TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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Trends in Long-Term Care:
Part 1. Washington, D.C., July 30, 1969
Part 2. St. Petersburg, Fla., January 9, 1970
Part 3. Hartford, Conn., January 15, 1970
Part 4. Washington, D.C., February 9, 1970 (Marietta Fire)
Part 5. Washington, D.C., February 10, 1970 (Marietta Fire)
Part 6. San Francisco, Calif., February 12, 1970
Part 7. Salt Lake City, Utah, February 13, 1970
Part 8. Washington, D.C., May 7, 1970
Part 9. Washington, D.C., August 19, 1970 (Salmonella)
Part 10. Washington, D.C., December 14, 1970 (Salmonella)
Part 11. Washington, D.C., December 17, 1970
Part 12. Chicago, Ill., April 2, 1971
Part 13. Chicago, Ill., April 3, 1971
Part 14. Washington, D.C., June 15, 1971
Part 15. Chicago, Ill., September 14, 1971
Part 16. Washington, D.C., September 29, 1971 (Lil-Haven Fire)
Part 17. Washington, D.C., October 14, 1971
Part 18. Washington, D.C., October 28, 1971
Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971
Part 19B. Minneapolis-St. Paul, Minn., November 29, 1971
Part 20. Washington, D.C., August 10, 1972
Part 21. Washington, D.C., October 10, 1973
Part 22. Washington, D.C., October 11, 1973

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

TRENDS IN LONG-TERM CARE

WEDNESDAY, OCTOBER 10, 1973

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

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 1114, Dirksen Office Building, Hon. Frank E. Moss, chairman, presiding.

Present: Senators Moss, Clark, Domenici, and Percy.

Also present: William E. Oriol, staff director; Val Halamandaris, associate counsel; John Guy Miller, minority staff director; Robert M. M. Seto, minority counsel; Margaret Faye, minority professional staff member; Patricia Oriol, chief clerk; Gerald Strickler, printing assistant; and Yvonne McCoy and Ann Todaro, clerks.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. I want to welcome you here this morning as the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging begins its 21st and 22d hearing in the series entitled "Trends in Long-Term Care." This series began on July 30, 1969, with an inquiry into the proposed regulations by the Department of Health, Education, and Welfare in implementation of the so-called Moss amendments of 1967.

It is somehow paradoxical that the committee's attention is continually returned to the question of nursing home standards.

The reason for these hearings is the enactment last year of Public Law 92–603 and specifically section 246. This section of Public Law 92–603 called for the unification of Medicare and Medicaid standards. Significantly, the statute spells out that the higher standard should be retained in every case. Quoting the language of the Senate Finance Committee's Summary of the Social Security Amendments of 1972:*

> A single definition and set of standards (for Medicare and Medicaid nursing homes) is established. . . . A "skilled nursing facility" is defined as an institution meeting the prior definition of an extended care facility and which also satisfies certain other Medicaid requirements.

What appears to be clear in the minds of many nursing home spokesmen is that the standards have been significantly weakened. The proposed regulations published in the Federal Register on July 12, 1973, delete many of the requirements and specifics which were contained in the previous regulations. Among these is the requirement for physician's visits.

*See p. 254S.

The old standard required that doctors see nursing home patients every 30 days. The new standard requires doctors to see patients every 30 days for 3 months with no further requirement.

The proposed standard for nursing personnel requires only one registered nurse on duty 5 days a week. Last year's H.R. 1 permitted the cutting back of this standard in rural areas under certain closely prescribed conditions. The effect of HEW's regulation is to make the entire country a rural area.

Sharp Drop in Quality of Care

Advocates for the infirm elderly contend that if the above standards are allowed to become final there will be a sharp drop in the quality of care offered in U.S. nursing homes.

All of these developments appear to me to be part of a continuum. The attitude of the Department of Health, Education, and Welfare from the very beginning has been something less than conscientious when it comes to promulgating and enforcing effective nursing home standards.

For all the rhetoric, the President's so-called nursing home initiatives viewed at their worst were a public relations gimmick and viewed at their best represent the idea of enlightened individuals who have since moved on to other positions.

The recent fire in Philadelphia in which 11 older Americans perished is another example of the indifferent attitude of the Department of Health, Education, and Welfare. The Washington Hill Nursing Home, where the fire occurred and some 400 others like it to do not meet the existing Federal standards. They have not met the standard for at least 3 years now. The Department of Health, Education, and Welfare has known this fact but has done nothing about it.

Finally, I have received information that on Friday Secretary Weinberger will brief the Cabinet on the administration's new national health insurance proposal. HEW sources told the committee staff that the new plan will be short on any nursing home benefits. The new benefits will be cut back well below the $3 billion annually spent by the Federal and State governments.

It is clear to me that a decision has been made by this administration that nursing homes and the people in them are not very important. I think this is grave misjudgment. If anything, we need more, not less nursing home coverage. The average nursing home in the United States costs $600 a month per person and the average retired couple has only about $300 in income. Few can afford nursing home care today and yet more and more of us are living longer and longer.

I want to examine these questions today and tomorrow and discover, if I can, who is in charge of nursing homes. The President, in 1971, said we needed to consolidate responsibility for nursing homes in one position. That we needed a nursing home "czar." Who is the czar? Who is responsible now?

Do you have any comments or opening remarks, Senator Clark?

Senator Clark. I have just a couple of minutes, Mr. Chairman, if you wish.

Senator Moss. Please go ahead.

STATEMENT BY SENATOR DICK CLARK OF IOWA

Senator CLARK. Thank you, Mr. Chairman.

It is a pleasure and privilege for me to be able to join you today as a temporary member of the Subcommittee on Long-Term Care of the elderly, one of the most active and vigorous subcommittees of the Special Committee on Aging. Over the years, this subcommittee and the full committee have played a major role in improving the lives of millions of America's senior citizens, and that role continues today.

The need for this kind of congressional vigilance never has been greater, especially in the area we're considering today—nursing home care.

Just last month, we learned that there had been yet another nursing home tragedy—this time, a fire in Philadelphia that killed 11 people. During the next few days, there were a number of charges that the home had not met minimum Federal standards, charges that both the State of Pennsylvania and the Department of Health, Education, and Welfare had been negligent in enforcing their own regulations.

This kind of nursing home tragedy gets headlines and national attention, but it is no less tragic every time an older American suffers or dies in a nursing home because of neglect. While it is too late for those who died in Philadelphia, it is not too late for more than 1 million patients in nursing homes across the country.

And that's why we're here this morning.

This subcommittee is concerned about nursing home standards—standards designed to protect nursing home patients, standards that insure that every nursing home patient gets a safe environment and good health care, standards that will help solve the problem if they're enforced.

When Congress passed the Medicare bill 8 years ago, it declared that the elderly had a right to good medical care regardless of their ability to pay for it. In these hearings, we want to find out if that resolution has been kept or ignored.

There certainly is reason enough for concern. Experts in the field of health care for the aged have charged that the regulations proposed by the administration for nursing homes participating in Medicare and Medicaid represent nothing more than a retreat from proper medical practices. In the light of the Philadelphia fire and innumerable other tragedies, these charges cannot be taken lightly.

EXISTING STANDARDS WEAKENED

I am particularly concerned about the regulations which determine how often doctors and nurses see their patients. A number of senior citizen organizations feel that the existing standards have been seriously weakened. The proposed implementation of section 247 of H.R. 1, passed last year by Congress, is no less troubling. It deals with the definition of the level of care and the definition of who will be eligible for it.

The law already provides the broad outlines, but not the precise definitions and that makes the proposed regulations all the more important. The definition of "skilled nursing" is a good example. This is the most comprehensive kind of nursing home care, the most ex-

tensive care available in a nursing home. I fear that a mistaken notion of economy will lead HEW to persist in its present plan to define "skilled nursing" very narrowly so that few patients will be able to qualify for it.

Any savings that might result will come at the expense of the patients.

There already are signs of this attitude. In my own State, there are about 11,000 nursing home patients. Many of them should be receiving "skilled nursing" care, but under the new definitions, only about 100 of them qualify for it. The rest fall into the category of "intermediate care" patients, and, for many of them, this kind of care simply will not be adequate.

I hope that these hearings succeed in illuminating the attitude of this administration toward nursing home patients. I hope that we will find that the welfare of the patient and not a sense of false economy directs our national policy. And if it does not, I hope that we find ways to redirect it.

Senator Moss. Senator Domenici, do you have any comments to make?

STATEMENT BY SENATOR PETE V. DOMENICI OF NEW MEXICO

Senator DOMENICI. Mr. Chairman, I want to thank you for calling these hearings and allowing me to join in expressing my grave concern for the welfare of America's most forgotten minority group, the 1 million individuals in our nursing homes.

Since I have been a member of this committee I have learned all too well that it can be hell to be old in America. It is being robbed of a decent standard of living, of your eyesight, your hearing, and even your human dignity. And, if it is hell to be old in this youth-oriented society, how much worse is it to be both old and ill.

I think all of us have grown up on the newspaper stories that describe nursing homes in the most uncomplimentary terms possible. Terms such as "elephant's graveyards" and "warehouses for the dying" were commonly used. Thankfully, there has been great improvement in the quality of care offered by our 23,000 nursing homes. Many facilities now provide care on a par with or even exceeding hospital care. I am grateful to have several such "model" homes in my own State of New Mexico.

Mr. Chairman, I feel that the enactment of Medicare and Medicaid in 1965 was the most important factor in this general improvement in the quality of nursing home care. When the Congress agreed to underwrite the cost of nursing home care, it also set forth minimum standards to be met by nursing home providers. A major portion of these Federal standards bear the name of our chairman, Senator Moss. Long ago he recognized the importance of uniform minimum Federal standards.

Minimum Federal standards were proposed to protect the public interest and the patient. Standards are an abstract expression of the quality of care. That is why this hearing today is so important. I believe it is important to remember that for all the talk about standards at this hearing, we are really talking about people and about nursing home care. We are talking about how often doctors and nurses should see patients.

We meet in a climate of accusation and recrimination. It is alleged that the Department of Health, Education, and Welfare in implementing last year's Medicare reform bill, H.R. 1 (Public Law 92–603), has scuttled existing Federal standards for nursing homes. Since the law clearly asks for a unification of Medicare and Medicaid standards with the retention of the higher standard in every case, this is a serious charge.

This is why I am here today. I intend to study carefully all the charges and to insist that the mandate of Congress be carried out. Since the taxpayer assumes three out of every four dollars in nursing home revenues, and because nursing home residents have no other spokesman, I feel that this is part of my responsibility.

Senator Moss. We do appreciate your presence and your genuine interest in the problems that we have.

We are going to get as much information in the record as we can, and this subcommittee will do what it can to improve the care that is extended to our elderly fellow citizens.

This morning we have a rather lengthy list of witnesses. I have asked the witnesses to try to confine their oral presentations to 10 minutes, and submit any written documents or extension that they may wish. We want the record to be full, and we would like to hear from the people who have come here to testify.

Without objection, I will place in the record a letter submitted to us by the American Federation of Labor and Congress of Industrial Organizations; * and the testimony of the National Council on Aging,** which will appear following the oral testimony of the witness that we will hear this morning.

At this point I am going to call our first witness, the Honorable Robert Steele, Congressman from Connecticut, who is chairman of the House Republican Task Force on Aging.

We welcome Representative Steele before the committee, we look forward to hearing from him.

Congressman Steele, would you proceed?

STATEMENT BY HON. ROBERT H. STEELE, CHAIRMAN, HOUSE REPUBLICAN TASK FORCE ON AGING

Mr. STEELE. Thank you, Mr. Chairman, members of the committee. It is a great pleasure to have this opportunity to testify on the skilled nursing facility regulations published in the Federal Register July 12, 1973. My testimony will discuss HEW's rulemaking procedures and the content of the regulations, because both have been the object of concern and study by the House Republican Task Force on Aging which I chair.

The task force is composed of 16 Republican Members of the House, organized by the Republican leadership, to study, report on, and develop policy alternatives relating to the problems of older people. At present, the task force is the only officially constituted group in the House which focuses exclusively on issues affecting older people.

*See app. 1, p. 2633.
**See app. 2, p. 2635.

Among the subjects the task force has addressed to date is that of improving nursing home care.

As you know, in passing H.R. 1 last year, the Congress expressed the clear intent to provide better quality patient care through nursing homes which receive Medicare and Medicaid funds. On July 19, 5 days after the publication of the skilled nursing facility regulations, the task force held a working session with Marie Callender, Special Assistant for Nursing Home Affairs in HEW. During the meeting we discussed the manner and delay in the publication of the nursing home regulations, as well as their content. I was concerned by several issues raised at that session, the first being HEW's rulemaking procedures in this case.

Prior to our July 19 meeting with Ms. Callender, we were aware that drafts of the proposed regulations were available within both the American Medical Association and the nursing home industry. The availability of the drafts was confirmed by the fact that a nursing home industry magazine carried public comment on them before the regulations were ever published. Moreover, some members of the task force, myself included, received detailed written letters on the draft regulations from nursing home operators in early June, prior to their publication in July.

Yet, in contrast, groups representing the aged, the ultimate consumers of nursing home services, were refused all access to the draft regulations by HEW. Similarly, the task force staff was refused a draft copy 3 weeks prior to publication.

Thus, the public, aging, and consumer groups, and even Members of Congress had 30 days to evaluate and develop their positions on the proposed regulations while health care providers had up to 6 months. In light of the complexity, length, and highly technical language of the regulations, most elderly groups were unable to effectively comment on them. In an effort to provide consumers with more time to study the proposed regulations, 14 members of the task force wrote to Secretary Weinberger asking for an extension of the public comment period and for an immediate review of HEW's policy.

One month later the Secretary responded by letter to our criticisms of the rulemaking procedure that was utilized. He said his decisions on the skilled nursing facility regulations were based solely on his view of the appropriate role for the Federal Government and on management considerations. He also stated that he was unaware of the views of the nursing home industry, and that he disapproved of any advance selective distribution of draft regulations. He did, however, offer an exhaustive investigation to be undertaken by the Assistant Secretary for Health, Dr. Charles Edwards. The Secretary also requested a report from his executive secretary on "any changes which should be made in the internal regulations procedures to insure equal and meaningful participation by concerned organizations and citizens." The task force has not received this report, which was promised for August 31, 1973. I would like permission to have the text of this correspondence included in the record.*

I am not a lawyer, but it is clear to me as a layman that the purpose of the proposed rulemaking procedure and publication in the Federal Register is to insure complete fairness and equal opportunity for

*See app. 3, items 1 and 2, pp. 2637, 2638.

all interested parties to comment. It is evident that in this case the system did not work as it was intended.

The Content of the Regulations

I would like to turn now to the substance of the regulations and reiterate the comments I submitted to the Commissioner of Social Security on the skilled nursing facility regulations.

But first I would like to make some general observations.

The skilled nursing facility regulations must be viewed in the context of the total health care available under Medicare. Skilled nursing facility care should be the most intensive and highest quality provided in this country short of hospital care. In framing these standards, we directly affect the level of care to be delivered in an intermediate care facility.

Until we formulate and enforce a well-planned and comprehensive policy to upgrade patient care in all nursing homes, we will simply repeat the same failures we have had in the past.

We must be willing to demand good care for our tax dollars, to properly place patients in homes providing an appropriate level of care, and we must be willing to pay for that care.

The Social Security Act Amendments of 1972 (Public Law 92–603) did in fact express the clear intent of Congress to upgrade the quality of nursing home care. We must review all regulations implementing that law rather than simply falling into the trap of setting inadequate standards which existing homes already need.

Unfortunately, after careful consideration of these and other factors, I have concluded that the proposed Medicare-Medicaid skilled nursing facility regulations fail to guarantee adequate patient care in several major areas.

First, they lack a requirement for a registered nurse 7 days per week. It is incomprehensible to me that any Federal funds should pay for skilled nursing care in a facility where there is no registered nurse on duty for a continuous 64-hour period over the weekend, as well as the 16-hour overnight period on weekdays. Moreover, the regulations lack a requirement for nurse-patient ratios which would assure professional level care.

I suggest requiring an R.N. 7 days per week for at least 16 hours per day. I also suggest the imposition of reasonable staff-patient ratios for all staff, including nurses.

Second, the regulations fail to require a physician visit after monthly visits during the first 90 days. This is appalling in light of the fact that the regulations tie all major services to physician's orders—patient activities, drugs, diet, nursing care, and restorative services. I have not discovered one shred of evidence that at the very least, a monthly visit is not needed. Moreover, it may well be that any patient not needing such monthly attention by a physician is in the wrong facility. If the standards for the skilled nursing facility are so low, I wonder what the intermediate care facility regulations will ultimately require?

Old People Terrified of Nursing Homes

Third, the regulations completely lack any focus on patient discharge and rehabilitation. This issue cuts to the heart of why old

people are terrified at the possibility of entering a nursing home. They know that for the vast majority of them, it is downhill from there on out. There is no inducement for the nursing home to reverse this trend. It is easiest for the nursing home to care for the least active patients.

Moreover, there is no financial incentive for homes to rehabilitate and discharge patients. Thus, I feel we must adopt a positive policy encouraging patients potentially able to reenter the community to do so. We should require at least a written patient discharge plan initiated on arrival, monthly physician visits, and social services to plan for and aid patient reentry into the community. A new emphasis on rehabilitation can save immense emotional as well as financial costs.

Last, as a strong advocate of fire safety and the sponsor of legislation to promote fire safety in nursing homes, I was particularly distressed by the fire safety provisions and their final enactment before the termination of the public comment period, effectively stifling debate on the adequacy of the standards. From long experience in drafting and observing enforcement of fire safety standards, there is no doubt in my mind that these standards, which permit the Secretary to waive portions of the Life Safety Code when (a) the regulations "if rigidly applied would result in unreasonable hardship on skilled nursing facilities, only if such waiver will not adversely affect the health and safety of patients," or (b) a State has fire safety laws which "adequately protects" patients in skilled nursing homes, are inadequate. The regulations offer no definition of "unreasonable hardship" in the first situation; and in the second, no definition of "adequately protects." No more specific requirement as to the standards of the State law is given, nor is provision made for cutoff of Federal funds to homes not in compliance with such State laws. What are the guidelines? Where are the teeth in their standards?

Mr. Chairman, I am appearing before you to raise these issues about the SNF regulations because we have a direct interest in them. We must insure that the intent of the Social Security Act Amendments of 1972 to provide better care is carried out. We must insure that Federal dollars are buying the best available care. Finally, and most importantly, we must insure the well-being of those older persons who are or will be in nursing homes.

I have visited scores of nursing homes and, in addition, I receive a large volume of mail from older people, as you gentlemen do. Thus, I am well aware that entering a nursing home, even one of the best, can be a frightening prospect and often depressing and even terrifying reality for many older persons. Chronic illness, separation from home and family, and fear of dying take an unbelievable toll. Yet, if we then add inadequate care, unsafe conditions, and no hope of improvement, we create an environment which is devastating to the well-being of the elderly patient.

Mr. Chairman, we cannot make every nursing home perfect by stiffer regulations, but we can set minimum standards along the lines I have suggested today. Thank you.

Senator Moss. Thank you, Congressman Steele, for a very excellent statement and your specific recommendations.

I want to commend you, and I commend you also for the work you do with the Special Task Force on Aging in the House.

Cooperation Needed To Solve Problem

Your chairmanship of that committee, and your interest and concern with this problem, is certainly very commendable. We welcome your advise and counsel, because we must work on this problem on both sides of the Capitol Building, and you are doing your part on the House side.

I think you made very clear the specific points that you think have been neglected in this revision of the regulations, and I am sure there are many more.

I am utterly astounded as I go down the list and see the number of factors that have been deleted, particularly when we thought and hoped they would be upgraded still more.

This decimation of the old standards is shocking to me indeed.

Senator Clark, do you have any questions?

Senator Clark. Just one brief statement. I was very impressed as well as by what you said.

You talked about H.R. 1, and the fulfillment of the goals of elderly people, particularly in regard to nursing home care.

Could you expand on why you think the intent of H.R. 1 really has not been fulfilled in these regulations?

Do you have any comments on why that has been the case, why the Department has gone so far afield from the intent of H.R. 1; and in that connection, do you have any specific recommendations as to what we could do to alter that?

Mr. Steele. I do not question, Senator, good will on the part of the people at HEW.

I think that as every administrative body, they have many interests that they have to take into consideration.

One is a concern not to close down nursing homes, which would narrow the number of homes available for the elderly.

They feel that in many instances, we do not have enough care at the present time.

I think the process of developing new regulations was extremely unfortunate, and it did give the industry itself a much greater say and a greater advantage in having that say than it would not normally have had, and I cannot help feeling, although I cannot prove it, that the industry knocked down some of the tougher requirements that were initially proposed. I think finally, that perhaps there is a lack of full understanding on the part of the people who are responsible for the regulations, of some of these points, that I and you gentlemen have raised, and I think all of those are factors.

I have, and I know you also have written to Mr. Weinberger, and I know that since we now have extra time to comment, I am certainly hopeful that your committee and our committee, and everyone concerned with this problem in Washington, will press for maximum consideration of our views, and I think we must keep the pressure on, publicly and privately, and in every other way, to command the attention we should be getting in HEW.

Senator Moss. Thank you very much, Congressman Steele. We appreciate your appearance, and we are very happy that you came to testify this morning.

Mr. Steele. Thank you, Senator.

Senator Moss. Without objection, I will place in the record the summary of section 246 of H.R. 1, about which we are speaking, a summary of the Social Security Amendments of 1972:

38. CONFORMING STANDARDS FOR EXTENDED CARE AND SKILLED NURSING FACILITIES

A single definition and set of standards for extended care facilities under medicare and skilled nursing homes under medicaid is established. The provision creates a single category of "skilled nursing facilities" which will be eligible to participate in both health care programs. A "skilled nursing facility" is defined as an institution meeting the prior definition of an extended care facility and which also satisfies certain other Medicaid requirements. Effective date: July 1973.

"SKILLED NURSING FACILITY" DEFINED

This is from a joint publication of the Committee on Finance of the Senate and Committee on Ways and Means of the House of Representatives. The last sentence relating to section 246 is the one I think we ought to have before us. It says: "A 'skilled nursing facility' is defined as an institution meeting the prior definition of an extended care facility and which also satisfies certain other Medicaid requirements."

Clearly, what concerns us, is that we have retreated from the old standards for extended care facilities. Instead of having the higher requirements prevail in every case, we have deleted specifics and retreated to the never-never land of generalization. This is the reason for the hearings, and the reason we are taking testimony.

We are pleased now to hear from the Honorable David Pryor, a former Congressman from Arkansas, and consultant to the American Association of Retired Persons, and the National Retired Teachers Association.

We remember Congressman Pryor very well, and the excellent work he did in the field of aging when he served in the House of Representatives. We are pleased, sir, that you are continuing your vigorous effort in this field and that you are here today, accompanied by these experts. I will ask you to introduce them. We welcome you gentlemen before our committee.

STATEMENT OF HON. DAVID PRYOR, FORMER CONGRESSMAN FROM ARKANSAS AND CONSULTANT TO THE AMERICAN ASSOCIATION OF RETIRED PERSONS/NATIONAL RETIRED TEACHERS ASSOCIATION; ACCOMPANIED BY FRANK ZELENKA AND LAURENCE LANE, LEGISLATIVE STAFF

Mr. PRYOR. Thank you, Mr. Chairman. I am David Pryor, consultant to the National Retired Teachers Association and the American Association of Retired Persons. Accompanying me to the witness stand this morning are Mr. Frank Zelenka who assisted in the preparation of the testimony which I am presenting this morning and Mr. Laurence Lane who specializes in health-related issues on the legislative staff of our associations.

Let me say, as a former Member of Congress, it is nice to be back in Washington, even if it is from the different side of the witness stand.

Our associations are extremely pleased that you heeded the request of our letter of August 15 asking you to convene this subcommittee to review the proposed regulations on skilled nursing facilities. It is a pleasure to know that we can petition the leadership of the Congress and receive a welcomed response and a fair hearing. We strongly believe that this public hearing on these proposed skilled nursing facility regulations will help inform the Congress, the public and the administration of the need for strengthening the skilled nursing care standards.

In our testimony today, we wish to comment on the following items: (1) The proposed standards in general; (2) the standard for physician services; (3) the standard for the organized nursing services; and (4) the level of care requirements for skilled nursing facility services. With respect to these items, we wish to make the following points:

Proposed Standards in General

Nothing in Public Law 92-603 called for or required the massive revision in the conditions of participation for extended care facilities in order to provide a common set of standards for skilled nursing facilities under titles XVIII and XIX of the Social Security Act, which massive revision these proposed standards are.

All that Public Law 92-603 required is that section 1861(j) of the Social Security Act have the following provisions added to it:

(a) A provision for disclosure of ownership; (b) a provision for independent medical evaluation; (c) a provision for institutional planning; and (d) such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967), as are applicable to nursing homes, and that section 1902(a)(28) of the Social Security Act be amended to read as follows:

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1861(j) * * *;

Thus, the existing regulations in subpart K of Social Security Administration regulations No. 5 could properly have remained applicable. Indeed, the Secretary underscored this point when he approved the provision in the proposed rulemaking which states:

During the period from July 1, 1973, to the date the proposed regulations are published in final in the Federal Register, the existing regulations in subpart K of Social Security Administration regulations No. 5, "Conditions of Participation: Extended Care Facilities" (20 C.F.R. 405.1101-405.1137) will be applicable. In addition, during the same period, conditions of participation set forth in § 405.1121, paragraphs (a), (c), and (e) of this documents, required by Public Law 92-603 will also be applicable.

Section 405.1121 (a), (c), and (3) embody the additions set forth above.

Hence, we are constrained to inquire why this massive revision in all of the conditions and why now? We hasten to make clear that we are not suggesting any improper action here. Mr. Howard Newman, Commissioner of the Medical Services Administration; Mr. James Cardwell, Commissioner of Social Security; and Mr. Arthur E. Hess are all dedicated public servants who seek nothing but the public well being. However, we do question the wisdom of presenting all of these changes to the field at once and together, thus court-

ing the dangers of unsound or diluted standards going unnoticed in the crowd, so to speak.

Some examples of change between the existing and proposed conditions which give us concern and for which we would like a demonstration of both the need for the change and the soundness of the change the following:

SECTION 405.1122—PATIENT CARE POLICIES

The existing standard requires that some members of the group who develop patient care policies for the facility should be neither owner nor employee of the facility.

The proposed standard is silent with respect to this issue.

SECTION 405.1123—PHYSICIAN SERVICES

The existing standard has more detail. It calls for a physician examination for each patient upon admission; it requires a 48-hour deadline for receipt of patient information; it requires the involvement of the charge nurse in the planning of a patient's care regimen.

The proposed standard is silent on all of these points. Indeed, it could be deemed stronger. However, expertise is required to properly evaluate whether it is stronger.

SECTION 405.1125—DIETETIC SERVICES

The existing standard has much detail relative to the specifics of this service.

The proposed standard has only generalities. It is, however, more specific than the existing standard with respect to the dietetic service supervisor.

SECTION 405.1134—PHYSICAL ENVIRONMENT

The existing standard requires that any agency granting a waiver from the Life Safety Code must (1) make a determination that the waived condition will not adversely affect the health and safety of the patient, and (2) keep a written record setting forth the basis of that determination.

The proposed standard does not provide for the above.

In the proposed standard, the nursing unit has only a generality respecting the use of "call systems." It says nothing about equipment for charting and recordkeeping. Neither does it say anything about the medication area being equipped with hot and cold running water. The same is true for toilet and handwashing facilities.

Under the proposed standard, the patient's room and toilet facilities lack the detail of present standards.

The proposed standard is silent on "examination rooms" and is generally less detailed than is the existing standard.

SECTION 405.1136—"DISASTER PLAN"

The proposed standard is less detailed and has no specificity with respect to rehearsal and drill requirements as does the existing standard.

Absenting any critical or vital need to move now and fast, we would suggest both a more piecemeal and go-slow approach.

Therefore, the National Retired Teachers Association and the American Association of Retired Persons ask this committee to insist that the Secretary document the need for these wholesale changes in all of the standards and that wherever these changes affect a service, for example, physician services, that the Secretary show proper and complete consultation with the appropriate professional organizations and that their comments were received by the Secretary and where he chose not to follow the recommendations made by these professionals, the Secretary show why he chose to do otherwise. Indeed, this is really no more than what the spirit of section 1863 of the Social Security Act presently requires.

PHYSICIAN SERVICES

Section 1861(j) of the Social Security Act defines the skilled nursing facility and in doing so sets forth some 15 subparagraphs which form the basis for the conditions of participation. Subparagraph 10 of section 1861(j) states that the skilled nursing facility "meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863)"; the only limitation placed upon the Secretary is that contained in section 1863, the thrust of which is to mandate that if a State or a political subdivision of a State imposes higher requirements on institutions, as a condition to the purchase of services in such institution under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements on such institutions in such State or subdivision as a condition to the payment for services therein.

Hence the Secretary has broad authority to expand the conditions imposed by section 1861(j).

Thus, the Secretary presently has authority to require a skilled nursing facility to have either a medical director and/or an organized medical staff to help ensure the adequacy and appropriateness of the medical care provided to patients in such facilities.

Therefore, the National Retired Teachers Association and the American Association of Retired Persons recommends to this committee that it make every effort to have the Secretary amend the conditions of participation for skilled nursing facilities in the following manner:

SECTION 405.1123—CONDITION OF PARTICIPATION: MEDICAL DIRECTION

The governing body retains a physician to serve as medical director (part time or full time, as appropriate to the needs of the facility) with responsibility for overall coordination of medical care, to insure the adequacy and appropriateness of the medical care provided to patients, and for surveillance of the occupational health status of employees and health and environment aspects of the facility. If the facility has an organized medical staff, a medical director need not be retained but the medical staff assumes responsibility for the functions of a medical director.

(a) Standard: Coordination of medical care.—Medical direction and coordination of medical care for patients are provided by the organized medical staff (if applicable) or by a medical director retained by the administrator. Medical direction includes the delineation of responsibilities as well as of clinical privileges of attending physicians or organized medical staff. Coordination of medical care includes liaison with attending physicians to insure their prompt orders upon admission of a patient, and periodic evaluation of the adequacy and appropriateness of supportive staff and services.

(b) Standard: Responsibility to facility.—The medical director or medical staff is responsible for surveillance of the occupational health status of the facility's employees and of the health and environmental aspects of the facility. Incidents and accidents to patients and personnel are reviewed by the medical director to identify health and safety hazards, and the administrator is given appropriate directions to insure a safe and sanitary environment for patients and personnel. Employees are provided, or referred for, periodic health examinations, and treated, or referred for treatment, as necessary.

This proposed requirement is not unique nor original with the National Retired Teachers Association and the American Association of Retired Persons. The facts are that this proposed requirement was included in the proposed conditions of participation for extended care facilities under Medicare which were reviewed 2 years ago by national voluntary health organizations and by Federal and State agencies that relate to the Medicare and Medicaid programs. Responses from these sources fully supported this proposed requirement to upgrade and strengthen the program requirement for provider institutions. The proposed requirement was also approved by HIBAC in early 1972, just prior to the development of the single set of standards for facilities under both programs (Medicare and Medicaid) by an interagency staff coordinating committee.

Of particular pertinence to this recommendation is the fact that this concept of organized medical direction in the skilled nursing facility has the endorsement and full support of the American Medical Association's council on medical service and of the AMA's house of delegates who at its 1973 annual convention adopted report B, "Guidelines for a Medical Service in Long-Term Care Facilities," of the AMA council on medical services which specifically states that such facilities should have either a medical director or an organized medical staff, or both, to help insure the adequacy and appropriateness of the medical care provided to patients in such facilities. We applaud and fully support HIBAC, the interagency staff, the AMA, and others in this recommendation.

Section 1863, to which we have earlier alluded, requires that:

> In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (j)(10), the Secretary shall consult with * * * HIBAC, appropriate state agencies and recognized national listing or accrediting bodies, and may consult with appropriate local agencies.

Hence it is the position of the National Retired Teachers Association and the American Association of Retired Persons that the Secretary has the authority to impose this requirement and that section 1863 be complied with fully and, therefore, the Secretary should act now to do so.

ORGANIZED NURSING SERVICE

The proposed condition of participation in section 405.1124 differs dramatically from the specific detail in the existing standard. It would take much time and space to detail all the differences here. However, there are some on which we wish to dwell. On the others, we again would urge the committee to insure that the appropriate agencies and organizations have been consulted and where they have not been listened to, that the Secretary document his reasons for acting otherwise.

The areas on which we wish to elaborate are the following:

(a) The director of nursing services; and (b) the absence of any ratios governing the number of supervisory nursing personnel to other nursing personnel, and any ratio governing the number of nursing personnel to patients.

The proposed condition of participation contains a startling and irrational proposal that a skilled nursing facility have the services of a registered nurse during the day tour of duty only 5 days a week.

There is absolutely nothing in Public Law 92–603 which requires the Secretary to propose this condition. Indeed, there is every reason to conclude that the legislative intent is to require the services of a registered nurse during the day tour of duty 7 days a week.

