed about the Civil Rights Act and their adherence to the Act is a part of the agreement they sign with the Colorado Department of Social Services in order to be a provider in the program.

No situation has been brought to my attention about patients who have been refused care because of their race, color or creed.

There are nursing homes in the state which have predominant occupancy by Spanish-Americans or blacks, but this is because of the population of one race or ethnic group within the county and the location of the nursing home.

In closing, I want to thank you, Mr. Chairman, for the privilege of addressing this committee on problems and goals of long-term care which are of concern to all units of government.

I hope that the findings of this committee will be forthcoming to assist us in planning medical facilities which will give the best of care to all people regardless of where they happen to live or how much money they have.

Thank you.

Senator Moss. I was rather glad that you ended by pointing out that nursing homes have improved greatly. They have moved up, but because there are still many problems and patients not getting adequate care we criticize. I think perhaps the impression goes out that we feel we are not making improvement. We are. We are doing much better. As Dr. Walter pointed out right at the beginning of his testimony, examination of Utah nursing homes has caused some of them to have their license withdrawn because they were not measuring up. Those who are the leaders in this field deserve the greatest of credit in trying to improve nursing home facilities, and we all hope that our congratulations come through.

Now, I just have one or two questions. I think that your statement is good. It indicates the long experience you have had in this field, and this is the reason we are so happy you came to testify here.

Your beginning in saying that, we get lost on controls and services and costs and sort of forget about the people who are the reason we have for setting up nursing facilities of any sort, is very accurate, and I am glad that is in the record.

I wonder, if because of this lack of adequate funding, do you have in Colorado nursing homes that now feel they can no longer take Medicaid patients, that they can't afford to take them?

Miss BIRKINS. Out of approximately 184 nursing homes in Colorado, all along we have had agreements with and participated with around 150 to 160 of these. To my knowledge, we have had no homes withdraw from participation in Medicaid. We have heard recently that some have withdrawn from participation in Medicare because of some of the new regulations and the auditing procedures.

Basically, the homes that do not participate in our program are homes that initially, when they opened, elected not to take welfare patients. They are more of the, shall I say, plush-type homes whose rates are much higher. There may be a few where this isn't the case, but, basically, these were homes that because of their initial funding or the way they were set up have at no time approached us to have our patients. We have, out of some 11,100 beds, which changes from day to day, most of the time 65 to 75 percent of the beds occupied by Medicaid patients. Colorado has had a nursing home program met and paid through welfare since 1958 under our old medical program, and for this reason we have been in the business longer on an organized basis than some States.

Senator Moss. I asked that because in San Francisco yesterday the situation was pointed out, and of course San Francisco is in a very high-cost area. Many homes refuse Medicaid patients. As a result of this refusal about half of their people who need nursing homes have to be sent out of San Francisco. They go a long ways from their home to be housed in a nursing home 50 to 100 miles away, and, of course, that is a very bad sociological thing we would all have to admit.

Miss BIRKINS. Well, Senator Moss, I might comment that we have come in the back door, I think, of a couple of nursing homes where initially they have decided they would not accept welfare patients. Then, as their private patients ran out of resources, instead of asking them to move, they have agreed to sign up with us and keep these patients on a welfare basis.

Senator Moss. Yes. We encountered a little of that down there. We found that some of the nursing homes had not required any of their patients to leave, but simply had adopted a policy of not accepting more under the circumstances.

I also appreciated your comments on the preventive medicine. This comes through again and again. One of the statements I remember from our hearing yesterday was that a witness said the entry into the medical care spectrum and the nursing home is through the door of the hospital, and it shouldn't be this way. What he was trying to say was that we need preventive medicine and cure before the medical needs becomes acute and requires admission to a hospital.

Miss BIRKINS. Well, I think you would find the majority of our placements are direct placements. We started off somewhere in the past with the idea that this had to be a hospital referral and this is, in many cases, a useless expenditure of 2, 3 days' hospitalization in order to come in the front door. We do, therefore, rely on our doctor's evaluation and medical report, and if a person has reached a point in his own home where he needs this particular kind of care, there can be direct placement insofar as our program is concerned.

Senator Moss. Thank you very much, Miss Birkins. Your comments about the rural problem apply in Utah just as much as they do in Colorado. Your suggestion that we have some intermediate sort of paramedical services so the acute patients can then be moved on is certainly a good one.

Miss BIRKINS. May I make one more comment. Dr. Walter mentioned liability. This is of concern to us, because we have talked with our medical society about the use of the associate pediatricians and training in rural areas, some of these people to do the screening and

the types of things they can do as an aid to the physician. This then adds to the liability of the physician and they are quite concerned about what this will do to their rates.

Senator Moss. Thank you very much.

Thank you, Dr. Walter, we very much appreciate your presence.

We are now going to hear from Dr. Melvin White, director of the Utah Division of Aging.

We are pleased to have you, Dr. White. We look forward to your testimony.

STATEMENT OF MELVIN A. WHITE, PH. D., DIRECTOR OF UTAH DIVISION OF AGING

Dr. WHITE. Thank you. May I express the appreciation of our board, and certainly, I am sure, the older people in Utah for the leadership that you and your committee has taken in long-term care and also the other areas considered by the Committee on Aging in the Senate.

I realize time is short, so I am going to keep my comments very brief and try to cover some of the major points that I would like to make.

I think as far as the State of Utah is concerned, one of our greatest needs is to take a look at this area of care in terms of a total system rather than as a segmented part thereof.

We tend to think in terms of nursing homes or adult family care homes or hospitals, but one of our greatest needs is to take a look at the total unit, all the units together rather than segmented units, and then understand the relationships that do exist between them. I think, unfortunately, even those individuals who run the facilities at times tend to think only in terms of their facility rather than thinking in terms of the continuity of care.

I have one comment here which I think perhaps sums this up and that is that patient care suffers in a system of discontinuities.

The division of aging at the present time has four major task forces operating in this area in an attempt to look at what is going on in Utah. One task force is looking at the area of housing, trying to determine what are the needs for housing, where are they needed, what type of housing is needed. Another task force is looking at the area of supportive services to enable people to remain in their own homes as long as possible. There is a growing body of evidence, scientific evidence, that indicates that moving from one's home can be a very traumatic event for an older person. It is our feeling that we should attempt to develop comprehensive programs to enable people to remain in their own homes as long as they are physically and mentally capable of doing so with supportive services such as "Meals on Wheels" and home health aid, telephone reassurance, friendly visitors, handiman services, and so forth.

The third task force is looking at this broad area of what we call residential facilities that Dr. Walter referred to. They are looking at what actually are the conditions in our boarding homes, some of our hotel facilities that offer limited personal care. We feel on the basis of our current information that one of our greatest needs in this State is to develop more residential care facilities that would perhaps fall between the individual's own home and the nursing home.

I feel that there probably are too many people today who are in nursing homes that need not be there, and perhaps they are paying a cost greater than that which they would have to pay for a residential care facility which would adequately meet their needs.

I know also from my own experience from a number of years of working with the Veterans' Administration hospitals that there are a number of older people in hospitals that could also benefit from either nursing home or certainly residential care facilities.

The fourth task force is focusing upon the nursing home facility and we will basically be looking at this in terms of the questions what currently do we have? What are our needs? Where are we going? How do we get there?

Following the complete study by these task forces we then hope through a workshop type of approach to bring together all of the reports and take a look at what is really available for people in the area of continuity of care in the State of Utah.

