NURSING HOMES AND RELATED LONG-TERM CARE SERVICES

HEARINGS

BEFORE THE

JOINT SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-EIGHTH CONGRESS

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NOTE.—Three hearings on nursing homes were held as follows:
Part 1—Washington, D.C., May 5, 1964.
Part 2—Washington, D.C., May 6, 1964.
Part 3—Washington, D.C., May 7, 1964.

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

STATEMENTS

NURSING HOMES AND RELATED LONG-TERM CARE SERVICES

THURSDAY, MAY 7, 1964

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

The subcommittee met, pursuant to recess, at 10:25 a.m., in room 4232, New Senate Office Building, Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss and Fong.

Also present: Frank C. Frantz and Jay B. Constantine, professional staff members; John Guy Miller, minority staff director, and Gerald P. Nye, professional staff member (minority).

Senator Moss. The committee will come to order.

We will proceed now with the hearing.

Our first witness will be Mr. J. L. Roney, the director of the American Public Welfare Association's Project on Aging.

We are very glad to have you, Mr. Roney, and look forward to your testimony.

Mr. RONEY. Thank you, Senator.

Senator Moss. Would you like to have your entire statement placed in the record and speak then emphasizing it or would you care to read it in full? You may proceed any way you like.

Mr. RONEY. I believe I would like to read it, Senator.

Senator Moss. All right, go right ahead.

STATEMENT OF JAY L. RONEY, DIRECTOR, AMERICAN PUBLIC WELFARE ASSOCIATION'S PROJECT ON AGING

Mr. RONEY. I am very pleased to appear before your committee, Mr. Chairman. As director of the American Public Welfare Association's Project on Aging, I am representing that organization here today.

Prior to accepting the directorship of this project, I was Director of the Bureau of Public Assistance (now known as the Bureau of Family Services) of the U.S. Department of Health, Education, and Welfare from 1954 to 1959. I have been engaged over the years in social welfare programs in various capacities—as caseworker, case supervisor, field representative, and State director of public welfare. The subject of your hearings is of special interest to me and to the organization I represent.

The American Public Welfare Association is the national voluntary organization of State and local public welfare departments and of individuals engaged in public welfare at all levels of government. Its membership includes Federal, State, and local welfare administrators, welfare workers, and board members from every jurisdiction. Since its organization in 1930, it has always been concerned with assisting public welfare agencies to administer effectively the programs for which they have responsibility and to develop programs which are needed to improve the welfare of all citizens and the Nation.

The Public Welfare Project on Aging was inaugurated in August 1959, through a 4-year grant provided by the Ford Foundation to enable the association—

to help State and local public welfare agencies to establish and operate or expand and improve programs to meet the social, economic, and health needs of aging people.

This Project, through a series of meetings, conferences, institutes, and committees, has made it possible for us to become more aware of the needs of the aging and the variety of services they require, as well as to encourage State and local departments of welfare to expand and improve services. Prior to the termination of this Project early in 1964, the Ford Foundation provided an additional 6-year grant directed to the training of administrative, supervisory, and direct service personnel in the area of aging.

Our close and continuous working relationships with public welfare personnel have made us cognizant of the nursing home situation and its attendant problems. State and local public welfare agencies clearly recognize the importance of the nursing home, particularly as the aged segment in our population increases in numbers and longevity. Recent testimony before your committee indicated that, in 1962, there was an expenditure of over $919 million for medical care by public welfare agencies, of which approximately 34 percent, or $275 million, was spent for nursing home care. Moreover, public assistance recipients were utilizing about 60 percent of the nursing home beds at that time.

Because of our awareness of the total medical problems in relationship to the aged, one in a series of seminars conducted by our Project on Aging was directed to the subject of "Medical Care for the Aging—Public Welfare's Administrative Role." This seminar, held in October 1962, included, as participants, selected personnel carrying administrative responsibilities for the provision of medical care of the aging through State and local public welfare departments. About 30 States were represented. Many problem areas were noted and discussed. Some of these, I am sure, are familiar to you, but I should like to focus primarily on those relating to nursing home care. I have left some copies of this publication for your use, if you are interested.

Senator Moss. Very good. That will be part of our files.

Mr. RONEY. Observations made by this seminar group have pertinence to the subject of nursing home care and related problems:

1. An extensive variety of facilities is grouped under the label "nursing homes." Some of these are high-powered medical care facilities; others are primarily personal care resources. There is an extensive number of small independent facilities. Changes in ownership or management frequently complicate relationships with public welfare

departments, while extensive turnover among staff undermines the effort to sustain high-quality care.

2. There was agreement in this session that in all States standards for licensure are minimal, although several States have raised these in the past few years. Welfare departments, this group felt, both could and should require higher standards for homes approved for placement of welfare recipients.

Clarification and establishment of standards, however, require an attempt to classify nursing homes by actual inspection of each home. Such inspection would include facilities and equipment, the qualifications and number of staff, the availability of medical and nursing records, planned menus and observation of actual services rendered. Also included in such an assessment would be an evaluation of the homelike qualities and the efforts made by staff to meet the psychological and social needs of patients. Such classification would also help determine the rate of pay for each home, based on the maximum potential for service represented by such factors as its facilities, equipment, staff, and so forth.

3. As a parallel to classification of homes, there is need to determine the initial and continuing evaluation of the needs of each patient to assure that the home selected best meets his particular requirements. Such evaluation is also important in order to determine whether other available and more suitable alternatives exist before a nursing home placement is made.

4. Public welfare departments which have had experience with either or both of these classification procedures report that a continuing reassessment of both homes and patients is required because of changes which can occur.

Public welfare departments face a number of problems in respect to meeting those recommendations. The large number of small independent facilities frequently change in ownership, turnover, and shortage of personnel, which may result in rapid deterioration in the quality of care provided in any given home. On the other hand, such changes can result in marked improvement.

Many nursing homes lack cost accounting systems or minimum financial records, although some State welfare departments require these. Records of patients are sometimes sparse. Initial study of the elderly patient and periodic review of his condition are highly essential because of rapid physical and mental changes that can occur. To be aware of the patient's changing needs, both medical and social evaluation must be provided. I am not as aware of the availability of medical services as I am of social casework services. To my knowledge, there is a shortage of casework personnel.

The participants of this seminar discussed progress which had been made by public welfare departments in helping raise standards of nursing homes. Various devices have been used, such as joint licensure of nursing homes, consultation provided by State and local health departments, use of registered or public health nurses to evaluate and classify homes, or a joint evaluation by a physician and a medical social worker. In some States, efforts of health departments and other voluntary and public agencies have been coordinated to provide training programs for nursing home staffs.

Some welfare departments, themselves, operate or have responsibility for long-term medical care facilities, but relatively few have become model nursing homes. Model facilities, if developed, can have certain values. They can demonstrate the feasibility of providing quality medical care toward rehabilitation goals; they can provide measures of cost that can be used to evaluate nonprofit and commercial facilities; they can offer opportunities for experimentation in the provisions of services which have not yet been tested.

Every State must balance strong competing claims for the limited welfare dollars among such objects of expenditure as income maintenance, medical care, and special services. As a result of pressures brought by organizations of nursing home operators, some States have assigned too large a share of their available funds for nursing home care. In contrast the ill aged are not organized and cannot bring the same kind of pressures to promote their own best interests. Many older persons might still be living in their own homes if enough money had gone into their assistance grants to prevent malnourishment and to provide adequate medical care, and if essential community services had been adequately financed.

Nevertheless, even with recognition that efforts are being directed in some States and communities toward the improvement of nursing homes, the reality factor of the low payments made for nursing home care by a number of States serves as a deterrent in the improvement of standards, staff, and facilities.

In reviewing the situation today, I should like to make the following comments from the viewpoint of public welfare:

1. The quantity and quality of facilities to provide for out-of-home care, both for short- and long-term periods, should be expanded and improved.

2. Licensing standards should provide for increased adequacy, greater uniformity, and should reflect the varying classifications of nursing services.

The various activities of the Federal representatives, recently described to you by previous witnesses, will help considerably in this area. These include: (*a*) the development of a suggested model State code for the licensing of nursing homes; (*b*) a study of the entire continuum of care for older people directed to clarifying the different types of care needed at differing times; and (*c*) a study of the costs of various levels or types of nursing home care provided in different areas of the country.

3. One of the basic public welfare needs is that of increased appropriations, especially from States and counties, to meet the costs of total needs. Recognition must be given as to potentials in each State. However, such an increase must be directed not to nursing homes alone but to the adequacy of grants to permit an individual to live in his own home as long as possible and to provide adequate medical care whenever needed.

I should like to refer to one aspect of financing. The American Public Welfare Association has, for several years, strongly supported the financing of some health costs through the social insurance mechanism, such as is provided in the King-Anderson bill. Enactment of such a measure would relieve public welfare of some of the medical care costs they are now meeting. Hopefully, this would enable the

States to divert some of their current expenditures to provide more adequate income maintenance and improve medical care, which would include the increased quality of nursing home care.

The 1962 Public Welfare Amendments have been instrumental and offer great potential by providing increased Federal participation to improve services to the aging. We believe that, with continued and increased implementation of these amendments, even further gains will result.