It is our opinion that what is occurring is the following:

(1) Public Law 89–97 which created Medicare and Medicaid contained section 1861(j)(6) which states the following:

> The term Extended Care Facility means * * * an institution * * * which provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed or provided in paragraph (2), and has at least one registered nurse employed full time; * * *

(2) Public Law 89–97 did not define the term "full time"; however, the Secretary, acting pursuant to section 1863 established the requirement that full time was 7 days a week. This standard has been in effect since 1967.

(3) Neither Public Law 90–248 nor Public Law 92–603 define the term "full time." However, Public Law 92–603, in section 267 thereof, "Waiver of Registered Nurse Requirement in Skilled Nursing Facilities in Rural Areas," amended section 1861(j) of the Social Security Act by adding to the end thereof the following new sentence:

> To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that * * *

(4) It would seem that the Congress in so acting made it permissive for the Secretary to define the term "full time" as being less than 7 days a week but not less than 40 hours per week.

(5) It would further seem that the Secretary has elected to exercise that option to thus propose the 5 days per week day tour of duty R.N. condition for skilled nursing facilities.

The National Retired Teachers Association and the American Association of Retired Persons urge this committee to oppose this dilution of the existing standards for the organized nursing service in a skilled nursing facility.

Weak Requirement Further Diluted

It is our strong opinion that there should be a registered nurse on duty 24 hours each day of each week of each year. However, we realize that existing law, namely section 1861(j)(6) of the Social Security Act, prevents the Secretary from proposing, let alone imposing, such a requirement. But, absenting any statutory requirement mandating a 5-day-week requirement, we are constrained to ask why the Secretary has elected to further dilute an already weak requirement.

We want here to add our support to the recommendation made by the American Nurses' Association with respect to section 405.1124. We concur completely with the recommendations and statements made by the ANA in a letter from Eileen M. Jacobi, executive director of the ANA, to Arthur E. Hess, dated August 7, 1973.*

It is our understanding that a similar recommendation was approved by HIBAC in early 1972 as well as by the interagency staff coordinating committee.

Thus, here the Secretary has ignored the recommendation of appropriate groups cited in section 1863 of the Social Security Act.

Again, we urge this committee to insist that the Secretary explain why he has elected to do so.

The fundamental issue involved in requiring a registered nurse on duty every day is that there are no 2 days in any given week when nursing care services are less critically needed than on the other 5 days. Also, it must be pointed out that if the weekend were the 2 days during which a registered nurse was not on duty, the situation could be more critical at that time because other health professionals, especially physicians, are often less available on weekends. Furthermore, nursing personnel less qualified than a registered nurse are not capable of recognizing many sudden and subtle, potentially dangerous changes that can take place in an ill aged patient, nor are they prepared to exercise the nursing judgment necessary to respond appropriately in any number of patient crises.

Although a qualified licensed practical nurse may be capable of functioning as charge nurse on a single tour of duty in a skilled nursing facility, the overall, around-the-clock direction of nursing services requires the knowledge and experience of a registered nurse. A responsibility of a registered nurse for the nursing service during the tours of duty when she is not present is to alert and advise staff in advance of potential patient problems, to insure their awareness of possible crises and that they take appropriate action when such occur. Inasmuch as the nursing service is the only service staffed in the facility 24 hours a day, 7 days a week, the requirement of a registered nurse at least on the day tour of duty each day is essential for continuity of patient care and the administration of services.

Skilled Nursing Care Needed

A major criterion for reimbursement to skilled nursing facilities in the Medicare and Medicaid programs is the need of the patient for skilled nursing care and/or restorative services. Although licensed practical nurses and other nursing staff personnel participate in pro-

*See app. 3, item 8, p. 2651.

viding skilled nursing care, the registered nurse is responsible for the initial assessment of the patient's needs and for the development and implementation of the patient's plan of care. Inasmuch as most patients are admitted on the day tour of duty, 7 days a week, a registered nurse should be available for prompt assessment of needs and initiation of the plan of care to insure continuity of services.

A statement in support of the foregoing appears in the January 16, 1973, report of the Secretary's Commission on Medical Malpractice, in chapter 5 on "Prevention of Medical Injuries":

> The Commission fully recognizes the importance of the professional nurse in patient care. The professional nurse still has the primary responsibility for supervising the therapy and patient care prescribed by the doctor. The trend in recent years has been to restructure many of the tasks which make up patient care in order to utilize people who do not require the same amount of training as professional nurses. The Commission is concerned with the trend in some areas to replace rather than supplement the professional nurse with paraprofessionals. The Commission believes that the lack of an adequate number of professional nurses to supervise and provide patient care can increase the likelihood of error and malpractice litigation.

With respect to the matter of ratios, we ask this committee to urge the Secretary to include within the standards for section 405.1124, those provisions required in section 1902(a)(28)(B) of the Social Security Act as enacted by Public Law 90–248, more commonly called—and properly so—the "Moss amendments," which states the following:

> * * * any skilled nursing home receiving payments under such plan must * * * (B) have and maintain an organized nursing service for its patients, which is under the direction of a professional registered nurse who is employed full time by such nursing home, and which is composed of sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services for such patients during all hours of each day and all days of each week; * * *

It is not clear to us whether section 246(a) of Public Law 92–603 amended section 1902(a)(28)(B) out of existence. However, if this is the case, the Secretary could still impose the provisions of section 1902(a)(28)(B) as condition of participation for skilled nursing facilities by having recourse to section 1861(j)(10) of the Social Security Act.

The legislative history of Public Law 92–603 makes clear that section 246 thereof originated in the Senate and that the House concurred in conference. Thus, we must turn to Senate report 92–1230 to determine the intent of this legislation. The U.S. Senate Committee on Finance comments on section 246 on pages 281–282. Toward the end of these comments, the committee makes clear that "the committee's amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities." Therefore, it seems clear to us that when the Congress conformed the standards for skilled nursing facilities under Medicare and Medicaid, and utilized section 1861(j) of the Social Security Act as the mechanism for bringing about that conformity, it did not intend for the higher standards contained in Medicaid to be ignored and left behind. It seems clear to us that Congress expected the Secretary to have recourse to section 1861(j)(10) to assist in bringing about this conformity and uniformity of standards. Thus, again, we ask this committee to urge this action upon the Secretary. Failure on the part of the Secretary to follow this suggested action will bring about the tragic situation where rather than being the better for Public Law 90–603, the patients in skilled nursing facilities will be the worse for it.

Recommendations

Recommended improvements which should be made in the standards relative to the organized nursing service:

(1) Define nursing personnel separately from auxiliary nursing personnel.

(2) Clearly specify that nursing personnel means "nurses" only. The term should be limited to the following: (a) R.N.'s; (b) LPN's or LVN's who are graduates of a State-approved school; (c) LPN's or LVN's not State-approved school graduates but certified to be the equivalent pursuant to section 241 of Public Law 92–603.

(3) Clearly specify that auxiliary nursing personnel are LPN's and LVN's who do not meet the above requirements as well as aides, orderlies, attendants, and ward clerks.

(4) In order to provide for adequate nursing care on a given tour of duty, it should specify a minimum ratio as between the total nursing staff (nursing personnel plus auxiliary nursing personnel) and the total number of patients.

(5) In order to provide for properly supervised nursing care on a given tour of duty, it should provide a minimum ratio as between a charge nurse and auxiliary nursing personnel.

(6) Relative to the standards for the organized nursing service exclude the charge nurse requirements from any waiver.

(7) Permit a waiver, however, from the ratios outlined herein. Permit such a waiver only when the facility establishes its inability to meet the standard despite persistent and total effort on its part to meet the standard.

(8) Such a waiver should be for 6 months only and no facility should be permitted to receive two successive waivers for the same condition.

(9) As a condition of any exercise of waiver, the State should be required to certify in writing that the granting of a given waiver does not constitute a hazard to neither the safety nor the well-being of the patient regardless of the hardship worked upon the facility.

Level of Care Requirements

Public Law 92–603 contains much that is good for the Nation because it makes for far-reaching and long-overdue improvements and expansions in Medicare and Medicaid. However, it contains within its provisions, the seeds for devastating tragedy. We have reference here to section 247 of Public Law 92–603 which amends Medicare and Medicaid to require that a beneficiary of these programs must need or have needed skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) on a "daily basis," that is to say, that the individual must need the "laying on of the skilled hands" on a daily basis either directly or indirectly.

If this requirement is applied on a narrow interpretation, then almost all Medicare and Medicaid recipients will be denied skilled nursing facility services. The potential for disaster here is terrifying.

We urge the Secretary to exercise caution in applying this requirement; and we urge this committee to join with us in carefully monitoring the application of this requirement. We further urge this committee to plan and schedule hearings in the near future which will treat only this requirement.

The rationale underlying hospitalization is that the individual so hospitalized has need for the continued availability of the resident medical staff and/or has need for access to the exotic equipment housed within the hospital and for use thereof. When the individual no longer requires the foregoing, but continues to require the availability of skilled nursing services, then the individual had ought to be transferred to a skilled nursing facility. The rationale, therefore, for the individual to be admitted and to be continued in a skilled nursing facility is that an individual's condition is such that there is need for the continued availability of skilled nursing services. The need for these services should be on a daily basis, not the laying on of hands.

Failure to recognize this long-honored basis for skilled nursing facility services can result in admission to a facility incapable of rendering skilled nursing services when the need for these arises on the sporadic basis that is common to elderly patients.

Therefore, again we urge this committee to do all they can to prevent the improper application of section 247 of Public Law 92–603.

Mr. Chairman, this concludes our testimony for today. We are available should you wish to question us.

Mr. Moss. Thank you, Mr. Pryor, and gentlemen, for a fine statement. I have no questions at this time.

Senator Clark.

Senator Clark. On behalf of the committee, let me say we appreciate your succinctness and the fact you are very specific in a number of suggestions and recommendations and your positions on them.

Let me ask very directly for the record, what it seems to me your statement says in many different ways: Do you believe that the intent of Congress in H.R. 1 has been violated by the proposed regulations?

Mr. Pryor. The intent of H.R. 1, of course, is good, and it is to bring about the best possible nursing home care that this Nation and our people can offer.

Proposals Must Go Forward

We do feel that the nature of the proposed regulations is not valid to that spirit. It is our opinion that we as people, and we as a Nation, cannot go backward, but only forward in this field and we feel that these proposals are taking us a step backward.

Mr. Lane. Mr. Chairman, I think in the written testimony we allude to the fact that there is some question within the law as to the specifics of what Congress did intend.

As the 1972 amendments were written, there is loose language as to what authority the Secretary does have in requiring registered nursing care, and that is where, possibly, the 5 days a week, 40 hours of requirement came from, so we do believe that there might be a need for further legislation.

It appears as if there will be need for an exact amendment to require 24 hours nursing care 7 days a week in a skilled nursing facility.

Senator Clark. That was going to be my other question.

Do you have any specific suggestions or proposals for reversing these regulations, and are you suggesting that an amendment might well be in order?

Mr. Pryor. Yes, sir.

Senator CLARK. Do any other people at the table have suggestions, with particular reference to recommendations or proposals, on any other matter you might want to discuss as well?

Mr. ZELENKA. Mr. Chairman, let me say, I do not think I completely agree with the idea that proposals are in violation of the intent of the Congress.

As a matter of fact, if anybody ought to be spanked, I think it is the Congress.

It enacted these programs in 1965, and we are 8 years into these programs. Congress has had several opportunities to provide better nursing care standards, and in each instance has turned away from these opportunities, so I do not think the administration and the Department should alone be the whipping boys.

I think the Congress comes in for a great deal of criticism.

For example, 8 years ago, Congress enacted section 1861(j)(6) in which it required that an extended care facility—now termed a skilled nursing care facility—had to have at least one R.N. employed full time. The Congress never defined what was meant by "full time." Now in Public Law 92–603, the Congress adds to section 1861(j) a provision which states that if the language in section 1861(j)(6) is deemed to mean more than 40 hours, that is to say, if the term full time is deemed to mean more than 40 hours, then under certain conditions, the rural nursing home need not have an R.N. for more than 40 hours. Therefore, here we have the very same people who, 8 years ago wrote section 1861(j)(6), now telling us that it need not mean more than 40 hours. Hence, it could be said that when the Secretary proposes that full time means 8 hours a day, 5 days a week on the daytime tour of duty, that the Secretary is making the best of a bad situation provided by the Congress. After all, if the Congress suggests that full time can mean not more than 40 hours, then a minimum standard would have to be only 40 hours and those 40 hours could be satisfied in any number of ways, for example, any 10 hours a day, any tour of duty, 4 days a week. This would be worse than what the Secretary is proposing. Yet the Congress is the initiator of the confusion.

SOUND RECOMMENDATIONS OVERLOOKED

In the situation we have now, I think what we really have to be concerned about, is the fact that 2 years ago, a review of the conditions of participation was started at the Department, which is a proper activity. From this review, many sound recommendations came forward from such groups as the interagency staff coordinating committee, and those recommendations have, for some reason, not appeared in these revisions. I think that the thing that has to be found out and determined is why this happened.

It is quite possible that a good number of the revisions are very sound, and yet they can end up being deemed inadequate.

For example, in the existing conditions of participation, it is required that upon admission, there will be a transfer of patient information, and if the information is not available upon admission then it will be transferred within 48 hours.

Well, the present standard proposes to eliminate the words "within 48 hours."

That may be a dilution; on the other hand it is something that allows no leeway, so to speak, thus it could be a strengthening of standards. So I think that as requested in this testimony, that this committee should ask indeed why the recommendations from the agencies were ignored. Then, perhaps we could make a determination of whether these revisions are sound.

I am not quick to say there is anything underhanded taking place.

These are honorable men who have been running these programs for 8 years, and they are good public servants, and I do not mean to say they are out to do any harm.

Senator CLARK. We don't want to prejudge the matter, and I would like to hear the administration's defense of these various regulations before you make up your mind.

Mr. ZELENKA. I would hope they would be required to make a thorough defense of these revisions, or explanation is a better word.

We all have fears when confronted with such a massive revision; and that is the only way the fears can be set aside.

"SUFFICIENT OPPORTUNITY TO ACT?"

Senator CLARK. One other question in that regard: Do you feel the Congress has had sufficient opportunity to act?

Should they have become more involved in terms of writing the standards?

Mr. ZELENKA. Well, not the standards. Section 1861(j) defines an extended care facility, now called skilled nursing care facility, which is a creation of Congress, and it has some 15 provisions there that make up a descriptive definition.

Time and time again, year after year, people have come forward, and have urged the adoption, for example, of a nursing standard that would require 24 hours R.N. coverage, and everybody has admitted how nice that would be, but that at this time, it would not be practical, and so it has been turned aside. At the same time, many have said one should set a standard on the basis of what is necessary for the job to be properly done, and not on the basis whether or not enough manpower is there to meet the standard; that the criteria for the standards should be what is intrinsically necessary, whereas the criteria for waivers should be what is attainable at a given time in a given place.

People have walked up this Hill for 8 years and said the same things to the Congress, the Congress still has not done anything.

Obviously this committee is not at fault. It has joined in these protestations. But it is someplace else on this Hill where the problem resides, and I think that is also part of our job, to say, not only whether the administration is at fault, but whether the Hill itself has failed.

Mr. LANE. Pursuing the line of questioning you are making, that is, with Mr. Zelenka, we would also say at this point there are some valid criticisms which have not been answered by the Congress. If you do increase the standards to a high enough level, what would be the cost problems involved, and who would be responsible for paying for these improvements within the nursing homes.

Now, not to plug the work of the subcommittee, but the staff of the subcommittee, the chairman and members of the subcommittee have sponsored a number of very, very important substantive pieces of leg-

islation in the Congress that would help improve nursing home facilities; would help provide loans to upgrade and improve the structure of these facilities; will help improve the training of the personnel within these facilities. We completely endorse these recommendations, and we urge, if anything else comes out of these hearings, perhaps it will be an impetus for passing these substantive quality pieces of legislation.

Senator Moss. Are there any other comments?

Since there are none, we thank you very much for coming this morning, and we appreciate your comments.

Mr. PRYOR. Thank you, Mr. Chairman.

Senator Moss. I must leave now; Senator Clark will assume the Chair.

Senator CLARK [presiding]. The next witness is Msgr. Charles J. Fahey, vice president, American Association of Homes for the Aged; director, Catholic Charities, diocese of Syracuse, N.Y.

Welcome to the committee, Monsignor Fahey.

STATEMENT OF MSGR. CHARLES J. FAHEY, VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGED; DIRECTOR, CATHOLIC CHARITIES, DIOCESE OF SYRACUSE, N.Y.

Monsignor FAHEY. Thank you, Mr. Chairman.

We are happy to be here. We are delighted to be with you, and we have responded to the regulations as proposed.

Second, we have a fairly lengthy statement, which I would propose to paraphrase at this time, and would ask my associate also to pick up on those points I might miss, and we do stand ready to answer any questions that you would deem appropriate.

We have four general areas of concern, several of which have been touched on already, and we merely add the weight and prestige of our organization to the comments that have been made.

In the present instance, in regard to the provisions around nursing services, we found the proposed regulations totally inadequate.

The inconsistencies are overwhelming: To be eligible for skilled nursing facilities, a person must be so sick as to require skilled services on a daily basis, and yet it is not mandated that these skilled services be available. We have two very specific suggestions which we have made in the past, and which we reiterate today: (1) That registered nurses be required on a 7-day-week basis, around the clock, and (2) that at least the provisions which are currently prevailing for Medicaid, in regard to nursing ratios, be mandated in the skilled nursing facility.

Without going into a great deal of detail, we feel these are the bare minimum of necessity.

Second, we find the lack of a mandate for a medical director and/or medical staff in these types of programs to be a serious omission.

All of us who are providers know of the difficulties of getting physicians to visit persons in nursing homes. We are talking about very serious sick people.

We find it is incredible that provision for a medical director or medical staff has been deleted. We call for the return of this particular matter to the regulations.

Skilled Nursing Facility Definition

Third, an area touched upon briefly, is what you really mean by the skilled nursing facility.

Many of the members of our organization initially participated in title 18 programs, only to be completely disillusioned.

We found to a large extent, extended care became tied not to the requirements of a patient, but rather to the fiscal constraint inherent in maintaining the integrity of the trust fund.

This is a matter of serious concern to us. The statute is somewhat broadened, but the tone of the proposed regulations would indicate to us that the mind set of the Medicare program predominates the SNF regulation.

If the predominant value will be maintaining the integrity of the trust fund, then it is inevitable that the skilled nursing facility definition will mean a drastic reduction in the number of people who are eligible for this program through either title XVIII or XIX, and, frankly, we are frightened to death.

This is especially dramatic when we view the proposed regulations in the light of intermediate care facilities. The proposed ICF regulations are not of primary concern today, but they must be considered. Congressional intent would seem to be that we have a continuum care.

If we maximize the level of care in skilled nursing and make it for very, very sick people, using the title XVIII approach, and on the other hand, suggest minimum standards for ICF's, as is proposed—we have a tendency for minimum standards to become maximum—we will have thousands and thousands of people in limbo; not sick enough for SNF but far too debilitated to be cared for in the ICF program.

The last general area we would call to your attention is the question of how serious this Congress and administration regard the question of entitlement.

We have testified over the years with a great deal of enthusiasm, in regard to a general federalizing of long-term care.

We feel that people should be entitled to quality care in decent surroundings, whether they be in Mississippi or New York or Florida or California.

We feel that there should be an assurance of quality care, whether it be for the private paying individual, or for those who are so economically distressed to be eligible for Medicaid, or for those in the insurance program under title XVIII. We were delighted to find under Public Law 92–603 that there was a creation of entitlement to fundamental levels of care for all citizens.

However, if there is not concomitant with the upgrading of services, programs, and facilities, a means whereby the Government is willing to pay for upgrading these programs, the advancement is illusory.

We cannot leave this question of entitlement to the local board of supervisors or even to State legislatures, or private philanthropy.

We feel it is absolutely necessary a cost-related system go along with the upgrading of standards.

Upgrading in facility and programs will be a costly affair.

It is estimated at least half the ICF facilities in the United States will not meet the Life Safety Code. They should be upgraded, but

unless we are willing to accept the notion of cost relatedness, simultaneously with the upgrading of standards, then we are calling for sheer disaster.

I do not know whether my colleague would like to comment at this time.

STATEMENT OF REV. WILLIAM EGGERS, FORMER PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGED; ADMINISTRATOR, HOMES FOR AGED LUTHERANS, WAUWATOSA, WIS.

Reverend EGGERS. I think, Senator, I would like to expand on just one aspect of what we said, and that is the relationship of the ICF to the SMS, because the patients will be excluded by definition from skilled nursing services, will have to fall into the intermediate care areas, and we are deeply concerned that there is not a sufficient provision made in the intermediate care standards, for their care professionally, the type of care that they need, nor that there is an adequate reimbursement provided for them, and if I could have a moment, I would like to expand in a concrete way on precisely what I mean in respect to that.

About a year ago, in Wisconsin, in order to try to cope with our reimbursement problems, the association, government, nongovernment, and hospital sponsorship, conducted a study, and determined that there was a charge category of patients who today would fall under the skilled nursing care definitions, but would require an immense amount of care.

In fact, all of us were quite shocked, and we checked and counterchecked the evidence, we were shocked to discover that this group which represents 5 to 10 percent in the title XIX group were requiring 4½ hours care a day by actual observation on the day the study was made, and I think that part of our deep concern is that under the present proposal, the definition for skilled nursing care will exclude many of these people, and will put them into the intermediate care facility range, and there will be inadequate reimbursement and there will be inadequate care for them, and as I said, this is sizable.

You may be interested to know that we are conducting a repeat experiment of this, and in all, in about 75 facilities of all sponsorships next week, and involving about 10 percent of the patients in them to validate the results of the previously achieved results, so we see a great gap of very great nature in this combination of the provisions.

Senator CLARK. Thank you very much.

I was particularly interested in the latter part of your statement, monsignor, about the fact that if we are going to require greater standards, and expect certain national standards, the Government, the Congress, and the President are going to have to be prepared for those.

One means little without the other. It seems in our military budget, we are hopefully coming out of the war in Southeast Asia, and establishing a détente, and yet the President added $4 billion to last year's budget. So it seems to me it is entirely possible that our priorities are such that if we are prepared to raise these standards, then we ought to be prepared to pay for them.

Monsignor FAHEY. We must, Senator. It is not as if this is a highly sophisticated well-established service area to people.

To a large extent, whatever the sponsorship, it is an area of transition. The poor and minorities have subsidized this service to a large extent, but we have turned our backs on this phenomenon.

The issue is now being framed very clearly. I do not think we can afford as a people to turn our backs on these problems. I am not speaking as a provider of service, but rather as an advocate for these people who are so vulnerable.

INFLATIONARY HARDSHIPS

Senator CLARK. Just one question. If we were to move toward reimbursement, as you recommend, would this not mean even greater hardships for the elderly from an inflationary standpoint?

Monsignor FAHEY. This is why it is so important to develop adequate third-party techniques, even to strengthen the title XIX system, or title XVIII or XIX, developing some sort of technique for catastrophic type of situations.

I do not think we can expect the elderly to be in a position to pay for their costs, save in exceptional circumstances.

I think we as a people should be in that position to develop techniques so that either through insurance or general tax revenues, we pick up this kind of cost. It is just that it be met by the general population, rather than by the individual.

Individual elderly who earned their money in another era, were forced out of the work force at an early age, and whose meager savings and often inadequate pensions are hard hit by inflation can hardly be expected to carry this burden alone.

It is just unrealistic, so we have to further develop the techniques of governmental payments for them in this area.

Senator CLARK. We very much appreciate your coming.

Since we have two men of the cloth, I might ask you to comment on two other standards that are deleted.

One is that patients who are able and who wish to do so, are able to attend religious services and the other one is that patient's requests to see their clergymen are honored for privacy during visits.

Do you have any particular comments on those?

Monsignor FAHEY. It has been our position, over the years, that those things that elderly people need, should be theirs. The right to exercise their religion should be safeguarded scrupulously.

Reverend EGGERS. Senator, I sat in on many code writing sessions, and this phase of human kindness gets listed under other activities and recreation.

Senator CLARK. Thank you very much for coming. We appreciate it very much.

Monsignor FAHEY. I thank you for the opportunity.

[The prepared statement of Monsignor Fahey and Reverend Eggers follows:]

PREPARED STATEMENT OF REV. MSGR. CHARLES FAHEY AND REV. WILLIAM T. EGGERS, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman and members of the committee, we welcome this opportunity to appear before you to testify on the proposed regulations for skilled nursing facilities.

My name is Msgr. Charles Fahey and I am the director for Catholic Charities in Syracuse, N.Y., and vice president of the American Association of Homes for the Aging. With me here today representing AAHA is Rev. William T. Eggers, administrator of the Home for Aged Lutherans, Wauwatosa, Wisc., and a former president of our association.

Mr. Chairman, the regulations we are looking at today grew out of the Social Security Amendments of 1972, or Public Law 92-603. They propose a common set of standards to be applied to "skilled nursing facilities," or to what used to be known as extended care facilities under Medicare, and skilled nursing homes under Medicaid. The purpose in having common standards, as explained by the Senate Finance Committee in its report on the forerunner of this law, H.R. 1, is to eliminate cumbersome and expensive administrative procedures which result from the existence of separate requirements and separate certification processes, despite substantial similarities in the services required of SNF's under both programs (Medicare and Medicaid).

The new regulations were "not," according to the Finance Committee, "to result in any dilution or weakening of standards," and they were to "incorporate the best features of the Medicare and Medicaid requirements." Despite this statement of congressional intent, the former requirement for physician visits has been weakened, and the proposed regulations fail to incorporate a key feature of the nursing service standards in the former Medicaid requirements.

Mr. Chairman, our association finds three major flaws with these regulations: (1) They provide inadequate requirements for skilled nursing services; (2) they provide inadequate requirements for physician involvement in skilled nursing facilities; and (3) they fail to recognize the basic differences between title XVIII and title XIX patients.

NURSING SERVICES

Let us look first at the nursing requirements. Although the regulations are confusing and inconsistent in some respects, they appear to require the services of a registered nurse during the day shift of 5 days a week only. The rest of the time—during the afternoons and evenings of 5 days, and throughout the entire day 2 days a week—the services of an RN are not required. The regulations seem to suggest that at 3 p.m. every day, through 7 a.m. the following morning, SNF patients suddenly become less ill, and therefore less in need of the services of an RN.

To fully appreciate why these standards are inadequate, it would be well to look at the types of services which are provided in an SNF, for they tell us something about the SNF patient. These services are those "provided directly by or requiring the supervision of skilled nursing personnel, or skilled rehabilitation services, which the patient needs on a daily basis, and which as a practical matter can only be provided in an SNF on an inpatient basis."

People who are placed in SNF's tend to be seriously and chronically ill, and more often than not, they suffer from an entire complex of disease. It is not unusual, for instance, for an SNF patient to have three or four different diseases simultaneously, some or all of which require sophisticated treatment from highly skilled personnel.

SNF patients are vulnerable to sudden and marked changes in their physical condition—changes which only professional nurses can assess and respond to appropriately. These changes can occur any time of the night or day, and without warning. Thus it is absurd to have regulations which imply, as these do, that such changes can be predicted ahead of time, and furthermore, that they occur only during certain specified periods of the day.

A second major problem with the requirements for nursing services is that they fail to establish nursing staff-to-patient ratios. They say only that there shall be a "sufficient" number of nurses to meet the needs of patients. This language is so loose and so unspecific that it might be interpreted to mean that one nurse can care for 50, 75, or 100 patients.

Although there are wide variations in nursing services which may exist among facilities, depending upon patient "mix," the seriousness of the illnesses and the facility's rehabilitation programs, the Department of HEW 2 years ago nonetheless did establish "bare minimums" for nursing staffing. In guidelines issued by HEW's Medical Services Administration (Program Regulation Guide 10, dated November 3, 1971), the Department said that nursing staffing should not be considered adequate under any circumstances if it fell below the following:

"Total staff time in the nursing department should amount to an average of not less than 2.25 hours of nursing department time per patient per 24-hour day."

Mr. Chairman, these nurse staffing guidelines were incorporated in the former Medicaid standards and were omitted from the proposed regulations.

To remedy the deficiencies in the regulations for nursing services, we recommend the following:

(1) A requirement for the services of a registered nurse 7 days a week, 24 hours a day;

(2) The establishment of specific nursing staff-to-patient ratios, as outlined in the Medical Service Administration's Program Reference Guide 10, issued November 3, 1971.

PHYSICIAN INVOLVEMENT

Mr. Chairman, let us now examine the regulations for physician visits. They read as follows:

"Each patient is seen by a physician at least every 30 days, or more often as needed, except that, after 90 days following admission, this requirement may be deemed to be met in those specific instances where the attending physician has furnished 'adequate' medical justification in the patient's medical record for an alternative schedule of visits, and provided that (1) the facility notifies the State Medicaid agency, when appropriate, and (2) the utilization review committee or medical review team has promptly re-evaluated such patient's need for monthly physician visits as well as his continued need for skilled nursing facility services."

Here again, the regulations are so loosely written that they might be interpreted as a requirement for no physician visits following the initial 90-day period.

Yet in a later appearing section of the regulations dealing with utilization review, there is a requirement for patient reviews by UR committees every 30 days.

The question arises: Why do the regulations, in the section on visits by the patient's physician which is supposedly intended to ensure adequate medical supervision—open the door to virtually no visits, whereas later on, they require utilization reviews—whose orientation is economy, efficiency, and cost containment—by UR committees every 30 days?

It has long been recognized that one of the major deficiencies of our national system of long term care stems from inadequate physician supervision of patients. It is common knowledge that doctors refuse to visit nursing homes because they are "too depressing," or because doctors wish to concentrate their efforts on patients with greater rehabilitation potential.

Because of this reluctance among physicians to become more directly involved in long term care, to a large extent, we in this country have entrusted what is perhaps one of the most sophisticated, sensitive, and complex jobs in the world—that of caring for sick and aged people—to unskilled and untrained workers.

Fortunately, the American Medical Association has recognized officially that it is time for doctors to play a more active role than they have in the past in the treatment of long term care patients. Working under an HEW grant, the AMA recently concluded a series of workshops, whose purpose was to determine how physician involvement in SNF facilities could be increased. The AMA formulated its own definition of a medical director for SNF's, and in so doing, laid the ground work for improved medical supervision of SNF patients.

We believe it is common knowledge that the proposed SNF standards originally contained a requirement for a medical director, and that the AMA work shops were conducted for HEW in the expectation that the new standards would require a medical director.

Mr. Chairman, we recommend that the beginning that has been made in this area be pursued, and that the regulations be amended to include a requirement for a medical director, who would be responsible for overall coordination of the medical care for the entire facility. This requirement would be a first step toward ensuring better physician supervision.

DIFFERENCES BETWEEN TITLE XVIII AND TITLE XIX PATIENTS

Mr. Chairman, our third major concern is that the regulations fail to recognize the basic differences between title XVIII (Medicare) and title XIX (Medicaid) patients.

Although it is true that both receive treatment in SNF's, and similar services are provided to both, there are significant differences between the two types of patients as well that require different types of treatment.

Yet in the case of both types of patients, the regulations require UR reviews no later than 21 days following admission, and subsequent reviews for medical necessity no more than 30 days later, and every 30 days thereafter.

Unlike the title XIX patient, the title XVIII patient is generally treated in an SNF on a short-term basis, and he also must have "rehabilitation potential." Thus, the above timetable for UR reviews might well be appropriate.

The title XIX patient, however, generally has far less—in many cases, very little—potential for rehabilitation. Very often, because of the title XIX patient's condition of overall physical deterioration, major efforts must be directed merely to sustaining his current capacities, or to making him more comfortable and easing his pain. An expectation for complete and early recovery, such as is implied by the regulations' timetable for UR reviews, is unrealistic.

In addition to the problem of an unrealistic timetable for UR reviews for the title XIX patient, we are concerned that the final determination of a patient's placement is limited to the physicians. The pertinent section of the regulations is as follows:

"Final determination regarding the necessity for admission or for further stay, including stay beyond the period of extended duration, *is limited to physician members of the committee*, and may be made by the full physician complement, a subcommittee, or a single committee physician."

Title XIX patients are not generally institutionalized unless there is a significant need for protective and supportive care. Their need for support in nonmedical areas—psychological, social, and emotional—is often as great, or even greater, than their need for medical attention and skilled nursing care. Many of these people have outlived their families and relatives. They have no homes, and because we have not yet in this country developed better alternatives to institutionalization, they literally have nowhere else to go. To aim for discharging patients merely for the sake of discharging them, with little or no thought to the capability—or even more importantly, the willingness—of the outside world to take care of these people—many of whom can hardly see, walk, or talk—is preposterous.

We need to fully appreciate the fact that the physical condition of SNF patients fluctuates a great deal. Merely because on 1 day or 1 week the patient does not happen to need skilled nursing care, but instead can get by with custodial care, does not mean that we can just move these people around from month to month or from week to week.

Our concern deepens when we look at section 247 of Public Law 92-603, which ignores the important differences in the conditions and needs of title XVIII and title XIX patients, and requires the use of the same criteria for both types of patients. The problems of denying care to people who need it, of discharging or transferring patients when there is no alternative care, will be greatly aggravated if the people making these UR reviews apply Medicare rules to Medicaid patients.