Let me move from the subject of alternatives to living and care into several other concerns that we have. I would like to express appreciation to the Veterans' Administration hospital staff and division of family services for some of these ideas.

One of the problems that we see is that the present system of compensation for care of patients in nursing homes is basically still based on a negative reward system. In essence, a nursing home administrator is paid more money if the patient is quite ill and less money if the patient becomes well. Now, going back to my experience in the VA hospital, they also had a similar negative reward system whereby if you kept the beds full, you could be assured of a full budget. If you helped the patient become well and they left the hospital, you were in danger of having the budget cut. I think we have to develop a more adequate system of rewarding care facilities, nursing homes, and other types of care facilities who have excellent rehabilitation programs going, both social and psychological as well as physical, and this is not an easy solution. It is a very difficult proposition, but I do not think we will ever achieve our ultimate goal here until we can find some way of avoiding this negative reward system in our care facilities.

Another problem area, I think, is there still is a need in our nursing homes to provide patients with an opportunity for social activity. Some of our nursing homes have improved in terms of their physical plant. They look like miniature hospitals, but there is still much lacking, I think, in social activities for the individual.

Again, we must look at the patient not just as a patient but as a total person, and cater to his total needs and not just his physical needs.

Another question that I would like to see some work done on would be to "what would be considered an optimum size of a nursing home?" I think there is some evidence to say that there may be a different optimum size according to the type of care. For instance, I question very seriously if patients who are being placed in nursing homes primarily for psychiatric treatment require the same type of home, the same facilities as those who are primarily there for extensive medical treatment. Perhaps we tend to place psychiatric patients in homes that are large and some of the personalized care aspects are missing that they need for their particular type of treatment.

A fourth point I would like to make is that certainly there is a tremendous lack of adequately trained manpower. This continues to undermine the efficiency and effectiveness of many of our long-term care facilities.

Recently, the board of aging conducted a factfinding tour throughout a major part of the State of Utah. One of our findings was that there are many widows in the State that are unemployed and basically unskilled but who would prefer to work rather than receive assistance from either church or State welfare. One suggestion that I would like to make would be that some program be considered and funds made available whereby those widows could be trained as nursing home aides or other types of positions where they perhaps could be utilized effectively in the nursing home programs throughout the State.

Generally speaking, those widows are mature, capable, and stable adults, and one of the problems in nursing homes, particularly with the nursing aide group, is the turnover of the staff. I feel that if we could effectively utilize some of our older people, we may not only help the older people but also improve the caliber of staff working in the nursing homes.

Dr. Kassel mentioned, too, the need for dissemination of information on Medicare. Here again, I would like to recommend that we consider using older people, particularly retired insurance people, who are living throughout the State, who could be trained to serve as consultants in their particular localities, communities, as experts on Medicare, Medicaid, and perhaps even experts on supplemental medical insurance. Generally speaking, older people do not understand insurance programs. They do not understand Medicare in spite of all the literature they have been bombarded with, and I think the only way to avoid this is to have local people in their communities well versed in these programs. I would like to see something done in this area.

Finally, let me say that although I recognize long-term facilities are necessary and a very integral part of our society, I feel that our primary responsibility and challenge is to avoid the necessity of individuals using these resources whenever possible. An old man of 85 years of age made this statement to me one time. He said, "You know, the basic need of an older person is a place to live, something to do, something to do with, someone to do for, and someone to care."

Who cares? Whether you are 80 or 60 or 50, we have the same basic social and psychological needs. As Dr. Kassel testified to earlier, when we are deprived of these needs we tend to develop both social and psychiatric problems, and I am sure physical problems accompany deterioration in these other two areas.

The Bureau of the Budget recently has cut the amount of money available through the title III, IV, and V programs of the Older Americans Act which has severely limited our programs in the State of Utah as far as developing what I would consider frontline programs which would enable older people to meet their basic needs. Prevention, I feel should be our major thrust. Again I would concur with Dr. Kassel, from my own experience, when I am now a staff member of the VA hospital, that if you try to patch up people after senility occurs, it is both expensive and discouraging, and your results are very limited.

If we can deter or prevent people from ever having to enter institutions in the State because of senility, I think we will save both money, personal loss, and social loss to our community.

Thank you.

Senator Moss. Thank you, Dr. White. That was an excellent statement, and we are most pleased to have it.

I agree with you wholeheartedly, that our priorities are scrambled, if we are cutting appropriations on areas such as in the Older Americans Act, which is stark fact and a point of conflict, as you know, on the national scene now. You have very strong feelings on this and, consequently, I shouldn't comment further.

As for your suggestion about a positive reward system, I had a nursing home operator before me and she said the greatest reward for her was to see one of her patients walk out of the door of the nursing home and be able to go to her own home. That is wonderful that she would feel that way, but we ought to make a more tangible system to accomplish this, if that is possible. I don't believe, of course, we should say that we expect everybody that enters a nursing home to be able to leave the nursing home. Obviously, a lot of them will never be able to leave. But if one does, it is an accomplishment because it means they have been rehabilitated to the point where they no longer need the full services of a skilled nursing home and they can either go to their own home or some other facility.

The negative system which we operate under that you described is very depressing. Of course, the longer patients are sick, the longer the income continues to the nursing home.

Your suggestion about using retired people, training them, particularly females that would like to work and have a kind of stability and maturity and sympathy for people, could be utilized very well with some system of training. It might solve a lot of our manpower problems.

I appreciate your testimony and the fine job you are doing here in Utah, Dr. White. We have problems and a lot to do, but we are making progress.

Dr. WHITE. Thank you very much.

Senator Moss. Your written statement will be made a part of the record.

(The statement follows:)

May I express the appreciation of the Utah Board of Aging and the Older Utahans for the leadership the Senate Sub-Committee on Aging has taken in long-term care and replaced areas.

Utah, where interpersonal cooperation is an integral part of the culture, share many of your Committee's concerns and is making a concerted effort to improve the opportunities for a meaningful life in our later years. Let me share with you some of our concerns and activities as they relate to long term care.

1. Need for a "Total System" approach to Housing and Care for the Elderly.

Too often we tend to examine one phase of care for the Aging independently of other interrelated programs. By this segmented approach we fail to see or understand the relationships that exist between programs and/or gaps or duplications. Patient care suffers in a system of inconcontinuities.

In an attempt to resolve this problem the Division of Aging, with full cooperation of many public and private agencies, has embarked on a project that we hope will result in a "Total System" approach to the problem.

Four major task forces are now operational—studying the areas of housing, supportive services to enable older people to remain in their own homes if desired, residential care and nursing homes. Let me elaborate briefly on each of these areas.

There is a need for independent low-cost housing for older people in Utah. The Task Force on housing is charged with the responsibility of answering such questions as: where, geographically, are houses for the elderly needed? What type of housing—single dwelling, high-rise, condominium, etc.? Rental or purchase units? Cost factor—what can people afford? What should the total environment for housing developments consist of? Should housing developments be age-segregated, etc.?

It is frequently socially, psychologically and even physically advisable for oldsters to remain in their own homes as long as possible. The second Task Force is charged with evaluating (1) What conditions precipitate situations that result in older people having to leave their homes? (2) What supportive services are required to enable the elderly to remain longer in their own homes, such as Meals on Wheels, Telephone Reassurance, Home Health Aids, Friendly Visitors, Handiman Service, and Homemaker Service? (3) Which of these services are "basic"? (4) What services are now available and what services are now needed? (5) How can these services be coordinated or developed into a comprehensive system?