4. Adequate financing should also be related to the reduction of caseloads for public welfare caseworkers. Such a reduction indicates funds for increased staff. I believe this device could have a profound effect on helping to raise nursing home standards. Since public welfare pays for 60 percent of the nursing home patients, the close observation afforded by frequent and longer visits to these homes would serve as a strong potential, in addition to licensing, to improve the quality of care and, thus, to raise standards. Public welfare staff must be given adequate time to evaluate each home and the quality of care provided currently, rather than base its judgment on a visit made 6 months previously. It must also help evaluate each patient's needs continuously to determine appropriateness of care afforded and to keep the physician informed of developments. Observation reflecting continued inadequate care would result in removal of patients. This cannot be accomplished with current caseloads, which sometimes exceed 250 cases per caseworker.

If frequent visiting were possible by local public welfare staffs, we believe it would not be a very long time before many inadequate nursing homes would raise their standards or cease to exist. Moreover, better utilization of nursing homes would be possible. Many patients now in homes could utilize other living arrangements. Some could return to their own homes, with the help of homemakers and home care programs; some might need foster home care or boarding home care; others might need hospital care. By the same token, many older persons now in their own homes, by virtue of more frequent visits and a better understanding of their situation, might require nursing home care.

The training provisions of the 1962 Public Welfare Amendments have helped make it possible for a number of caseworkers to secure professional training, thus improving their capabilities in providing counseling and other social services. Increased training will serve as another strengthening device.

5. And finally, and certainly not on an all-inclusive approach, I should like to call attention to the need for coordination of health and welfare services on the community level. Currently, many nursing homes, even of low quality, are being utilized because other alternative services have not been developed to meet specific and varying needs of elderly people. Such services include programs of homemakers, organized home care, day care centers, and counseling. We, in public welfare, are fully aware of the importance of the physician, the nurse, the occupational, recreational, and physical therapist, and their tremendous influence on the quality of care provided in the community, including the nursing home. Their efforts, together with those of us in public welfare, jointly focused and directed toward the improvement of care of aging persons, will, I believe, have a beneficial effect.

33-257—64—pt. 3——2

I thank you, Senator, for the opportunity of appearing before you.

Senator Moss. We stand in recess for 10 minutes and then we will question you, sir.

(Recess.)

Senator Moss. The hearing will resume.

I apologize to you, Mr. Roney, for running out, but that is the way things go these days. It had to be done.

I appreciate your statement. It was a very fine statement.

There are two or three questions I would like to ask you.

You pointed out that there were a number of still unlicensed nursing homes.

Do you have any information on the number of welfare patients that are in unlicensed nursing homes?

Mr. RONEY. No.

Senator Moss. Do you have a rough estimate?

Mr. RONEY. I do not believe I could even make a guess, Senator. It would be dangerous for me to even try—the fact that there are any or some, I guess, is the major concern.

This could well be information that should be secured, I would imagine. I do not know that it exists in any one place.

Senator Moss. You do not know whether that has been collected anyplace?

Mr. RONEY. Not to my knowledge at least.

Senator Moss. A number of our States have licensing, I guess they all have licensing now, but a great many of them have grandfather-clause licensing.

Do you have any estimate on that? How many would fall in this grandfather-clause licensing situation?

Mr. RONEY. No; I do not.

Senator Moss. We will try to get it. I thought you might possibly have that information.

You pointed out that your seminar felt and recommended that welfare departments could and should require higher standards for welfare recipients, and yet yesterday we heard that if standards in most areas were raised, or were rigidly enforced, there would be no accommodations for many patients.

Now, what do you suggest in this dilemma?

Mr. RONEY. Well, hopefully, that welfare departments could secure enough financing so that they could pay more adequately and thus demand better facilities.

Along with this additional financing, I would refer to the part of my testimony of additional social workers as well, so that they can have more current knowledge of the needs of a patient in terms of which nursing homes are available. They would have more knowledge of the quality of the various nursing homes since they do vary considerably.

I mean it is not only a matter of payment, but it is a matter of knowing enough about the patient and his needs and the nursing home facilities that are available, which takes staff—more staff than most welfare departments have.

Senator Moss. You mentioned in your testimony that some welfare departments are doing this continuing evaluation of the individual patient needs. Can you tell me what States are involved in doing this?

Mr. RONEY. No, I cannot, Senator.

In this meeting as it was written up, the States who spoke were not identified as the various proposals were made, and it varies considerably. I do not know that any State is doing it in the *n*th degree—and I hesitate to start mentioning any States——

Senator MOSS. You might leave some out?

Mr. RONEY. That is right, so I would rather not point out any.

This suggests the possibility that this committee is considering having hearings over the country in some States. I would think this would be a very excellent idea for getting some of this kind of information.

Senator MOSS. Would this individual evaluation be done by a caseworker or by specialized inspection staff?

Mr. RONEY. Well, it can be done either way, but it would not be a caseworker alone; it would be in conjunction with a person who has medical knowledge as well, usually a nurse rather than a physician, but a physician's consulting services would also be utilized.

In other words, the combination of the health and the social skills.

Senator MOSS. Apropos your suggestion that we hopefully would have more welfare money, I should point out that many of the States have difficulty in financing their share of the cost of welfare payments. In my State of Utah, for example, the Kerr-Mills program originally had very liberal benefits, but in November of 1963, the Department of Public Welfare out there was obliged to reduce these benefits because it was overspending its appropriation. This poses a continuing problem as we deal with the individual States.

Of course, I know the answer but it is a question of how you get there.

Mr. RONEY. That is right. And many States face this same problem and this eventually affects the nursing home situation, too. The amount they can pay, affects quality, and so forth.

Senator MOSS. Would the problem be improved considerably if we had the King-Anderson bill on some hospitalization for these older people which in turn would relieve the States of some of their matching burdens?

Mr. RONEY. We believe it would. I would assume that the States, under the present arrangement would retain the amount of money they are now spending. If they were relieved of some of the present financial costs of hospitalization, they could then provide more adequately for the other aspects of health care as well as maintenance, which is equally important, whether in a nursing home or elsewhere.

Senator MOSS. I understand, welfare payments would extend, of course, to people in their own homes as well as in long-term care hospitals.

The fact that the King-Anderson bill would provide for these home health visits would tend to reduce the number that would be required to go into nursing homes, too; is that not so?

Mr. RONEY. Hopefully, yes.

Senator MOSS. My staff indicates there is an estimate that has been made that at least $200 million in assistance medical payments would be offset by the King-Anderson program, so under your theory that much more would be released that could be made available in this welfare area?

Mr. RONEY. If the appropriation is continued.

Senator MOSS. Thank you very much, Mr. Roney. We do appreciate your testimony. It has been very helpful. We are glad to have you here today.

Mr. RONEY. Thank you, Senator.

Senator MOSS. Mr. Francis Stover, who is the national legislative director of the Veterans of Foreign Wars, will be our next witness.

We are very glad to have you, Mr. Stover.

STATEMENT OF FRANCIS W. STOVER, NATIONAL LEGISLATIVE DIRECTOR, VETERANS OF FOREIGN WARS; ACCOMPANIED BY JOHN D. FAGAN, ASSISTANT DIRECTOR, VETERANS OF FOREIGN WARS

Mr. STOVER. Mr. Chairman, I am accompanied on my right by John D. Fagan, assistant director of the National Legislative Service of the Veterans of Foreign Wars.

Mr. Chairman, and members of the subcommittee, thank you for the courtesy and privilege to appear before this subcommittee to present the views of the Veterans of Foreign Wars of the United States with respect to the problem of long-term care of our aging veteran population. My name is Francis W. Stover and I am the Veterans of Foreign Wars national legislative director.

So far as the Veterans of Foreign Wars is concerned our remarks are addressed only to the care of veterans. By veterans it is meant those citizens who served during wartime and who may be entitled to medical care by or under the control of the Veterans' Administration.

Generally speaking, there are two kinds of medical care for veterans of any age, which have been made available by a grateful Congress in recognition of the service rendered this Nation during wartime. First and foremost is the care extended to veterans whose disabilities are service-connected; that is, caused by active duty in the Armed Forces during wartime. Presently, for example, there are approximately 2 million veterans receiving disability compensation payments, for service-incurred disabilities. There are quite a few more who have service-connected conditions which are quiescent or are not disabling enough to warrant at least a 10-percent disability compensation payment. These service-connected veterans, Mr. Chairman, are the ones who have priority admission to all veterans' hospitals, and the veterans' hospitals and medical care program is designed primarily to take care of these service-connected veterans. Not only are they provided outpatient disability treatment, but they are given priority admission to one of the VA hospitals when needed. The average daily patient load of the Veterans' Administration is approximately 112,000 a day out of a maximum of 125,000 beds that have been authorized by the President to be in operation for the care and treatment of war veterans

Veterans without service-connected disabilities may be admitted to any one of these Veterans' Administration hospitals provided there is a bed available or vacant, and the veteran is in need of hospital care and states that he is unable to defray the cost of the special treatment. I am now speaking of non-service-connected conditions, for conditions occurring after active war service. In furtherance of his statement that he cannot pay for this treatment the veteran is required to fill

out a detailed form of his income, assets, etc. Even with these strict limitations, as of the last count, there were approximately 18,000 veterans who were waiting for admission to Veterans' Administration hospitals having certified that they are otherwise eligible, but there were no beds available. Another statistic is that over half, or about 55,000 of the beds in Veterans' Administration hospitals are occupied by veterans with neuropsychiatric disorders.

The Veterans' Administration also renders other assistance to veterans by its operation of 18 domiciliary homes which take care of approximately 16,000 veterans. The domiciliary is the present-day version of the "old soldiers' home" and has been characterized as taking care of those veterans who have become dislocated from society. Last, but not least, the Veterans' Administration renders assistance to 28 States which operate 33 homes for 9,000 veterans by paying up to half of the veteran's care, not to exceed $2.50 a day. This program is quite limited and as indicated, only 28 of the 50 States have a State home for veterans.