Mr. Chairman, we recommend that the entire regulations, and most especially the section on utilization review, be re-evaluated, with special attention given to the differences between title XVIII and title XIX patients, and to the realities of long term care. We further recommend that Congress reconsider the assumption underlying section 247, namely that Medicare and Medicaid patients are just alike.

These, then, are our major criticisms of these regulations and our recommendations for improving them.

Mr. Chairman, on the one hand our Medicare and Medicaid laws say that those people who need skilled nursing care should be entitled to it. Yet on the other hand, the watered down regulations and the budgetary policies of both the Federal and State governments often bar people from receiving the care to which we say they are entitled.

It is an appropriate time, as we review these regulations, to ask ourselves whether we are really serious about wanting to improve long term care in this country. And if we wish to do so, are we willing to pay for the improvements?

In the past, this committee has collected documentation to prove that nursing homes can and do sometimes make large profits at the expense of patient care Unfortunately, it is not always clearly recognized that, at the same time, Medicaid reimbursement rates for skilled nursing facilities in many States are woefully inadequate if the SNF's are to do the kind of job we want them to do.

It would be well to point out at this stage that, in addition to calling for revised regulations for skilled nursing facilities, the Social Security Amendments of 1972 also require that the individual States formulate Medicaid reimbursement systems which are "reasonably related to cost" by 1976. It is our view that such reimbursement systems should be implemented as soon as possible, and certainly before 1976.

The effective date for reasonably cost-related reimbursement should correspond to the effective date of these regulations, as Federal requirements should be reimbursable items. We recognize that the regulations for SNF's will become effective before the end of the year, even before regulations for reasonable cost reimbursement sections of the law are proposed. We therefore urge that the effective date for cost-related reimbursement be moved forward as early as possible, so that this will become a reality by early 1974 at the latest.

The Federal Government simply must recognize that if we are to achieve improvements in long term care, we must be willing, as a Nation, to commit the resources that are necessary to do the job.

Mr. Chairman, this concludes our testimony for today, but in closing, we wish to thank you for calling these hearings and to acknowledge once again the work you and other members of this subcommittee have done in an effort to improve conditions for our elderly population.

Thank you.

Senator CLARK. Next we are going to hear from Dr. Edward J. Lorenze, medical director, Burke Rehabilitation Center, White Plains, N.Y., on behalf of the American Medical Association, and he is accompanied by Charles Pahl, assistant director, legislative department, American Medical Association, and Herman Gruber, secretary, committee on aging, American Medical Association.

Welcome to the committee, gentlemen.

STATEMENT OF DR. EDWARD J. LORENZE, MEDICAL DIRECTOR, BURKE REHABILITATION CENTER, WHITE PLAINS, N.Y., ACCOMPANIED BY CHARLES PAHL, ASSISTANT DIRECTOR, LEGISLATIVE DEPARTMENT, AMERICAN MEDICAL ASSOCIATION, AND HERMAN GRUBER, SECRETARY, COMMITTEE ON AGING, AMERICAN MEDICAL ASSOCIATION

Dr. LORENZE. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am Dr. Edward J. Lorenze, medical director of the Burke Rehabilitation Center in White Plains, N.Y. I am a member of the American Medical Association's committee on aging of the council on medical service. With me is Mr. Herman W. Gruber, secretary of the committee on aging, and Mr. Charles W. Pahl, assistant director, AMA legislative department.

It is appropriate that public hearings are being held on the proposed HEW regulations for skilled nursing facilities since they could have a significant effect on future quality of nursing home care.

We will limit our remarks today to section 405.1122(b) of the proposed rules, published in the Federal Register of July 12, 1973. The proposed rules would make a physician, a registered nurse, or a medical staff responsible for the execution of patient care policies.

While there is no question that nurses could have a major role in the execution of patient care policies, we strongly believe that responsibility for this function belongs only to a physician or an organized medical staff.

The American Nurses Association has stated in comments on this proposed rule, that it "endorses the concept of nurses assuming a

major role in the execution of patient care policies." However, they added, "delegating the responsibility for the execution of patient care policies to the registered nurse demands that there be adequate and continuing medical guidance and support."

We believe that the role of a medical director in a skilled nursing facility has to be defined if the needed direction and supervision is to be accomplished. We also believe there is a need for a vigorous program of continuing education and guidance for physicians becoming medical directors.

Quality medical care depends upon cooperation and coordination between the various providers of medical, nursing, and supportive services. Additionally, quality medical care depends on maintenance of effective liaison between nursing home administrators and attending physicians to keep care at a constantly high level.

Supported by Other Organizations

We are supported in our position by many national organizations, such as the American College of Nursing Home Administrators, American Association of Retired Persons, and the American Association of Homes for the Aging. These groups are well aware of the present needs of patients in skilled nursing facilities. These are groups who know the value of skilled nursing home care and realize that provision of such care can be better assured if a physician is responsible for the organization and integration of patient care. Properly structured, this position can be filled by either a part-time or full-time medical director, thus making such an arrangement feasible for all such facilities regardless of their size.

Because the American Medical Association has long been concerned about the quality of nursing home care, we welcomed President Nixon's statement of August 6, 1971, when he noted, that although "many of our nursing homes demonstrate the capacity of our society to care for even the most dependent of its elderly citizens in a decent and compassionate manner many (other) facilities fall woefully short of this standard."

The President pledged action to meet the challenge of the substandard nursing home and outlined a now well-known eight-point program. Included in this program was a directive to the Department of Health, Education, and Welfare to institute short-term training courses for physicians and other health professionals who work regularly with nursing home patients.

HEW, in compliance with the directive, entered into a contract with the American Medical Association in June 1972. The contract provided for a joint training experience for physicians and nursing home administrators on the medical director's role in the long-term care facility. The training was designed to coordinate awareness of the medical director's role with physicians serving in that position and with nursing home administrators.

I might say, Mr. Chairman, that I have attained a grant from HEW for the setting up of such a curriculum for the training of physicians as medical directors in nursing facilities.

During a 13-month period ending July 31, 1973, the AMA conducted 10 seminars, 1 in each HEW region. The seminars, focusing

on the role of the medical director, were attended by 1,533 health professionals, including 558 physicians.

Role of the Medical Director

Because little background information was available, the seminars were largely exploratory. We began with a preliminary set of guidelines on the role of the medical director and gradually developed a more comprehensive statement.

The early guidelines * recommended that skilled nursing facilities could be improved if each had a medical director with responsibility—

(1) To help define the scope and characteristics of the services provided at each level of care;

(2) To share in developing standards of care for each discipline such as nursing and rehabilitation;

(3) To help insure quality controls; and

(4) To assume responsibility for overall management and delivery of patient care services—by agreement with the administrator.

The more comprehensive statement ** of the council on medical service provides detailed guidelines for a medical director in a long-term facility. This report, approved by the AMA house of delegates at its annual convention in June 1973, affirms that "long-term care facilities should have either a medical director and/or an organized medical staff, to help insure the adequacy and appropriateness of the medical care provided to the patients in such facilities."

Experience indicates that physicians with patients in long-term care facilities seldom organize themselves into a formal medical staff, as they do in hospitals, because the mode of practice in the nursing home is quite different than in the acute general hospital. Therefore, it has been more usual that a medical director be appointed in the long-term care facility to perform the same tasks that the organized medical staff performs in the general hospital.

It should be noted that over 90 percent of the participants in AMA's seminars recognized the difficulty in organizing a medical staff and agreed on the need for a medical director in the long-term care facility.

Nevertheless, the AMA believes that the responsibility for the execution of patient care policies can be done equally well by an organized medical staff or a medical director. We have no preference, since both can provide the needed medical direction and supervision.

Government Willingness To Share Cost

Much concern was also expressed at these seminars about the willingness of the Government to share in the cost of a medical director. A draft of regulations for skilled nursing facilities was first distributed for public comment by HEW in July 1971. At that time, these facilities were called extended care facilities. That draft, and subsequent drafts, called for a medical director or an organized medical staff in each facility. If such a provision were to become a Federal

*See app. 3, item 4, exhibit A, p. 2641.
**See app. 3, item 5, exhibit B, p. 2644.

requirement, it would be logical to expect the Federal Government to pay its share of the cost of the medical director.

The Bureau of Health Insurance of the Social Security Administration currently allows reasonable compensation through Medicare, to be paid to a medical director in a skilled nursing facility when he performs necessary administrative duties. The amount of Medicare reimbursement varies, depending upon the number of Medicare beneficiaries in the institution. This seems reasonable.

State Medicaid reimbursement ceilings may have to be reevaluated if a Federal requirement for a medical director in a skilled nursing facility is established, since increased costs could be incurred.

We firmly believe that nursing homes cannot achieve standards of optimum quality care unless they strengthen ties with physicians. Such ties are needed for the more than direct medical services to patients even if they mean increased costs.

Physician presence and participation are also needed to exercise medical-administrative direction and perform other functions that properly fall to physicians. These functions are outlined in "Guidelines for a Medical Director in a Long-Term Care Facility." *

Following publication of the proposed rule for skilled nursing facilities in the Federal Register on July 12, 1973, the AMA submitted its comments ** to the Commissioner of Social Security, urging that the responsibility for overall patient care policies be the responsibility of an organized medical staff or a full- or part-time medical director. We continue in this position and are hopeful that this requirement is reflected when the final regulations are promulgated.

Mr. Chairman, this completes our statement. We are very grateful to have had this opportunity to present our views and will now be happy to try to answer any questions which the committee may wish to ask us.

Senator CLARK. Dr. Lorenze, you are obviously very active in the field of geriatrics. Could you tell us of the things the American Medical Association might be doing in the way of extending that interest or any activities in the association that might promote interest in geriatrics?

INCREASED PHYSICIAN PARTICIPATION

Dr. LORENZE. Well, I think that the AMA is firmly committed to the concept that one of the problems in the development of quality care in long-term care facilities is the necessity for increased physicians' participation and activity.

To some extent, one of the problems of the long-term care facility has been the fact that it has been outside of the mainstream of medical care. It is our concept and the concept of others that the development of the role of a medical doctor would bridge this gap, and integrate our physician services into these facilities.

As a matter of fact, I think that we would feel that you cannot in fact provide skilled nursing care without skilled physicians.

This is something of a myth. If the physicians are not actually involved in the care of patients, then one cannot in fact have skilled nursing care.

*See app. 3, item 5, exhibit B, p. 2644.
**See app. 3, item 6, exhibit C, p. 2645.

They intertwine and are mutually dependent.

The AMA, through the committee on aging and council of medical services, has tried to develop this concept.

They did so in conjunction with HEW in setting up a series of seminars around the country.

The AMA has reapplied to HEW, has applied to private foundations, and to a variety of national organizations to attempt to develop ways in which a continuation of the process of orientation, training, and delineation of this role of the medical director could be established.

Perhaps one of my colleagues would like to comment.

Senator CLARK. Well, with regard to that and the role of the medical director, does that impose any unrealistic increased burden on doctors, or could we move into that direction with speed, in your opinion?

Dr. LORENZE. This discussion always raises the question of the 10 bad nursing homes out someplace far away covering a four-county area in which there is no physician.

However, I do not think that is a model toward which we must work, and I think this is a problem with these guidelines.

In our experience in working—on the curriculum for the training of this medical director—we had the opportunity of discussing this in executive meetings, in open forums, with representatives of the Government, with representatives of medical and other healing professions, and with the representatives of those associations that are involved and concerned with overall problems of aging, and I think that we clearly came away with a recognition that the role of the medical director does in fact exist.

Certainly, in a facility of any size, whether he is called a medical director or not, this role, this medical administrative role for the development of patient care policies, or development of rules and regulations by which the physicians and others will conduct themselves within the facility, has been established, so I do not think we are talking about something which is not real.

It certainly is real in the larger facilities, it certainly is very real in the voluntary segment of the facilities.

MOVING IN OPPOSITE DIRECTION?

Senator CLARK. From your testimony, I assume you feel that the newly proposed regulations, HEW regulations, do not move in that direction, but rather in the opposite direction, is that a correct interpretation or not?

Dr. LORENZE. I think my feeling is, after having had the opportunity of looking at what apparently were suggested guidelines, which included a fairly well defined identification of the role for the medical director, which were distributed, and studied by a variety of groups, that I was shocked when the particular aspect was dropped.

I do not know the reason why it was dropped, nor has anyone ever given us any evidence that it would be an appropriate or invalid idea to have a medical director.

I think on the face of the matter, it is clear that this is the role. As a matter of fact, even in the guidelines as they are currently proposed,

there are many instances where the physician is proposed to help in the development of rules and regulations and other procedures.

What is obscure is how does he fit in the picture.

We think he could be designated as a medical director, and these very obvious functions of integrated service would come into play.

Let me point out, also, we are not thinking of this medical director as usurping the responsibilities of the administrator, or of the director of nurses, or of others in the organizational setup of the facility, but that he must bring a particular expertise to work with them in the establishment of programs of care which adhere more to the kind of organizational setup of delivery that we have within our hospitals.

I do not mean the atmosphere of a skilled nursing home necessarily to be that of a hospital, but the delivery system as far as skilled medical nursing care certainly should follow those guidelines.

Senator CLARK. Let me ask just one question. Generally, you spoke of increased physician participation.

Do you feel that if these regulations were to go into effect, you would have increased physician participation?

Dr. LORENZE. The regulations as currently proposed? No, I should not think so.

Senator CLARK. One last question. It is my understanding that this committee has done a questionnaire surveying 104 medical schools, and that only three were found to have geriatrics as a specialty.

Why is it Scandinavian countries and many other countries pay more attention to that? Do you have any general comments about that?

Dr. LORENZE. Yes, I think that a questionnaire to a medical school about whether they do or do they not have a department of geriatric medicine would yield the results which you mentioned.

In this country in general, geriatrics is not considered a specialty in the sense of our well-established specialties: that is, of internal medicine, of surgery, of orthopedics, and so forth.

GERIATRIC CARE—A SUBSPECIALTY

Geriatrics is something like pediatrics, and it runs across the board.

I think more in terms of geriatrics as a subspecialty of some of the other major disciplines.

In other words, many who are practicing internal medicine do it largely with the geriatrics population, many surgeons are involved, and from point of fact, the delivery of a vast amount of our health care is in the form of geriatrics care, in the sense that in most of our hospitals, the vast majority of surgery is provided for the people over the age of 65. So it is a feeling that geriatrics is an important consideration, very important, but it is not a specialty in the sense of the way our medical specialties are organized at present, that one should probably have a basic training in one of the fields such as medicine, surgery, orthopedics, and then if one wishes to specialize, subspecialize in geriatrics, that is fine.

Mr. MILLER. I have a question.

Dr. Lorenze, you have largely confined your statement to the question of the importance of a medical director in a skilled nursing facility.

As you know, and as you have heard this morning, the proposed

regulations have been criticized, or at least questions have been raised about them on a number of other aspects.

Do you have any comments about these other items, for example, the regulations as related to the level of skilled nursing requirements, and so forth?

Dr. LORENZE. Well, I would have this comment, as one talks with a variety of physicians and other people concerned with skilled, with long-term care facilities, one tends to get an opinion.

On the one hand, there are people who will say we need more nurses, we need more doctors, we need more intensive care programs for the patients, and then in the same group, you will have other people who say you do not need a doctor every 30 days, you may not need a doctor every 90 days, our patients do not require much, except feeding and bathing, and they are not going anywhere.

This has always surprised me to hear the varying points of view. What it reflects is that in our long-term care facilities we have a variety of patients with a variety of needs, and that they range from the patient who is bedridden to the patient who is not, who does not need much in the way of skilled nursing care, or skilled physicians services.

I think it is important that we differentiate between patients in terms of their needs, and that they be in the appropriate program or facility at the appropriate time in the course of their illness.

I think if we have patients appropriately evaluated as to their needs, then there will be some people who will require high levels of nursing care, and other patients who will not require as much.

Since we are talking about skilled nursing facilities, my general impression would be that what we should be concerned about is upgrading, as we are talking primarily at this point about those patients who require skilled nursing care, and skilled medical care. In general, I cannot speak for the AMA, but my own impression would be there seems to be a tendency to be less specific about the numbers of nurses, the ratios, and so forth.

Mr. MILLER. Your response would suggest that you share something of the concern previously expressed by the witnesses for the American Association for Homes for the Aged about both the intermediate care facilities and skilled nursing care facilities and the whole gambit of facilities that serve the long-term care patient, is that right?

Dr. LORENZE. I have not studied this in depth, but I have some feeling about it. It does seem to me in organizing a patient's care program, that moving to ratios of nursing levels would not appear on the surface to be a movement toward upgrading level of care.

There may be reasons for it.

30-DAY PHYSICIAN VISIT

Senator CLARK. In that connection, what do you think of the regulation of not requiring a physician to visit each 30 days, would you be for that regulation or not?

Dr. LORENZE. I think there are circumstances. As I described, there would appear to be patients in our long-term care facilities who, presumably on the basis of the judgment of the physician, or the facility, may under some circumstances not require the visitation every 30 days.

This seems to be so for a category of patients. This is difficult for me to accept. My own feeling is that if a patient is in a nursing home,

he should require more rather than less physician attention, but it depends a great deal on the particular case.

It seems to me in this situation, if we have patients who do not in fact require more frequent visitation by the physician, then perhaps that patient is not in the appropriate facility, and should not be in an extended care facility or in a skilled nursing care program.

I do not like to get hung up on the frequency of visitation.

Mr. MILLER. Could this bear any relationship to the competence of the nursing staff in the institution, and its ability perhaps to check with the physician by telephone?

Dr. LORENZE. I think this would be one of the factors. On the other hand, I would tie this role of the medical director into this discussion.

I think the fact the physicians are in the facility, or engaged in activities around the facility, even if they are not treating a specific patient, that this is the kind of thing that has a positive effect on the morale, on the nursing, and other staffs, on patients, and so forth.

If the physicians are not coming in, are not active, are not participating in the program, then you have the situation where there is general decline in morale, in enthusiasm, and of the level of care.

I think to some extent, having a medical director in the facility, who is actively involved in the organization of delivery of services, being around, even if he is not seeing a specific patient for a specific problem would meet many of the difficulties that we run into.

Mr. MILLER. In a sense, the medical director would be serving as ombudsman with high professional qualifications on behalf of the entire patient load in the institution, is that correct?

Dr. LORENZE. Yes. I would feel that all of the professionals who are involved in the care of the patients, the nurses, and more than that, the nonprofessionals, the aides, they are all involved in this. A breakdown at any level causes a breakdown in the whole system, but I think in any health care system, and it seems to me, that is what we are talking about in a skilled facility, that the physician's role is a crucial one.

Senator CLARK. Thank you very much.

Dr. LORENZE. Thank you.

Senator CLARK. We are going to hear next from Sister Marilyn Schwab, chairman, executive committee, division on geriatric nursing, American Nurses Association, Inc., and she is accompanied by Eileen M. Jacobi, executive director, ANA.

Welcome to the committee, ladies, and you may proceed in any way you feel appropriate.

STATEMENT OF SISTER MARILYN SCHWAB, CHAIRMAN, EXECUTIVE COMMITTEE, DIVISION ON GERIATRIC NURSING, AMERICAN NURSES ASSOCIATION, INC., ACCOMPANIED BY EILEEN M. JACOBI, EXECUTIVE DIRECTOR OF THE ANA

Sister SCHWAB. I am Sister Marilyn Schwab, R.N., OSB, clinical specialist in gerontological nursing, Benedictine Center for Nursing and Rehabilitation, Mount Angel, Oreg., and chairman of the American Nurses' Association Division on Geriatric Nursing. Accompanying me today is Eileen M. Jacobi, Ed. D., R.N., executive director of the American Nurses' Association. The division of geriatric nursing is one of the five divisions of nursing practice which ANA members

can select to join; 47,000 members of ANA belong to the division on geriatric nursing. The purposes of the division are to foster high standards of geriatric nursing practice—and I would like to submit a copy of the standards of geriatric nursing*—to stimulate interest in the nursing care of geriatric patients as a special area of nursing practice, and to promote clinical research and continuing education in the nursing care of the aged.

I appreciate this opportunity to share with you the concerns of the American Nurses' Association regarding the proposed regulations for skilled nursing facilities as published in the Federal Register on July 12, 1973. On behalf of the ANA, I commend the chairman and the subcommittee for conducting these hearings.

On August 7, 1973, the American Nurses' Association responded to the proposed regulations. Our comments were limited to a few specific standards we believed possible and crucial to change in the final regulations. We focused our comments on the requirements for registered nurses in skilled nursing facilities. We wish to reiterate at this time that a skilled nursing facility does not exist without an adequate nursing service comprised of registered nurses, licensed practical nurses, and nurses aides. Standards of patient care can be implemented only by adequate and appropriate nursing personnel. I would like to submit a copy of our comments on the regulations.**

We would like during this time to address ourselves to three major concerns:

(1) The skilled nursing facilities regulations (including relationship to intermediate care facility regulations);

(2) The definition of skilled nursing care; and

(3) Nursing personnel.

The American Nurses' Association contends that it is not possible to deal with skilled nursing facilities and intermediate care facilities as separate entities.

Emphasis on Restorative Nursing Care

The intermediate care facilities proposed regulations—published in the Federal Register, March 5, 1973—require individual plans for care. The goal of the care plan is to assist the individual resident to attain or maintain the optimal physical, intellectual, social, and vocational functioning of which he or she is presently or potentially capable. The skilled nursing facility proposed regulations specify awareness of and provisions for meeting the total medical and psychosocial needs of patients, including discharge planning, and the protection of their personal rights. Both regulations place emphasis upon active programs in restorative nursing care. These programs are to be directed toward assisting each patient to achieve and maintain an optimal level of self-care and independence. The separate proposed regulations for skilled nursing facilities and intermediate care facilities both indicate the range of professional health services to be provided for patients.

Skilled nursing facilities itemize the following:

Physician services, nursing services, dietetic services, specialized restorative services, pharmaceutical services, laboratory and radiologic

*See app. 3, item 7, p. 2646.
**See app. 3, items 8 and 9, pp. 2651, 2653.

services, dental services, social services, patient activities programs, maintenance of clinical records, and transfer agreements under which inpatient hospital care and other hospital services are available promptly.

Intermediate care facilities list the following:

Continuing supervision of a physician; restorative nursing care; a rehabilitative program directly or through arrangements with qualified outside resources consisting of at least physical therapy, occupational therapy, speech therapy, and audiology; arrangements for professional planning and supervision of menus and meal service of both regular and special diets; pharmaceutical services; effective arrangements for obtaining laboratory, X-ray, and other diagnostic services, routine and emergency dental care, pediatric services, optometrical services and supplies; social services; activity programing including opportunities for participation in activities outside the facility through community educational, social, recreational, religious resources; maintenance of resident records; and transfer agreements for hospital or skilled nursing care.

The requirements for professional health services are similar for both skilled nursing facilities and intermediate care facilities. The basic difference is the staffing requirement for nursing services.

ANA believes that guiding the innumerable activities which constitute restorative nursing requires broad nursing knowledge and skills, the exercise of sensitive clinical judgments, persistence when progress seems halted, and the ability to guide patients in forming positive attitudes and abandoning old habits. One of the most important prerequisites of a functioning program in restorative nursing is the capacity to plan and direct the work of all members of the nursing care team. Registered nurses are prepared by education to guide and direct the work required to meet nursing care needs.

The ICF proposed regulations require a health services supervisor on all days of each week. This person may be either an R.N. or an LPN, but in the event it is an LPN then the facility is required to employ an R.N. on a consultant basis for only 4 hours a week. The SNF requires that there be an R.N. at least 40 hours a week on the day tour of duty.

Multiple Rehabilitation Services

It is our contention that the classification of skilled nursing facilities and intermediate care facilities emphasizes who is providing service for how many hours per week and not on the needs of the residents of these facilities. The classification of intermediate and skilled nursing care facilities should be differentiated by the care needed by the patient. An individual who has had a stroke may need multiple rehabilitation services (speech and hearing, occupational, recreational and physical therapy, and restorative nursing), although able to manage his own personal hygiene, eating and dressing with minimal assistance. Another stroke victim may require assistance and instruction in self-care and be progressively moving toward an active rehabilitation program. And, still another person may need to be maintained at a minimum level of rehabilitation. These three different patients need services provided by registered nurses, practical nurses, and nursing assistants in different settings and with different intensity.

Active programs for restorative care demand that there be coordination of the different components of health services and provision for continuity in the absence of the specialty therapist, that is, when the physical therapist isn't present, the nursing staff must continue to carry out the care defined by the therapist. A care plan must be continuously evaluated. This demands the clinical judgment of the professional nurse.

Nursing is concerned with the total human response to disability, illness and/or disease. A common disease in the elderly is diabetes. The person with diabetes may suffer from weakness and apathy because of insufficient insulin or hyperactivity as a result of too much insulin. The condition can be volatile. It is possible to go from one extreme to the other within a 24-hour period.

The elderly diabetic may have concomitant cardiovascular and renal disorders. Hypertension, changes in vision, congestive heart failure, and parasthesis (loss of feeling) are other disorders found in the elderly diabetic. It is imperative that there be early recognition of signs and symptoms; knowledge as to what constitutes an emergency; when to put into effect emergency plans; when to call the physician; and when to transfer to an acute care facility. These needs require clinical judgments. The diabetic person can experience mood changes of irritability, apathy, and confusion. These are beyond the control of the individual. There is as much need for understanding and support as there is for the physical care.

It is important that food consumption compensate for the insulin intake and vice versa. Confusion, irritability and speech changes may accompany either impending insulin shock or diabetic coma. It is important that all nursing personnel recognize the need for food and for insulin as well as the signs and symptoms of impending shock or coma. The registered nurse must be sure all nursing personnel know how to detect the symptoms to take action. Teaching personnel is an ongoing activity.

The difference between professional and nonprofessional nursing care is often the difference between therapeutic and custodial care. To illustrate, a resident with loss of bowel and bladder control may be kept clean and dry. This is custodial care. Understanding why control has been lost; planning a training program with the resident and staff; understanding the feeling of both the resident and staff in dealing with this uncomfortable disability and assisting the resident and staff to cope with the unpleasantness is therapeutic nursing care. We believe that there is no such thing as custodial residents, only custodial care. The professional nurse is responsible for the quality of nursing care in the facility regardless of who gives that care. The R.N. maintains this responsibility 24 hours a day.

Proposed ICF Regulations

The ICF proposed regulations specify that "the numbers and categories of personnel are determined by the number of residents and their particular needs in accord with accepted policies of effective institutional care." They further specify that immediate supervision of the facilities health services on all days of each week is (provided) by a registered nurse or licensed practical (vocational) nurse employed

full time on the day shift. If the supervision of health services is provided by an LPN, consultation by an R.N. is provided at regular intervals but not less than 4 hours weekly. The SNF proposed regulations indicate "nursing personnel, including at least one registered nurse on the day tour of duty 5 days a week, licensed practical nurses, nurse aides, orderlies, and ward clerks are assigned duties consistent with their education and experience, and based on the characteristic of the patient load and the kinds of nursing skill needed to provide care to the patients." These regulations recognize that nursing personnel are prepared for different competency levels and that effective around-the-clock nursing care involves an appropriate blend of the competencies of nursing personnel and the needs of patients.

Our primary concern with these regulations is that some proprietors of ICF and skilled nursing facilities will comply with the letter of the regulations rather than their spirit or intent. There is no mechanism to insure that an adequate number of registered nurses will be employed when the proposed regulations specify "nursing service which is sufficient to meet nursing needs, . . ." and "including at least one registered nurse on the day tour of duty 5 days a week. . . ." or in the case of ICF "consultation by a registered nurse of not less than 4 hours a week." Minimum staffing requirements indicated in Federal rules and regulations have an uncanny way of becoming the maximum staffing patterns for many ICF's and SNF's across the Nation.

Nursing care could not be provided to people anywhere in this country without licensed practical nurses and/or nurses aides. Licensed practical nurses are essential in long-term facilities such as nursing homes. We are also concerned that minimal standards containing such statements as "a licensed nurse" can be interpreted to mean one licensed practical nurse particularly during the evening and night tours of duty. This is unfair to both the patients and the nurse. Each member of the nursing team makes a contribution to nursing care and as with any team each member is dependent on the other to achieve the goal—good patient care.

The need for preservice training of aides is almost self-evident. Care of the elderly is not a matter of simply applying a little commonsense. Knowledge and skill is required. As well as preservice training, continuous inservice training is a must. It is not either practical or feasible for small facilities to provide their own pre- and inservice training, funding—Federal funding—would be well spent to provide pre- and inservice training within a geographic area. At the present time ANA has a HEW contract to provide continuing educational programs for R.N.'s employed in nursing homes and the National League for Nursing has one for LPN's. It would be a shame if this Federal support was "one-shot" support. A long-range plan must be developed to provide support for such training on a continuing basis.

Majority are Long-Term Residents

In conclusion, I again wish to thank this committee for the opportunity to express our concerns. The patient in long-term care facilities are predominantly elderly people with either physical or mental health problems and frequently both. The average age is 79. Seventy percent are women, 32 percent of whom have never married. In a recent study in a nursing home, 50 percent of the residents did not have a next of

kin (even to notify in case of death). Seventeen percent of the residents have some mental disturbance other than senility. Approximately 60 percent of the residents are ambulatory but require some assistance or support. While 33 percent of the residents in these facilities come and go, the remaining two-thirds are long-term residents. Fifty-five percent have been in the facility between 1 and 5 years and 15 percent of the residents have been there 5 or more years.

Contrary to the popular belief that long-term care facilities are "dumping grounds" where children can dispose of unwanted parents, long-term care facilities are needed to provide care for people who cannot be cared for elsewhere. We need to upgrade this care and we need to find viable alternatives for those who could be maintained in other settings.

Senator CLARK. Thank you very much. One of the things that we have been particularly concerned about is the definition of skilled nursing care; one of the three areas you mentioned that you are particularly interested in.

If the statistics the committee has are correct, it would seem to me that we are going to have a tremendous shift from skilled to intermediate care.

Assuming the statistics that I have in front of me are accurate, 1 million nursing home patients are now considered under skilled care, and they would shift considerably to intermediate care.

That is going to have an enormous impact.

Does that, in your experience, seem to be somewhat accurate? Are you in a position to judge that?

Sister SCHWAB. If I may use a personal experience, the facility in which I am presently working is a 100-bed facility, and we have a 19-bed skilled nursing unit, the other 81 beds are intermediate care. In the skilled facility, we have Medicare patients, and we average about 8 to 10 Medicare patients at any one time.

The Medicaid program in our State never seems to qualify anybody as being skilled.

We have 32 patients in our facility that are presently in the Medicaid program.

Only three of these qualify (all three are young people, but none of the aging patients are qualified by their terms) as needing skilled care.

We believe they need skilled care.

We give them skilled care, but they are not classified as needing skilled nursing care.

I concur with the concern of several witnesses that there are going to be many, many patients left in limbo.

I estimate that something like three-fourths of the patients in our facility are neither covered by the description in the IFC regulations, or by the skilled type nursing care regulations.

Senator CLARK. Three-fourths?

Sister SCHWAB. Let us say over half, because they are very long term, very sick, and sick in the sense that they are not acutely sick.

They require a great deal of nursing care, and nursing time.

Someone said 4½ hours, the previous witness, and I would concur with that.

There are cases that require that much care over months and months and years.

They neither qualify nor look like the kind of patient in the intermediate care regulations, who seem to be up and around, he is in all kinds of things, but only occasionally he might need some nursing, nor do they qualify as skilled care patients. I would concur with what you have said, a vast majority of patients still left in limbo.

Few Qualify Under "Skilled Nursing Care"

Senator Clark. It seems to me we are talking a lot about skilled nursing care, and yet in my State of Iowa—we have gotten this from two sources of information, Blue Cross and Blue Shield, and the Iowa Department of Social Services—less than 1 percent of the patients would even qualify under skilled nursing care. We have around 100 patients in the whole State of Iowa that would qualify under those regulations.

It seems to me we ought to pay a good deal of attention to the definition of that term.

Sister Schwab. One of the gravest paradoxes to me is that one of the requirements, one of the criteria used, in defining whether a patient needs skilled care, whether he needs the services of a registered nurse around the clock, and if he does not need it at night, by somebody's judgment, he is said not to need such care.

It is said we do not need registered nurses around the clock.

Senator Clark. The problems of providing care to patients, other than acute care in hospitals, is obviously very complex, and it cannot be resolved in haste.

Would the American Nurses Association be prepared to form a committee of appropriate groups of nurses to report back to this committee, let us say in a year from now, at the latest, on the following issues: (1) A definition of skilled nursing care that could guide those in developing Federal programs; (2) how and where such care could be provided.

I would also like you to include alternatives to institutional care, what factors now inhibit utilization of such settings, and so forth, the kind of personnel needed to provide adequate care in the various settings, methods of reimbursement for care that will promote best use of funds for quality services, and training programs needed to assure a supply of up-to-date nursing personnel. Would you be prepared to consider that?

Mrs. Jacobi. I think the definition of practice has been given some attention, but I think we welcome this request, and we would be prepared to work diligently within a specific period of time to try to come up with some responses to these very complex issues regarding care of the aged.