A third Task Force is studying a broad spectrum of living arrangements and care including boarding homes, adult foster care and related facilities where "some" personal care is provided. All of these facilities have been grouped into a category under the name of Residential Facilities.

On the basis of our current information there appears to be a pressing need for care facilities that offer personal care not available to an individual in his own home yet not needing the extensive professional care provided in nursing homes. Currently there are individuals occupying beds in nursing homes who do not require the extensive care provided, nor should they be paying the cost of professional services they do not require. On the other hand some older people living alone require minimal personal care and would benefit from residential care facilities. The purpose of this Task Force is to evaluate the need for residential care, ascertain the number, nature and function of existing services, and make recommendations for new types of facilities or modifications in the existing program.

The fourth Task Force is focusing on the nursing home facility and to answer the same type of questions challenging the other task forces.

When the assigned responsibility of all task forces is completed, a Steering Committee, including the Task Force Chairmen, will analyze and evaluate the findings and recommendations, keeping in mind the housing and care system as a whole.

A workshop type of approach will then be utilized to determine what changes will be made in the care system, who or which agency or group will initiate the change, when the change will be accomplished, and what the cost will be and by whom the cost will be met.

We feel that this "total" approach has considerable merit and we trust that we can count on the resources of your committee—particularly in the implementation or action phase of this project.

Let me now mention briefly, without much elaboration, some of our other concerns in the long-term care area. I wish to express my appreciation to the Salt Lake Veterans' Administration Hospital, The Division of Family Services and many others who shared with us their concerns in this field. The following concerns and suggestions are those that were most frequently mentioned:

(1) The present system of compensation for care of patients in nursing homes is derived at basically from a negative reward system where the more disabled the patient is, the greater the monetary reward to the nursing home administrator. Receiving adequate payment for rehabilitative efforts and improvements in total physical, social, mental and emotional functioning should be given to nursing homes to emphasize restoration and rehabilitation.

(2) There is a need for nursing homes to provide patients with an opportunity for social activity and this is, for the most part, lacking. Most nursing homes merely provide room and board with little opportunity for self-appreciation through programmed activities such as handicraft, art, music, sewing and recreational activities.

(3) Consideration should be given to determine what is the optimum size of a nursing home to maintain a balance between the economics of care and "personalized" care. The optimum size may vary according to the types of patients receiving care in a particular institution.

(4) The lack of adequately-trained manpower continues to undermine the efficiency and effectiveness of many long-term care facilities. Recently the Board of Aging conducted a fact-finding tour throughout Utah. In addition to other information, we learned that there were a number of unemployed widows over the age of 45 who prefer to work rather than receive help from the State or Church Welfare. These women are generally mature, capable

and stable adults. Could not (if funds were available) these women be trained as aides and employed in our long-term facilities? I would suspect that the quality of care would improve and the rapid turnover of aides decrease.

(5) Long-term care facilities are a necessary and integral part of our societies; however, I feel that our primary responsibility is to avoid the necessity of individuals using these resources as long as possible. The factors that contribute to institutionalization of the aged are multiple and complex and are biological, social and psychological in nature. It is generally believed by experts in the field of Aging that by providing a person, regardless of age, the opportunity to feel like an accepted, contributing member of a community, that many problems resulting in mental and physical deterioration can be avoided, or at least deterred.

Congress, and certainly your Committee, has been extremely supportive of the Administration on Aging and the State Units on Aging. However, the current limitations on Titles III, IV and V funds under the Older American Act could have negative effects on our efforts to prevent regression and deterioration. I certainly would encourage your Committee to take whatever action is necessary and appropriate to obtain more federal funds for the development and operation of "Frontline" programs designed to prevent or deter conditions requiring long-term care.

I thank you.

Senator Moss. I apologize for pressing on so rapidly, but we have deadlines we are trying to meet. We want to hear from Berkeley Bennett. Mr. Bennett is now the executive vice president of the National Council of Health Care Services.

We are most pleased to have you. Mr. Bennett has come from Washington here to appear before us.

We are glad to hear from you, sir.

**STATEMENT OF BERKELEY V. BENNETT, EXECUTIVE VICE
PRESIDENT, NATIONAL COUNCIL OF HEALTH CARE SERVICES,
WASHINGTON, D.C.**

Mr. BENNETT. Thank you, Senator Moss.

My name is Berkeley V. Bennett of Washington, D.C. I am executive vice president of the National Council of Health Care Services. The council is an association of multifacility nursing homes and proprietary hospitals representing the major companies in the industry. Our aims and objectives are to provide better patient care at lower cost and to assure the patient that he will receive the level of care appropriate to his particular needs.

This Special Committee on Aging and the public generally is concerned with the rising cost of health care and the fact that patients and beneficiaries are not receiving the benefits promised under the Medicare program. The multifacility nursing home industry could be the answer to solving these problems.

Everyone is conscious of the fact that there are just so many health dollars to go around. There will never be enough money for all health programs. If confusion and inefficiency within the industry persist, then fewer people will receive benefits. Certainly the Government, the taxpayer, the beneficiary, and the provider of services must be concerned with how much our society is willing to pay and how the health dollars should best be spent.

It seems highly improbable that anyone will be able to force the health care establishment to operate efficiently, but through centralized management, such as used by our members, a number of advantages can be gained through such highly advanced services as: Data processing, group purchasing, pooled insurance, prototype

design, standard construction, controlled staffing, a systems approach to patient care, and standardized procedures.

Let's discuss, first of all, the use of data processing in centralized management. Not all of our members are fully computerized, but those that are not are involved in time-sharing or are presently using some form of manual statistical analysis. Perhaps the most important management function in using data processing is to understand what information is relative and to obtain it in time to take the necessary and indicated action.

One member receives weekly computerized statements on over 50 facilities. Each Monday morning the responsible department heads meet in the central office to compare controllable expenses such as payroll, food, and supplies. When this type of comparison is initiated, it becomes obvious that costs vary from facility to facility. If the payroll analysis or labor productivity is out of line, either high or low, then immediate attention must be paid to this nursing home. Because the health service business is totally a service industry, the cost to deliver a unit of such service is dependent on labor productivity.

I think you will find the following chart rather interesting and revealing.

MINI-STATEMENT		FACILITY A			
WEEK ENDING	PAT. DAYS	EARNED INCOME	PAYROLL & TAXES	FOOD	SUPPLIES
		11,820.90	6,336.13	918.78	476.38
		15.19	8.14	1.18	.61
10-23-69	778	100.0	53.6	7.8	4.0
		11,346.30	6,361.33	264.17	179.26
		14.66	8.22	.34	.23
10-30-69	774	100.0	56.1	2.3	1.6
		12,092.20	6,584.52	741.39	731.57
		15.83	8.61	.97	.96
11-06-69	764	100.0	54.4	6.1	6.0
		11,965.80	6,440.59	339.94	33.85
		15.81	8.51	.45	.04
11-13-69	757	100.0	53.8	2.8	.3
		11,921.00	6,534.24	716.79	169.95
		15.83	8.68	.95	.23
11-20-69	753	100.0	54.8	6.0	1.4
		11,727.50	7,073.72	.00	.00
		15.83	9.54	.00	.00
11-27-69	741	100.0	60.2	.0	.0

In the above chart, numbers in the last four columns refer to: top, Total amount in dollars; middle, Amount per patient; bottom, Percentage of total.