Despite the marvelous record established by the Veterans' Administration and the great forward strides and progress it has made since World War II, the Veterans of Foreign Wars is nevertheless extremely disappointed that this agency has not gone forward with establishing facilities and providing nursing home care for the veteran who will be an invalid for the rest of his life. Our aims and purposes are embodied in a bill which has received unanimous approval of the House and is now pending in the Subcommittee on Veterans' Affairs of the Senate Labor and Public Welfare Committee. I refer to H.R. 8009, the nursing home care bill in this 88th Congress. Hearings have been concluded by the subcommittee and the Veterans of Foreign Wars is extremely hopeful that the Senate will promptly approve the bill and it will be the signal for the beginning of increased medical care for a growing number of veterans who are now reaching an age when this type of care is desperately needed.

What are some of the reasons the Veterans of Foreign Wars is supporting and working overtime for this legislation—H.R. 8009?

The principal reason is found in the statistics which I just referred to above. What better medical system is there in this land of ours and is more and better fitted to take the lead in this program than the Veterans' Administration. Already the Veterans' Administration hospitals by its own count has 9,700 veterans who could be released to a nursing home or to their own home if they had one to go to, at a greatly reduced cost if such facilities were available. Therefore, the biggest national nursing home program in existence is being operated by the Veterans' Administration. Just for the purpose of emphasis, let me repeat just what the VA medical system consists of—168 hospitals, 112,000 veterans is the average daily patient load, 18 domiciliaries taking care of 16,000 veterans, most of whom are at an advanced age; 33 State homes in 28 States with an average daily member load of 9,000 veterans, and taking care of and paying some of the cost of 3,000 qualifying veterans who are hospitalized in other than veterans' facilities. This demonstrates the magnitude and the depth and the experience which has been gained by this agency and the Veterans of Foreign Wars is strongly convinced that H.R. 8009 is not only desperately needed by veterans but is the instrument and

the pilot project which will gain the vital experience necessary to establish a program of similar nature for all citizens.

At the present time, H.R. 8009, Mr. Chairman and members of the subcommittee, will do the following in the nursing home care field:

1. It will establish not less than an additional 2,000 nursing home care beds at existing VA facilities.

2. It will authorize the Veterans' Administration to transfer from a Veterans' Administration facility to a public or private nursing home any veteran who has received maximum hospital benefits and who would require an additional substantial period of nursing home care. This would be at the cost of the Government, subject, however, to a limit of 6 months unless in a rare instance the Administrator determines a longer period is necessary. A further safeguard is that the cost of such care cannot exceed one-third of the cost of the care being furnished by the Veterans' Administration in a general hospital.

3. For those States providing nursing home care, their per diem rate will be increased to $3.50 a day and a matching grants program is also authorized and provided for at the rate of $5 million a year to enable States to construct, modernize or renovate facilities for furnishing nursing home care to war veterans.

The heart of this program is the section which will permit the Veterans' Administration to release veterans from VA hospitals needing nursing home care to facilities either public or private in or near the veteran's hometown. This will provide the necessary authority for the Veterans' Administration to immediately go forward to establish facilities, standards, criteria, and definitions which will enable all interested and involved in this type of program to greatly benefit. The Veterans of Foreign Wars has always pointed with great pride to the magnificent contribution made in the field of education with the first national education program which you recall as the World War II GI bill, and the subsequent Korean GI bill. Likewise, this same GI bill performed another invaluable assist in the field of housing through the administration of the guaranteed home loan program—a truly national program which brought about warranties, for example, for homeowners, the first enforceable warranty on a national scale, which subsequently was adopted by the FHA.

These two programs, of course, have been highly successful and have laid the foundation and success for other similar Government programs. The Veterans' Administration can do it again in the nursing care field—establishing a national nursing home care program if H.R. 8009 is enacted into law.

The problem of taking care of aging veterans was brought to the attention of the late President Kennedy, who after reviewing the problem, sent a memorandum to the Veterans' Administrator which authorized the establishment of 2,000 nursing home beds in the present Veterans' Administration system. (H.R. 8009 by the way would authorize at least another 2,000 beds, making a minimum total of 4,000 to get this program started.) The President's memorandum eloquently states some of the reasons why he established these 2,000 beds. I quote from his memorandum of August 12, 1963:

> The changing characteristics of our veterans population, particularly those who served during the First World War, are resulting in an adverse effect on the acute medical programs administered by the Veterans' Administration. Nearly

one million war veterans are aged 70 or over. The number will increase 50 percent by 1966.

Older veterans account for one-third of your hospital admissions and they comprise the bulk of the long-term care patient load. Many have attained maximum benefits of hospitalization but attempts at community placement have been unsuccessful because of the lack of facilities, inadequate financial resources, absence of family ties, and other reasons. Retention of these patients in facilities designed for acute care is costly and places an undue strain on the 125,000 hospital-bed limit under which you are now operating.

In order to relieve this situation, I authorize you to activate and operate facilities and beds for 2,000 nursing-home-type patients in addition to the 125,000 hospital beds presently authorized. This will provide arrangements more consistent with patient requirements and improve utilization of acute care facilities. The higher patient turnover will also defer the need for increasing present bed levels. Existing buildings best suited for this purpose and appropriately located throughout the country according to your judgment, should be utilized. No construction, other than for necessary conversion of existing facilities, is authorized.

This authorization is to enable the Veterans' Administration to gain firsthand knowledge and experience in the operation of beds specifially designated for patients requiring attendant-type services. It will be possible to evaluate a full range of care form domiciliaries through acute medical care, restoration centers, and nursing home care where outplacement is not possible.

I am sure that as a part of your administrative studies, cost control systems will be established so that direct cost comparison will be definitive; also that you will continue to work toward the development and utilization of community and private resources in the best interest of veterans and the Nation.

Now the Veterans' Administration has not gone forward with the speed desired with this program as we had hoped. That is not a primary concern of this committee, but suffice it to say that the Veterans of Foreign Wars is extremely hopeful that this administration and the Veterans' Administration will be providing the necessary funds to implement or more fully implement President Kennedy's order at the earliest practicable date. Likewise we are equally hopeful that the Senate Labor and Public Welfare Committee and the full Senate will approve this bill, H.R. 8009, in the same manner as the House, and that the provision contained therein will be implemented as rapidly as possible. The Veterans' Administration system, as diverse and far-flung as it is, is always subject to constructive criticism. The purpose of H.R. 8009 is to provide congressional approval and authority for the Veterans' Administration to make available another phase or type of care which, I am sure this committee will agree after all the evidence is in, is overwhelmingly needed by the elderly citizens of this Nation and especially the war veterans.

In summary, Mr. Chairman, the Veterans of Foreign Wars is asking Congress in approving H.R. 8009, to continue its recognition of the service rendered by war veterans, some of whom unfortunately in their twilight years are invalids. Nursing care as provided in this bill will be extremely limited, since only those veterans who are unable to pay the cost of the care can qualify. I think the record should show that the Veterans of Foreign Wars is asking for this type of special consideration for only a small group of citizens who were selected by their country to serve in battle and give their lives if need be for the preservation of this country and its institutions. These are citizens who wore the uniform and receive an honorable discharge for service rendered. By providing this type of care, it will encourage our young men and women of today to serve their country in the present hour of need. It will make war veterans feel that a grateful

country has further recognized their sacrifice and service by having this type of care available in the event that their own personal lives should find themselves in such circumstances.

Again, may I thank you for this opportunity to appear here today.

Senator Moss. Thank you, Mr. Stover. We appreciate the fine statement and your explanation and position of the Veterans of Foreign Wars.

You indicated that there is a need for standards in nursing homes. Do you think that there should be Federal imposition of standards or publication of standards for nursing homes to met in their services?

Mr. STOVER. I think so far as veterans are concerned that we have always advocated that the treatment and care of veterans should be according to a Federal standard. In other words, a veteran, regardless of his situation, regardless of which State he might be in or which VA facility should receive the same kind and similar treatment as a veteran would be receiving, as nearly as possible, no matter where this veteran may be located, and that would be, of course, a Federal standard laid down by the Veterans' Administration.

Senator Moss. Do you think this same standard, then, could serve as a standard generally for other nursing homes not confined just to veterans?

Mr. STOVER. Yes. I think that the Veterans' Administration is extremely qualified to establish national or Federal standards; they have an abundance of doctors, nurses, social workers, and so forth. They are one of the biggest agencies, building, constructing, renovating hospitals continuously—year round—all the time. Under President Kennedy's order they have been ordered, of course, to establish 2,000 more nursing home beds and to establish criteria. I think that any standards that the Veterans' Administration will come up with will certainly be the product of the best available brains and experience. If there are any experts in this field, if there is a team ready to make nursing home care a reality I think you will find them in the Veterans' Administration. H.R. 8009 will provide the VA with an opportunity to get this nursing care off the ground.

Senator Moss. Thank you, sir. We appreciate your being here and you, Mr. Fagan, for coming to be at this hearing this morning.

Your testimony has been very helpful.

Mr. STOVER. Thank you very much, sir.

Senator Moss. Our next witness is Mr. Winborn Davis, who is the director of the State Department of Hospitals of the State of Louisiana. He is representing the National Association of State Mental Health Program Directors.

We will ask you to proceed, Mr. Davis, as soon as you are ready.

