BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

PART 11—ALBUQUERQUE, N. MEX.

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- Part 1. Washington, D.C., March 5, 1973.
- Part 2. Washington, D.C., March 6, 1973.
- Part 3. Livermore Falls, Maine, April 23, 1973.
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(Additional hearings anticipated but not scheduled at time of this printing.)

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BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

SATURDAY, MAY 25, 1974

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY OF THE
SPECIAL COMMITTEE ON AGING,
Albuquerque, N. Mex.

The committee met, pursuant to notice, at 9 a.m., in the Civic Auditorium, Hon. Pete V. Domenici presiding.

Present: Senator Domenici.

Also present: William E. Oriol, staff director; Patricia G. Oriol, chief clerk; John Guy Miller, minority staff director; and Caroleen Silver, legislative assistant to Senator Domenici.

OPENING STATMENT BY SENATOR PETE V. DOMENICI, PRESIDING

Senator DOMENICI. The committee hearing will come to order.

First, let me thank you all for coming. We will try to stay on schedule. There are many people that want to be heard, that might not get an opportunity to be heard, so let me say right at the outset that if you do not get to express your views on specific problems, if you will take one of these forms, you can identify yourself, and write what your impressions are of various needs in the area of barriers to health care, or any problem of senior citizens. We will take these with us, and make them part of the record of this hearing and the ongoing hearings. The record will remain open for 30 days and we would very much appreciate your views.

Let me start with an opening statement so as we progress through the morning, you will better understand why we are here.

First, I would like to give you a historical note.

I've checked and found that today's hearing is the first one ever conducted by the Senate Special Committee on Aging in New Mexico. So we are here for a precedent-making occasion, and I'm proud to be the one that started this.

Second, I would like to thank everyone here for coming early on this Saturday morning for a proceeding which will necessarily deal with very serious problems and very earnest attempts to do something about those problems.

Our subject is "Barriers to health care for older Americans." We will keep a written record of all that takes place here in Albuquerque this morning and at an afternoon session in Santa Fe. The facts we obtain here will thus become part of the published proceedings of previous hearings conducted in Washington and in four other States, Maine, Illinois, Idaho, and Utah.

As the title of the hearing suggests, we on the Committee on Aging are concerned about problems which elderly persons encounter when they stand in need of medical or health maintenance attention.

The Subcommittee on Health of the Elderly, which is conducting these hearings and on which I serve as ranking Republican member, has already dealt with many such problems.

Medicare Coverage Inadequate

We know, for example, that Medicare—valuable and essential as it is—covers only a little over 40 percent of all health care costs of the elderly. Averages can be misleading, of course. Medicare serves many older Americans very well, and it prevents financial disaster when illness strikes. But it has many holes in its protection, and we are exploring these holes very closely. This kind of inspection is very much needed, particularly when there is so much talk about establishing a national health insurance program for all age groups.

One of the biggest gaps in Medicare today—as our earlier hearings have shown—is its failure to encourage greater use of home health care to help those who don't really need to be in institutions. I have sponsored legislation which would help to correct this situation, and I am looking forward to the testimony which I know will be given on this subject later today.

I am also concerned by reports—in the press [1] and elsewhere—about problems arising from the transfer of patients from State hospitals to boarding homes. Later today, I will be hearing about the situation in Las Vegas and Santa Fe where, as in many other cities, boarding homes have been established to meet this new demand.

But we're interested not only in problems but in solutions and in proposed solutions to the problems.

We're interested in getting the facts and then using those facts to insure that Congress does its part in building a better health care system for older Americans.

We in Congress, of course, can do only part of the job. What is really needed to solve the problems are imaginative, hard-working people working in their own communities to make things better.

We're about to hear from some of those people today, and as one who knows from firsthand experience just how much they and others contribute to this particular community, I am proud to be here, and I am anxious, too, for their testimony.

Now, let me, in my own way if I can, explain some of the problems that have arisen. There are more people in the region that we are covering involved in the problems of our senior citizens than we could invite here as witnesses, many more than we can hear today as witnesses.

There are many more involved in my own community, in their own community, in their own way, in trying to solve the problems of our elderly.

I hope you understand that we could not, in about 3 hours in Albuquerque and 2 hours in Santa Fe, invite everyone that is actively involved in this problem to come, to attend, and be a witness.

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[1] See appendix 1, p. 1113.

If I did not hold these hearings today—on this very difficult weekend, when many people would prefer to have the extended vacation—I do not think we could have held them for 3 or 4 months. This fact-finding in Congress itself is a continuing process, and for those who wonder when will we do this in another community, when will we hear the problems that we did not arrange to hear today, I can only assure you that either formally or informally, throughout my stay, and so long as I am on the Special Committee on Aging, we will try to go to different parts of the State and formally or informally hear the other problems that you want to discuss.

Now, I also know that many of you would like, when the questions come up, to speak in Spanish. You may do that. We welcome it. You know I understand it, but we also have David Vargas from Congressman Manuel Lujan's office, who will be the official interpreter for the record, so that your questions, your comments, if they happen to be in Spanish, will be properly stated for the record, exactly as you have stated them to us.

It is not possible to go through 3 hours in both Spanish and English. We could not get it done. We asked around and most people agreed that we should proceed in English, but those who want to speak in Spanish, we welcome it, and we will have it interpreted; and if the audience needs to understand it, we will state it for them.

For the witnesses, I think you already know we are behind schedule some 20 minutes. You have been asked to keep your remarks within a given time frame. Please try to do that, and try to understand it is not that we are trying to limit you, but rather we are trying to be fair to all of the witnesses we want to hear today.

I think some of you who are witnesses know that a lot of hard work goes into preparing for a hearing. We are very, very fortunate. First, I am fortunate to be on the Special Committee on Aging. We have some of the staff people here helping us. I want to introduce them to you. They work for the U.S. Senate and not for me, but they are here to serve me in my capacity of trying to help the committee understand what the problems are.

On my right is Bill Oriol, who is the staff director of the Senate Special Committee on Aging. On my left is John Guy Miller, the minority staff director of the committee. And then next to Bill is Caroleen Silver from my office; many of you who are corresponding, writing, or calling have previously gotten to know her over the long-distance telephone and through the mails. I thought you ought to meet her in person. I might say to all of you that she is indeed pleased with what she found in terms of your responsiveness. I hope you who are working for New Mexico find her to be equally responsive, as she has told me you have been.

Then we have Patricia Oriol, chief clerk, from the Senate committee.

This proceeding is being reported in its entirety. It will be made a part of the special committee's record; and eventually, as we proceed with legislation, portions of it will be used to justify either changes in legislation or suggested administrative changes.

I will violate my own rules and tell you two other things, because I do not want to forget them later.

BOARDING HOME PROBLEMS

First of all, there has been a great deal said in the papers about the boarding home problem.[1] I am aware of them, and I hope nobody thinks that Senator Domenici came to town to be some kind of a critic, that he has some kind of magic wand.

Quite to the contrary, we all know there is a problem.

The State of New Mexico has a role, and we are not here to criticize; we are here to help. The State of New Mexico recognizes the problem. They may without help be able to solve it; they may not.

The purpose of this hearing is to see that board-and-room facilities for our elderly are as good as we can possibly afford; and where legislation is needed, we hope these hearings will help.

We are prodding, pushing, shoving, coercing, even rethinking ways to help solve the problems. We hope our hearings will contribute somewhat to that.

We are going to proceed now with the witnesses.

Mr. ORIOL. Yes.

Senator DOMENICI. We do have two guests that certainly play a vital role in giving us the facts. We have Leroy Smith, president of the New Mexico Health Care Facilities Association; where is Mr. Smith?

We thank you for coming. Mr. Smith will make his statement later on. The Health Care Facilities Association has worked with nursing home care.

And then we have Dr. Robert J. Miller—will you stand up, Dr. Miller—we may have time to hear from Dr. Miller.[2] He is from Truth or Consequences. He is with the American Optometric Association. He is the head of that group. They are interested in the Committee on Aging.

Doctor, we thank you for coming from Truth or Consequences. We hope to hear from you if time permits.

First, we are going to hear from a panel. On this panel are John Segura, Albuquerque; Mrs. Selma Clever, community relations aide, Albuquerque; Mrs. Cora Cooper, Albuquerque; and Mrs. Reyes Abeita, outreach worker, Isleta Community Action program.

John, I think we have agreed you are going to go first, is that correct?

This is Mr. John Segura. John, if you would start, then we will go right to Mrs. Clever.

Mr. SEGURA. All right. I think, as most of you know, we are here on transportation needs for the elderly people.

Senator DOMENICI. John, maybe I could ask one question, and if it is going to be answered in your general statement, wait until then. I am wondering if you have any special problem in persuading elderly persons to participate in the nutrition programs. If you do, do you have any ideas of how we can overcome these problems? It is kind of difficult to get them to participate, is it not?

Mr. SEGURA. No; the greatest problem I have encountered in contacting the people is that they have no means or way of commuting to places where the sites are.

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[1] See appendix 1, p. 1113.
[2] See statement, p. 1109.

Senator DOMENICI. All right. You proceed with your statement, John.

STATEMENT OF JOHN SEGURA, ALBUQUERQUE, N. MEX.

Mr. SEGURA. As most of you know, the elderly people from the south, and that reaches all the way from here down to Isleta, and beyond that point, most of them are from Latin descendants; some of them are indigent, and some are white, but age has no color barrier, and it has no restriction of where you live. This is one of the reasons why at the meal sites now, we have not had as many as we would like to have, because these people live out in an area from, you might say, from North Fort or South Fort all the way to Isleta, and beyond that.

Most of the people, if I spoke to them and asked them to stand, would have a problem, and some of those folks do have automobiles, but others do not have automobiles, and they have to be transported.

This being the main cost, than you would see that these people, some of them have not been out of their homes for quite a while.

Some of them are 80, 74, 65, and so on. Some of them have what you might call an ailment, rheumatism, arthritis, and as forth, and these are the problems that hinder them from coming to the various sites for their meals.

Now, not only is that the problem, but there are many other problems that we could talk about for the whole day, and just speak about the many needs they have, just speak about one, would be to deprive the other one from coming into light, but I am not going to speak about all of these. My companions will also speak in those fields.

TRANSPORTATION SHORTAGE ACUTE

I would like to say that some of those folks, unfortunately, could not make it here today, because they could not be brought. That is how bad and acute our transportation is for the elderly people.

For the younger generation, I do have something, and I think that you should always be attentive to those that are older. But I would ask at this time, please help us, that these folks may come and be helped, that they may be able to participate, and then be renovated, and become a part of that field which once was their society, and help you with the many probelms, and with their many experiences in life.

I know that you would probably say, "What have they contributed that we might be able to help them?"

If you look about in the State of New Mexico, for these older people, it was a time of trial, and it also was a struggle to come about to this end, but they have kept this State what you call "The Land of Enchantment."

They have come so far that they have already entrusted their work unto the younger generations, so you look about, and you see them. I do not want you to think of those that are old as past, but as a champion of a few days that have passed by, who gave you this land that you have.

It is for this reason that I think that these people who are not able now to perform in the full capacity should be helped by you, and by

our Nation. I wonder all the time, is it possible for us to forget our elderly people. Could you forget your grandfather, could you forget your father, could you forget yourself, because you will be right in the same boat we are in now. So this is one of the things that I would suggest, give us help, that we might help these people.

Give us aid that might let them live the days they have just with the hope you have given them.

Let them have the life which you will have in the days to come. Perhaps, I am one of the fellows that speaks too much, but to the far right, you will see a gentleman over there, a few days ago he could barely walk, but the transportation that has been available, and the food given to him, has made it possible for him to stand, it has made it possible for him to be counted back into a society that he was a part of, so I would like to say, do what you can to save these people.

If not then, maybe we will pass, and you will come to light of the picture later on. But as for now, as the chairman has stated before, he is here with his companions to try to find out. I would say this is the time to start acting, so that part of New Mexico, and part of the rest of the world might know that our Nation still cares for the elderly.

Senator DOMENICI. John, let me ask you this: I heard you describe the situation, and you are telling us that transportation, whether it be to meals, or medical type of services, is a very serious problem for the senior citizens. Is that correct?

Mr. SEGURA. Right. The main thing, that needs, let me spell it out a little bit for you. The needs would probably be income, but that is just a minor problem.

The next one would probably be negligence, Medicare, and hospitalization, transportation; but this would probably be one of the minor things you would encounter in the older people today. But you would find that the greatest problem is transportation.

He cannot get to the places where he wants to go. He cannot go to where he would wish to go, simply because he does not have a way and means to get there. If he does, he has to have someone who is kind-hearted, or who wishes to help.

Would this answer your question?

Senator DOMENICI. Yes, John. I have a series of photographs from the South Valley senior citizens in front of me taken by photographer Maria Costa. These are photographs of a van with a gentleman, very old, somewhat lacking in capacity to walk. He is being helped down from this panel truck, and I see somebody helping him. They are leading him to the van, this other gentleman. He has a cane.

I assume this describes the function of the senior citizens center in helping this older gentleman get some place where his needs are supposed to be satisfied—food or health services. Am I correct that this is one of the things that you do?

Mr. SEGURA. Yes, of course. As you see there, we only have one bus.

Senator DOMENICI. And that bus is actually operated by that senior center?

Mr. SEGURA. By a group of them, yes.

Senator DOMENICI. Now, how did we get the bus, and where did we get the money to pay for the bus?

Mr. SEGURA. The AAA nutrition program at the Westside Community Center. I am quite sure you are aware where it is. This is one of the places that we have.

Most of our people that are in those pictures come to receive the aid they have in food and in care. At the same time they are transported, as you can see. In the status of their life, they find it difficult to be transported. This is federally funded.

Senator DOMENICI. Do you have enough of that type of transportation to do what the requirements of that center would dictate?

SHORTAGE OF FUNDS

Mr. SEGURA. No, sir. No, sir. Right now, we find one of the worse problems we have is transportation. However, we cannot accommodate all of these folks that need to be helped. The next thing is, we find we are short on funds, and we cannot feed as many as we would like to. The center is quite a distance from place to place. We find a lot of these older folks cannot be helped because it is impossible with the staff that we have.

Senator DOMENICI. I have two remaining questions. On the same series of photographs, your van shows a very elderly woman who obviously uses a wheelchair. It shows her getting out of your van, and being placed in the wheelchair and then I assume the wheelchair would be taken into the center where the food is being distributed.

Mr. SEGURA. Right.

Senator DOMENICI. Do you often have that type of person in the region?

Mr. SEGURA. Yes. In fact, today we have one of the elderly men that could not come for that reason, could not be mobilized. I don't know, but maybe you can ask Mrs. Costa if that young lady is here.

Senator DOMENICI. Maria, you made these photographs?

Mrs. COSTA. Yes.

Senator DOMENICI. Do you work there full time?

Mrs. COSTA. I am a volunteer.

Senator DOMENICI. You are a volunteer?

Mrs. COSTA. Yes, I am a volunteer with the metropolitan nutrition project, and we have only recently acquired this bus—which was acquired for us—for the nutrition program. I tried simply to give you a picture of the kinds of people we are trying to reach.

There are many, many more we are not able to reach. First the bus operates only 4 hours a day. It belongs to some others. The pictures are simply a way to tell you that this is one way to meet the needs.

Senator DOMENICI. Before we leave this, I would ask that these photographs be made a part of the record,[1] and that they be identified by the conversation that we have just had with Maria Costa and our first witness of the day.

MEALS ON WHEELS

One last question. Are you familiar with the meals-on-wheels program?

[1] Retained in committee files.

Mrs. COSTA. Yes. I was acquainted with it for about a year or so before we ever started in South Valley. I think it is coming to a close, which I regret to hear. I would like to see it go farther if possible.

Senator DOMENICI. Would you say, based on your observations at this point, Mr. Segura, that many of the people you have helped with transportation, could more easily be helped with the program if the meals were taken to their homes, rather than try to transport them to a place to feed them?

Mr. SEGURA. Yes. Some of the older people cannot be moved because of the medical denials. Some are veterans, and some have medical problems. These are people that could be reached, if outreach could be possibly extended and if our buses could be made more available, they could go out and find these people that really need the services. But we have been serving the people in between, the ambulant ones.

Senator DOMENICI. One last request. Could you ask your community center—within the 30-day limit—to give us whatever detailed facts they have about the number of people that need transportation to centers for either nutrition, or health delivery services, and the capacity you now have to deliver them?

Mr. SEGURA. I would be very glad to.

Senator DOMENICI. Would you have that sent to us as per the instructions on the green list. I assume it would be a rather objective analysis.

Mr. SEGURA. I would be glad to do it.

Senator DOMENICI. Let's go to the next witness, Mrs. Selma Clever, community relations aide.

STATEMENT OF SELMA CLEVER, COMMUNITY RELATIONS AIDE, ALBUQUERQUE, N. MEX.

Mrs. CLEVER. Mr. Chairman, I would like to talk about how the meals program got started with the Office on Aging. When we were organizing to work with the senior citizens, we did not want to do anything that would be against the rules of the senior citizens. At our first meeting, we set up an advisory committee. At this meeting there were about 200 people participating. We talked with them about what they would like to do, and it was decided that we would go to a Santa Fe meal site.

On the way back, on the bus, they asked our supervisor if we could have the same thing in Albuquerque. She said, "This is your program, and whatever you would like to have, that is what you will have."

We started our meal program in the summer of 1970, a 21-day pilot program. At this time, I do not have the figures, but we served quite a few meals. Before the school term. we contracted out the APS for two meal sites—one at John Marshall Elementary School, one at Albuquerque High.

MEAL PROGRAM STIMULATES ELDERLY

We served those meals at the school until April 30 of this year. There has been a lot of people that were helped. At first, some of our

senior citizens did not want to go to the meal sites because they were poorly dressed. They did not have dentures and many other things that kept them from wanting to come to the meal site. We finally talked and persuaded them to go. At the end of the program, they all hated to see the program go out, but we were glad that the metro area agency could continue the meals in our model cities area.

I would just like to tell you about one senior citizen; she is dead now, but she was in her 80's. At first she did not want to come to the meal site. After she started coming, she could hardly wait until the time to serve the meal the next day.

At first she did not comb her hair. She put a bandana over her hat, and she would wear a large fur coat. I have the picture, but I left it in the car. I would like everybody in the audience to see how she was helped by the meals at the school site. Later on, she started to put make-up on her face, cleaning herself up, and even came to our office where we had ceramics and different activities for the senior citizens. She made some potholders and put little bells on them which we cherish until this day.

I would like to tell you about two other people that are in the audience today. One is 84, the other is 83; will you both please stand? Mr. Corteriz and Mrs. Blair. Thank you, you may be seated. At first, they did not care about getting out of their houses, and going out, but after they got started—if all of you know the Spanish dance group—they are the best dancers in their group. It is not only those two, but I could point out several in the audience today that have been helped by the meals.

We have the home meals, which we are now serving 40 homebound people. Up until April 30, we were serving 50. Due to the lack of funds, we had to cut those 50 down to 40; however, some of our people that work with the senior citizens had to be laid off, our home visitors were laid off; there are just a few of us in our office. Seven in our office, to do the work that 22 were doing.

We are not doing everything in our office that we know needs to be done, but we are doing our best. I was so happy to see that the metro AAA is going to get going in the area, because we know that not only in the model cities area, but Albuquerque, as a whole, senior citizens need help. I can tell you about another experience I had in the community with senior citizens. I have a client now that gets out of her house about once or twice every 2 or 3 months, and she is in bad shape. Her housing is not what it should be.

Back in the fall of 1972 or 1973, I do not remember the date exactly, she did not have water in the house. She did not have a way to cook. She did not have water for anything, even for the bathroom.

HEALTH DEPARTMENT INDIFFERENT

I see ladies in the room today that have carried her to her house. I called the health department, and they did not do anything about it. I read in the paper a few days ago where the department representative said, "Well, nobody informed us about it." We constantly stayed on the health department about many of our senior citizens, and it seemed like it was not too much done about it. If you are in an environment

where there is an odor in the house, and other things like that, you do not have an appetite to eat.

How can you eat in such an environment? I am asking the health department to be more considerate for our senior citizens.

Senator DOMENICI. Mrs. Clever, I am going to have to ask you that if you have any other specifics, would you put them in writing, because we are running behind, and we need to get on. However, I want to ask you several questions. You mentioned APS. I just wanted to clarify that. That is the Albuquerque public schools?

Mrs. CLEVER. Yes.

Senator DOMENICI. What you have done is taken a school site that has facilitates to cook and dispense food, and contracted with them. That becomes the meal site for your program?

Mrs. CLEVER. That is right.

Senator DOMENICI. One last question. The AAA that you are speaking of, as I understand it, is the agency that is brought into being under the Older Americans Act?

Mrs. CLEVER. Right.

Senator DOMENICI. One further question. You are telling us we could use more meals on wheels, rather than less. Is that correct?

Mrs. CLEVER. Right.

Senator DOMENICI. Would you have your agency submit to us for our records the facts you have about the number of senior citizens in your area who you cannot serve, but could use meals on wheels. Submit it in writing, so we will have that specific set of facts in the record.[1]

Mrs. CLEVER. I certainly will.

Senator DOMENICI. Thank you very much. Our next witness is Mrs. Cora Cooper of Albuquerque.

STATEMENT OF CORA COOPER, ALBUQUERQUE, N. MEX.

Mrs. COOPER. Mr. Chairman, I realize time is short for you, and I was going to speak informally, but that sometimes takes a little longer.

It would be quicker if you would permit me to read the couple of pages I have. I would first make it clear that I am a home health aide, nursing the terminally ill in their own home, and it is from this viewpoint that I will be speaking. I want to reflect the attitudes, the comments, and the reflections of such people in their homes. To me, this is a unique way of looking at old age, from these people who are in a terminal state.

My observations have been arrived at after 15 years of tending elderly patients in their own homes. I do this work because few people choose it. But I have found a new dimension of service and appreciation in this type of personal nursing. Whereas the institutional nurse must be objective, businesslike and always with the goal of getting a patient up and about, the terminal nurse has a different role: Providing family and patient a buffer against the trauma of final separation; to relieve family from certain necessary chores of nursing care; to reinforce their courage and cheerfulness during a long stage.

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[1] See appendix 2, item 6, p. 1150.

If terminal illness sounds more appropriate a subject for professionals to discuss, that is unfortunate. The last span of life is the most private and poignant time. Staying at home means surrounded by familiar and loved possessions, all members of the circle close by, cherished memories—one's own bed and blanket. There is no other right and natural way to go.

Hospitals should be for the young and hopeful, the emergencies, for repair and correction—for the getting well. It is less than human to dump wasted bodies into Lysol ghettos, concrete cubicles of steel, plaster, and plastic that serve only to portend what is coming. Strange hands with threatening instruments that poke, pump, squeeze, and shock. Tubes up the nose, needles in the veins, and ankles bound with straps.

AMERICANS FEAR AGING

Yet, most people are dismayed at the idea of nursing the terminally ill. Americans have a horror of aging and dying. It's ghoulish, they think, to deal with death. Is this a hangover from the middle ages, like sex? Does a puritan ethic condition us to shy away from dealing with it? So, we abdicate the last labor of love, relegating it to total strangers. Custom for nearly a century has decreed we go to the hospital to die. Therefore, families are not prepared to cope with this last episode.

But consider living at home in the final time. In all my cases home was insisted upon by the patient and in every case with the doctor's approval. In such a setting there is time for meditation and reflection. What are their thoughts in retrospect? What concerns them most about their aging? Though they came from diverse stations and occupations, their thoughts focus in on a few concepts common to them all: A sense of not being appreciated in their mature years; regret at not having close enough ties with grandchildren and not being with the young as much as they would like; a feeling of failure to pass on whatever unique wisdom that nearly three-quarters of a century has endowed them with; and finally, the innate rightness that when their time arrives, it should come swiftly.

They express these thoughts over and over in many ways. Such as "The children were too far away; they didn't have the time and I didn't have the money to visit them." Or, "I didn't get to know my grandchildren very well, nor they to know me."

Again, "They lived in Spokane, I never got to visit them there."

"Nobody listens to me."

They weren't speaking of their complaints, but that none listens to their advice. An 84-year-old said softly as he gazed out his bedroom window to a peach tree in full blossom: "I planted it years ago; isn't it beautiful?" an that must have been the vision he took, for a few hours later he was gone peacefully. To have something beautiful, then go.

I submit that the lessons from knowing their final introspections are clear:

(1) That the problems of aging are not primarily medical ones.

(2) That Americans don't know how to die. We don't know how to diminish ourselves gradually and gracefully.

(3) That the tragedy of aging is set off early—allowing children to mock and taunt the old. As a most generous people who pamper

their animal pets to ridiculous extremes, we disrespect and despise the old human members. Sometimes we wish they'd hurry and go. In the Orient, the aged are safe in dark streets. You can observe mini-skirted teenagers escorting hobbling old relatives to the Buddhist temples. Students go to wise old men for counsel. I ask you seniors here, how often does your grandchild come to you for advice?

It begins, too, with the way we build our houses: multiple bedrooms for the children, but whoever heard of a grandparent's room? The Chinese build a wing for them. In Taichung, while visiting a native home, young family members proudly led me to the quarters of their ancient matriarch—at her invitation. It was the largest room in the house, and every member looked forward to the privilege of occupying that room and that position someday. In America, we design all kinds of rooms for our homes: family room, den, bar, laundry room, guest room, garage for the car, even a dog house. But a grandma room? How funny that sounds. So, grandparents know well in advance that they won't be wanted. Thus develop unconscious fears of abandonment.

As for the wisdom of their experiences—who thinks old people know anything? Imagine a young man saying to his dying grandfather, in my presence, "Grandpa, don't be stupid." Now I have never known a stupid grandpa. No modern scientist, he, but surely he has gleaned some sage knowledge from over half a century of living. The loneliest sheepherder and the lowliest work-worn washerwoman have specks of philosophy worth passing on. Nonappreciation induces apathy, depression, and atrophy quicker than any disease.

This brings up retirement: Retire from what? From living in the mainstream, from being used and needed? Retire to isolation and stagnation? Yes; we do want to retire from the anxieties of earning a livelihood, from the strain of rearing and feeding a family, from society's push and shove. We do want freedom to order our days the way we like; to pursue a few dreams of our youth, to refresh our lives with latent skills, neglected friendships, to contribute in our own individual way—not the usual anonymous giving a dollar. For we know now time is fleeting.

We could be doing all this if we were not so hamstrung by fears of rejection, loss of esteem, loss of voice in the body politic. We could, if our funds were not diminished at a time when we need more medications, more personal services. We could, if retreat was made easier.

Few Changes "Could Work Miracles"

I submit that it would not cost much to satisfy these wants. Stopgap measures to correct a wrong do cost a lot. I contend that a few changes, a few steps, could work miracles in helping older people live happier, better lives:

(1) Encourage corporations, organizations, and business firms to use their retiring members in an advisory capacity. Let them be honorary members. Let it be a part of the pension system. Any senior citizen who wishes, should have a place in advisory councils in every field of human endeavor.

(2) Nearly free transportation; low travel rates for those over 65.

(3) Allow special exemptions for grandparents living with their families. Find incentives for keeping the disabled oldsters in the family circle.

(4) For those not living with family, design smaller multiple housing of 6 to 12 units, on the ground floor with patios and gardens for individual use, and let there be a home nurse living on the premises. Let them share her services. Such home retirement could bridge the extremes of being too close to family and the huge, sprawling institutional housing. The last home should be intimate, small, but cozy and comforting.

(5) For those living at home: Train high school girls to be home health aides for nominal wages. From age 14 up through college, young girls are a natural for this work. It is simple, useful part-time work. All girls need the experience.

These steps, in my opinion, should begin to eliminate the special traits within our culture that give impetus to chronic and resentful aging. Hopefully, we would lose our fears of growing older, not gain new fears as we now do. We would hoard less, and disperse our gifts while living, not after death. We should not fear growing old—we should live growing old.

Senator DOMENICI. Thank you very much. I think everyone would agree that you have some excellent ideas. I will share this with you. The Special Committee on Aging has held hearings on Death With Dignity.

I hate to even couch it that way, but I think that is what you have been speaking to, and it impressed a lot of people, and brought into focus the need for home health legislation.

After having been advised by the staff of your wide experience in the area, and relegating you to such a small amount of time here today, I would greatly appreciate it if you would give some specific attention to the home health legislation. Try to fit what now exists and how to improve it without a lot of expense.

As to the present home health legislation, we would greatly appreciate it, if you could focus on that. I thank you for your thoughts.

Mrs. COOPER. I would be glad to. Thank you.

Senator DOMENICI. Now we are going to hear from Mrs. Reyes Abeita, Outreach worker, Isleta Community Action program.

STATEMENT OF REYES ABEITA, OUTREACH WORKER, COMMUNITY ACTION PROGRAM, ISLETA, N. MEX.

Mrs. ABEITA. Mr. Chairman, I am Mrs. Reyes Abeita of Isleta, and I am an Outreach worker for the community program, and a director of the elderly program.

The program we have for the Isleta people is more active than any other program. Transportation, compounded by distances, and medical services, and inadequate income are problems. With that understanding and respect, the elderly on the reservations did not have this program until our program came in—the food stamps and medical aid—and it should be pointed out that most people on the reservation live below the poverty level as set down by the U.S. Government. They are in tremendous need.

To have elderly Indian people spend 20 percent of their income on food stamps is unequal and an injustice. This situation is further compounded by the lack of transportation, time away from home,

and to get certified in general, a lack of understanding of Indian culture.

FOOD STAMP CERTIFICATION DIFFICULT

I think the best thing to do would be at least for somebody from the food stamp center to go down to the reservation and certify the people themselves. The transportation there is bad, and for the Indian people there. When something does come about, we are the last ones to receive anything.

Senator DOMENICI. How far away is the certifying center from Isleta?

Mrs. ABEITA. Thirteen miles.

Senator DOMENICI. Where is it?

Mrs. ABEITA. In the South Valley.

Senator DOMENICI. There is no certifying taking place in the pueblo itself?

Mrs. ABEITA. No, Mr. Chairman.

Senator DOMENICI. Go ahead.

Mrs. ABEITA. And when we do get this, well, by the time they are certified, and if they have the money to buy their food stamps, by the time we get to the issuing desk to buy our food stamps, by then it is time for us to leave, and all they tell us is that it is already 4 p.m. "You will have to come back tomorrow." So tomorrow—well, people have no way of going up there, and when they get there, then they are there for another day again.

Senator DOMENICI. How many people do you estimate are in need of this kind of certifying from the pueblo, Mrs. Abeita?

Mrs. ABEITA. It is somewhere between 100 or 200 people.

Senator DOMENICI. Between 100 and 200?

Mrs. ABEITA. Yes, because I have interviewed each home on all of these problems that they have had.

Senator DOMENICI. If you will move on from the certifying and food stamp program, we will send an inquiry to the State about that, and see if they could work out something that is more accommodating. If you will go on to some other subject now, that would be fine.

Mrs. ABEITA. I think the best thing would be if we can have our own funds instead of the State, because by the time we get our funds, someone else has already gotten there. We are always the last ones in on this.

I think it would be much better if we had it the way we did before.

Senator DOMENICI. Are you now referring to other programs, not only food stamps? Are you talking about the Older Americans Act, and the funding under that kind of program?

Mrs. ABEITA. Yes, Mr. Chairman.

Senator DOMENICI. You are telling us that as far as your pueblo, and your experience goes, you think Congress should consider the direct relationship with the Indian people, and their particular unit of government, as a means of funding senior citizen programs, rather than as a part of the State?

Mrs. ABEITA. Yes, Mr. Chairman.

Senator DOMENICI. I would tell you that there is some consideration being given, and I believe there is some mention in a particular bill

that will be studied in terms of directly handling Indian senior citizen funding with the Indian people.

I do not know which direction it is moving, but we will certainly note that it is your opinion that it would be better to handle this matter locally by the Indian unit of government.

MORE FUNDS NEEDED

Mrs. ABEITA. With more funds to support the elderly, I think we would have a better program, provide more staff, could feed the people, as we also have a feeding program.

Senator DOMENICI. How do you handle your feeding program? Do you use a school, or your own community center?

Mrs. ABEITA. We have our own community center, plus our own kitchen, and we have a full-time head cook and a cook's aide on half-time. I think if we had more funds, we could have a bigger program and have more people coming in with more transportation.

Senator DOMENICI. Do you have some transportation now?

Mrs. ABEITA. Yes, sir; we have a bus now.

Senator DOMENICI. Would you give us an estimate of what percentage of the people who come to your food center are transported there by you, and what percentage come on their own?

Mrs. ABEITA. Oh, I don't know, I would say about 80 percent.

Senator DOMENICI. Eighty percent?

Mrs. ABEITA. Yes.

Senator DOMENICI. Eighty percent come on their own, or come through public transportation?

Mrs. ABEITA. The ones that live nearby walk over. The others, there are three separate villages there, the people from the outside only know the pueblo, and they don't know the outskirts of the other pueblos, one in Chical and one in Los Charcos. We have elderly people there that are brought in by the bus from Chical.

Senator DOMENICI. Can you tell me, is the 80 percent the ones you bring in by bus?

Mrs. ABEITA. Yes, sir.

Senator DOMENICI. All right. Go on.

Mrs. ABEITA. I think that it would be so much better if we had more people to help, more food staff to help us out. I would like very much to see the other pueblos get the same treatment, or have a feeding program of their own like we do in our own pueblo. I have had other people come to our center from other pueblos, which they say they do not have, because the other counties have it, and they want it. For instance, they want people to bring the people in from the other pueblos, and why couldn't they have their own funds, and their own feeding programs just like the rest of us, just like Isleta does.

I believe Isleta is the only pueblo that has a feeding program. It would benefit the elderly, and besides, this is our land to begin with, and, well, I guess that is about all.

Senator DOMENICI. Thank you very much. I want to talk with you a little more, if I can. You heard Mrs. Cooper talk about the custom of caring for our elderly.

She is suggesting, if I understand it correctly, that the programs we have in this country are moving us away from the family—considering the aging as part of family life. Would you tell me in the Indian culture, and at Isleta, as people grow old, and get sick because they are old and feeble, is it the custom that the family takes care of that person, and keeps them in the house, or do they have a custom of sending them off by themselves, or putting them in a nursing home, or a hospital? Will you tell us about that?

Indians Care for Elderly

Mrs. Abeita. The Indian people take care of their own; the elders, if they have children, maybe they have two or three daughters, they take turns by the week to take care of their own people. The Indian people do not want their people to go to a rest home at all, but I have known several that have been there, and are still there.

Senator Domenici. Would you say that is because we do not have any way of helping the Indian people take care of them at home? We do not have enough programs to help them to do that. Is that why they are sending them to a nursing home?

Mrs. Abeita. I believe so. If we had more funds, I think it would be much better, too. In other words, it is our custom that we have to look after our elderly Indian people, and to take care of one another. We have to take care of them. They took care of us, so why should we not take care of them.

Senator Domenici. I understand the director of your center, who is also named Abeita, is here.

Mr. Abeita, would you stand up? Would you have any quick comment you want to add?

Mr. Abeita. Only that our funding for the feeding program now is coming through the State, and we are just subcontracting from the county, and we feel that the State or the county, or metropolitan Albuquerque do not understand our needs in Isleta.

We feel that we should have direct funding, individually with individual tribes. Whatever it is, we want to cut out the middleman.