Another member uses a daily "analysis of nursing personnel" to compare the number of actual nursing hours per patient. This immediately reveals whether the patient is receiving the proper nursing care.

Through accurate data, comparisons, and experience, utilizing the instant information available on computers, better care and lower costs can be achieved. Without these, administration is managing in the dark.

In the area of purchasing, we know that similar homes have similar needs and purchasing requirements can be fairly well standardized. Through mass purchasing the lowest price can be obtained. This leverage also makes it possible to buy high quality items at the right price. For instance, in purchasing patient vests the local distributor's list price is \$8.40 each. By buying through centralized purchasing, the price is \$5.85 delivered, or a saving to the patient or third party payer of \$2.10 each. The purchasing departments can also be better informed and up to date on new and improved supplies that will provide the patient with better products more efficiently utilized. It is certainly not unusual that in one town there will be a number of hospitals and nursing homes all buying similar items who should work together to disclose their sources of supply and prices paid, so that they can concentrate their purchases. The savings could be monumental. Simple comparisons of this type on a timely basis would put relevant information in the hands of those that could best help reduce the cost of health care. There are other advantages relating to professional evaluation of products: Time saved in interviewing salesmen, saving in nurse's time, and savings in storage through drop shipments.

One member has effected a consolidation of insurance plans and insurance companies so that yearly premiums have been reduced by 40 percent with more extensive coverage without deductibles.

It is interesting to note that many health care facilities are built on a one-time basis. A community decides it needs a particular institution or an individual or some company decides to enter the nursing home field. An architect is hired who may or may not have a knowledge of health care facilities and probably one who has not done the kind of analysis that is necessary to appropriately design a functional unit. Functional design is extremely important. It has an impact on the operational cost of the facility over its entire lifetime. The initial construction must be analyzed to determine the number of steps the nurse must take, the production layout of the kitchen, the type of construction material which will lessen maintenance, and many other considerations gained through experience. An architect must have a precise understanding of the functions which occur within a health care facility and only through experience and repetitive design work can facilities be conceived which are responsive to the activities which occur within these facilities.

Many nursing home companies today have their own architectural departments or subsidiary offices as well as construction companies that are geared to provide the kind of facility needed for tomorrow's patient. One member of the National Council of Health Care Services estimates a saving in design and construction of between 20 and 25 percent due to these "in-house" departments working at cost and also due to their standardized construction.

Must the nursing home industry go through the fragmentation existent in education where there is no prototype construction, no prototype design, and extremely high costs per pupil?

Once again, experience can make available the kind of facility which the aged and the Government can afford.

In a study reported in the December 1969 issue of *Inquiry*, a Blue Cross Association publication, entitled "Planned Capital Formation in Nursing Homes in New York City" cost figures were analyzed by ownership of nursing homes and by size, as shown by the following chart:

Size in beds	Number of projects	Number of beds added	Average cost per bed
Voluntary:			
Total.....	22	3,728	¹ \$22,797
300 and over.....	6	2,380	24,759
200 to 299.....	3	732	19,350
1 to 199.....	8	616	18,230
Proprietary:			
Total.....	29	5,737	² 9,736
300 and over.....	4	1,430	11,811
200 to 299.....	15	3,265	9,181
1 to 199.....	9	992	8,888

¹ Does not include cost of land.

² Includes cost of land.

Can there be this much difference in the building and the furnishings offered? Can our society support this costly an institution?

Some taxpaying facilities tend to simplistically believe that the application of good business practices and a proper payment mechanism will instantly solve all major problems of the health care industry. Some administrators of nontaxpaying institutions simplistically equate good business practices with a lowering of qualitative standards. Neither of these positions seems tenable.

One multifacility company in a cost-quality analysis has determined that in one facility it may take a nurse 6 minutes to make a bed with an ill patient in it, while in another facility it might take as long as 22 minutes under the same conditions. The high cost facility will equate the cost with a high level of care, whereas this probably is not relevant.

Excellence costs money and so does inefficiency: Today's administrator must learn to recognize the difference.

The same company found that not all of their facilities offered the same service and that they first had to identify precisely what jobs were to be performed and then by observation determine approximately the best way to perform these jobs. With this information in hand they are able to standardize procedures and in so doing make jobs relevant and costs standard. This is modern management. It is extremely doubtful that the Medicare rules, requiring procedural manuals for nursing, dietary, and pharmaceutical services are really being monitored by the inspection agency, yet training and analysis procedures are the backbone of the efficient nursing home. Without procedures and policies the patient will suffer. Only through experienced management can the true benefits of Federal programs be carried out.

Staffing standards and centralized personnel administration go hand in hand if there is regular analysis of time and performance. Through detailed personnel policies, procedural manuals, indoctrination, tested

interview methods, job training, job description, counseling, job review, wage ranges, and professional supervision, patient values can be recognized and handled appropriately. Payroll costs being the largest item in caring for the patient and the item most subject to upward wage pressures emphasizes the importance of quality control and productivity.

Productivity is directly related to skills, training, and motivation. Perhaps uppermost in the goals of the national council and its members is the importance of high standards of care for the convalescing and chronically ill patients. The level of care of the nursing home patient is important and nursing homes are anxious to cooperate with appropriate agencies in more adequately defining this area for the patient. Efficient use of utilization review or peer review would solve many of these problems.

Nursing home companies are anxious to care for a patient for only that length of time in which care is required. This would not only benefit the patient but would be a significant cost-saving factor through proper utilization in the hospital and nursing home. Today the physician leaves the patient in the hospital where he is assured of coverage when he might be better at home or in an ECF, receiving more appropriate care. Standards also go hand in hand with efficiency. Lower cost does not necessarily mean lower quality of patient care. Because multifacility nursing homes are in the competitive market, it means they must offer true value for the services performed.

In order to have efficiency, there must be an incentive plan. An incentive for the patient to choose the appropriate facility for his needs and an incentive for the provider to make available to the patient the best combination of quality and price.

To discourage overutilization or expensive selection, patients should be free to choose the proper type of facility and, within that type, the best combination of quality and cost. If the patient is able to pay a share of the cost of his care, he should. If the patient is unable to pay, then he needs Government help for payment and assistance in selection of the proper facility. Utilization review should be strengthened and made uniform and the number of covered days should be reduced.

To encourage efficiency among providers and simplicity of administration, free enterprise principles should be adopted, with backup governmental controls only where these are essential. The natural laws of supply and demand create the fairest prices by encouraging an abundance of competition among facilities that qualify for Medicare. There is nothing immoral about profit motivating people to provide the best service for the money. Free enterprise controls have developed over a long period. Reliance on them would mean fewer artificial Government controls and would greatly simplify reporting and auditing. The free enterprise system can provide the best combination of quality and cost, encouraging competition for profit among both self-supporting and subsidized facilities. Wherever possible, the customer should decide who offers the best services for the money and the businessman should design and price his own service. Many needs of the Nation have been met by small businesses in the free enterprise system. Extended care can be a classic case in point.

A professionally and financially sound Medicare program cannot be attained by a program that rewards the unscrupulous nor one

that requires excessive regulation. It can be attained by a program that distinguishes profit from profiteering, one that encourages a proper balance of quality and economy. Congress, the administration, the ECF's should work together, using free enterprise principles, to give good care to every beneficiary at the lowest possible cost.

Inherent in better standards would be the need for better communications within companies and within the industry. An exchange of information can be valuable to all. It is difficult to administer a health care facility in a vacuum.