STATEMENT OF WINBORN DAVIS, DIRECTOR, STATE DEPARTMENT OF HOSPITALS, STATE OF LOUISIANA

Mr. DAVIS. Gentlemen, we appreciate the opportunity to have a representative of the State Mental Health Program Directors testify. Unfortunately, the association is meeting at the present time in Los Angeles, and our president and executive director cannot be here. They did send me an official statement which with your permission I would like to read and then make some elaborations on it.

Senator Moss. All right, will you proceed in that manner?

Mr. DAVIS. The National Association of State Mental Health Program Directors recognizes that certain aged persons suffer from treatable mental illnesses like those that affect younger persons, and that some aged have such profound deterioration of memory, judgment and behavior that they must be treated in psychiatric facilities. These aged are the legitimate concern of State and local mental health programs.

Other aged persons suffer from physical or neurological disorders that require general hospital care and treatment.

Others are slightly forgetful, mildly confused, and need various degrees of nursing care of domiciliary care which should be provided in approved nursing homes or personal care homes. They should not be required to live in State mental hospitals in 60- to 100-bed wards with gang bathrooms, and loss of all individuality and personal dignity, even though this type of "human warehousing" is cheaper than care in nursing homes.

Any infirm person, but especially the aged-infirm, should be kept as near to home as possible, where family, friends, and familiar surroundings offer the best possible link with his usual life.

Units such as nursing homes and personal care homes should be provided for the aged who need only these services in small and personalized facilities in each town and city.

In the establishment or selection of such units it is important to keep in mind the fragile health of the patient group and to insure immediate access to general hospital facilities which can provide a high caliber of medical and surgical care when it is needed.

The State mental hospitals are already successfully moving to such units many senile-aged who are sent to them.

Economic dependency should not be a reason for sending physically ill and socially dependent oldsters to State mental hospitals.

Financial arrangements should be made to give them physical, nursing, and domiciliary care in their own communities.

The State mental hospitals have also been moving into nursing homes and personal care homes substantial numbers of chronic mental patients who have grown old in the hospitals, but who no longer require the full range of hospital services.

This is the official statement of the association.

Senator Moss. Thank you, sir.

You have a statement, also, of your own?

Mr. DAVIS. Yes, but I do not think I will read it. I will just make some comments from it, if I may.

Senator Moss. All right. The entire statement will be placed in the record and we will ask for your comments.

(The statement follows:)

PREPARED STATEMENT BY WINBORN E. DAVIS, MEMBER, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

AGED PATIENTS AND MENTAL HEALTH

Aged patients in mental hospitals.—For years elderly people who are behavior problems in their homes have been placed in State mental hospitals and more often left there for the rest of their lives. Until 1959, State mental hospitals populations increased year by year, with the aged person making up a considerable portion of the total. As an example, the State of Washington reports that

33.2 percent of all patients in residence in their State mental hospitals are over 65 years of age. Also, 17 percent of their admissions are over 65. Louisiana's figures are less but still too high. During 1962–63, persons over age 65 made up 19.4 percent of the mental hospital population. Admissions of aged were down to 9.1 percent only because of a concerted effort beginning in 1960 to reduce admissions of this group. Malcolm W. Thewlis in his book, "The Care of the Aged," reports that 23.5 percent of all people in the United States who are over 60 may have to be hospitalized for mental illness. This is an indictment against our present handling of the aging person.

State mental health directors recognize that many mental hospitals have become repositories for the aged. Older people are admitted when they become senile and difficult to handle in the community. Indeed the aged are often physically and emotionally fragile so that the family feels they must be placed in an institution. More often the family circle is then closed to the patient, his room is turned over to someone else, those who look after him make other plans, and there is no interest in his return to the family.

Long-term care facilities are needed for the aged, but in their absence mental hospitals often must provide this service. Various approaches to the solution of this problem have been undertaken, some so recently that adequate evaluation of their effectiveness has not been possible.

(1) Private nursing home facilities is one major approach. Their number has increased tremendously in recent years. State licensing authorities now insure that proper standards for construction and for care will be met. In the 1950's nursing home operators, by and large, resisted the admission of aged persons who were disturbed or who had previously been mental patients. They did not feel adequate to handle them, other residents of the nursing home were afraid of them, and the community criticized placement of mental patients in the community. Most nursing homes are proprietary, they must make money, and the disturbed person drives others from the home.

More recently some of the State mental health authorities and the nursing home operators have joined hands in an education and training program. Nursing home operators who are interested in accepting former mental patients are given training in understanding and handling them.

An area needing much attention is education of the public to accept former mental patients as residents of nursing homes in the community. They need to know that experience shows a high rate of successful adjustment on the part of aged mental patients in nursing homes. Again we can refer to a recent survey made by the State of Washington which shows that of 1,247 former mental patients in nursing homes, only 19 were getting along poorly and another 10 were said to be not entirely satisfactory. This means 2.3 percent of the total had problems of adjustment.

(2) Foster home placement is another approach to removing aged patients from the mental hospital. In Louisiana, one mental hospital assigns social workers to locate private homes that will take a maximum of two aged patients. They give continuing consultation to these foster homes, and have found the practice to be highly satisfactory during the short time that it has operated.

(3) The State geriatric hospital is a third approach to removing the aged from mental hospitals. Both Louisiana and Minnesota currently have facilities in operation, and the State of Pennsylvania reports that it is setting up a similar program. Nevada, Georgia, and several other States have shown interest in the geriatric hospital now in operation in Louisiana. The Louisiana facility was specifically designed to remove from the mental hospitals nonpsychotic patients who are 65 years and older. Through collaboration with the State department of public welfare, the hospital utilized the OAA and MAA programs to finance the project. An attached fact sheet gives a more complete picture of how the facility was organized and how it operates.

This unit appears to be highly successful as patients discharged from mental hospitals and admitted to the geriatric hospital have improved considerably in their attitudes and outlook on life. There is much more concentration on enjoyment of what life has to offer, talking about new things the hospital program brings to their lives, and playing down the prior focus on their symptoms and problems.

Prevention in the geriatics field is a term that has not been greatly used. Yet it appears that much can be done to reduce admissions of the aged to mental hospitals. Several programs are being tried by the various States. (1) Consultation in comprehensive community mental health centers and regular health

centers provides more adequate planning for the aged at the local level. The family, the physician, and the committing authority has a resource to turn to. Information is available on community resources such as nursing homes to which the aged can be directed rather than sent away to mental hospitals.

(2) Waiting lists have been established for the aged at mental hospitals in some States. Previously, most commitments of the aged were reported as emergencies by local authorities and the family. It has been surprising that upon placing the patients' names on the waiting list, the emergency often disappears and constructive planning at the community level can begin.

(3) Conditional admissions are being undertaken in some mental hospitals. An example is the Central Louisiana Hospital, Pineville, where families and committing authorities must agree to remove the aged patient from the mental hospital as soon as the staff contacts them indicating the patient is ready for discharge. Sometimes they are required to sign a statement to this effect. Many aged people are found to be loaded with various patent medicines and prescribed drugs which disturb their behavior.

Generally, in these cases, a few days of hospitalization are adequate to dry the person out and return him to normal functioning. While this treatment is going on, the hospital makes an effort to plan with the family toward the long-range care of the aged person.

Statement.—It is not possible to speak for all the States, but in Louisiana there is the firm belief that long-term care of the aged should be provided in the community and not in State mental hospitals or public State facilities removed from the community. It is believed that consultation should be provided by the local mental health facilities in an effort to reduce mental hospital admissions and to properly place the aged person when this is indicated. Training programs for nursing home operators, public educational programs in the acceptance of mental patients in the community, and financial assistance to the aged seem imperative to the promotion of local responsibility.

There is some controversary over whether the State should set up public geriatric units to remove the nonpsychotic aged patient from mental hospitals. Some feel an adequate staff to do discharge planning and to work with the community can return the aged to some community facility. Still others feel there will always be patients whose behavior is too much of a problem to be adequately handled even in skilled nursing homes. They believe that the State should have a facility to which nursing homes may send the aged they cannot handle and to which mental hospitals may transfer the nonpsychotic aged who cannot be placed in the community.

Villa Feliciana Geriatric Hospital, Jackson, La.

Background: Villa Feliciana Geriatric Hospital was created August 1, 1961, by the State Department of Hospitals. "Operation Old Age" began on that date at East Louisiana Hospital (mental) by screening all patients 65 and older. The geriatric hospital was formally opened March 1, 1962, with 59 patients, and now has 525.

Purpose: Villa Feliciana was created to remove from the State mental hospitals aged people who are no longer psychotic but are in need of continued medical and nursing care. It is designed to house indigent aged who qualify for some public assistance and the Federal MAA benefits.

Physical plant: Three buildings at East Louisiana Hospital were separated from the mental institution and a new facility created. Each building has 4 wards and the total capacity is 750. The villa has its own geographical boundaries and is administered as a separate facility from the mental hospital.

Program and staff: The villa is considered a geriatric hospital rather than a nursing home. There are two full-time physicians on the staff and a part-time physician in each medical specialty needed. Recreational, occupational, and other forms of activity therapy are provided. Menus and special diets are supervised by a registered ADA dietitian. Catholic and Protestant chaplains hold regular religious services and are available for individual counseling. A coordinator of volunteers brings the facility and the community as close together as possible. A beauty parlor and barber shop, along with nursing services, promote personal grooming. Social service assists with problems of adjustment to the hospital and maintains contact with patients' relatives. Men and women are housed separately but participate in activities together.