Senator Domenici. Thank you very much, Mr. Abeita. You have heard the comment from the director who elaborated on Mrs. Abeita's statement of not wanting the senior citizen funds to go through the State. He explains that it comes from the State through the county, and they basically contract with the county, for his people, and what they would like is a more direct route, as he put it, elimination of a middle man.

We thank the panel very much. We are running a bit behind time, but we greatly appreciate your efforts to stay within the time frame. If you have any comments that come to mind that you had intended to tell me about, please get them in writing, get them to us within 30 days.

We would like to have the record complete with any thoughts you have here this morning, because of the nature of the meeting. Thank you very much.

Mr. Smith. I wonder if I might take just a minute. I think really what we are talking a great deal about here this morning——

Senator DOMENICI. Mr. Smith, if you do not mind, we are going to have an opportunity for you to comment later. We are trying to move ahead on schedule. I think it best that your observations be expanded upon later.[1]

Our next witness is Mrs. Anne Beckman, job placement director, American Association of Retired Persons, Albuquerque.

Mrs. Beckman is not under the AARP, although she is very active in it. She is under a manpower program, and she may wish to identify that manpower program more correctly.

We welcome you here this morning, Mrs. Beckman. Please proceed. We know you have a lot to tell us, and we appreciate your trying to stay within the time frame.

We are delighted to have you. Will you first tell us the name of the agency, the correct name, that you presently work with?

STATEMENT OF ANNE BECKMAN, DIRECTOR, AARP JOB PLACEMENT SERVICE

Mrs. BECKMAN. Thank you, Mr. Chairman. We do not go under the American Association of Retired Persons, because they have not recognized our organization as being a part of their organization, but they have allowed us to use the initials AARP. So everybody just plain calls us the AARP Job Placement Service for elderly people over 55 years of age, which is sponsored by a chapter of the American Association of Retired Persons, 1364. We are a subcontractor of the Office of Manpower Programs.

May we add to that, we are the minority group in the manpower program. We are sort of a stepchild, one where they have a little extra money left over, they say, well, maybe Beckman can use it.

I am speaking on behalf of the people who do not want funds from the Federal Government. Maybe the Senate committee is not interested in our group, because of that reason, but we would like to have some help in eliminating the Social Security restrictions on the $200 that they can earn in 1 month.

This is a definite health barrier. We have people who are living so close. May I interrupt at this time, and tell you about a man whom I have known for many, many years?

He and his wife are very, very close personal friends of mine, and I have known them for a long time. They have attended ball games. They have climbed mountains. They have gone every place that I can think of in New Mexico. All of a sudden she became very, very ill. The two of them have gone downhill just terribly, and it is not because of the illness alone.

EXPENSES DEPLETE SOCIAL SECURITY INCOME

As far as he is concerned, it takes in more than that. He would like to come to me and be able to work, but he cannot, because he has to help his wife. These are the kind of people that I deal with every day of my life. This gentleman could get by very well on the $406.48 that

[1] See statement, p. 1108.

he and his wife get under Social Security, but he pays $265 a month to keep his wife in a fairly decent nursing home. He pays $15 a month for medication. He pays $15 a month for two calls by a doctor. He pays $82 a month rent, and he has to have a phone because he wants to keep in constant communication with the rest home.

How much does this leave him to eat on; $20.48. He also has to pay their insurance. He also has to do many, many other things, so he is slowly but surely selling off their possessions, using up their very badly depleted savings. At the end of 1974, we realized that he will probably be a potential welfare person.

He does not want this, and he is fighting it. Of course, he cannot be a welfare person because he is getting too much Social Security.

What is this man supposed to do? What is his wife supposed to do?

These are the kinds of things I deal with every day. They do not want money from the Federal Government. They want the privilege to be able to go out and work and earn their money and be able to live with dignity in their old age.

Now, that is all they are asking for. I have women that come to me, their husbands died unexpectedly. They come to me at the age of 56; they come to me at the age of 60; they have never worked a day in their life. They find out all of a sudden that they are getting $120, $140, $180 Social Security, and they still owe $135 payment on their house each month, and so forth. They come to me in bewilderment, and they say, "Anne, what did we do wrong? Where did we go wrong? Where do we go from here?"

I work with these people every day of my life.

Senator DOMENICI. Let me interrupt for a minute. Basically, your testimony might properly be called Social Security barriers to employment.

Mrs. BECKMAN. And to their health, too.

Senator DOMENICI. But you have one specific concern you talked about, and that is that we have restrictions on what people can earn who are on Social Security.

Mrs. BECKMAN. Right.

Senator DOMENICI. Can you talk about that with me for a minute? As you know, you can now earn $2,100 a year.

Mrs. BECKMAN. You can earn $2,400.

Senator DOMENICI. It was $2,100, and they changed it to $2,400, and there is presently legislation to increase it to $3,000. Do you have people that come to you that say, we cannot do what we want to do. We have a job, but we can't take it, because in fact, it will put us over the allowable $2,400?

Mrs. BECKMAN. I hear that every day.

Senator DOMENICI. Do you have any way of knowing statistics on this?

Mrs. BECKMAN. Well, I certainly could give you statistics, because we have them in the office.

EARNINGS LIMITATION UNJUST

The thing that bugs me about this whole thing is the fact that the elderly, the elderly affluent can earn whatever they want with their

stocks and bonds, and the person that wants to keep his wife in a decent environment in a rest home, he cannot go out and get a job. For one thing, his wife does need him. And another thing, if he did get a job, it would have to be a nighttime job, and the little bit he could earn in a nighttime job at the age of 70, would probably be the very minimum. But then on the other hand, you have this other person who could lead a very, very secure life if they did not have this restriction.

Senator DOMENICI. Now, may I ask you a very specific question? Frankly, it seems to me there will really be no serious effort by Congress to completely lift the amount you can earn. I think each year we get pushed, and we up it $400 or $500. Anytime we talk about lifting it across the board, we get statistics as to how much this will cost in this program or that program, or the like. Are you perhaps suggesting that there be a further exemption for a senior citizen who wants to work, and earn more than the limitation, if in fact they are spending money to take care of someone for whom they are responsible, that there be a further exemption for them?

Mrs. BECKMAN. Right. I have a case where the elderly are taking care of a son who is 45 years old, and is retarded. He needs a lot of medication and a lot of care.

They do not want to put him in an institution. He was in an institution, and he almost went out of his mind. He wanted to be home with his parents.

When he is home with his parents, he is an ideal person, and a wonderful person. Of course, he is childlike, but these people cannot keep him in the home and still go out and work. One of them could go out and work, but it is really very difficult.

I have a 90-year-old mother who is very spry, and who does do house sitting for me to support her 62-year-old daughter who is completely blind. But this money does not stretch very far. House sitting only pays $5 a day, and it is very, very rough on these people, very rough.

Senator DOMENICI. All right. Do you have other comments?

Mrs. BECKMAN. The only thing I did want to bring out is the fact that if we could get that sort of notice somewhere along the line to help the inbetween people—not the people on Medicare and Medicaid, and not the rich and the affluent, but the middle people, that is what I am asking for.

Senator DOMENICI. I think we might have hit on another real and perhaps palatable exception to the earnings rule, that being one that would permit additional earnings, if in fact you are spending money on health care.

Mrs. BECKMAN. Right.

Senator DOMENICI. Could you send us some examples of people, for instance, as specifics, as saying, Mrs. Jones earns $2,400, because that is all she can earn, but she has prospects of earning an additional $1,000. She could earn it, and it is offered to her.

Mr. Jones is incapacitated; she could use that to take care of her husband. Could you give us three or four examples of that type? [1]

Mrs. BECKMAN. Surely.

[1] See appendix 2, item 1, p. 1125.

Senator DOMENICI. And we may have an acceptable additional exception for senior citizens, if they are spending the extra money on health care of the spouse, or someone for whom they are legally responsible.

Mrs. BECKMAN. Thank you.

Senator DOMENICI. I thank you very much for your testimony.

Our fourth witness is Don Morphew, Assistant District Manager, Social Security Administration, Albuquerque.

You have given us a statement with reference to Medicare and Medicaid for the record.[1] If you would, please proceed with your facts about Albuquerque's recipients of Medicare benefits.

STATEMENT OF DON MORPHEW, ASSISTANT DISTRICT MANAGER, SOCIAL SECURITY ADMINISTRATION, ALBUQUERQUE

Mr. MORPHEW. Well, I do not have any statistics for you this morning. I really think from the presentations that have already been heard, the people are really more concerned with the actual practical aspects of the problems. It seems from Mr. Segura's remarks, and Mrs. Beckman's remarks, and several others, that it mostly revolves around money. Mrs. Beckman brought out a point that I was attempting to bring out when I submitted this statement—the people who are worse off financially, at least have the help of the Medicaid on top of the Medicare, and virtually all of their medical needs, at least the financial part. Their needs can be met through these two programs, because together Medicare and Medicaid actually pay two-thirds of the health care costs for all of the elderly in the United States.

Senator DOMENICI. Why don't you go into it?

Mr. MORPHEW. What Mrs. Beckman was talking about, her figures she was giving were a little higher than I had in mind.

To qualify for Medicaid, you have to have a certain income. It cannot be for single persons presently earning over $160 per month income to qualify for Medicaid.

These people with monthly incomes of less than that qualify for the supplemental help. They have the Medicare, premiums paid for by the Medicaid program, by the State, all of the deductibles and the supplementals, and all of the rest of these things are paid for under this Medicaid program.

Now, where the facilities do get to this health care, is that it will be up to somebody else, who knows more about it than I. When the person has income of, let us say, single individuals of over $160, he does not qualify for the Federal Supplemental Security Income program that has just started the first of this year, and, therefore, he does not qualify for Medicaid either.

A couple who earn, who has an income, that is, and this is to be from stocks and bonds, or any other source, of over $230, does not qualify for this Supplemental Security Income program, and, therefore, does not qualify for any aid under Medicaid.

Those people have the Medicare program, but they have to pay a premium each month for this. This premium has gone from $3 per

[1] See p. 1075.

month in 1966, when Medicare orignated, to $6.90 per month in July of this year. You can quickly figure out how much that is as a medical insurance premium per year. It runs over $80 for that.

In addition to that, these people who do not have Medicaid supplements have to pay a $60 deductible every year on their part for Medicare for their doctor bill program.

In addition to that, if they are hospitalized, if they have to pay for the first day of hospitalization, which under Medicare is set at $84 for the first day, so they have this expense plus the deductibles which are coinsurance payments.

Many Services Not Covered

In addition to this, Medicare does not provide for cost of drugs, eyeglasses, dentures, hearing aids, the things that many elderly people need, as well as dental care. They are not provided for, so it seems to me that those people who fall somewhere below the level of being affluent or wealthy, and somewhere above this $160 per month income for a single person or $230 a month for a couple, the people there are the ones that really find it difficult to manage financially for their medical treatment, and the necessary health care. I guess with the inflation rate, and all of these costs tied to inflation, and I think the last month's figure for the yearly rate of inflation was 11 percent per annum, and with food and clothes and shelter going up, perhaps at even a higher rate, the necessities of life I am speaking of, one of the first things that an elderly person would defer would be things that would relate to their health, or that might further damage their health.

Senator Domenici. Don, it is obvious from your testimony, in considering any new national health plan, the phrase has been used that we want to build on what we have done. You are certainly giving us an admonition to be careful we do not make assumptions that Medicare is doing more than it is when we build on it, in particular as we consider the combination of Medicare, Medicaid for a certain group of Americans, versus only Medicare of another group of Americans; is that correct?

Mr. Morphew. That is correct.

Senator Domenici. Now, I assume that my question to Mrs. Beckman with reference to the exemption of earnings is a very narrow question, or more properly it is as broad as you were discussing.

Earnings Limitation Misunderstood

Mr. Morphew. I think so. I think also there is one thing, there is a vast misunderstanding about work limitations under Social Security. You really can work and earn more than $2,400 a year and still receive part of your Social Security, depending on how much more you work and earn, so you are never worse off by continuing to work, you are always ahead some.

It just gets to be less than it would be if you just earned $2,400 and quit, because you have got that, plus all of your Social Security, but not experiences, statistically, forgive me, Mrs. Beckman, there would be a small number of people that really could find work that would pay them more than that, or physically able to work and earn

more than that, so they really would not benefit so much generally by this. Of course, the reason for the retirement test, as you point out, is partially a cost.

It also ties in with what do you mean, someone is retired, so it is the definition of retirement to qualify.

Senator DOMENICI. We understand that there was and perhaps still is a concern for the available work force in America, and what retirement should mean in terms of the work force.

Let me proceed to another subject on which we get many complaints, and I am sure you do also. I understand that these complaints are at least regional in nature and are with reference to the conversion to the Supplemental Security Income program, and subsequent problems. We had one gentleman testify today, and if the facts are correct, there was a 5-month lapse in terms of getting the conversion from Social Security to the income supplement program.

Do you find that the advent of the Supplementary Security Income program has increased your work significantly, and have you had any staff additions?

Mr. MORPHEW. Yes, sir. The workload has increased remarkably, and we have not had a remarkable increase in staff. We have had to start with programs, as you pointed out. One of the highest workloads has been the frustration of the conversion to the Federal system, where we have been unable to get something accomplished, as maybe for this gentleman here, and unfortunately, there are some instances where we are unable to give them emergency help.

In most instances, we are able to give them emergency help, but for some in a certain category, we are unable to do that.

Senator DOMENICI. One last question in this regard. Are you aware of any inhibitions in terms of going back in time, or can you tell us, if it takes us another 7 months to clear up these records? If you find the constituent was entitled to benefits back to January 1, are there any restrictions on that?

Mr. MORPHEW. No, sir. The payments go back to when they were due. The only way a person loses anything is if they are not actually signed up, and they did qualify.

You can only start paying under this program the month they signed up. I would just like to make one more suggestion. First of all, I think the Supplemental Security Income program does not pay enough or it does provide payments that are high enough. One would help, even if the payments were not raised. If they will be raised $9 for a couple in July and $6 for an individual, it would be helpful, but even if the payments themselves could not be raised, if there could be some proviso qualifying for Medicaid, that the person might not qualify for monthly cash payments, but they could qualify for Medicaid if their income was below $300 a month, or whatever figure might be a reasonable figure. There should be two types of qualification, one would be for health care, and the other would be for monthly payments.

Senator DOMENICI. Right. We will make your analysis part of the record, and we thank you very much for your testimony and your cooperation in the last few days.

Mr. MORPHEW. Thank you very much.

Mr. CHAPMAN. Mr. Chairman, may I speak from the floor? There has been a gross injustice here to the older people.

Senator DOMENICI. Mr. Chapman, you will get a chance after the formal witnesses speak. If you could hold up until then, we would appreciate it.

Mr. CHAPMAN. Fine.

[The prepared statement of Mr. Morphew follows:]

PREPARED STATEMENT OF DON MORPHEW

Medicare and Medicaid together paid two-thirds of the total health care bill for the elderly in fiscal year 1972—$13 billion of $19.8 billion.

Those older citizens who qualify for both Medicare and Medicaid get their entire medical costs paid—including eyeglasses, drugs, hearing aids, and custodial care—all but routine dental care.

Ironically, those older persons who have too much income to qualify for the Supplementary Security Income program (and therefore can't qualify for Medicaid) are hardest hit. These people pay their own Medicare premiums for part B—$3 in 1966—$6.90 in July this year. They must pay their own part B deductible each year—currently $60.

They must pay their own first day of hospitalization—currently $84. These people must buy their own drugs, eyeglasses, dentures, hearing aids—everything Medicare doesn't provide.

All of these expenses are tied to costs. The yearly rate of inflation in March was 11 percent. The rate of inflation on essentials—food, clothes, shelter—appears to be even higher.

Fixed income—rising costs. The problem is not hard to see.

A single person who has $160 per month income doesn't qualify for SSI or Medicaid.

A couple that has $230 per month income doesn't qualify for Supplemental Security Income or Medicaid.

Outside larger towns few medical facilities exist. This means even those elderly persons who have the means must travel for adequate treatment if they live in rural locations.

Senator DOMENICI. Our next witness is Dr. Robert McCarthy, Ph. D., assistant professor, department of psychiatry, University of New Mexico, Albuquerque.

Doctor, before you start, you are going to speak, at least from the professional standpoint, on boarding homes. We do want to tell the people here that we had intended to call the news reporter from the Tribune who wrote a series of articles on boarding homes. Her observations are the basis of her story. She is not available. She just does not happen to be in New Mexico at this particular time, and she could not adjust her schedule to ours.

We have her articles[1] as the basis of her findings, and certainly that does not mean they are scientific in light, but we have them. We are sorry she cannot be here to supplement what you have to say, or to be part of the panel.

If you will proceed, we would appreciate it.

STATEMENT OF ROBERT J. McCARTHY, PH. D., CLINICAL PSYCHOLOGIST, ASSISTANT PROFESSOR, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF NEW MEXICO, ALBUQUERQUE, N. MEX.; COORDINATOR, PROGRAMS ON AGING, BERNALILLO COUNTY MENTAL HEALTH/MENTAL RETARDATION CENTER; PRESIDENT, NEW MEXICO (STATE) PSYCHOLOGICAL ASSOCIATION

Dr. McCARTHY. If you will allow me, I will read a statement. I would like to get it all in.

[1] See appendix 2, item 2, p. 1126.

I have worked directly in the valley sections of Albuquerque for the past 5½ years on the outpatient teams of the Bernalillo County Mental Health/Mental Retardation Center (MHC). My background in geriatrics incudes 1 year's psychology internship on a geriatric, psychiatric ward, and nursing home care unit of the Wadsworth (Kansas) Veterans' Administration Center.

During this time I have had opportunity to visit several boarding homes regarding mental health center clients and have chronically discussed living situations with our own staff as well as staffs of various public agencies. At present, we have approximately 110 boarding home residents who are patients of the mental health center. These patients include both the young and the elderly.

I would hypothesize that if formal psychiatric or psychological evaluations were done on all residents, this number would easily increase. In addition, with a handful of homes, nontraditional psychotherapeutic activities are carried out with residents not formally registered as patients of the mental health center, based on more of a consultation to the home model, that is, some operators are interested in help. In regard to the elderly, this has become a pilot project focus this year.

In general, I would agree with Ms. McCord's reporting on boarding homes this month in the Albuquerque Tribune which is understood to be included as part of the committee testimony.[1] It would only be redundant to repeat similar testimony. Such reporting has been made in the past and unfortunately the only result has been that the good operator suffers. Thus, although responsibility for what you now find rests on many operators, it also rests on the community at large which has been told but has chosen not to respond.

Comments on Nursing Home Recommendations

I would like to comment briefly on recommendations made in yesterday's Albuquerque Tribune regarding steps to end the problem. For example, requiring compliance with standards for homes with three or more SSI patients: (1) The word "patient" which appears several times implies the receiving of medical or allied health service care; you do not get medical care for $4 a day ($140 minus the theoretical $20 for personal use, divided by 30 days). If allied health care is expected then adequate financial assistance should be provided; hotels and motels which provide rooming and are not required to provide assistance with tasks of daily living do not have "patients"; (2) if an operator has less than three SSI residents, what is the leverage then; (3) who is going to take in the SSI recipient? The denial of Federal funds to facilities not meeting standards, for some facilities may mean nothing, as they may do quite well on the unfortunate situation where relatives are willing to pay the private rate to have mother or father or son or daughter in a less than adequate situation "out of their hair."

On the other hand, what is an adequate situation? The regulations somewhat clearly define physical plant requirements but what are the requirements for the psychological and medical environment, for example, sitting all day with nothing to do in some instances decreases

[1] See appendix 1, p. 1113.

muscle tone, healthy blood circulation, et cetera, et cetera, and can simulate a sensory deprivation situation which lends itself to cognitive confusion, disorganization, and personality decompensation, all of which may set the stage for more intensive/extensive need for medical and psychiatric care which often for the elderly in formal institutions across the country is second rate to begin with.

As is less common with the young, the interrelation between physical and mental condition becomes somewhat more critical with the elderly.

Again regarding adequacy, what are the criteria for adequate operators—what are their backgrounds, education, experience, that is the basis for what is expected from an operator? "Let the buyer beware" cannot be the watchword as the "buyer" in many instances is often cognitively limited to make a realistic judgment.

Two areas that have not been mentioned to my knowledge, are the unlicensed boarding home and the low rent hotel. The unlicensed home can board two or less individuals. One caseworker estimated that there are about 700 such homes—this could mean a potential bed capacity of 1,400 individuals.

In addition, what is the quality of life for those elderly whose relatives attempt to maintain them in their home especially in the weeks or months just prior to the last resort of boarding or institutional placement. Often the problem here is behavior management, which could be assisted through mental health consultation and education to the family prior to the crisis stage. Outreach manpower and trained staff could alleviate the need for many placements or assist with replacement in the family home.

Economic considerations: In 1963, the Comprehensive Community Mental Health Centers Act was passed and funded. Among goals were future, local, and self supporting existence, new methods of service delivery, decrease of large institutionalized populations, et cetera.

Part of the developed and workable innovative delivery system relies heavily on so-called paraprofessional mental health workers (partly developed with Department of Labor funded new careers programs, incidentally now dated for financial deletion). Medicare, another part of the Federal system, however, does not recognize what goes on in other parts of the Federal system. Medicare will not cover outpatient services of a Ph. D. psychologist, let alone a mental health worker under his or a psychiatrist's supervision.

Private Psychiatric Care "Nonexistent"

Private psychiatric coverage of nursing homes, let alone boarding homes, is virtually nonexistent. Further, gerontological research is preponderantly carried on by psychologists, but the Government does not recognize this expertise potential in the instance of medicare. To further complicate the issue, of eight bills under consideration for national health insurance, only the Scott-Percy bill recognizes psychologists as primary health care providers. If public health facilities staff of mental and physical health paraprofessionals, nurses, social workers, psychologists, psychiatrists, and physicians, are to generate income, provide and expand service and the like, something has to give from time to time.

Another aspect of the money game, is a review of the domestic Federal assistance programs. The Comprehensive Older Americans Act is the only specific program for the elderly. Other groups, for example, children, appear to be covered by several possibilities. New Mexico, as I understand, is slated for $691,000 under title III; if that were distributed to the 60 and over population in Bernalillo County alone it would amount to only $23 per person. And those moneys are not earmarked for health but the gamut of problems facing the elderly. We will be asked during the coming year—what's been done—the judgment will probably be not much—the decision will be it should be done away with—are we being set up to fail?

What can be done? Several recommendations have been gathered and reported by Ms. McCord [1] and I assume the committee has made contact with the various proposees for further details. Indeed, immediate action is necessary. My own thinking on the matter has the drawback of not providing an immediate solution, but does suggest the cooperative effort of the public and private sector to develop the boarding home concept of a small semi-independent care facility. Assuming that boarding homes will continue to be around, what can be done to assist the operator to make a living while at the same time assist the resident, both intermittently handicapped young and elderly, to partake of a high quality of living possible in this country?

Explore Boarding Home Operation

A living laboratory is proposed to objectively explore boarding home operation. What are the day-to-day problems of the operation—financial management, dietary management and purchasing, psychological and medical assistance required by residents, unidentified sources of stress on both the operator and residents, ancillary support available, used, problems encountered with, and so forth.

From data obtained, one would be in a more objective position to say whether operators are ripping people off or perhaps in situations where such and such is the case, *x* amount of supplementary public dollars would be economically and pragmatically spent. The method for a living laboratory could be trained staff working in a sample number of homes for a year or operating a facsimile home for approximately 2 years. In addition to the above, an end product would be the development of a boarding home operators training package for training and continuous followup consultation on a statewide basis. A more detailed proposal will be submitted.[2]

Briefly, I also wish to encourage the concept of skills of daily living centers. Occupational, physical, corrective, speech, psychological therapies are provided on a daylong basis for 1 to 3 months for an illness to restore and prevent major deterioration of the elder person. This is critical where the elder person is living with a working couple who can continue to maintain the relative in the home at night, during and after the period of therapies.

Finally, geriatrics is perhaps the least preferred area of work among

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[1] See p. 1121.
[2] See appendix 2, item 2, p. 1126.

the various health disciplines. In addition, the physical and psychological problems of the elderly are in many ways unique as are the problems of other ages and groups such as the addictions. As such, care for the elderly requires specialized trained staff.

To complement any changes in alternative living/care facilities and the skills of daily living centers, funding of a well trained geriatric physical and psychological care team to assist with finding the elderly, applying preventative techniques to the well elderly and preretirees, providing direct service, and providing consultation to families and ancillary agencies would provide somewhat of a comprehensive care system.

In regard to health care of the elderly in general, I would recommend the committee invite various associations within States, for example, nursing, social work, psychology, medicine, psychiatry, occupational-physical-speech therapies, and the like, to develop a trans-discipline committee within each State. Functions of such a committee could be, for example:

To review the health resources of the State and make recommendations as appropriate to, for example, the State commission on aging, various health planning councils, State health agencies, and the like.

To review educational/training programs of the various health disciplines regarding orienting students to providing services to the elderly once members of their professions and to encourage students regarding specialization in geriatric care.

To review existing programs or to recommend a program for preventive health care as separate from or as specialized within—that is, through coordination—existing, but often separate, health programs.

To review such situations, conditions, or services that indirectly relate to or have an effect on the physical and mental well being of the elderly, for example, boarding and nursing homes, pharmacies, and the like.

To stimulate an interest in providing care to the elderly on the part of professionals within their own disciplines; to attempt an understanding of disinterest in providing service care; and where indicated to recommend, plan or develop education/training for professionals who have, in general, not received such in their professional preparation.

I would suggest that consideration of reimbursement, that is, per diem, mileage, and clerical assistance, as well as some official State sanction, would facilitate such committee work.

I wish to thank you for the opportunity to testify in behalf of Los Vecinos. In closing, although I've never heard an elder person state it, one feels it expressed in the suicide rate, one feels it sometimes when projecting what it will be like when one is old, you think you see it in their eyes sometimes, that is paraphrasing Patrick Henry, "Give me life or give me death."

Senator DOMENICI. Thank you very much. Doctor, let me say that perhaps your statement is a bit technical for some, but there is a real need for people back in Washington who understand the relationship of the profession that deals with the area you have discussed, and how those professionals view the work—especially from one who has been

working at it, as you have indicated, 5½ years. We appreciate your statement, and it is one of the best we have had in the technical area that you have spoken to.

There is a genuine concern in Congress about many problems you have discussed. There is an effort being made to establish geriatric type centers. There is a broad base of consideration around the country. It has been very difficult to get them adequately funded. You probably know that last year the Appropriations Committee deleted such centers totally. Furthermore, it was on the floor of the Senate that money for somewhere between four and five of the contemplated broad-based centers under the geriatric center bill were put back in.

We have been inquiring regularly as to HEW's refinement of the process of establishing where they are going to be, and what discipline will be in them. We can report that they have not come up with a conclusive set of regulations and decisions.

The medical schools have been working with us; we have been trying to figure out whether we have a chance for one of those. We are not sure of that, but I want you to know that we have taken an active part in communicating with HEW about it.

We know it is inadequate, but if we can get the four or five started, some of the ideas you have expressed will be in some and not in others, but hopefully in due time it will form a network across the country, and we will learn more about the responsibility.

I also appreciate your candor about boardinghouse problems, because you are trying to look at it from the standpoint of where we have put everyone. You are not saying anyone is all or totally right. We cannot expect boarding homes to be nursing homes, if we do not have the amount of money to spend for them. We cannot expect them to take care of patients at the rate elderly people are able to afford, but we have to come up with some answers.

We greatly appreciate your analysis in that regard. We do hope that you try to develop something, and we can continue on with your vast experience.

Smaller Homes Conducive to Intimate Care

There is concern for the homes that would have less than three patients. I for one do not want to be part of pushing that kind out of the business, because it would seem to me, based on testimony, the more intimate the relationship of care is—even if it is not always family—the better thrust we are making as far as the national policy. On the other hand, if they are exempt from something that is good, how do we make sure that those that are in a home for only two are also getting the benefits you describe.

Thank you very much.

Our next witness is Mrs. Josie Candelaria, health planner, Mid Rio Grande Health Planning Council, Albuquerque.

Let me ask a couple of questions about your testimony so we will all understand. As I understand it, Mrs. Candelaria, you have a closed circuit television program that indicates what you have found. It would be a half hour, but that you have tried to cut it down to 10 minutes.

Mrs. CANDELARIA. Yes. You can cut us off at any time, and I will explain the reason for doing this.

Senator DOMENICI. All right. Let us together try to figure out how this would best work out.

Mrs. CANDELARIA. We would especially like for you to see it.

Senator DOMENICI. Perhaps I had better go down there and look this way, so that we can all be looking at the video tape.

[Whereupon, the video tape was shown and transcribed as follows:]

Mrs. CANDELARIA. I will begin by expressing my appreciation to Bob McCarthy and Della Mirabal, Mountain View Satellite Sustained Contact Team. Della, for her assistance in contacting and scheduling the people to be interviewed. Bob, for allowing and securing the video tape, both manpower and equipment.

Mr. Williams, could you tell us perhaps a little bit about yourself, how long you have lived here?

Mr. WILLIAMS. In Albuquerque?

Mrs. CANDELARIA. Right here, perhaps.

Mr. WILLIAMS. Since 1928 in Albuquerque, about 20 years.

Mrs. CANDELARIA. I see. How long have you been confined to a wheelchair or to rephrase it, how long has it been since you have been able to walk?

Mr. WILLIAMS. I went on crutches in 1951, and then a trip to the hospital, and I think I was confined to a wheelchair, and during that period, I would say about 1963–1965, 1967.

Mrs. CANDELARIA. Would you elaborate as to the type of illness that confined you to a wheelchair and later on, I saw you walking around on crutches, so I know you had not let that get you down.

Mr. WILLIAMS. We have never really known all of the facts. The doctors have never been able to really figure it out, what I have. It is the hip joint, in the pocket, which causes the leg to become shorter.

Mrs. CANDELARIA. How long have you had this condition now?

Mr. WILLIAMS. Since 1966.

Mrs. CANDELARIA. 1966?

Mr. WILLIAMS. Yes.

Mrs. CANDELARIA. Are you covered by Medicare?

Mr. WILLIAMS. Yes.

Mrs. CANDELARIA. And you find that Medicare is adequate?

Mr. WILLIAMS. Well, I do not use it as much as I should. It has been very inconvenient because I do not travel, and I have not had much luck in handling Medicare through the telephone.

Mrs. CANDELARIA. I would be interested to hear from you, the way you really feel about Medicare, as we were discussing it earlier.

Mr. WILLIAMS. Well, Medicare is the thing that we have to have. Social Security was raised, and so was Medicare costs, so one balanced the other. Actually, we do not get anywhere. We just stand in one place and work like a treadmill. One price goes up, and the other price goes up to meet it.

Mrs. CANDELARIA. Have you had any kind of assistance from outside the home, any kind of home health care?

Mr. WILLIAMS. Yes, I have the visiting nurses, the first year and a half or so, I think, after I came out of the hospital.

Mrs. CANDELARIA. For about a year and a half. Did you find the type of health care that they provided to be adequate?

Mr. WILLIAMS. Yes, the girls were very efficient that we had.

Mrs. CANDELARIA. Perhaps the question then, the other question should be directed to Mrs. Williams. I am sure that it was a very traumatic time for you, and you welcomed the kind of assistance that was rendered to you.

Mrs. WILLIAMS. Yes, indeed. It was very helpful for me.

Mrs. CANDELARIA. How many days a week did you receive any kind of assistance with your husband?

Mrs. WILLIAMS. One day.

Mrs. CANDELARIA. One day a week?

Mrs. WILLIAMS. Yes.

Mrs. CANDELARIA. Did you find that adequate?

Mrs. WILLIAMS. Yes.

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Mrs. CANDELARIA. Earlier you discussed the fact that you were far more fortunate than other people that perhaps did not know about many of the resources available. Will you elaborate on it?

Mr. WILLIAMS. In what respect?

Mrs. CANDELARIA. You said you were able to get around, and you did not let the idea of being in a wheelchair get you down, and you were able to do things for yourself, and a little garden you have out there kind of attests that you were able to get around.

Mr. WILLIAMS. Well, that is one of the things you had to learn to do to live, is do what you have to do with, and make use of it, and so it serves two purposes, it keeps you busy, it keeps your mind occupied, and it keeps your joints, in my particular case, in workable condition, I might say.

Mrs. CANDELARIA. You had experience with Medicare and again with home health care. If there was anything that you were able to do, or any kind of advice or opinion that you were able to give, what would they be, what kind of suggestion would you have for the improvement of those kinds of services for those people?

Mr. WILLIAMS. Well, I do not know too much about their present set-up, or the things they were trying to do, even at that time.

Now, when I first came out of the hospital, I was fitted with a leg brace, and Easter Seals helped out on that considerably.

What Medicare did not take care of, Easter Seal picked up the tab, and the thing I objected to on that was that the people, the man who made the brace and the handling of it was apparently trying to get rich off of one brace.

Mrs. CANDELARIA. You mean you had to pay for the brace?

Mr. WILLIAMS. Well, in the end he billed me, for I think $180, and above what the brace is supposed to have cost, and one of the visiting nurses here who had quite a bit of experience around in such things, picked that up, and we took it back to him, and that is the last I ever heard of it.

After he had billed me about three or four times, I did not even realize really that it was a bill. I thought it was just a copy of some procedure report that he had to make out and send to Medicare and to other officials.

Mrs. CANDELARIA. You were on Social Security at that time, and I suppose you are still on Social Security?

Mr. WILLIAMS. Yes.

Mrs. CANDELARIA. Was that adequate to take care of all your medical expenses?

Mr. WILLIAMS. No, it never is. I do not know anybody that had enough Social Security to fully take care of just their everyday needs, much less hospital and doctor bills. Doctor bills have gone clear out of sight, and as you know, hospitals have gone clear out of sight, and they are what Medicare and Social Security will take care of.

Mrs. CANDELARIA. Are you under Medicare care now?

Mr. WILLIAMS. Yes, the doctors in the medical centers are my doctors, and they keep in contact with me, and I have a kidney infection, and that gets taken care of. They just look after the infection in my kidneys, and they have to be watched very carefully, and I have taken just about all of the medication, which is very expensive, that is known to the medical profession, and he keeps changing from time to time, for instance, I have some here that the price of the medication was $60 for 40 pills.

Mrs. CANDELARIA. That is quite expensive.

Mr. WILLIAMS. And how are you going to make Medicare and Social Security meet those things?

Mrs. WILLIAMS. I do not know how anybody could believe that they would charge that much.

Mrs. CANDELARIA. Your telling us about it helps. It might start the ball rolling in the right direction to alleviate some of the conditions that exist.

Della, would you like to say something at this point?

Mrs. MIRABAL. I was going to ask Mr. Williams, do you feel that you are well informed, and that you knew where to get all of the services that you required?

Mr. WILLIAMS. No, I never was.

Mrs. CANDELARIA. Do you feel that it would be helpful to the people, who say they are not getting any services at all, if the people were informed where to get the services?

Mr. WILLIAMS. Yes, and another thing that would be helpful would be for a depot or some center where unneeded equipment such as wheelchairs and walkers and trapeze from the beds over their heads to help them to turn over and move in bed, a lot of people have more trouble than you imagine, and I am one of them, but I have all of those things due to the fact my son was a welder, and I will show you those pretty soon.

The things that I have, that other people do not have made available to them, and if we had the center where those unneeded things could be collected, and then given to the people who do need them, that would be one of the things that would help a lot.

Mrs. CANDELARIA. You suggest that those things be given to the people without cost?