Senator Clark. That is excellent.

I know on behalf of the committee, that they will be most helpful. I certainly do appreciate it.

Do you have any other comments?

If not, we thank you very, very much for your very excellent presentation.

Sister Schwab. Thank you.

Senator Clark. Our next witness is William Reichel, M.D., coordinator, information and consultation center, American Geriatrics Society.

STATEMENT OF WILLIAM REICHEL, M.D., COORDINATOR, INFORMATION AND CONSULTATION CENTER, AMERICAN GERIATRICS SOCIETY

Dr. REICHEL. Mr. Chairman, members of the subcommittee, ladies and gentlemen.

I am privileged to be asked to be here today to represent the American Geriatrics Society in this hearing concerning proposed regulations for skilled nursing homes.

As a background to my comments, please note that my past experience in geriatric medicine includes the following: I am a board certified internist in the practice of internal medicine and I am also chairman of a residency program in family practice at a community hospital, Franklin Square Hospital, in Baltimore, Md. This is one of the 173 American Medical Association approved residencies in the new specialty of family practice. I am also clinical director of a training program for physician assistants. This program is one of 28 American Medical Association approved training programs for physician assistants and it is directed to training a physician assistant in geriatrics. I am a member of the board of directors of the American Geriatrics Society and I am chairman of the public policy committee and chairman of the research and education committee of that society. I am the liaison representative of the American Geriatrics Society to the American Medical Association committee on aging and I have served on the AMA-HEW ad hoc committee on training of medical directors.

I am currently coordinator of the American Geriatrics Society information and consultation center, editor-in-chief of the newsletter of the American Geriatrics Society, and associate editor of the Journal of the American Geriatrics Society. As background, let me also mention that the American Geriatrics Society contains 7,500 physician members and is the largest society in the world concerned with geriatric medicine and the clinical aspects of aging.

With this as background, let me read from my recent editorial which was published this month in the newsletter of the American Geriatrics Society.

The editor of this newsletter wishes to point out that the American Medical Association committee on aging has recently concluded a series of 10 highly successful seminars on the role of the medical director in the long-term care facility. In 10 regions of the United States, physicians and administrators met together to identify ways in which physician leadership can work in improving patient care. Seminar participants agreed almost unanimously on the need for a medical director in a long-term facility.

It should be pointed out that any of the seminar directors and participants represented leaders and members of the American Geriatrics Society. It was the common consensus in these seminars that long-term care facilities should have either a medical director and/or an organized medical staff to insure the adequacy and appropriateness of medical care provided the patient in such facilities. Another recommendation which came out of the conferences included that if a long-term care facility has both an organized medical staff and a medical director, that the medical director should be appointed with the approval of the medical staff.

Conditions of employment of the medical director were suggested in these seminars. At the 1973 American Medical Association annual convention in New York City, the AMA adopted the above recommendations concerning the appointment of a medical director. Also, a suggested list of services which the medical director should provide was adopted.

It is gratifying that progress is being made in the effort to upgrade the level of medical care provided in long-term care facilities. I want to applaud the efforts of American Geriatrics Society members who have been closely involved with the evolution of the medical director concept—including Dr. Edward Lorenze of White Plains, N.Y., and Dr. Pierre Salmon of San Mateo, Calif., both members of the AMA committee on aging; Dr. Charles Beber of Miami, Fla.; Dr. Raymond Gladue of Baltimore, Md.; Dr. Jack Kleh of Washington, D.C.; and many others. I also want to recognize the leadership of Mr. Herman Gruber, secretary of the AMA committee on aging, who has worked several years in bringing about the acceptance of the above guidelines and recommendations. The efforts of all of the above individuals have contributed to insure a higher quality patient care in long-term care facilities around the United States.

This editorial expresses my views that the quality of care within our nursing homes would benefit from either a medical director and/or an organized medical staff to help assure the adequacy of medical care provided the patients.

New Approaches Suggested

At the present time, medical care within nursing homes is not within the mainstream of medical practice. Several models or new approaches have been suggested for bringing about systems in which physicians participate in peer review and are part of the total practice of the community. Dr. Pierre Salmon of San Mateo, Calif., has suggested that attending physicians at several nursing homes within a community might form a medical staff.

This is the medical staff equivalent.

In 1972, as chairman of a subcommittee within the Maryland State Commission on Aging, I developed with the help of Dr. Raymond Gladue and other associates, the concept that there might be a 1-to-1 relationship of an organized staff and/or medical director of a nursing home to a medical staff of a community hospital or to a local medical society. The appointment to the organized staff of a nursing home or the appointment of a medical director to a nursing home would be contingent upon approval by the executive committee of a community hospital or the local medical society.

If the medical director is concerned that a certain physician is not providing proper medical care and if he has tried to deal with this problem within his own institution, he has the option of seeking action from the executive committee of the local hospital.

In these two models, the medical staff equivalent and the 1-to-1 relationship, the nursing home would not be isolated but would be in the mainstream of the community's total medical practice. These new models will be of greater importance as Professional Standards Review Organizations (PSRO's) reach out to include review of medical care within long-term care facilities.

The Professional Standards Review Organization will work with much greater effectiveness if the work of physicians within nursing homes is integrated into the medical practice of the community.

A first step in this direction would be to require medical leadership by means of a medical director and/or organized medical staff.

Role of the Medical Director

What is the potential role of the medical director in relationship to new types of paramedical workers?

To me this is one of the most significant areas of hope within the field of long-term care. Perhaps certain duties within long-term care facilities can be delegated to nurse practitioners (nurses with an extended role in the field of geriatric nursing) or to physician assistants in geriatric medicine.

As I have mentioned above, I am presently directing a program which has 11 students in training to be physician assistants in geriatrics. This is possibly the first physician assistant in geriatrics training program in the United States.

It is clear that the physician is finding it difficult to care for the more than 1 million Americans who are confined to long-term care facilities. It is my belief that many of the duties of the physician in the nursing home could be best assumed under a nurse practitioner or physician assistant in geriatrics who is responsible to the medical director. This nurse practitioner or physician assistant directly responsible to the medical director would have the time to spend with the patient, would be able to check for early signs of new medical problems, and would be involved in the psychological and social problems of those whose lives have been disrupted by institutional care.

I wholeheartedly support the medical director concept, its importance in bringing medical leadership to long-term care facilities, and its role in peer review and in supervision of new types of paramedical workers.

What are the problems which exist in bringing this about as a reality?

In my opinion, there is one primary problem other than financial which must be faced if the medical director concept is to become real. I am reading now in part from my publication, "New Models in Geriatrics and Long-Term Care," published in the Journal of the American Geriatrics Society. First, there is a lack of university attention in the field of geriatrics and long-term care.

This area of medicine is similar to the area of family practice.

Medical schools, with their heavy emphasis on specialization, have neglected both of these vital areas of primary care.

The medical schools were not the first to move ahead in making family practice an important part of the curriculum.

Many of the strongest programs first developed in family practice at the community hospital level, for example, the excellent program at York Hospital in Pennsylvania. If some of the difficult problems in geriatrics and long-term care are to be solved such as finding suitable medical directors for our many nursing homes, then there will have to be a similar educational movement to bring geriatrics and long-term care into the mainstream of American medical education.

Second, there exists a negative attitude of physicians in regards to comprehensive care of the elderly.

We are in a tradition of ultraspecialization largely created by our university centers. There are specialists of the kidney, of the eye, of the mind, of the heart, of the lung, and of the skin.

We also need those who are interested in and want to accept responsibility for the medical care of the old, the incontinent, and the incurable. Many physicians tend to be interested only in the clinical problems of the elderly and are not willing to accept responsibility for organizing the total care of the patient, including long-term rehabilitation and continued nursing care when required.

There is a need for the real physician—one who is involved with the clinical, social, and psychological aspects of the patient, one who is concerned about how his patient's care is organized, and one who is willing to follow his patient's care after all else fails.

These two aspects are most important—the lack of university attention to the field of geriatrics and long-term care, and the attitudes of our own profession against caring for those who are incurable.

Greater Educational Opportunities

The answer to both of these problems lies in our system of medical education. There is a vacuum in our system of medical education in care of the elderly and chronically ill at the undergraduate, graduate, and postgraduate levels.

The American Geriatrics Society, since its inception in 1942, has attempted to bring about greater educational opportunities within our medical system at all three levels.

Though all three of these levels, the undergraduate level in medical school, the graduate level of residency and fellowship, and the continuing education phase are all important, it is felt that immediately the greatest of emphasis should be placed on continuing education in order to reach as many physicians as possible who are currently in practice. Of course, if we are concerned for the future, then we must also work at the undergraduate and graduate levels.

The American Geriatrics Society, as mentioned before, supports and applauds the efforts of the American Medical Association in its first 10 training courses of medical directors of long-term care facilities. Also, the American Geriatrics Society has developed its own continuing education series around the United States which is concerned with clinical, psychological, social, and organizational-administrative matters. In 1972, we went to the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare for support to get our continuing education programs started, but for lack of immediate funding, the American Geriatrics Society is attempting to develop its educational programs through its own means.

I want to recommend that consideration be given to continuing support for the American Medical Association training courses for physicians in practice to train physicians immediately for the role of the medical director.

Second, I want to recommend broadly that geriatric education at all levels—undergraduate, graduate, and postgraduate—be developed and encouraged in our medical education system.

The efforts of the American Geriatrics Society around the United States in developing postgraduate programs in geriatric medicine and long term care are one type of program which if supported, would do a great deal for the improvement of medical care of the elderly. As in the critical area of family practice, it is most important that Federal support be given to make possible this change in emphasis in our present system of medical education.

Is there need for a new type of medical specialist, for example, the medical director?

It is interesting that in Great Britain, geriatric medicine is recognized as a specialty and there are 270 specialists in geriatric medicine who run departments of geriatrics.

Birth of a New Field

We are at a time in medical history similar to that immediately prior to the birth of pediatrics. There are enough special and unique aspects of the care of the elderly to stimulate the birth of a new field with new forms and new models.

I would hope to see that our medical schools pay attention to this new field.

Do we need a new specialty as with pediatrics? Not necessarily. I personally recommend that each specialty, for example, internal medicine, family practice, psychiatry, and surgery, create a subspecialty in geriatrics as it pertains to that specialty.

Time will tell which form will develop, a new specialty or a subspecialty within existing fields. In medicine today, we see the need for a neonatologist, a specialist who takes care of babies in their first month of life. We might also need a specialist or subspecialist who takes care of the special problems of those in their last remaining months of life.

Mr. Chairman, I wish to thank the subcommittee for listening to my views. If the American Geriatrics Society can work with the members of this subcommittee in advising on how to best bring about the medical director concept, how it will effect peer review and the developing professional standards review organizations, how it will effect the supervision of new types of paramedical workers, and how to best accomplish the training of the new medical director, then we would be most happy to make whatever effort is necessary in providing our consultation and expertise.

Let me, though, reiterate that there is no question that our long-term care facilities need medical leadership—a medical director and/or organized medical staff—to help insure the adequacy and appropriateness of medical care provided the patients in such facilities.

Thank you very much.

Senator Clark. Thank you.

You and Dr. Lorenze of the American Medical Association both make a very strong case for the reconsideration of the proposal that we have of medical directors and, it is our understanding, that is under very active consideration.

I am just wondering in average size States, in view of the new definition, or of this proposed definition of skilled care, how practical that is.

I think it sounds like a good idea, but if our statistics are right, then we in Iowa, an average State in size, would have only 100 such patients, since we have 99 counties, I guess that would mean we would have one in each county that would qualify in skilled care.

Whether in States of that size, or smaller, where we have more geography than people in some cases, could that be applied with any meaning?

Dr. Reichel. You made that point previously.

I am in daily practice within a hospital, and these differences of skilled and intermediate care are not always real. These are semantic differences, and that is a separate problem.

I personally would recommend a medical director concept for institutions over certain sizes.

I think we are faced with the problem of diversity, and Dr. Lorenze referred to the problem of the small nursing home of 10 patients in taking care of 4 counties.

Larger Institution Concept

I am not certain where I would draw the line, but I am certain there is diversity in the United States, depending on urban versus rural and other factors. The medical director concept would create a pressure toward larger institutions, and it would require more study along that line. But I could see the real problem that smaller homes could not handle it.

Diversity according to geography and size of institutions would be a problem.

Senator Clark. Senator Percy, do you have any questions of the witness?

Senator Percy [presiding]. I do, Mr. Chairman.

Dr. Reichel, have you indicated the need for a full-time medical director?

Dr. Reichel. No, neither the American Medical Association nor the American Geriatrics Society have ever felt a need for full-time medical directors. We have stated a need for a part-time or full-time medical director, and/or organized medical staff, depending on the size of the home. Certainly the United States could not afford at this time a full-time director for all institutions, and I believe the question would be a part-time director for most institutions or facilities.

Senator Percy. How do you feel about nursing help, and the need for registered nurses?

Dr. Reichel. I indicated in my statement that I would like to see greater use of the nurse with an extended role a nurse practitioner.

I believe that they have much to offer. They are doing this to some extent already.

I would like to see it formalized, but again, I think there must be medical leadership.

As to the parts of the regulations, 5-day versus 7-day nurses, again, there are problems around the United States with diversity of urban versus rural, but I think we should set an ideal.

What is ideal is 7 days. We should strive for the ideal. Although I am certain there are many institutions in the United States that could not support that.

Senator Percy. I would like to get a little more expansion. In just glancing at your testimony, in which you talk about the need for a new specialty in pediatrics——

Dr. Reichel. In geriatrics, as comparing to the evolution of pediatrics some 30 years ago.

Senator Percy. Could you give us the benefit of the advantages that you have found through your studies in Great Britain, and tell us why in your judgment they seem to be so far ahead of us in providing necessary programs to take care of the elderly?

Dr. Reichel. I do not know historically why in Great Britain or in Scandinavia, but they seem to be ahead in areas of alternatives to institutionalization and their concentration on geriatrics.

In many countries, there has been a much greater emphasis on primary medical care.

Greater Emphasis on Ultraspecialization

I think we have seen in the last 20 or 30 years a greater emphasis in this country on forms of ultraspecialization at the university level. In setting models for our medical students, attention has been placed on research over basic primary care. But in the basic areas of family practice and geriatrics, I believe that there have been shortcomings, and as I cite in my testimony, I believe it is our university medical schools which have been at fault, with greater emphasis on ultraspecialists.

The statistics will bear me out on the shortages of primary care physicians. In the area of family practice, it has been dwindling, and only recently with the new efforts of the American Academy of Family Physicians, have there been signs of making it a vital thing again.

In geriatrics, there has been really no effort on the part of our medical schools to make it a specialty, or a subspecialty.

I have stated that I do not know if our system would allow another full specialty, because our specialty structure is quite fixed, between internal medicine, family practice, surgery, psychiatry, and so forth. However, I make the argument that if we have subspecialties in child psychiatry, perhaps we need a subspecialty in geriatric psychiatry.

Perhaps certain surgeons should have specialized fellowship training of 1 or 2 years in their field. So what I am saying, even if we may not make this a full specialty, because that would require a major change in our medical education system, at least that each existing specialty—internal medicine, psychiatry, and so forth—each existing specialty pays more attention to the area of geriatrics. It is a basic and most important area of primary care.

Senator Percy. Counsel has a comment.

Mr. Halamandaris. Dr. Reichel, I would like you to comment for the record, if we can go back to Senator Moss's long list of deletions from the existing standards. One of the existing standards was that the physician, if he was going to leave town, would make arrangements with another physician to cover his patients in his particular nursing home. That standard is now dropped.

Choosing a Physician

Likewise, a previous standard required the nursing home, insofar as possible, to allow the patient to choose his own physician. That particular requirement has been deleted.

Do you think it is important that nursing home patients should be allowed to choose their own physician?

Dr. Reichel. I think all Americans should be allowed to choose their own physicians, and I think the standards of nursing home care should be equal within the mainstream of community hospitals, and within office and clinic settings.

If a physician will be out of town, of course he should arrange for somebody to cover.

Of course, there should be a chain of command. If he is at fault, there should be a system of peer review, that would be able to provide medical discipline, and I see only one way of getting within the mainstream, and that is by having leadership in the form of a medi-

cal director, part-time or full-time medical director and/or organized medical staff.

Senator PERCY. Thank you very much. We appreciate very much your coming to testify.

Dr. REICHEL. Thank you.

Senator PERCY. Since I must leave soon, I would like to ask counsel if he will conduct these hearings, and whether there is authority for the committee staff to carry on the proceedings? I can stay for a quarter of an hour.

Mr. HALAMANDARIS. I answer both questions in the affirmative.

Senator PERCY. Thank you.

Our next witness is Roger Lipitz, vice president of the National Council of Health Care Services, and he is accompanied by Elizabeth Connell, director of government relations, NCHCS.

We are delighted to have both of you here, and if you would care to go ahead, please do.

STATEMENT OF ROGER LIPITZ, VICE PRESIDENT OF THE NATIONAL COUNCIL OF HEALTH CARE SERVICES, ACCOMPANIED BY ELIZABETH CONNELL, DIRECTOR OF GOVERNMENT RELATIONS, NCHCS

Ms. CONNELL. Mr. Chairman and members of the committee, my name is Elizabeth J. Connell, and I am director of government relations of the National Council of Health Care Services, based in Washington, D.C., with member companies throughout the country.

The National Council of Health Care Services represents a select group of taxpaying health care companies owning and/or managing nursing homes, hospitals, psychiatric facilities, clinics, pharmacies, home health agencies, surgical supply companies, homemaker services, and day care centers.

As a condition of membership the council members' facilities must be accredited by the Joint Commission on Accreditation of Hospitals where accreditation programs are in effect. The Joint Commission on Accreditation is a nongovernmental standard of quality care surpassing Medicare and Medicaid regulations.

Accreditation is voluntary and is a yardstick to the progressive facility that meets standards set by a professional, knowledgeable, nationally recognized group.

In addition, each member is dedicated to seeking innovative approaches to providing quality patient care in the appropriate cost-effective setting.

MAKING SYSTEM RESPONSIVE TO PUBLIC NEEDS

The council believes that proprietary, taxpaying, management-oriented health care companies can offer assistance in solving the problems of making the health delivery system responsive to public needs.

With me today to present the council's testimony is Roger C. Lipitz, president of Medical Services Corp., and vice president of the National Council. Mr. Lipitz is past president of the Maryland Nursing Home Association, formerly served as a member of the Maryland Medicaid Citizens Advisory Board and presently serves on the Maryland Licensure Board for Nursing Home Administrators.

Medical Services Corp., presently operates 17 nursing centers with over 2,200 beds. MSC employs over 1,300 people and is active in developing a hospital as well as experimental outpatient services.

Senator, we appreciate the opportunity to appear before your committee to discuss the vitally important subject of regulations for nursing facilities.

Mr. LIPITZ. I believe you all have copies of our testimony in full, and I am going to attempt to paraphrase the testimony as much as possible.

What prompted these hearings? We think they are being held out of a concern on the part of this committee and others that the standards now being developed by HEW for skilled nursing facilities and intermediate care facilities are not as good as they should be.

We understand that concern has been expressed from several quarters that nursing home interest groups were given an opportunity to comment on the proposed standards prior to their release to the general public or to consumer groups.

These concerned parties insist that any such early disclosure was completely improper and that it was in a large measure responsible for the allegedly low standards now being written.

We believe that industry should be heard during the regulation writing process. Experts both within and outside the industry must be consulted before and during the writing of regulations.

Not to do so is ludicrous.

I might digress for a moment.

I am sure very often, in drafting legislation, you Senators would like to consult the experts just as the Department of Health, Education, and Welfare has done in this case.

Bureaucrats cannot write regulations in a vacuum. This should not, however, preclude consumer groups and other interested and knowledgeable groups from having the same opportunities to have input into the writing of regulations.

On the question of the amount of impact which the nursing home industry's comments may have had, we ask why, if we so materially reduced standards, did the proposed regulations for intermediate care facilities published in the Federal Register on March 5, 1973, not include the National Council's recommendation to HEW, made in June of 1972, to require around-the-clock licensed nursing coverage in all intermediate care facilities?

POSITION ON REGULATIONS

We believe that if our influence on HEW was as great as has been alleged, this recommendation would have been included.

Our position on the regulations themselves is based on the following basic premises:

(1) We have stated over and over again that before one can evaluate the reasonableness of standards, the type or types of patients being cared for must be defined.

The National Council has repeatedly asked that this be done, and the Government has just as consistently refused. Thus, because the individual States have complete freedom to define and classify patients the same patients in one State might receive substandard care at a

substandard rate—vis-a-vis his condition—where in another State he might receive care at too high a level with too high a payment with regard to his condition. Again, the patient must be defined before setting standards and regulations for his care.

(2) Quality and cost must be inextricably and purposefully related to each other as standards for nursing facilities are developed, implemented, and enforced. Without adequate payment from some source, it is obvious that adequate standards for physical facility, staffing, et cetera, cannot be met by the nursing facility. As we all know, almost no effort has been made in this direction either legislatively or by Federal and State regulatory agencies.

Where quality and payment are not related, equally detrimental situations may result. In one instance, standards may be set too high to be met by the facility in relation to the amount of payment. On the other hand, standards which are set too low tend to perpetuate a too low rate of payment for the furnishing of appropriate care. We fear that implementation of section 249 of Public Law 92–603, which requires States to develop approved "cost-related" reimbursement systems for their Medicaid nursing home programs may perpetuate this situation.

If a State must pay on the basis of cost and if the cost of meeting that State's minimal or substandard regulations is low, then the State will not be able to or may be unwilling to materially increase payments to nursing facilities so that standards may be raised appropriately. We hope that some attention will be focused on this potential major problem.

(3) Safety standards, including fire safety in particular for facilities which house elderly, sometimes confused, and ill patients/residents—whether they are bedridden or not, must be the same whether the facility is staffed as a skilled nursing facility or an intermediate care facility.

Simply put, the Life Safety Code must be adhered to.

Final Regulations Not Published

(4) Almost 2 years have passed since the passage of Public Law 92–223, which transferred intermediate care to title XIX from title XI. Almost 1 year has passed since Public Law 92–603 mandated combining standards for skilled nursing facilities under title XVIII and title XIX. Yet, final regulations for both types of facilities have still not been published. There can be no justification for such a timelag between passage and implementation of legislation and promulgation of regulations in an area where sets of regulations were already in existence. Perhaps, in the future, Congress should mandate, as part of its legislation, a final date for promulgation of regulations to implement the legislation.

The proposed regulations for skilled nursing facilities and intermediate care facilities do not mention "distinct parts," implicitly leaving this question up to either the individual facility or the individual State.

The National Council strongly recommends that language be added to the ICF regulations specifically permitting the individual facility to determine whether or not to have distinct parts.

This should not be a State option, but may become one if the regulations remain silent on this point. Silence in the Federal regulations on this point may even leave some States with the impression that the Federal Government is requiring distinct parts.

An excerpt from the recently released report of the Maryland Govvornor's Commission on Nursing Homes (State of Maryland, July 1973, page 10) illustrates the potential harm to patients from enforcement of distinct parts:

> For the patient classified skilled and for whom a skilled bed is located, the problem of the pathological orientation is far from over. If he or she benefits from the care provided and the level of nursing care required drops to the intermediate level, more often than not the patient is forced to either move to an intermediate wing within the facility (thus having to leave the room and roommate with whom he is familiar) or in many cases, since the skilled facility may not have intermediate beds, to a home offering intermediate care. (Often this second facility may be on the other side of town, far from friends and relatives.)

The National Council of Health Care Services hopes that these hearings will be effective in directing public and congressional attention toward assuring that the regulations which are finally published will create uniformly high standards for skilled nursing and intermediate care facilities, which will assure the safety, comfort, and well-being of patients within those facilities.

With the above mentioned basic points as a reference, I would like to discuss some specific topics relating to the proposed regulations.

The patient must be defined before setting standards and regulations for his care. Neither the SNF nor the ICF proposed regulations make even a single effort in this direction.

Standards Are Confusing

Senator, before you got here, this point came up on several occasions.

If you look at the two sets of standards and consider those standards by the way they tend to stand by themselves, there is such a void between the intermediate care regulations and the skilled nursing care. It has been estimated by somebody else who testified, that over 50 percent of the patients technically might not fall in either category.

Whether they do or not, it is a decision left up to the States, because nobody has specifically defined what patients go in what facilities.

The National Council believes that the Congress took a positive step in this direction when it passed section 247 of Public Law 92–603, "Level of Care Requirements for Skilled Nursing Home Services."

We question why the Department of Health, Education, and Welfare did not at least use the definition of skilled care contained in section 247 when it wrote the proposed regulations, in light of congressional intent.

However, the omission of any definition of patient will probably have its most serious and harmful effect when applied to intermediate care facility regulations.

The National Council believes that one of the major defects in the proposed ICF regulations is the several different and sometimes conflicting definitions of the intermediate care facility patient which are suggested by various sections of the proposed regulations. Implicit definitions of patients describe patient/residents whose conditions range from ambulatory, mentally alert individuals capable of ad-

ministering medications to themselves and participating in community activities outside the facility (residential ICF) to blind, physically handicapped, nonambulatory mentally debilitated persons whose conditions range from mild illnesses to serious and incapacitating conditions (nursing ICF). The ICF proposed regulations, however, which were published in the Federal Register March 5, 1973, appear to be written almost totally to serve the needs of the "residential ICF" with little or no regard for the needs of the "nursing ICF" patient.

If this broad range of patients is indeed envisioned as the typical patient mix in an intermediate care facility (and we believe that such a broad range is wrong), then the National Council of Health Care Services strongly recommends that licensed nursing coverage for intermediate care facilities be required around the clock, 7 days a week, rather than the limited coverage required in the proposed regulations, section 249.12(a)(6)(1). Licensed personnel should always be present in case an emergency occurs.

We realize that this may present major difficulties for some very small facilities or facilities in areas where it is impossible to find licensed personnel, but we cannot justify a compromise here, where the health and safety of patients is so materially at stake. Perhaps the solution to this problem is to mandate two levels of ICF's to care for the two types of identifiable ICF patients and require only ICF's caring for "nursing" type patients to provide around-the-clock licensed nursing coverage.

Reflecting Congressional Intent

We understand the concern of the Department of Health, Education, and Welfare to write regulations for intermediate care which reflect the congressional intent. The Senate Committee on Finance, in its report accompanying the legislation transferring intermediate care to title XIX (Public Law 92–223), did indeed state that intermediate care was envisioned as a lower cost alternative to skilled nursing care.

However:

> In few areas is there more confusion among Federal, State, and local health officials than in the area of levels of care. It is evident that the current system and the accompanying payment mechanisms operate from a pathological model; that is, we pay for illness rather than for health. (Report of the Maryland Governor's Commission on Nursing Homes, July 1973, pages 9–10.)

We believe that compatibility between regulations and congressional intent can be established if the patient is defined and if the definition of the patient fits the regulations for the facility. The problems begin where the congressional intent conflicts with the definition of the patient to be cared for in the regulated facility.

Figures from a study made by HEW and dated November 13, 1973, indicate that some States pay as little as $6.53 per day (flat rate) for intermediate care under Medicaid.

Obviously, a nursing facility would find it impossible to deliver appropriate care to a "nursing ICF" patient for that amount of payment. If the Department of Health, Education, and Welfare chooses not to exert leadership on a Federal level to the States and accordingly keeps standards for intermediate care on a minimal level to mollify States, some providers, and to maintain a cost differential, then HEW must

also rigidly define the ICF patient to be only what the National Council has called the "residential ICF." All other patients, including those presently being cared for in ICF's who fall into the "nursing ICF" category must be immediately reclassified as skilled patients and their care must be paid for accordingly.

Senator PERCY. Mr. Lipitz, with your indulgence, because I have to leave in 5 minutes, and I would not have a chance to question you or elicit information before leaving, I will leave it to our majority counsel to decide whether you should finish your statement when I leave, or he might want to question you.

Whichever is done, the entire testimony will be put in the record, and I have read your full statement now, and I appreciate it very much indeed.

Of your organization, you are vice president?

Mr. LIPITZ. That is correct.

Ms. CONNELL. We represent, Senator, some 17 companies which have a total of about 50,000 beds.

Senator PERCY. Out of what total number in the country?

Ms. CONNELL. If you want to include residential care facilities, about 700,000.

We have purposely limited our membership to only those companies which are willing to meet the high standards imposed by the Joint Commission on Accreditation of Hospitals, which is higher than Medicare and Medicaid standards.

Senator PERCY. You have indicated it is a select group.

I think for that reason the committee would be particularly interested in your feelings about other facilities since you could have something of an objective viewpoint.

You are in the business, you operate them, you operate them under given conditions, and so forth.

Are you familiar with the hearings that Senator Moss and I conducted in Chicago?

Mr. LIPITZ. Yes, I am.

Senator PERCY. What was your reaction? How did you feel as a member of a profession against which shocking revelations were brought out in those hearings?

They were mentioned in your statement here. Without adequate payment, obviously adequate standards cannot be met. But with subpenaed financial statements, we revealed in the testimony the fact that some owners were receiving 40 to 50 percent profit on their investment, that they ballooned this into a fantastic sort of thing that they were literally serving garbage to people, scraping it off one plate to give to another.

WAREHOUSES FOR THE DYING

We have sworn investigators who testified. They went in posing as employees and were hired by these facilities. It was the Better Government Association, the operation watchdog that I formed in Chicago years ago, so I know these people, and I know their credibility. These facilities were termed by the Chicago Tribune as warehouses for the dying. How do you feel about those kinds of facilities? How do you explain the fact that while the majority maintains high standards, a large part of your industry engages in what looks like exploitation of

the poor, exploitation of the elderly poor for personal profit and benefit without any kind of humanitarian approach.

I am not saying a reasonable profit is not desired. We work on a profit system.

Mr. LIPITZ. I do not even tend to excuse individuals who really operate warehouses for the dying.

I will distinguish that specifically from nursing homes where people do frequently die.

That is an unfortunate aspect of our business, and we should not be criticized for it.

We are going to have a large percentage of patients who expire in our facility, that is inevitable.

The best as well as the worst, you will see that, but we should also have a lot of people that can return and utilize community resources.

We do that if we get an opportunity, but to deal specifically with this statement, I know our facilities, all of ours individually in the membership.

The first thing we do is avoid entering areas of this country, and there are many of them, that do not fit what we call the equation of matching a reasonable profit to a reasonable quality of care, and later on in the testimony, we even make that statement.

We call it an equation. We equate it very simply, that the type of patient, plus the appropriate reimbursement associated with that patient equals appropriate standards.

We devised it that way because we were discussing standards.

That is the truth, and you do not go into certain areas of this country, either because the Medicaid standard of payment is too low, for the regulations imposed, and you avoid that because if you do not avoid it, you could end up in the same box of accepting no profit or taking a loss.

I have no objection to reasonable profit. I object to the concept of huge profits.

Mr. Halamandaris is probably aware, I know he has done a study, the public companies in the long-term facilities, their gross margins have decreased over the years.

Their profits have gone up because their revenues have increased, but most of their gross margins have decreased.

WHAT CONSTITUTES REASONABLE COST?

More services are needed, patients are becoming more difficult, and a lot of businesses have furnished and done very well with reduced gross margins, but the other point, and I think the most important to make in terms of your broad approach to this is the question of what constitutes, what develops reasonable costs, and that is a problem that we are going to live with until we develop a system that prospectively looks at what costs should be.

If you go into Illinois today, into that same area that you studied, and looked at the costs of care, and you have just in effect said it, you could not justify increasing the rate of payment, based on the cost of operating that care.

You have to do it on a prospective basis and decide what the care should be, and then what it costs, and the Social Security amendments do not offer that opportunity.

All they ask for by 1976, is that we be on cost related.

That can perpetuate itself at the same level.

Senator PERCY. But did you share the same level of outrage that we did?

Mr. LIPITZ. I know how the problems can occur, I can understand how they can develop.

I cannot understand how anybody can live with that and take out large sums of money from the business.

Where we find the problems, we end up.

Senator PERCY. We were successful in driving some of them out of business. I would imagine that they knew I was making surprise visits to a lot of them on Sundays. After some homes had been certified, we went back to see if they really had come up to standards or if the changes were only cosmetic. I think we succeeded in making real changes and true progress.

You argue for the need to define the type or types of patients to be cared for.

What definitions would you recommend for the skilled or intermediate facilities?

Mr. LIPITZ. Yes, sir, we have defined them in two position papers, which we have submitted to the various agencies responsible.

Senator PERCY. Suppose then we just extract those and put them in the appendix of the record.*

Mr. LIPITZ. We will be giving this to you. We have them very carefully defined for the ICF patient and skilled patient care.

Senator PERCY. Do you support the recommendations made by Monsignor Fahey that we move quickly toward reimbursement on the basis of reasonable costs?

Mr. LIPITZ. Yes, if it is related prospectively as title XVIII does it now.

Senator PERCY. Do you have any estimate at all as to what reasonable costs would come to as far as what it would cost the taxpayer?

Mr. LIPITZ. I have not the faintest idea.

I could give you a pretty good educated guess in the States we operate in.