Financing: The villa is operated by the State Department of Hospitals but is a joint project with the Louisiana State Department of Public Welfare. Hospitals determine that the patient is nonpsychotic but in need of continued medical and nursing care. DPW determines financial eligibility and makes payment to each individual at the villa. Payments are from the OAA and MAA programs, representing 73 percent Federal and 27 percent State funds, all provided by the Department of Public Welfare. There is no State appropriation to the villa. Quarterly audits of the villa are made by DPW and monthly rates determined on the basis of actual cost of operation, currently amounting to $183 monthly per person. Additionally, DPW provides each patient with $17 monthly for personal incidentals.

Admission criteria: In the beginning admission was from a State mental hospital only. A person had to be aged 65 or over, nonpsychotic, in need of continued medical and nursing care, and eligible for public assistance. Some have small private or social security income, in which case DPW provides the difference between their income and monthly cost of operation. Recently the villa began to accept from private nursing homes cases which they could not handle. Though senescent or senile, they are not psychotic and are sent to the villa rather than a mental hospital. Some of these are self-pay and are charged the regular monthly rate.

For further information write to: Winborn E. Davis, acting director, State Department of Hospitals, Capitol Building, Baton Rouge, La., 70804.

Mr. DAVIS. I would like to point out that we as mental health directors have become acutely aware that mental hospitals have become repositories for aged people. Though I could not obtain for you in the brief time available national statistics, I quote from a survey made by the State of Washington, which indicates 33.2 percent of their patient population in State mental hospitals are over age 65. Our own State of Louisiana has 19.4 percent of the resident population over 65. Admissions to the Washington hospitals run 17 percent, age 65 or over. In Louisiana, admissions of aged are down to 9.1 percent mostly because we have had a concerted program since 1960 to reduce admission of this particular group.

I would like to point out that 9.1 percent of the population in the United States are 65 years and older as of the 1960 census. This means Louisiana admits just about the number expected on a ratio basis.

The problem is that more often, when the aged are admitted to the hospital the family circle is closed to the patient. They turn the room over to somebody else, the person who takes care of them makes other plans, and there is little or no interest in the family to return the patient.

We know long-term care facilities are needed and you have heard the description of some of them earlier. We subscribe wholly to the idea of private nursing home facilities as one of the major approaches to removing the mentally ill oldster from the State mental hospital. There are problems in this area. Nursing home operators have been afraid to accept mental patients; the other oldsters in the homes have objected because they are afraid of mental patients; the community has objected because they do not like to see an ex-mental patient walking down the street. We often get calls saying that persons from a hospital, now in a nursing home, are walking up and down the streets. We often reply by asking if anybody else is walking up and down the street? There should be little or no difference, but the community is afraid if people have the tag of an ex-mental patient.

We believe, too, that another move in the direction of getting the oldster out of mental hospitals is the education of the public. They

should know, as an example, that so far the few projects that have been undertaken to remove the oldster from the mental hospital and put him in the nursing home have been quite successful. I refer again to Washington where they placed 1,247 former mental patients in nursing homes. Of this number, only 19 were not getting along well, and 10 were not entirely satisfactory. That means only 2.3 percent were having any kind of difficulty.

Another approach to getting aged out is foster home placement in which mental hospital personnel find homes that will take—in Louisiana—a maximum of two. If they take more than two, by law they are a nursing home and will have to be licensed. Staff gives continuing consultation to operators of the home, the private home, caring for the aged mental patient.

A third approach is the setting up of a specific geriatric hospital. In Louisiana, and in Minnesota, this has been done and we hear that the State of Pennsylvania contemplates the same thing. In the last 2 weeks we have had inquiries from Nevada, Georgia, and several other States to know how this has been done, and attached to this statement is a brief fact sheet showing how we did it in Louisiana. We literally cut off three buildings from a mental hospital and set up a new institution. Oldsters who were no longer psychotic, but had no place to go, were placed in the new institution. You might be interested to know one of them was admitted to the mental hospital in 1899 and he was transferred to the geriatric hospital at the age of 103. He celebrated his 104th birthday yesterday. There was no place for him in the community.

We set up this institution in the absence of an adequate number of private facilities. Today we have 525 oldsters who are nonpsychotic, though they have some mental aberrations. They have a continuing medical and nursing care need. This was done jointly with the Department of Public Welfare, and all of the patients are supported by OAA and MAA funds. There is no State appropriation to the geriatric hospital.

The Department of Public Welfare pays each person on the basis of the actual per monthly cost of operating the institution.

Another more important approach, is prevention of admission of oldsters to State mental hospitals. This can be done, first, by setting up consultation in community mental health centers, the new and rather fascinating approach to mental health that we have heard so much about. We are doing this as are several other States. The family, the physician, and the committing authorities will have a place to turn to, a place that will have information on all the community resources that might be available to take care of aged people.

In this way we think that many of them will never go to the hospital because, after all, they are generally not psychotic; they have behavior difficulties that make it extremely difficult to take care of them in the home or in the nursing home.

Another gimmick, and it is just that, is being used by some of the State mental hospitals. They set up waiting lists, for the admitting of the aged even though they may have a bed for them. In the past everyone had thought admission of aged to a hospital was an emergency. When we set up a waiting list the emergency situation seems

to disappear, and plans are made on a local level which often presents hospital admission.

Another approach is conditional admissions, and this is something new that we have just recently begun. A lot of aged are loaded up on patent medicines, if I may mention a few—Nervine, Peruna, and so on, and they do begin to behave peculiarly. But, if you can put them in the hospital for a week or so, they will usually dry out and return to their normal behavior. I don't mean like they act as they did when they were 25, but as they did before they got too loaded up on drugs. This is not just patent medicines, but prescribed drugs also. They are getting regular checkups and are really having toxic reactions to the drugs.

Upon admission the family will sign a statement agreeing to pick up the patient when we call and say he is ready. We have found this to be a highly successful means of getting them back into the community.

To complete my own statement, we believe that in the case of the aged person in the mental hospital, there is a twofold approach: (1) to prevent their admission, and (2) the development of private nursing homes and other domiciliary facilities for their care. State mental health authorities should assist these resources by training their personnel, and by educational programs for the community so people can know the ex-mental patient does just about as well in the community as one who has never been labeled as mentally ill.

Thank you.

Senator Moss. Thank you very much for that most interesting testimony, Mr. Davis. Your description of moving a number of the older people from the mental institution into a domiciliary nursing home type of care is very interesting. Are there still a number of elderly patients in this situation yet to be moved in Louisiana?

Mr. Davis. Yes, we know that in one hospital there are 600 we could move if we had the personnel and the private nursing home facilities to move them to.

Senator Moss. I understand that a number of States have indicated they have rather large numbers that certainly could be moved.

Do you have any national figures on the number of people who could be adequately cared for or even better cared for in nursing homes rather than retaining them in our mental hospitals?

Mr. Davis. That would have to be a rather wild guess.

Senator Moss. Give us an estimate, a ball park estimate, as we learn to say around here.

Mr. Davis. There are approximately 750,000 mental beds in the United States at any given time and the occupancy is 85 percent or more. I do not have national percentages on how many are 65 and over. But I would say, based on our own experience in Louisiana, that 75 percent of the people who are 65 and over sent to mental hospitals should either not go there in the first place or could be returned to the community with adequate facilities.

Senator Moss. What is your estimate on percentages?

Mr. Davis. I would say 75 percent. Now, if you ask me how many are in our hospitals 65 or over, that we could move out, it would be a higher percentage, I would say 85 percent of those 65 and over in our mental hospitals now could be removed to the community with adequate facilities.

Senator Moss. That is an astonishing figure, and I am glad to get it in the record. It gives us something to think about.

Mr. DAVIS. It will be challenged, you may be sure.

Senator Moss. It certainly is a challenge.

In your statement, the one made for the association, you pointed out that it is necessary to insure immediate access to general hospital facilities when these patients are placed in nursing homes. From that, would you say it is desirable to have a formal affiliation between the nursing home and the hospital for this type of patient placed in the nursing home?

Mr. DAVIS. Definitely. In fact, we encourage the construction of nursing-home facilities in conjunction with a general hospital, and if not, before we will license them they must have some agreement with a general hospital for the transfer of patients.

Mr. FRANTZ. Do I understand correctly that in your State licensing, you require a formal agreement with a hospital?

Mr. DAVIS. Yes. We have quite a number of nursing homes that are built in conjunction with general hospitals. Twelve of the 155 licensed nursing homes in Louisiana are a part of a general hospital.

Mr. FRANTZ. Are a part?

Mr. DAVIS. And much of your Hill-Burton money that comes to Louisiana for nursing homes goes to those that are affiliated with a hospital. We make it pretty difficult for them to build with Hill-Burton money unless it has that affiliation.

Mr. FRANTZ. For the others that are not actually part of the hospital, is there a standard form of agreement which the State prescribes?

Mr. DAVIS. At present we do not have a specific form, but they must have an agreement satisfactory to our inspectors. You heard earlier about inspection. We have regular inspectors going to every nursing home to study every aspect from sanitation, fire control, diet, and nursing care to see that they are up to standard.

Senator Moss. Do you think there ought to be stricter standards applied to these nursing homes that take patients who have been moved out of the mental hospitals?

Mr. DAVIS. If we made them any stricter in Louisiana we would put them out of business. I do not think they should be any different from nursing homes that care for the regular aged person. We would like to remove this mental illness tag and reduce its connotations as much as possible, because it does not belong there.