Mr. WILLIAMS. That is right. It would be strictly on a donation basis, people who do not need them anymore. Now, there are people who, for instance, they have hospital beds and things like that in their homes, and they are no longer needed. Well, a lot of times those go to the garage, storage, or thrown away, instead of getting to the proper places where they are actually available for somebody to use that needs them.

Mrs. CANDELARIA. Thank you, again, Mr. and Mrs. Williams. This is Fred Walters. He has a different kind of problem; would you care to tell us a little bit about your illness, and the number of years you have been ill?

Mr. WALTERS. Well, I have been ill with emphysema going on 8 years, and it is gradually getting a little worse. As long as I behave myself, I can get along pretty good, and I do not try to overdo and overwork.

Mrs. CANDELARIA. You are under Medicare and medication?

Mr. WALTERS. I sure am, taking three at a time of medicines.

Mrs. CANDELARIA. Are you covered by Medicare?

Mr. WALTERS. Yes.

Mrs. CANDELARIA. Do you find this is adequate?

Mr. WALTERS. No, not entirely adequate. We have a little insurance that we have had for several years. In fact, we have had the hospital policy, I imagine, since I have had the darn thing for 35 years.

Mrs. CANDELARIA. I see.

Mr. WALTERS. It does not pay much anymore. It is kind of outdated, but it helps.

Mrs. CANDELARIA. I see. Well, about 7 years ago, I met you under different kinds of conditions. At that time, you were bedridden, and you needed different kind of assistance than what you need today. Were there agencies available to assist you and to help in caring for you at home with your illness?

Mr. WALTERS. None whatsoever, except my wife, and that is what we do need, I think, out here in this district, is some home nursing care of some kind, so that he could help people. I do not claim to know what it is about, how to go about doing it, but one thing we do need out here is that. We are supposed to have it, but you never see the people around.

Mrs. CANDELARIA. You were never referred, your doctor never referred anyone to you to assist your wife with the care, home health care type things?

Mr. WALTERS. Not a bit, no, never, no.

Mrs. CANDELARIA. In your opinion, was the care something that you could have used, or was your wife able to take care of you adequately?

Mr. WALTERS. At that time, we needed help, because I was almost helpless, at that time. I would have to stop several times just to walk across the room, and I could not do nothing, not a thing. She had to do all of the work, inside and outside, and we have a pretty large lot up there, too large, and for one person to take care of, that is a lot of work.

Mrs. CANDELARIA. Plus caring for a sick person.

Mr. WALTERS. That is another thing. I think we need somebody. Now, I cannot afford to pay wages, the going wages for stuff, but I know there are people that do things cheaper, like painting the eaves on the house ,and stuff like that, around the edges of the house, and it needs it bad, and I just cannot afford to have it done, but I know there is people out that set up in some community, where some older person, I do not care how long it would take them, to give me a flat price.

Mrs. CANDELARIA. So there are all kinds of needs by not only the elderly, but those not able to function because of some illness.

Mr. WALTERS. I know that. If I could do it, I would do it myself gladly, but that is what I say, there are probably some old people out here willing to do the job, if you just knew that they were there.

We need an information center, really, to let people know who does these things, and how to get it done.

Mrs. CANDELARIA. I would agree with you. We have tried for many years in this area to develop some kind of multipurpose center, but hopefully now with the mental health coming in, something might materialize.

Mr. WALTERS. I hope so.

Mrs. CANDELARIA. Della, is there anything that you would like to ask Mr. Walters? With the kind of dedication we have from Della, that is almost unheard of these days.

Mrs. MIRABAL. Are you having any problems?

Mr. WALTERS. I cannot think of anything except that we should have an information center set up over there. The list of things that people will do, you know, they can do. I know there are a lot of people around the neighborhood that would like to work a couple of hours a day or something, but nobody knows how to get ahold of them.

Mrs. MIRABAL. The people need to be informed?

Mr. WALTERS. That is what I say, we need an information center over there, as much as we need anything.

Mrs. CANDELARIA. Thank you, Mr. Walters. It has been a pleasure, and I am very glad to see you under different circumstances up and around.

Mr. WALTERS. I remember the last time, I imagine I looked quite a bit different.

Mrs. CANDELARIA. Thank you.

[Mr. Ramon Benegas did not appear on the video tape, although he was interviewed. Mr. Benegas is age 83, married, retired, and an invalid since 1956, 18 years ago. He has railroad retirement, Medicare, and no home health care assistance of any kind, sought assistance from HSSD, but was told he was making too much money. Mr. Benegas has rheumatism, has had a medical problem, and he has gained the use of his arms, unable to walk. Mrs. Benegas is age 65, and she has full responsibility for total care without outside help.]

STATEMENT OF JOSIE CANDELARIA, HEALTH PLANNER, MID RIO GRANDE HEALTH PLANNING COUNCIL, ALBUQUERQUE, N. MEX.

Mrs. CANDELARIA. I have identified needs, and I have come up with several recommendations, Mr. Chairman, which were presented to our council. They were approved, but yet have not been adopted, and they will be a part of your record. I have submitted them to your committee.[1]

Some of the problems in the area are that we have found that there is a need for doctor consumer education, of standards for agency licensure for providers which have been touched on, standards for home health aides, and certification of home health needs. This would also include insurance provisions for home health, that they be mandatory. I just thought I would mention that.

I have done something a little differently in the area of interviews, with the assistance of Dr. McCarthy, and also with the cooperation from the mental health centers that provided the manpower and equipment for us to go out into the community and take these interviews.

I also wanted to stress a point, that many people would love to be here again, people who are unable to come for many reasons, transportation, illness, and what have you.

We interviewed a total of four, three we video taped. The fourth one, we were not able to tape for the simple reason that it is the classic experience of insecurity of the elderly. Anyone that comes into their

[1] See appendix 2, item 3, p. 1136.

home, they feel is a threat to their security, and that is what happened with the fourth person.

Senator DOMENICI. Thank you very much. We are going to have to move on to the other witnesses. The transcript of the three people interviewed will be made a part of the committee's record. Certainly it will not be as good as seeing it, but it is the best we can do under the circumstances.

We greatly appreciate your helping us, Mrs. Candelaria, on this point, and ask that your stay in touch, as we move through the legislation throughout the next few months.

Mrs. CANDELARIA. Thank you very much.

Senator DOMENICI. Our next witness is David Jensen, executive director, Cooperative Health Services, Albuquerque. I understand you will be telling us about some ways we might fill the very, very serious vacuum in home delivery of services to the elderly, including nurse practitioners, paramedical type.

Mr. JENSEN. Essentially, practitioners.

Senator DOMENICI. You may proceed.

STATEMENT OF DAVID JENSEN, EXECUTIVE DIRECTOR, COOPERATIVE HEALTH SERVICES, ALBUQUERQUE, N. MEX.

Mr. JENSEN. Cooperative Health Services, a joint venture of Presbyterian Hospital Center and St. Joseph Hospital in Albuquerque, was formed in 1971 to pursue solutions to the broad problem of cost and availability of health care in both urban and rural New Mexico through the application of the resources from the private sector. During the past 3 years, Cooperative Health Services has developed four major programs aimed at improving health care for area residents. The programs, all operational, include two primary care clinics in medically underserved rural communities, a hospital-based home health care program, an emergency services system, and a prepaid, comprehensive health care plan—HMO—which is sponsored by our hospitals and their medical staffs.

Cooperative Health Services is not incorporated, but has organized four separate nonprofit section 501(c)(3) corporations to administer our programs which include the following:

(1) Southwest Health Care Corp. (SWHCC), which administers clinics in rural, medically underserved communities. The clinics include the Bernalillo Medical Clinic and the Hope Medical Center in Estancia. Clinics in Pecos and Tijeras Canyon are planned to open in July 1974.

(2) New Mexico Health Care Corp. (NMHCC)—Mastercare, a prepaid health care plan sponsored by Presbyterian Hospital Center and St. Joseph Hospital and 230 participating physicians on their medical staffs. Mastercare is in its second year of operation and is a self-insured health care service organization.

(3) Bernalillo Health Care Corp.—an emergency medical services system which operates Albuquerque Ambulance Service.

(4) Home Health Care—a hospital-based home health care agency, which is Medicare-certified.

Of primary concern to this committee are our activities in rural health care delivery. All our rural clinic personnel are employed by

the Southwest Health Care Corp. The Bernalillo Medical Clinic is staffed by a salaried physician and receives Medicare reimbursement. The Hope Medical Center is staffed by a family nurse practitioner, a type of midlevel medical practitioner, and is not presently eligible for reimbursement under Medicare, part B.

The Hope Medical Center operates as follows: The center is staffed by a family nurse practitioner, who functions under the standing orders and supervision of a panel of physicians in private practice in Albuquerque, 60 miles away. Mrs. Martha Schwebach, the family nurse practitioner at the Hope Medical Center, was the first family nurse practitioner in the United States.

The model was developed by Edward A. Mortimer, Jr., M.D., and others at the University of New Mexico Medical School in 1969 under HSMHA contract No. 110–69–241, "A New Manpower Model of Rural-Urban Linkage for Improved Health Services."

I am certain you have heard of the project. An exhaustive report covering the results of the $750,000 5-year project established the fact that high-quality medical care is provided by such a carefully supervised nurse practitioner. The report went on to analyze many demographic, economic, and epidemiological aspects of the impact of delivery in this new model.

Cooperative Health Services

In October 1972, Cooperative Health Services, a joint venture of Presbyterian Hospital Center and St. Joseph Hospital in Albuquerque, assumed management of the Hope Medical Center and placed the nurse practitioner under supervision of a panel of private physicians in Albuquerque. The model has worked well indeed. Not only does it provide high-quality primary care to rural areas, but the model is economically viable in sparsely populated areas which cannot support or attract a physician. We are pleased with our experience at Estancia, and we plan to open two new family nurse practitioner clinics in July 1974.

As I mentioned, we are at financial risk for the success of the clinics we manage. We are reimbursed for the nurse practitioner services by Medicaid and by New Mexico Blue Shield, as well as by commercial insurance companies.

The one stumbling block which has prevented us from breaking even and reaching older persons effectively has been the legal prohibition by Medicare for reimbursement of services when a physician is not onsite.

Since Medicare will not reimburse Hope Medical Center, most patients with Medicare pay out-of-pocket, and then must meet their deductible all over again when they are referred to one of our backup physicians or other Albuquerque specialists. Many retired persons are located in the area served by Hope Medical Center, but we have to tell them that Medicare will not reimburse us. It is all very confusing and inequitable, to say the least, leaving the elderly without accessibility to Hope Medical Center and to some degree, damaging the center's reputation and its prospects for breaking even.

Just this week, a woman came into the Hope Medical Center, and when the staff told her that Medicare would not pay for services provided at Hope, she decided that she would travel to Albuquerque to see a physician. She had already met her deductible for the year out of part B and naturally was reluctant to incur additional out-of-pocket expenses.

By refusing to reimburse for services provided by the family nurse practitioner, Medicare is in effect telling Medicare beneficiaries that the insurance they have paid for is not valid at the only source of medical care available to them within 60 miles. The irony is even greater when it is realized that the cost of care is significantly less at the center than it is in Albuquerque—thus Medicare is seen to be driving up its own costs by not reimbursing nurse practitioners.

Torrance County, like other rural counties in New Mexico, has a large number of older persons. These older persons have stayed in their home towns while their children have moved to the cities. Yet we see Medicare denying coverage to these senior citizens where the care is most readily available.

Another irony about this situation must be mentioned. On one hand we have the Federal Government encouraging the development of new types of physician extender manpower and funding the training of such personnel—I've already mentioned the $750,000 University of New Mexico Medical School grant—but then, on the other hand, we have the Federal Government refusing to reimburse for their services.

Rural Health Care Financially Risky

Providing health care in a rural area is a risky financial venture because of the sparse population density. There is not enough money in rural areas to support a physician at the salary level which they demand. Our experience has been that the total cost of a family nurse practitioner clinic is about $35,000 per year, and we feel that a clinic with this modest budget can become self-sufficient in a rural area without Federal subsidy. However, such clinics cannot hope to break even without receiving reimbursement which would go to other providers for similar services.

Both the clinic as well as the older residents of rural areas are being starved out of existence. Seventy percent of the patients pay the fees out-of-pocket and have no health insurance for outpatient care.

It is incumbent on Congress to move strongly in the direction of amending the Medicare laws so that physician extenders of all categories can be reimbursed. As an interim step, it is our understanding that the Social Security Amendments of 1972, section 222, title II, provided for a demonstration program of reimbursement under Medicare for services provided by nurse practitioners and physician assistants. This section has yet to be implemented, although we have heard that steps are now being taken to bring it about. We would like to participate in such a program of experimental reimbursement and, in fact, have been seeking such a solution for several years.

Senator Domenici. Would you say physicians assume the full responsibility?

Mr. JENSEN. Yes, they assume the legal and ethical responsibility; so she is totally backed up.

I believe that our organizational design meets both requirements stated in section 222, title II, of the Social Security Amendments of 1972, which are:

(1) The family nurse practitioner is legally authorized to perform in New Mexico.

(2) Physicians assume full legal and ethical responsibility for the necessity, propriety, and quality of care rendered by the nurse practitioner at the clinic.

Any assistance which this committee could provide would be greatly appreciated and should be directed to: Office of Research and Statistics, Social Security Administration, Washington, D.C. 20009.

I am enclosing a packet of materials for your files about our Hope medical project:[1]

(1) Copy of the AMA publication, PRISM, article of October 1973, describes the operations and organization of the Hope Medical Center.

(2) Copy of the Albuquerque Tribune article of March 6, 1974.

(3) Copy of a physician contract to supervise the family nurse practitioner and to assume professional liability for her activities.

(4) Copy of a letter from the group insurer of professional liability in New Mexico regarding physician involvement at Hope.

(5) Copy of Hope Medical Center stationery, which shows the professional organization of the center.[2]

In addition to these data, we prepare monthly financial statements—balance sheet and earnings statement—which would be available to you upon request. Accounting is done on an accrual basis. Our direct patient expenses average about $2,500 per month. Average patient revenue is $2,200. Obviously we are extremely close to the breakeven point, and with the ability to serve Medicare patients and collect from Medicare, we could operate at better than breakeven.

Again any help that you could give us in having Hope Medical Center and our two new family nurse practitioner clinic sites of Tijeras Canyon and Pecos selected as sites for experimental direct Medicare reimbursement would be of great help.

In summary, if the needs of rural health care are to be effectively met, especially the needs of elderly rural residents, then it is incumbent that Congress continue to support the development of physician extender roles, and that Congress amend the Social Security laws to allow Medicare reimbursement for such extender roles. I might add that some of the present congressional concern with national health insurance should be directed to seeing that physician extender roles are included and reimbursed under the NHI law whenever it is forthcoming and whatever form it takes. Thank you.

Senator DOMENICI. In terms of the operating statement of the Hope Medical Center, would it not be your observation, because of the failure of Medicare to pick up senior citizens expenses, that perhaps the senior citizens would otherwise use that facility who are going somewhere else?

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[1] See appendix 2, item 4 p. 1140.

[2] Retained in committee files.

Mr. JENSEN. Precisely. The senior citizens are forced to travel to Albuquerque, 60 miles away, and they incur those expenses of travel, but they do get their care there, because we cannot support it at the clinic.

If we could support it at the clinic, the clinic would break even, and health care would be accessible to these elderly people, so we think it would be a distinctly viable health resource.

Senator DOMENICI. Is it not true that in the normal operation of the center many of the services that you are performing in one of your satellite clinics are indeed performed within a more typical institution of medical delivery—the doctor's office, the clinic, or the hospital—and in fact, Medicare pays for a portion of that?

Mr. JENSEN. Right.

Senator DOMENICI. Medicare will not reimburse any services at your clinic?

Mr. JENSEN. That is correct, unless the doctor is onsite, and has actually rendered services to the patient. Medicare will not pay for any physician replacement activities, which is essentially what a nurse practitioner or a physician assistant is doing.

USE OF QUALIFIED PRACTITIONERS

They are doing this midlevel sort of thing that can be done by less than a physician, but still a highly qualified practitioner.

Senator DOMENICI. I would like to know—and perhaps you can review it in your spare time—how you feel about a bill introduced by Senator Church, the chairman of the Special Committee on Aging, that would encourage greater use of nurse practitioners. It is our understanding that it deals only with nursing homes, and certainly you are not objecting to that; your testimony has to do with the method differently, completely different in use.

Mr. JENSEN. We would certainly encourage that particular bill, but would like to see people move beyond that bill, and we recognize that midlevel practitioners should be reimbursed, if they are appropriately supervised, and not just in specific instances, but across the board.

Senator DOMENICI. We thank you very much.

Mr. JENSEN. Thank you, Mr. Chairman.

Senator DOMENICI. Our next witness is Mr. Lester Rigby, director, Area Agency on Aging, Socorro.

Let me share with you a few thoughts, because it is relevant in much of the testimony.

The White House Conference on Aging, which many of you are aware of, certainly from the standpoint of ideas, indicated that it was desirable for this country to move to alternatives to the present institutions in terms of delivery of health care for senior citizens.

Much of the testimony today goes to that, but it is our observation on that very few objective improvements in changes go toward the kinds of things we have heard about this morning, away from typical institutional approaches. It is nowhere closer to reality today than it was when the 1971 White House Conference on Aging concluded.

Mr. Rigby comes from Socorro, which I assume most of us would call rural New Mexico, in the sense of distinguishing it from a metropolitan area like Albuquerque.

For those who have expressed concern to me privately today that we ought to zero in on rural health problems, I want you to know even if we cannot bring the formal hearing committee process to rural problems this year, I will attempt to have some informal hearings that will zero in on health delivery problems in rural New Mexico.

We will build it into our own itinerary between now and December, so we will have a chance to focus in on a couple of communities for a few hours on differences between metropolitan problems and rural problems. I think Mr. Rigby will speak to that, at least to some extent today, in his capacity as director of the Area Agency on Aging in Socorro.

Will you please proceed, sir.

STATEMENT OF LESTER RIGBY, DIRECTOR, AREA AGENCY ON AGING, SOCORRO, N. MEX.

Mr. Rigby. Thank you very much, Senator, members of the Senate staff, and the people who are interested in the elderly. I am very glad to be here from the rural area, and it is certainly that. We have 10,900 people in 6,600 square miles, and that would indicate that we are rural residents. I also have two other counties, and one of them is even more rural, and that is Sierra County, and the other is a little more populated, which includes Dona Ana, the center being Las Cruces.

The elderly in the rural areas have the same problems as the elderly in urban areas. However, the rural dwellers problems are compounded by distance, disinterest, and monetary delimitations.

They are not discriminated against because of race, creed, or ethnic background, but rather because of geography.

One of the most difficult problems in rural areas stems from the lack of advocacy. The provincial sociology is not only prevalent among the elderly, but it touches all of the rural institutions—the municipal and/or political management find money hard to come by, and much harder to get back into circulation, particularly to alleviate human distress. The levels of education, and lack of affluence fail to produce sustained leadership, and the rural elderly are more resistant to social services than those in urban areas. The vigor of the young is prominently missing because they leave the occupations of the soil for more promising opportunities.

Critical Need for Doctors

The critical need for doctors is prevalent throughout the rural area of this State. In a particular case of which I am aware, a scattered population of 2,800 is in dire need of a doctor. There is not a practicing physician or any medical facility extending from the city of Socorro to Springerville, Ariz.—a distance of 157 miles.

In an attempt to get a physician through the offices of the National Medical Service the hope of these people was thwarted by the failure of the area medical association to give its approval of the application. It is difficult for these people to understand why the decisions of the National Medical Service, in making awards, must depend upon the

whims of a professional association, which if it were truly professional, should be spearheading the search for qualified doctors for these rural areas instead of autocratically shutting the door to professional medical progress and support. This smacks of blackballing, which is an undesirable practice in private organizations, but must not be tolerated when it interferes with the public's interest.

Those elderly in rural areas and indeed in rural cities, must pay on the nose for the purchase of drugs. I mention elderly specifically because they have more health problems. Independent drugstores in rural areas charge from 50 to 300 percent more for drugs and medical supplies than the cutrate urban market. This highlights the fact that indigence and high cost have an unholy alliance. In an instance when I personally took the prescriptions of an elderly lady to a drugstore and was astounded at the cost, she merely acknowledged it by saying "them what has, gets." This old saw may not be dignified by good grammar, but one does not have to have a doctorate in economics to recognize the truism.

Transportation is a tremendous problem. Not only are there no public buses, no cabs, but the rural poor and the rural elderly usually own the least reliable private transportation. In cases of emergency, where each minute is important and the nearest doctor or hospital is from 25 to 80 miles distant, you have little difficulty in considering the probabilities.

The matter of long-term care is indeed a tragic matter. Those elderly who are no longer able to care for themselves, who are not acutely ill, but have reached the inevitable period of senility must be admitted to nursing homes. But the nursing homes are not located in rural areas. Those final helpless years must be spent isolated from family and friends.

All the money spent on programs for the aging—to induce the elderly to stay in the mainstream of life is thrown to the winds at this critical time in their lives. Too old to walk straight, too old to see the small print, too old to wash one's hair, they also become too old to enjoy the warmth of family and old friends. It makes one wonder about the loss of the three generation family, and the regression to our present status. They become displaced persons in a land of plenty.

The social agencies dealing in health, aging, and welfare, or at least the workers in these agencies know that.

The per capita costs for service in the rural areas are greater than that in the urban areas. Thus the cost of outreach to the rural areas receive only the amount that's left over, which does not begin to meet the needs. Funded programs do not have the elasticity to provide help in these remote areas.

Private resources in the rural areas are a great deal less than in urban areas. The smallness of religious groups, the absence of service clubs, the loss of protective members of the family group, and the insensitivity of the metropolitan areas, where the largess exists who fail to play a role or accept responsibility for adjacent rural areas are all contributing factors.

To finalize, the concept may be that the rural elderly have a row of corn, a row of chili, a patch of potatoes, a big fat hen, a bottle of

liniment, a bag of asafetida, a wood-burning stove, and a roof over their heads to fall back on, and their human sufferings are out of sight. While this may sound like Charles Dickens in the early 19th century, one may find, in some instances, that is not an overdramatization of how things are today—in the boondocks.

Senator DOMENICI. Thank you very much. Let me say that I am impressed with your observation about the lack of advocacy. I might say, however, you attribute the fact that one need not be a longtime resident of rural New Mexico to become an advocate for their needs. Some of you do not know that he is a transplant in New Mexico, and he did not come from rural anywhere. He came from New Jersey, in fact, he was the county commissioner, not somebody that worked out in the county. He was the mayor of a city. If we could find more advocates that so often are ranks, that do not have to have lived it, but understand it, perhaps the advocacy of rural health care would get a great boost. We greatly appreciate your observations. I do not think it is Dickens. I think it is for real.

MATCHING REQUIREMENTS

I want to ask you one question dealing with the Older Americans Act, as it deals with rural areas. Is there a difficulty in meeting the matching requirements of 75/25 for community services for nutrition?

Mr. RIGBY. Well, normally we can meet in-kind contributions until we reach 25. After 25, it becomes an extremely difficult problem.

Senator DOMENICI. So you meet it with service and the like? It would be almost impossible if it were truly dollar for dollar?

Mr. RIGBY. It just is not there, not dollar for dollar. In-kind, it is.

Senator DOMENICI. Do you feel, as I understand your description of so-called established ways of funding the needs of society, that the county commissions, mayors, and their functions are finding it very difficult to bridge the transition from the more established roles to the role that requires that they be involved in the kind of program you are discussing? Is that correct?

Mr. RIGBY. That is correct. It takes a great deal of selling actually from outside social groups.

Senator DOMENICI. We thank you very much and appreciate your coming here.

Mr. RIGBY. Thank you for the very nice compliment.

Senator DOMENICI. I want to comment on that part of the discussion, Mr. Rigby, that has to do with drugs and rural America. I hope you understand there are an awful lot of people concerned, and that there is an effort to try to solve this problem.

There are a number of bills in the Congress, and a number of actions to try to zero in on how to get doctors or adequate professional medical people into rural America.

Nobody has solved the problem yet. We will take the one observation you have about who ought to certify what into consideration. We were unaware that we had that kind of problem existing, but if there are any suggestions as to how we can better encourage doctors, through legislation or otherwise, we would greatly appreciate it.

It is a very longstanding and difficult problem. We are nearing the end of the hearing, and I want to remind you that if you want a

copy of this transcript, which the Special Committee on Aging will make available to those who attend these hearings, you will have to leave your name and address at the door.

There is no other way we have of getting it to you. If you leave your name and address you will in due time receive a copy from the committee for your own use, or use in your activities, and you pursue it because we are discussing what is imperative to you here today.

Our next witness is Dr. Eric Best, president, Albuquerque-Bernalillo County Medical Society, Albuquerque. Is Dr. Best here?

Doctor, we appreciate your taking the time out to come here, and I know that we could spend a lot of time talking together, and asking questions of you.

We do not have the time, but I know of your willingness to discuss the problems so we would appreciate it if you would make your statement within the time allotted.

STATEMENT OF ERIC BEST, M.D., PRESIDENT, ALBUQUERQUE-BERNALILLO COUNTY MEDICAL SOCIETY, ALBUQUERQUE, N. MEX.

Dr. BEST. I would like to thank the committee to allow me to appear. Before I go into my formal statement, I should comment on Mr. Rigby's comment about the medical societies, the figures in rural communities.

The medical societies per se have nothing to do with the physician's practice. In fact, you need not be a member of the medical society to practice in New Mexico. One needs to meet the licensing requirements of the State to be able to practice in the city of your choice. The State medical society has recognized the needs of rural medicine, and we have this year formed a committee on rural health and also a committee on aging, and we hope we will be able to work with your committee, in formulating certain policies.

I have only a few general comments to make, and I would like to start by saying that the World Health Organization defined health as a state of complete physical, mental, and social well-being, and not merely the lack of disease and infirmity.

The significant health problems of the aged is the ability to adapt to the problems of chronic illness. Approximately 25 percent of the elderly have major problems of adaptability, because of a problem in chronic illness. Medical care to date has been directed at handling a few problems primarily, and not at the chronic problems that many of the elderly have a burden with.

I think we need to formulate a system of support which is different than what we are routinely concerned with. I think the elderly by and large need to have programs directed at personal care, which would include hygiene, personal hygiene, grooming, dressing, and so forth.

They also need supportive medical care, they need extension of the physician in areas that have been mentioned by many here today, in the form of practitioners, social workers, outreach workers, and so on.

This we need to be involved in, and certainly I think your committee, and the Government, has taken steps in this direction. I think more needs to be done.

Maintenance services are a necessity for the aged, the housekeeping, the environmental hygiene, food preparation, all of this needs to be done.

Mental health counseling, we need to be concerned with, and most important, I think, probably not, but important, we need outreach information of what support services are available.

We need transportation and communication with the elderly, so that we can make available to them the resources that we now have available without duplication. I think that society's attitude is social ostracism. This has been mentioned before, and I think we need to devise ways through the media, giving the elderly a place in the society again.

Many Elderly Feel Useless

The previously multigeneration family has been displaced by the nuclear family, which means the elderly now are put out of a primary home, and they feel useless, and I think we have to by some mechanism devise a plan that they can again feel useful.

Many of the elderly, I would say, most of the elderly were productive citizens, and at the age of 65, there is no need to lose their productivity. I think the Social Security system can prevent this from occurring, and I think we have to do something about it.

I think there are many jobs that we should encourage the elderly to be a part of, and I think this will go a long way toward improving their mental health.

If I might talk a minute about economics, to me the income of the elderly is less than half that of a younger counterpart, $95 a week for a couple is the median income of the elderly.

The Government has not decreased compensation for health care providers, which actually defeats the purpose of Medicare itself, for it increases the burden of expense on the elderly. They have also established what we now call a professional review organization, which is termed PSRO, which the medical profession finds somewhat objectionable, but certainly is willing to accept and cooperate with their program, provided certain amendments are made in the PSRO law, which I hope to include in my report to you.

To summarize briefly, I think there is really no magic formula in determining what to do with this problem. It is a big problem, but I would like to offer some suggestions. I think we should upgrade the outpatient home aspects of health care, with different manpower equivalent. That is, using more nutritionists, more outreach workers, more social workers, more paraprofessionals in order to support a community system.

We should create an atmosphere of need by utilizing the experiences of the elderly, again without penalizing them for being involved in gainful employment.

We should continue to rely on federally sponsored programs, rather than State programs, for I feel that three States, California, New York, and Pennsylvania, have approximately one-fourth of the population over 65, and they are composed of only 25 percent of the total population, so I think Federal involvement is mandatory and necessary.

I think we need to have realistic standards of quality of care, both in institutional and by provider groups, but I think these standards should best be handled by peer review instead of a governmental review.

I think we should provide somehow incentive for home care so that many of the elderly will function outside of an institution, and that they would function in society.

I think that if we could do this, we may well be able to decrease the amount of moneys spent in institutional care.

Approximately 48 percent of the health costs, of those over 65, was used in caring for the patient in the hospital for an acute problem: 17 percent of the health care dollar was utilized in nursing home care; 18 percent for physicians' care, 10 percent for drugs, and 8 percent for other professional services.

Medicare for Preventive Medicine

I think the thrust of the Medicare program should be toward preventive medicine, rather than in the area of treating acute problems. I think even if we were not able to decrease the moneys expended in treating the elderly, we certainly would be able to give them a more meaningful life, a better quality of life.

I again appreciate this opportunity to address this committee.

Senator Domenici. Doctor, we all appreciate your views, and I think we are all searching for the same thing. The question is how long will it take us to get there. I think I have an answer to my first question, based on the philosophy you have expressed.

Is it fair for me to assume that you favor the attitude expressed by the witness describing the Hope satellite facility in Estancia, and you would favor the inclusion of care costs within the concept as part of Medicare?

Dr. Best. Yes, and I would think that the paramedical personnel, or the nurse practitioner, should continue to be under the direction of a physician.

I would think that the responsibility of care and the ethics of treatment should continue to be directed by the physician through the nurse practitioner or the paramedical personnel, but we agree with the concept.

Senator Domenici. You mentioned the percentages of medical dollars spent for the senior citizens. A very high percentage, attributable to treatment in an institution called a hospital.

Dr. Best. Yes, sir.

Senator Domenici. Now, you are not suggesting that that is necessarily too high a percentage, but I gather from your philosophy again, that you favor the basic trend expressed here this morning—that we ought to move toward alternative type treatments, as a national policy, so as to minimize total reliance on institutional-type treatment, either because it comes too late, or it is perhaps used when it should not be, because of limitations imposed on helping our citizens pay for medical care. Is that a fair assumption?

Dr. Best. This is true. I would like to comment that I think that there is very little overutilization of hospital beds. I think semantically, we have used the term which in the Medicaid philosophy, hospital necessity, which would mean that it is necessary for this person to

be in the hospital, and then there is a term hospital need, which the physicians use frequently. The difference is that under the Medicaid law now, if you have one cataract operation, it is not a medical necessity for you to have the other cataract attended to because you can see. However, medically, it is a need to have the operation so you can see better. I think there is not an overutilization of hospital beds, but I hope that by preventive medicine, we would be able to reduce the number of patients who need to go to the hospital, so in essence, yes, sir, I agree with your comments.

Senator DOMENICI. Then speaking in your capacity, would your association—or individually—would it be fair to further assume that you favor a development of paramedics, paratype medical delivery system and personnel, so long as they are trained properly from the beginning, as a means of delivery in the preventive area as compared with what we are now doing, which is basically bring the patient to the established kind of delivery system?

Dr. BEST. That is very true, plus I would like to expand on that just a little bit if I might.

Senator DOMENICI. Please do.

HEALTH CARE COMMITTEE CONCERN

Dr. BEST. I think physicians have been concerned primarily with medical care. This committee is concerned with health care, which includes medical care, plus many other areas of health needs of the aged, which means that we would not be involved in the total health care of the individual, we would only be involved in the medical care, and the extension of that medical care to paramedics.

In other areas, we would need to have expertise so the nutritionists, the social workers, the psychologists, the outreach workers, the environmentalists, transportation authorities, on how best to have handled these other problems, but I think a total thrust envelops many professional groups in order to provide health care to the elderly.

Senator DOMENICI. But it is fair to assume that the medical profession, as you view it in your representative capacity, would be willing to cooperate and work toward that end? Is that correct?

Dr. BEST. That is correct, sir.

Senator DOMENICI. One last question has to do with the part of Medicare, which permits physicians to refuse an assignment and not be limited by what Medicare describes as reasonable fees. We have some indication that this causes a great deal of confusion among Medicare recipients who think Medicare covers 80 percent of the Medicare part B, physicians' fee.

Do you have any suggestions or thoughts with reference to dealing with that problem?

Dr. BEST. Yes, sir. I feel that the Medicare now pays, I believe, at the median level of 75 percent for the 1969 fee level, which is less than the usual office fee that the physician charges. I feel that the physician should be reimbursed on his present fee level. Remember that only 17 percent of the health care dollar goes to physicians' bills, so this is not the expense in Medicare. The expense is 48 percent that goes to institutional care, and nursing home care, and I think the

adequate reimbursement for the physician would probably handle this problem.

Senator DOMENICI. Two last questions. We are running over, but it is not your fault.

SPECIALISTS LACKING

Let me ask you, is it not true that basically the medical doctor does not really specialize, there is not a great deal of specialization in terms of their overall practice being strictly to take care of the problem of the elderly?

Dr. BEST. There are very few physicians in Albuquerque, in fact, I think there are none who specialize in geriatrics.

Senator DOMENICI. So, therefore, any infringement upon the fee schedule in terms of Medicare setting its percentage, or using a schedule that is too old, in a sense is only a small portion of the medical doctor's total practice, is that correct?

Dr. BEST. In Albuquerque, this is true, and probably in most other communities.

I do not really know the percentage of practice that is in the over-65 age group. I would say it is about 10 percent, but I am not really sure.

Senator DOMENICI. So that a real financial crunch on the medical doctor would be in a situation where most patients were Medicare, Medicaid, and senior citizen, or senior citizen oriented. Is that correct?

Dr. BEST. This is true, and this occurs in some parts of the State where it does create a financial hardship on certain physicians.

Senator DOMENICI. This is a completely different question, but in terms of getting doctors to rural America, and rural New Mexico, do you think there is any merit to start at the very beginning in medical school with the notion that, based upon incentives, physicians commit a portion of their early medical practice to rural America? We would appreciate your thoughts on that.

Dr. BEST. I think in the past programs such as this have failed. Certain of the Southern States I am aware of pay medical school expenses, provided you were to practice in an area selected by them, which would be a rural area, and this did fail.

I feel that I do not have the answer to how the physicians in the rural community would take that. We are an urbanized society, and I think physicians like others migrate to the urban areas. I think as a stopgap measure, the use of paramedical personnel would be helpful, but I do not have the answer to the problem. I hope that our committee on rural medicine this year will come up with some suggestions on how this can be accomplished.

Senator DOMENICI. One last thought in the area, you need not address yourself to it, but it appears to me that the medical profession in America is beginning to recognize that there very well might be areas of delivery of their service which get closer to public need than the old and enduring and good patient-client relationship.

It seems to me that we can only wait so long for a serious vacuum to be filled, and then we tend to look for an answer in the public health service area.

I find, and it is healthy, as I see it, that the medical professions are beginning to try to work with people, are concerned about that, and not

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instantly accuse them of destroying the relationship with the doctor and patient, which I think most people want to preserve.