I know what our costs are, but I would say probably nationally, around 25 to 50 percent higher than the rates that public assistance is paying.

INCENTIVE PAYMENT SYSTEM

Ms. CONNELL. I might also add that the National Council is presently working on developing an incentive payment system under section 222 of Public Law 92-603, in which we hope we can develop some data to tell us what costs should be prospectively in facilities, and judge payment by that, rather than see runaway costs, with bricks and mortar and other things like that.

Senator PERCY. My last question pertains to recommendations that you have made for three levels of long-term care.

Is it possible for HEW to mandate two levels of intermediate care plus skilled nursing care, or would this require new legislation in your judgment?

*See app. 3, item 10, p. 2653.

Mr. LIPITZ. I know the law specifically allows States to have two levels of intermediate care. Not being a lawyer, I would not want to say whether or not that would allow them to mandate two levels of care, but certainly the option is there to push very hard in this direction if it could be mandated, but whether it would require new legislation, I am not positive.

Senator PERCY. I thank you both very much indeed, and I turn you over to our majority counsel.

I was extremely distressed at having missed the beginning of the hearings.

I left New York on the early morning shuttle so I would be here on time. But at the Foreign Relations Committee hearing we had no chairman, nor any other member of the Senate available to conduct hearings on confirmation proceedings that were extremely important. It was necessary for me to remain there, but I will review all of the testimony that was given here today.

This is a field of intense interest to all of us, and I must say that I have tremendous confidence in the staff. Knowing their devotion to the interests of the elderly, I have no reluctance at all in leaving the questioning temporarily in their hands.

I think the staff knows a great deal more about these subjects than the Senators themselves, and to conduct the hearing, we have an able majority counsel. Certainly all of us on the committee will pick up and read the questions and the testimony. We thank all of our witnesses very much indeed for being here.

Mr. HALAMANDARIS. Thank you, Senator. Thank you for those kind words.

Senator PERCY. It is praise instead of a raise.

Mr. HALAMANDARIS [presiding]. I sincerely doubt whether any of the staff knows as much about this subject as Senator Percy.

His expertise is well known, and I am delighted he was here even for this short time.

Mr. Lipitz, if I may, I would like to impose on you to finish your statement.

WHAT STATES ARE AVOIDED?

I was interested in something you said about avoiding certain States that do not meet your formula, and I would like you to comment on that, and specifically to name some of the States that you avoid. You and I had a conversation a couple of years ago in the cafeteria of the Senate Office Building, and I asked you the same question, what States do you avoid, which States do you go into; and I would like you to put your answer in the record.

Mr. LIPITZ. After I finish reading my statement, I will be glad to answer that.

Mr. HALAMANDARIS. Please go ahead.

Mr. LIPITZ. The National Council strongly recommends that both Congress and HEW begin a concerted effort to tie quality of service and cost/payment for that service inextricably together in both legislation and regulation.

To date, we have seen little effort made in this direction in Congress and none at HEW.

In fact, the functions of standard setting and ratesetting have traditionally been done in vacuums from each other, to the detriment of all concerned, especially the patient.

It is not too difficult to understand that without this tie-in, facilities may not have the financial resources to meet increased standards.

As we have previously stated, low standards work to maintain low costs.

And, under the cost-related reimbursement mandated for State Medicaid programs by 1976, low costs will maintain low standards, because where the cost of meeting minimal standards is low, then providers will not be able to get rate increases to allow them to increase standards.

Three factors must be related: The type of patient, the standards for his care, and the payment to be made for that care to that patient.

We think that an equation may be developed to illustrate this point: Type of patient plus appropriate reimbursement associated with that patient equals appropriate standards.

Take any of them away, and you are not going to have a balance.

Something will be out of kilter, and the person that suffers in the long run materially is the patient.

If tomorrow the State of Maryland, that we operate in, significantly changes their reimbursement formula downward because of some financial crisis, we will manage, up to a degree, to reduce our operating costs so we do not go out of business.

Anybody who comes before the committee to tell you they are going out of business, and they have been saying that for 2 years, something is the matter, why are they not out of business, because they have managed to survive, they may be losing money, they may be losing a little bit, but who suffers when you mess up that equation, the patient.

In setting high standards, the National Council believes that there is one major area where no equivocation is possible—safety from fire.

Life Safety Code Requirement

We strongly recommend that meeting the provisions of the Life Safety Code of the National Fire Protection Association be made a basic and unconditional requirement for both intermediate care facilities and skilled nursing facilities.

We believe that there can be no justification in terms of patient safety, for making fire safety standards any lower in intermediate care facilities than those required for skilled nursing homes.

As an example, I would like to describe a situation my company faced with one of our nursing facilities.

The Medical Service Corp. nursing facility in Catonsville, Md., is a converted structure which is sprinklered throughout, but which cannot meet some other conditions of the Life Safety Code, such as door and corridor width.

Medical Services Corp. believes that our company must set a leadership position and therefore decided to replace the facility with a new one.

Between the time we made our decision to replace the facility and the time of new facility's opening, scheduled for November 1, 1973, the State of Maryland said that the old Catonsville facility could no

longer participate in the skilled nursing facility program and would have to be downgraded to an intermediate care facility.

We ask—if the facility is too dangerous to house skilled nursing patients, why isn't it too dangerous to house intermediate care patients as well?

How can you distinguish?

In order to allow any facility that wishes to do so to install a sprinkler system or otherwise to meet requirements of the Life Safety Code, we strongly recommend legislation allowing long-term federally guaranteed loans covering the cost of meeting fire safety requirements be passed without further delay.

Certainly, we do not support the motion of exempting older, converted facilities from meeting Life Safety Code requirements.

It is these very facilities which are most in need of even greater fire safety measures and which are most often involved in the too frequent nursing home fires, such as the fire at the Washington Hill skilled nursing facility in Philadelphia, which claimed 11 lives.

It is one thing to exempt an intermediate care facility having only "residential ICF" patients who are ambulatory from such Life Safety Code requirements as corridor width and doorway width requirements, but entirely another to exempt any facility from meeting Life Safety Code fire rating or sprinklering requirements.

Further, an absolute but reasonable time limit ought to be established for compliance with provisions of the Life Safety Code. For too long now, HEW and the State agencies have been issuing conditional certifications to facilities giving them yet another period of time in which to meet fire safety requirements. This cannot and should not be allowed to continue. We hope that the administration is serious in its commitment to close down substandard homes, and believe that the lack of adequate fire safety measures is ample reason to do so.

Standards Should Be Strengthened

With specific regard to proposed skilled nursing facility standards, the National Council believes that these standards should be strengthened, not lowered. Now that these standards will cover both skilled nursing patients under Medicaid (mostly long-term patients) and patients in need of extended care under Medicare (generally short term and more acute), standards cannot be relaxed. We are, for example concerned that no requirements exist in the proposed skilled nursing facility combined standards for any formal arrangements between the skilled nursing facility and a physician adviser who would have delegated to him responsibilities for medical supervision in the facility and care for patients who do not have their own physician. This does not mean that skilled nursing facilities should be required to employ a staff physician, but does mean that there should be formal arrangements required between physician and nursing facility. We cannot imagine keeping ill patients, in need of constant skilled nursing care, in a facility not under the medical supervision of a physician.

Finally, we hope that the "new breed" nursing facility surveyor will become competent to assume the sophisticated judgmental functions required of him/her in the new regulations.

The new regulations, in not setting forth "factors" by which compliance with standards is to be judged, place a great deal of reliance on the competence of surveyors.

In the past, such confidence would not have been justified.

We hope that new training procedures and on-the-job experience will develop these sophisticated capabilities, because, without capable surveyors, regulations will be applied either too stringently or too loosely.

Neither is desirable.

The National Council questions whether presently existing surveyors now possess the training or ability to perform these functions.

We believe that existing training programs place too much reliance on classroom instruction and too little time is spent in on-the-job training.

The National Council has offered in the past, and now repeats that offer, to make any of its member companies' facilities available for on-the-job training of surveyors.

Hopefully, as surveyors develop the requisite competence, they will be able to assist facilities in evaluating the quality of care being given.

For example, surveyors could evaluate the nursing service of facilities to assure that skilled nursing facilities are at all times under the supervision of qualified licensed nursing personnel, in a mix appropriate to the needs of the facility's patients.

If I might back up a second, the question was asked whether or not there would be a problem in finding physicians to serve, and it will be a horrible problem.

It has nothing to do with rural or urban, and that is going to be a problem.

That does not mean that waivers cannot be granted, but it is another thing to drop the regulations, because it is going to be difficult.

We hope that the promulgation of high standards for nursing facility care will be accompanied with evenhanded, but strict enforcement of them, for without this, they are meaningless.

These comments have only scratched the surface of the many hours which the National Council of Health Care Services has spent in analyzing and developing a position on both the intermediate care and skilled nursing facility proposed regulations.

In order to truly understand the full position of the council, it is necessary to read the two position papers,* one dealing with intermediate care facilities, the other with skilled nursing facility standards.

I thank you for the opportunity to talk. We have spent many hours in the development of our position in detail of the ICF regulations, and we will be glad to answer any questions that you may have.

Mr. HALAMANDARIS. Thank you for an excellent statement.

I would like you, if you would please, to answer the question that I asked before, to give us some specific States that you might go into if you owned a series of corporate nursing homes, and what States would you stay away from?

*See app. 3, item 10, p. 2653.

Unsatisfactory Care in Some States

Mr. Lipitz. One of the things I could tell you now, since the time I talked to you, I have not been as close to individual operations as I used to be, but a generalization can honestly be made that fixed rate States tend to produce a level of care in our opinion that is not satisfactory.

That is not always true, and fixed rate has a lot of connotations to it.

You might call Texas fixed rate, but it has three rates.

You might call Illinois fixed rate, but it has an individual patient rate in terms of the point system.

The reasons fixed rates are inappropriate is that they are not looked at in terms of cost relating prospectively.

I am all for fixed rates if it goes to the cost of care.

The Southern States general, the Deep South, but not Virginia, North Carolina; they usually fall into the other category, but States in this category usually present all kinds of problems, and we have avoided them.

The Midwest with some exclusions, Colorado.

Mr. Halamandaris. Because of the reimbursement system?

Mr. Lipitz. Yes. They are fixed rates that are not related to costs. Colorado has a ceiling.

Mr. Halamandaris. Am I correct, that Colorado allows you a profit, guarantees you a profit, something like 89 cents per day?

Mr. Lipitz. To the extent your costs do not go above their maximum ceiling.

I do not know what the Colorado ceiling is. Let us assume it is $17.50; if a nursing home cost is $20, they still only get $17.50.

If this cost is $16.50, excluding the profit factor, they will get $16.50 plus 80 cents.

Mr. Halamandaris. I think we can agree Colorado is a desirable State from that point of view, if they might want to expand, and Illinois might be a desirable State because of the point system—the higher the rate of reimbursement, the better.

Mr. Lipitz. It is a generalization.

There are pockets of Illinois so high cost, because of their urbanization, that the general maximum rates, or the average rates that all patients tend to flow to.

Mr. Halamandaris. Let me throw a few others at you.

Is California a desirable State because of the union reimbursement?

Mr. Lipitz. I do not know anything about California. We do not know anything about California. We do not have any facilities.

Mr. Halamandaris. Michigan, Wisconsin?

Mr. Lipitz. Michigan is good. Wisconsin is good; the concept is good, but, as I remember, their ceiling is a little too low.

Mr. Halamandaris. And, of course, Virginia, it is not too bad at the present time?

Mr. Lipitz. Right, and the complexity of the problem has become so great, since intermediate care has become such a viable program, and one of the first things our research people bring us back, they say this looks like a terrific reimbursement program, we find out like in Iowa, the way they identify the patient, everybody seems to be in intermediate care.

Mr. HALAMANDARIS. Recently, the State of Pennsylvania upped their rates to $20 maximum for skilled care. Do you think anybody would be interested in going to Pennsylvania?

Mr. LIPITZ. Finally, yes.

I think the State of Pennsylvania has created this monster by their inadequate formula.

Mr. HALAMANDARIS. How would you rank Pennsylvania before the increase in rates?

Mr. LIPITZ. One of the worst. You have to look at the average rate scale; $12 can be OK in one place, and be too low for another.

Mr. HALAMANDARIS. Could you single out some other States you would not advise going into?

What about the State of New York?

Mr. LIPITZ. I know the reimbursement formula makes a lot of sense.

I assume it would be all right.

I know the reimbursement formula has a lot of validity in it.

Mr. HALAMANDARIS. I know there are people from New York here and people from Pennsylvania.

Mr. LIPITZ. I knew they were here.

Mr. HALAMANDARIS. I have another purpose. I am trying to build a record which relates to a report we are about to issue.

ADMINISTERING MEDICATIONS

I note that the new regulations dropped their requirement that they had previously contained, that only licensed personnel could set up and administer medications.

The Medicaid guidelines which were even more explicit were also dropped.

The Federal regulations and guidelines pointed out that unlicensed personnel could not pass medications. This applies to Medicare and Medicaid as well, and we also have some Nurse Practice Acts which say the same thing. That is, that unlicensed personnel should not set up medications. I wonder if you agree with me that the new regulations are a substantial loss in that they allow unlicensed personnel to set up and distribute drugs.

Mr. LIPITZ. I believe it is a loss. We did not get it in those terms. We are interested in this, but we did not look at these recent ones. but we did not like the old regulations in that they were inflexible.

A lot of our companies have pretty darn good in-service training programs, pretty valid, and we have trained people in the past, unlicensed people who under the supervision of a licensed nurse were quite capable of giving regular type doses of medication.

We are losing that flexibility, and we have taken away an opportunity for them to perform a lot of skills.

We need controls in the area of medication. I personally do not believe it should be so stringent to say only licensed personnel, but, you see, all regulations should produce a quality, so that if the quality is not there, whether it is being done by a licensed person or unlicensed person, a survey ought to be able to determine that and insist the quality be improved.

Ms. CONNELL. I think also it might very well be possible to draw a distinction between traditional methods of passing medication and unit dose systems.

Where you have good unit dose systems of medication, you could probably easily apply a lesser level of skill at the patient's bedside, out of a well-marked package and put it into the patient's mouth.

Mr. HALAMANDARIS. You make a good point. I am sort of telegraphing what we are going to do when HEW comes in tomorrow, we are going to quote some statistics about drugs being administered, that 30 or 40 percent are administered in error, and then we are going to ask HEW why the standards have been watered down.

I do not know how they are going to answer that.

I just happen to think this is one of the critical problems.

Mr. LIPITZ. The thing we have to avoid at all cost, we have to avoid it in our company, and nationally, that somebody who takes a look at a set of standards, even if it says R.N.'s 7 days a week, and they check that off, that they have got good nursing care, but they must look more carefully.

Mr. HALAMANDARIS. My question is whether you would prefer to have specifics, or whether you would prefer to have generalities for nursing home standards.

GENERALITIES HARD TO ENFORCE

I know from a lawyer's point of view, it is difficult to enforce generalizations.

If you go into court, and you try to sue a nursing home because of a violation of a standard, and the standard requires "adequate care." One can only wonder what constitutes "adequate care?" Proof would be difficult or impossible, but if it says 2.25 hours of nursing time per patient, per day, and so on. You can find out whether that standard was met, and you can enforce it.

Mr. LIPITZ. I respect that problem.

As an operator, I want flexibility, but as a lawyer, I can understand your concern for specifics.

Mr. HALAMANDARIS. The new regulations are generalization with too much flexibility. They are so flexible it is questionable whether there is anything left of the original standards.

Mr. LIPITZ. I suspect there is an area to give us some flexibility, and yet accomplish a more specific regulation.

I am sure there are things we could do in that area to compromise on both, and produce a pretty good result.

Mr. HALAMANDARIS. I hope so.

I want to thank you both for appearing, and I think we will get onto our next panel.

We appreciate very much your being here and allowing us to question you.

Mr. LIPITZ. Thank you.

Mr. HALAMANDARIS. We will next hear from a panel composed of George Warner, M.D., director, bureau of chronic disease and geriatrics, State of New York; Frederick Traill, chief, division of health facilities and standards, Michigan Department of Health; and Marx Leopold, general counsel, Pennsylvania Department of Public Welfare and assistant attorney general.

STATEMENT OF GEORGE WARNER, M.D., DIRECTOR, BUREAU OF CHRONIC DISEASE AND GERIATRICS, STATE OF NEW YORK

Dr. WARNER. With your permission, I would like to capsulize the written statement which has been sent to you. I also have a few extemporaneous remarks which I would like to address, one of the core issues which has been touched on this morning, the relationship of costs to standards.

The three points we attempted to make in the written position statement furnished to you are about: (1) The SNF standards themselves as they appeared in the July 12, 1973, issue of the Federal Register; (2) the concerns we have with section 247, the statutory definitions of level of care requirement now applicable to both Medicare and Medicaid; and (3) our concerns about the rulemaking procedures used by HEW in developing standards such as those that appeared in the July 12 publication.

On the first matter, the standards themselves, there were two concerns expressed by representatives this morning, both of them highlighted in great detail.

First, is the watering down of the requirement for nursing services. We feel as do many of the representatives themselves, that this does not reflect the current pattern of what is happening, and what has been occurring in the last 4 or 5 years in the long-term care arena.

I will mention a few of the events that have occurred.

(1) Old facilities are being replaced with new ones; (2) small facilities are being replaced by large ones; (3) to an ever-increasing extent, facilities are located closer to hospitals; (4) patients are being referred earlier from general hospitals to long-term care facilities for continuation of this care.

They are being referred with more serious, more complex illnesses; they are being referred earlier; the nature of their care needs are more complex; and placement demands on the long-care institutions to meet patient needs is greater.

VARIETY OF CARE FURNISHED

Also, there is the increasing development of geriatric complexes, where, within one campus type of setting, a whole series of levels of care are being furnished, ranging from hospital care to residential facilities.

In view of these kinds of trends, it seems a very inopportune point in time, indeed, to attempt or to even consider watering down the requirements that are imposed, and were intended by Congress to be imposed, on that level of institution which is next to the hospital level.

The apparent watering down of the nursing standards certainly is to be decried.

The second area touched on this morning is the lack of requirement for medical direction in long-term care institutions.

I use the term "direction" to distinguish it from the "medical director," on the basis there are many ways of meeting requirements for the needed medical care and medical surveillance and control in these facilities, in addition to the employment of a part- or full-time medical director.

Both Dr. Lorenze and Dr. Reichel referred to one of the alternatives, namely, the appointment of a medical staff, or a medical board, or medical executive committee that makes medical and related policy for the institution.

It would be our hope that these two portions of the standards would be strengthened, and that patients in long-term care institutions at this level would, therefore, have the benefit of some assurance of good quality care.

I would like to turn to the second topic that concerns many State agencies and many providers as well, a topic referred to this morning, namely, the hazards that potentially are inherent in section 247 and in the interpretations thereof.

As we all know, this section sets a new definition of "skilled nursing services" and adds to this definition the term "skilled rehabilitation services," in order to qualify patients for their Medicare benefits.

Whether it was done by intent or by afterthought, this section also applies the same definition used for title XVIII beneficiaries, that same definition of what the patients' needs must be, to determine, now or very shortly, whether or not patients are eligible for Medicaid SNF benefits.

We see very severe problems. One of these already has been referred to, namely, the overrigid or inflexible interpretation in regulation or policy form.

Second, and perhaps more seriously, we see the identical application of section 247 to both the Medicare and Medicaid programs as causing or potentially causing or requiring the wholesale reclassification of institutions, or the wholesale reclassification of huge portions of institutions. Along with this and because of the requirements of section 207 (which as you may recall, mandates differentials of reimbursement between SNF's and ICF's on statewide basis), we see the need for States to make large-scale revisions of their rates of payment to individual institutions or for the care of individual patients within the institutions.

The provisions of section 247, as currently understood, we think have the potential for causing almost sheer chaos in the long-term care field.

Reclassification of Nursing Home Patients

It was mentioned earlier that 700,000 out of 1 million long-term care patients until now were classifiable as needing the skilled nursing facility level of care with the other 300,000 deemed in need of ICF care. Predictions this morning were that section 247 could reclassify the numbers of persons needing skilled nursing or skilled rehabilitation services from 700,000 down to 100,000 and thus cause reclassification of 600,000 nursing home patients to the intermediate care level.

We can envision the problems posed to State surveillance agencies and to the intermediaries of Medicare and Medicaid in trying to tailor their payments to a continuous shifting of population from one category of care to another.

What the solutions are or should be, we do not feel at this point in time as having the wisdom to determine.

We would simply like to point out that these portions of Public Law 92–603 have very serious connotations, particularly to the patients and especially it should be required that patients be moved en masse from

one institution to another, or even from one distinct part to another distinct part of that same institution.

Incidentally, free choice of institution by patients, and patient's rights may have some role, and perhaps should be viewed in looking at this matter.

The third set of topics to which we would like to address ourselves are the rulemaking procedures used by HEW for developing and promulgating standards in the heath care field.

We would like to cite examples of how the rules are developed properly in some States, in order to contrast them with methods used in developing rules and promulgating them at the Federal level.

State agency staffs prepare early drafts. These are sent out in wide distribution to all parties and all agencies concerned with or affected by the rules.

Distribution includes the organizational representatives of practicing medicine and other health professions, the organizations representing the institutional health care providers, the regional planning agencies within the States, the State health planning commission itself, consumer organizations concerned with the effects of the rulemaking process, and others. All such parties should be and are provided full opportunity to furnish feedback, at least in written form. Quite frequently prolonged nose-to-nose negotiating sessions are held when the State representatives and the organizations and individuals concerned disagree about specific items in the standards.

As a result of this kind of process, there often are numerous modifications of proposed regulations before they become near-final. In the process, they have had the benefit of full public exposure and full public view.

At this near-final point, there are requirements in some States that the proposed rules must go to the State legislative body along with careful staff analyses of the cost impacts, the reasons for need for each particular rule or regulation proposed, the long-range effects on the State itself and on the State economy and the anticipated effects on the consumers, especially on the users of the health facilities.

Rulemaking Conducted Openly

Only when all these steps have been completed are the rules finally adopted and promulgated by the appropriate agency, often the State board of health in the case of standards for health care providers.

I cite this example primarily to note that rulemaking in many States at the State level is conducted completely in the open and by conferral and involvement of all parties concerned.

This has not been our experience with rulemaking procedures at the Federal Government level. In particular, we feel compelled to note that State health agencies are required by section 239 of the Federal law, and by prior Federal legislation to be the organizations that implement these Federal requirements, particularly in the health care industry. State health agencies, per se, have not had a meaningful role in drafting, modifying, and reviewing Federal regulations.

We believe the much-vaunted Federal-State partnership has been suffering from neglect. We believe it is time for "creative Federalism" to have its day. These should be full State-Federal partnerships with HEW in the rulemaking process. Going a few steps further in rule-

making, completely open, public processes are needed and consumer organizations and the professions also should take part.

Those are the three major points I wish to make.

I would like to turn to the cost area, and the relationship of spiraling health care costs in the long-term care field to what has been happening historically in the last 4 or 5 years.

Concern has been expressed by HEW and by Congress that high standards will up the costs.

Costs of long-term care have been cited as having increased astronomically in the last 4 or 5 years.

We would like to point out that there are many factors that have contributed significantly to these increases.

Monsignor Fahey referred to them as "catchup" factors. I think that is an excellent term.

First, certainly there were major changes in the financing and eligibility criteria with the advent of Medicare and Medicaid. Major changes in the responsibility of relatives to pay for the health care of their elderly also occurred.

Certainly, the elimination of relative responsibility added enormously to the tax burden and bills for the Medicaid part of long-term care.

Another cost additive "catchup" factor is the replacement of old facilities with conforming new institutions. This has meant the replacement of old institutions whose realty costs were practically entirely amortized with new institutions in which realty costs are much greater and significant proportions of total costs of operation.

Replacement of Old Institutions

We have also seen and encouraged the replacement of old institutions with new ones that now have more and better space for services such as rehabilitation therapies and activities programs, better and more space in patient rooms, more spaces for nurses and other staff to work, and that contain many other improved environmental features in addition to simply conforming to fire safety and structural codes.

Until all older unsuitable facilities are replaced, there will be these disproportionate environmental catchup costs.

Another catchup cost has been with wages and employee benefits. In New York State, for example, one round of labor-management negotiations, settled at a given point in time approximately 3 years ago, increased by 30 percent the cost of inpatient health facilities care overnight.

Certainly labor in the health care spectrum has been a disadvantaged group in the past. We can expect more and very significant catchup costs of this kind in the future.

Another catchup cost is adding enough facilities and beds to meet the needs of the elderly for inpatient health care services.

For example, in New York State, we have moved from having 42,000 nursing home beds 7 years ago to the present time of having 62,000 beds.

The opening of new beds, additional beds other than replacements and modernizations, to meet needs of our populace for the skilled nursing facility level of care have been an enormous catchup cost.

Improvements and utilization of more modern equipment is another catchup cost.

There also have been large-scale sociologic and demographic factors functional in our society; namely, increases in the numbers of elderly, and among them increases in numbers of sick elderly requiring institutional care.

We have already observed, and in very direct ways, the changing clinical characteristics of patients using these long-term care institutions (that is, sicker patients being transferred earlier to SNF's from hospitals). The cost of care are greater for sicker patients.

In a few States, there have even been minor factors such as catchups in Medicaid billing and payments for care.

The final item in this list of catchup costs is improvements in quality of care in relation to existing standards and the enforcement thereof (1970 and previous in Medicaid and 1967 in Medicare). We still are in the midst of this catchup process and have a ways to go yet with some institutions. The costs of this part of the catchup are modest, indeed.

We would editorialize at this point by saying that, of all the cost increases which have contributed to the supposedly horrendous total increases in the public bills for long-term care services in the last 5 years, increases in standards, as embodied in amended Federal and State laws and regulations, have played a very small part.

Increases in the total bill for long-term care attributable to other catchup costs eventually will do just that—level off, stabilize, and for the most part, be caught up. These increases in catchup costs are probably unavoidable now and for at least several years ahead so long as it is social and public policy that there must be sufficient, safe, acceptable and accessible facilities and services for the long-term inpatient care of our sick elderly.

Trends Cannot be Halted

In light of these historically recent and continuing events, it seems contrary to social and public policy to try to reverse these trends. They have led and still are leading to the replacement of bad buildings with good ones, of inadequate payments for care with fair payments, of substandard wages and benefits with decent ones, and of insufficient supplies of facilities, beds, and services with more adequate resources. Irreversible trends such as the increases in the numbers of sicker, older people requiring care certainly cannot be halted, nor can improvements in the science and costs of health care readily be slowed or reversed.

Two avenues seem to have been singled out for controlling the presently spiraling costs and public payments for long-term care. One is to attempt to define artificially by Federal statute (and regulation) what the clinical health care needs of sick elderly people must be in order for their care to be reimbursable out of Medicare and Medicaid funds. We predict this method of control is unworkable because laws and regulations cannot adequately describe and define the complexities of chronic illness conditions among older people which cause them to require institutional services. Judgments as to the needs of each patient should and must be the responsibility of each patient's physician in collaboration with the other health care professions, backed up by normal reasonable controls over utilization.

The other method, apparently, is to attempt to control costs by amending the standards governing the operations and quality of services provided by long-term care facilities. Since operational standards bear little relationship to catchup costs, the holding of standards to marginal levels or their downward modification will have little or no effect on the still spiraling public bill for long-term care services.

We see the need, then, for better recognition of the extremely important role of the catchup factors which have been, are, and will be causing great increases in the public bills and payments for long-term care. At the same time, we see the need for maintaining, improving, and implementing standards which govern quality of services but not for artificially categorizing human beings and their needs through the statutory and regulatory rather than through the individualized professional judgment of physicians and other health care workers in relation to each patient.

Thank you.

Mr. HALAMANDARIS. Thank you very much.

I really wish that Senator Moss could have heard that statement. I think I got the salient points down. First, higher standards are needed, and second, that there are other factors that do go into increasing nursing home costs besides compliance with standards.

ARE MEDICAID RATES ADEQUATE?

I want to ask you, as an expert in the field, in your participation, in your organization, the State and territorial health officers, is it your opinion that Medicaid rates tend to be adequate, inadequate, or how would you categorize them, or can you generalize?

Dr. WARNER. I think here I have to sit back and wear another hat, that is, representing our own State health agency in New York State.

In New York State, as I am sure you know, all health facility rates are established on a prospective, cost-related and cost-controlled basis. For the most part, and I am not sure all of our friends will agree with us, but for the most part rates are adequate.

There have been certain cost constraints imposed, and some facilities claim to have suffered from these.

Mr. HALAMANDARIS. You talk about the rulemaking procedure.

Basically, you suggest HEW's rulemaking procedure be more open, that it be made more public, is that the thrust of your comment?

Dr. WARNER. Yes.

We do recognize, especially with the attempts to implement the many, many provisions of Public Law 92–603, that the Federal agencies are under very serious time constraints, pressures from within HEW and from Congress itself, and pressures from the public to get regulations out promptly. There may not be sufficient time to go through the complex kind of public rulemaking that I described somewhat earlier.

Despite this, and in view of the fact some shortcuts can be made, we would still plead for rulemaking as an open, public process.

Mr. HALAMANDARIS. Let me ask you one more question. We focused this hearing on two problems, on nurses, and how many nurses there are, and nursing standards, whether it should then be 7 days a week or 5 days a week. There seems to be a consensus of opinion that there

should be 7 days a week coverage. There also seems to be a consensus of opinion that we need some medical direction.

Would you agree if HEW came in here tomorrow, that all of a sudden we had a requirement for a medical director, and that we had 7 day a week nursing, that would be the end of the problem, with the regulations?

I would postulate that there are some significant standards that have been deleted and watered down and need to be put back in.

Do you share my view that probably the most important problem would still be untouched, that is, this section 247, the definitions of level of care?

Dr. WARNER. That is a complex of questions.

Let me respond to the question with regard to rulemaking, that it is sufficient to correct the situation.

The answer is no!

Someone earlier this morning addressed himself to the fact that there are 10-bed nursing homes still in existence, I hope not very many, but there certainly are 20-, 30-, and 40-bed nursing homes in existence. There are some in New York State and in other States. There are some located where there are no physicians in practice. Therefore, the simple passage of regulations is not enough.

Regulations must somehow take into account availability of manpower and other problems as well as facility size.

ALTERNATIVE TO "YES OR NO" AVENUE

We do feel, however, that in the regulatory approach in trying to secure informance, there are alternatives to the straight out "yes or no," compliance or noncompliance avenue. There are other routes which HEW can take, and which some States take. First is to require high standards, and second is to flexibly apply the standards to specific situations where the facilities may encounter problems.

Let me cite three of these flexible alternatives. One is to establish each standard as a high level requirement, but to make that requirement applicable only when there are patients who need that particular service.

Rehabilitation therapy is a good example. If it is needed, then it ought to be furnished by people who are properly licensed. If no patients need such services, the standard is not applicable.

This has to be linked to a requirement that the facility not admit a patient if it cannot provide the service for him, or if he is admitted, to secure as promptly as possible his transfer to another facility which can furnish the service he needs.

The intense application of the periodic medical review process can help assure that each patient's needs are matched and that each institution is furnishing the services its patients need.

Second is to permit the State health agency some flexibility in granting exceptions to the requirements.

For example, in a rural area, where the nearest hospital or high quality nursing home is 40 or 50 miles away, a small nursing home may be an absolute necessity. It may be serving a well demonstrated though limited public need.

That small nursing home certainly should not be exempted from any Federal or State requirements that have to do with life safety of patients. However, it might be exempted or excepted from certain requirements for furnishing sophisticated services and be confined to furnishing of simple services. Some kind of exception process or authority is needed. Applying this would require very close collaboration, highly professional collaboration, between the State and Federal agencies.

A third approach is to provide in the regulatory route for equivalencies.

For example, in some areas where there are shortages of physicians, and physicians are not available to perform certain medical functions, or to actually visit their patients, an equivalents process could be provided for.

HEW is strongly encouraging programs to develop a core of manpower in the form of physicians' associates or physicians' assistants.

There have been trials, successful already, of the use of these physicians' assistants to visit patients in nursing homes on behalf of physicians.

This is an equivalent. Maybe it is not as good as a visit by the medical doctor, but in certain circumstances, it may be better than having no visit at all.

So we feel that the equivalencies, and exceptions routes in regulations are ways of meeting problems of the nonapplicability of high standards.

With these kinds of avenues available, there are even less excuses for low standards to certain kinds of nursing homes under special conditions in certain geographic areas.

Mr. HALAMANDARIS. Let me ask you what section 247 is going to do to the State of New York?

How many skilled patients do you have, and how many do you have to the ICF's?

I know there are no final figures, but whatever you can give me would be appreciated.

Dr. WARNER. In 1972 we did reviews of some 48,000 Medicaid beneficiaries in nursing homes in New York State. Using the common definition of what the need was for skilled nursing care at that time, we found inappropriate placement ranged within the rather narrow limits of 3 to 12 percent.

WHOLESALE RECLASSIFICATIONS EXPECTED

In a situation in which between 88 and 97 percent of the patients, depending on the region of the State involved, were found to require skilled nursing care at that time, what section 247 will do, we do not know. A great deal will depend on the implementing regulations and what they say. It is clear that we could expect wholesale reclassifications of a majority of patients who we and the facilities found in need of skilled nursing care to some other lesser level of care and payments if the section 247 definition is applied strictly.