To repeat, one of the primary objectives of our health care facilities is to establish high standards for all levels of patient care and to see that the patient and the Government receive their money's worth.

The multifacility health care industry has some of these answers and we offer the following recommendations:

(1) The administering agencies of governmental programs have arbitrarily issued regulations and instructions and have made retroactive rulings harmful to standards of patient care and have undermined the confidence of the patient and the provider of services. Governmental agencies have been reluctant to issue guidelines in many Medicare areas, but then make decisions after-the-fact. It is recommended that no decisions be made without prior consultation with the providers of service.

(2) The mass of paperwork and red tape that engulfs the patient and the provider must be reduced. Presently all providers must have increased staffs to handle the accounting and paperwork, and yet they are not reimbursed specifically for the additional office load brought about by the Medicare program. It is recommended that a sensible and understandable payment mechanism be instituted that would eliminate cost reporting and audit. Going to a copayment program for all patients would eliminate the disproportionate costs of administration.

(3) Presently the patient has little interest in the level of care or the costliness of care. He will naturally choose the most costly institution or level of care if it costs him nothing but costs the Government more than is necessary. It is recommended that if the patient were to have a stake in the cost of care, then health care institutions would be forced to tailor their levels of care to meet the demands of the patient. Only when the patient pays his share of the cost will there be any incentive to select the appropriate facility.

(4) There is an inadequate amount of communication between the Government and the nursing home, the Government and the fiscal intermediary, and the fiscal intermediary and the nursing home, not to mention a lack of understanding of the Medicare program on the part of the patient. Without good communications there is confusion and unrealized hopes on the part of all concerned. It is recommended that communications among all those involved be stepped-up, and that definitive guidelines be issued. In addition, the Government should, above all, be honest with the beneficiary in informing him of exactly what he is entitled to in the way of care.

Perhaps it is not too late to tell the public the true story and perhaps even to restore Congress' original conception of Medicare and services for the elderly. All of these recommendations, if instituted,

would allow the nursing homes to concentrate on their No. 1 objective, that is, to be concerned with the patient. This should be their target.

Thank you, Senator.

Senator Moss. Thank you very much, Mr. Bennett. That is a fine presentation and you had some excellent recommendations.

You concentrated primarily on this area of efficiency and cutting of costs and also providing incentives through utilizing the free enterprise system.

You say in the end that we should concentrate on the patient. I agree with this goal. But it seems to me a possible danger of centralized management is that we might remove the operator too far away from the people in his home and undercut the sort of personal confidence and relationship that we need.

Mr. BENNETT. We don't believe so. We think that through centralized personnel administration, which would include the administrator as well, you are in a position to train and to attract better people to work for you, who would be more competent in the areas of administration, nursing, or whatever area. So we think that by having a real management approach to this, we can attract better people.

Senator Moss. Certainly we need the efficiency and the cost controls and these factors as you pointed out.

But I think, what is coming through the strongest is the great psychological and social needs of these people. I just want to make sure that these needs are included in our overall study of the problem.

Mr. BENNETT. Yes, indeed, these people can have centralized physical therapy consultants, for instance, or dietary consultants, or occupation therapy, pharmaceutical services which are more professional, you know, than what we have been talking about for years with an administrator being all things to all people. It is getting more difficult.

Senator Moss. Thank you very much. We certainly do appreciate your appearance and your traveling here from Washington to appear.

We have remaining in the very limited time we have a panel composed of Merlin A. Reeder, president-elect of the Utah Nursing Home Association and also the administrator of Highland Manor here in Salt Lake City, and Mr. Lee Dalebout, who is the executive director of the Utah Nursing Home Association.

Will those two gentlemen come forward, please?

We are pleased to have you, gentlemen. You have sat here with us this morning and have heard a great deal of testimony from many people. You are the ones who are right on the fring line and doing the job, and we look forward to hearing from you.

STATEMENT OF MERLIN A. REEDER, PRESIDENT-ELECT, UTAH NURSING HOME ASSOCIATION, ADMINISTRATOR, HIGHLAND MANOR, SALT LAKE CITY; AND LEE W. DALEBOUT, EXECUTIVE DIRECTOR, UTAH NURSING HOME ASSOCIATION

Mr. DALEBOUT. If it is agreeable with you, Mr. Reeder and I will, if the occasion seems to call for it, interrupt each other or supplement one another's statements and this sort of thing.

Senator Moss. That will be all right.

Mr. DALEBOUT. And, if you will, expect us to be rather more conversational rather than formal in its presentation.

No. 1, though we are identified with the Utah Nursing Home Association, it is not only for the association that we speak but we called ECF's together for about a 2½ or 3 hour session and started a tape recorder so that we could arrive at consensus and we wouldn't just be expressing our own point of view or the association's point of view, but a consensus point of view. So what we say is consensus.

Senator MOSS. Thank you.

Mr. DALEBOUT. On the 11th of this month, 2 days ago, an editorial appeared in the Salt Lake Tribune. It was a lead editorial and was entitled "Medicare is Sick". We in our consensus would like to paraphrase that caption and say that, as it is presently constituted in Utah, "Medicare is dead". There is a story told about three horsemen who were riding in the wilderness. They stopped at a stream to give their horses a drink. While I don't exactly believe in voices, anyway voices came from a distance to these three horsemen telling them to bend down to the streambed and fill their pockets with pebbles from the stream. The voice further said, "If you do this, tomorrow you will be both glad and sorry." So they filled their pockets with pebbles from the streambed and rode on. The following morning, lo and behold, they were both glad and sorry because they emptied their pockets of the pebbles and they found that the pebbles were not indeed pebbles but were precious stones. They were glad they had taken as many as they had, but sorry they hadn't taken more.

This is the position in which ECF's in the State of Utah now find themselves. They are glad that in spite of Medicare they have survived thus far and sorry that they ever heard of it. Our consensus was, as we talked, that Medicare in the State of Utah as presently constituted is hopeless, completely and utterly hopeless, hopelessly and irretrievably hopeless; that the only answer for the remaining people in Medicare in the State of Utah, as presently constituted, is to do what a number of facilities have already done, for example, Sunshine Terrace, Sunshine Terrace in Logan, Dunn's in Ogden, Bonner's in Salt Lake, Central Utah in Utah County, and Carbon County Nursing Home have withdrawn from the program.

At the present time on the verge of withdrawal are five other facilities, namely, the Golden Manor of Ogden, the Golden Manor of Salt Lake, the Highland Manor of Salt Lake, the Maytime Manor of Salt Lake, and the Central Utah Extended Care Facility in Provo. This means that if this happens, and I really believe that it is going to happen, they are going to do this, they are going to file their letters of withdrawal, decertification with the State health department, and if this happens, of course, this will leave Utah, in large measure, bereft of ECF's. These last homes that are on the verge of withdrawing now represent about 450 beds.

We have a very simple solution to offer, but it has been our past experience that State, county, Federal, city governments usually are not interested in simple solutions. Our simple solution is this: That nursing homes who are ECF's be asked by the Government once per year to set a daily rate under which they would take care of Medicare patients, that any nursing home which was certified could bid and that the Government take the best bidder and the State health department, which is so excellent in the State of Utah and which has our

complete confidence and with whom we, to the best of our knowledge, completely cooperate and who do such a good job of seeing to it that good patient care is given, with an occasional exception here and there, as for instance, mentioned by Mr. Walch earlier, I am sure that Mr. Walch is happy with me that these isolated incidents are, indeed, isolated incidents. I am sure he and I are both happy about that. So our solution, then, would be to arrange with, let's say, Highland Manor or Golden Manor for a year's arrangement to take care of a patient for x number of dollars. The State Health Department will satisfy to it that we meet the expectations and in this way we could greatly minimize, conceivably even eliminate, the fiscal intermediary and the tremendous costs that are now involved in doing the auditing.