I find areas where I wonder if we are ever going to fill—cities of 2,000, 3,000, areas of 8,000 with one doctor—we do not seem to have found the clue as to how we get the actual professional man, the doctor there.

Would you just comment briefly on what I have just said and if you do not care to, I would certainly understand.

Dr. Best. I think that the physicians feel sacred the relationship between the patient and the physician, and I think this is an all-important concept to preserve.

I think many of our fears regarding PSRO is that the records will be made available, not only to anyone who might be managing the computer, but would be available to any secretary, or anyone else who might want to come into your office to view the records, and there certainly we would want somehow to see some restriction.

Paramedics Can Do More

I feel that we recognize that we cannot handle the health care needs of the population. It is much more specialized now than it was. We still feel we can handle the medical needs of the population. We do not feel by using paramedics, we are losing this concept.

We do not feel that this is a violation of the patient-physician relationship, because a paramedical personnel also will be part of the physician or paramedical patient relationship which is so meaningful.

We recognize that the third party payments now handle 50 percent of the over-65 health dollar, and I think about 50 percent of the population of New Mexico have some type of health insurance.

If we can separate this from the physician-patient relationship, which so far we have done, I think this is good. I think we can work with this very well.

Senator Domenici. Thank you very much, Doctor.

Dr. Best. Thank you.

Senator Domenici. We will now hear from a panel of witnesses. We are running slightly behind, but not enough so that we will not finish up.

The members of the panel are Mrs. Barbara D. Menzie, executive director, Metropolitan Areawide Agency, Albuquerque; accompanied by Mrs. Emma Sabatka, also by Mrs. Mary Lou Banks, supervisor of nursing staff, district III, Bernalillo County Health Department, and Mrs. Mary McKinney, Outreach worker, Bernalillo Family Health Clinic.

Mrs. Menzie, you and your staff have been very helpful. As I understand it, you will open, and then we will proceed with Mrs. Sabatka, Mrs. Banks, and Mrs. McKinney.

However, if you do not want to do it that way, you use your own approach.

Mrs. Menzie. We do have a substitute for Mrs. Banks. Dr. Henry is substituting for Mrs. Banks.

Senator Domenici. Thank you very much.

STATEMENT OF BARBARA D. MENZIE, EXECUTIVE DIRECTOR, METROPOLITAN AREAWIDE AGENCY, ALBUQUERQUE, N. MEX.

Mrs. MENZIE. We do appreciate from the standpoint of the Metropolitan Areawide Agency, this opportunity to testify at this hearing, Senator.

We have felt that what you wanted in a closing panel were perspectives on the local health issues as we see them, and we have tried to do that.

I would like to say a few words on the perspective of the areawide agency, and we would like Mrs. Sabatka to speak from the perspective of an older person, who has worked many years in the field, as a volunteer.

From the standpoint of public health will be Dr. Henry, and then from the standpoint of Outreach and family health will be Mrs. McKinney.

First, I feel that I must respond to the emphasis on needs of the rural elderly that has been stated earlier.

I must say that right in the beginning, I could not agree more with stated needs and problems of the rural elderly, especially in the area of health care, but I would like to totally disagree with the statement that many, many resources are available for urban elderly. This is a myth. There are over 35,000 elderly in Bernalillo County alone, of which 5,000 to 6,000 are totally isolated, as much isolated as if they were living 80 miles from Albuquerque.

The largest proportion of elderly poor are living within the metropolitan area, and for them urban resources do not exist.

It is even more difficult for the urban elderly to use the system. In fact, they are unable to use the systems that have been developed, for many reasons expressed in the testimony today. This is compounded by higher costs of living within the urban area. Because of the new emphasis placed on the AAA, agencies in the community are coming to us for funding, rather than the other way around. From the perspective of the area agency, in planning, developing, and tapping resources, and eventual delivery of service relating to health care of older Americans, we seem to be caught in the bind of restructuring and of new mandates from the Administration on Aging.

As a result of the comprehensive amendments of 1973, we are tied up in directives, mandates, clarifications, channels of communications, the restructuring of our State agencies, and a bewildering chain of events all following the 1973 amendments to the Older Americans Act.

As the 1973 amendments have been conceived, eventually the "buck will stop" at the area aging agency in the local community, for breaking down all of the barriers for health care for the elderly, in developing the resources, and finding more effective health delivery systems.

I find there are four major barriers to the AAA, as to their ability to function as mandated, in developing health resources.

First, the situation we know as the "hardening of the categories" is to be considered. The dismantling of the system of categories that we had learned to depend upon, the downgrading of categorical grants with the new federalism, the inability to even get categorical grants, because local match has become totally unavailable, is frustrating.

Elderly Benefit Little From Revenue Sharing

As to revenue sharing funds, as you know, less than two-tenths of 1 percent have been used for programs for elderly.

As far as we know, not 1 cent of revenue sharing money has been used in our own community for programs for the elderly.

Of course, we are beset in our area with many other problems, problems of drug addiction, problems of transients, problems of crime and law enforcement, which is where most of our revenue sharing money goes.

In fact, revenue sharing has been bad news for the elderly of our area, as far as we are concerned, with the accompanying downgrading of categorical grants.

Special revenue funds have been promised, but not forthcoming. The community development revenue sharing through HUD has not been passed, for example.

Second, the decrease of availability of title III funds. In particular, I am talking about the 1972 discretionary funds that were impounded and not released to the States, which were designated originally to go to areawide model projects.

Only recently, we were told that New Mexico would get $141,000 of 1972 discretionary funds, as our share. These funds were not allocated for services, but for SSI-Alert, training, and educational programs.

With the exception of SSI-Alert, which I felt has been very valuable, and very needed in New Mexico, the $141,000 is going to do very little good to the elderly of our State, rural or urban.

It is not being allocated to the programs where the need is. Preretirement planning for State and county officials—although I am not downgrading the value of these programs—does not help relieve the desperate needs of hundreds of high-risk elderly.

The university training projects, thousands of dollars go into that, to universities that have been allocated title III discretionary funds for retraining programs. This does not help us relieve problems of our elderly.

The third point is the 1973 amendments themselves. Those of us working in the field of aging for many years were elated with the comprehensive amendments of 1973, as being the approach that we have been looking for for 10 years, but there is a huge gap between the intent of the legislation as comes out of the Senate Committee on Aging, and as was passed by Congress, and later in the way that the Administration on Aging delineates the Federal regulations, the way it is coming down to us in the local area. There is a real gap.

I would like to refer you to the Banfield Report on Model Cities for similarities in the programs.

We are being overregulated and underfunded, and I would only echo what Dr. McCarthy said a little earlier, that we practically have a blueprint for failure.

The difficulty has been that our priorities have been pretty well set for us. Our objectives were supposed to come from the local level, but they have been preset for us, mandatory AAA functions with insufficient funding to carry out the functions.

The confusion on how to tap title VI under the Social Security Administration, looks very bleak to us, too.

The fourth point that I would like to mention is the multiplicity of health planning agencies. It is a frightening labyrinth of bureaucracy. If we are to plan decent health service systems for our elderly, and with our elderly, it becomes terribly complicated, and it has a bewildering effect on older people.

Health programs themselves have been cut back in their funding, and they are coming to us for title III funding, which are not available for health programs.

I would also go along with Dr. Best, and support very strongly a continued national emphasis.

We have a New Mexico interim legislative committee on health and aging, and I believe that eventually we will get good State legislation, but I think we are going to have to have some national emphasis. This is very important.

I would like to call on Mrs. Sabatka now to present the local health issues in perspective, from her point of view.

STATEMENT OF EMMA SABATKA

Mrs. Sabatka. Senator Domenici, members of the staff of this Special Committee on Aging, my name is Mrs. Emma Sabatka, and I am to present the local health issues perspective from that point of view. I am on the task force of the AAA, and I have served on the nutrition committee as well.

I am a retired person of 67, and what your committee might term as a consumer of elderly services. For 3½ years, I have resided in a very small apartment, and in a very tall building, and in a retirement complex in Albuquerque just across the freeway. God willing, I would like to live there another 25 or more years.

My limited income consists of Social Security, which I earned, and a pension which I did not. This is a widow's pension, which my late husband's employment provided.

Combined, these two together give me slightly more than the Government's designation of the poverty level. I believe that I am an average senior adult, with children and many grandchildren, but I prefer to live independently as long as I am able.

Persons of our age group are very appreciative of the great strides that have been made in geriatrics, as well as for the quality of medical care, which the new techniques employ, but how much of this is actually available to people in the middle income bracket?

Medicare Coverage Inadequate

I feel very comfortable carrying my Medicare card with the assurance that it will provide great medical benefits should I ever need hospitalization. Meanwhile, I am in reasonably good health, but I am alarmed over the rising costs of preventive health care. Would you believe that last year I had medical expenses of over $1,000 despite the fact I am not under the care of a physician, nor do I take any medication. Medicare did not meet my needs. It was the year of oral surgery

and dentures, in addition to requiring a hearing aid, and not to mention an ulcer threat.

When Medicare is revamped, to better serve the elderly, the extremely important health needs of vision and hearing aids, and dentures must be provided. The best dollar that Congress can save is the one spent on keeping the elderly well.

I am likewise concerned about the high cost of prescription drugs. Most of my neighbors are using prescribed medication, and many of them require such an expensive program, I wonder that there is sufficient money left to provide for a proper diet.

How can these costs be modified? Many aspects of the older person's well-being have received consideration at this hearing today, all worthy, but a vital element for total health care is adequate housing, and I beseech you, help lift the moratorium on the building of more fine retirement housing.

Housing allowance is a poor substitute. I thank you for providing this opportunity to hear from us, the new generation.

Senator DOMENICI. Thank you very much. Who is next?

Mrs. MENZIE. We will hear from Dr. Henry next.

STATEMENT OF DR. MARIETTA M. HENRY, BERNALILLO COUNTY HEALTH DEPARTMENT

Dr. HENRY. I am a public health physician with the Bernalillo Health Department, and I am representing Dr. Eva Wallen of the district office, who has prepared a proposal for health care for geriatric patients through the health department.

The first problem is a lack of funding. Although the New Mexico Public Health Department provides good care for children with children's examinations, and for women in the childbearing age in the family planning program, there is at present no program designed to care for the health and medical needs of the elderly, and more citizens are in this category in New Mexico each year, because of better medical care and longer life, and people coming here to retire.

Public health should give service to all ages, and the offices are already set up with much of the equipment and personnel which could supply important services to the elderly. In this program, we are proposing that regular monthly geriatric clinics be programed in the existing health offices.

In Albuquerque, we have recently expanded our capacity for giving service by two new health centers in the valleys, one in the north valley, one in the south valley.

Senator DOMENICI. Doctor, assume that became a reality, how many dispensing entities would that be?

UTILIZE PUBLIC HEALTH NURSE

Dr. HENRY. The public health department would have three centers then, one in the north valley, in the south valley, and the Stanford Street Center. We could use the local public health nurses, who could be trained by physicians and their staffs to do physical examinations, such as taking blood pressure, using stethoscopes to check the heart and the chest.

This nurse could check out major health problems, they could check for cardiac problems by doing EKG's, diabetic patients, both with health education, and by doing urinalysis and blood tests, anemia, any venereal disease problems which occur, vision and hearing problems—this would be mainly screening tests by using visual testing equipment and audiometers—tuberculosis, skin tests, and free chest X-rays, which would be available at our main office, and in the field of female cancer by doing perhaps the Pap test, and by teaching self-breast examinations.

These patients with abnormal findings by the nurse would then be evaluated by a public health physician, and it is possible that simple care could be given, and the more complex cases would be referred elsewhere.

Cardiac and tuberculosis clinics are already carried on in our main health office, and these patients would also receive the following services: health education, with nutrition in their personal health problems, and proper referral for social service needs, which our department already does, a sympathetic ear from someone who cares. Transportation would be a needed factor to get the patient to our health facilities. Home health visits, which we can do now with our public health nurses, who are already overworked, would be facilitated if we had Outreach workers.

So the main thing is that through public health, we already have an administration, we have medical personnel, we have most of the necessary tools, and what we need is the funding for extra personnel—health personnel such as public health nurses, or licensed practical nurses, and Outreach workers, and some form of transportation available for the patients.

Senator DOMENICI. What you are basically saying is that within the existing structure, if we could add to the resource capacity, that these facilities be expanded to take care of the kind of preventive and basic sort of health care that no one would object to from the medical delivery standpoint, because it is already licensed. It is professionally assured and the like, but you cannot deliver it now as a specialty for the elderly because of resources.

Dr. HENRY. Right. In maternal and child health, we have resources but nothing for geriatrics.

Senator DOMENICI. Do you have any idea of what funding would be necessary?

Dr. HENRY. It is estimated $14,000 to $15,000 per year for Albuquerque.

Senator DOMENICI. What is the recent status of such a proposal for funding?

Dr. HENRY. The proposal went through the health and social services department in Santa Fe, and it was rejected because of a lack of funds.

Senator DOMENICI. That would be the logical way it would go within the recent structure?

Dr. HENRY. Yes.

Senator DOMENICI. Thank you very much.

Who will be our next witness?

Mrs. MENZIE. We will now hear from Mrs. McKinney.

STATEMENT OF MARY McKINNEY, OUTREACH WORKER, BERNALILLO FAMILY HEALTH CLINIC

Mrs. McKINNEY. Mr. Chairman, and the committee, I am Mrs. Mary McKinney, Outreach worker, Family Health Clinic, and this is funded through HEW under comprehensive health services.

I see some of the barriers in the inner city of Albuquerque as being for the aged as a slow way to suicide, and as a community health worker, spending about 55 percent of my time with senior citizens, in one way or the other, as a direct health care service delivery, or doing blood pressure screening at the meal sites, supportive services, recreation centers, and home visiting, and giving lots of tender loving care, you become a friend to many of the aging people that you visit, or just, in one case, a daughter that cares they still exist, you do help them sometimes.

Many of our senior citizens have no families. Many of our senior citizens live alone. Many of those that I have daily contact with, when you hear and see them, it seems you are reading a mystery story.

As an example, there is this 83-year-old female living alone, her income is $116, before she started getting her SSI payment. Her rent was $75 a month for a very dilapidated house, plus utilities, and a telephone, the house did not even meet the city codes, and she really depended on her neighbors, her church, visiting nurses, the family health center, the mental health center, homemakers, and her caseworker, so you can see there were many agencies involved with this person.

Out of that money, she paid $14 for stamps. She had impaired hearing, she was in need of a hearing aid. She also had impaired vision, and she was in need of glasses.

After having a slight stroke, she had an impairment of her right hand and arm and of her right leg. She would also say, "I have been a good horse, and I have laid the foundation, and now nobody needs me, so they are going to put me in a pasture where there's no green grass." Her feeling was that she was not fit for anything, but just to die.

Before she went into the hospital, she felt that if I do not go to the hospital, they are going to put me in a nursing home, and when I leave the hospital with no one there to care for me, I would end up in a nursing home to die.

Senator DOMENICI. Could I stop you a minute there, please.

Let us assume that this lady that you just described all of a sudden she found herself in metropolitan Albuquerque. I do not know where she came from, but she is in a house somewhere in this town. Some friend or relative finds her in the condition she is in. She has had a mild stroke. I do not know how she survived to that point, but nevertheless, where does that person go in this metropolitan area to find out what is available to her?

Mrs. McKINNEY. She had the telephone number for the family health center, and when the neighbor found her in the condition she was in, she immediately called the family health center for help, and at that point I went out to see what the condition was, and called in a physician, who could give more medical evaluation, and she was admitted into the hospital.

Senator DOMENICI. But to a senior citizen, or senior citizen and friend looking for this kind of service, how do they know that a name like the family health center means anything to senior citizens?

INFORMATION CENTERS NEEDED

Mrs. MCKINNEY. Being an Outreach worker, part of my job is to inform the senior citizens, along with other agencies, what resources are available to them, but as I said before, I am just one person from this area that is doing outreach from the family health center, and there are many, many thousands of isolated senior citizens out there, so my plea would be to have some kind of program where you have funds to meet the needs and manpower, and not where you will give it 3 to 5 years, and then take it away, I mean a continuation of funds to reach these isolated people, centralized numbers and available persons to do followup.

Senator DOMENICI. My question is directed at this. Should not there be an appropriate office that is directly related to, by name and total dissemination of information as a place for the elderly, or the senior citizen to go to, or that someone could go from to find out what it is that is available in their community if for nothing else, than in the area of health care. There is no such facility, as I take it.

Mrs. MCKINNEY. Not yet.

Senator DOMENICI. It is being established?

Mrs. MCKINNEY. Yes.

Senator DOMENICI. Are you aware of it sufficiently to talk about it a minute?

Mrs. MCKINNEY. No; I am not.

Senator DOMENICI. Who is?

Mrs. MENZIE. One of the mandates for the area aging agency is to establish a total information and referral service with followup, and it is mandated, and also to bring together the information of referral services of Social Security information, the Federal information, all existing information of referral services in your community.

It is mandated that we do it. We are just getting off the ground.

Senator DOMENICI. What will it be called?

Mrs. MENZIE. We will call it Senior Army Service of the AAA. It is the total network of services in the community.

Senator DOMENICI. Fine. Go ahead.

Mrs. MCKINNEY. Just to reemphasize the problem, we do have a community council that has a lot of referrals and information and resources available to them, but what happens to the senior citizens, it is not somebody there to take them to their resources. How do we get it to them if they are isolated in their homes?

After this lady was discharged from the hospital, she came home, but as I said, there were a lot of agencies taking care of her. Her son was in California, and I called him, and he took her there, so it was kind of a success story, in the sense of somebody coming for her.

PREVENTIVE HEALTH PROGRAM

Without a preventive health program for the senior citizens, I can see that we will be slowly draining and fading away, and I would plead

at this time for some type of preventive program here in the State of New Mexico for the senior citizens, because we do not have anything like that right now.

Living alone, some of the barriers of living alone, low income, education, I would like to see a service for the senior citizens that prevents hospitalization as a last resort.

Many of our citizens are babysitters to earn extra income, which is a problem for them to get to the sites, or for other activities that would give them strength, or for giving medical services at their need. Social and economic problems are varied for our senior citizens. There are many that are very lonely, and there is lots of discrimination for our senior citizens because of their aging.

This causes physical and emotional pain. Legal services are also a barrier for our senior citizens. Agencies joining together, as one big band, to let you know that we want our services and funds, in the State of New Mexico, for our senior citizens, this is what we are working toward.

We will try to accomplish a common goal to get the highest quality of care for our senior citizens in the State of New Mexico, and given the funds, not as a token, not as a pacifier, but we can make it happen.

As a community health worker, my goal has been to the community, but I find myself being an advocacy in the wind, including health education, and sharing with them the things that they need, sometimes just to read a letter, sometimes it is just tender loving care, sometimes it is just a knock on the door and a hold of the hand.

Relocation has been a great barrier for some of our senior citizens. Taking them away from the community, putting them far away from their friends and from their services is not good.

Without transportation, they are completely lost, so they fold their hands, they close their door, and they pull the blinds, and they sit and wait to die. Many of our senior citizens need glasses and cannot get them.

Many times I have spent hours on the phone trying to call around, trying to get help for hearing aids, glasses, and transportation, and again, I hit a blank wall.

Are the elderly just being given a pacifier to quiet them down, or are we going to see them progress on their own?

Senator DOMENICI. I thank you very much. I wish we had time to continue on, but let me thank everyone that has appeared. We are going to go to four or five people that want to make some comments from the floor.

Let me thank a few other people. I hope you all understand our problem with time. I think perhaps some of you do not quite understand the nature of this hearing, so let me take a few minutes to tell you about it.

The Senate Special Committee on Aging is chaired by Senator Church from Idaho. It has a number of subcommittees, a subcommittee headed by Senator Muskie from Maine is the subcommittee that is having this hearing. He is the chairman of the Subcommittee on Health Care for the Elderly.

I want to express in the record my appreciation to him for granting us permission to have the hearing here, and in particular for his approval of my chairing the hearing.

It is a very vital part in regard to making strides for our senior citizens. This special committee has emphasized this problem as it was never emphasized before. You have contributed by your efforts here today. We thank you for it, and we certainly think that between this morning and this afternoon in Santa Fe, we will get some constructive ideas to help move our country ahead.

Now, Mr. Murphy, president of the North Valley Senior Citizens' Association, has submitted a written statement. We thank you, Mr. Murphy, and it will be made a part of the record.[1]

We have about 10 minutes, so we are going to ask those people who wanted to comment, to do so briefly.

The first person from the floor that we will hear from is John Chapman of Albuquerque. He was here earlier. Perhaps he could not stay. I think his comments would have been in the area of nursing homes, though I am not sure.

And then we have the name of Mrs. Sarah Sorenson of Albuquerque. Mrs. Sorenson, did you have a question or want to comment?

STATEMENT OF SARAH SORENSON, ALBUQUERQUE, N. MEX.

Mrs. SORENSON. I had a comment on exploitation. We want minibuses to help us, to help the blind, and the disabled. They cannot get on those buses. We need buses with platforms to pick us up and bring us to doctors, to hospitals, and stores, and so on.

Further, we should like to have a system of "Dial and Ride," a system adopted in other cities in the United States—Ann Arbor, Mich., and Sausalito, Calif., and others—whereby elderly people can call for a ride, be picked up at their door and returned. We already have 6,000 petitions requesting this service for Albuquerque.

As senior citizens, we are taxpayers, and we find we have to pay the fees for the doctors, we have to pay for drugs, for food, and other expenses. We live on a fixed income, and we cannot afford to face all those difficult problems. Therefore, we urge you to get us minibuses so we can get to our centers.

Now, other cities have them. In Maryland, they pick up the senior citizens at 10, and bring them to the centers, and come back for them at 4, and bring them home, and I think in Albuquerque, we should follow that example.

Senator DOMENICI. Thank you very much. We will next hear from Mrs. Beryl Beal of Albuquerque, N. Mex.

STATEMENT OF BERYL BEAL, ALBUQUERQUE, N. MEX.

Mrs. BEAL. A lot of our senior citizens would like to be independent, a lot of them have had to sell their homes because they have not had the money to live on, their Social Security is not adequate.

Now, in July, our stamps will go up again for senior citizens. There will be a raise of $3 per person, and what will that $3 buy, when $10 is added to your stamp program.

Our people are hungry; they do not eat. They come to our meal site, you bring them in wheelchairs, the best you can do, or in cars. Many of

[1] See appendix 2, item 5, p. 1148.

them will not go to a doctor, because they have not gotten the money, not even with Medicare. Subsidies and the SSI program is not adequate.

They do not want charity. They want to be independent, and transportation is the best thing.

Senator DOMENICI. I understand that you know from experience about what you speak, because you are an Outreach worker in South Valley.

Mrs. BEAL. Yes, well, our men and women that we have that are covered with Social Security, when they get a raise from Social Security, and their husband has died, and is a veteran, whenever they get a $10 raise in Social Security they are cut off in the veterans' pension, so really, you get no raise, you get nothing. We have some members that are really coming out, and we cannot help them. It is a big problem.

Senator DOMENICI. Thank you very much.

We will now hear from Mrs. Peggy Mallony, Albuquerque, N. Mex.

STATEMENT OF PEGGY MALLONY, ALBUQUERQUE, N. MEX.

Mrs. MALLONY. I just would like to make a comment, not for just myself, but for other people in the same shape.

Because of other payments that we knew we were getting from the SSI, we were cut off completely, and that cut off the Medicaid services. I personally have been fighting, not fighting, put discussing with them my situation since February, and to date I still have not received any more supplemental income, or my Medicaid card. I am having to buy my medicine, and I am at a point where I cannot do it on what I get.

Senator DOMENICI. You are referring to the conversion from the old Social Security rule to the new income supplement payments, and that old computer problem they have been having?

Mrs. MALLONY. They told me the computer will not accept the data that they are putting into it.

Senator DOMENICI. Have you been in touch with them?

Mrs. MALLONY. Constantly.

Senator DOMENICI. I am not suggesting that they are not doing their job properly, but we do appreciate your problem. However, we do not know how to straighten up the computer problems that they have been having very quickly.

Mrs. MALLONY. They even tried to bypass the system, and I still have not gotten any results, and I thank you for letting me talk about that.

Senator DOMENICI. You are most welcome. We will now hear from Leroy Smith, Lovington, N. Mex. He wanted to speak on the nursing home situation.

STATEMENT OF LEROY SMITH, LOVINGTON, N. MEX.

Mr. SMITH. Yes, I would. I am the president of the New Mexico Health Care Facility Association.

A great many things have been said here today, and a great many good programs are going on in New Mexico, but I would like to say

just this for you and for me and our industry. Certainly, our State has a long way to go yet. We need money to do that. One of the things that is taking up most of mine and your time is filling out forms, and answering all of these things that come about as a result of the Federal regulations.

There are a great many things that are required today, and it seems that it is getting worse, Senator, instead of better. It does take money to provide those services to the people who are in need. It takes money, Senator. So money is the barrier:

(1) Federal regulations requires more professional people—nurses, dietitians, therapists, and so forth.

(2) Also expensive fire safety devices are required by regulations where safety had already been applied.

(3) More recordkeeping—forms, and so forth—is more time consuming and therefore more costly.

(4) The cost of living is constantly on the incline in the nursing home as well as other industries.

(5) Our main goal is to meet the needs of the older American as economically as possible and yet render good quality care.

Sir, with these and many other Federal regulations, patient care continues to be high quality care. However, the Federal and State governments are unwilling to pay costs that are required to buy these additional services.

Senator DOMENICI. Thank you very much, Mr. Smith.

We will now hear from Dr. Robert Miller of Truth or Consequences, N. Mex. Doctor, would you want to comment?

STATEMENT OF DR. ROBERT MILLER, TRUTH OR CONSEQUENCES, N. MEX.

Dr. MILLER. Yes, I am Dr. Robert Miller, and I practice in Truth or Consequences. I would consider my practice strictly geriatric, and so I have problems which are very different from other doctors.

At the present time, according to a public health survey, approximately 95 percent of all people over the age of 65 need visual help. This usually means corrective lenses.

However, according to an American Optometric Association study, only about 19.8 percent of these people are receiving any type of visual care. So it looks as if this is an area where we do need to do something to take care of these people.

Earlier in this hearing, the Senator asked if a doctor with a geriatric practice had problems receiving payment from the various government agencies. I would say he definitely does. At least this is true in my practice. In dealing with governmental agencies, I never know how much or when I will be paid.

At the present time, the Medicaid payment agency is in the process of changing its computer system. This has caused payment to be delayed an additional 3 weeks. When something like this occurs, and 80 percent of one's income depends on it, he certainly feels it. Problems like this happen at least twice a year with the Medicaid program.

Senator DOMENICI. I assume that you agree with the testimony stated in the record about the need to include glasses, hearing aids, and

other typical senior citizen medical needs within the scope of coverage, rather than as presently existing, being excluded.

Dr. MILLER. That is correct. Unless a senior citizen has an above average income, or exists at the poverty level, he is left out in the cold as far as visual care is concerned.

Senator DOMENICI. Thank you very much.

Dr. MILLER. Thank you.

Senator DOMENICI. We had one other person that perhaps wanted to comment.

Mrs. Sharon Wussow, Albuquerque, N. Mex.

STATEMENT OF SHARON WUSSOW, ALBUQUERQUE, N. MEX.

Mrs. WUSSOW. Thank you. In the earlier part of February, I contacted Laurie McCord, and asked her if she would be interested in looking at the conditions of the boarding homes.

After a few meetings, we did go together 1 day and visit a number of boarding homes.

A "DEPLORABLE SITUATION"

The main thing that I found was the deplorable situation that these people are living under. There are no immediate needs being met for these elderly citizens. There were no railings in the bathrooms. There were no siderails to help these people in their beds so they could move around. There were no clean towels. There was no water in the shower, there was a bathroom that was not usable. There was no washer to wash clothes. The people were not being changed.

We watched a man bring in a meal for an older woman who was very crippled from arthritis, who had no teeth and no dentures. She was brought in her piece of meat that looked like round steak, and was not cut up. She had a cup of coffee, and she asked if she could have milk. He said, we do not have any. The plate was removed from her while we were there visiting, and she had not eaten anything that was on that plate. There were many more things that we had seen, but I do not want to go into them here today.

I think many of the things have been discussed openly in the press, that Laurie covered very well. I just sit and pray that many people will become interested in the forgotten people that are pushed away, pushed under the rug, so that everybody does not have to look at it. They have to be brought out and taken care of.

Senator DOMENICI. Thank you very much. I understand that you are the one that called this to the attention of the "Tribune" reporter. A great deal of light on the situation, and I understand from talking with you and others that your motive was purely personal concern for people. As a result of your concern a special report on boarding homes was printed in the Albuquerque Tribune.[1] I am sure it has not ended, but perhaps as a result of your effort, we have focused on the problem, that we can better solve it now than we could have before. We thank you very much.

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[1] See appendix 1, p. 1113.

We have two guests with us. They have a very important role. We have the chairman of the Commission on Aging, Mr. Whiting. We appreciate your presence. And we have Joe Sanchez, a member of that commission. He was here most of the morning.

We thank both of you for your interest. We hope, Mr. Whiting, that you understand that the Committee on Aging has a sincere commitment to try to get the facts and come up with solutions. People like you are now charged with the ever-expanding role on delivering the services.

We hope you feel free to communicate with the committee and with me as a member.

We will now hear from Mrs. Lola Jaramillo, Albuquerque.

STATEMENT OF LOLA JARAMILLO, ALBUQUERQUE, N. MEX.

Mrs. JARAMILLO. I agree with this lady here. I know what is going on, and it is not only in one place, but it is in a lot of places that they are doing the same thing.

I don't know, they go and collect a check for these people from Social Security. These people do not know how to write. They put their cross on it, and turn over the check. They go out and change it and they give them $5. They go out and buy a glass of wine and give it to them, and take the other $5.

We saw some people where the only food they were getting was rice. We are not Chinese. We like to have something to eat once in a while. We take and do a lot of things for the senior citizen, but everytime we try to do something, we have a hard time. Sometimes we see the senior citizens attacked by some young people, and we want that to stop.

We want to work with the senior citizens. We want to help the senior citizens, and we want to do everything we can for the senior citizens, because they do need help. Not only from the hospital, not only from Medicare, but they need a lot of help, and I hope that you, Senator, can do something about this health center that we have got now, the Medicare center, so that you try to help them. They are running out of money, and they need the money, and we need those centers. Thank you.

Senator DOMENICI. Thank you. One last announcement. If you want a record of this hearing, please turn your name in at the door. I do earnestly believe that the leadership of this country has the same motives that you have.

I think Congress has the same motives, the same desires. I believe the American people would be willing to see Congress appropriate the kind of money, establish the kind of programs to give the senior citizens of this country what we all agree they are entitled to.

I do not think there is any disagreement in the desire, in the attitude, and I think even those who want to cut Federal expenditures, would put highest on the priority list, the very serious moral responsibility of this country to take care of those who preceded us, those who have lived and worked to make this a good country for us.

The problem is not the motive, the problem is the way—how do we do it. It is meetings like these that will help people like myself find a better way.

If there are any other comments you want to make or direct to the committee for purposes of this hearing we would appreciate hearing from you. You can send your comments to the committee, as the instructions say, on your way out.

To you who sat here and listened, to learn and to help, we thank you, and for those who worked hard to testify, we thank you very much.

I must be in Santa Fe by 2 p.m., that means I have got to get there by car, and to some of the press, I have promised 10 minutes for an interview, so I am going to be late in Santa Fe, but it was a pleasure being here with you all this morning.

Thank you very much. [Applause.]

The hearing stands in recess.

[Whereupon, the committee was recessed at 1 p.m.]

APPENDIXES

Appendix 1

REPRINT FROM THE ALBUQUERQUE TRIBUNE OF A SPECIAL REPORT ON BOARDING HOMES IN ALBUQUERQUE, N. MEX.; BY LAURIE McCORD, TRIBUNE STAFF WRITER

[Albuquerque Tribune, May 13, 1974]

ABUSE, NEGLECT TOO OFTEN MARK GOLDEN YEARS

(First in Series)

"I walked in and found a woman tied to the toilet with a sheet.

"I asked the aide what on earth was going on. She said they were trying to 'regulate' the woman, that the woman was always messing up her bed.

"I asked if they had taken her to a doctor, and the aide said they had not.

"I untied the woman. She was black and blue. She was paying the full $175."

The story is told by Anne Beckman, director of the Albuquerque chapter of the American Association of Retired Persons.

It is the account of a visit she paid to an Albuquerque boarding home for the elderly.

Another story about a boarding home for the elderly in Bernalillo County appeared in the newspapers here recently. It told of the alleged beating of an 82-year-old woman by the proprietor of Mi Casa Su Casa boarding home at 2332 Margo SW.

In that incident, the Bernalillo County Sheriff's Department took action, arresting the proprietor, Mrs. Laura Andrade.

There is chilling evidence, however, that other incidents just as grisly—incidents such as the one witnessed by Anne Beckman—may not be at all uncommon. And even when such incidents are reported to authorities, the evidence further suggests, they often go unchecked.

A month-long investigation, including visits to more than 15 boarding homes in Bernalillo County and conversations with some 40 persons connected in one way or another with boarding homes, has produced the following reports:

—In some boarding homes, "incontinent" old people are left to lie for days on wet sheets or in their own excrement.

—In some facilities, people have been found shut up in basements or locked in their rooms.

—Workers in one boarding home recently found an old woman with a half-inch crust on her head from lack of bathing, another with her nylons rotting onto her legs, and another with toenails like claws, so long she could not put on shoes.

—In one South Valley boarding home, residents must go outside, even in mid-winter, to get to a central bathroom. In that home, and in others, the stench of urine in the sleeping quarters is almost overpowering.

—Social workers around the state report that many welfare recipients living in boarding homes are lucky if they keep any of their welfare payments for personal expenses, that some operators have the checks signed directly over to them.

—Lunch in many boarding homes has been found to be no more substantial than dry toast or a chunk of carrot boiled in water; in some, only two meals a day are served.

Situations such as these do not occur in all boarding homes.

Everyone interviewed mention examples of fine, caring homes such as Padilla's, at 2111 Raven Lane SW. And some insisted that the gruesome situations occur in only a small minority of homes.

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But incidents of abuse and neglect, of ignorance and exploitation, do go on.

And there is a complex network of unfortunate circumstance, indifference and bureaucratic bungling that seems almost to foster such incidents in boarding homes.

In Bernalillo County, there are roughly 35 boarding homes licensed by the state Health and Social Services Department for a total capacity of about 350 residents, Robert Frankalucci, head of the HSSD institutional licensing section reports.

Not temporary abodes for transient workmen passing through town, nor the old-fashioned boarding houses where townsfolk gather for dinner on Sundays, these boarding homes serve a different function.

They are homes for the dispossessed, people who cannot survive alone, but whose families—where there are families—cannot or will not keep them at home.

Some of the boarders are mentally handicapped adults. But by far the largest number in Bernalillo County homes are merely aged.

Some are senile, some just physically wearing down.

They are not sick; they do not need hospitals, or even nursing homes.

But they do need care. Someone to cook their meals, or to help them remember when it is time to eat.

Someone to help them comb their hair or take a bath, or to make sure they get to a doctor should they become ill.

There is a name for this kind of care. Custodial care, it is called.

And New Mexico, theoretically, has taken into account the need for custodial care with a special state license for "sheltered-care homes."