Mr. HALAMANDARIS. Just to illustrate, it is a serious problem we are talking about, and I am sure you are aware of some of the studies that have been done documenting transfer shock. When you transfer individuals from one facility to the other, you get a high instance

of death, and I think it happened in California, and we documented this in August 1972.

There were some articles from the Los Angeles Times that were in the record, which related to the effect of the transfer of patients from skilled to intermediary care in California. One reporter found out that 32 patients had died that were transferred in a short period of time. I would ask you if you anticipate this happening in other States and in New York?

Dr. WARNER. Yes; and studies in facilities in New York State show the same kind of increases in mortality rates, of increases in clinical disturbances and in conditions that are emotionally based, and so forth. The mortality rates studies show this can happen due even to moving patients within different parts of the same institution. We certainly can anticipate problems.

We hope this type of wholesale transfer and reclassification can be avoided.

Mr. HALAMANDARIS. To emphasize, do you think that is the most critical issue facing us today in terms of the standards that we have in section 247, the way it is defined?

Dr. WARNER. Yes!

Mr. HALAMANDARIS. We thank you very much, Doctor.

Dr. WARNER. Thank you.

[The prepared statement of Dr. Warner follows:]

PREPARED STATEMENT OF DR. GEORGE M. WARNER

Thank you Senator Moss, distinguished members of your subcommittee on long-term care and your staff for providing this opportunity for representatives of State health agencies to be heard on skilled nursing facility standards and closely related matters.

For the guests of this subcommittee, its chairman, Senator Moss, and its members and staff, I first will identify the source and concerns of this testimony. I am Dr. George M. Warner, director of the Bureau of Chronic Disease and Geriatrics of the New York State Department of Health. In presenting this statement today and in responding to your questions, I am wearing two not-dissimilar hats: (1) As a full-time staff member in charge of the unit in the department of health in which many of the concerns of New York State government with long term care institutions and their health services are focused; and (2) as the elected president of the National Association of Directors of Health Facility Licensure and Certification Programs, an organization of professionals who, like me, are concerned and responsible at the State governmental level for health facility and health service standards and their implementation in the 50 States and other U.S. jurisdictions. This interstate association is an official affiliate of the Association of State and Territorial Health Officers. The latter organization, ASTHO, is designated by Federal statute as the agency which works with the Federal Government in developing, implementing and modifying Federal health policies and programs.

I am a physician, licensed to practice in New York State, and qualified by training and experience as a specialist in preventive medicine and public health, in which specialty I am certified by the American Board of Preventive Medicine and Public Health. My subspecialty interests are in chronic disease and geriatrics, subject areas in which I have had over 20 years of experience. Some of this has been in the clinical care of chronically ill and elderly patients, some of it in the training of the medical nursing and allied health professions and some of it in the administration of medical care and standards programs. I have worked for voluntary agencies as well as for government at the local, State, and Federal level.

There are three subject areas to which this testimony will address itself:

(1) Federal standards governing the provision of institutional long-term care services to the chronically ill and elderly and the relationships which these standards should have to the needs of the users of services and to the current and future trends among the providers of services;

(2) The hazards of certain provisions of Public Law 92–603 governing definitions of the levels of services provided by specified categories of long-term care institutions and governing the levels of needs of their users; and

(3) Problems with the processes used by Federal agencies to draft, review, and implement Federal regulations and policies affecting State agencies, long-term care institutions and the services they provide, and other parties.

To place these three subjects in proper perspective, it may be helpful to examine the current status and changing roles of long term care institutions in our health care systems. Several salient points are:

(1) Federal legislation adopting the 1967 edition of the Life Safety Code of NFPA is forcing or should force the decertification and closure of many small, nonconforming, nonfire resistive, hazard facilities. If HEW's regulations and policies remain firm regarding the interpretation of these structural and safety standards and regarding the issuance of waivers, the structurally substandard and unsafe skilled nursing and intermediate care facilities shortly will be eliminated from the scene.

(2) Long-term care institutions that have opened in the last several years and new ones now under construction are larger than those of the past and presumably completely modern and safe. They provide not only more suitable patient rooms and nursing service areas but also much better and more adequate space for support services such as the rehabilitation therapies, patient activities, and other much needed programs.

(3) With the advent of administrator licensing in 1972 and the spelling out of the responsibilities and accountabilities of facility administration and management there already are marked improvements in the expertise and professionalism of operation of these institutions.

(4) Many newer facilities are located in close proximity to other health care institutions and centers (such as hospitals, medical arts buildings, etc.). Such locations along with considerable improvements in the substance of the affiliations between long-term care institutions and the more acute facilities have brought chronic illness care out of limbo and more centrally into the health care scene.

(5) Earlier transfer of sicker patients from hospitals to nursing homes has been occurring and increasing. This has increased the demands on long-term care facilities for more sophisticated and intensive services (such as for oxygen and inhalation therapy, better restorative nursing and more professional and intense physical rehabilitation services, etc.).

(6) There is early evidence of some improvements in physician attention to and care of long-term care patients. Part of these modest improvements hopefully reflect increasing concern in the medical profession for the geriatric portion of medical care practice; part may reffect some improvements brought about by periodic medical review and medical inspection activities in some States.

(7) There is increasing recognition of the need for and increasing growth of geriatric center complexes, especially in urban areas, which furnish services and levels of care ranging from the chronic disease hospital level through the skilled nursing and intermediate care facility to protective environment housing and residential living arrangements—all collected together in campus type settings. A few such complexes also now are furnishing or planning to furnish extention services in the form of day-hospital and day-treatment programs, clinics, meals on wheels, and home health agency services (or certain modifications thereof) for the chronically ill and elderly in the surrounding community.

Changes of the kind just described are occurring, rapidly in some instances, in most parts of the United States. Nevertheless, it must be recognized that needs for small, less complex long-term care facilities still exist and will continue to exist for some years in sparsely populated areas, particularly where small communities are far apart and where there is little or no public transportation or where weather conditions at certain periods of the year make auto transportation difficult. In such situations there is little, if any, reason for continuing to certify and recognize facilities that are actually or potentially hazardous from the structural and fire safety viewpoints. However, there is good rationale for recognizing and certifying small institutions that offer less than full range of services and that have difficulties meeting the detailed, technical requirements of standards that are most applicable to large, modern facilities.

We believe there are several useful methods for requiring high levels and wide ranges of services from the larger, newer institutions while accommodating to the fact that the smaller, simpler and less urban type facilities will be needed for some time to come. We believe these accommodations can be expressed in

Federal regulatory language and that minimums can be set that will not reduce the expectations of and requirements imposed on the larger, more sophisticated institutions. We believe the regulatory minimums should be based on what the roles of the large, modern institutions should be rather than being geared to the small rural institutions.

(1) One such method is to combine two techniques. First of these, in regulatory form, is to require that, when and if the facility offers a specific service, the person directing or providing consultation to that service must meet certain minimal professional qualifications and that each service itself must meet certain acceptable standards. For example, if a facility offers or arranges physical therapy, the PT service should be under the direction of or with consultation by a qualified, registered physical therapist and the therapy services themselves should be administered properly and by reasonably qualified personnel. If the facility does not provide or arrange any physical therapy, the standard would be "not applicable." The second linked technique is to require that a facility unable to provide or arrange certain specific services needed by individual patients not admit or retain such patients unless the facility can modify its operations and become able to meet each identified patient's needs. The periodic medical review and medical inspection, required by title XIX is one of several very potent ways of determining whether or not a specific facility assays the specific needs of each patient and provides or arranges specific services appropriately in response thereto.

(2) A second method, expressable in Federal regulations, is to allow State health agencies (those responsible for health facility surveillance and certification) some latitude in professional judgment in applying Federal standards. One might refer to this as Federal and/or State "exception" granting authority. Regulations could specify the conditions under which "exceptions" to or modifications of specific Federal regulatory requirements could be granted. For example, a small nursing home offering limited services in a small rural community may be needed and may play an important role in that community and the surrounding areas, even though its services are quite limited. Such facility could be "expected" from certain specific requirements under condition that the State health agency furnish adequate data to demonstrate that (a) there is need for the facility to continue in operation, (b) it is accepting only patients whose needs it is capable of meeting and (c) patients having needs for more complex and sophisticated services are identified and are transferred to more distant, larger institutions more capable of meeting their needs. Such "exception" process would require a high degree of professionalism at the State and Federal level and close State-Federal collaboration.

(3) The third method suggested is to permit long-term care institutions to furnish "equivalents" in services that are nearly as good (and practically as well protected as to quality) as the services which the Federal regulation itself requires. The leading example might be approval of the use of physicians' associates or qualified nurse practitioners to visit patients and provide clinical supervision on behalf of physicians in those instances where there are demonstrated and serious shortages of physician manpower and inability of the facility to meet the physician visitation and care requirements. Again, as with the second example given above, State health agencies and providers should be under the onus of having to document the physician shortages in each specific situation, assure that the nurse practitioner or physician's associate is properly qualified and assure that there is consultation and review of the clinical problems of each patient by a properly licensed, qualified physician, even though he may personally visit the facility only infrequently.

The same "equivalency" principles could be applied in nursing services, the various rehabilitation therapies, dietary services, nursing home administration and in other areas. It does seem more practical and in favor of better quality of care to recognize and certify this "front line with backup" kind of arrangement than to unnecessarily lower standards simply because there are small, isolated institutions that cannot meet higher requirements. It should be emphasized that documentation and professionalism at the Federal and State governmental surveillance level are vital to the successful application of this method.

We turn now to the three issues which seem of considerable importance in the long-term care scene at the present moment. Each will be described and discussed briefly, not necessarily in order of importance.

The first is the combined title XVIII–XIX proposed rulemaking for skilled nursing facilities as published in the Federal Register, July 12, 1973. Two problems should be highlighted, we believe. One is the watering down of the nursing

service requirements and the other is the absence of any requirements for medical direction and medical supervision of physician care furnished to patients in these settings.

Regarding nursing services, we are somewhat alarmed by the publication of Federal draft regulations containing the subminimum requirement for the services of a registered professional nurse in the facility for only the day tour of duty only 5 days a week. Despite other strengthening language in regulation 405.1124, this RN part of the nursing services requirement is far below the level at which it should be to assure sound, safe, professionally supervised nursing care for each and every patient. In many nursing homes in New York State (and in many other States we understand) there is demonstrated need for an RN on duty and in charge of each nursing unit for each of three shifts per day, 7 days per week. Nursing, along with dietary services, is one of the most important if not the most important products of skilled nursing facilities. Clinically demonstrated patients' needs for good nursing care is the principle reason, presumably, why they are referred and admitted to nursing homes. This point in time, 1973, when such institutions have become more complex, larger, and more sophisticated seems hardly the time to reduce nursing service requirements.

To accommodate to problems with nurse manpower and nurse staffing in small facilities in sparsely populated areas, regulations could well allow for some "exception" or "equivalency" without substantially lowering and watering down Federal standards which previously already were at their minimum levels.

The modern nursing home is greatly in need of physician direction and physician supervision. Findings from over 125,000 periodic medical reviews and medical inspections done in New York State in the last 18 months clearly indicate that the leading problems faced by skilled nursing facilities are in obtaining good quality physician care for their patients. Such facilities need to establish and implement sound ground rules governing the physician care of their patients. Administrators and directors of nursing in long term care institutions cannot assure that physicians perform properly unless they have medical leadership and involvement of organized medicine.

The American Medical Association, with funding and program support from the Public Health Service and other sources, recently completed a series of ten regional conferences dealing with the subject of medical direction and the roles of medical directors in skilled nursing facilities. In each of these ten regional meetings, and as an overall output from all of them, there were continuing pleas for the establishment of medical direction requirements and hundreds of very meaningful clinical stories about the benefits derived for patients (and for the institutions as well) when well formulated medical policies were adopted and good medical direction and supervision over physicians' services were furnished.

Support for instituting this kind of requirement has come from the agencies representing the various elements of the nursing home industry, organized medicine itself, from State health agencies and a number of other quarters. The absence of such a requirement is particularly disappointing in light of the fact that medical direction provisions were said to have been a part of previous SNF Draft Regulations prepared by HEW staff.

The watering down of the requirement for each physician to review and revise each of his patient's program of care on a once every 30 days or more often basis also is disappointing, although the regulation stipulates that such lessening of visits cannot be permitted until at least 90 days after the patient's admission. Again, we note that the increasingly complex and more sophisticated nature of the facilities, along with the more intense levels of illness and needs for services of their patients, seem to warrant equal or higher, rather than lesser, requirements. We also note that the "exception" or "equivalency" approach might be used to accommodate to and recognize those situations where medical direction and frequency of medical visitation requirements are difficult or impossible to meet.

Other notes about the July 12, 1973, publication are that:

(1) Federal regulations still fail to recognize the due process rights which are required by statute in most States;

(2) The regulations are praiseworthy in that they tighten the controls over pharmaceuticals which may be prescribed and used and strengthen controls over the dispensation and administration of prescribed medications;

(3) The social service provisions, in the absence of a needed statutory base (eliminated by Public Law 92–603) are quite well written but still point out the need for congressional restoration of social service requirements in the law;

(4) The provisions relating to facilities meeting standards applicable to buildings used by physically handicapped persons are commendable as are the establishment of square-feet-per-bed minimums for multiple and single patient rooms;

(5) Utilization review continues to be extremely confusing and overlapping with parallel provisions presumably to be implemented by PSRO's, State Medicaid agencies, or others;

(6) Further, the UR requirement imposes costly and difficult, if not impossible, review provisions that are expected to be unproductive.

In the second issue we address ourselves to the hazardous features of "section 247 level of care requirements" of Public Law 92–603. On this subject I am pleased to make available to you, Mr. Chairman, and to subcommittee members, copies of an analysis and report prepared earlier this year by representatives of health, Medicaid, and other agencies from 10 States. These States were urban and rural, industrial and agricultural and geograhically representative of the various regions of the United States. The report later was approved and adopted by the Association of State and Territorial Health Officers and other organizations.* It was forwarded to the HEW Secretary and to the administrators of the principal HEW agencies concerned.

Section 247(a) seems intended to liberalize the skilled nursing facility benefits available in the title XVIII program. The specific language now permits a beneficiary to be clinically eligible if he needs services "provided directly by or requiring the supervision of skilled nursing personnel." It also permits eligibility if the individual needs "skilled rehabilitation services" rather than or in addition to, nursing care.

Generally, State agencies, SNF providers and intermediaries welcome these liberations of the Medicare benefit. They seem intended to reverse the restrictions placed on title XVIII long-term care services by fiat in 1968.

However, section 247(b), whether by intent or afterthought, applies precisely the same title XVIII definition of level of care requirements (used to determine Medicare patient eligibility) to Medicaid patients to determine their SNF benefit in the title XIX program. This seems to mean that if a clinical determination has been made that a Medicare beneficiary no longer needs skilled nursing facility care, there is no Medicaid benefit or payment available for continuation of his care at the SNF level. Yet, in our view many or nearly all such patients continue to require skilled nursing facility level of care, sometimes for months after the more acute phase of their illness has come under control, sometimes even for the remainder of their institutional lives.

Strict and identical application of the 247 (a) and (b) definitions strongly suggests or arbitrarily requires that the patient be moved to another institution or to a different part of the same institution or that the level of payment for his care be decreased the moment a fiscal intermediary determines that he is no longer eligible, clinically, for Medicare Part A benefits and payments. Was it congressional intent, in such instances, that the title XVIII intermediaries control title XIX patient placements and benefits? Was it congressional intent to remove clinical judgments and determinations from the hands of patient's physicians and UR committees in the title XIX program?

Nowhere is there recognition in section 247 or elsewhere in Public Law 92–603 or in preceding Federal statutes that many or most chronically ill institutionalized elderly require services provided under the 24-hour-a-day supervision of professionally qualified nurses, even though they may not need direct provision of skilled nursing services "by or requiring the supervision of" an RN. The intermediate care facilities, by statute and proposed regulations, are not required and essentially are prohibited from functioning at the level where they might provide 24-hour-per-day nursing supervision. It might be proper to question, then, where do the patients go and what do the State Medicaid agencies do about payments when patients are found no longer in need of the title XVIII benefit?

State health, Medicaid and other agencies foresee and fear mass chaos. We can expect and predict, we believe, that we will have to reclassify entire nursing homes or large, distinct parts thereof en masse as intermediate care facilities. The wholesale shifting of patients and of personnel within institutions also is a possibility. Continuing attempts to readjust Medicaid payment rates are envisaged because of the stautorily required differentials between skilled nursing facility and intermediate care facility rates as spelled out in section 207. Or we may encounter another kind of confusion in setting a differential rate for each

*See app. 3, item 11, p. 26S4.

patient and in changing levels of payment for his care each time his level of care needs intensifies or decreases during the fluctuating course of his illness.

We urge that these and other potentially very serious effects of section 247, especially of the (b) portion of that section, be reviewed and analyzed very carefully by Congress. The repeal of section 247(b) might be one way of averting a potentially disastrous situation in most States and among most long-term care provider institutions. Probably there are other alternatives.

Certainly, the diminution or elimination by statute of the clinical judgment of physicians, nurses and social workers about the care needs of their chronically ill and elderly patients cannot have been the intent of this leigslation. Whatever the intent, it would seem that less and less consideration is being given to the health-related social and emotional needs of the institutionalized elderly. Decreasing credence is given to the professional judgment of health care providers and to the fact that most chronic illness conditions in older people are not stable, static conditions. Rather, they are complex illness problems that fluctuate day to day, require continuous professional attention and supervision, and do not lend themselves to "purist" definitions that are in turn linked directly to payment mechanisms.

The third area of concern is about the Federal regulatory drafting, clearing and reviewing processes. From the viewpoint of the State health agencies, the aura of secretiveness has intensified to the point of near-complete frustration. For example, draft regulations in the skilled nursing and intermediate care facility arenas have been held so close to the vest by HEW that State health agencies have been unable to obtain information as to their intent, content or details until their first publication in the Federal Register. Yet, these same State health agencies are required to apply the regulations to the provider institutions. State government is given only the same routine courtesy of 30 days to respond to the Federal Register publication as are the provider organizations and other interested parties—hardly time to formulate interstate responses that take into account the variations of conditions among the various States and the effect of proposed regulations on various kinds of providers, their patients and other interested parties.

An even more important point is that State health agencies, as agents of HEW in implementing regulations, have a wealth of experience in devising health facility standards, in applying them to providers and in determining what is or is not workable in practice. Because of what seem like tight security measures, the benefits of State experiences apparently are not available directly and during the drafting process to HEW staff. The aura of mystery and secretiveness cretainly is not in keeping with Federal assurances about needing and wanting useful Federal-State partnerships.

We would like to describe briefly the process used in many States for drafting, clearing and promulgating health care standards. Early drafts of new standards or amendments to existing ones are prepared by State agency staff, often after meeting with or requesting suggestions from provider organizations, consumer groups and other parties concerned. The drafts are distributed widely to provider organizations, regional and statewide planning agencies, intermediaries and carriers such as Blue Cross and Blue Shield, other State agencies involved (directly or indirectly), the medical nursing and other professions and consumer organizations. Written responses, at least, are requested. In many instances, State agency staff meet in prolonged negotiating sessions with the provider organizations and other groups.

Quite frequently the proposed standards go through many revisions in response to the wealth of information which flows into and is considered by the State agency during these processes.

When the standards or their amendments are in more nearly final form, they then go to the officially designated advisory or standard-making agency (such as a State board of health, or State hospital council or some equivalent thereof) for information purposes. In some States, the near final (but still draft) standards go to the State legislative bodies. Several States, such as New York, require by law that each proposed standard or amendment thereof must go to the legislature and that it must be accompanied by State agency staff analysis as to the need for the standard, its effect on the target group to which it is directed, its financial implications for State budget (or other sources of revenue) and its long range implications.

These kinds of processes assure that State standards and amendments thereof are in the public domain and under full public scrutiny almost from the first moment of early drafts until they finally are officially adopted and become part of the codes, rules or regulations of that particular State.

The above described processes require intense staff work plus patience, professionalism and time. We recognize the time constraints imposed on HEW agencies, especially in connection with the tight deadlines of many provisions of Public Law 92-603. Nevertheless, we believe the long-range benefits of doing business in the open and spending time in doing it carefully far outweigh the disadvantages. We only wish that there were more readily identifiable and stronger consumer representation in these processes. However, we encourage and fully expect that the voices of consumers will be clearer and more expressive very soon.

We strongly urge that the secrecy be lifted from the drafting, clearing and promulgating of Federal regulations and policies affecting health care services and that these be exposed to full public view from the earliest stages on. We further urge that State health agencies be taken into full partnership in these processes. It is most timely, indeed, for the much vaunted theories of "creative federalism" to be put into practice.

It is not our role in this testimony to discuss relationships of Federal administrative agencies with Congress (or of State agencies with State legislatures). However, we do express the hope that members of the Senate and House who are interested in health matters become and remain as well informed about Federal agency activities in the health arenas as we at State government level would like to be. After all, we, all of us, have and do share the same concerns—which are and should be with the people who need and use health services. We most appreciate this opportunity to be heard by you, Senator Moss, and the distinguished members of your subcommittee.

Mr. HALAMANDARIS. Our next witness is Mr. Marx Leopold, general counsel of the Pennsylvania Department of Public Welfare and Assistant Attorney General.

STATEMENT OF MARX LEOPOLD, GENERAL COUNSEL, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE AND ASSISTANT ATTORNEY GENERAL

Mr. LEOPOLD. Senator Moss, members of the Special Committee on Aging, thank you for giving me the opportunity to appear today before your committee so that I may discuss nursing home issues relevant to Pennsylvania.

I know that like us Pennsylvanians, you are concerned about the recent nursing home fire in Philadelphia and I will attempt to provide you with some information concerning the licensing of that facility.

In addition, I would like to discuss the subsequent position in which Pennsylvania finds itself, what it is doing and planning to do to alleviate the problem and a few recommendations as to where the Federal Government could help.

The Washington Hill Nursing Home at 605-607 North 43d Street, Philadelphia, was issued a license to operate a skilled nursing home effective January 31, 1973, until January 30, 1974.

This license was issued by the Pennsylvania Department of Public Welfare for 54 patients, but it indicated that the second and third floors were to be used for ambulatory patients only.

In addition, the license indicated that it was to be subject to a letter from George Kuchta, director of the bureau of medical facilities of the Pennsylvania Department of Public Welfare relating to Life Safety Code deficiencies.

On August 2, 1973, a reinspection was made by the Pennsylvania Department of Labor and Industry pursuant to a contract entered into between the departments which provided that labor and industry would do the Life Safety Code inspection.

Thirty-one deficiencies were found in regard to the Life Safety Code.

As a followup to that visit, a letter was sent by the Pennsylvania Department of Labor and Industry on September 6, 1973, indicating the 31 deficiencies and asking for a written response within 10 days.

In the meantime, the fire took place.

Safety Codes Approved by City

I should point out that on February 14 and March 27, 1973 the institution was inspected by the city of Philadelphia, Department of License and Inspection, which approved it as being in compliance with that city's safety codes.

The Washington Hill Nursing Home was one of those facilities which had previously been funded out of the cash assistance program, not the medical assistance system.

Until January of 1973, Pennsylvania had two systems of payment for nursing home care.

The first system was the Medicaid system providing a vendor payment to the nursing home; the second system and the one in which most nursing homes participated involved a payment to a cash assistance recipient of a grant sufficient to pay for his nursing home care up to the amount paid for Medicaid recipients. The cash assistance recipient then paid the nursing home operator, usually by endorsing his check to the operator of the home.

As a consequence of section 249(d) of H.R. 1, Public Law 92-603, nursing home payments under the cash assistance system were no longer eligible for Federal financial participation.

The Commonwealth of Pennsylvania was faced with a dilemma from which it has not been able to extricate itself. If either had to stop all funding for more than 300 nursing homes or allow them to continue funding with a concomitant assistance from the State in complying with the Life Safety Code of 1967. We clearly could not force the nursing home residents out into the street and for this reason accepted the second alternative.

There are those who say that we have dragged our feet in the implementation of the Life Safety Code, but the facts will indicate that immediately subsequent to the election of Governor Shapp as Governor of the State of Pennsylvania, the Pennsylvania Department of Labor and Industry began work in upgrading its life safety requirements.

In August of 1971 it proposed a new set of regulations to which there was very strenuous objection by the nursing home industry.

In November of 1971 tough regulations were adopted. However, in January of 1972 the Department of Health, Education, and Welfare, because the Pennsylvania regulations were not entirely the same as the Life Safety Code of 1967, said that the State was not adequately complying with the Social Security Act.

After a number of discussions, the State proposed that adoption of chapter 10 (institutional occupancies) of the 1967 Life Safety Code for all nursing homes in the Commonwealth and that regulation was adopted effective July 1, 1972.

Steps were taken to certify, first the medical assistance homes and then other homes. This was an enormous undertaking because it involved all facilities providing health care even if they were not nursing homes.

As you know, the Commonwealth was substantially hindered by the floods caused by Hurricane Agnes, but by the month of September 1972 we were able to inspect all medical assistance homes in accordance with the Life Safety Code of 1967.

In October of 1972, H.R. 1, Public Law 92–603, was passed with section 249(d) outlawing the cash assistance payment system for persons in nursing homes.

Steps were taken to comply with that change in the law and in January of 1973 a conversion to a vendor payment system under title XIX was effectuated. That conversion process was accompanied by a number of meetings with nursing home operators in the four regions of Pennsylvania.

The department also took steps to find the person who could assist with the greatly expanded Medicaid program and was able to hire Dr. Roger Cutt, a recent employee of HEW.

The first department plan of action for the complete certification of all skilled nursing facilities was prepared by the department under the direction of Dr. Cutt, by June of 1973.

84 Homes Out of Compliance

Although the department was working closely with HEW to certify all the homes, on July 9, 1973, the Commonwealth was advised by the Department of Health, Education, and Welfare that 84 homes were out of compliance with the Life Safety Code and that steps had to be taken immediately to obtain certification.

On August 30, 1973, a complete report was furnished Secretary Weinberger concerning activities under the nursing home plan of action as it related to the cited facilities.

All but three were certified and HEW responded by saying it was "encouraged with the State's positive response in complying with Secretary Weinberger's July 9, 1973, mandate."

We are in the process of obtaining certification for the remaining homes presently in the medical assistance system which used to be in the cash assistance system.

However, we know that many of those homes will not be able to comply with the Life Safety Code. What do we do with the people in the meantime?

There are those people in and outside of the Department of Health, Education, and Welfare who will tell you that Pennsylvania is one of the few States which is having serious problems with meeting the Life Safety Code requirements.

I do not believe it, and neither should you. I suggest that you take a random sample of nursing home facilities all around the country which are presently certified for medical assistance eligibility and see whether they comply with the Life Safety Code of 1967.

Pennsylvania has been honest enough to indicate when homes do not meet Life Safety Code requirements. For this, the Commonwealth may be penalized.

Pennsylvania finds itself in a very serious position. There are presently thousands of persons in nursing homes which may not meet Life Safety Code requirements. As you are aware, the mere act of transfer of the elderly can seriously impair health and life.

However, transfer implies that there are beds that are vacant which can be used for the patient. In Pennsylvania, there are some vacant beds in good nursing homes, with charges from $23 to $30 per day. In an attempt to secure access for Medicaid patients, Pennsylvania has raised its nursing home rates from $15 to $20 per day.

We are willing to make a reasonable monetary investment if that's what it takes.

However, raising the per diem rates is not enough. Nursing home operators, whether profit, nonprofit, or governmental, need help in securing financing for nursing home improvements and renovations.

$59 Million Bond Issue Authorized

When it was determined that facilities run by the Pennsylvania Department of Public Welfare would need substantial renovations to meet the Life Safety Code, the department was able to convince the Pennsylvania Legislature to authorize a $59 million bond issue.

Counties and private facility operators do not have access to the funds necessary to invest in such renovations. Governmental help is necessary. Some mechanism of governmental guaranties and low interest rates would help. Pennsylvania is ready to do its part as legislation will be introduced by Governor Shapp in the very near future, but this is more than a State problem.

Substantial Federal support for nursing home construction and renovation is absolutely necessary.

Grants to governments and nonprofit organizations and guaranteed low-interest loans for private operators are what is needed. Pennsylvania is not alone as your random sample will indicate to you.

We in Pennsylvania are doing our part. In addition to the $59 million set aside for renovation of the department of public welfare facilities to meet the Life Safety Code, the department has by regulation given right of access to community groups wishing to visit nursing homes, whether public or private.

In addition, we have a vastly increased staff to do medical reviews, title XIX compliance reviews and Life Safety Code reviews.

We have developed a nursing home patient relocation plan but we still need places to which to transfer the patients.

Finally, Pennsylvania has serious reservations about the massive amount of utilization review required by the proposed skilled nursing facility regulations. In an attempt to save funds, enormous amounts of those funds will be spent to administer the successful utilization reviews required by the proposed regulations.

We estimate that the cost of utilization review pursuant to the proposed section 405.1137 will approach $13 million per year.

For normally healthy persons discharged from hospitals to nursing homes, frequent reviews can have a significant fiscal and health impact.

However, most Medicaid patients do not fit that category. For them a semiannual utilization review is programmatically sound.

Thank you for allowing me to appear here today to express a number of concerns to you.

Let me add here that the last thing I heard Mr. Lipitz say was that we have a rate which it is possible that perhaps we will have

people interested in coming into Pennsylvania in the nursing home industry.

We feel our major problem is the absence of appropriate facilities within the State.

Also, while I was listening here today, I put down a few additional comments or notes that I want to leave with you.

Fiscal Considerations

I have the strong feeling that the ICF regulations and the skilled nursing home regulations that have been proposed are really, they only have one object, and that is fiscal considerations.

If you look at these regulations, you will see that they define skilled nursing homes so that they no longer exist, and then provide for standards for intermediate care which are inadequate for most of the people presently in skilled nursing home care, therefore, we avoid the high cost of the skilled nursing home, we have low standards for those same people, and then whatever else you do to save money, you have added a great deal of utilization review.

I think if we look at each one of the standards in terms of trying to save the dollar, that is where the decision has been made.

We can debate, I guess, at length over whether that is a good idea or not, it is very clear from our contacts with HEW, that that is the overriding reason for every action taken by that agency for at least the last 10 months.

That is all I have.

Mr. Halamandaris. Thank you for a fine statement.

I think the record is well served by that and I wish there were some people from HEW here to hear you.

I have just a couple of questions.

Why did it take the State of Pennsylvania until July 1972, to adopt the Life Safety Code?

Most of the States had adopted it before then.

Mr. Leopold. At the time we adopted the Life Safety Code, my understanding was there were about 17 States that had not adopted, but that is not a reason, and I cannot testify as to why it was not adopted before January 1971.

I do know that immediately upon the taking of office of Secretary Smith of our department of labor and industry, that was one of his preliminary concerns, and the industrial board which is responsible for this kind of regulation met at length with architects, with engineers, with safety specialists, and they came up with what we considered to be an excellent set of standards, which they proposed in August of 1971.

Some places they may have been more lax in the Life Safety Code.

In others, they were substantially stricter.

We thought that they were a better set of standards than the safety code.

HEW determined that they were not sufficiently close to the Life Safety Code to conform to the Social Security Act, and we had to do an about face, but you get an agency set up to go one way, and they start operating that way, and then you tell them that way is not any good, and you have to turn around and go some other way, you are going to lose 6 or 7 months, and that is exactly what happened.

After that time, I think that for budgetary reasons, there were not enough personnel to do the inspections.

LIFE SAFETY CODE INSPECTIONS

We have now provided by contracts to make sure that there are enough personnel to do the inspections, to be paid for by the department of public welfare, even if they are in the department of labor or industry, and those people are hired only for Life Safety Code for Medicaid facilities.

Mr. HALAMANDARIS. Another question, you pointed out if the committee were to take a random sample of nursing homes across the United States, we would find a large percentage would not meet the Life Safety Code.

We heard this morning a statement that 50 percent of intermediate care facilities do not meet this standard. Do you contend it is true with skilled nursing facilities?

Mr. LEOPOLD. Yes.

If you had 15 States that did not even have the Life Safety Code for nursing homes, as late as June of 1972, I cannot imagine that you will be able to find large numbers of facilities in those noncompliance States that meet the Life Safety Code.

You may be wrong, but I suggest that we look to see how much really of a national problem we have, and just from the little bit I know, I think you will find, just on a purely random basis, go check out these facilities, you will find they will not meet the standards.

Mr. HALAMANDARIS. You imply that the State of Pennsylvania is being singled out.

Are you really saying that, and if so, what is the reason for it?

Mr. LEOPOLD. The facts would indicate that we are being singled out. For example, in May and June of 1973, in those months, it was in very close contact between the HEW regional office, the Department of Public Welfare, with regard to steps that we were taking to get our facilities certified, and the action plan had been developed, and yet the Secretary of Health, Education, and Welfare chose to send a very public letter to our department, to our Governor, as a matter of fact, and followed it up with I believe a public press conference in the city of Philadelphia over the issue.