Senator Moss. Mr. Frantz has one other question he would like to ask.

Mr. FRANTZ. You emphasized the private nursing home as a resource for the placement of these people and just for the record, I wanted to clarify whether you included nonprofit and church-related homes along with this?

Mr. DAVIS. Yes, proprietary and nonprofit; we have no real preference in the matter, except we like to see people build nursing homes that they personally are going to operate. Absentee ownership is not the best means of providing good nursing home care. It should not be a thing to go into to make money out of, in that sense. We find that people who own and operate their own nursing homes do the best job.

Senator Moss. That is an interesting point. We have asked this a number of times of other witnesses and I do not think we have ever had as direct a statement of opinion and speaking from experience that you have given us.

Thank you, Mr. Davis. We appreciate this very much.

Our next witnesses represent the Blue Cross Association: Mr. James M. Ensign, director of professional relations; Mr. Steven Sieverts, who is the assistant director, and Mr. Bert Tollefson, Jr., who is the Washington representative.

I am glad to have you gentlemen with us and we look forward to receiving your statement.

Mr. ENSIGN. Thank you, sir.

STATEMENT OF JAMES M. ENSIGN, DIRECTOR OF PROFESSIONAL RELATIONS, BLUE CROSS ASSOCIATION, ACCOMPANIED BY STEVEN SIEVERTS, ASSISTANT DIRECTOR, AND BERT TOLLEFSON, JR., WASHINGTON REPRESENTATIVE, BLUE CROSS ASSOCIATION

Mr. ENSIGN. My name is James M. Ensign. I am director of professional relations for the Blue Cross Association, the national organization of nonprofit Blue Cross hospital service plans. I appear before you today as the representative of these plans, which collectively provide hospital service benefits to some 59 million American citizens of all ages. With me today is Mr. Steven Sieverts, assistant director of professional relations and Mr. Bert Tollefson, Washington representative for the Blue Cross Association. We appreciate this opportunity to present Blue Cross views on the financing of long-term care.

Blue Cross initially focused on the acute general hospital. Our concern for many years dealt primarily with the financing of care in the hospital for episodes of acute illness. With the passage of time, however, our communities have demanded broader coverage of services within and without the hospital, so that today, in addition to the purely inpatient aspects of care in general and special hospitals, Blue Cross covers emergency room services, outpatient services, skilled nursing facility (or nursing home) services, and services in the home (visiting nurse or coordinated home care services) in many or most areas of the country. The public, having become accustomed to voluntary nonprofit prepayment of acute hospital care, has come to desire equivalent protection on a broader front.

The phrase, "long-term care" describing your subcommittee's interest, encompasses an extremely complex area of concern. Health problems do not separate neatly into chronic disease and acute disease; one can be chronically ill and need little medical care for short periods of time, or be acutely ill for an extended period of time. It is the financing of expensive services over periods of months and years that presents serious problems, not the question of whether the diseases requiring long-term care are technically "chronic" or "acute."

Treatment of long-term conditions takes place in many settings: the doctor's office, the home, the acute general hospital, the outpatient department, the chronic disease hospital, the mental institution, the tuberculosis sanitarium, the nursing home, the convalescent home, the home for the aged and its infirmary. Most often these are sepa-

rately owned and administered and sometimes located in separate communities. A major problem lies in bringing these facilities, programs, and personnel into a continuum of coordinated care for the patient with proper reference to quality and economy. We in Blue Cross are well aware that the benefits which we select and how we administer them with particular reference to standards will help shape the patterns of care which develop in the future.

In the general hospital setting Blue Cross has frequently found itself financing long-term care. Often the acute general hospital is the most appropriate locus for a long-term patient who requires its comprehensive or acute services. It has been estimated that some 10 percent of Blue Cross subscribers admitted to the hospital for illness or accident stay 15 or more days and utilize nearly 40 percent of hospital days for all subscribers. It is common for Blue Cross contracts to cover up to 120 days of hospital care; maximum benefits of 365 or 730 days are not uncommon.

It is also true, however, that some persons who are presently patients in hospitals for extended periods of time would be better cared for in facilities more specifically attuned to their needs and conditions. The exact numbers of persons fitting this description has not been determined accurately. The very lack of professionally sound long-term-care facilities in a community may make the hospital the treatment location of choice by default. Many other factors may contribute to the choice of the hospital for care of long-term patients. Convenience for the physician who may be used to working in the hospital setting, remote location of appropriate facilities beyond the hospital, and the existence of coverage for in-hospital services only, are but a few of factors which may be involved.

Serious questions are raised about whether the fact of prepayment is acting as an inducement for some patients to remain hospitalized because transfer to postacute facilities or programs such as chronic disease facilities, nursing homes, or other postacute programs might mean extra financial burdens for these patients. We in Blue Cross are deeply concerned with this problem, and not only for the obvious reason that hospital care costs considerably more per day than does care in settings which may be more appropriate for certain long-term-care conditions. Our community sponsorship and our close cooperation with the community's hospitals give us a profound interest in the quality of care available in the community. We are quite aware of the fact that there is a range in quality from the excellent to the shockingly poor in postacute facilities and programs; we are not willing to commit our subscriber's purchasing power to the support and perpetuation of inferior or inappropriate facilities and services.

Individual Blue Cross plans in their development of postacute benefits recognized the problems of inferior care in substandard institutions by seeking quality standards adequate to protect their subscribers. At the national level the development of a professionally sound accreditation program for skilled nursing homes is one of the most troublesome of postacute care problems. Forty-five percent of the nursing homes listed as "skilled" by the U.S. Public Health Service do not have a registered nurse in attendance at all. More than 40 percent of the total "skilled" nursing home beds are listed as "unacceptable" under the State Hill-Burton program standards. State

nursing home licensure laws are often so loose or permissively administered as to allow homes with less than professionally acceptable or physically safe standards to obtain licensure.

With reference to national programs of standards, 2 years ago Blue Cross Association, in developing guidelines for its member plans, urged the Joint Commission on Accreditation of Hospitals to assume the accreditation of skilled nursing facilities as an ongoing program. The joint commission has a time-honored and widely accepted professional reputation in measuring adequacy of hospital facilities and applying standards of care. This agency is multilateral in its membership, bringing the knowledge and reputation of the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons with the skills and talents of full-time doctor of medicine surveyors to bear on this important task. However, as you have heard from others, the joint commission members reached an impasse on the logical extension of accreditation into skilled nursing facilities.

Having already endorsed the American Hospital Association's listing (now registration) program for inpatient care institutions other than hospitals as a desirable prerequisite to accreditation or as an acceptable alternative until joint commission action, the Blue Cross Association went on record in support of strengthened AHA registration and continued efforts by the AHA to work toward accreditation. The American Hospital Association standards and program format were felt to be essentially sound in differentiating among acceptable and unacceptable facilities. The Blue Cross Association will continue to support the AHA registration program until a successful breakthrough occurs in returning to the concept of a multilateral accreditation program such as that originally proposed by the Joint Commission on Accreditation of Hospitals.

In more than half of the Blue Cross plans, some skilled nursing facility benefits are now available under certain subscriber contracts, especially the special contracts written for the aged. We do not pretend that the arrangements under which these benefits are being delivered are fully satisfactory in all areas. Blue Cross has stepped in to fill a need and has provided benefits on a limited scale to gradually gain experience in this field of coverage. Our collective experience reinforces our conviction that there is need for a professionally administered, sound program to define adequate standards for skilled nursing facility care.

In many instances long-term care is most appropriately administered in the patient's own home. Blue Cross has helped to pioneer in the development of coordinated home care in the United States. Major home care efforts are being supported by Blue Cross. Programs in Michigan, New Jersey, Greater New York City, Greater Rochester, New York, and Delaware are notable examples.

Let me stress our conviction concerning the necessity of careful planning in the next steps in improving the availability and the quality of long-term care facilities and programs. It is apparent that more and more funds from State and Federal Government will be directed toward expanded health services for the older citizens who are most in need of long-term care of all kinds. We have already seen the proliferation of substandard nursing homes built and operated at

levels dictated by meager governmental financing for old-age assistance recipients; the infusion of fresh money will not by itself guarantee better standards. What will be needed is a strong, yet flexible, control mechanism with quality standards set high to assure adequate care. We will face the dilemma, as I mentioned earlier, of keeping these standards adequate and working toward an adequate supply of services at the same time, in order to meet the substantial needs of those requiring long-term care. If an error is made in balancing needed quality and needed quantity, we would submit that it would be preferable to err on the side of quality, and to allow time and the existence of expanded purchasing power to fill the gaps.

Further, we would urge that the planning for long-term care be carried on within regions or on an areawide basis, with reference to the need for an active coordinating role on the part of hospitals, to include physicians, and all health services, facilities, and personnel. Hospitals, for example, might extend their purview to "adopt" skilled nursing facilities through affiliation agreements, or build long-term care units in order to achieve continuity of care for the long-term patient. Other programs for long-term patients must be coordinated within the community to extend this continuity into the home, the doctor's office and the outpatient departments. Here, again, we feel the community hospital has a strong role to play.

In conclusion, we accept the fact that the financing mechanisms should permit and encourage the use of the most appropriate treatment modalities at the right time, and we accept an active role in behalf of the aged, as well as all members of the community, in promoting standards and the growth of public oriented and effectively operated facilities.

Blue Cross Association is pleased to offer these comments. If we can assist the subcommittee further, we will be happy to do so.

Senator Moss. Thank you very much. It was a very fine statement, Mr. Ensign.