A sheltered-care home, the licensing regulations state, is a "place which provides, on a continuing 24-hour basis, facilities and resources to give personal services (but no skilled nursing care) to two or more persons not related to the operator."

Those persons, the regulations continue, are ones who "because of age, infirmity, physical or mental limitations and dependence, need help and assistance in daily living activities."

The "personal services" to be rendered, the regulations suggest, might include such things as help in walking, getting in and out of bed, bathing, dressing.

Neatly, on paper, the need has been met.

But in reality, there are only about seven licensed sheltered-care facilities in the entire county, and all are full, Joan Tefft, county supervisor of adult services with the HSSD Social Services Agency, said.

And so hundreds of needy, but technically not ill old people must look elsewhere.

If they happen to be wealthy, or if their families have enough money, they probably can be placed in a nursing home, even though they do not need medical care.

If they must rely on Medicaid, however, they will not be admitted to a nursing home, for in a nursing home situation, Medicaid covers only actual illness, and not the ordinary pains and needs of growing old.

The only alternative for a large number of the elderly poor is a boarding home.

And under state licensing requirements, a boarding home is required to provide little more than a bed to sleep in and food to eat.

Many of Bernalillo County's boarding homes—the large majority, probably—do provide a somewhat higher level of service than the minimum required by law.

But often, the quality of that service is directly proportionate to the cost.

Sandia Ranch at 603 Edith NE, a sprawling, homey structure that once served as a mental hospital, is often praised for the quality of its care.

The home has an extensive staff of aides and orderlies to tend to the residents' needs, and there is even a full-time nurse on duty.

"We cater to their every wish" said proprietor John Chapman.

But rates at Sandia Ranch, start upward at around $350 per month.

And for large segments of the elderly population, $350 a month is a sum quite impossible to obtain.

There are an estimated 248 aged and mentally handicapped persons in Bernalillo County boarding homes who live on public assistance, welfare.

The federal government, which as of Jan. 1, took over formerly state-administered financial assistance programs for the elderly, blind and disabled, pays a maximum of $140 per month.

Countless other persons in boarding homes subsist on Social Security payments, which now average $174 a month. Others survive on small pensions providing roughly the same income.

For all those people, there is not much choice as to where they end up.

They land in boarding homes willing to take low-income residents. If they're lucky, they get good food and good care. If they're not. . . .

Anne Beckman, whose organization helps find employment for retired persons, tells of one boarding-home owner who called her a year ago at Easter time.

"She wanted a cook-housekeeper. I sent a woman to the home at 3 p.m. on Friday. She found nothing at all to eat for dinner, and she had to call her husband to go out and buy groceries.

"The next day, the owner arrived with food for dinner that night: one slice of ham and one potato. She told the woman to slice up the potato and give everyone a couple of slices."

Visiting nurses who go into boarding homes to tend patients after their release from hospitals have many stories to tell of their encounters in boarding homes.

Jan Thornberg and Judy Mitchell of the cooperative St. Joseph and Presbyterian Hospitals Home Health Care program tell of nurses being turned away at the door by boarding home proprietors.

Ms. Mitchell, director of the program, said she has seen only one decent boarding home in eight years of nursing.

Muriel James, director of the Visiting Nurses Service, Inc., described a visit by one of her nurses to a home where the water and toilets had been turned off, apparently to reduce the water bill; where the food consisted of watery soup; and where residents bore definite signs of mistreatment—explained by the owner as the result of falling out of beds.

Mrs. James said she reports all such situations to various state and local authorities, but said in frustration that she has been reporting them for years.

Most of those authorities indicate that they are aware of conditions in boarding homes.

"Some of them admittedly aren't so good," said Bill Allen, Chief Sanitarian with the General Sanitation Division of the city-county Environmental Health Department.

Other people—a former adult specialist with HSSD program development now a social work professor at Highlands University, for one—put it a little more strongly.

"The situation is deplorable, and that's an understatement," said Highlands' Adelina Hill.

"The definition of a boarding home in New Mexico is a flop house.

"Many of the homes are overcrowded. Some are licensed for eight people and have 12.

"I've seen the operators give them half a Vienna sausage out of a can for lunch. I've seen filthy, filthy dishes stacked up. One place doesn't let residents burn lights after 5:30.

"There's no one to monitor the monthly fee," Ms. Hill continued. "Some operators rip off the whole check.

"It's incredible that the situation has been kept under wraps for so long."

Albert Sanchez, staff social worker at Bernalillo County Medical Center, in charge of finding suitable situations for persons who might need supervision after their release from the hospital, said he tries to avoid "resorting to" boarding homes.

And one reason, he said, is the condition in which some patients come to the hospital from boarding homes.

Once or twice a month, Mr. Sanchez said, people who have fallen in a boarding home and dislocated a hip, or broken a bone, are brought to BCMC—one or two days after the accident has occurred.

The list of boarding home critics is long.

Barbara Menzie, director of the Metro Areawide Aging Agency also uses the term "flophouse" to describe most boarding homes today.

"In one home, they found three old ladies in a basement, one in a wheelchair. There were no windows, and they hadn't seen the light of day in two years. One of the ladies' son was a banker. He couldn't have cared less."

Lt. Paul Adent of the Albuquerque Fire Prevention Bureau, which does at least yearly inspections of Albuquerque's boarding homes, voiced perhaps the most resounding condemnation of the homes.

"Even the penitentiary," he said, "would be better than some of these places."

[Albuquerque Tribune, May 14, 1974]

GREED, POVERTY? BOTH ARE ALLEGED

(Second in Series)

The roots of the boarding-home problem in Bernalillo County are hard to define, lost in a mire of blame and defensiveness, accusations and excuses.

There are critics who charge greed, and defenders who plead poverty; there are charges of malice, and defenses of ignorance. There are claims that regulations are too strict, and that they are too lax.

Most likely, the problem is rooted in all those areas. For boarding homes are a complex problem, not easily laid open and not easily solved.

Money is a major area of contention.

Many people, from boarding-home operators to their harshest critics, feel the sums of money boarding homes receive from welfare recipients—who may constitute more than half of the roughly 350 residents of Bernalillo County boarding homes—are simply not high enough.

The federal government, which on Jan. 1 took over all formerly state-administered programs of financial assistance for the elderly, blind and disabled, currently pays those welfare recipients a maximum of $140 per month.

Assuming the boarding-home operator feels his boarders should have $20 a month for personal expenses, the maximum fee he can charge welfare recipients is $120, or about $4 a day.

J. Patrick Kneafsey, director of the city Environmental Health Department, said he can't imagine running anything other than a "flop house" for $4 a day.

"You can't even buy food for $4 a day," he said.

"Even in your own home," agreed Anne Beckman, Albuquerque job placement director for the elderly of the American Association of Retired Persons, "you couldn't take care of someone for $120 a month."

That $120 a month is a considerable jump from the amount boarding-home operators could charge welfare recipients before the Jan. 1 federal takeover.

When the state administered aid to the elderly and disabled, there was an $88-per-month limit on what an operator could charge, with an additional $22 reserved for the recipient's personal use.

And just two years ago, the state-mandated maximum charge was $66.

But operators say the recent increase is being outstripped by rising costs.

Connie Padilla, who runs a highly regarded boarding home at 2111 Raven Lane SW, said her grocery bills are climbing by $20 to $30 each month.

Seven of Mrs. Padilla's nine boarders are welfare recipients.

Mela Anaya, who operates another well-reputed boarding home in the South Valley house where she was raised, takes only private-pay patients for a fee of $150 a month.

Yet even at that rate, Mrs. Anaya says she fears she may be driven out of business by rising prices.

"Some of these people can eat $90 worth of groceries a month, what with the fruits, milk, vegetables, juices, eggs," she said.

"And if I can't make a profit with private patients, I can't imagine what it's like with welfare patients."

Mrs. Anaya points out that operating a boarding home well is not an ordinary job.

"This is 24 hours a day, seven days a week," she says. "These people need care, they need help.

"A person could never get rich doing this."

Some observers, however, contend that quite the opposite of struggling to get by, many boarding-home operators are enjoying enormous prosperity.

They concede that operators such as Mrs. Anaya and Mrs. Padilla, who give good, concerned treatment for a relatively low fee, may not be getting rich.

But they note the homes which charge upwards of $400 a month.

And even many homes with low-income boarders, they claim, are making sizable profits by skimping on meals, not worrying about clean linens, limiting bathing privileges to cut the water bill—eliminating the concerned treatment offered by Mrs. Padilla and Mrs. Anaya.

"I have a feeling the profits are quite large," said Adelina Hill, a social-work professor at Highlands University in Las Vegas and a former adult specialist with the state Health and Social Services Department (HSSD).

"You can run a boarding home in a house that would be nearly condemned anywhere. We have a home here (in Las Vegas) where there are four men living in a trailer the owner bought for $50.

"For what some of these homes are providing, they shouldn't get more than $1 a night."

Lt. Paul Adent of the Albuquerque Fire Prevention Bureau said, "They must be making money. We've seen them put in $10,000 worth of improvements immediately after one of our inspections."

There are many stories of exploitation in boarding homes.

An HSSD worker tells, for example, of operators who "buy one newspaper and charge everyone in the home 10 cents for it, or who charge extra for the use of the telephone."

Such situations have become particularly common, she said, since the federal takeover of aid to the elderly and disabled, as the federal regulations contain no provision to prevent operators from taking every cent of the welfare recipients' checks.

Larry Brown, state director of the HSSD Social Services Agency in Santa Fe, said caseworkers around the state have been reporting frequent instances of operators eliciting the full sum of their welfare boarders' monthly checks, leaving those persons no money at all for personal expenses.

Mr. Brown said he would like to see all charges for boarding-home services posted in the homes to prevent unscrupulous padding of fees, but said, "Our only authority is persuasion."

Armando Griego, director of the HSSD Public Assistance Agency for south Bernalillo County, said however, that he is attempting to work out a voluntary agreement with boarding-home operators whereby they would leave their welfare clients some money for personal use, and not take the full $140 from them.

Despite the many tales of seemingly deliberate neglect and exploitation in boarding homes, however, there is at least one person who believes that some of the conditions in boarding homes may stem from ignorance.

"Many boarding-home operators have no knowledge of financial management, or of dietary management," said Dr. Robert McCarthy, a psychologist with the Bernalillo County Mental Health Center, who periodically works in several of the homes.

Dr. McCarthy does acknowledge some "less than adequate" situations in boarding homes, and he does not offer his explanation as a justification for those situations *to continue.*

He proposes, however, to take a "positive approach," as he calls it, and to that end he is applying for grant money to set up a model boarding home where the real needs and inadequacies of boarding homes could be studied, and the operators trained.

Boarding homes are not a new problem.

"We fought it for 12 years," said Mr. Kneafsey of the Environmental Health Department, which stopped making regular inspections of boarding homes about two years ago.

It might seem that the families of old people would have demanded action on the boarding home situations, or the residents themselves.

And there have been complaints.

But for the most part, both those groups probably have helped perpetuate conditions in the homes.

The families of people in boarding homes, it seems, are not much different from the rest of society, which has allowed conditions to remain as they are for so long.

Joan Tefft, county supervisor of adult services with the HSSD Social Services Agency, said reasons given by people who come to her seeking placement for their elderly parents often are: "She's too much trouble," or "My husband says he's going to leave me if my mother is in the house one more day."

Many of the families, quite simply, do not want their old or difficult relatives, and do not really care what happens to them once they are out of sight.

Why then don't the residents complain, or just move out?

Many of the mentally ill or retarded ones are incapable of taking action on their own behalf.

And that situation may also apply to some of the old people.

But with many others, the obstacles are more complex.

"They are afraid," said one state official. "Afraid of losing what little they have, or afraid of the boarding-home operator, or just of the unknown."

Feeling rejected, in many cases, by their families, they feel "lucky to have a roof over their heads," said Albert Sanchez, staff social worker at Bernalillo County Medical Center.

After the recent arrest, for example, of the proprietor of a South Valley boarding home for allegedly beating an 82-year-old woman, state and county officials revealed that they had received complaints of mistreatment in that home before.

In each previous case, however, the officials said they were unable to get testimony from any of the aged residents of the home.

Dr. McCarthy tells of a woman in one boarding home who bore bruises from beatings by the operator of the home.

He talked to her, he said, about moving, but the old woman didn't want to leave the friends she had in the home.

In addition, he said, she told him that her family lived just down the street where she could walk to visit them, and that she felt if she moved, they would never come to see her.

And so the poignant fears of the old people themselves are a part of the sorry web of circumstance that makes many of their lives so miserable.

"They feel like they're in prison once they go into a boarding home," said Ms. Tefft of the Social Services Agency.

"But they're not. If they would just call us. . . ."

[Albuquerque Tribune, May 15, 1974]

Five Agencies Authorized To Inspect—But There's Catch-22

(Third in Series)

At least five state and local agencies are authorized to inspect boarding homes for the elderly and mentally handicapped in Bernalillo County.

Any one of the agencies has the power to shut down a boarding home on one ground or another—for failure to meet complex fire and safety regulations, food regulations, health regulations or any number of other regulations.

And there are educated guesses from within the agencies themselves that they could move in and shut down almost every boarding home in the county.

Yet within the past two years, the total number of boarding homes closed by official action probably could be counted on the fingers of two hands.

The catch-22 kind of reasoning that brings responsible officials to blink at open examples of filth, abuse, neglect and exploitation in boarding homes is circular and self-defeating.

The agencies, in their wisdom, have recognized that certain minimum standards must be maintained in order to support the health, well-being and the very survival of the residents of boarding homes.

Yet none of the agencies has provided for alternative housing in cases where the boarding homes fail to meet those subsistence standards.

The prospect of taking in old and mentally handicapped people apparently is not appealing or lucrative enough to attract large numbers of private individuals willing to operate top-quality boarding homes.

And the state, county and city themselves have not seen fit to establish any facilities to house that group of people.

So when outraged observers of boarding homes cry "Do something!" to public officials, the officials lamely answer, "What can we do? There's no place else to put them."

Of the five agencies authorized to inspect boarding homes—the state Health and Social Services Department (HSSD), the city Environmental Health Department, the city Housing and Development Department, the county Fire Marshal's Office and the Albuquerque Fire Prevention Bureau—only the last on the list has shown much inclination to act against the homes.

Most of the closings over the past two years, in fact, have been the work of the Fire Prevention Bureau.

But some of them have been accompanied by tear-jerking media accounts of homeless old people being cast out into the streets, and the Bureau, not the negligent boarding-home operators, emerged as the villain in those accounts.

There are other factors which contribute to the state of inaction on boarding homes.

Two of the agencies—the Housing and Development Department and the Environmental Health Department—make inspections only upon receipt of a complaint.

And such complaints are few and far between, so those agencies seldom visit boarding homes.

Another reason for the lack of official action is that for all the boarding homes in the state, some 100 of them, as well as every sheltered-care home, nursing home, hospital, 24-hour child care center, day-care center and foster home in New Mexico—more than 2,000 facilities—there are only three HSSD licensings inspectors.

Then there is the matter of the efficiency of that HSSD licensing department

For example, the most recent list of licensed boarding homes released by Robert Frankalucci, head of the department, does not contain the names of several boarding homes his own department has licensed.

A striking example of the department's operations came just a few weeks ago when a licensing inspector revoked the license of Mi Casa Su Casa, a South Valley boarding home whose proprietor, Mrs. Laura Andrade, had been arrested the night before on a charge of beating an 82-year-old resident of the home.

Under the state Boarding Home Licensure Act, a boarding home cannot operate without a license, and all welfare clients living in the home should be removed immediately.

A week later, however, the more than half a dozen private-pay residents of the home were still there.

Questioned about the situation, state workers talked vaguely about not being sure of their legal authority.

The point became moot a few days later, however, when the HSSD legal department decreed that the very licensing regulation under which the home had been closed was in direct conflict with state law requiring a hearing before any such action is taken.

The Boarding Home Licensure Act, passed by the State Legislature in 1972, does represent an attempt on the part of the state to improve conditions in its boarding homes.

It provided for the first licensing of the homes and subsequent regulations to govern them.

And some things in the homes may have gotten better since then.

"If you think they're bad now, you should have seen them two years ago. There were people living in chicken houses, on mats in basements," said Larry Brown, state director of the HSSD Social Services Agency.

But Adelina Hill, a former adult specialist with HSSD and now a professor of social work at Highlands University in Las Vegas, said, "There has been no significant change because the regulations aren't enforced."

And others agree with her.

Joan Tefft, county supervisor for adult services with the Social Services Agency, commented only that it would be "hard to say" whether things had improved.

Even if the regulations were fully enforced, however, there is a question raised by many as to their real worth.

For with the exception of a few token phrases, the regulations totally ignore an area in which many of the bad conditions in boarding homes exist: care.

They deal almost entirely with physical plant requirements such as bathroom facilities or heating and water systems.

Perhaps the developers of the regulations covered themselves by implying that no care should be needed in a boarding home, defining such a place as one which provides only "a combination of rooming and eating . . . and which does not provide nursing care or assistance in daily living."

Those needing assistance in daily living, theoretically, would be taken care of in sheltered-care homes, which are defined under separate regulations as places providing that care.

But even state officials are aware that there are not enough sheltered-care homes to house all the people needing assistance.

"We've had the problem for many years. Perhaps who should be in sheltered-care homes, people with a chronic ailment, are in boarding homes," said Thomas Shinus, deputy director for the HSSD State Health Agency.

Mrs. Connie Padilla, who runs a highly reputed boarding home in the South Valley, says that she must bathe seven of her nine boarders, that they are physically unable to bathe themselves.

And the majority of the aged people living in boarding homes require similar care.

The main reason they are in such homes is because they cannot get along by themselves, they do need assistance.

Many of the old ones cannot bathe themselves, or clip their own toenails, or even find their way to the bathroom.

The retarded or mentally ill ones may need guidance, or transportation, or other kinds of help.

If they are in a home run by someone like Mrs. Padilla, who provides far more than is required by state regulations, they are lucky.

But an operator is perfectly within his legal rights to provide only bed and board.

Mr. Shinus suggested an HSSD program, the Homemakers, as "a real glimmer of hope" for helping residents of boarding homes.

The Homemakers do, indeed, provide services such as giving bed baths, preparing special diets, and the like.

But they go only into private homes, Mary Vaughn, county director of the program, said.

What of the people in boarding homes?

"That's the visiting nurses' problem," she said.

The visiting nurses, however, provide medical, not "custodial" care, according to Muriel James, director of one of the organizations, Visiting Nursing Service, a non-profit United Community Fund agency which tends to people who need occasional medical attention in private or boarding homes after their release from the hospital.

Mrs. James, who has been complaining about boarding homes to state and local officials for several years, says she always gets the run-around, the "there's-no-place-to-put-them" line.

"HSSD has totally abdicated responsibility in this," she said.

Anne Beckman, Albuquerque director of the American Association of Retired Persons Job Placement for the Elderly, said she, too, has run into a brick wall in trying to make someone take responsibility for the boarding-home situation.

"I've tried talking to state legislators about boarding homes time and again. They'll talk about anything else but that."

Midway through 1973, HSSD did begin a massive survey to determine whether welfare clients living in room-and-board arrangements actually were in need of a higher level of care.

The survey offered foster care, sheltered care, day care, nursing homes and other situations as alternatives.

The results of the survey are still being tabulated, but the State Health Agency's Shinus said he estimated that by the time results were in, it would be revealed that 50 to 60 per cent of the people need a higher level of care.

If his estimate proved true. Shinus said, he would move to encourage the development of more sheltered-care homes.

Henry Keck, adult specialist with the HSSD Social Services Agency, said, however, that more than half of the results have been tabulated, and only a meager two per cent have been shown to need more care.

Like Shinus, Mr. Keck had expected the percentage to be higher.

And, he said, "I have a lot of doubts about the results."

Questioned on the matter, county adult services supervisor Joan Tefft, whose department conducted the survey here, said she had interpreted the survey as offering only nursing homes and hospitals as alternatives, an interpretation she based on a cover memo that arrived with the survey questionnaires.

And obviously, she said, most of the people surveyed did not need such a drastic change in care.

And so, through misunderstanding and crossed wires, what might have proved an invaluable tool for defining the specific needs of a much-neglected group, and thereby establishing goals toward which to work, has been rendered meaningless, at least in Bernalillo County.

In true bureaucratic form, the agencies and officials in New Mexico have ignored the conditions in boarding homes or messed up whatever efforts they have made to correct them.

Adelina Hill at Highlands describes the situation as "a merry-go-round." And the old people, the old and helpless ones, will ride forever.

[Albuquerque Tribune, May 16, 1974]

RANGE OF PROPOSALS COULD GIVE HOPE TO ELDERLY

(Last in Series)

In the Santa Fe headquarters of the state Health and Social Services Department (HSSD) there exists a proposal for a statewide system of family foster homes for the elderly.

The proposal was developed by Adelina Hill, a former HSSD adult specialist, as an alternative to the boarding homes which currently provide the only place for hundreds of New Mexico's elderly to live.

The plan would cost relatively little, Ms. Hill said, because unlike the foster-home program for children, under which the state pays foster families $70 to $100 a month for each child, the elderly themselves would pay for their care, as they do now in boarding homes.

The cost to the state would boil down mainly to salaries for about six staff members to select appropriate foster families and monitor whatever specific guidelines were established for the program.

Experts see a foster-family situation as ideal for the elderly, offering them a feeling of belonging and a chance to participate in a family routine.

Members of the HSSD Board seem to agree. They gave the go-ahead on the foster-home plan some seven months ago.

Since that time, however, the plan apparently has been just where it is today: "under study."

"We're working on the plan," said Larry Brown, state director of the HSSD Social Services Agency, "but it hasn't been implemented yet. And I couldn't give a target date."

Such seeming lack of urgency on programs for the elderly is not unusual, observers say.

"The main thrust of social work has been child welfare," explained Ms. Hill, who is now a social work professor at Highlands University in Las Vegas.

"But the elderly population is growing," she said, "and something must be done."

As Anne Beckman, Albuquerque director of the American Association of Retired Persons Job Placement for the Elderly, put it: "People are going to keep living longer and longer, and it's about time someone started learning something about it. You can't just throw them into a pit."

With stories ranging from underfeeding to actual beatings, some of the boarding homes in which elderly people now are forced to live seem little better than pits.

But there are alternatives such as the family foster-care plan, and people who work with old people talk excitedly and longingly about them.

Dale Libby, an inspector with the HSSD Institutional Licensing Section, notes that there is an informal foster-care program already working in Truth or Consequences.

"With all of the older people in T or C, there is only one boarding home, because families take in one or two elderly persons. The town is full of individual homes which take in older people," Mr. Libby said.

As far as Libby is concerned, that situation is perfect.

But there is a range of other choices.

Some are preventive: efforts to keep old people out of boarding homes, active and independent in their own homes for as long as possible.

Such alternatives would entail massive expansion and coordination of programs such as Meals on Wheels, a Model Cities effort that delivers pre-cooked meals to elderly people's doorsteps.

Those are exactly the kinds of alternatives that Barbara Menzie, director of the Metro Areawide Aging Agency, is working toward.

Her agency has spent the last year developing an area plan for the elderly which, if approved by the state and funded locally, will draw more than $200,000 of federal funds in matching grants.

The plan for Bernalillo County, where 19,348 of the state's 70,611-strong, over-65 population resides, according to 1970 census figures, would include such

programs as an outreach team to go into the homes of the elderly and do such odd jobs as fixing a light switch or a kitchen cabinet; a mini-bus transportation system to offer door-to-door service for the elderly; a preventive health project.

A 1973 Scripps-Howard article quoted the deputy chief of research and demonstration for the U.S. Health, Education and Welfare Department's division on aging as saying that 18 to 50 per cent of the elderly people in institutions would not be there if there were adequate services in the community.

For elderly persons who are not able to make their way alone with just periodic visits by community workers, however, there is another alternative to boarding homes: day care.

The concept of day-care centers for the elderly is still fairly new.

As of March 1973, there were only about 50 such centers in the United States according to an article in U.S. News & World Report.

The concept has been heralded by some, however, as "the answer to a prayer," and Ms. Menzie said she hopes by next year she can convince the city to begin a program of day-care for the elderly.

The advantages of such care are plentiful. A center would offer working families who might otherwise be forced to place elderly relatives in a boarding home a chance to keep those relatives with them instead.

It also would allow an old person who did not want to give up his own home the opportunity to retain it, returning to it each night.

As proposed by Ms. Menzie for Albuquerque, day-care centers would offer 10 or 11 hours of daily service. There would be a registered nurse on hand at all times, and part-time physical and speech therapists.

At least one nutritious meal a day would be served, and transportation would be provided.

A main goal would be to keep elderly citizens active through various rehabilitative programs in the centers.

Another alternative that would foster activity and independence in the aged is "group homes."

Like the foster-home proposal, a plan for group homes was developed under the direction of Adelina Hill and accepted by the HSSD Board in September, Ms. Hill said.

Group homes would provide a situation in which elderly people assembled by state agencies could rent a house of their own and hire whatever persons they might need to assist them—a cook, for example.

Such residences would be, in a sense, boarding homes without an operator. But the welcome burden of personal responsibility often spells the difference between senility and a full, purposeful life for the aged.

Another alternative to boarding homes that is often mentioned is multi-level-care facilities.

Joan Tefft, county supervisor for adult services with the HSSD Social Services Agency, envisions such facilities located in two or three places around the city.

"One level would have regular apartments with cooking facilities," she said.

"Another level would contain one or two or three 'boarding-home' set-ups, little areas where residents would have their own rooms, but would come to central dining areas for their meals.

"Then there would be a level for those needing a little more physical care, and a top-notch nursing home."

Ms. Tefft said such facilities are common in the East.

Barbara Menzie said it was just the type of facility described by Ms. Tefft that she and other planners had in mind when they began working on Encino House, a low-to-moderate-income apartment building at 609 Encino Place NE.

Various confrontations with the Department of Housing and Urban Development, which was financing the project with government loans, however, resulted in the elimination of the central kitchen and most of the other "frills" in their plan.

As a result, Encino House offers only pleasant, small apartments at reasonable rates for the "well-elderly," as manager Randy Parker described the residents.

A last alternative is to improve the boarding home-sheltered-care home system that presently exists.

One possibility toward that end would be to grant food stamps to low-income persons who could receive them under federal regulations were they not living in boarding homes.

There are some who oppose that idea on the grounds that food stamps is a nonprofit program that should not be used in a profit-making venture such as a boarding home.

But several persons, including boarding home critics, say the idea would considerably ease the burden on boarding home operators with low-paying welfare boarders, and would at least help solve one of the chronic problems in boarding homes: underfeeding.

Another possibility suggested by some would be for the state or federal government to offer some sort of boarding home supplement.

J. Patrick Kneafsey, head of the city Environmental Health Department, said, for example, that he saw only two ways to improve the boarding home situation: "raise payments enough so the boarding homes can be decent and safe facilities," or "have the state operate homes."

Mela Anaya, operator of a well regarded boarding home in the South Valley, said she felt an operator today could barely break even charging $175 a month, let alone the less than $140 (the maximum welfare payment for the elderly) they now can charge.

A suggestion offered by Thomas Shinus, deputy director of the HSSD State Health Agency, proposes a system of "vendor" payments for boarding and sheltered-care homes, to work much in the same way as Medicaid works in nursing homes.

The system would pay the facilities certain amounts based on the level of care for each eligible person in the homes.

Most of the services needed in such homes are "custodial" in nature, but Shinus said in reality, many could be considered "low-level medical needs."

Because sheltered-care facilities by definition are supposed to offer greater care than boarding homes, but for roughly the same price a vendor system could offer more incentive for development of sheltered-care facilities.

When questioned about the possibility of such a system, Charles Lopez, state director of the HSSD Public Assistance Agency commented only that his agency was out of the business of helping the elderly, with the exception of Medicaid, since the federal government took over the states' financial assistance programs Jan. 1.

A federal government pamphlet on its new welfare program for the elderly, blind and disabled, however, notes that some states currently are supplementing the federal payments.

A vendor system might be one way New Mexico could follow suit.

The money, theoretically, exists, or could exist: Lopez said the federal takeover had saved the state $5 million to $6 million a year.

And Adelina Hill charges that by leaving conditions in boarding homes as they are, leaving people without rudimentary care until they actually become sick, the state ends up spending more money in the long run in expensive Medicaid payments.

"We are debilitating our old people," she said. "It costs more in the end."

You Visit Many Homes of All Moods and Appearances . . .

You cannot tell, in a brief visit to a boarding home, whether there are only two meals a day served, or whether the old people languish for days with illness or broken bones before a doctor is notified, or whether the boarding-home operator strikes the old people when they get on her nerves.

But you can see old people lining the walls, staring blankly with nothing to do; you can see torn sheets, and filth; you can see boarders, aged and mentally ill, who look so dirty you want to back away when they extend their hands in friendship; you can smell urine so strong it almost makes you retch.

And so these are the things you have to go on, these things and the warnings of operators you meet along the way whose homes are full, but who tell you to be careful of "some of these places."

Magdalen Urban may have an opening in her boarding home, Casa Maria, 1024 Lead SW, she tells you.

Sitting in the French Provincial living room of the home, you couldn't imagine a nicer place for your mother.

"It's rest time now. Everyone has to rest between one and three," Mrs. Urban says.

You wonder if your mother necessarily would want to rest between those hours.

But you go on through the house.

"The rate is $416, including tax," Mrs. Urban says, and you begin to see why everything is so nice.

You see the house, and another building with bedrooms in the back, equally as nice.

The rooms are cheerful and clean. The bathtubs have handholds, and there are ramps instead of steps leading to the buildings.

You tell Mrs. Urban you will call her.

Pat Madrid's boarding home, Mi Casita, at 416 Arno SE, is a big, old place.

You walk into the living room and there are maybe nine old ladies seated in chairs and on sofas against the wall.

Two of them are looking at a magazine, but most just sit and stare, saying nothing.

"They are over the hill," Mrs. Madrid explains, indicating their senility.

The boarders have just finished lunch.

The dining room table has a large fern as its centerpiece, and the table is clean.

You visit another boarding house and it is the worst you have seen.

Most of the boarders live in a rectangular building in back of the owner's home.

And the building is filthy. The bathroom sink has standing water in it on two consecutive visits you pay the home, almost two weeks apart. The second time you call, it has what unmistakably appears to be human excrement smeared on the side.

The front room is inhabited by a World War I veteran, the old man himself tells you.

He gestures in the air with dirty, arthritic hands. His shirt and pants are caked with dirt, the neck of the shirt closed with a large safety pin. The old man's room is no longer than the bed he sleeps in. It, too, is dirty, and it smells of urine. In it, there is a small table and chair. In warm weather, like today, the old man sits outside in a chair. In winter, you guess, he must live in his little box.

The second room in the line is inhabited by a "mean Indian," the owner tells you.

But he lets you in to see. You can barely stand it, the odor is of urine is so strong, and you leave quickly.

You go into the main house to see where the food is prepared.

The old stove where the boarders' meals are kept warm is streaked with grease and dirt.

"I have to do everything myself," the owner's wife says. "Sometimes my daughter comes to help."

And you wonder if this woman who looks herself to be in her 60s should be running a home for nine aged and mentally ill people who need a little more than she can give.

The next place you visit is Connie Padilla's boarding home. It looks like paradise.

Clean, cheerful, with everyone out of bed and moving around, it is a most pleasant place.

The beds are neatly made, the counters clear and tidy, the bathrooms scrubbed to a shine.

"Go visit the other homes before you make your decision," Mrs. Padilla urges you.

And you do. You visit many homes of all moods and appearances.

But a week later, you know what you knew in the beginning: that there are many things you cannot tell on a brief visit to a boarding home.

You read in the paper that the proprietor of a home in the South Valley has been arrested on a charge of beating an 82-year-old woman.

It was a home you had visited.

And you had thought it was nice.

Appendix 2

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1. LETTER FROM ANNE BECKMAN, AMERICAN ASSOCIATION OF RETIRED PERSONS, ALBUQUERQUE, N. MEX., TO SENATOR PETE V. DOMENICI, DATED MAY 31, 1974

HONORABLE SIR: Following my testimony at the hearing Saturday, May 25, you requested that I send you some facts on how cutting off the Social Security Income of the elderly, could be a "Barrier to Health Care for Older Americans".

CASE NO. 1

She is 69 and he is 65. Their combined monthly income is slightly over $400.00 (Social Security). But due to protracted illness of the wife who has been hospitalized following a fall, they only have slightly over $5000.00 left in what was once a sizable savings. The cost of her care in a rest home, rent, telephone, her medication and doctors' fees leaves him with approximately $20.00 a month for insurance, transportation and food. Because his wife needs constant day time attention, he must stay at the rest home during the day. He could work part-time at his trade (bookkeeper). However, most bookkeeping jobs are full-time and he didn't see how he could lose part of his Social Security as it takes a long time to be reinstated to the full amount after it is once cut off. We were just informed that his wife is again in the hospital, so he had to leave his part-time job again to stay with her.

If he could work and earn more money than $200.00 a month during his wife's stable stages and place more money in their savings without losing his "safety value" of Social Security, he would be able to manage better when he has to be with her during her comatose stages. (We have on our file many similar cases.)

CASE NO. 2

She is 62. She has not applied for Social Security as she is able to work and earns, on the average, $500.00 a month. She has a 32 year old daughter who had been healthy all her life until she suffered a brain damage from an accident. Her three children were taken from her when her husband divorced her and this has been a very traumatic experience for the daughter. The mother supported the daughter and provided all her needs including a full-time "live-in" until the daughter became ambulatory. This was very costly and the mother used up all her savings, and sold many of her possessions, and borrowed a sizeable sum of money. The mother could afford to give her daughter a good home and take care of her if she could get her Social Security and retain all of it while working. As it is, she is worrying herself sick, because her daughter must take welfare in order to live and receive Medicaid.

The mother has to wait in the free clinic with her daughter from 8 a.m. to way in the afternoon to see a doctor and the doctors change quite often. The mother is paying off debts incurred by her daughter.

CASE NO. 3

This older couple have a 42 year old retarded son whom they have loved and cherished all these years. Their income from Social Security is $62.10 each as they were always self-employed and failed to file their income for Social Security benefits. They managed very well on this amount and the part-time work they could get under $200.00 a month. Then the father suffered severe burns and lost the use of his hands—she is getting by on child care jobs but would like to go back to her secretarial work, thereby, losing her safety value in her Social

Security check. She is frightened that she will be needed at home at times and would lose wages due to this. If she could get home care for her husband and son daily, she could hold down a good job. Somehow, she feels, she cannot give up her Social Security check. So they went on welfare. (With age differences, this type of a case is frequent.)

CASE NO. 4

The husband has been ill for many years. Both are 67. She keeps on working to support him. She could use the added income from her Social Security, but is earning too much to qualify. Her sister who married a very wealthy man, who is also, now an invalid, gets her Social Security every month, while they enjoy trips to Europe, etc. Makes one wonder!!!

The sister is 65. (This case can be multiplied numerous times in many other instances.)

ITEM 2. A SHORT RANGE PROGRAM FOR LONG RANGE BOARDING HOME SUPPORT AND DEVELOPMENT, SUBMITTED BY DR. ROBERT J. McCARTHY, UNIVERSITY OF NEW MEXICO, ALBUQUERQUE

BUDGET

This grant proposal includes two alternate proposals—Project A and Project B. Understanding of the budget breakdown may necessitate reference to the Projects' timetables.