That is a way to amicably resolve problems, then I misunderstand a lot of psychology.

I do not think it is an amicable way. Perhaps there were some people there that were perhaps overzealous. I know that there could be, I am not saying there are, but there could be substantial political reasons why Pennsylvania would be singled out.

I know that, for example, the State of Maryland which has a democratic Governor, it certainly has been singled out for its social services program, and it has been subject to an unbelievable audit, that no State should have to go through.

It is only coincidental, the day the democratic Governor who might seek reelection, and that we have a democratic Governor who might seek reelection, that we must go through this.

I am saying that, and letting the chips fall as they may.

Mr. HALAMANDARIS. That concludes the questions that I have.

We will hear briefly from our friend from Michigan Department of Health, Mr. Frederick Traill.

We do thank you very much, Mr. Leopold.

Mr. LEOPOLD. Thank you.

Mr. HALAMANDARIS. Mr. Traill, you may proceed with your statement.

STATEMENT OF FREDERICK TRAILL, CHIEF, DIVISION OF HEALTH FACILITIES AND STANDARDS, MICHIGAN DEPARTMENT OF HEALTH

Mr. TRAILL. Thank you. I appreciate the opportunity to be here. I do have a prepared statement which I will submit for the record which I do not intend to read.*

Many of the points that are in my text have been covered by Dr. Warner. It is interesting to note that while we have known each other for many years and are testifying very similarly, we did not have the opportunity of setting it up.

One of the points I would like to discuss is in the very problem of rulemaking, not only in the skilled nursing regulations, the medicare regulations, but also the proposed hospital regulations.

The problem as I can see it, is the need for somebody who is in charge of the rulemaking process to decide what they want to define as a rule, and decide also what parts of the now proposed regulations, should be something other than rules.

In our perhaps simplistic approach to rule enforcement, a rule is something below which you do not go, and still stay in business. The rules that are proposed are vague, nonspecific, a collection of generalities, which defy accepted concepts of rulemaking.

In having gone through a good many court cases on rules as they now exist, I can assure you the attorneys are very adept at flipping the words about, and making you try to identify the substance of the rule you are applying. If the rule you are working with its not specific and subject related and written with great clarity, it really defies enforcement.

The rules we are dealing with are anything but specific, anything but clear, and anything but subject related. I can take what is considered a standard in any one of these three sets of rules, and find it covers anything from apple sauce to peanut butter. Enforcing that standard will be a practical impossibility. So on the one hand we are concerned about the quality of care and quality of life at these homes, and then we see rules come up which essentially defeat the efforts of many agencies, State, and Federal, to improve the quality of life and care in these facilities.

HUMAN FRAILTIES INVOLVED

Inflexibility of application, one thing we think is being foisted on the administering agencies, is the concept of absolute compliance with all of a large number of very general and nonspecific rules. In the best run facility in the country, be it a hospital, nursing home, or what else, you will find that facility in violation of some rules on any given day.

*See p. 2625.

We are dealing with a whole process that is human oriented, the people operating facilities are human, and have human frailties that we all have. Procedures can be developed, procedures can be enforced, but they are still going to break down at a point in time.

If that particular point in time happens to be when a survey is being done, then a facility which may be an excellent facility is going to be penalized. If the rules are administered as honestly as they should be, the facility will be penalized for perhaps a temporary human error in its operation. If flexibility is given as has been used in the past, the Medicare concept of substantial compliance, this temporary lapse can be accommodated to, made a matter of the record, involved for improvement, and followed for improvement.

If, however, we are faced with absolute rigid application and full compliance, the facility is going to be out of the program, at great harm to both the facility and, more importantly, to the beneficiaries of the programs who are the facility's patients. So we would plead for clarity, subject related rules, and certain flexibility of application.

I think the other point that Dr. Warner has mentioned, one we have also brought up, is that there needs to be some very careful consideration of the level of need of patients, and relating the level of need to the level of certification of facilities.

The association of directors of State and territorial health facility licensing programs in 1970 developed what was called a definition of levels of care, for institutions and patients.

That is not an exact title, but it (the pamphlet) is part of my presentation. The relatively simple and definable levels of need as they relate to certification are defined in the pamphlet, and they are really quite workable. They have been used by the State of Michigan for several years, and describe a very workable system. Its objective is to get the right person in the right place at the right time trying to get the right mix of services.

It is very difficult to say in our experience that there is one kind of level of service that every patient should receive, and that every patient needs the same mix of services and benefits, which seems to be the intent of the standards we are looking at now. I would have to agree if the standards are rigidly enforced, even though they are general and nondirective in nature, that they will result in great chaos, in the whole health care industry, and of great disadvantage to the patients that they really intend to protect. Unfortunately, they will create a tremendous disincentive to an honest, conscientious, surveyor who is trying to balance in his own conscience what that facility can offer, what it should offer, what the patient needs, and what the rules are calling for.

Mr. HALAMANDARIS. Thank you, Mr. Traill.

We appreciate your appearance here this morning. You really set my mind working with some of those ideas. I would like to pursue a number of them, but not to keep everybody else here, maybe you and I can sit down and spend a few minutes exploring these topics. Your prepared statement will be inserted in the hearing record.

Mr. TRAILL. Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF FREDERICK A. TRAILL

Honorable members of the Senate Special Committee on Aging, I am Frederick A. Traill and serve as chief of the division of health facility standards and licensing, Michigan Department of Public Health. The statement and documents I wish to present are presented in behalf of that department which is responsible for conducting programs for licensure, Medicare and Medicaid certification of approximately 800 health care institutions. These institutions provide Michigan citizens with an estimated 28,491,400 days of health care at an annual cost exceeding $1,633 million.

As an introduction to the subject of skilled nursing facility and intermediate care facility regulations, I should like to voice the department's alarm at the apparent rigid, uncompromising attitude of the Social and Rehabilitation Service and the Social Security Administration with respect to implementation of the "full compliance concept." The Medicare and Medicaid administrators have foistered the concept of full compliance with all standards. While this is an admirable goal, it is one that is almost impossible of attainment by any health facility on any given day. It is essential that State agencies be permitted some leeway for discretion in determining "substantial" compliance with applicable standards in order to avoid the chaotic situation which has existed over the last year with respect to the survey, evaluation and certification of nursing care facilities based on the full compliance concept. It is clearly evident that the Medicare and Medicaid administrators have had to back away from the full compliance concept by permitting a third 6-month certification of skilled nursing facilities and the implementation of the certification with automatic cancellation date. However, these measures are simply in effect delaying tactics on the part of the Federal administrators.

Unless the concept of substantial compliance, as originally embodied in the Medicare certification process is continued, many facilities will be eliminated as certified providers on the basis of picayune technicalities, thus doing a great disservice to the beneficiaries of the programs as well as to the provider facilities.

The Michigan Department of Public Health recently reviewed the standards proposed for skilled nursing facilities and those for intermediate care facilities. The following comments on those proposed standards are the result of that review.

(I) The administration of institutional benefits under any health care program requires the understanding and acceptance of a concept of levels of health facility and related institutional care. Such a concept is essential to:

(A) Accurate evaluation of an individual's care needs and appropriate utilization of care and services.

(B) Effective facility licensure and certification based on compliance with pertinent and reasonable standards.

(C) Reimbursement related to the reasonable cost of providing care plus a reasonable profit for proprietary facilities. Such reimbursement must be equitable to the individual, the provider, and in the case of governmental health programs, the taxpaying public.

(D) Objective health facility and related institutional planning, construction and operation consistent with community need.

While the Medicare and Medicaid programs partially embody a concept of levels of health facility care at the hospital and skilled nursing care level, the Medicaid program perpetuates confusion with respect to what is called "intermediate care." It is essential that the Medicaid administrators come to grips with this matter and realistically accept that there are at least two levels of intermediate care, namely, intermediate nursing care, and intermediate supervised personal care.

It should be emphasized that intermediate care is properly defined in law as being less than skilled nursing care but more than room and board. If this benefit service is to be utilized and efficiently administered, acceptance of a nonnursing level of intermediate care by the Medicaid administrators must occur.

The above recommendations are entirely consistent with the position of the Association of Directors of Health Facility Licensure and Certification Programs, and the definition of health care institutions now being developed by the American Hospital Association.

(II) The proposed standards for the administrative processing of facility certifications published by SSA and SRS are worded somewhat differently. This is unfortunate and should be corrected since the differences in wording will undoubtedly give rise to differences in interpretation by the staffs of the respective agencies at the regional office level. This will continue the diverse approach of the two agencies to what we believe Congress intended to be a unified certification program using common standards.

(III) There is a serious conflict between Medicare certification regulations and the statutes related to public disclosure. Furthermore, there is a conflict between the above and the time-limited agreement procedures set forth in proposed regulation and directives. These conflicts, if not modified, will make it impossible to manage both State and Federal level activities in a manner consistent with the regulations.

The MDPH has suggested a positive alternative to the conflicting regulations as summarized in the following:

It must be kept in mind that the State survey agency, the Social Security Administration, the Social and Rehabilitation Service, and the State Medicaid agency must routinize these procedures in a consistent fashion if they are to be handled in a mutually satisfactory manner. It is impossible for State survey agencies particularly, to undertake or accommodate to an additional resurvey procedure during the 90 days prior to the annual certification date during which the annual survey and certification procedures must occur. This period of time is of necessity consumed with report processing, obtaining plans of correction, and required followup leading to certification and time-limited provider agreement recommendations based on the annual survey. Therefore we recommend:

(A) All resurveys for items of noncompliance should occur beyond the certification date and the begining date of the new time-limited provider agreement.

(B) Time-limited provider agreements with an automatic cancellation date should be written so that the automatic date is established at least 90 days beyond the certification date and beginning date for the time-limited provider agreement. This will permit the resurvey for items of noncompliance to be done effectively and efficiently without in any way conflicting with the annual certification process.

(C) Procedures established for certification of skilled nursing facilities and the issuance of time-limited provider agreements should eventually be applicable to all types of providers participating in the Medicare and Medicaid programs.

We sincerely hope that when final regulations and procedures are published that they are published concurrently for both programs using the same wording so that there can be no question that the same requirements are applicable to both programs.

(IV) It is essential that the same format be used for regulations setting forth all certification standards. Also, the same format should be used to develop survey report forms used in the certification process. This is essential in order to assure an acceptable level of consistency and comparability in reporting survey findings.

(V) The lack of program coordination between SSA and SRS which creates almost insurmountable problems for State licensure and certification agencies is further evidenced by the fact that SSA has moved ahead to issue both regulations and directives related to public disclosure while SRS has not yet done so. It is exceedingly difficult to develop, administer and operate a unified licensure and certification program when Federal regulations and directives either conflict, are issued at different times, or are enforced in different ways by SSA and SRS.

(VI) The proposed standards, for hospitals, for SNF's and for ICF's lack any degree of specificity and seem to demonstrate a violation of fundamental concepts of rulemaking. There are two basic types of rules or standards, namely, performance standards and specific standards. To illustrate, a performance standard might say, "Patient rooms will provide 80 square feet per patient bed (in multiple occupancies) and will be so arranged as to allow circulation space around each bed." A specific standard might say, "Patient rooms will provide (in multiple occupancies) 80 square feet per patient bed with not less than 3 feet of clear space available at each side and the foot of each bed." Either form of rule is enforceable in so long as it is specific, limited in scope and clearly written.

The proposed standards for hospitals, SNF's and ICF's attempt to condense a wide range of subject matter into a limited amount of verbiage. The result is a vague and largely incomprehensible collection of nondirectional, unenforceable generalities. These generalities, coupled with a rigid "full compliance" attitude previously identified, serve to create a strong disincentive to the conduct of

honest in-depth surveys and thus serve to defeat the very purpose of assuring patient protection which, after all, is the intention of these rules and programs in the first place.

I would like to offer the following documents for introduction into the record of this hearing:

A letter dated July 19, 1973 from Maurice S. Reizen, M.D., director, Michigan Department of Public Health to Arthur E. Hess, Acting Commissioner, SSA, and James S. Dwight Jr., Administrator, SRS, transmitting the Department's analysis of the proposed regulations for skilled nursing facilities. A copy of the analysis transmitted with the above referenced July 19 letter (See appendix 3, item 12, p. 2691.)

A letter dated March 20, 1973 from Maurice S. Reizen, M.D., director, Michigan Department of Public Health to the Administrator, SRS, transmitting the Department's analysis of the proposed regulations for intermediate care facilities. A copy of the analysis transmitted with the above referenced March 20 letter. (See appendix 3, item 13, p. 2699.)

Time phasing chart—Michigan Department of Public Health dated September 5, 1973*

Definition of levels of health facility and related institutional care dated October 2, 1970, adopted by the Association of Directors of Health Facility Licensure and Certification Programs.*

Text of a speech on "The Concept of Levels of Health Facility and Related Institutional Care and its Relationship to Health Care Programming" presented before the 16th annual convocation, American Academy of Medical Administrators, Chicago, Ill., by Herman A. Ziel, Jr., M.D., MPH on August 20, 1973.*

On behalf of MDPH and its director, I would like to thank this committee for allowing us the opportunity to present this statement and the enclosed documents. If there are any questions which the committee feels I may be able to answer, I would be most happy to do so at this time.

Mr. HALAMANDARIS. The Chair will hear from two others who would like to testify, Milton Morris and Rev. John Mason.

We will hear from Reverend Mason first.

STATEMENT OF REV. JOHN MASON, DIVISION OF SOCIAL SERVICES, AMERICAN LUTHERAN CHURCH, MINNEAPOLIS, MINN.

Reverend MASON. Thank you for permitting me at the last moment to make a statement.

I have no prepared statement. I did give you a document which, I think, says some of the things that I would like to say this morning.**

I simply want to address myself very briefly to a philosophical position or statement.

I am asking the question, will our system of health service in the United States survive?

In the document that you received, you will find that I say that if the present trend, the trend that began to develop with the inception of Medicare continues, it is my opinion that our health delivery system will collapse.

The trend that we have been following in these years has been one that has been a system's oriented program that has not addressed itself to the human needs of old people.

We are caught up in a cost containment concept that, as the gentleman from Pennsylvania pointed out, is simply irresponsible.

The decisions as to what we are going to do with people are being made not on the basis of what is good for people, but on how much it

*Retained in committee files.
**See app. 3, item 14, p. 2703.

costs, and we are finding some very dangerous things happening in our country.

I believe that the present trend is counterproductive, that in the long run it is going to increase the cost of health care enormously. I believe that we are in a pattern wherein one layer of bureaucratic regulation after another is being piled up on the health delivery system to the point where the system is beginning to suffocate.

I do not believe that it can survive if the present trend continues.

We are downgrading quality of service which in the long run means that more people are going to require far more expensive hospital care than would be the case if we would upgrade levels of service so that we could practice preventive medicine.

If we could practice more of that, and have a system wherein we try to rehabilitate people, the total cost actually would go down over a period of time rather than what is happening now through our cost containment concept where we are driving people downhill and eventually we will end up paying far more for health services.

There are many aspects that we could speak to. I think that they have all been covered very adequately by people who have testified before you today, and I am not going to repeat them.

I think you have heard some excellent testimony today.

Nation Must Turn Its Direction

I do think that until our Nation turns its direction and looks in a different way, we are not going to find the answer that we are looking for.

As a people, we simply have to rise up and say, that people concern is the way to find the answer to the cost of health care, and until we look that way, and away from this, I would say, stupid, cost containment policy, we are not going to find the answer to our problem.

One more thing, I have read every word of this 238-page Life Safety Code.

I would like to change the title. It is a building safety code.

There are only 2 pages here devoted to what I would call effective life safety measures. The most effective life safety device is a human being on duty trained to react at a time of an emergency.

I know we need good buildings, we need fire-protective devices, but give me a good, trained staff that knows how to react in a case of emergency, and you will have the best kind of life safety device.

We have had five fires in homes owned by the congregations of the American Lutheran Church. We have never had a loss of life because we have had staff trained to know what to do if a fire occurs, and yet out of 240 pages, only 2 pages are devoted to any kind of fire drill, and then when you get toward the end of the book on page 229, I guess it is, it says that after all, fire drills do not need much attention. The thing you really have to do is get a fireproof building, which is an impossibility.

Mr. Halamandaris. Dr. Mason, I know you have something like 130 homes in the American Lutheran Church?

Reverend Mason. 150 structures.

Mr. Halamandaris. You became famous or infamous because of the fact you are the only nursing home group willing to share your cost data with this committee and other consumer or public groups.

I for one am glad you have done this, and I recall your latest audits indicate the average cost is something in the order of $12 a day per patient, and I would like you to comment, if you would, on the adequacy of the State reimbursement rates, and how that comes together with this average cost of $12 per day.

Reverend MASON. When you are speaking about averages, you must understand that some costs are higher, and some costs are lower.

Now, when a State says they will pay $12 a day for nursing care, this does not really mean that, because that is not an average figure.

If they would give us a straight across-the-board average of $12 per day, say in the State of Iowa, for all of the residents in our homes, we would be in good shape, but they do not do that.

OPERATING A LOW-COST PROGRAM

They reclassify, and this health screening team going around the States, reclassifying people simply because we have remotivated them, rehabilitated them, reclassifying them into an ICF where the rate is not $12, but maybe $7, or maybe, as it happened in one case, $6.50, it just simply is not going to work. Our average costs—and our books are open to anyone—they are as shown in the report that I gave to you, and they have been going up a little bit every year, but nevertheless, because we do a good job of training and education of staff, the administrators, the charge nurses, the nurses' aides, even the board members, we are able to operate programs at a lower cost. I would like to have people come out and visit our homes in the Midwest, I think they would be surprised at the high quality of care provided.

The statement was made here today that there were only 100 people in the State of Iowa that needed skilled nursing care. I must have misunderstood the statement but I thought that is what was said.

Mr. GARWIG [from the audience]. The point is in Iowa, the Department of Social Services is only classifying 45 people in the whole State per day on skilled nursing, and under Medicare, there are only 77 covered under skilled nursing.

That is the statement. We did not say that is all that is required.

That is all that are being covered.

I am George Garwig, administrator of the hospital and extended care facility in Kanawha, Iowa.

Reverend MASON. I could not believe there were only 100 people that needed such care.

If this trend continues, our delivery system will collapse, and we are going to have hospitals and homes on the verge of bankruptcy.

If my office did not happen to have a little bit of money in back of it where we have been able to let certain homes have a moratorium on payment of interest, on capital debt, they would be closed today.

This is going to happen unless policies change.

Mr. HALAMANDARIS. Let me ask you one final question and let you go.

What is going to happen to the patients you used to rehabilitate? Do you project they would be sent to an ICF, where they would decline or perhaps die?

Reverend MASON. It would be almost inevitable.

As soon as you take a person—rehabilitated person—and transfer him to St. Peter's row, or whatever you want to call it, he will go

downhill fast, and he will not come back to skilled nursing, he will go to the hospital where the costs are $100 a day. We have to start looking in a different direction in our philosophy of care.

Mr. HALAMANDARIS. Thank you, Dr. Mason.

Reverend MASON. Thank you.

Mr. HALAMANDARIS. Our next witness is Milton Morris, of Milwaukee, Wis., administrator of the Sage Nursing Home and representing the Wisconsin Association of Nursing Homes.

STATEMENT OF MILTON MORRIS, ADMINISTRATOR, SAGE NURSING HOME, AND REPRESENTATIVE OF THE WISCONSIN ASSOCIATION OF NURSING HOMES, MILWAUKEE, WIS.

Mr. MORRIS. My name is Milton Morris, of Milwaukee, Wis. I am appearing in a dual capacity; as the administrator of the Sage Nursing Home, Milwaukee, Wis., a 426-bed, skilled care nursing home, title XIX, and as the representative of the Wisconsin Association of Nursing Homes, an association representing more than 13,000 beds.

The purpose of this memorandum is to acquaint the reader with the views of the associations representing the vast majority of skilled nursing home beds in the State of Wisconsin concerning utilization review.

We will suggest in this memorandum an effective and superior procedure to accomplish the purpose of utilization review—refer to section 237(a)(4). We consider "utilization" the key to congressional thought. We believe no plan should be adopted or regulation promulgated by HEW which, while attempting to accomplish the purpose of conserving the use of skilled care beds, does, by its procedure, squander the most scarce of all health care commodities, professional skills, the limited time and energy of physicians and nurses.

You will undoubtedly hear from thousands of alarmed administrators, accountants, and executives in responsible positions that HEW's regulations for utilization review place a heavy cost on the nursing homes generally estimated at $400 per patient, per year. They also contend that it is apparently impossible to obtain compliance due to the scarcity of physicians and their refusal to act.

I wish to point out a different position. There is one thing this country's health delivery system can less afford than the enforcement of this regulation and noncompliance; that would be enforcement and compliance.

Compliance would surely waste millions of dollars but that would be as nothing compared with 30 minutes per month spent by each of two physicians for each patient plus staff preparation of documentation and subsequent recording of committee notes and decisions for each patient, then the forwarding of such information, its review, use and statistical organization.

It is this writer's contention that congressional interest in its H.R. 1 can best be served by a regulation that assures the proper utilization of facilities, skills, and fuels.

These are the procedures for each patient:

(1) Certification by the patient's physician.

(2) Independent medical review.

(3) Utilization review.

The writer proposes:

(1) Certification by patient's physician on admission.

(2) Recertification by patient's physician every 60 days.

(3) Combined independent medical review and utilization review by State agency each 6 months on site. Independent medical review and utilization review replaces recertification twice each year.

Physicians Willing To Cooperate

Your attention is called to the absolute minimization of duplicate physician effort and paperwork while maintaining controls and granting deserved respect to the patients' physicians' professional integrity. I have the greatest confidence that physicians will respond to these reasonable requests with willing cooperation.

The physician presently sees his patient each month so that recertification can be considered on alternate visits. The State agencies' independent medical review can be expanded to include physicians' onsite utilization review every 6 months, assuring independence and experience by the evaluators.

The work of utilization review will be concentrated in the hands of a few physicians at a more reasonable interval. It is a better utilization of money and professional skills.

The writer felt limited in this memorandum to an outline of thoughts for ease of reading and conservation of the reader's time.

He is ready to respond to any questions put to him concerning the memorandum by members of this committee or any other interested party.

I would like to add to this statement that the definition of the nursing home patient standards, and that there is a need for utilization review of course will be a moot question.

Are there any questions?

Mr. Halamandaris. I would like you to amplify one point just a little if you would.

Do you have any sort of cost projections, any idea what the increase in cost of utilization review will mean in your State or to your facilities?

Mr. Morris. When we read the original proposed rule, we did a sort of a ballpark evaluation of what it would mean to us.

No Change With Utilization Review

In the State of Wisconsin, we have 13,000 skilled nursing home patients. We presently have an evaluation that determine whether the patient is skilled or less than skilled, by using a medical criteria, by using a criteria in regard to fiscal areas, and with regard to emotional and behavioral areas, and it is our contention that no change would occur with utilization review, and the costs have been estimated at about $5 million with no real change.

However, the change will come if the definition of skilled is changed, and in our facility, I would think that about 95 to 98 percent will be ICF.

Mr. Halamandaris. That is a fine statement, Mr. Morris.

Mr. Morris. Could I just comment on a statement you made earlier in regard to the regulations as to the passing of medication in which

the deletions of licensed personnel was put in there, as well as the administrator, I am a registered pharmacist, and I have lectured to a nursing staff much more in the past, and I have trained paramedical personnel in the passing of medication.

I am not opposed to the dropping of a licensed requirement, because one has to ask the question that medication does not make a skilled nursing home patient primarily, and how can one say in an ICF case, medication may be passed without supervision, and yet medication, and the use of medically trained people under supervision should be prohibited, and I think that the use of paramedical personnel is a valid use of their kind, and primarily in a skilled nursing home, where many, many medications are defined as maintenance and routine, I see no reason why the registered nurse should not have a designee or an arm of herself trained to function in this capacity.

By definition of a skilled nursing home patient, if that should pass, automatically it would also pass that personnel without supervision will be able to carry out this function without any supervision whatsoever around the clock.

Mr. HALAMANDARIS. Thank you for your statement.

The hearing will stand in recess until tomorrow morning at 9:30, when we will hear witnesses from the Department of Health, Education, and Welfare.

[Whereupon, the hearing was recessed at 2 p.m.]

APPENDIXES

Appendix 1

LETTER FROM AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGAINZATIONS, TO SENATOR FRANK E. MOSS, OCTOBER 5, 1973*

DEAR SENATOR MOSS: I am writing to express the views of the AFL–CIO on the Skilled Nursing Facilities Regulations as announced in the Federal Register on July 12, 1973 on which your Subcommittee will commence hearings on October 10–11, 1973.

We are greatly concerned about these regulations because they disregard protections essential to the welfare of patients. We assume that in view of the clear Congressional mandate in P.L. 92–603 to improve the quality of nursing home care, the regulations implementing that legislation would raise standards, not lower them. There are several areas of particular concern and we urge that your Subcommittee give them careful scrutiny.

Current regulations require a doctor to visit a patient at least every thirty days. The proposed regulations would not require a doctor to see a patient more than once a year after that patient had been in a nursing home for three months. This will certainly lead to medical neglect of patients. It seems obvious that patients requiring skilled nursing care have health conditions which require the services of a physician at least once a month.

The regulations should require the services of more than one registered nurse 24 hours a day, seven days a week in all skilled nursing homes. These regulations permit nursing homes, regardless of size, to employ only one nurse who must be on duty only five days a week. Many nursing homes have 200 beds and one registered nurse cannot possibly provide the level of supervision to adequately protect the health of patients. We also fail to see the rationale for not requiring a registered nurse to be on duty seven days a week for there is no scientific basis for assuming nursing home patients are not as apt to get sick on weekends as on other days. The availability of such care is even more important on weekends since the services of other health professionals are more difficult to secure or are frequently unavailable at that time.

The overall effect of the regulations will be to generally lower the level of care in skilled nursing home facilities. One indication of their regressive impact is that the proposed regulations undercut the clear Congressional intent that skilled nursing homes be centers for rehabilitation. The Senate Finance Committee in referring to skilled nursing homes stated that they "would include those skilled services which are essential to the rehabilitation and recovery of the patient, and also those which are necessary to prevent deterioration of the patient's condition and sustain the patient's current capacities even when full recovery or medical improvement is not imminent."

Yet the proposed regulations would delete from current regulations the requirement that "therapists collaborate with the facility's medical and nursing staff in developing the patient's total plan of care." We urge a requirement that therapists participate in developing and executing the facility's patient care policies and that qualified therapists participate in developing individual patient care plans. We urge a general upgrading in the rehabilitation provisions of the regulations. Without such improvement, the only alternative will be a lifetime stay in a nursing home resulting in a bleak existence for the patient and increased cost to the public.

*See statement by Senator Moss, p. 2539.

We commend you for holding hearings on the Skilled Nursing Facilities Regulations. Your leadership has been responsible for much of the progress that has been made in recent years in raising nursing home standards. The inadequacy of the Administration's proposed standards make it clear that once again the elderly will be looking to your leadership to insure that there is no retrogression in existing standards and that progress is made. Please be assured that you will have the full support of the AFL–CIO in this effort.

Sincerely,

ANDREW J. BIEMILLER, *Director,*
Department of Legislation.

Appendix 2

PREPARED STATEMENT OF JACK OSSOFSKY, EXECUTIVE DIRECTOR, NATIONAL COUNCIL ON THE AGING*

The National Council on the Aging welcomes the opportunity to submit this statement to the Subcommittee on Long-Term Care in its hearings on the adequacy of HEW's proposed regulations for Skilled Nursing Facilities. For the past twenty-three years, the National Council on the Aging has provided continuing leadership and training to public and private agencies at the national, state, and local levels in the field of aging. As a private nonprofit organization, we have been a national resource for planning, information and service in the many areas—such as employment, health, housing, institutional care, and senior center activities—which affect the lives of our nation's elderly population.

Our organization is deeply concerned about the HEW proposal as published in the Federal Register of July 12, 1973, and we commend your Subcommittee for focusing attention on this critical matter. In our view, the proposed regulations fall far short of the goals set in President Nixon's plan to upgrade nursing home care for this nation's elderly. Many of the regulations reflect, in fact, a lowering of current standards—or, equally distressing, a continuation of several inadequate provisions now in operation. NCOA wishes to share with you its specific objections in this regard.

First, regulations now in effect require a registered nurse only five days a week; the proposal continues this inadequate standard in § 405.1126 instead of strengthening it. In order to provide adequate protection for patients, it is absolutely imperative in our view that a registered nurse be on duty twenty-four hours a day, 7 days a week.

NCOA also objects to the exclusion of rehabilitative services standards in § 405.1126. Physicians need no longer specify plans of therapy (including frequency, equipment, and goals) for nursing home patients. We have urged HEW to reinstate the former regulations with regard to rehabilitation in nursing homes.

Thirdly, the proposal weakens an already lax standard in the area of physician visits (§ 405.1123). It requires no more than yearly visits by a doctor to patients who have been in the skilled nursing facility for over three months, waiving the current requirement that a doctor must visit a patient at least every thirty days. While we concede that the number of patient visits cannot guarantee high quality of patient care, at the very least monthly visits can provide a safeguard against abuse.

HEW has responded that its proposed quarterly medical audit mechanism will guard the patients in this regard. Definition of the medical audit is not, however, provided in the regulations; thus, the criteria will be left to unenforceable guidelines. It is indeed difficult to support an unknown mechanism and unfortunate that public comment has not been required for such an important procedure. Thus, NCOA urges that HEW include the medical audit definition—as well as requirements and criteria for such an audit—in the regulations and that the procedure be issued as a proposed regulation in the Federal Register for public response. This critically important provision, as one of the only pivotal factors in distinguishing between an Intermediate Care Facility and a Skilled Nursing Facility, should not be relegated to guideline status.

Finally, NCOA believes that nursing homes should be required to prepare relocation plans for their patients in the event of fire, natural disasters, or loss of certification. Such plans—updated on a half-yearly basis and reviewed by the State Agency—should include alternate bed sites, counseling plans, and medical procedures.

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*See statement by Senator Moss, p. 2539.

Taken together, the proposed regulations represent a significant downgrading in skilled nursing home care. It is, in fact, becoming increasingly difficult to differentiate between an Intermediate Care Facility and a Skilled Nursing Facility in light of such downgrading. Without any national policy on long-term care as guidance, NCOA finds this present ambiguity between the two levels of care unacceptable.

Again, we commend the Subcommittee for bringing attention to the HEW proposal, NCOA shares your alarm and sense of urgency in correcting this critical situation and stands ready to assist you in this important endeavor on behalf of our nation's nursing home residents.

Thank you.

Appendix 3

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1. LETTER FROM ROBERT H. STEELE,* CHAIRMAN, HOUSE REPUBLICAN TASK FORCE ON AGING, TO SECRETARY CASPAR W. WEINBERGER, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, JULY 31, 1973

DEAR MR. SECRETARY: On Thursday, July 19, 1973, the House Republican Task Force on Aging had an extremely informative meeting with Ms. Marie Callender, Special Assistant for Nursing Home Affairs in the Office of the Assistant Secretary for Health. The meeting was on the topic of the proposed skilled nursing facility regulations that were published in the Federal Register on July 12, 1973. We requested this meeting because several of our members had been contacted by the nursing home industry and representatives of the elderly concerning the context of the standards, the delay in their publication, and the short duration of the public comment period thereon. Ms. Callender was most cooperative in discussing these three areas in depth with us.

Prior to this meeting it had been brought to our attention that as long as six months ago drafts of the proposed regulations had become available within both the American Medical Association and the nursing home industry. The availability of the draft or drafts is confirmed by the fact that a nursing home industry magazine carried public comment on them before the regulations were ever published. Moreover, some members of this Task Force received detailed written letters on the draft regulations from nursing home operators in early June.

On the other hand, groups representing the aged—the ultimate consumers of nursing home services—were refused all access to the draft regulations. Similarly, the Task Force staff requested copies about three weeks prior to publication and was turned down.

It is our firm belief that public participation in rule making and general principles of equity require that all concerned individuals have an equal opportunity for input into the rule-making process at all stages of deliberations. HEW has demonstrated a total disregard for these principles. Moreover, the Department has certainly violated the spirit of its statement of policy printed in the Federal Register on February 5, 1971.

Under the mandate of the Social Security Amendments of 1972 (PL 93–603) HEW should have promulgated the SNF regulations July 1, 1973. We believe that the regulations should be made effective as soon as possible after all parties have had an equal opportunity to register their comments, objectives and recommendations. However, in this particular case where it is general knowledge that one major element in the debate, the nursing home industry, has had the opportunity to study and comment upon the regulations for nearly six months, it is only equitable that the public comment period be extended.

We therefore recommend in the strongest terms that the comment period be extended to October 12, 1973. Such an extension is essential to encourage a free and complete dialogue on these complex and controversial standards, and eliminate any possible allegation of inequitable treatment by the Department. It is not only the individual nursing home operator or elderly patient that has a stake in these regulations. Taxpayers contribtue some $2 billion a year in nursing home payments and virtually every citizen faces the possibility of either himself or a close relative living in one of these homes.