I noticed in your statement you indicated there were contracts covering up to 120 days, some were as many as 365 or 730 days.

Are these in common use now?

Mr. ENSIGN. 120-day contracts are very common now; yes, sir.

Senator Moss. And what percentage of your contracts do you think would fall in that area?

Mr. ENSIGN. We do not have that here available at the present time.

Our most common national contract is the 120-day contract. This is one serving national accounts; that is, employed groups of multi-State corporations.

Senator Moss. The others, though, the 365 would be a rather unusual one?

Mr. ENSIGN. Not unusual, I would say, in some of the highly industrialized areas. Michigan, for example, offers a 365-day contract which is quite commonly in use in that State.

Senator Moss. Many of the Blue Cross plans pay the hospitals on the basis of audited costs. Do these plans offering nursing home benefits specify the type of costs on which reimbursement would be based?

Mr. ENSIGN. The benefits in nursing homes have not reached the sophisticated point where Blue Cross plans are paying on the basis of audited costs to nursing homes. There is some thought and experimentation going on in this area. However, the practice is one of providing, at the present time, indemnified benefits in nursing homes. That is the pattern in reimbursement to nursing homes, so that often there is an indemnified payment, for example, of 60 percent of the daily charge or $8 per day.

Now, we are convinced that probably the earliest steps in providing reimbursement based on nursing home costs will take place in nursing homes that are either affiliated closely with hospitals or are actually owned and operated by hospitals. One reason is that the hospitals over the years have reached the point of sophistication in accounting and administration which permits this, whereas in most of the nursing home facilities audited costs are difficult to obtain.

Senator Moss. Do you feel you get a higher level of care in hospital-affiliated nursing homes than you do in the unaffiliated?

Mr. ENSIGN. I would say the organized medical staff, medical records committee, and many of the other organizational aspects of a hospital which promote high quality care would necessarily rub off on the nursing home which becomes affiliated with an acute general hospital; yes, sir.

Senator Moss. In your experience has the availability of the skilled nursing home benefits significantly reduced the average length of stay in the hospital?

Mr. ENSIGN. No, sir. This is largely because the benefit is not yet widely enough available, and because of the lack in many years of skilled nursing home facilities which could effectively take on the load of patients which they might assume were they to meet high standards. The use of these facilities by physicians at the moment is limited and would be expanded if there were higher quality facilities closely related to the hospitals so that the process of discharge from hospital to nursing home would become a sort of routine thing rather than being an exceptional case.

Senator Moss. Does Blue Cross experience any significant difference in the services rendered in the proprietary homes and those available in nonprofit institutions?

Mr. ENSIGN. I can only speak of isolated instances. We have no general statement to make on that point.

But based on personal observations, I can say that one of the types of facilities where we see high standards of quality adhered to to a greater extent than in the proprietary institution is the home for the aged with an infirmary. These are largely nonprofit, and the programs for the elderly patients who find themselves in need of medical services tend to be of a higher quality than we have seen in a broad range of other skilled nursing facilities or nursing homes around the country.

Senator Moss. In talking about accreditation, which you strongly urge, I wondered why the Blue Cross Association urges its member plans to use the American Hospital Association's registration program as a standard rather than the accreditation of the American Medical Association-American Nursing Home Association?

Mr. ENSIGN. Well, we feel that it is important to have an organization do the accrediting job which has standards that focus on medical staff organization, the requirement of certain level of nursing care around the clock, the provision of adequate medical records and a number of other things which are characteristic of the American Hospital Association registration program.

Now, the existence of the AMA–ANHA accreditation program is of such recent vintage that we have not fully been able to evaluate the standards and the administration of this program. We have, as I indicated in my statement, supported the American Hospital Association registration program for more than 2 years. It has, in fact, registered a significant number of skilled nursing facilities, as I am sure you heard from the American Hospital Association. I believe the figure is 1,221 facilities registered to date.

We feel that the American Hospital Association program by urging affiliation with hospitals, by setting a standard which requires medical staff organization, by requiring registered nurses for supervision of the care in the institution, has a program which will have to be adequate for the moment. It is the one that we have elected to support as an association.

Senator Moss. You think it is adequate in the present instance and as far as you see will be adequate in the future?

Mr. ENSIGN. As I indicated in my testimony, I would hope that accreditation by a multilateral agency such as the joint commission will return to the scene as the agency for accreditation.

We find in some areas, in California, for example, that this kind of program is in existence. We hope that a national program comparable to the California program will develop.

Senator Moss. All right. Mr. Frantz has one more question, he says, on this.

Mr. FRANTZ. You mentioned that the National Council on Accreditation program was very recent and I believe that only 279, I think is the figure, homes have received their accreditation.

Do you have any information to the effect that even of this number many of those may have received their accreditation before the standards were adopted which would actually be a grandfather clause accreditation?

Mr. ENSIGN. Yes; we have that information.

Mr. FRANTZ. Could you tell us how many such instances have occurred?

Mr. ENSIGN. I imagine this would be considered entirely hearsay. However, I would say a substantial majority of those that are now listed as being accredited by the National Council on Accreditation had formerly been accredited by the ANHA program which was a unilateral program prior to the formation of the AMA–ANHA Council.

Senator Moss. Thank you, Mr. Ensign, Mr. Sieverts, and Mr. Tollefson. We appreciate your coming and giving us this testimony. It has been most helpful and we appreciate it.

Mr. ENSIGN. Thank you, sir.

Senator Moss. Our next witness is Dr. Mitchell Wendell, who is counsel for the Council of State Governments. I am very glad to have you, Dr. Wendell, glad to see you again, and have you before the committee on which I sit. We appreciate having your testimony.

STATEMENT OF DR. MITCHELL WENDELL, COUNSEL TO THE COUNCIL OF STATE GOVERNMENTS

Dr. WENDELL. Thank you very much.

Mr. Chairman, since you have received the prepared statement in advance in multiple copies, I would ask permission to have it included in its entirety in the record and I will simply highlight it and summarize it here this morning and respond to such questions as you may have.

Senator Moss. Thank you. The entire statement will be placed in the record and you can go ahead with your comments or highlighting of it as you care to.

(The statement follows:)

PREPARED STATEMENT OF DR. MITCHELL WENDELL

My name is Mitchell Wendell. I appear in my capacity as counsel to the Council of State Governments, a joint agency of the 50 States and the Commonwealth of Puerto Rico for Federal-State and interstate relations.

In the early 1940's the Council of State Governments organized what is now its committee of State officials on suggested State legislation. This committee is composed of State legislators, attorneys general, legislative service personnel, and uniform law commissioners. Its purpose is to draw upon the experience of all the States in calling to the attention of State governments problems of new or urgent concern and suggesting, frequently in draft bill form, specific avenues which may be employed in dealing with the problems. Sometimes such suggested legislation is modeled closely on an enactment of a particular State, sometimes it is a blending of relevant statutes in several States, and sometimes it is a new product developed either by the committee of State officials itself or by one or more groups known to have expertise in the field of the proposal.

At the present time, the committee of State officials on suggested State legislation is working on a comprehensive nursing home statute. The project was begun last fall after the wide variation in the scope of State laws on the subject was called to our attention by staff members in the Department of Health, Education, and Welfare who have been doing research in the nursing home field for some time. As the result of a subsequent meeting with the President's Council on Aging, the cooperation of that group in our undertaking also has been secured.

A first draft of our projected nursing home statute has been prepared. In addition to a subcommittee of the committee of State officials on suggested State legislation, an advisory group has been constituted to review the draft with an eye to making criticisms of it which can form the basis of a revised document. This advisory group and the subcommittee will hold a first meeting on May 20. This process of comment and revision will be repeated until we are satisfied that we have as good a product as we can develop. The draft will then be submitted to the full membership of the committee of State officials. If approved by the full committee, it will become part of one of the "Programs of Suggested State Legislation" of the Council of State Governments. These programs are annual publications of the Council of State Governments which are furnished to all State legislators, legislative drafting and research agencies, and to many other groups of State officials as well. Items appearing in them are not necessarily intended to be enacted by all States in exactly the form that they appear in the publication. It is inevitable that each State should examine these models with a view toward their own existing laws, the scope of the problem which they face, and their own policy judgments. Nevertheless, the "Programs of Suggested State Legislation" have had substantial influence, and the substance of draft bills contained in them has found its way into the laws of many States.

Since the first revision of our draft statute will not be made until after the meeting of May 20, it is not possible at this time to set forth the ultimate contents of the final product in specific terms. The principal purposes of my appearance before you today are to inform you that we are at work, to tell you something of the group which is to serve with us, and to provide whatever

information we can. It is probably true that at this stage of its work the committee of State officials can learn as much from you as it can tell you.

In forming our advisory group we have been conscious that a good suggested State act is most likely to be developed by calling upon those with professional training and experience in the several aspects of the nursing home problem, as well as those with competence in the drafting of legislation. Consequently, our group consists of a number of Federal and State officials, and representatives of the leading medical, nursing, and related associations, as well as of several individuals who have been asked to serve because of their personal qualifications in the nursing home field.

Perhaps the best way to offer our substantive comments on the nursing home problem and on the more important provisions of a comprehensive State law is to reproduce the major portion of the explanatory memorandum which was sent to the members of our advisory group along with the first draft of the suggested act. The memorandum in relevant part is as follows:

EXPLANATORY STATEMENT TO ACCOMPANY SUGGESTED NURSING HOME ACT

An ever-increasing number of persons require the services of nursing homes. On the whole, it is probable that the demand for nursing home care in connection with convalescence remains relatively constant and any upward trend is to be explained as merely a reflection of the Nation's increasing population. On the other hand, the number of elderly persons in our society is undergoing a marked increase. In part, this is due to an ever-larger population, but even more it results from greater longevity among our people and to the consequently greater significance of the degenerative diseases as causes of infirmity.