To each yearly budget must be added 25.76% of salary and wages for overhead/administrative costs as required by the University of New Mexico and as approved as budget items by federal grants. Part of the 25.76% may be negotiated for in-kind match.

The budgets may have to be revised slightly to consider inflationary rises not accounted for in the initial preparation of the grant in March, 1974.

(Draft proposal continued on p. 1130.)

BUDGET—PROJECT A

	Itemized	Total
1st year:		
3 staff (mental health workers III, IV and/or V and licensed practical nurse) at $6,400	19,200	
1 clinical psychologist (planner-coordinator):		
25 percent time	5,000	
15 percent fringe	3,630	
Total	27,830	27,830
Consultant Fees:		
Occupational, physical, corrective and/or recreational therapist etc., at $10 per hour, for 50 hrs		500
¼-time secretary		1,375
Audio-visual equipment (see attached)		2,839
Training (including travel, books, journals)		2,500
Local mileage		540
Miscellaneous: Part time space rental and phone; typewriter, stationery, printing, et cetera		1,500
Total		37,084
2d year:		
3 staff (as above)	19,200	
Psychologist: increase to 35 percent time	7,000	
	26,200	
Plus 6 percent cost of living	1,572	
	27,772	
15 percent fringe	4,166	
Subtotal	31,938	31,938
Consultant fees (decrease time)		250
½-time secretary (increase time)		2,914
Training		1,500
Mileage		550
Miscellaneous; as above with additional video tapes		1,500
Total		38,652
3d year:		
3 staff (as above)	20,352	
6 percent cost of living	1,221	
	21,573	
10 percent possible merit increase	2,157	
Total	23,730	
Psychologist:		
Increase to 40 percent time	8,000	
6 percent cost of living as prorated from 1st year base	989	
Subtotal	8,989	
Total	32,719	
½-time secretary	2,914	
6 percent cost of living	175	
Subtotal	3,089	
Total	35,808	
Fringe benefits, 15 percent	5,371	
Grand total	41,179	41,179
Seminar travel		1,200
Mileage (difficult to estimate because of statewide travel)		2,500
Miscellaneous (as previously)		1,500
Total		46,379

Income.—Consideration, but no estimate, may be given to reimbursement for approved psychiatric/psychological treatment during part of the project period. It is also suggested that consideration be given to the possible realization of one of the objectives of the project, i.e., supplemental support to boarding home operators by the health and social services department or the department of hospitals and institutions. As such, reimbursement for operator training may be obtained, during the 3d project year.

PROJECT—B BUDGET

	Itemized	Total
1st year:		
Operations assistant (B.A. to M.A. level)	10,000	
Mental health worker V	6,400	
Mental health worker IV	5,800	
Mental health worker III	5,400	
Clinical psychologist (planner-coordinator 25 percent time)	5,000	
Live in cook/housekeeper (at $4,576 per year for 6 mo and 2 weeks)	2,479	
Subtotal	35,079	
15 percent fringe benefits	5,262	
Subtotal	40,341	
Secretary ¼ time	1,375	
Total	41,716	41,716
Food at $700 for 6 mo of operation		4,200
Rent at $300 per month for 12 mo as used for office, staff training, and renovation		3,600
Utilities including phone at $100 per month		1,200
Equipment, household furnishings (see attached)		8,000
Renovation: including rugs and drapes, safety equipment e.g. handrails, ramps, et cetera		3,000
Mileage		600
Audio-visual equipment (see attached)		2,839
Training, including travel, books, and journals		2,500
Total		67,655

Possible income.—12 residents receiving SSI: $140–20 for personal use=$120 per month program timetable: 6th–8th month: progressive enrollment of residents; 8th–12th months full enrollment. 12 residents × $120 per mo= $1,400 per mo. $1,400 per month × 5 mo = $7,200. Plus $1,400 from initial 2 mo = $8,640. Unknown amount generated through possible psychiatric services. Possible budget: $67,655 — 8,640 = $59,015.

BUDGET—PROJECT B—CONTINUED

	Itemized	Total
2d year:		
Same staff	35,079	
Increase cook to full time	2,479	
Increase secretary to half time	2,750	
Subtotal	40,308	
6 percent cost of living	2,419	
15 percent fringe benefits	6,409	
Subtotal	49,136	49,136
Food at $700 per month × 12 months	8,400	
Rent at $300 per month × 12 months	3,600	
Utilities at $100 per month × 12 months	1,200	
5 percent cost of living	660	
Subtotal	13,860	13,860
Equipment: upkeep, repairs, replacements		2,000
Additional renovation and physical plant repairs		500
Mileage		600
Training and travel		1,500
Grand Total		67,596

Possible income.—12 residents receiving SSI of $120 per months × 12 month=$17,280. Plus unknown SSI increase. Plus unknown reimbursement for psychiatric services. Possible budget: $67,596–17,280=$50,316.

BUDGET—PROJECT B—CONTINUED

	Itemized	Total
3d year:		
Staff:		
Operations assistant and mental	29,256	
Health workers: possible 10 percent	2,926	
Merit increase	32,182	
6 percent cost of living	1,931	
Subtotal	34,113	34,113
Cook:		
Decrease to ½ year	2,425	
3 percent cost of living	73	
Subtotal	2,498	2,498
Secretary:		
Increase to full time	5,830	
6 percent cost of living	350	
Subtotal	6,180	6,180
Psychologist:		
Increase to 40 percent time	8,480	
6 percent cost of living	509	
Subtotal	8,989	8,989
Total Staff	51,780	
15 percent fringe benefits	7,767	7,767
Subtotal	59,547	
Food at $735 per month × 6 months	4,410	
2.5 percent cost of living	110	
	4,520	4,520
Rent and Utilities at	5,040	
5 percent cost of living (Building kept for office and training)	252	
Subtotal	5,292	5,292
Equipment:		
Office supplies, preparation of training materials, video tapes, et cetera		3,000
General building upkeep and custodian		600
Mileage		600
Seminar travel		1,500
Grand total		75,063

Possible income.—1st 6 mo. similar to last 6 mo. of project year. Possible budget: $75,063 − 8,640 = $66,423.

BUDGET—PROJECT B—CONTINUED

	Itemized	Total
4th year:		
Staff:		
Same staff (discontinue cook)	49,282	
6 percent cost of living	2,957	
15 percent fringe benefit	7,836	
Subtotal	60,075	60,075
Rent and utilities	5,292	
5 percent cost of living	265	
Subtotal	5,557	5,557
Office supplies, further preparation and printing of training package		3,000
General building upkeep and custodian		800
Mileage for instate training		2,500
Grand total		71,932

Possible income.—It is suggested that consideration be given to the possible realization of one of the objectives of the project, i.e. supplemental support to boarding home operators by the health and social services department or the department of hospitals and institutions. As such, reimbursement for operator training may be obtained during the 4th project year.

11-055—75——6

INTRODUCTION

During the preparation of the final draft of this proposal, the following story appeared in the *APA Monitor* (The American Psychological Association, March, 1974):

NEW YORK TOWN BANS MENTAL PATIENTS

Long Beach, New York . . . passed an ordinance . . . that bans anybody requiring "continuous" psychiatric, medical or nursing care, or medication from being registered in any of the city's facilities . . . Carried to its logical conclusion, the . . . law would treat former mental patients (and present mildly or moderately disabled individuals, ed.) as permanent lepers and would cripple the progressive movement toward community-based outpatient care. (The rate of admissions to New Mexico State Hospital from Bernalillo County has decreased from 27% prior to the development of a community based program to 4%, while the number of applicants for service has tripled, ed.)

The article points out that the city's intention is not to ban mental patients but to regulate and supervise the city's 30 odd hotels and *rooming houses* which were never intended to be health care facilities and many of which are substandard. Apparently, however, the city is regulating people and not substandard facilities as no positive support or closing of substandard facilities is indicated. Proponents of the law reportedly also represent some senior citizen groups who shouldn't be forced to live with mental patients. The point is elaborated on in the article with the consideration, would any one put his mother in the same room with a mental patient. Obviously not; but, perhaps as equally important and in reference to this proposal, would anyone put their mother in a substandard rooming house or "hotel" or situation which does not consider the more intangible aspects of quality living-social stimulation, opportunities for a sense of self worth and competence. (The complete text of the article is an addendum to the proposal.)

At another level, consideration should be given to reference in the 1970 U.S. Government Census Report regarding persons in group living situations. One reference, listed along with prisons, is to inmates of homes for the aged—lacking further definition, it is assumed reference is to nursing homes as rooming houses are also listed. Nonetheless, it is felt that the use of the term inmate carries a popular negative connotation although the denotative reference is also not necessarily complimentary: one of a group occupying a single residence; especially a person confined in an asylum, prison or poorhouse. (Today's nursing homes are indeed costly and the poorhouse can be where you "end up" after being in one; "confined" implies, as against one's will which is not necessarily true of a person who voluntarily uses a nursing home facility.)

More specifically in regard to the project, it is assumed that any agency providing human services develop their intervention plan with due regard for both the figure and background aspects of the client. As an example, it would be foolhardy for a client to be prescribed a medication and have no financial means of obtaining it, i.e. the agency would refer or assist the client to or with resources, eg. an HSSD application. Similarly, agencies such as mental health, various medical programs and rehabilitation programs develop intervention plans, but unintentionally may overlook a possible variable which can seriously jeopardize the plan (or even limit potential clients from seeking services). This variable is the client's psychological and physical residence which, for many, is a boarding home. With due respect to the fine boarding home operators, general public opinion appears to be pessimistic about the quality of living provided and negativistic about the intentions of operators. No known local project has existed which attempts to offer positive consideration of operators' "side of the story." The proposed project is such an attempt: Project staff will be trained; work in boarding homes or operate one for a specified period; provide psycho/social services; gather management and other data; analyze data and develop a *Boarding Home Operations Training Package* for statewide use that focuses on fiscal/physical management and Physical/Psychological Care Development. If, as indicated by the data, further positive support is necessary, the data will be presented to possible resources, e.g., the Health & Social Services Department and/or the Department of Hospitals and Institutions.

Many boarding homes contain a mixture of older and younger residents. The Project will: 1) Focus on this typical boarding home resident pattern as best as possible and 2) Be considered as part of the development of a comprehensive (mental health) program on aging.

As a final introductory comment, it may be argued that the proposal focus, boarding homes and their operation, fall beyond the realm of sponsorship by a mental health facility. However, it is suggested that this is a service gap area and that the Mental Health Care/Department of Psychiatry play only a leadership and stimulation role that will eventually bring forth a, perhaps, more appropriate sponsoring agency or the development of a private organization of boarding (and perhaps nursing) home operators. In addition, the two alternative methods for obtaining the objectives of the Project are time limited.

BOARDING HOMES

Boarding homes are not to be confused with skilled or intermediate care nursing homes. The latter provides a residential situation with trained nursing personnel. The former is not required to provide in-house nursing care. A boarding home is a group residence which provides sleeping facilities and meals. In those instances where some physical assistance is provided, e.g. dressing, bathing, feeding and where certain physical plant requirements are met, e.g. crash bars on the doors, the home may be designated a sheltered home. Few homes are so designated because of the financial expense of meeting the physical plant requirements. (Often a room and board operator may assist with feeding, bathing, etc. because of his own personality style.) An individual who seeks to board more than two individuals in his home, must meet license requirements (primarily related to the physical plant) of the New Mexico Health & Social Services Department.

At present, there are thirty-nine licensed facilities in Bernalillo County and fifty-five in the remainder of the state with many in Las Vegas where the State Psychiatric Hospital is located. Four facilities in Bernalillo County will be excluded from statistical presentation; (three related to drug rehabilitation programs and one sponsored by the Albuquerque Association for Retarded Children). Thus, the licensed capacity of the remaining thirty-five homes is approximately 350. For the rest of the state, it is 485. In addition to licensed facilities, it is estimated by HSSD personnel that there are 700 unlicensed facilities locally creating a potential capacity of 1,400. Little supervision or knowledge of these homes is available. Expanding further on the spectrum of "living" facilities are the many less expensive motels and hotels in the core city where elder or the younger disabled may reside.

Who live in boarding homes? No concrete "diagnostic" or descriptive material is available. However, as community based mental health staff have occasion to consult or work with residents over the past five years, one might characterize a majority of the residents as the infirmed elderly, the young and older adult retarded and the young and older adult marginal functioning individual, oftentimes ex-state hospital patient.

Why a concern for boarding homes as they are a private, profit making business? As, it is believed, Mark Twain once said about the weather, everybody talks about it, but nobody ever does anything about it. Refer to any agency personnel that has contact with boarding homes—Visiting Nursing Service, Office of Economic Opportunity, Family Health Center, Mental Health Center, Coordinated Action for Senior Adults, Albuquerque Community Council, Mid-Rio Grande Health Planning Council, Community Services Office of New Mexico State Hospital, Health & Social Services Department, Environmental Health—and question the quality of living aspects of many boarding homes. Over a year ago, community concern, that periodically waxes and wanes resulted in the closing of a few facilities for fire-safety violations, e.g. insulation of heating equipment, too many residents, including one blind person living in a basement bedroom, etc. The concern, however, that stifles many more closings is where are the residents to be "shifted." Indeed, it should be up to the individual to move if he is not satisfied, however, because of lack of cognitive/emotional capacity or the limited financial resources of many, the number of choice alternatives is limited. Further, speaking recently to a senior resident who was exploring her plight of being physically mishandled, she at the time was reluctant to be placed elsewhere as she had established friends in the home and was also fearful she would no longer be able to visit with relatives in the general neighborhood.

For at least the last five years, the general attitude regarding boarding homes has been a negativism mixed with outrageous indignation and a sense of punitiveness. The general solutions offered are for tougher regulations, enforcement and closing. Several other "input" variables need to be considered: (1) Several states

are moving to close state institutions. California is a leader in this regard, but as one recent visitor to California stated, "They have created new 'ghettos'—the mentally ill district." In other words, adequate community placement plans or facilities appear to be lacking; (2) Las Lunas Training School seeks to place residents in the community as does the Acute Geriatric Unit of New Mexico State Hospital; (3) Future planning for New Mexico seeks to attract retirees including some folks who may eventually run out of retirement "nest eggs" and who will be in need of some type of less expensive form of residence; and (4) The National Cancer Center at the University of New Mexico has the potential for drawing in future residents who may eventually be in need of a boarding home type of residence.

What kind of care are residents of boarding homes receiving? Excluding the condition of the physical plant of some homes, residents contract for care as one would in a motel—none (with due respect to the motel industry). Boarding homes are not treatment/care facilities—boarders are boarders and not patients. Some operators are concerned about their image—many do attempt to provide some care, Mr. and Mrs. X who would transport a resident to the emergency room in the middle of the night and stay two-three hours, or to the doctor during the day, or oversee, as best as possible, a resident's medication, or allow a church group into the house to visit, or take a resident to a Day Treatment Program, etc., etc. Several operators have banded together in the past to attempt to foster the image of a Residential Aide and Service Homes Organization. Perhaps a positive action approach could develop a potential resource into a strong supplement to any rehabilitative attempts with all categories of social service agency clients. Put another way, are out patient attempts at treatment of a medical or mental health facility or on a specific DVR client enhanced or detracted from when the client lives in a boarding home as many currently exist.

TOWARD A POSITIVE APPROACH

Writing in *Mental Health: Principles and Training Techniques in Nursing Home Care* (DHEW Publication No. (HSM) 73–9046) W. Beattie, Director of the Gerontology Center of Syracuse University points out that "most of the administrators of these facilities are not educated beyond the high school level and the personnel have scant education and receive minimal wages." Reference here is to nursing homes—one may speculate on the "qualifying" background of boarding home operators (again, many of whom have the best of intentions).

As briefly reported in *Hospital and Community Psychiatry,* (1974, 25, 125), a program was recently begun in California to provide operators of residential homes for the developmentally disabled an intensive eighteen week training program to increase their awareness of the resident's capacity for growth and full participation in normal community life and to increase their own skills to promote such growth. The training is followed by nine months of personalized training in the caretakers' homes. (The "news brief" does not present specifics in regard to the residential homes, but it should be remembered that the level of welfare aid is higher in California than New Mexico.)

At present, it appears that there are some facts known and feelings that exist about boarding homes. However, it is proposed that a living laboratory situation be established in regard to boarding homes. Two alternative models for such a living laboratory will be presented with the following objectives:

1. To obtain objective data on boarding home management, e.g. financial, dietary, medical, behavioral, stress factors and as yet unknown variables that affect, positively or negatively the operator and resident.
2. To develop and teach operators problem solving skills in areas as related to Objective 1.
3. To provide data to and coordinate with, for example, the Department of Health & Social Services or Department of Hospitals and Institutions in the development of, if indicated by analysis of project material: (a) Possible supplementary financial support to homes for staffing, physical plant, etc; (b) Standards regarding qualification and screening of new operator application for licensure; (c) Further standards for operation as consistent with 3a; (d) Methods of stimulating initiation of additional homes through the private sector or other local sources; (e) Alternative forms of semi-independent living situations.
4. To provide a focal point and more positive attitude of community/agency support to encourage attempts at self-help organizing among operators such as RASH.

5. To provide, on a limited basis, direct mental health care of various degrees and formats and referral for ancillary services—medical, physical/social rehabilitation, financial, legal services.

6. To explore exit difficulties and possibilities.

7. To develop a training/counseling program whereby relatives who place a resident can resume responsibility and care of the relative in their own home as previously.

8. To develop a system of analysis of current boarding homes whereby potential residents could be matched with a home by more formal/objective means to both the satisfaction of the resident and operator.

9. To study and make recommendations or stimulate a more formal system for interactions regarding two way placements between New Mexico State Hospital, Nursing Homes, Boarding Homes, Mental Health Center, HSSD, Los Lunas Training Hospital and the like.

10. To provide a focal point for coordination of allied services which can be involved in boarding homes, e.g. Family Health Center, Visiting Nursing Service, Public Health Service, HSSD, and the like. Within the past month and a half, a mini team, LOS VECINOS, of the outpatient program of the Bernalillo County Mental Health Center is focusing, on a part time basis, on three boarding homes with the intent of providing mental health services or social/activities program in addition to eliciting other supportive services, i.e. Family Health Center to do general medical screening, e.g. blood pressure checks.

11. To explore use of the project as an on-the-job training experience for other programs to develop skills for advanced placement in homes or other care facilities.

12. To provide practicum situations for psychiatric residents, medical, nursing, graduate psychology, counseling and guidance students and related disciplines to provide them with a minimal awareness of geriatrics and other younger developmental disabilities or encourage specialization in these areas.

13. To develop a *Boarding Home Operation Training Package* that could expand on materials as presented in the California project of above.

14. To train project staff in skills of teaching/training that at the end of the project, project staff could consult and train boarding home operators within the county and throughout the state. To again quote Beattie in reviewing the National Conference, "It was pointed out that there is a need to train not only administrators and staff (of nursing homes) but, as a first step, train the trainers, all of whom must be knowledgeable in areas of aging and mental health, *as well as aware of the multifaceted problems faced by homes in caring for their residents*" [emphasis added].

CONSIDERATIONS COMMON TO PROJECTS A & B

The target area of either project would be within the Primary Service Area (PSA) of the Bernalillo County Mental Health/Mental Retardation Center (MHC). Carlisle NE & SE roughly divides the two service areas, with the western portion of the County being the PSA. For MHC/federal funding purposes, this area is also designated as a poverty area. In addition, approximately 16,000 of the 30,000 plus individuals over the age 60 reside in this portion of the county. Close to 9,000 individuals over the age of 60 are Spanish speaking or Spanish surnamed; this area of the county, i.e. the Valley is traditionally known as the preferred residence area of the Spanish American and therefore it is presumed to contain the major portion of elderly. Similar information on other ethnic groups is not available through 1970 census statistics. The South Broadway and Kirtland areas of the PSA are however recognized as the prime residence areas of the Black community. The majority (approximately 90%) of the licensed boarding homes are located within the PSA.

The Metropolitan Areawide Aging Agency is charged with the task of coordinating and planning programs on aging. It has drawn together personnel of various agencies and senior citizens to develop a Comprehensive Areawide Plan for the Elderly. The Project would draw upon Metro 3A for community support and participation. In addition, the residents of the homes themselves could be developed into a formal task group or would be a primary informal data source in addition to the home operator.

The Senior Aide Program (Department of Labor) could be involved in either project at two levels: (1) Assistance with work placement of residents over the age of 55; and (2) Placing individuals in the project providing additional

manpower to the project. In regard to rehabilitation of the elderly, it is noted that the Senior Aides Program, with a limited enrollment capacity, has assisted in work placement beyond the Senior Aides Program of 47 persons in the last year and one half.

In addition, as guidelines become available to the local Manpower Program for the Comprehensive Education and Training Act (Department of Labor), efforts would be made to supplement the Project and provide for job training for CETA enrollees for future job placement in boarding homes or, perhaps, more likely, nursing homes.

The Small Business Administration has expressed interest in the project as a possible consultant regarding management of such a residential operation. As a specific agreement has not been approved as yet, other sources could be sought out as providing consultation to the Project's analysis methods regarding management, e.g. local business persons such as Kiwanis, whose International Theme Year is focused on the senior citizen, the Institute for Social Research and Development (University of New Mexico) and the like.

It is noted that both Projects have positive and negative aspects in terms of an *in vivo* study and service. As best as possible, outside services will be involved to critique the project as it progresses. As best as possible, simulation (versus the ideal) will be the watchword.

A major task of the Project will be developing a trusting rapport with operators who often perceive themselves as having been "burned" in the past. It is thought, that approval of a project designed and intended as supportive to boarding operation in the long run will be a first step in developing such a rapport.

PROJECT A

Three full time staff would constitute the core of the program. Boarding home operators would be solicited to place staff in their home on a 3–4 day work week for one year as part of a three year project. Preference will be given to homes with a proportion of older residents, younger adult retarded or other disabled or handicapped individuals. Staff would primarily work days, but would also periodically be required to work various "shifts", early evening, early morning and weekend shifts to obtain as best as possible overview of life in a home. Schedules may also vary periodically where a worker may work several shifts successively. Staff role would be multiple including: (1) Performing regular household chores such as cleaning, feeding, changing beds; (2) Reaching the outlined objectives and (3) Providing limited psycho-social services. As best as can be developed with an operator, the staff may assume responsibility for the complete operation of the home for a period of time, e.g. for a month or two, i.e. ordering the food, collecting the reimbursements, etc.

Once a week all staff would meet to review their placements, receive supervision, performance data collecting/reporting tasks as developed for the Project, participate in self-development experiences and the like as necessary. As feasible, staff would also participate with the Los Vecinos Program when not in the Project meeting or home.

Staff would be of paraprofessional caliber with a previous background in mental health or human service area; after careful consideration of personality approach (as with all applicants), consideration could be given to one applicant with a business background. Strong preference would be given to a bilingual applicant. A Licensed Practical Nurse will be recruited for at least one position to provide input regarding medical aspects for data input. There are three staff and homes to provide a sampling of situations and to minimize the effects on data gathering and overall analysis resulting from possible staff turnover.

PROJECT TIMETABLE

Month:	
1st–2nd	Recruitment, development of training program for Project staff. Development of placement sites. Arranging for consultants.
3rd–6th	Training regarding psychodynamics of aging and younger developmental disabilities, therapeutic techniques and programs, personal awareness, use of audio-visual equipment. Development of instruments for data gathering, eg. budget schedules, problem check lists, self report inventories for staff and residents, other agencies, service rating check list and the like.
7th–18th	Work in boarding homes and gather data.

PROJECT TIMETABLE—continued

19th–24th	Cease work in homes. Analyze data. Write/develop training package. Continue minimal consult to homes. Train Project staff in techniques of teaching regarding training package.
25th–36th	Statewide training in boarding homes. Seek support for continuous training program.

PROJECT B

The Project would provide support for the establishment (on a lease basis), operation and staffing of a project boarding home for two years as part of a four year project. As best as possible, the following mix of twelve residents would be attempted: eight residents over the age of sixty, at least six of whom would be ambulatory and at the minimum four younger cognitively or emotionally disabled individuals; and, at the least, a four-to-one sex ratio. It is expected that most residents be receiving Supplemental Security Income (SSI); however, an applicant will not be denied residence because of an inability to pay—in accepting a completely indigent resident, consideration can be given to acceptance of a private pay resident. The acceptance of a private pay resident will be subject to close review. In accepting a resident, careful consideration will be given to the intent of the Project—to simulate the average (or below) pattern of boarding home residents.

As this home may have advantages over other homes, eg. staffing pattern, every attempt will be made to avoid being in competition with other homes; for example, a waiting list will not be maintained. However, as situations develop, it would be hoped that policies would develop among boarding home operators, as per Project objective, to work through such potential problem areas.

In addition, some homes may not have "around the clock coverage". However, because Project Home is sponsored by a public agency, such a safety precaution is thought necessary, and in any event, should be a licensure requirement.

Staffing will consist of an operations assistant who will oversee the day to day functioning of the home; assist the project director with carrying out the objectives of the Project and supervision of staff; provide on-call backup to night and weekend staff and assist with the development of the Training Package. A Mental Health Worker V, who primarily covers the day "shift", provides assistance to meeting the Project objectives; assists with supervision/training of trainees, volunteers, etc., and assists with backup as may be necessary. A Mental Health Worker IV who works approximately a 2–10 "shift" and continues day-time activities to a lesser degree. A Mental Health Worker III who works approximately 8:00 AM–10:00 PM (14 hours each shift) Saturday and Sunday and one day shift during the regular work week: accumulates four hours shift differential (time off) per week; continues weekday activities to lesser degree; provides for general weekend supervision of residents; and prepares weekend meals. A live-in cook/housekeeper who prepares meals and performs housekeeping duties (salaried), provides 10:00 PM–8:00 AM assistance (e.g. call for fire or medical help, etc.) of residents (in exchange for room and board).

All staff assist with vacation, sick leave and emergency coverage as necessary. Staff may be assigned various shifts to obtain a more rounded overview of home operation and changes that take place during various segments of a day. Staff may assist with other duties as assigned by the Coordinator for Programs on Aging.

PROJECT TIMETABLE

Months:	
0 to 5	Find residential building similar to those now in use: obtain Fire/Environmental Health & HSSD approval for licensure. Renovate for needs of disabled, eg. bath and toilet rails, ramps and the like. Purchase and equip home with furnishings. Visit possible related projects, eg. California project. Prepare staff training program. Recruit and train staff, eg. psychodynamics of aging and younger developmental disabilities, Principles of Behavior Modification, Remotivation and Reality Orientation Techniques, Active listening techniques, first aid, fundamental medical care and observation, visits to various homes where other MHC may consult. Begin initial contact with area operators and

PROJECT TIMETABLE—continued

	allied agency personnel. Develop instruments for data gathering, eg. budget schedules, problem check lists, self report inventories for staff and residents and the like.
6 to 8	Accept referrals on a progressive basis. Begin formal meetings with allied agency personnel.
9 to 27	Attempt to meet various Project objectives through operation of home.
28 to 29	Begin final displacement of residents.
30 to 35	Gather/analyze data generated by Project. Develop training program package (manual, audio visual tapes, lecture material).
36 to 48	Consult/train operators throughout the state and new applicants for boarding home licensure. Seek local funding or placement for staff for continued training/consultation services, eg. Department of Hospitals and Institutions, Health & Social Services Department, Division of Vocational Rehabilitation, or an organization developed by boarding home operators (perhaps in conjunction with nursing home facilities.)

ITEM 3. MIDDLE RIO GRANDE—HEALTH PLANNING COUNCIL HOME HEALTH CARE COMMITTEE REPORT

[Submitted by Josie Candelaria, Health Planner, Mid-Rio Grande Health Planning Council, Albuquerque, N. Mex.]

Mid-Rio Grande Health Planning Council is a private, independent, non agency organized under the Federal "Partnership for Health" Act. It was created to deal with health care problems, primarily the lack of planning which often has resulted in high costs and wasteful duplication, and to bring about better coordination towards improved health care services for all.

Health planning Council functions as an advocate for health needs as expressed by the people themselves. The agency tries to coordinate all segments of the health field and give cohesive direction toward a better, more efficient health care system for all people.

To accomplish gains in any area of activity, a plan is essential, and accordingly we established committees on every aspect of health. It was out of this auspices that the Home Health Care Committee was created.

The charges to the committee included:

1. Identification of problems and potential problems with respect to Home Health Care.
2. Identification of resources that respond to Home Health Care in the Four County Area.
3. Recommendations regarding solutions and implementation of Home Health Care problems.

This information was compiled and presented to the Council to be part of the "Mid-Rio Grande Health Planning Council Planning Document."

The committee report was approved but has not been adopted by MRG–HPC.

If the needs of the elderly are to be effectively met, then Congress must amend the Social Security laws to allow proper payment so that Home Health Care becomes a viable alternative to expensive hospital care.

[Enclosure]

I. HOME HEALTH CARE COMMITTEE MEMBERS

Committee members.—Filomena Griego, Chairperson, Dorothy Ayers, Mary Lou Banks, Josie Chavez, Helen Ellis, Muriel James, Frank McGuire, Judy Mitchell, Sister Margaret Rooney, and R. Kurt Nicewander, M.D.

II. HOME HEALTH CARE COMMITTEE PROBLEMS AND PRIORITIES NARROWED PROBLEMS

Problems

1. Doctor education.
2. Consumer education.

3. Standards for agencies.
4. Licensure for providers.
5. Standards for H/A aide.
6. Certification for Home Health Aide.
7. Insurance Provisions—mandatory.
8. Utilization of available Home Health Care.
9. Adequate payment mechanism.
10. Government payment mechanism.
11. State interpretation of Federal regs.
12. Adequate personnel (money problem).
13. Availability of Home Health Care in district.

Narrowed problems

1. Doctor & consumer education.
2. Standards for agencies, Licensure for providers.
3. Standards for Home Health Aides.
   Certification for Home Health Aides.
4. Insurance provisions for Home Health, and that they be made mandatory.
5. Utilization of existing Home Health Care & availability of Home Health Care in District 3.

Staff

Rudy Pendall.
Josie Candelaria.
Beverly Serns—Student intern.

III. RESOURCES

1. Albuquerque Practical Nurses, Inc.—Gladys McDonell, 712 Central SE 87102.
2. Bernalillo County Health Dept. District 3—Director: Eva Wallen MD, 1111 Stanford NE 87106.
3. Bernalillo County/Mental Health Mental Retardation Center, 2600 Marble NE 87106—Sue Crews.
4. American Association of Retired Persons, Inc., Albuquerque Chapter 347, 2323 Kathryn S.E. 87108; Minnie Gould, Director.
5. Crippled Children Services, 400 Walter NE 87102; Lindsay Watson, Asst. Dir. 265–3771.
6. Elks (Cerebral Palsy), Walter Kindaid, 2900 Edith NE 87107.
7. Family Health Centers—Eloy Apodaca, Director; 816 Broadway SW 87102, 842–8940; 2324 Isleta SW 87105, 877–6731; and 1620 Griegos NW 87107, 345–2631.
8. Homemakers, Inc. (Upjohn), Frank McGuire, Director, Medical Arts Square Building 1, Suite 1, 87106, 247–3629.
9. Kirtland Air Force Base Hospital—Col. Isley CHAP.
10. Maternal and Infant Care Project—Allan Noyes, Adm. 1111 Stanford NE 87106.
11. Medical Personnel Pool, National Building, 505 Marquette NW, Suite 911, 87102.
12. Professional Nurse Registry—Laura Horn, Dir., 812 Central SE.
13. Simmons Nursing Service—Ann Simmons, 6409 Esther NE, 87109.
14. St. Joseph/Presbyterian Hospital—Home Health Care, Judy Mitchell, 400 Walter SE, 87102, 842–5968.
15. U.S. Public Health Service, Division of Indian Health, 801 Vassar Drive NE, 87106, Maxine Nicolson.
16. V.A.—Virginia Walsh, 2000 Ridgecrest DR. SE 87108.
17. Visiting Nursing Service—815 Vassar Drive N.E., Albuquerque, NM 87106, Muriel James, Director.

IV, HOME HEALTH COMMITTEE POSITION PAPER

A POSITION PAPER REGARDING THE DELIVERY OF HOME HEALTH CARE

Great concern is being expressed today by health providers, legislators, governmental officials, and consumers over financing personal health care and the ever increasing costs of institutional care.[1]

[1] Excerpts taken from CHP of Western Penn. Inc.

Home health services are a complex of services which may be brought into the home singly or in combination in order to achieve and sustain an optimum state of health, activity, and independence for individuals of all ages (offering a meaningful alternative to institutionalization) and, at the same time, assuring continuity of care through convalescence and return to health.

Home health care can and does provide more appropriate care for an increasing number of patients, and the cost of this care is generally much less than hospital or nursing home care. The concept thereby also offers an accepted need for cost containment.

The American Medical Association defines home health care as "any arrangement for providing, under medical supervision, needed health care and supportive services to a sick or disabled person in his home surroundings."

PATTERNS AND LEVELS OF HOME CARE[2]

Home care services are available from a variety of sources. They may be provided through: (1) a single service agency such as a homemaker-home health aide services program or a meals-on-wheels program, (2) a multiple-service agency that arranges for two or more types of services, such as home nursing care, physical therapy, and homemaker-home health aide, (3) a coordinated home care program that arranges for a wide range of home services designated to meet the patient's individual needs through one centralized administration. The coordinated home care program also is responsible for planning, evaluation and follow-up procedures to provide physician-directed medical, nursing, social, and related services to selected patients at home.

Home care is generally considered to be categorized into three component levels: (1) concentrated or intensive care, (2) intermediate service, and (3) basic services.

BENEFITS OF HOME CARE SERVICES

The benefits of effective home health care programs can be summarized as follows:

Patients prefer care that can be provided in the normalcy of their home environment.

Home-bound people can be taught to live in a relatively independent status.

The need for initial admission or readmission to inpatient institutions can be diminished.

For the necessary institutional admission, unnecessary days can be decreased.

The efficiency of the practicing physician can be increased by expanding the team approach. The physician can care for a greater number of patients through a home care program because he does not have to assemble and coordinate individually the services needed for his patients in their home settings.

Home care staff can readily interpret medical orders, explain treatment regimens, and offer reassurance and support.

Home care staff can identify day-to-day problems and thus help to reduce the possibility of emergency situations arising.

V. PROBLEMS, OBJECTIVES, RECOMMENDATIONS

Home Health Care Committee—Problem No. 1

1. *Problem—*

7.2 million dollars of the cost of health care in the State of New Mexico this year is due to this State's Gross Receipts Tax on medical and health care goods and services.

$1.5 million of this tax will be paid through private and government insurance programs, while $5.5 million will come directly out of the pockets of sick and disabled consumers.

To the best information available New Mexico is the only state that has a tax on medical and health services.

(Source of public figures—Fred O'Chesky, Director, NM Bureau of Revenue. Source documented—tax analysis NM Interim Legislative Study Committee on Health & Aging, Phil Lynch, Legislative Counsel.)

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[2] From AMA's statement on home health care.

A. *Objective.*—To encourage an amendment to the gross receipt tax law to exempt medical and health care goods and services for the citizens of New Mexico by 1975 legislative session.

B. *Recommendations*—

1. That the HPC take a strong public stand favoring an amendment exempting from the state gross receipt tax law the cost of medical and health care goods and services.

2. HPC instruct its Legislative Committee to promote this amendment to all civic groups including labor and management organizations; medical, dental, pharmaceutical, and related organizations, and senior citizens groups, to encourage legislative support.