We can eliminate one of the greatest headaches that we have, that is, retroactive denials of service that we have performed. Patients have benefited by services and then we get retroactive denials.

I am just going to make one more statement before I ask Mr. Reeder to interrupt me.

I have a lot of contact with the emotionally disturbed people. Lots of times they tell me, what can we do, our prayers seem not to rise above the ceiling. I would now have you know that in the present situation ECF's are emotionally disturbed people and their prayers do not rise beyond Denver. Denver is very interested in our problems, they are very solicitous, they are very cooperative, but beyond Denver we reach the ivory towers and our prayers do not go beyond Denver and we wish they would.

Senator Moss. Thank you, Lee.

I have an appointment and I am going to leave Mr. Halamandaris here to finish taking testimony because I want it all in the record.

Your statement about Medicare is, of course, very disturbing. In saying that the situation is hopeless, are you talking about Medicare or Medicaid?

Mr. DALEBOUT. We are talking about Medicare and so far we haven't had enough experience with Medicaid, but we presume since the standards are just about the same that this will be equally as hopeless, although we can't just make this flat statement about Medicaid.

Senator Moss. Medicare does, of course, have the more flexible standard of reasonable costs of care. Medicaid has a flat ceiling put on it, although they have some variations here in Utah, which is set by the State, as to the types of care. That is the reason I asked about the distinction.

But you say it is Medicare and that you have a number of withdrawals already from the program and others that are imminent. One of the problems is this retroactive denial which, of course, I agree is a shocking thing. We heard something about that earlier.

The other, I guess, is that in determining what is reasonable reimbursement you just feel that it is unrealistic the way the computation is made.

Mr. DALEBOUT. Oh, yes. One can't expect private industry to invest its money for nothing. The very basic premise here is wrong. One should expect an ECF to be able to make a reasonable return on investment, that is part of the American system. But, of course, as

you know, there is no return on investment and about the only possible thing that an ECF can rely upon now is the depreciation money, but very shortly we expect that this will be blocked as well.

So we asked one of the men at the little conference confab that we had, why are you in it? We hoped it would get better. Why are you staying in it? We are not going to stay in it because we want a return on our investment. The recent increase in bank rates alone would make it far wiser for us to put our money in the bank than it is to put it in ECF.

Senator Moss. I want you to complete your testimony and, of course, we want to hear from Mr. Reeder, too. I apologize that I must leave, but the staff members will stay here. Let us get the full story down as we can for the record. If it is possible for me to return before you leave the stand, I will. It is good to see you again.

Mr. DALEBOUT. It does distress us a little that you can't be here to hear all of our testimony because we saw our testimony as being so very important. You being our own Senator, it does distress us a little that you are leaving.

Senator Moss. I will read every word of it in the record.

Mr. DALEBOUT. We feel it is more effective through direct, person-to-person communication.

Senator Moss. If you want to wait, I have an appointment right at 12:30.

Mr. REEDER. As for my part, I would prefer to wait. I would like to talk to the man that I came to talk to.

Senator Moss. All right. You just stay there and I will be back. We will take a short recess.

(There followed a short recess.)

Senator Moss. We will resume.

Thank you for waiting. I am sorry I had to be out for three-15-minutes, but we will now hear from Mr. Reeder, president-elect of the Utah Nursing Home Association.

Mr. Reeder.

Mr. REEDER. Thank you.

We sit here today representing the association, trying not to represent our own personal opinion, but rather to reflect to you the feeling of ECF operators in the State of Utah. However, I have to say that their feeling is a reflection of my personal feeling as I have worked in the Medicare program. We do not say that the concept of Medicare is hopeless. I wouldn't want you to read that from Mr. Dalebout's remarks. But the direction it is headed now and the way it is working it is hopeless. I say that as an administrator from an economic point of view.

It was 3 years ago when nursing homes and hospitals and doctors were wedded to the Federal Government. Some people have labeled it a shotgun marriage. At any rate, we are married under the Medicare program.

The Medicare program has many things that can bring real good to the elderly people. What I want to talk about at this point is not the patient and patient care. Let me just make a statement that what has been said in testimony this morning regarding patient care and what our concern should be, we subscribe to wholeheartedly, so we don't

mean to lose sight of the patient, but I am going to emphasize the economic point of view in my testimony because it is a point of view that hasn't been really zeroed in on today.

The reason it hasn't been zeroed in on today is because, outside of myself and Mr. Bennett, no one else is on the economic firing line in this program. Administrators are there. Our complaint and our problem does not lie with the standards themselves. We subscribe to a high standard of patient care. This is necessary because it is moral. Our problem is, in rendering this level of service and meeting these standards, who pays the bill? The present reimbursement formula does not provide incentives for efficiency and productivity.

We heard Mr. Bennett discuss here what can be done with good management and good centralized personnel work and management training and all of this, and this is wonderful. But it has to be paid for, you can save money and perform this service at less cost but you are not rewarded for it, which simply means that, to some degree, inefficiency is being rewarded because one nursing home down the street, if they have poor management but can successfully identify costs in terms of this management, they will be paid for it, whereas if Joe Doe up the street runs an efficient and effective operation and his cost is a dollar a day less, that is all he is going to get.

One standard at this point that is chafing nursing home administrators is the social worker requirement that is being imposed. It has always been there, but it is raising its head at this point. The health agency is being asked to enforce the social worker concept. We are not against social work, but here is another service that we are expected to perform and yet neither the law nor the regulations nor the reimbursement formula defines how you will recover the cost of this worker, if you will recover it at all.

A statement could be made, sure, it will be recovered through your regular formula, but if you have five patients in nursing homes out of 50 potential patients, that is five-fiftieths, and that pays five-fiftieths of that social worker's cost. Yet you can't get a social worker to work for five-fiftieths of a salary so you pay him the full salary. Where does the rest of the money come from is our question. Problems like this, we feel, would be solved if we went on a contract basis.

Here the nursing home is going to provide a full service and the health department would certify through inspections that this full service was, in fact, being administered to the patient and then would pay on a contract basis for it.

The role of this social worker has not clearly been defined for us, so that we as administrators can sit down and say, all right, I have a social worker, now what shall I have him do. Maybe Utah is unique in this respect, I don't know, but at least here in Utah social services are not as lacking as one might at first think they are. Through the closeknit family network and the close church relationships, we as administrators find that social needs of patients are being met. Bishops are doing a big job here in filling the gap. Families come in and take care of the problem.

You do find some instances where a patient doesn't have a family and then you have to fill the gap. The welfare social workers take a tremendous load off our shoulders in dealing with social problems.

As we observe these activities going on all the time and see the social needs taken care of quite adequately in most cases, the question comes to our mind, what shall I have this new person do that I bring into my home, how shall I cut the bishop out or the family out and have this social worker now perform this service?

We are not saying that social work is not important, but it needs to be related to a need rather than just be a standard requirement that is there for everybody on an ongoing basis.

I think it should take on more the complexion of the physical therapy, where in the estimation of the administrator and the nurse and working with the doctor, et cetera, you determine that there is a social problem here, then these services are brought in and are performed on behalf of that patient.