States have undertaken to regulate nursing homes, both by statute and by administrative action. However, the extent of the laws in the individual States varies widely from jurisdiction to jurisdiction. The suggested legislation is designed to serve as a comprehensive statute dealing with all of the phases of nursing home regulation which are appropriate for treatment in statute. It should be noted that many matters are more appropriate for administrative regulations. In such areas, the suggested legislation provides for the objectives to be attained by such administrative action and confers the necessary rule-making power on an appropriate State agency. A number of matters do lend themselves to direct statutory treatment. They are covered specifically.

1. *Licensing.*—The basic public concern with nursing homes is to see that they offer facilities and services appropriate to and adequate for the health and comfort of their patients. As an enforcement problem, this involves passing upon qualification of personnel and inspecting facilities to see that they meet desirable standards. Licensure can serve as the central element in approaching this part of the governmental task. In order to cover both the facilities and personnel aspects, the act provides for a nursing home license which is actually a facilities license, and a nursing home administrator's license, which is the license to be required of the person in charge of the home. The qualifications of other personnel, including medical and nursing personnel, are described in broad terms and left for supplementation by administrative rules and regulations.

2. *Patients to be accommodated.*—The question of classification for nursing homes can be a difficult one. In some respects, these institutions are like hospitals; but since they are not intended to cater to the completely disabled, and since it is desirable to produce as cheerful and normal an atmosphere in a nursing home as possible, it would be improper to think of a nursing home as a hospital and to regulate it as though it were one. At the other end of the scale—particularly where elderly persons are concerned—the nursing home has some of the characteristics of a hotel or boardinghouse. Yet it is not accurate to regulate it as though it were such an establishment, because much more specialized services are required. Consequently the suggested act attempts to steer a middle course. It provides for the exclusion of patients who really need hospital services. While it does not expressly forbid the admission of persons who are well enough to live in hotel-type residences, it may be assumed that such individuals normally would not seek out the nursing home as a place of abode and that no provision of law is necessary to discourage them.

3. *Substandard homes.*—The principal provision of the suggested act in its present form which relates to substandard homes is the provision for revocation of a nursing home license. It is probable that the only satisfactory way to deal with substandard facilities, or facilities so poorly operated that they fall below minimum permissible standards, is to require discontinuance of the establish-

ment. On the other hand, many other violations of the act's provisions should be the occasion for the imposing of legal penalties. At this stage of the work on the draft, no attempt has been made to write such penalty sections.

Dr. WENDELL. As you know, Mr. Chairman, the Council of State Governments is a joint official organization of all the States and Commonwealth of Puerto Rico. It has a number of separate functions which it carries on on behalf of the States, only one of them is of direct concern here this morning, and that is in the province of the committee of State officials on suggested State legislation which is a committee of the Council of State Governments and for all of its forbidding title, what it actually does is to pool the experience of the States in legislation which they may be developing to handle new or urgent problems. The committee itself consists of a number of State legislators, for that matter virtually every State in the country has at least one State official representative on the committee on suggested State legislation, sometimes more than one; it consists of State legislators, of State attorneys general, of legislative reference and other legislative service people, of bill drafters, and we in the Council of State Governments staff act as secretariat to this committee as we do to other committees and affiliates of the Council of State Governments.

Sometimes the committee also in a new field does break new ground and does develop its own legislation which it then makes available to the States for such use as they might wish to make of it.

A project in which we are currently engaged is the development of a comprehensive model State nursing home act. The legislation in the regulation of nursing homes for all of the standards, of course, which the Federal Government provides through its various agencies in respect of those programs that can be federally aided, legislation in this field is, of course, State legislation. It was called to our attention rather forcefully and rather pointedly back last fall that this legislation from State to State was, of course, widely varying in content and in scope and it would be desirable to improve and perhaps even to get a more common core into the State legislation in this particular field.

This is the reason for our having undertaken the project.

We have drafted in preliminary first draft fashion a model nursing home act and we have also recruited an advisory group to work with a subcommittee of the committee of State officials on suggested State legislation, to help us go over this draft and successive drafts of this comprehensive model nursing home act and what we propose to do is repeat this drafting and review procedure with our advisory groups and the members of the subcommittee as many times as necessary until we are satisfied that we have as good a product as we can recommend to the States.

At that point it will be offered to the full committee of State officials and hopefully, if we do not go too far wrong, why, they will adopt it and carry it in the program of suggested legislation which is an annual publication made available to all State legislators and to many other State officials in all of the States calling to their attention the desirability of perhaps updating and improving what they may now have in the individual States by way of law on this particular subject.

We are in a very preliminary stage, as I have just indicated. The first meeting of our subcommittee and advisory group is going to

be held on the 26th of this month at our offices here in Washington, and the makeup of that advisory group consists of a number of Federal and State officials with experience and responsibility in this particular field, and also representation of the leading medical and nursing and other organizations with responsibilities or interests or knowledge in this particular field.

We have also, Mr. Chairman, invited your committee to be represented on our advisory group and to assist us, and if you find that possible, why, we will be very glad to cooperate with you and to also receive the help of the knowledge that you and your staff have developed in the course of your work in this particular subject and in putting our act together.

Senator Moss. We appreciate the invitation to participate in formulating this model act that the Council of State Governments has set about to work upon and I will be most happy to ask Mr. Frantz, our professional staff member here on the subcommittee to meet with your group and to render such assistance and advice as he can give to this committee.

Dr. WENDELL. Thank you very much. That will be most appreciated.

Senator Moss. The drafting of model codes, I think, represents a real service by the Council of State Governments. We have a diversification that exists among our 50 States and a need for some greater degree of uniformity in many areas of regulation.

I am aware that the Public Health Service, of course, has recommended standards already to the States in these nursing homes and homes for the aged. I wondered to what degree a model code would follow this recommendation or vary from it or supersede the recommendations of the Public Health Service?

Dr. WENDELL. Well, the Public Health Service is one of the Federal agencies with which we are cooperating and their people are part of our advisory group as well as the others. We have been over the Public Health Service standards and some other materials that they have developed over the course of the past couple of years. Most of what they developed is really not statutory material, it has to do on the whole with the mechanical and physical measurements for nursing home facilities, with certain other requirements that are more appropriate for administrative rules and regulations than for a statute.

I have been guided by those standards in preparing the first draft to the extent that they did constitute statutory material rather than administrative rule and regulation.

In its first draft form what the statute proposes to do is to set out, and does set out, those things that we feel can specifically be handled by statute and then within the framework of the statute the draft presently confers rulemaking power on the State agency that would administer the act and I am sure that much of the material, either verbatim or similar to what the Public Health Service recommends, would be expected to be incorporated into these implementing rules and regulations.

Senator Moss. Does the model code in any way call for additional inspection and enforcement? We have heard that one of the problems we have is the inadequacy of enforcement of any licensing features that we have now and I am wondering about that next step.

Dr. WENDELL. Well, you understand, Mr. Chairman, that anything

I say about this rough draft in its present form does not at this stage represent anything other than what is in the first draft and what will be reviewed and the policy for which may be changed, depending on what our advisory group and our committee thinks.

With that caveat, I can say what is in the rough draft.

The rough draft proceeds basically on the licensure principles; it does provide that in order to get a license, in order to keep a license—and there are two types of licenses involved in the rough draft as it now stands: One for the physical facility, that is the nursing home, and the other for the chief person who is in charge of operating it, whom the draft calls a nursing home administrator—in order to get and to keep such licenses the draft does provide for initial inspections, for then a probationary period while the facility is just getting into operation; another inspection before it becomes a permanently going licensed facility; annual inspection at least thereafter, and with respect to the personnel, to the nursing home administrator, why, I am suggesting in this first draft that he be examined prior to licensure and that a minimum course of training be required, in either hospital administration or nursing home administration or some such allied field. Then, of course, his continuance, his license, could be revoked if it were demonstrated that he did not continue to perform satisfactorily.

As for other types of inspection to see that there are proper facilities and that there are proper personnel on the premises, the draft specifically provides at the present stage, that all of the necessary building codes and other applicable codes such as the codes the Departments of Health may have for the preparation of serving food and so on, remain applicable and must be complied with and evidence that they are being complied with must be submitted as prerequisites to the initial obtaining of a nursing home license and then of the annual renewals of such licenses.

With respect to other professional personnel, such as medical and nursing personnel, the first draft provides that there shall be such persons available and such services available, but it leaves up to rules and regulations how many because this is bound to vary with the size of the institution and the conditions in the institution and perhaps even with its location.

Senator Moss. Thank you, Dr. Wendell. I think this is a very significant step in finding a solution to the problem that we are examining and it is most helpful to us to know that the Council of State Governments is proceeding in this way. We will be most happy to cooperate in every way that we can to assist in recognition of the role of the State and the need for States to improve these standards and bring some uniformity to the improvements.

We appreciate your coming today and bringing us this statement, giving us your testimony and answering our questions.

Thank you, sir.

Dr. WENDELL. Thank you very much, Mr. Chairman.

Senator Moss. This has now completed the list of witnesses for the hearings and the hearings will now be adjourned.

(Whereupon, at 12:25 p.m., the hearings were adjourned.)

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