3. HPC inform NORCHAP and other A & B HPC's of their position, to solicit their support.

4. HPC inform The State Interim Legislative Study Committee on Health and Aging and the Legislative Interim Tax Study Committee, as well as all candidates running for the Governor's office, of its position.

5. The HPC inform, in writing, the Director, NM Bureau of Revenue.

6. After the State's 1974 primary in June, the HPC inform, in writing, all candidates in District 3, running the State Representative and State Senator.

M.R.B. H.P.C.—Home Health Care Committee—Problem No. 2

2. *Problem*—

Empirical evidence that physicians and consumers are not knowledgeable regarding the availability, scope, viability, and extent of home health care services available.

1973 Needs and Resources Study by the Community Council substantiated the lack of utilization of Home Health Care in the Albuquerque area.

A. *Objective*—To educate physicians and consumers of the availability and benefits of Home Health Care in order to increase appropriate utilization by 1975.

B. *Recommendations.*—That there be an immediate development of a list of resources regarding the availability, scope, viability, and extent of Home Health services available for physician and consumer education.

1. That HPC encourage all Medical Societies in District No. 3 to develop a directory of physicians for home visits by physicians when requested and felt needed by Home Health agencies.

2. At medical school level—guest speakers, films showings, and seminars.

3. Establish speakers bureau—available to public groups and organizations.

4. Publish availability of bibliographies of films, books, pamphlets available, and circulate to Church groups.

5. Medical society sponsor a Dr's Program for Providers.

6. That the HPC be furnished in layman's terms, for distribution, general Home Health Care provisions thru Medicare Parts A & B, Medicaid, Blue Cross, HMO's, and other major Insurance carriers.

7. Stimulate the public media, newspapers, radio, TV (including Channel 5), interest and coverage.

8. Prepare a "Shopping List" of services available with phone numbers/addresses for mailing to all Dr's and Pharmacists, including Welcome Wagon and all services available to the homebound patient i.e., mobile X-ray, EKG, etc.

9. Viability of the work of Home Health Care agencies through participation as a member of A & B Health Planning Councils.

3. *Problem.*—Except for Bernalillo County, Home Health Care is extremely limited in availability. The establishment of statewide standards and licensing procedure for Home Health agencies would promote the development of Home Health Care in the State of New Mexico and offer protection for the consumer of these services.

A. *Objective.*—To encourage the establishment of statewide standards and licensing procedures for Home Health Agencies by 1975.

B. *Recommendations*—

1. That MRG HPC take a strong stand endorsing the establishment of statewide standards and licensing procedure for Home Health Agencies.

2. That MRG HPC instruct its legislative advisory committee to promote the establishment of statewide standards and licensing procedures for Home Health Agencies.

3. That MRG HPC inform State HSSD director of its position favoring the establishment of standards and licensing for Home Health Agencies.

4. That MRG HPC inform NORCHAP and other HPC's of its position favoring the establishment of standards and licensing for Home Health Agencies.

5. That MRG HPC advise the N.M. Interim Legislative Study Committee on Health and Aging of its position favoring statewide standards and licensing for Home Health Agencies.

4. *Problem.*—Homemaker-Home Health Aides are an integral part of Home Health Care Services. Nationally as well as locally ½ to ⅔'s of the services performed in the home are provided by Home Health Aides. The State of New Mexico has no standards or certification to protect the consumer as well as the Home Health Care Aide.

Definition Homemaker—HHC Aide

Home Health Care is provided ideally by para-professional persons, employees of an agency, a service, an administrative unit which is responsible for the selection, training and performance of the worker. The Homemaker-Home Health Aide is one and the same person. Training and supervision stress both aspects of his or her functions which are:

(1) Personal care of the patient, that is, carrying out the physician-prescribed therapeutic regimen.

(2) Performance of certain household services essential to healthful living in a decent environment, such as cleaning, shopping, preparation of food and other household tasks normally assumed by the Homemaker.

Just as important as the functions which the HM–HHA carries out are her personal aptitudes: emotional stability, capacity to acquire skills, the capacity to adapt to varying situations, discrimination, judgment, "maturity", common sense, self-discipline, and a sense of humor. On-going training and professional supervision should help develop a variety of special skills.

A. *Objective.*—To promote the establishment of statewide standard and certification for Homemaker-Home Health Aides by 1975.

B. *Recommendations*—

1. That MRG HPC take a strong stand endorsing the establishment of statewide standards and certification procedures for Homemaker-Home Health Aides.

2. That MRG HPC instruct its legislative advisory committee to promote the establishment of statewide standards and certification for Homemaker-Home Health Aides.

3. That MRG HPC inform state HSSD director of its position favoring the establishment of standards of certification for Homemaker-Home Health Aides.

4. That MRG HPC inform NORCHAP and other HPC's of its position favoring establishment of statewide standards and certification Homemaker-Home Health Aides.

5. That MRG HPC advise the State Interim Legislative Study Committee on Health and Aging of its position favoring statewide standards and certification for Home Health Aides.

ITEM 4. HOPE MEDICAL CENTER PROJECT, OPERATIONS AND ORGANIZATION, SUBMITTED BY DAVID JENSEN, EXECUTIVE DIRECTOR, COOPERATIVE HEALTH SERVICES, ALBUQUERQUE

[From PRISM, October 1973]

THANKS TO MARTHA SCHWEBACH

(By Carol Brierly, Senior Editor)

Five years ago, after the only physician left town, the 800 folks who live in Estancia, New Mexico, had only one alternative when they got hurt, took sick, or needed medical attention.

They piled into the family car, boarded the bus, or, in rare emergencies, hired the local ambulance, and traveled 60 miles through the mountains to Albuquerque. Not anymore.

Now, when they need care, most of the farmers and ranchers and their families in the Estancia area, 60 miles southeast of Albuquerque, head for the Hope Medical Center. There, in a neat, modern little medical facility, they can get

immediate emergency care and help with chronic medical problems, as well as assistance with many health needs.

There's still no practicing physician in Estancia. But there is the nation's first family nurse practitioner, who for nearly four years has been the pivotal point of an exciting new experiment in providing family medical care in this isolated rural setting.

Functioning much as a general practitioner might, Mrs. Martha Schwebach is providing primary health services not only to Estancia residents but to many of the 5,000 people living in the sprawling 50-by-50 mile Torrance County area.

Martha's work as a nurse practitioner still generates controversy. Even though she works under the supervision of one or more physicians, she assumes far greater responsibility and performs many more duties than the typical registered nurse. When supervising physicians are 60 miles away, as they are in the Estancia program, can quality of patient care be assured? And what about legal risks, to the nurse herself as well as to those who oversee her work? (See "Let's Get the Nurse's Role Into Focus," PRISM, September, 1973.)

Some doctors violently object to allowing a nurse to assume family health care responsibilities, even when she has been intensively trained for the job. A few feel threatened by the expansion of the nurse's role. "What's to keep her from setting up her own office?" ask these critics. In fact, one East Coast R.N. already has done so.

But other physicians see the nurse practitioner idea as a valid, if temporary, solution to shortages of health care personnel in cities as well as in rural areas. Physicians and others closely involved with the Estancia pilot program believe that there has been no adverse effect on the quality of care provided, that malpractice risks are slight, and that the merits of the plan far outweigh the drawbacks.

Obviously, it was an either-or proposition in Estancia. The town can't get a physician, and its hope of doing so is far from bright. With only 800 people, a good share of them Spanish-speaking, Estancia is the center of a lettuce- and potato-growing area. A high percentage of the people in the area are on welfare. Without the nurse practitioner, there would be no care available locally at all.

The Estancia program evolved partly by design, partly by chance. After the loss of the physician who had served the town for a generation early in the sixties, townspeople raised funds to build a clinic in hopes of attracting a new doctor. The facility opened in 1965. A new physician came to town, but he didn't stay long.

Martha Schwebach, thirtyish, bright, attractive, the wife of a local rancher, and mother of four, began working nights for the new M.D. and staying with expectant mothers who were about to deliver at the center (there is no county hospital). Later, she became his office nurse.

"The busier he became, the more he taught me," she reports. "He trained me to do x-rays, take electrocardiograms, do simple lab work and many other procedures."

A year and a half later, the physician left, closing the clinic, and nurse Schwebach began commuting daily from her home in nearby Moriarty into Albuquerque to continue nursing.

"People started coming to my door at night," she recalls. "They brought convulsive babies, children with terribly high fevers, old people having heart attacks, others with broken bones and severe lacerations to me, because there wasn't anyplace else to go in the area. It was a real problem."

Meanwhile, the townspeople, searching for another doctor, approached the faculty of the University of New Mexico Medical School for help, pointing out that Mrs. Schwebach's informal ministrations provided the only medical care there.

That kindled an idea. Pediatric nurse practitioners were being trained in Denver to provide pediatric care. So why not train a nurse to work as a family nurse practitioner?

Intrigued with the idea, the medical school's Department of Community Medicine set out to find a good candidate and to solicit funds for the project. Estancians suggested Martha Schwebach, obviously the perfect choice. She knew the town and the people. She had broad experience as a surgical, obstetrical, school and medical office nurse, and she had worked in a hospital emergency room.

The Department of Health, Education, and Welfare (HEW) agreed to invest $750,000 in a three-year pilot study to test the feasibility of using a nurse practitioner, linked to an urban medical center, to provide medical care in a rural

setting. While the medical school faculty members were tailoring a special six-month course for her, others mapped sociological studies to be run in connection with the program, to assess numbers and types of problems the nurse practitioner-to-be might encounter, and to measure community acceptance of this new health care model.

Sitting alongside medical students in their classes, working with physicians in hospitals and their own offices, Mrs. Schwebach was trained to do well-baby, well-child, prenatal, and adult examinations, to offer family planning advice, to monitor the course of chronic illnesses, and to deal with problems of acute illness or accident.

"A cardinal principle of the training program was to sort out normal from abnormal findings, enumerate problems, and *not* apply diagnostic labels," designers of the experiment stressed.

PROBLEM-ORIENTED APPROACH

Her training began with a brief review of human structure and function drawn from a textbook for nurses. She was taught how to take histories and perform physical examinations using Weed's problem-oriented approach. To keep her work in focus, special forms were designed for recording patients' problems, related actions, and details of the history and physical examination. In addition, nurse Schwebach was trained to perform certain laboratory and x-ray procedures, and she spent many weeks observing patients.

A month-long "test period" wound up the intensive training during which she studied assigned patients in emergency rooms at Albuquerque's two major hospitals and phoned her findings to a supervising physician. He then examined the patient himself, noting and discussing any discrepancies with her.

The clinic was refurnished, equipped with an x-ray facility, a small laboratory, and other necessary items. Dubbed the Hope Medical Center, it reopened in January, 1969, this time with nurse practitioner Schwebach in charge. She worked on the basis of standing orders prepared for her by medical school physicians.

After taking a patient's history and examining him, she'd call a pediatrician or internist at the medical school via a direct phone line to verify the proper course of action to take. A telephone-mediated electrocardiographic system was made available, and a licensed practical nurse joined the staff following special laboratory training that equipped her to perform simple but essential procedures. X-rays were sent to Albuquerque on the morning bus, read at the medical school, and results were phoned to the center in the afternoon.

"Though the university stressed pediatrics in my training, I asked for more work in medicine, because I knew I would need it." says nurse practitioner Schwebach. "Services at public health clinics held regularly in Estancia are limited mostly to prenatal and well-baby care. Many of our chronically ill people get no care at all. Part of the reason is that the younger generations commute 120 miles each day to work in Albuquerque. They don't want to haul along the older folks to sit in a doctor's office all day.

"I also got some surgical training—learned how to suture minor lacerations, identify an acute abdomen, things of that sort. So it became a triage situation, determining what could be handled in Estancia, what should be sent to Albuquerque, and what might be saved for the physicians who come to the center two mornings a week from the medical school."

For the first year, supervision of the nurse practitioner's work was very close. She called in for guidance with practically every patient. When the pediatrician and the internist visited the center during the week, they reviewed and signed all charts and prescription forms.

Changes in these somewhat cumbersome clinical procedures came about in an unlikely way. A Norwegian physician, touring U.S. medical facilities under HEW's aegis in search of transportable models for health care delivery, came to Estancia. "It's hogwash to insist that you call the medical school every time you see a patient," he told Martha. "You can use a lot more judgment than that." And he told the medical school so.

His forthright comments led faculty members involved with the Estancia project to re-evaluate instructions. As a result, Mrs. Schwebach was given more leeway in deciding when she should telephone the medical school for guidance

and when she might merely follow the standing orders that had been so carefully designed for her by her physician-mentors.

Standing orders work fine most of the time, Martha reports. When a child is brought in with physical findings indicating an ear infection, for example, she consults the orders for specific instructions on proper medication and follow-up care.

FOLLOWING STANDING ORDERS

"But if it is an ear infection with pneumonia in a child under a year of age, it can be very serious. You have to take a lot of things into consideration. What is the family background? Can the mother afford to buy the medicine? Will she actually give it, even if we help her obtain it? Some mothers keep bringing children back so often I wonder if they really do give the medicine," she muses.

One mother brought in a child late one afternoon saying he wasn't breathing right. He wasn't, though he had no temperature and didn't appear ill. Mrs. Schwebach encouraged the woman to recount the events of the entire day. It had been rough. Her husband had been drinking, the kids cranky, an argument ensued.

Mrs. Schwebach investigated further and found that the child was loaded with aspirin. "Whether he ingested it himself during the family quarrel or whether his mother fed it to him to keep him quiet, I couldn't find out," she says. "But I had to warn her that he could suffer salicylate poisoning, and I urged her to get him to a physician in Albuquerque."

Mrs. Schwebach was given some basic training in psychological counseling, too; so, occasionally, if a family requests help, she will schedule sessions to help them work out their problems.

"But in Estancia," she says, "people are crisis-oriented. Most people who come to the center are really sick. We try to orient them toward preventive medicine, but it is costly and this is a poor area."

During the four years the university ran the Hope Center, 14 people researched all aspects of the operation—quality of care, acceptance, types of patients seen—and accumulated considerable sociometric data. The consensus was that the experiment proved the feasibility of using a nurse practitioner to deliver quality care in a rural community and that the community would accept her.

Then in August, 1972, the federal grant ran out. Once again, the Estancia clinic faced the prospect of closing its doors. Patients were paying for care, but at extremely low rates, and the clinic was losing money. A private organization, Cooperative Health Services (CHS) of Albuquerque, was induced to take over the center's operation as an outreach project.

RUNNING THE CLINIC

David A. Jensen, associate director of CHS, tells how it happened:

"CHS is a joint venture of Presbyterian Hospital Center and St. Joseph Hospital of Albuquerque. It is set up to encourage development of shared services, control costs, develop an alternative health care delivery system, and assist in the development of clinics in areas short of medical care." (Physicians staffs at the two hospitals, through CHS, already have set up a comprehensive prepaid health care plan.)

"Because Torrance County is so large, we felt that people there would face a severe problem if the center closed," Jensen says. "So we put up funds to keep it open while we did a close analysis of the operation, talked with the people there, and made an effort to determine whether we could run the clinic successfully on a break-even or sustaining basis."

CHS reduced the payroll by one and effected many economies in the center's operation, partly by dropping expensive but rarely used procedures whose equipment boosted costs.

Legally, Mrs. Schwebach could not function unless physicians agreed to supervise her; so a panel of seven Albuquerque physicians in private practice was established. These M.D.'s manage, control and supervise her work, but they don't get paid except through an occasional referral. They took on the job, because they believe the nurse practitioner approach is viable for a rural area.

"These physicians directly oversee the medical care she provides, review and sign off on her charts, sign prescriptions, and do those other things that are required to enable her to offer primarly health services," Jensen reports.

The research-oriented university project had required completion of long patient history forms and extensive physical work-ups.

Internist J. William Warren, one of the supervising physicians, says that a patient coming in under the original set-up for a urinary tract infection or a

sprained ankle often faced a 90-minute office visit. "Some of them didn't come back," he admits.

A new, abbreviated but more workable set of records was installed.

Will the Estancia center succeed now that it runs under private auspices? Prospects for becoming financially solvent within a year or so are increasingly bright, say those who are closely involved. "We are drawing new patients each month," Mrs. Schwebach reports.

But the clinic faces two problems, one financial, the other, a lack of public awareness of its existence. When it was under university auspices, the clinic's fees were pegged at the lowest reimbursable levels, because researchers wanted no barriers to stand in the way of attracting patients. The medical center itself underwrote any deficits, drawing from HEW grant funds. When the center switched to a private basis, however, it wasn't possible to raise fees to a more realistic level, because the fee freeze was on. Hence, the only way to make the clinic self-supporting was to effect economies in operation and attempt to pull more patients.

The Hope Medical Center was never well publicized during its university-run days, but now the CHS is working to increase public awareness of the center and its services. To publicize the change-over from a university-run to a private, pay-as-you-go clinic, a new sign was put out front, indicating the tie-in with Albuquerque's two largest voluntary hospitals, and informational campaigns were begun.

"We held an open house early last summer for townspeople in which a number of Albuquerque physicians participated," says Jensen. "We're distributing information cards through the local Welcome Wagon, and we're trying to further awareness of what the clinic can and can't do and to acquaint people with the ways in which Martha, as a nurse practitioner, can serve them."

FINANCIAL ASSISTANCE

While the center builds its patient roster to the break-even point—and perhaps one day to the point where it may show a small profit—CHS is exploring other sources of temporary financial help. According to Jensen, several private philanthropic foundations with interest in encouraging new ways of delivering health services have indicated they might be willing to provide financial assistance during the initial phase of private operation. What these foundations like about the Estancia model is that here a nurse practitioner works with a group of private, supervising physicians rather than with a university structure. This makes the concept more easily adaptable to small towns and rural areas.

Under the new administration, Martha Schwebach is presented with more challenges than in the past.

"The new standing orders are more flexible," says Jensen. "But Martha is experienced; she has had no malpractice suit, and we don't expect one. She can see a patient, look at him, treat him if she knows what's wrong with him. But she's also expected to recognize something beyond her scope and contact one of the physicians for further directions."

Physicians still review and sign every patient chart, and there is direct hospital back-up. Emergency room physicians at both participating Albuquerque hospitals have agreed to advise Martha on any problem at any hour of the day or night. Consequently, she often alerts hospitals, in advance, to the kind of case she is sending in, and they can prepare for it.

Is nurse practitioner Schwebach "diagnosing" patients' problems?

"Certainly," say her supervising physicians flatly.

"She observes in the sense that she doesn't miss things," Dr. Warren says. "She may be asked, for example, to 'diagnose' an acute respiratory infection. But when she makes that simple diagnosis, she must satisfy herself that this is not an occult manifestation of a more serious disease. We're anxious that whenever she is uncertain, she contact us, and she has been doing this."

Surprisingly perhaps, nurses, not physicians, have been most opposed to the nurse practitioner idea.

"A nurse practitioner does things that nurses haven't done in the past. So I was a threat to other R.N.'s," Mrs. Schwebach points out. "But in the last year, I've seen a tremendous change in nurses' attitudes." (The University of New Mexico Medical School currently has a dozen students enrolled in its nurse practitioner training program.)

Some health professionals can't yet accept the idea that a highly trained R.N. can actually "diagnose" minor health care problems. Nor do laws in most states provide for such activities.

"To get around this objection, we stress that Martha *observes* patients, operating under the supervision of qualified M.D.'s," says Mr. Jensen.

Before launching the program, the university sought an informal opinion from the state's attorney general on the legality of the Estancia project. He indicated it would not be illegal, and the state medical society backed the plan.

Under the new set-up, supervising physicians have signed consensual agreements assuring that they will supervise her activities. The parallel is much like that of the industrial nurse, working under the supervision of a physician not regularly on the factory premises, say the doctors involved.

Each supervising doctor checked in advance with his own malpractice carrier to make sure his coverage would extend to the Hope Center. Every insurer agreed. Mrs. Schwebach carries her own malpractice insurance through the American Nurses Association—$300,000–$600,000 in protection.

"I was never frightened about the legal responsibility," she reports. "I feel that if you do the right thing for the patient, he will think twice about suing you."

One major change made at the center is that there are no designated days when doctors are on duty there. "We want people in the area to go to Martha, not to save up their medical problems for the time a physician visits the clinic," says Dr. Warren. "However, when one of us is there to review charts, Martha can schedule any patients she may have some questions about, and we'll see them."

What makes Martha Schwebach's work different from that of a typical general practitioner is that she acts as an extension of a patient's own physician. She photocopies each patient's record and sends it to his physician. And she may phone the doctor for additional information or guidance. She also encourages the patient to return to his own doctor when he needs care beyond her scope.

"We wish all doctors would extend such courtesies," says Dr. Warren. "We have asked her to be scrupulous in her professional relationships with physicians. In other words, we are asking her to be Caesar's wife—above reproach." And she rigidly follows that advice.

One day an elderly Spanish woman came to the clinic, obviously in heart failure, fluid dripping from both legs. She had never seen a real physician before and had been "referred" to the center by a *curandera,* the Spanish equivalent of a witch doctor, in the hills. With help from the Spanish-speaking receptionist and laboratory technician, Mrs. Schwebach persuaded the woman to go to an Albuquerque hospital immediately. After care from a cardiologist in the city, the woman returned to Estancia sometime later, minus 65 pounds and breathing easier. Nurse practitioner Schwebach saw her and, following the clinic's referral policy, sent her back to her original "doctor" for care of her routine problems. The clinic continued to supervise her heart condition.

"We hope that eventually physicians in Albuquerque who have patients in the Estancia area will use Martha and the clinic as an adjunct to their offices," say the supervising physicians. "She can serve as an extension of their care, sparing patients long drives into town and reducing office overloads.

"The time will come when the individual physician is forced to the wall by an overload of work," Dr. Warren believes. "Because he is conscientious, he will realize he needs help. A nurse practitioner may be one answer, working alongside him in his office or in an outreach program."

Supervising physicians make one thing very clear. Should a family physician come along who is interested in practicing in Estancia, he gets the whole package—Martha Schwebach and all—to help him.

"We're interested in providing good care out there," say the doctors. "If there is a better or more acceptable form of care that can be offered, we'll be happy to see it come in."

As for Mrs. Schwebach, someday she would like to go to medical school—if her husband doesn't object.

[From the Albuquerque Tribune, Mar. 6, 1974]

Nurse Practitioner: Martha Schwebach Solves Rural Health Problems

(By Patricia Gins)

Anyone who's ever been responsible for a convulsive child, pregnant woman, burn victim or loved one with a coronary knows the feeling of relief when you finally reach your family doctor or the local emergency room.

What if it weren't that way?

What if the nearest doctor or emergency room was 60 miles away or farther?

You'd have to drive the victim of a raging fever or broken leg or heart pains that 60 miles for medical help.

That's what the 800 people of Estancia, N.M. faced six years ago when the town's only doctor retired and moved away.

This small ranching community 60 miles southeast of Albuquerque and 17 miles south of Moriarity along with much of the sprawling Torrance County area was left with only one doctor in the county, a private physician in Mountainair.

Their problem's been solved now—in a unique way that may well become a model for other rural communities around the country.

Martha Schwebach, the nation's first Family Nurse Practitioner, operates Hope Medical Center in Estancia and provides primary health care to the people in that area.

She's been specially trained in a program at the University of New Mexico School of Medicine to function much as a general practitioner under the supervision of doctors in Albuquerque.

It's a unique situation and the people of Estancia like it—and asked for it.

When their doctor first left, townspeople raised money to build a modern clinic for a new doctor.

He stayed only a year and a half. During that time, Mrs. Schwebach, wife of a Moriarity rancher and mother of four, was his night nurse staying with expectant mothers.

Later she became his office nurse and right hand helper.

"The busier he got, the more he taught me," Martha remembered.

Pretty soon she was doing X-rays, simple lab work, taking electrocardiograms and helping with other procedures.

When the doctor left, Martha went back to commuting to Albuquerque to work.

The people of Estancia, in the meantime approached Dr. Ted Mortimer, chairman of the pediatrics department at UNM, and asked him what the university was going to do about the problem of rural health care.

UNM recognized the need and devised a program to take a nurse with a varied background and give her special training in care of the family.

The Estancia townspeople recommended Martha, who was then at Bataan Hospital as the first trainee.

"Dr. Mortimer called me at the hospital one day and began by saying he hoped when he died, people were saying about him what they were already saying about me." Martha laughed.

Mrs. Schwebach's extensive training in her native Kansas and a wide variety of nursing jobs in California and New Mexico made her the ideal trainee.

Moreover she lived in the community, knew the people and understood their problems and concerns.

Her six month training program included such things as well—child care, maternal health care, the care of acute and chronically ill children and adults, and emergency care.

She was taught how to take histories and do physicals. She was trained to do some x-ray and laboratory procedures.

In short, her nurses training and background was expanded upon to make her competent to assume the duties of a general practitioner.

There was no other program like it in the U.S. at the time and in 1969 Martha Schwebach became the first Family Nurse Practitioner.

Originally UNM operated the Hope Medical Center in Estancia where Martha practices. She called doctors at Bernalillo County Medical Center for advice on patients and they carefully supervised her work.

Eventually the university withdrew and Cooperative Health Services of Presbyterian Hospital Center and St. Joseph's Hospital took over management.

Martha now works within certain guidelines on the basis of standing orders, developed by her supervising doctors. Within these guidelines, she's free to treat.

Six local private physicians act without pay as her supervisors. They guide her treatment, sign prescription blanks and assume legal responsibility for Martha's work. They have agreed to guarantee the quality of care available at Hope Medical Center.

Martha may call them at any time for consultation or refer one of her patients to one of the doctors for more extensive treatment.

"The panel of physicians obviously has confidence in Martha," said Barbara Seigal, Martha's boss at Cooperative Health Services. "They know she's a good clinician and conservative. She does not go beyond the scope of her training."

In addition Martha is backed up by all the technical expertise and backup available at the state's two largest hospitals.

After on-the-spot emergency care, Martha contacts one of the hospitals and sends patients in for further treatment. X-rays and laboratory work are sent to Albuquerque. Expectant mothers see Martha on their first visit, are sent to a doctor in Albuquerque for their second visit.

Martha follows their progress for eight months and then it's back to the doctor for the last month and delivery.

An attractive, slim brunette, Martha spends her days treating exactly the injuries and diseases any small town doctor would see.

Farming accidents, feverish children, pregnant mothers and the chronic illness of old age are common.

She might do a college physical in one of the clinic treatment rooms, change the bandages on a lacerated arm in another and do a six month old baby's check up in a third.

The clinic boasts a lab, x-ray room and well-stocked emergency room. In addition Dr. Richard Lewis, an Albuqueque dentist visits the clinic one day a week and Dr. Arthur Rosenberg, an opthalmologist sees patients every three weeks. Jack Wohl, an optician is there once a week to fit glasses.

Martha spends a half a day each week in Albuquerque consulting with doctors, making hospital rounds, sitting in on lectures, etc. to keep herself in touch with the medical profession.

"One of the primary reasons doctors leave small communities is isolation from the medical community," Martha said. "I enjoy my contacts and I want to keep them up. I don't want to get left behind in medicine."

The Torrance County community has accepted Martha with open arms. Patients come from as far away as 125 miles.

"Some people accepted me right away," Martha said. "Others had to learn what nurse practitioner meant.

"I was doing things other nurses didn't and it took a little adjusting."

Even now many of Martha's patients refer to her as doctor.

"They know I'm a nurse, but they can best understand what I do by calling me doctor, because I doctor them."

Martha's success at Hope Medical Center has been a model for the rest of the country. Similar FNP programs are available at several schools around the country.

Estancia's combination of a clinic staffed by a FNP within commuting distance of a major medical complex is believed to be the ideal situation to insure proper backup.

Martha's familiarity with the area is also an unmeasurable asset.

"I was able to tell the doctors training me what I would need," she pointed out. "I also knew what the community would and wouldn't stand for."

"I live here so in emergencies, I can meet sick or injured people at the clinic."

Cooperative Health Services plans to continue adding to the services available at Hope. This month a bilingual health educator will begin working under Martha's supervision.

She'll help people learn how to manage their health and avoid problems or adjust to chronic illnesses.

For Martha, there's no going back. She loves her work, the people she sees and even the responsibilities she's assumed.

"I could never go back," she said. "I'd be so bored with regular nursing, it would drive me out of my mind.

"I utilize nursing, but I've progressed to a new area of expertise."

AGREEMENT

This agreement made this 1st day of October, 1972, by and between Southwest Health Care Corporation (SWHCC) and J. William Warren, M.D.;

Whereas, the parties desire to provide medical and other services to Hope Medical Center in Estancia, New Mexico; and

Whereas, the continued operation of the Hope Medical Center in Estancia, New Mexico, will result in benefits to all parties;

Now, therefore, for and in consideration of the mutual covenants and promises herein contained, the parties agree as follows:

1. The undersigned physician agrees to manage, control and supervise the work of the Family Nurse Practitioner located at the Hope Medical Center in Estancia, New Mexico.

2. The relationship between physician and the nurse practitioner will be that of employer and employee relationship; the nurse practitioner will operate as an extension of the physician's private office practice.

3. The undersigned physician agrees to prescribe and direct the Family Nurse Practitioner in the administration of medications and treatment to patients of the clinic and further agrees to provide standing orders, telephone consultation, chart review, signing of prescriptions and other services as required in order that the Family Nurse Practitioner can provide services at the Hope Medical Center in Estancia, New Mexico, under direct supervision of a physician.

4. The sponsoring physician agrees to periodically visit the Hope Medical Center in Estancia, New Mexico, to see patients requiring diagnosis and treatment.

5. The undersigned physician understands that as a supervising physician, his name will appear on letterheads and other items indicating his professional association with the Hope Medical Center in Estancia, New Mexico, and the Family Nurse Practitioner.

6. Southwest Health Care Corporation agrees to pay for all expenses associated with the operation of the Hope Medical Center in Estancia, New Mexico.

7. Within the context of its nonprofit status, Southwest Health Care Corporation will work to improve the efficiency and cost control of the Hope Medical Center in an effort to make the operation at least self-sustaining. In the event that the clinic earns a surplus over expenses, said surplus will be set aside to compensate supervising physicians on a fee-for-service basis.

8. The term of this agreement is indefinite and may be terminated by either party by giving ninety (90) days' written notice.

J. William Warren, M.D.

Charles O. Finley & Company, Inc.,
New Mexico Medical Society,
Albuquerque, N. Mex., September 21, 1972.

Mr. David Jensen,
Cooperative Health Services,
Albuquerque, N. Mex.

Dear Mr. Jensen: This is to confirm our recent telephone conversation regarding the consultation of several doctors with a nurse practitioner at Hope Medical Center in Estancia.

The New Mexico Medical Society Professional Liability Group Program policy, underwritten by the Travelers Insurance Company, states the doctor is covered for "injury arising out of the rendering of or failure to render, during the policy period, professional services by the individual insured, or by any person for whose acts or omissions such insured is legally responsible . . .". Therefore, the doctors insured through the Medical Society Program would be covered for the consultation with no change in premium.

If we can be of any further service to you in any way, please let us know.

Sincerely,

D. J. Letherer,
Administrator.

ITEM 5. PREPARED STATEMENT OF JOHN P. MURPHY, PRESIDENT, NORTHERN VALLEY SENIOR CITIZENS ASSOCIATION, ALBUQUERQUE, N. MEX.

Because I was born in another era in another century in a category in which the immigrant was the dominating factor, I believe that I am qualified to speak on the subject of assistance to those who are in need of help, specifically because I have devoted nearly a half century to study of the handling of people when they become needful of assistance.

Born into the European culture which saw me and many of my contemporaries taken in hand by the American way, particularly the school system, we early learned that Government did actually care about the welfare of the newer arrivals in this country. In the working class—and that category did exist—the producers were allowed to "make their own way." The children were trained in American culture, to become part of the great national heritage. Old people, after their producing days were done, were generally taken care of in an age old formula which saw them cared for in the home until they were properly buried after their lives had run out. The few that were, for many reasons, not able to participate in the general manner were taken care of by the public. In this category, one outstanding error existed; they were classified with the paupers; and, a stigma existed, although these older people under public care were, in many cases, self supporting through the economic phase of the "poor house." This situation was not the best possible way of handling the problem, but it did work until a better method could be devised.

In the social revolution that followed the world shaking events of the early part of this century, the labor unions came into full focus. Many of these organizations, much different in principle and policy than the unions we know, had been started to accomplish two programs. The first was to obtain justice in economics for the workers through organized effort, and the second was to utilize that power and effort to protect the older worker after his best producing years were gone.

Abuses that then existed in the handling of the elderly put the "poor house" in a position that the unions, joined, by social groups, agitated for the end of that degrading institution. They proposed a system wherein Government representing the people, would take the responsibility for care of the needful elderly by eliminating the institution of the poor house altogether. I was part of that movement as a legislative agent in Washington during the "New Deal." If we had—at that time—known the experiences of older people in need through Government handling—there is no doubt that the term "poor house" would have been upgraded as the term "welfare" was, and the institution; cleaned up and modernized and under a different name, would still be part of the national economic and social picture. It has been said that the treatment of Indians is a national disgrace. Compare this matter with that given to our elderly citizens and join them, and you have a condition that this nation can not, in conscience, allow to exist. Some years ago, a furor existed because a concerned person asked the question "What has become of the conscience of America?" I again ask that question. When we see the conditions that prevail in the segment of our society that experiences threats and abuse in their helpless times, when they have earned the right to peace with dignity, and the answer of our civilizations is "So what" it is time to act. In our social order we see powerful organizations set up to use power to force action against human vultures who prey on the helpless. We have the Society for the Prevention of Cruelty to Children. We also have the Society for the Prevention of Cruelty to Animals—together with organizations to help convicted criminals and drug users and alcoholics and others. Not one of these types of organizations exist to protect the needy old people, and here exists the greatest blot on our society that must be cleared up before we can answer the question "What has become of the conscience of America" without hearing the echo that it has been swept under the rug.

In our national structure we have set powerful bureaus designed to accomplish certain designs. We have the womens bureau, and the childrens bureau, and facilities to protect consumers, and workers and farmers and all categories except the most needful, the elderly poor. As a gesture in that direction, we have set up the President's Commission on Aging. In this matter we ask one vital question "Who are the people picked to represent the elderly poor?" Not one person in this category is allowed into the presence of this group who meet; get their publicity and their pictures taken; and then feel that they have lulled the conscience of America into its annual stupor.

To assist in clearing up the mess that we should be ashamed of, I offer the following program:

(1) That legislation be promptly entered in Congress establishing an independent bureau of sub-Cabinet standing for the purpose of protecting the elderly against any type of exploitation on any level.

(2) That the present committees and commissions of Federal Government be requested to continue on a national scale the formula here established to get the facts on care of the aging.

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(3) That, in the administration of Federal funds in the aging category, a committee be established in each area, in the membership of which group at least one person be from among the nonprofessional elderly nonaffluent, and that this commission be given power to examine the funding and the programs of all agencies, public and private, that claim to represent the aging, and to publish their findings.

(4) That a survey of establishments in each area be promptly made to include all establishments that receive funds either from or for the elderly, and that a code of uniform standards be established for the administration of these establishments with policing powers placed in hands no lower than the State level.

(5) That, in each area there be set up a board to hear complaints from the aging, with postage-free material available and that each complaint be recognized promptly, and that the Social Security office in each area be named the receiving agency for complaints.