I don't want to spend too much time there. Let's move on to the reimbursement formula itself.

I think if there is any one thing that accounts for nursing homes pulling out of the program it is the reimbursement formula itself. It is an economic problem. We just cannot take in less money than we spend and survive, nor can we continue to take in the same amount of money that we spend and survive, because this type of program does not allow perpetuation of your business, there is no room for expansion, there is no room for additional programs or anything like this. When you render a service there has to be something left over so that you can render the service again tomorrow on an even better level than you rendered it today. This takes money, planning, development, new facilities, purchase of new equipment as it comes out, et cetera.

There is a fear on the part of the administrator in terms of pay back. If I haven't billed this out just right, I have this big monster hanging over my back that I may have to pay back X thousands of dollars. The audit program under the present reimbursement program is quite inefficient. The Federal Government is spending literally thousands of dollars to recover pennies in many instances.

I believe that there should be some sort of check made to insure that profiteering is not being done, but, on the other hand, on our recommendation where you would go on a contract basis, fair competition itself would level this out. It does it in all other phases of business. The free enterprise system can save the Medicare program. We could eliminate these costly audits. We have enough history behind us now in these past 3 years that the Federal Government should be able to know when they are paying too much for a particular type of service. A good judgment could be made as to whether \$20 a day is the rate we should pay in this area or whether it should be closer to \$15 per day in this particular area.

As Dr. Walter mentioned, there are regions throughout the United States and these regions have problems peculiar to the region. So we could effect, I believe, a great deal of savings there.

This would not totally eliminate the fiscal intermediary. I still see a need for claims evaluation, I see a need for spot checks in the nursing home to be sure that the patient is there on proper doctor certification and this type of thing, so there needs to be this type of check going on.

Another thing that is difficult and many times impossible under this present formula is the problem of cost identification. What I label as a cost the auditor does not think is a cost related to the care of the patient. I give you just one for instance and others could be related.

I will refer to my own home. We provide the laundry services for all of our patients included in the rates. This is quite a typical arrangement in nursing homes in Utah, to provide this laundry service. Medicare's reimbursement formula says we will pay for linens, wash cloths, towels, pillow cases, sheets, and patient gowns, all of these things that are owned by the facility we will pay for the laundry of those; but we will not pay for the laundering of the personal clothes of the patient.

I have heard a lot of talk today about rehabilitation, getting the patient up, getting him out, and getting him home. We all know we don't send a patient home in a nightgown. We send him home in street clothes. The sooner we can get him back into those street clothes and up and around, we give him a sense of worth, we return him to his former status. It is all too true that clothes make the man. When you are in a nightgown, you are going to act sick. You get them up and around in clothes, it makes good sense. It just seems inconsistent with commonsense that we would not be paid for washing the trousers and the shirt of a patient that we are rehabilitating.

The distinct part concept has been referred to today and I want to say just a little bit about it. That is a big problem in the reimbursement structure. It is an impossible situation the way it works at the present time. When the distinct part concept is audited or reviewed, the auditors are subjected to regulations that make us all become more concerned with brick and mortar and where the patient is located.

Virtually no attention is paid to the care that the patient received. In other words, if you have a patient outside of the distinct part, it doesn't make any difference what type of care you are giving him, if he does not happen to be in this bed located in this room, Medicare cannot pay for that service. This is not consistent with good care. Patient placement in nursing homes cannot be reduced to this type of situation. There is a compatibility problem between patients for one reason or another and you may not be able to put that patient in that particular bed at that particular time; you may have to put him in another bed.

The basis for reimbursement, we feel, should be based on the answer to four questions and not worried automatically about a distinct part.

The first question should be, Did the patient qualify as a potential recipient for Medicare? In other words, was he 65, was he enrolled in the program?

The second question, Has his doctor prescribed the level of care that Medicare would pay for?

The third one, Was he placed in a certified facility capable of giving this level of care?

The fourth question, Did he receive the care?

If the answer to those four questions is "Yes", the nursing home should be paid. This reimbursement program simply forces us all to live on our depreciation and, as we have referred to before, you can't continue this way.

For a nursing home to survive under the present reimbursement program, I think his chances of survival are about equal to the starving man who slices his own wrist and sucks his own blood and tells himself the famine is over.

Where do we go from here? I come back to our recommendation, some sort of a program, a contract basis or whatever, that would reward efficiencies and would reward productivity on the part of the nursing home.

It has been 3 years now since this marriage took place. I would like to state for the record that the honeymoon is over. If nursing homes and Medicare are going to continue to live together, things are going to have to be different from now on. For 3 years the nursing homes have been an unwilling and somewhat disenchanted bride in this arrangement. We have participated in a program that is full of conditions and inequities that have actually subordinated us to second-class economic status.

Simply what I am saying is that our cup is full, we demand consideration, we demand a change in the basic philosophy of our spouse. If we can't effect this, then self-preservation dictates that we must seek separation and divorce.

Thank you.

Senator MOSS. Thank you. That was very colorfully put.

Mr. DALEBOUT. May I just add in connection with what Mr. Reeder said, that is, that getting to the here and now, today, the 13th of February, there are patients in our local hospitals who ought to be in ECF's, they are not. Why are they not? Some ECF's are sitting there with empty beds and paying expensive staff for distinct part and there is no reward for it, instead they are in the hospitals today where it is costing Uncle Sam two or three times as much as it would in a nursing home that can take care of them equally well or in some instances even better.

I had one other short comment to make, that is, that we have been told because physicians generally seem not to know very much about Medicare that we should educate the physicians. Can you see that, nursing home administrators educating physicians?

One more point on these negative rewards. It is true that this philosophy does underlie the existence of patients in nursing homes if they are welfare patients, the philosophy does underlie it, but I think the generalizations are far too broad and far too inaccurate because there are too many nursing homes in which the people who operate them are dedicated people who are eager to get people up on their feet and who say to the caseworkers who come in, we don't need this person in category 3 or 4 any more, this person can go into category 2 because we have him on his feet.

I think it is only fair to mention this, that it is very easy to make generalizations, but, even though the philosophy lends itself to this, this isn't generally true in most of the good nursing homes in the State of Utah.

Senator Moss. I have to agree with that. I think it is obvious that most of the nursing homes are operated by those who are motivated by real concern for the people to whom they extend the care. I think what the other witnesses were trying to say is that there ought to be some way so this underlying philosophy doesn't raise any doubt about what their motivation is.

I certainly agree with you that this problem of having people remaining in the hospital well beyond the time they ought to be in an acute care facility is unfortunate. That is the reason this committee is on the road. We have been aware of that. The problem is not only here

in Utah, it is all over the United States. Something has to be done about the administration. What your testimony has been telling us is exactly the kind of thing we have been trying to gather for the record, because of our great concern with the fact that Medicare and Medicaid are not working to their optimum potential.

I was glad when Mr. Reeder said that the concept of Medicare is good and it is just the present operation that is defective. I would agree that we ought to find some way that is as simplified in procedure and that would enable the nursing home operator to give skilled, maximum-degree care, the type that the patient needs, and to be reimbursed for it at a position where, the operator can have some income margin above the exact cost. As long as the profit margin is kept at a reasonable level that is where it ought to be and perhaps the free enterprise system is the best way of arriving at this.