(6) That, through our representatives in Government, the Congress be respectfully requested to order that no action of the Government that attempts to curb the effect of inflation on the living standard of the elderly be met with action that will reduce living standards, such as increasing rentals or other expenses or decreasing pension payments or other benefits.

(7) That an immediate survey be made to include all phases of need of the elderly in any category, and that legislation be entered to establish the condition of the aged that was intended in the social legislation of the so-called "New Deal."

More than 40 years ago, we thought that we were social revolutionaries when we struck the chains from the wage slaves and the conditions from the elderly that led them "Over the hill to the poorhouse." Following Bellamy's formula, we now are "Looking Backwards" and what we see is not pleasant. Strikes and labor strife are still current, in such a fashion that fewer than one in five of the workers are joined in labor unions, while the so-called "leaders" of this nation are charged with high crimes and misdemeanors that cry out for justice. The backward glance shows our greatest error, because we destroyed the poor house and left many of our elderly with no place to turn. If what we read in the daily press is true, and there is no reason to doubt it, then we not only look backward, but our path to civilized freedom is reversed. Many of our older people would gladly take a choice of either returning to the syndrome of the poor house or to the more civilized practice of the Eskimos, who in their charity allow their elders to peacefully die rather than face what we call our civilized way. Given my choice, I will take the way of the Eskimo in preference to this civilized way in which we allow the torture of our elderly, mentally and physically, to prepare them for the peace of death. If this is civilization, you may have my share of it.

We have had more than we can take of words and promises. This nation has failed its elderly citizens miserably. Let us hope that this hearing is not just one more of the many that we have suffered through in the past 40 odd years. Many of us can take care of ourselves while we wait for our government to ease the way for the less fortunate. Let us hope that this hearing is not just one more in a long procession of failures to do our duty by the people who did just that when we needed them.

ITEM 6. ADDITIONAL STATEMENT OF SELMA CLEVER, ALBUQUERQUE, N. MEX.

We recommend that people served at the Title VII meal sites be allowed to take food left on their plates home with them.

People who bring elderly to the meals to eat in the sites should be able to get meals for 50¢ instead of $1.00.

Encourage younger people to participate in the meals program for public relations to make others aware of the programs for seniors and the problems seniors encounter.

Revenue sharing money should be used for elderly programs.

We would like to see the meals on wheels program continue in the Model Neighborhood area and through the county. This is a very important program and so far the areawide agency has no plans to continue these services.

In order to expand these services areawide more buses and more paid help are necessary.

More paid staff is needed in the Model Cities aging program. At least one more full time position is needed although, there is not enough money presently in the budget for another position.

The MNA Senior Center should be continued as a meeting and recreation center for the 3,000 seniors in the Model Neighborhood area. Since the close of the Hospitality House on Broadway many people from there have come to the Senior Center for recreation.

There seems to be an emphasis to use voluntary help in present and newly planned senior programs. We have found that it is impossible to run a program using exclusively or predominantly voluntary staff. They are usually undependable and only show up when they want to. They cannot be relied upon to work regular hours or for extended periods of time. We feel these programs should be staffed with paid employees and use only volunteers in areas not requiring regular dependable services.

In spite of the above we would like to request one or two volunteers, if any become available, to help with home visiting and other services.

Appendix 3

STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. STATEMENT OF MRS. FRANCES QUAKENBUSH, PRESIDENT, RESIDENTIAL AID & SERVICE HOMES (R.A.S.H.), ALBUQUERQUE, N. MEX.

POSITION PAPER, R.A.S.H. INC.

We, the members of the New Mexico Residential Aid & Service Homes, Inc. (R.A.S.H.) wish to comment on the meeting held in Albuquerque and Santa Fe May 25, 1974 concerning the welfare of the aged, blind and disabled.

We are in agreement with any change that will improve this situation. With that in mind we would like to point out a few problems overlooked by all the speakers at that meeting. They had many fine ideas, mostly on a long range program research etc., nothing definite for "now action." The problem has been with us for many years, we need action now, not two to five years from now. We the people that live, work, and cope with this problem 365 days a year, feel we are in a position to recommend suggestions for a possible solution.

1. Adequate finances on an individual basis, i.e. those able and live alone and wanting to.
2. Those that must be placed in a nursing home needing that type of care.
3. Residential Aid & Service Home types. This is the most needed and is the least recognized.
4. Boarding Home—bed and board only.

This No. 3 type of person regardless of age or condition other than 24 hour nursing care need a family type home or living arrangements where they will be treated as an individual getting personal attention, care and service.

If they could receive adequate financial assistance, then they or the responsible party could select a home of this type to care for them. They or the responsible party would not have to shop around for the cheapest living arrangements. This would automatically eliminate the so-called "flop houses" or undesirable "Boarding Homes." The operators of a Residential Home would have to have adequate pay from its residents to operate a desirable place. Giving the operator and/or owner a reasonable compensation for services rendered. An operator cannot operate a desirable home for these people on social security assistance or HSSD aid. What is required of the "Boarding Homes and operators" far exceeds the income received from their residents. Therefore, creating the well publicized undesirable "Boarding Homes."

The majority of the licensed Boarding Homes in New Mexico are striving and/or have already met the requirements of the Licensure Law for their homes plus the Life and Safety Code.

RASH feels a resident should receive approximately $220.00 per month for the operation and/or owner and $40.00 per month for their personal needs. This is being very conservative. This is lower than the "poverty level." This figure should be reviewed and evaluated every two years to keep up with the cost of living.

Since the aged, blind and disabled who are not in need of 24 hour nursing service but do need aid and service is our concern we do feel that the homes we operate should be classified as Residential, Aid & Service Homes. There must be requirements, through rules and regulations as to the type and amount of care to qualify as R.A.S.H.

The difference between a Boarding Home and a Residential Aid & Service Home is the type and care given a resident. As it is now we all fall under Boarding Homes. This is not a true picture of the situation because 90% of the people we have in our homes are definitely unable to function in a Boarding Home situation,

which is a home providing nothing but bed and board. Therefore, a model Boarding Home is out of the question because of the difference in requirements and care of the people we are concerned about and are now caring for. A retirement home, a day care center would not be the answer either for the same reasons.

Spending money on this type of a pilot program would be a waste of tax payers money (which is our money, too). The money spent on such a study would go a long way towards helping our classification of people "now." It would also take several years to formulate such a program to get it off the ground floor or finally arrive at the conclusion that it was not feasible.

Example conflicting reports of the printed statement which was in the Albuquerque Tribune May 24, 1974 on page A–8. If we assume that it cost $220.00 for 8 persons for food and utilities, that would be $27.75 per person per month. Impossible! If we assume that it cost $220.00 per person per month that would be a total cost to the operator of $1760.00 per month which would be $640.00 more than the income. Also impossible!

If this State Official can outline and show Boarding Home operators how one can furnish 3 meals per day (not counting utilities) on $27.75 per month we will welcome with open arms his plan. That is approximately 31¢ per meal on a 30 day month. Cost to the operator involves more than groceries and utilities, i.e. 4% tax on income, telephone (a necessity), insurance, mortgages or rent, car expense (used in business operation over and above personal use), salaries (most operators do without this service because one 8 hour employee would be approximately $480.00 per month based on the new Federal Wage Law when it is enacted by our Legislators, not counting SS and ES tax) are just a few other expenses an operator has to pay. Also the desirable Boarding Homes have had added cost, i.e. remodeling, maintenance and necessary equipment to meet the Life & Safety Codes.

This is another vital concern of RASH:

1. Operators and/or owners shall be:
   a. Reliable, dedicated, and responsible.
   b. Licensure Board approval of operators.
   c. Homes should be covered with 24 hours by reliable and responsible person(s).
2. Operator and/or owner working outside of home must meet above qualifications #1, a,b,c.

Most of our members are dedicated reliable people and care about their residents but we want to be sure all licensed homes have that type of personnel.

Trusting the committee to give favorable consideration to our suggestions. We would like to thank everyone who has shown concern, and contributed in any way to the solution of this problem.

ITEM 2. STATEMENT OF JOHN HERNANDEZ, SR., MESILLA PARK, N. MEX.

The main problems of old persons in obtaining medical service are the same as those being encountered by all persons of all ages, the only difference being that an older person is by reason of age more prone to illness and therefore requires medical care more often and for longer periods.

The problems are in order of importance.

1. A shortage of physicians.

Local doctors are refusing to accept new patients because their schedules are already full, some will not accept medicare and medicaid patients for reason that it takes time and effort to prepare the claims and then must wait for a number of months for reimbursement. Patients who are accepted must wait for weeks or months for an appointment, and on appointment day must wait for hours in the doctor's waiting room. This waiting is exceptionally hard on older persons. If a person is not a regular patient there is no way for such person to be admitted to the local hospital other than by being taken to the emergency room. Admittance to emergency room costs $50.00. Admittance to the hospital is only by order of a physician.

There are a number of New Mexico communities that do not have a resident doctor, and have been unsuccessful in obtaining one after offering substantial money, guarantees and other inducements.

The director in charge of the Eastside Community Center in Las Cruces states that the most serious problem that is encountered daily is the many requests for assistance in getting medical service for poor people, assistance in getting to a doctor, assistance in getting a sick person admitted to the hospital and in finding ways and means to pay costs of medical care. Local nursing homes will accept Medicaid patients, but are not staffed to care for Medicare patients.

There are no certified medical nursing homes in the Las Cruces area and possibly only one in El Paso. Full time registered nurse requirements should be eased.

There is a home care service "Home Health Service Inc." which is a non-profit organization funded by federal funds. The service is very limited due to the fact that it must depend on doctor referrals.

The Federal Public and State Public Health service are doing good work but here again service that may be rendered is limited by the restrictions imposed by the medical profession.

Transportation is a major factor. Elderly poor very often must pay several dollars in taxi fare a month to go to and from doctor's office.

Nurses report that in some cases as much as 50% of their time is devoted to doing secretarial work for doctors or for the hospital, this could be corrected by training medical secretaries. They also suggest the training of hospital administrative employees at all levels, especially clerks who handle insurance claims. All nurses interviewed state that there are many services now performed by doctors that can be performed by a well trained experienced registered nurse thus relieving the doctor of minor time consuming duties. Most doctors will not authorize nurses to perform these duties.

There is a general feeling among all persons interviewed that *women* and some ethnic groups have been discriminated in admittance to medical schools and that this discrimination must be corrected. Federal funds are now disbursed by a large number of agencies resulting in duplication and in the conduct of useless surveys and planning.

The second most serious obstacle encountered by older persons is the excessive cost of medical service, doctors fees, hospital costs, drug costs and nursing care charges. An operation plus a stay in a hospital for three or four weeks can very easily wipe out the savings of a life time.

RECOMMENDATIONS

A registered nurse with many years of experience has submitted the following suggestions as a partial solution to the shortage that exists.

"That there be established neighborhood clinics, based on need and population to relieve the shortage of doctors and nurss." "A registered nurse who has had experience after graduation could man a clinic in the capacity of nurse practitioner with the assistance of a secretary." "Nurse practitioner would refer patients requiring special care to physicians."

"Special training could be provided for both nurse practitioners and clinic secretaries."

"Guide lines for conduct of these clinics to be established and supervised by the U.S. Health Service." The establishment of neighborhood clinics was one of the recommendations that were made in a Planning Halth Service for the Elderly study prepared by the Syracuse University School of Social Work through a grant from Administration on Aging, U.S. Dept. of Health, Education and Welfare and published by the National Council on Aging under contract with the office of Economic Opportunity.

Recently the University of New Mexico Medical School requested a grant of $100,000.00, for each year beginning 1975–1976 fiscal year, for the establishment of a four year pilot project to train 24 family nurse practitioners. The need issued on a national scale to be financed by the Federal Government, an estimated 5000 registered nurses and paramedics should be trained during each of the next five years, to staff neighborhood clinics.

I am informed that at one time a neighborhood clinic was established in Las Cruces, but it failed for reason that it was underfinanced and the service rendered was that of patient referral to doctors.

Neighborhood clinics are now serving a great need in New Mexico and Texas. The Bobby Garcia Memorial Clinic del Barrio in San Jose is one of them.

Doctor James A. Harkins, Norwich, Conn., has proposed a campaign for the establishment of a national medical academy for the training of 2000 physicians yearly. We agree with this proposal.

We further propose that surplus military bases in the U.S. and foreign countries be converted to teaching hospitials and residential centers for older Americans. Above observations have been prepared from information obtained from the interviews of about 20 persons, 4 registered nurses, two Community Action Agency employees, three public health employees, one city employee engaged in Senior Citizen projects and about 10 senior citizens.

The U.S. Medical service is a vast industry, most of the service is very good but extremely expensive. This vast industry is subject to the direct and indirect control of a group of physicians associated together through the American Medical Association.

The control exercised amounts to the creation of monopolies to a large extent financed by tax funds. The net results now is that medical costs are excessively high and for the protection of the general public the Federal Government must impose a measure of control through the U.S. Public Health Service. Cost guide lines should be established.

Whenever a group of individuals band themselves for the purpose of creating a monopoly, they should be controlled in the same way as the public utility industry is regulated and controlled.

The spending of a vast sum of money as proposed in two plans called "National Health Insurance" will not solve the existing shortage of doctors. The spending of vast sums on insurance will only add to inflation and higher medical costs.

There are entirely too many agencies on aging, all getting federal assistance, doing surveys, duplicating each other, all should be under one agency to save both money and effort. In communities such as Las Cruces, Federal and State agencies and elected officials tend to contact only a few prominent people who in turn get only their own people named to federal and state committees on aging, to the exclusion of rank and file.

There should be employment opportunities opened for the older American for part time work, perhaps four to eight hours weekly to supplement income.

ITEM 3. LETTER FROM A. E. TRIVIZ, PRESIDENT, CHAPTER 182, NARFE, AND LEGISLATIVE CHAIRMAN, CHAPTER 1230, AARP, LAS CRUCES, N. MEX., TO SENATOR PETE V. DOMENICI, DATED MAY 27, 1974.

DEAR SENATOR DOMENICI: Thank you sincerely for your recent letter informing me of the forthcoming hearing in New Mexico on the health problems of the elderly. I congratulate you on your efforts on this subject and for bringing the U.S. Senate Special Committee on Aging to New Mexico. I appreciate your invitation to be present at the hearing. Since I am not a witness I shall pass on such an opportunity but I will accept your suggestion to submit a written statement for the record.

While my comments may be somewhat superfluous and repeating due to the fact that witnesses will no doubt cover the points I may mention, as legislative chairman of local chapter 1230 of AARP and president of local chapter 182 of NARFE, I feel I would be remiss to these groups if I did not submit a statement. I shall be rather brief and not all inclusive as I am sure representatives of AARP–NRTA–NARFE in the Albuquerque area will be present at the hearing and can more adequately express our mutual problems and concerns.

As you are well aware, during the past few months there has been quite a bit of agitation toward passage of some kind of national health insurance program. Among these are:

(1) The Administration's (President's) Comprehensive Health Insurance Program—(CHIP).

(2) The Kennedy-Mills Comprehensive National Insurance Act, and

(3) The Comprehensive Medicare Reform Act of 1974—Introduced by Senator Ribicoff and drafted in cooperation with AARP–NRTA.

Obviously, there are similarities among these various bills and also some differences. The main differences seem to be in extent of coverage and method of financing or paying for the program. I shall not compare one against the other.

Naturally, as retirees and senior citizens in general, we are inclined to favor the bill drafted in cooperation with AARP–NRTA. I am sure you are familiar with this legislation.

I am sure you will also recall that rather recently I wrote to you relative to the problem of financing the costs of nursing home or extended care needs of the elderly. I appreciated your prompt reply to my letter and I am sure this problem will come up at your hearing. This is still a major problem and for more specifics I would refer you to my previous correspondence. Some of the points we are interested in—without going into too much detail and not being all inclusive, are as follows:

1. A comprehensive program which provides health protection with the least out-of-pocket cost to the elderly—not to exceed $750 annually for catastrophic illness.
2. A program to include coverage of unlimited hospital, physician, and nursing home or extended care.
3. A program to cover out-patient prescription drugs.
4. A program to cover eyeglasses, hearing aids, walking aids, and other medical equipment and supplies.
5. A program to include and cover all aged citizens without regard to their insured status for Social Security benefits. This would include coverage for retired and/or disabled teachers, policemen, firemen, and other public employees, including federal civil service retirees.

In this connection, I would point out that Civil Service retirees, about ⅔ of them, are not under Social Security and if they should be covered under a new national health insurance program, a coordination effort must be made with the now existing Federal Health Benefits program of such retirees and employees. Certainly they should not be discriminated against but also the program should not be made to work against their welfare and benefit.

6. The three day hospitalization requirement before being eligible for payment when entering a nursing home or extended care facility should be eliminated.
7. Coverage on an unlimited basis for nursing home or intermediate nursing care should be allowed so long as the facility meets minimum requirements of professional personnel on duty.

As mentioned in my previous communication to you, the above points would seem to alleviate some of the problems from a governmental program standpoint. However, another problem remains with the various health insurance companies and various health programs of AARP–NRTA–NARFE. Retirees are enrolled and paying premiums to many insurance companies and retiree group policy programs only to find in time of need that such policies pay only at certain approved facilities meeting certain governmental requirements and regulations. Many localities do not have such facilities and if they do, they do not have them to the extent of meeting the needs of the whole community. Liberalization of private health insurance programs needs to be made in line with governmental expansion programs.

As a NARFE representative, I must also point out a matter of premium payment for health insurance by those NARFE members who are also covered by Medicare. This would be about ⅓ of all NARFE members. As a NARFE member the retiree is paying a full premium rate, as if not covered by Medicare, under the Federal Health Benefits Program. As previously stated about ⅓ of the Civil Service retirees are also covered by Medicare. When such an individual goes to the hospital or sees a doctor—Medicare covers 80% of the cost—after the deductibles—. Thus, the Federal Health Benefits program only considers the remaining 20% of the cost and yet the retiree is paying for such program the full premium the same as if he were not covered by Medicare. This does not seem logical and fair to the retiree and should be looked into. I would remind you that such a situation applies to NARFE members who are also under Social Security and this amounts to about ⅓ of the total NARFE membership which on a national basis would be several hundred thousand members. The remaining ⅔ of the NARFE membership do not come under Social Security and thus are not so affected by this premium. I have explained before why the majority of the Civil Service retirees are not under Social Security. This being because all those federal employees who worked only under Civil Service all or most of their lives did not qualify for Social Security as they could not receive service time for two federal programs simultaneously. About ⅓ of the Civil Service retirees qualified for Social Security either before or after their Civil Service employment.

I hesitate to go into any more detail or specifics. As previously stated, we are primarily interested in legislation of greatest benefit to the elderly in general with specific remedial action to alleviate certain problems of specific retiree groups. Health is a major problem of the elderly or older Americans. As age progresses so do the illnesses and incapacities of such people. This too is the time when health costs are more frequent and higher and the elder citizen finds himself with a fixed income—in many cases a low income—and is in dire need of assistance. Knowing of your interest in helping the senior citizens we leave it to your wise discretion as to what type of a program should be enacted to be of major assistance.

Thank you again for affording me the opportunity to make these comments. I am sure there are several other aspects that could be covered but I feel you will get wider reaction at the forthcoming hearing. I hope I shall have an opportunity to see you the next time you are in Las Cruces. Good luck and best wishes to you and your committee in your hearing and efforts to help your constituents.

Appendix 4

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

If there had been time for everyone to speak at the hearing on "Barriers To Health Care for Older Americans," in Albuquerque, M. Mex., May 25, 1974, I would have said:

The following replies were received:

JOSEPHINE BOLOGH, ALBUQUERQUE, N. MEX.

I am a member of RASH which stands for Residential Aid Service Home, Inc. Our organization has sent you a position letter which reflects my ideals and opinions very well. Please give serious consideration to the material contained in our organization's letter.

TONY Q. CHAN, O.D., ALBUQUERQUE, N. MEX.

As president of the New Mexico Optometric Association, I would state that the senior citizens after working for many years to reach the status of retirement are finding it very difficult to perform simple tasks such as reading because of presbyopia, a condition which due to normal physiological changes makes it very difficult to focus. The present programs under Medicare only allow a correction if one has had cataract surgery, this is a small minority of the aged that need visual care. We would like to see a program that will provide a complete visual examination and prosthesis, that will allow our senior citizens to perform in a normal environment visually.

CRESPIN'S BOARDING HOME, LAS VEGAS, N. MEX.

Who cares enough to take needy people under their roof?
Who pays attention to a person that is mentally disturbed?
Who has the patience to deal with an emotionally disturbed person day after day?
Who prepares meals for a people that everyone else has cast away?
Who takes the time to teach a blind person to tie her shoes?
Who makes a lonely person feel that he belongs and is accomplishing something?
RASH does and I strongly agree that RASH's needs should be met!

PRISCILLA CRESPIN, LAS VEGAS, N. MEX.

I am a member of RASH organization, and I feel that I have taken on a responsibility that most of society has blindly neglected.

In order for me to meet up to the demands of the special committee on aging, I will need more financial support.

I believe that too many people have neglected the aged, the disabled, and since we of RASH organization are trying to help these needy people, we would deeply appreciate your undivided attention.

Senator Domenici, we need your support.

ROSALITA E. CRESPIN, LAS VEGAS, N. MEX.

This letter is pertaining to the proposals that RASH organization has sent to you.

We definitely feel that if given the proper attention RASH will be of better service to the aged and disabled.

Without adequate funds and recognition, so desperately needed by RASH, there is no real future for advancement of the aged and disabled.

There are special demands being made on boarding home operators. Again without proper funds these demands are becoming harder to meet.

We agree with RASH in all that they so humbly ask for. Please give these dedicated people your utmost attention.

PRISCELLA GONZALES, ALBUQUERQUE, N. MEX.

Working with senior citizens for over 4 years you find that they are the most forgotten people. Problems they encounter are medical, dentures, and housing. One problem I find is they're usually lost because when they go to an agency there seems to be a failure of the agency to communicate.

Their income is so limited, most of them cannot even afford to buy food stamps after they are certified. Housing, if they own their own home, just keeping up with taxes and upkeep, so usually they can't up keep their home. One problem for South West Valley is the water. Can they afford to hook up to city water? This is a health problem.

One example: A 80-year-old woman South West Valley resident, thought Medicare paid all doctor and hospital bills, after getting quite a few bills (about 1 year) threatened to be sent to credit bureau called me to interpret and explain letters. Now she is so behind on bills she'd been in hospitals; also husband getting medical attention. Have quite a few doctor bills they are mailing $3 to $5 a month. Will they ever pay off bills? One 60-year-old woman receiving supplemental security. Doesn't even have inside facilities except gas and light. Water outside and bathroom outside. Can't even afford to buy the stamps. House needs repairs so badly, but can't even afford to have bathroom installed much less upkeep of home.

TILLIE GONZALES, LAS VEGAS, N. MEX.

As a member of RASH I stand behind the organization 100 percent on the letter that was submitted to your office.

ADELINE LUCERO, OJO CALIENTE, N. MEX.

I am a boarding home operator and I am in favor of the letter that was sent to you (the RASH). Hope you help us.

MARY MCKINNEY, ALBUQUERQUE, N. MEX.

Health care barriers for the aging is slow suicide here in Albuquerque. As CHW spending about 55 percent of my time with the senior citizen one way or the other as a direct health care service or supportive servant. Blood pressure screening at the meal sites boarding homes and living facilities and recreation center for the senior citizen and home visiting and giving lots of *TLC*. You become a friend, daughter, or just someone who cares that you are alive, many of our seniors have no families. I think of the many encounters that just shouldn't be real but they are: example: 83 year old living alone income $116/$140 SSI; rent $75 plus utilities and telephone. House did not meet city code for many months. Air condition year in and year out. $14 for $38 food stamps; impaired hearing and sight and slight stroke slight impaired right side. Before and after hospitalization fear of nursing home—VNS, homemaker meals on wheels and local church and F.H.C. as of May 1. Son came from California and took mother with him. Dental care for senior citizen is almost extinct which is a major

barrier for good health. Without a preventive health program project, it might be too late when we reach some of our senior citizens.

Some barriers, living alone, low income, education. I would like to see a service for senior citizen that prevents hospitalization. Many of our senior citizens are babysitters which hinders them from the activities at the meal sites or even getting a medical checkup. Social and economic problem are health barriers for our senior citizen, loneliness, discrimination, because of their age and this causes physical and emotional pain. Legal services and agencies joining together to accomplish a common goal to get the highest quality of care for its senior citizen, and given the funds we can make it happen.

As a CHW my goal is health outreach to the community, but I find myself being a social advocacy including health education. Some seniors share their medication. Relocation and boundaries, illness that are chronic environments, glasses, hearing aids. Are the elderly given just a pacifier to quiet them down? Paraprofessional can't generate fees for care. Read their mail, pay their bills, pick up food stamp.

OWEN L. MORROW, CARLSBAD, N. MEX.

I am administrator of the Lakeview Christian Home, certified for Medicare and Medicaid. Although a number of bed patients and helpless people are in this home but cannot collect one penny of Medicare. This number includes some who have just had surgery for the pinning of a broken hip and were put out of the hospital within a week to 2 weeks.

We have not been able to receive payment for any new applicants for Medicaid since the new Social Security law went into effect. At least nine people are in our facility; some of them as much as 4 months and we still can't get through the *red tape* of getting payment.

Interpretation of law by Federal authorities is so exacting and in excess of the spirit of the law (in some instances) that cost of care is getting completely out of hand for Social Security recipients.

Paperwork requirements are increasing to the level of impossibility to comply without hiring extra staff just to do nothing but paperwork.

LUKE MURPHY, ALBUQUERQUE, N. MEX.

I do volunteer work for the Mental Health Association. One of the girls who was reasonable young and strong had to look after an elderly gentleman in a boarding home.

This gentleman was unable to control his normal bodily functions.

The girl became more and more unhappy over this situation so was moved to another home. She voluntarily went to Las Vegas State Hospital which she seemed to prefer to a boarding home.

The elderly gentleman should have been in a nursing home rather than a boarding home.

It seems to me that some persons who are in charge of these homes put too much work on those living there. They should be kept busy but not taken advantage of. After all, they are victims of circumstances.

BERTHA T. PALMER, LAS VEGAS, N. MEX.

How can a handful of reporters be malicious and cutting about New Mexico boarding homes? Did they stop to consider the reputations of a small group of steadfast, dedicated, and truly concerned American citizens? Did they take time to dig deep into the problems boarding home operators are having?

It's very easy to be a critic, but a person should be knowledgeable in the field he wants to criticize, before he opens his mouth.

I as an American citizen do not condone the unfair action that was taken against boarding home operators in New Mexico.

I want to express my deep support for RASH organization. Let's not turn our backs on RASH any longer.

PETER A. PANKRATZ, ALBUQUERQUE, N. MEX.

A resolution proposed to the National Association of Federal Employee's NARFE:

Where as the majority of Federal retirees do not have Medicare, and the Federal health insurance does not provide any help for nursing home insurance. Be it resolved, that NARFE, and our Federal representatives give their support to have the Federal health insurance include an optional insurance to cover nursing homes on a 50–50 basis.

GROVER E. PETTY, ALBUQUERQUE, N. MEX.

Having followed closely the articles in the Albuquerque Journal and Tribune, concerning some of the problems of the aged, blind and disabled. Having worked with these problems for the past 8 years, it seems rather obvious that the solution to all or most of these problems mentioned is basically more money.

Since we have had with us the problems of the aged, blind, disabled, and will continue to have them, it would seem that the Social Security program and the welfare program, which have been in operation for many years; these programs were basically formed to provide for the underprivileged, i.e., aged, blind, and disabled, would be the proper programs to provide a large percent of the necessary funds needed to solve the problems of the aged, blind and disabled.

If the State and Federal Government through these two agencies would provide every person who fits into the above category, a monthly income of $350 regardless of where they were living, then the people themselves would be in a position to solve a great many of their own problems.

Problems which at the present time others are making a big fuss over and trying to get Government grants to finance programs for.

Why not make use of our existing programs and some of the existing facilities and people who are and have been doing as much as possible to alleviate the situation even tho it seemed to be an unrewarding, hopeless task.

We have those in every community who are willing, able, and would like to care for the aged, blind, and disabled. Many of these people feel that they should receive reasonable compensation for their efforts. They feel (and rightly so) that this type of service is worth more than a minimum wage.

If these people in each community were able to acquire a home that met life and safety code requirements and would accommodate six to ten residents, each resident was receiving $350 per month, there would be sufficient monies to operate the home in keeping with decent living standards, as well as a fair amount for the operator, and spending money for each resident's personal needs.

This amount may seem rather high. But why? The people in question are in need of help through no fault of their own. Any time any one of us may fit into this cateagory. It is a sure thing that we will all become old (if we don't die young from *pure damn stingyness*).

Any day any one of us might be stricken with some form of sickness which would leave us unable to function profitably in society. Don't think "it can't happen to me," because it does happen to some every day.

For many years the AGED, BLIND, AND DISABLED have received a pitiful subsistence sum which has never been enough.

In most instances there has not been enough for a bare existence.

NOW is the time to become a NATION which stands proud of our ability to take good care of our parents, grandparents, and others who are unable to take care of themselves.

LENA M. RUDOLPH, ALBUQUERQUE, N. MEX.

We need a real discount on medicine with no tax because we use more medication than younger people. I am 78 years old and live alone. My income is from some stocks which were given to me by my family, so I would have my own income. It is very modest, but because I am single I pay more income tax than many people who have deductions real and otherwise. This is a real burden for me. I don't ask anyone for anything and I do my own work. Luckily, I am still driving, or I would be out of luck. I can't see why food should be taxed. I find that people who have food stamps eat much better than I do, and can buy more. I have watched some of them shop. I have worked as a volunteer at BCMC for 4 years and at other places since, and I feel that I and other seniors are not receiving due consideration.

LEROY SMITH, LOVINGTON, N. MEX.

I am president of the Nursing Home Association and obviously anxious that every elderly person in our State have the very best care possible. We feel that the most economical way to provide this care is in the existing institutions within our State. This is not to say that the total care of the total person is not being provided in all of the existing homes (boarding homes). These certainly need much improvement. A great many of them are deplorable. With right amounts of reimbursement they could improve. I cannot see home health care as providing the best care and the cost of it would be prohibitive.

EDITH SNOW, ALBUQUERQUE, N. MEX.

I am interested in securing services for Dial-A-Ride for senior citizens. At present there is no bus to take them to doctors, shopping or for recreation and they have to depend on volunteer. Even if they were able to board the transit buses, they don't operate on Sunday or after 7 p.m. at night. Even the city has built a very modern meeting place on Pala-Dara and no transportation which is something that should have been arranged for by the city of Albuquerque before it was built. I am affiliated with the AARP chapter 347 and the Senior Citizens Friendship Club, meeting at the synagogue on Washington and Indian School Road and have been president of a group called the Silvertones for 3 years. The cause of our disbanding was that our meetings were at night, had they been during the day we would still be in operation.

During our 5 years we were established we did sewing for BCMC—had all kinds of projects where money was made—gave to the Jewish Community Center a total of over $6,000 for use in building a senior citizen nonpartisan home.

P.S.—Another problem to senior citizens tax charged on food. Doctors and hospital. The Friendship Club has distributed a petition with regards to Dial-A-Ride and at present have many over a thousand signatures—this will be sent to our Congressman and the head of the transportation of Albuquerque after we have secured more signatures.

GLORIA B. TEEL, ALBUQUERQUE, N. MEX.

I work with about 30 senior citizens and all of them have problems and each day I get more and more disgusted with this system that cannot provide the most desperately needed services. These services include: Eyeglasses, dental care and dentures, hearing aids, and homemakers. (To all who need them and not only those who get less than $200 a month.)

We have a patient, Mrs. ——— ——— who has worked all her life and paid taxes. She has a bill at BCMC for $2,000 and no income—she was told she did not qualify for Social Security because she owns a small section of land. Is this justice? She is completely disabled.

Another patient, Mrs. ——— ——— is partially blind and needs help at home, but she does not qualify for homemakers because she gets $200 a month. No consideration to the fact that she pays most of it in rent.

SHARON WUSSOW, ALBUQUERQUE, N. MEX.

I find it uncomprehensible that the degrading conditions continue to be present, in some boarding homes in this city.

It appears that the licensing of boarding homes have been anything but adequate. There are regulations but without enforcement, it is merely a waste of time.

The fact that other States are just as deplorable or worse, does not condone the conditions found present here in New Mexico.

FAMILY HEALTH CENTER, ALBUQUERQUE, N. MEX.

We need dental services and transportation.

Iralito Tarres, Ruben Salazar, Edwarde Gulurry, Richard Sanchez, Juan V. Lucezo, Porfirio Turrieta, Ben Martinez, Frank E. Martinez, Frank Guiggo,

Teochero Byo, Herlinda Salazar, Juanita R. Padella, Helen C. Buchanan, Emma Ingram, Peggy Malory, Lupe D. Gardea, Paulino Gardea, Gred W. Montoya, and Jesus Silva.

W. E. TAYLOR, CLOVIS, N. MEX.

The barriers to health care for the elderly are multifaceted. Today you heard testimony of an impressive array of vitally interested people, who know their subjects well; however, the situation in Planning District IV of the State of New Mexico is different enough to merit separate testimony.

Geography and transportation are the most imperative problems we face. With a total population of 86,000 people, and an elderly population of 12,000, spaced over 18,000 square miles, we are indeed faced with a transportation and geographic barrier. One of our counties has but 1,348 population, with 21 percent elderly, all spread out over 1,599 square miles. There are *no* services in the health field available for over 60 miles in any direction (at the nearest point). The other seven counties are somewhat better off; however, there are notable discrepancies in health care even in our most populous city.

It is our contention that these barriers can be overcome through the efforts of the Areawide Agency on Aging, working in close cooperation with local officials, State agencies and Federal agencies, to expand existing services to cover areas not now service providers; and to develop innovative ideas to support these activities. One of the most promising is that of the medical school in Albuquerque whereby the State will require repayment of stipend for schooling to be accomplished in service to the State in various counties, over a period of 2 years. Based on data, this could provide approximately 35 medical doctors per year and will allow concrete planning efforts to be developed in support of these practitioners. Transportation may also be accomplished under various plans made in the counties, through the Regional Council of Governments (Eastern Plains Planning Council).

It is also our contention that Federal support must be expanded in certain areas to help rural areas maintain the health of the elderly. There should be a modification to the eligibility rules for the health service corps. As it stands now, they cannot begin to aid an area unless there is a doctor/patient ratio of approximately 1/4,000. As indicated above. one of our counties is only a population of 1,348 but with no practitioners. We also feel that the government themselves have inserted barriers to the health care of the elderly. One example might be the income limits on Medicare, Medicaid and SSI benefits. When a citizen has reached the age of 60 plus, and feels that he needs these services, the factor of income should not be a barrier. We preach that continued employment will prolong life (if desired) yet in the same breath we deny services to those that are employed, or who have invested in our country and have a small annuity.

Commenting on some of the other speeches, we feel that much more importance must be placed on publicizing and educating the medical practitioners in the use of paraprofessionals. Here in the field we still find rather strenuous opposition to their use. It might be possible to introduce separate legislation regarding the responsibility of these paraprofessionals, thereby removing the areas of responsibility from the medical doctor. Finally, although the remarks of Dr. Best were quite cogent, we feel that the Areawide Agencies of Aging have the mandate to report statistics on the elderly population, and if they can be funded sufficiently to fulfill the entire mandate under Public Law 93-29, that barriers of all sorts can be removed for our older Americans.