On your suggestion that we ought to go to a bid system and let operators submit bids for a year at the amount for which patients could be cared for in the respective nursing homes, suppose the proprietary nursing homes all submitted their bid, as it were, would the Federal Government then choose the lowest one and the others have to conform, because all of the Medicare patients couldn't go into one home? Wouldn't this militate against the nursing home who didn't feel they could take people at the lowest bid? Where do we come out on that?

Mr. REEDER. I don't think that you would take the lowest bidder and ask all homes to subscribe to that bid rate, but the Veterans' hospital has been working on a bid basis with nursing homes for a number of years and rather successfully. They sit right down with you and they go over the level of care that they are going to require and it is negotiated, it is a negotiated bid, where I support my case and they support their case.

Senator MOSS. I see.

Mr. REEDER. You could take the bids from a general area, say, the Salt Lake County area, and you could strike a reasonable average that could tell you if a person here is going to honor the bids or not honor the bids, that would be a guide for you as to whether a nursing home is bidding too high or too low. Some nursing homes have different cost factors entirely, different overhead problems, and a lot of these things that affect their cost. They have to be reimbursed for this, you know. If you build a home today, you are paying 8 percent interest. Our home right now is paying $5\frac{1}{4}$ percent interest. These factors are going to affect the overhead, so you couldn't ask a home that is being built today to operate on my bid, I could underbid him every time. But you can take a look at his cost statements and find out where he is on an operation basis and find out whether his bid is realistic or not.

Senator MOSS. I am glad to have that clarification. This would be more of a negotiated bid proposition rather than sealed bids and traditional things we think of when people are bidding.

Mr. REEDER. I think it would have to be to be fair.

Mr. DALEBOUT. Make it refined and sophisticated and appropriate to the purpose, but at least this way any ECF that took care of patients for a period of time would feel they were doing it because they chose to do it and we wouldn't have to choose it if they didn't want to choose to do it.

Senator Moss. If the Salt Lake County area, after they negotiated with a number of these homes, came to the idea that there was a certain figure that would be their maximum, they would have to take into account how many of the nursing homes are willing to take it at that figure, wouldn't they, so they would have enough room for the people who need the care?

Mr. REEDER. That's correct.

Senator Moss. That makes sense. Of course, the things that you pointed out about this post eligibility, and so on, are so shocking and have caused so much trouble that, as I say, they are one reason we have been out having these oversight hearings. We are trying to find out what the real problems are in the administration as it is being carried on now by HEW. To have a patient taken into the nursing home and then after having been there for a period of time to be told he doesn't qualify and there can't be reimbursement is shattering to him and to the home as well because they are both out.

Mr. REEDER. I would like to make one comment just in case I would be misunderstood, when I said this auditing program is costing you money, I meant that, but I mean that the requirement for even having an auditing program is what is costing money. The people who are conducting the audit, I think, are doing probably as efficient a job as a group of auditors could do. At least that is our experience here in Utah. I don't see people sitting on their hands while they are doing the audit, that isn't the problem. Our problem is not with the personnel in the program, as Mr. Dalebout has brought out, the regional people from Denver, people like those here in the Blue Cross program, even local social security people are most cooperative, we see eye to eye. The problem is we all see the problem in just about the same light. We come to loggerheads with good business sense.

Senator Moss. Don't you, in operating the business of your home, have to have your own internal audit, as it were, for tax purposes and otherwise? You certainly have auditors.

Mr. REEDER. Yes, we have to for income tax purposes and one thing and another, but if you take the cost reporting forms and so forth that we have to go through for Medicare and compare it, say, to an Internal Revenue report, the Medicare report makes the Internal Revenue report look like an elementary exercise in third grade arithmetic. [Laughter.]

Senator Moss. You have really frightened me now. I can't get through my income tax forms.

Obviously, there is a mountain of redtape around this audit situation and we have been aware of that. I don't know why we have to get buried in so much redtape. As you point out, probably even if they would discover an unscrupulous operator someplace or other, they have spent more in the effort of going through all of the rest of the audits than can be gained in the discovery of the one unscrupulous operator.

I am glad to have the testimony of you men who are on the firing line. As you say, you are the ones who have to live with the system and it isn't working well at all. That means that we have simply to either insist on change of regulations within the Department of Health, Education and Welfare or perhaps resort to legislation may be required.

Do you have any further matters?

Mr. DALEBOUT. One more brief statement. I was mentioning to Val a minute ago that without any disrespect for your subcommittee, but rather with disrespect for the system, I might say that we don't really expect anything to come of this hearing today.

Senator Moss. You are a full cynic, Lee, a full cynic.

Mr. DALEBOUT. We have come to feel this is sort of like a banana peel, fruitless, you know.

Senator Moss. I am sorry you are so disillusioned. I must confess that the congressional legislative process does not move swiftly, it takes time. This is a subcommittee that has to work up through a full committee to make a recommendation. I certainly can't promise you things are going to change tomorrow or in 30 days or 90 days. There is no way of saying. The system under which we operate requires that we take these steps in order to bring it to the attention of the 505 Members of the Congress if it is going to require congressional action. We might be able to get some action sooner by calling before us the Secretary of HEW and some of the staff people there and by persuasion and perhaps by some threat of legislation in the future we might be able to get a quicker result within the degree that he can make changes as permitted by the legislation under which he operates.

I would have to agree with you, there isn't going to be any change tomorrow, but I would disagree with you that this does not constitute a significant step in moving toward correcting the problem we are talking about.

Mr. REEDER. Could I make one last observation. As we have worked in this program and have talked to the various administrators of the program from Baltimore down through Denver and even on our local level, it has become apparent to us on more than one occasion that the intent of Congress in the passing of the Medicare bill itself is not being preserved in the interpretation and the regulations that come out of HEW. I see this as probably the key to many of our problems. If you gentlemen on Capitol Hill can somehow send a message to HEW as to what your intent is and what you meant when you passed such and such a regulation, and be sure that they don't get their own private interpretation put on it, I think we would fare a lot better on this end of the game. This private interpretation and handing out of regulations and change of policy is killing us.

I had an opportunity to spend 2 hours in the Blue Cross office in Denver, Colo. 2 weeks ago, and I talked with the gentleman in charge of public relations. His job is simply that of troubleshooting nursing home problems. He told me that he really doesn't know where he is going in the Medicare program because he has in his file over 500 different directives which are changes in interpretation of regulations.

Senator Moss. You have stated it well and this is one of the frustrations there is in the legislative committees and in the Senate as a whole, that we feel that in this program and in some others the legislative intent has been thwarted in many regards and we have had some very pointed hearings with personnel of HEW on this. Sometimes we have been able to get corrections right away and at other times it has been more lengthy, but it is true that in setting up statutes such as this, it has to be handed to a department to administer and the department itself promulgates regulations for internal purposes and

this is where the redtape begins to build up especially when they build up so many checks and counterchecks. With all of this, we sometimes do get buried in paper and Medicare seems to be one of the places where that has happened.

We appreciate your coming and talking very frankly and candidly with us about the problem.

We thank the others who have appeared. I think we have had a very good hearing. We have on the record a lot of information we needed. Obviously there is a great interest in this because most of you have stayed through now for about 4½ hours as we have sat here talking about this matter.

I appreciate your interest and your attention to this. Let me assure you that we have the deepest concern and we are trying to find some way to rectify the problems that have developed around this care for the elderly. In judging the trends of long-term care, we want to see a trend of change here.

We are now adjourned.

(Whereupon, at 1:30 p.m., the hearing was adjourned.)