In addition, we wish to formally request that a review of Department policy be undertaken immediately to prevent such uneven treatment in the future

*See statement, p. 2543.

and to guarantee that all interested parties have a voice at both formal and informal stages of the rule making process.

Thank you for your prompt and attentive consideration in this matter.

With best personal regards,

Sincerely,

Robert H. Steele, M.C., Chairman; James Harvey, M.C., H. John Heinz III, M.C., Charles A. Mosher, M.C., Joel Pritchard, M.C., Victor V. Veysey, M.C., C. W. Bill Young, M.C., L. A. Skip Bafalis, M.C., Margaret M. Heckler, M.C., William Keating, M.C., Peter A. Peyser M.C., Ronald A. Sarasin, M.C., William B. Widnall, M.C., Samuel H. Young, M.C.

ITEM 2. LETTER FROM CASPAR W. WEINBERGER, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, TO HON. ROBERT H. STEELE,* CHAIRMAN, HOUSE REPUBLICAN TASK FORCE ON AGING, AUGUST 27, 1973

DEAR MR. CHAIRMAN: Thank you for your letter of July 31, 1973, requesting the Department to extend the comment period for skilled nursing facilities regulations for 60 days. After considering your request, and the reasons for it, I have decided to provide for an extension of the comment period. The extension will be until September 13, 1973, and a notice to this effect appeared in the Federal Register on Tuesday, August 14.

The reason why we were unable to extend this period for 60 days is that there are provisions in these regulations which involve the certification of nursing homes and statutory deadlines for the finalization of provider agreements and very serious problems would be created if we delay the comment period beyond 30 days. As it is, we will have to mobilize a concerted staff effort to analyze thoroughly the comments after the 30 day extension in order not to delay promulgation of final regulations. However, I believe that a 30 day extension will be equitable and provide sufficient time for the development of additional comments by all concerned parties.

Your letter makes critical reference to the fact that early drafts of these regulations were apparently provided to certain nursing home organizations and that based on this advance information they were able to influence the content of the proposed rule. Senators Clark and Moss have also raised this issue. I have asked the Assistant Secretary for Health, Dr. Charles C. Edwards, to look into the criticism that you have raised to determine the facts. I have also asked the Department's Executive Secretary to recommend to me any changes we should make in our internal regulations procedures to insure equitable and meaningful participation by concerned organizations and citizens.

When I have Dr. Edwards' report and the Executive Secretary's recommendations, I will write to you further. However, I can say at this time I did not approve nor was I aware of any advance selective distribution of draft regulations. My policy has been and continues to be to refrain from distributing any such draft materials outside the Department and to provide everyone with the opportunity of expressing their views through the established mechanism of the Notice of Proposed Rule Making and comment period. We take this comment period very seriously and frequently make substantial revisions based on the constructive advice and suggestions we receive from a broad variety of organizations and private citizens. Although it is appropriate for program officials to solicit suggestions about what the Department's policy should be before regulations are drafted, I do not believe it is appropriate to distribute draft regulations to selected groups while various recommendations and alternatives are under review in my office. I can also say that in making the policy decisions on these regulations, I was not aware of the views of nursing home organizations and consequently such views, whatever they might be, did not influence my decisions on the content of the notice of proposed rulemaking. My decisions were based on what I consider to be an appropriate role for the Federal Government and on what I believe to be the most efficient, equitable, and enforceable procedures from a management standpoint.

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*See statement, p. 2543.

You should know that one issue in these regulations—the waiver of the life safety code—was published in final form to carry out an already effective statutory provision. Those provisions that were finalized were published on August 8.

I will be sending you a full and responsive reply within 30 days and would appreciate any help you can give us by suggesting to concerned parties that they send their comments in as soon as possible. Too often groups will wait to the end of the comment period before providing them. The earlier we have their views, the better job we can do in analyzing them.

Let me assure you that I share your concern that the Department will have the benefit of a broad range of views and that interests will be solicited in an equitable manner.

Sincerely,

CASPAR W. WEINBERGER,
Secretary.

ITEM 3. LETTER FROM HON. ROBERT H. STEELE,* CHAIRMAN, HOUSE REPUBLICAN TASK FORCE ON AGING, TO HON. ARTHUR E. HESS, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION, SEPTEMBER 13, 1973

DEAR COMMISSIONER HESS: Following up on the meeting of July 19, 1973 of the House Republican Task Force on Aging with Ms. Marie Callendar, Office of Nursing Home Affairs, HEW, I am submitting the following comments to the Medicare, Medicaid Skilled Nursing Facilities regulations, proposed in the July 12, 1973 Federal Register (vol. 38, #133).

The Social Security Act Amendments of 1972, H.R. 1, include provisions designed to provide better quality nursing home care. After careful consideration, I do not believe the proposed Medicare-Medicaid Skilled Nursing Facility regulations guarantee adequate patient care in several major areas.

I realize that fashioning of these regulations involves a delicate balance of interests of consumers, providers and state and federal government. Moreover, long range upgrading of patient care will of necessity pose difficulties for and, in some cases, eliminate, certain nursing facilities not meeting stiff regulatory requirements. Imposition of higher standards, like licensing, in any industry is never without this hardship on those who fail to make the grade. Yet, unless we make a firm decision to set and enforce a national program to upgrade patient care, staffing and policies through reasonable federal standards, all of our pious talk about improving the quality of nursing home care will indeed be hallow. The spirit of H.R. 1 will be obliterated. It is with that spirit in mind that we must frame our standards, rather than falling into the alluring trap of simply setting standards which existing homes can meet.

Moreover, Skilled Nursing Facilities by definition must offer the most intensive and highest quality care (short of hospital treatment) available in this country. Patients are placed in such facilities because they are more fragile and require the very best patient care, including the 24-hour attention of trained professionals and the very best patient care. Because their condition is serious they need the close attention from attending physicians and social service personnel. If they do not need these services they are in the wrong facility. If they do need these services, we who are contracting with the providers have the responsibility to guarantee that these services are delivered.

In line with this view, I am particularly distressed by the following shortcomings of the proposed regulations, many of which were raised in the July nineteenth meeting with Ms. Callender:

(a) The lack of focus on patient discharge and rehabilitation.

I suggest the following provisions, presently lacking:

(1) that a specific written discharge plan and record thereof be required to be initiated upon patient arrival (see 405.1122(a)), (2) that physician visits be required every thirty days (405.1123(c). (3) that social services be required to plan for and aid patient reentry into the community (405.1130(b)). In terms of staff time and effort it is easiest for the provider to merely maintain a patient rather than promote activity and independence. Also, there is no financial incentive for nursing homes to encourage patients to leave the facility. It is time to adopt a policy to encourage patient reentry into the community

*See statement, p. 2543.

to prevent patients deteriorating in institutions until death and can substantially lower federal Medicaid and Medicare costs.

(b) The absence of a requirement for any physician visits after three visits in the first ninety days (405.1123(c)).

This is appalling in light of the fact that the regulations tie all major services to instructions of a medical doctor. These services include patient drugs, patient activities, all restorative therapy, diet and nursing treatments. By failing to require regular physician visits after the first 90 days provision 405.1123(c) is consequently weaker from current extended care facility regulations which require a monthly visit and is weaker still than the proposed intermediate care facility standard of a quarterly visit. Not only is there not one scintilla of evidence that a monthly visit is not needed, but it may well be any patient who does not need at least monthly attention by a physician is improperly placed in a skilled nursing facility. Moreover, if the skilled nursing facility regulations require no visit after ninety days, I am deeply concerned that intermediate care facility regulations, yet to be issued, may lack requirements for any visit at all, an unthinkable possibility.

(c) The weakness of staff requirements.

I strongly suggest provisions, now lacking, requiring the services of a registered nurse seven days per week as well as of a physical therapist, and of a social worker. It is unthinkable that federal funds are paying for skilled nursing care in an institution where there is no registered nurse on duty for a continuous 64 hour period over the weekend to handle emergencies, to supervise patient care and to carry out patient care policies and plans (required under 405.1122(b) and 405.1124). A continuing regular program under a physical therapist is imperative to any rehabilitation whether it be to improve a patient while in the nursing home or to rehabilitate the patient to the point he or she can be discharged. A social worker or at least an in-facility social services program is necessary to deal with the emotional, social and financial problems of adjusting to a nursing home stay and if possible to prepare for reentry into the community. While staff additions may prove unreasonably costly for small homes, a cut-off point could be fashioned requiring all 50 or 65 bed homes to employ more and higher qualified personnel than those with fewer patients. Reasonable patient/staff ratios, completely lacking now, could also be imposed.

(d) The lack of any consumer input.

Public involvement in health care in the community is an invaluable means of encouraging competition among providers to upgrade the level of care. Provision for consumer participation should be made at the federal, state and local decision-making levels in developing regulations conducting inspections and carrying out utilization review. I have previously commented on the inequitable manner in which HEW carried the rulemaking procedure in regard to skilled nursing facilities regulations. I feel this has been one instance illustrative of unfortunate consequences of not involving consumers in the decision-making process from the outset.

(e) Laxness of fire safety regulations.

As a strong advocate of fire safety, I was particularly distressed by the fire safety provisions and their final enactment before the termination of the public comment period, effectively stifling debate on the adequacy of your provision. From long experience in drafting and observing enforcement of fire safety standards, there is no doubt in my mind that these standards, which permit the Secretary to waive portions of the Life Safety Code allow widespread possibilities for abuse. Two major loopholes are allowed when the Secretary may waive enforcement of the Fire Safety Code when (a) the regulations, "if rigidly applied would result in unreasonable hardship on skilled nursing facilities, only if such waiver will not adversely affect the health and safety of patients" or (b) a state has fire safety laws which adequately protect patients in skilled nursing homes (see 405.1134). The regulations offer no definition of "unreasonable hardship" in the first situation and in the second, no definition of "adequately protect". No more specific requirement as to the standards of the state law is given, nor is provision made for cut-off of federal funds to homes not in compliance with such state laws. Where are the guidelines or the teeth in such standards?

I wish to encourage in the strongest terms the reevaluation of the proposed regulations in line with these suggestions as well as of the entire rulemaking process, especially the incorporation of outside public comment as suggested to you in my letter of July 31, 1973.

I would also like to express my continuing concern that the Office of Nursing Home Affairs in HEW continues to receive strong attention and the staff direction after Marie Callender's departure. The need for vigorous and concerned spokesmen for our nations' elderly in inner government circles is ever present and growing. Moreover, the Office of Nursing Home Affairs is involved in a key issue, the health of the elderly. This is an area that has had insufficient attention for too long.

I urge your favorable consideration of these comments and I look forward to your response.

With best personal regards, I am

Sincerely,

ROBERT H. STEELE.

ITEM 4. "TOWARD A BRIGHTER FUTURE FOR NURSING HOMES", ARTICLE FROM HEALTH SERVICES REPORTS, APRIL 1973, BY JOHN R. KERNODLE; SUBMITTED BY DR. EDWARD J. LORENZE,* MEDICAL DIRECTOR, BURKE REHABILITATION CENTER, WHITE PLAINS, N.Y.

EXHIBIT A

Whatever type of national health insurance finally comes out of Congress, it will place a strong emphasis on extended care facilities and similar alternatives to hospital care, primarily for the purpose of reducing costs.

This emphasis is going to place the nursing homes and homes for the aged squarely in the middle of the health and medical care delivery system. It is going to involve the homes' administrators and the members of my profession, the physicians, in a partnership. Perhaps some administrators do not conceive of their institutions as part of the health care delivery system. But the pressure to become part of the health care system is going to come, not only from government, but from the residents of homes and their families. I base that remark partly on personal experience and partly on general observations.

I serve on the board of a retirement home in North Carolina. At the outset, we never perceived of the home as any kind of nursing home or extended care facility. But it has been our experience that, unless we made specific provisions for medical care, we simply could not attract persons into the home. Looking back, I think we should have expected this. After all, concern for one's health does not diminish with age—if anything, it intensifies. This intensified concern is supported by the fact that, within 4 years of admission, 35 to 40 percent of the residents will require some medical care, and some portion of these persons will be bedridden.

Our response to this reality has been to set aside part of our facility for nursing home care. It anticipates needs before they occur, and it reassures potential residents that their medical needs will be met.

It also reassures their families, and that is not an unimportant consideration. For as more and more families turn to homes for the aged and nursing homes as a home for their elderly—and that is very clearly the trend—there is going to be increased public scrutiny of these institutions. Most assuredly, the quality of medical care will be an important factor in the public judgment.

A NEW PARTNERSHIP

As I have said, this public concern places home administrators and physicians in a partnership, and I want to discuss this relationship on several levels, including the objectives, methods of cooperation and financing, and education of the public. I think it behooves the administrators of homes for the aged and nursing homes to work out, in cooperation with physicians, a clear definition of the role of the homes in the medical care delivery system. The scope and limitations must be defined lest you in the nursing homes find, as we in the medical profession have found, that you become the victims of unreasonable expectations.

In preparing for this speech, I talked with officials of the Joint Commission for the Accreditation of Hospitals (JCAH). I learned from them that only about 10 percent—1,800 of some 20,000 homes—are now accredited. The JACH officials informed me that lack of adequate medical supervision is the primary problem that they find in their inspections. Unfortunately, one of the major rea-

*See statement, p. 2567.

sons for this lack is either the unavailability of a physician or lack of interest among those physicians who are available.

I recognize these lacks as a problem, and one for which my profession bears the major responsibility to correct. Maybe the final answer lies in the development of a new specialty. But that answer lies down the road a bit. In the meantime, there are some steps we in the AMA are taking to provide some immediate relief. We are undertaking both a general education effort with our members and a specific program to develop expertise for service by physicians as medical directors.

In 1971, the House of Delegates of the American Medical Association adopted a series of 10 concepts for guidance to physicians in their care and attitudes toward elderly patients. I will not list the 10, but they are instructive for the insight they give on our professional approach to this particular portion of the population. The guidelines, which can be obtained from the AMA Committee on Aging, appear in Report G of the Council on Medical Service (A–71).

Working from the base established by these 10 concepts, we are now engaged in the second phase of our educational effort. This phase is much more direct. Under a contract with the Department of Health, Education, and Welfare (HEW), the AMA Committee on Aging has launched a series of 10 seminars across the country for home administrators and medical directors. There will be one seminar held in each of the 10 regions of HEW. Each will offer 14 to 16 hours of instruction over a 2-day period. (The first seminar was held November 9–10 in White Plains, N.Y.; the series is expected to conclude in April 1973.)

The short range objective is to prepare physicians to serve as medical directors and to upgrade the skills and knowledge of those who now serve in such posts. The long range goal is to use the seminars to establish permanent State and local work groups that would have continuing responsibility for upgrading medical services in the homes. It is hoped that this activity will result in an increased supply of physicians willing and capable of serving nursing homes and homes for the aged as medical directors.

In the interim, I recommend that administrators and directors of nursing homes develop a working relationship with the local medical society. Make its members aware of the problems and needs of the homes in their area and ask for assistance in resolving them. I do not believe that any of our societies would turn a deaf ear. I would urge an open mind and a flexible attitude in working out a plan to insure adequate medical care and supervision.

Medical Director's Role

Once a home has found a medical director, what should be expected and required of him? As defined by the AMA, the medical director should have four major areas of responsibility.

1. To help define the scope and characteristics of the services provided at each level of care
2. To share in developing standards of care for each discipline, such as nursing and rehabilitation
3. To help insure quality controls
4. To assume specific responsibility for overall management and delivery of patient care services—by agreement with the administrator. I would underline the phrase "by agreement with the administrator."

To meet these objectives and to insure a relatively high quality of care will not, in most instances, require a full-time medical director. This can be accomplished if the medical director will adopt a series of guidelines developed for the seminars by the staff of the Committee on Aging.

The first guideline is to develop written policies governing care and to insure that they are executed. These policies should provide for meeting the total underlying and psychological needs of the patient.

The medical director should coordinate medical care, maintain effective liaison with attending physicians, and implement methods to keep the quality of care under constant surveillance.

In cooperation with the home's professional staff, he should develop a definition of the therapeutic goals for the patient and should assure a planned regimen of medical care for each patient—including medication, restorative services, and diet.

Finally, he should insure that each patient is receiving adequate services and that a patient will be transferred to an alternative method of care when a transfer is appropriate.

Those duties are what an administrator should expect of the medical director and what should be required of him. Insistence on adherence to these guidelines will insure the quality of care residents deserve and will eliminate or prevent a lot of problems.

Health Care and Medical Care

I have talked about medical care in the belief that that is the matter of most immediate concern to administrators in the managements of their homes. Now I want to change the perspective to health care. I have two reasons for doing so. First, we at the AMA are becoming more and more conscious of the need to draw a clear distinction between health care and medical care and to educate the American people as to the difference.

In general terms, health is largely in a person's own hands. We as physicians normally enter the picture only when there is a health malfunction. Many of those malfunctions are avoidable if only the individual will take proper care of himself. There is one other distinction—health care is relatively inexpensive; proper medical care, particularly long-term care, is not.

As extended care homes get more deeply involved in the medical care system, the economic pressures on them are going to intensify. Administrators will be seeking ways to control and reduce costs. A sound medical program employing utilization review is one way. Avoiding unnecessary medical care is another. And this can be done without in any way shortchanging the residents.

Destroying a Stereotype

We are all familiar with the stereotype that most younger persons have about the elderly. They conceive of them as being chronically ill, forgetful, and emotionally unstable, that stereotype has some validity—many older people are exactly like that. But what is not valid is the assumed cause of that condition. The cause is not age, but the conditions we impose on older persons. As Dr. Frederick C. Swartz, the chairman of the AMA Committee on Aging, testified before Congress in July 1969:*

> Forgetfulness and mental retardation result largely from lack of attention, failure to concentrate and loss of motivation. This can largely be prevented if we will continue to encourage people of all ages to maintain the habits of study learned in school. We can prevent mental deterioration by helping older people to continue in employment. Some serious reading and thinking should be a part of each man's daily life. The muscles are strengthened and the wits sharpened only by proper physical exercise and mental activity.

These daily activities, along with proper nutrition and control of harmful habits, are what I mean when I speak of health care. Proper health care will serve the interests of patients and will save money in the long run by reducing the need for medical care.

Let me now turn to the other task I have put forth for our partnership to accomplish—public education. All our other tasks are minor compared to this one, both in terms of need and in terms of successful accomplishment.

Health education is the most difficult task we at the AMA face. We try very hard to get the public to take care of itself. We have had only limited success.

Changing the public's mind about anything is a formidable task. Yet we must try if we are to bring about a true revolution in this nation's attitude toward aging and the elderly. We must make a supreme effort to destroy the stereotype of the aged and the myths on which it is based. The scientific facts are exactly the opposite to the popular conception of old age. We at the AMA discovered this almost by accident.

About 16 years ago the AMA began to get deeply interested in the problems of the elderly. At that time, the AMA established what it called the Geriatric Committee. The name of that committee is significant. Since geriatrics was defined as the study of the diseases of the aging, it all seemed to be rather simple. All the committee had to do was to discover what diseases were the result of the aging process and undertake their study and eventual conquest.

But the committee and other researchers were unable to find a single disease entity that depended directly on the passage of time. What they did find was that diseases usually associated with older persons also occurred in the young and vice versa. One result of that discovery was to change the name of the committee from

* U.S. Senate. Special Committee on Aging. Hearings before the Subcommittee Health of the Elderly, July 17–19, 1969, 91st Cong., p. 624.

the Geriatric Committee to the Committee on Aging. Far more important, it also changed the perspective of the committee, the AMA, and ultimately, I hope, the perspective of the medical profession as to the nature of the medical problems that affect the aged.

That no disease entity or any single physical or mental condition is endemic to a particular age clearly has vast implications for the medical profession. It is the basis from which all who care for the elderly must begin. It is this basic fact that we must get across to the American public so that we, as a nation, can begin to develop a realistic, rational philosophy of aging. That need is fundamental to all else we may wish to do.

The need is urgent because the over 65 age group is the fastest growing segment of the U.S. population. According to the 1970 census, 10 percent of the population is now over 65. They represent one of the largest blocs of votes in the country, and no politician is even going to try to resist the temptation that this bloc presents. Change is coming; the only question is the nature of the change—whether it will be merely the usual band-aid approach of government programs or whether it will be a truly revolutionary change that touches the spirit and the mind of the nation. The answer to that question is largely up to us. And the place to begin is by asking the most basic question of all.

What is aging?

The AMA Committee on Aging faced that question and answered it this way: "Aging is really living, growing, and developing so that the final days and contributions should be far different in the future than they seem to be today."

To make that statement come true, to make it the national concept of aging, is the most important duty of all nursing home administrators.

ITEM 5. AMERICAN MEDICAL ASSOCIATION, REPORT OF THE COUNCIL ON MEDICAL SERVICE, GUIDELINES FOR A MEDICAL DIRECTOR IN A LONG-TERM CARE FACILITY; SUBMITTED BY DR. EDWARD J. LORENZE,* MEDICAL DIRECTOR, BURKE REHABILITATION CENTER, WHITE PLAINS, N.Y.

EXHIBIT B

The Committee on Aging of the Council on Medical Service has been conducting, with U.S. Department of Health, Education, and Welfare (DHEW) support and assistance, a highly successful series of 10 seminars on the role of the medical director in the long-term care facility. Physicians and administrators have met together to identify ways in which physician leadership can work with attending physicians and allied health professionals in improving patient care. Seminar participants have agreed almost unanimously on the need for a medical director in a long-term care facility.

The Council believes that long-term care facilities should have either a medical director and/or an organized medical staff to help ensure the adequacy and appropriateness of the medical care provided to patients in such facilities. It is recognized that medical directors are being appointed because physicians with patients in long-term care facilities seldom organize themselves into a formal medical staff.

The Council on Medical Service, therefore, recommends that the American Medical Association adopt these guidelines for a medical director in a long-term care facility. It is recommended that if a long-term care facility has both an organized medical staff and a medical director, the medical director should be appointed with the approval of the medical staff. The conditions of employment for the medical director should be spelled out in a formal agreement. The agreement should specify the amount of time deemed necessary for the medical director to fulfill assigned administrative duties.

The medical director should be compensated for his administrative services. Compensation should not be in the form of rebate, referral of patients, or referral for consultation. This arrangement does not preclude the medical director from providing direct patient care under other financial arrangements.

To help ensure the adequacy and appropriateness of the medical care provided to patients, the Council recommends that wherever feasible the medical director should:

1. Assist in arranging for continuous physician coverage for medical emergencies and in developing procedures for emergency treatment of patients.

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*See statement, p. 2567.

2. Participate in development of a system providing a medical care plan for each patient, which covers medications, nursing care, restorative services, diet and other services, and, if appropriate, a plan for discharge.
3. Be the medical representative of the facility in the community.
4. Develop liaison with attending staff physicians in efforts to ensure effective medical care.
5. In the absence of an organized medical staff, be responsible for the development of written bylaws, rules and regulations applicable to each physician attending patients in the facility.
6. If there is an organized medical staff, be a member, attend meetings and help assure adherence to medical staff bylaws, rules and regulations.
7. Participate in developing written policies governing the medical, nursing, and related health services provided in the facility.
8. Participate in developing patient admission and discharge policies.
9. Participate in an effective program of long-term care review.
10. Be available for consultation in the development and maintenance of an adequate medical record system.
11. Advise the administrator as to the adequacy of the facility's patient care services and medical equipment.
12. Be available for consultation with the administrator and the director of nursing in evaluating the adequacy of the nursing staff and the facility to meet the psychosocial as well as the medical and physical needs of patients.
13. Be available for consultation and participation in in-service training programs.
14. Advise the administration on employee health policies.
15. Be knowledgeable concerning policies and programs of public health agencies which may affect patient care programs in the facility.

ITEM 6. LETTER FROM ERNEST B. HOWARD, M.D., AMERICAN MEDICAL ASSOCIATION, TO COMMISSIONER, SOCIAL SECURITY ADMINISTRATION; SUBMITTED BY DR. EDWARD J. LORENZE,* MEDICAL DIRECTOR, BURKE REHABILITATION CENTER, WHITE PLAINS, N.Y.

EXHIBIT C

SEPTEMBER 24, 1973.

DEAR COMMISSIONER: The American Medical Association appreciates this opportunity to comment upon section 405.1122 (b) of the proposed rules governing Skilled Nursing Facilities, published in the Federal Register of July 12, 1973.

The Association's House of Delegates, at its 1973 Annual Convention, adopted a report from its Council on Medical Service on "Guidelines for a Medical Director in a Long-Term Care Facility" which specifically states that such facilities should have either a medical director or an organized medical staff, or both to help ensure the adequacy and appropriateness of the medical care provided to patients in such facilities. Sec. 405.1122 (b) would permit execution of patient care policies to be the responsibility of a physician, a medical staff, or a registered nurse; we would strongly urge that the responsibility be assigned only to a medical director who is a physician, or to an organized medical staff.

We recognize that smaller facilities may have this requirement fulfilled by a part-time rather than a full-time medical director, but the Association does emphatically believe that the requirement that over-all patient care policies be the responsibility of an organized medical staff or a full or part-time medical director will contribute significantly to improvement in the quality of care.

We would, therefore, urge that the Department of HEW and the Social Security Administration continue their efforts to bring about improvements in the quality of care rendered and received in long-term care facilities by encouraging such institutions to place the responsibility of carrying out patient care policies in a medical director and/or organized medical staff. Such emphasis will surely result in a higher quality of medical care in these institutions.

Thank you for permitting us this opportunity to offer our views. I hope they will be helpful to you.

Sincerely,

ERNEST B. HOWARD, M.D.

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*See statement, p. 2567.

ITEM 7. GERIATRIC NURSING PRACTICE, STANDARDS, FROM THE AMERICAN NURSES' ASSOCIATION; SUBMITTED BY SISTER MARILYN SCHWAB,* R.N. CHAIRMAN, EXECUTIVE COMMITTEE DIVISION OF GERIATRIC NURSING, AMERICAN NURSES' ASSOCIATION, INC.

WHY STANDARDS OF PRACTICE?

"A professional association is an organization of practitioners who judge one another as professionally competent and who have banded together to perform social functions which they cannot perform in their separate capacity as individuals."[1]

A professional association, because of its nature, must provide measures to judge the competency of its membership and to evaluate the quality of its services. Studies show that the tendency for self-organization has been found to be characteristic of professions and the establishment and implementation of standards characteristic of the organization. Mary Follet in her work, *American Nursing: History and Interpretation,* points out that professional associations have one function above all others:

"The members do not come together merely for the pleasure of meeting others of the same occupation; nor do they meet primarily to increase their pecuniary gain; although this may be one of the objects. They join in order to better perform their functions. They meet:

To establish standards.
To maintain standards.
To improve standards.
To keep members up to standards.
To educate the public to appreciate standards.
To protect the public from those individuals who have not attained standards or willfully do not follow them.
To protect individual members of the profession from each other."[2]

A profession's concern for the quality of its service constitutes the heart of its responsibility to the public. The more expertise required to perform the service, the greater is society's dependence upon those who carry it out. A profession must seek control of its practice in order to guarantee the quality of its service to the public. Behind that guarantee are the standards of the profession that provide the assurance that the guarantee will be met. This is essential both for the protection of the public and the profession itself. A profession that does not maintain the confidence of the public will soon cease to be a social force.

In recognition of the importance of standards of professional practice and the need to guarantee quality service, the various Divisions of Nursing Practice have each formulated a set of standards. The American Nurses' Association recognizes that as standards are implemented in practice settings and as the scope of nursing practice enlarges and the theoretical basis upon which this practice rests becomes more sharply delineated, ongoing revision of the standards of professional practice will be warranted.

Congress for Nursing Practice

References

[1] Merton, Robert K. "The Functions of the Professional Association." **American Journal of Nursing,** Vol. 58 (January 1958), p. 50.

[2] **Dynamic Administration,** The Collected Papers of Mary Follet edited by Henry C. Metcalf and L. Urwick. New York: Harper & Brothers, 1942, p. 136.

*See statement, p. 2574.

AMERICAN NURSES' ASSOCIATION

STANDARDS OF GERIATRIC NURSING PRACTICE

Nursing practice is a direct service, goal directed and adaptable to the needs of the individual, family and community during health and illness.

Geriatric Nursing is concerned with the assessment of the nursing needs of older people; planning and implementing nursing care to meet these needs, and evaluating the effectiveness of such care to achieve and maintain a level of wellness consistent with the limitations imposed by the aging process.

There are primary factors which make the nursing of older persons different. Among these factors are: the chronological age and the effect of the aging process;the multiplicity of an older person's losses; social, economic, psychologic and biologic factors; the frequently atypical response of the aged to disease, coupled with the different forms disease entities may assume in the aged person; the accumulative disabling effect of multiple chronic illnesses and/or degenerative process; cultural values associated with aging and social attitudes toward the aged.

The Standards of Geriatric Nursing Practice stem from the premise that knowledge and theories of the aging process when applied to nursing practice should improve the care of the aged. In the practice of Geriatric Nursing, the nurse must acquire, test and selectively use this knowledge and these theories in the development and implementation of the nursing care plan

The Standards focus on practice. They provide a means for determining the quality of nursing which a client/patient receives regardless of whether such services are provided solely by a professional nurse or by a professional nurse and nonprofessional assistants.

The Standards are stated according to a systematic approach to nursing practice: the assessment of the client's/patient's status, the plan of nursing actions, the implementation of the plan, and the evaluation. These specific divisions are not intended to imply that practice consists of a series of discrete steps, taken in strict sequence, beginning with assessment and ending with evaluation. The processes described are used concurrently and recurrently. Assessment, for example, frequently continues during implementation; similarly, evaluation dictates reassessment and replanning.

The Standards of Geriatric Nursing Practice apply to nursing practice in a variety of settings. Nursing practice in all settings must possess the characteristics identified by these Standards if patients are to receive a high quality of nursing care. Each Standard is followed by a rationale and assessment factors. Assessment factors are to be used in determining achievement of the Standard.

One of the major issues in Geriatric Nursing is the attitude of the practitioner providing the care. Therefore, the Standards of Geriatric Nursing Practice begin with two statements concerning attitudes.

STANDARD I

THE NURSE DEMONSTRATES AN APPRECIATION OF THE HERITAGE, VALUES AND WISDOM OF OLDER PERSONS.

Rationale: The nurse has some understanding and appreciation of the social and historic settings in which older people have developed and how these factors may affect their behavior and values. This enables her to respect the older person as an individual and provides for enrichment of the nurse's life. Such an appreciation also provides ways in which the nurse can point out how the present generation has built on their foundation, thus helping to keep older persons in the present.

Assessment Factors:

1. The nurse helps older persons share their experiences and talents with the present generation.
2. The nurse respects the older person's right to practice religion as he desires.
3. The nurse accepts the older person's desire to cling to a particular item, such as a piece of jewelry or a photograph.
4. The nurse accepts the older person's right to wear the clothes he is accustomed to wearing, such as a night cap or long underwear.

STANDARD II

THE NURSE SEEKS TO RESOLVE HER CONFLICTING ATTITUDES REGARDING AGING, DEATH AND DEPENDENCY SO THAT SHE CAN ASSIST OLDER PERSONS AND THEIR RELATIVES TO MAINTAIN LIFE WITH DIGNITY AND COMFORT UNTIL DEATH ENSUES.

Rationale: If the nurse does not recognize and seek to resolve conflicts regarding aging, death and dependency, functioning can be impaired and personal satisfaction not be achieved from her work. These conflicts are resolved to enable the nurse to enlarge her capacity to express empathy and compassion.

Dying and death are common emotional and stressful experiences. Preparation for death is an imminent developmental task of old age. The older person is more frequently exposed to dying and death. The nurse needs to assist older persons, personnel, relatives and other persons who are experiencing dying, death and bereavement in order that they may express their feelings, thoughts and rituals.

Rituals provide a socially acceptable way of coping with emotion; therefore, the nurse enables the older person to participate in rituals meaningful to him.

Assessment Factors:

1. The nurse recognizes that the dependency-independency conflict is perpetuated throughout life.
2. The nurse recognizes that many of her own attitudes concerning death and dying are learned from the culture of the society in which she lives.
3. The nurse freely shares her feelings about her attitude toward aging and death with colleagues or other individuals.
4. The nurse recognizes the many ways of coping with death.
5. The nurse calls the appropriate religious advisor or provides for last rites.
6. Upon request or other indication, the nurse assists in the preparation for dying, making of the will, plans for burial and notification of other persons.

STANDARD III

THE NURSE OBSERVES AND INTERPRETS MINIMAL AS WELL AS GROSS SIGNS AND SYMPTOMS ASSOCIATED WITH BOTH NORMAL AGING AND PATHOLOGIC CHANGES AND INSTITUTES APPROPRIATE NURSING MEASURES.

Rationale: In older persons, pathology may be ignored because their symptoms may be ascribed to the normal aging process. Older persons do not attend to and are frequently not able to express or recognize the importance of symptoms. They have lived with some symptoms, such as pain, for a long time and have adapted to it. As a result, they either

ignore or exaggerate the symptom. Sensory and cognitive changes are often slowly progressive and may be ignored until the adaptive response of the aged may interfere with functions or health, such as a personality change due to progressive loss of hearing.

Assessment Factors:

1. Falling, irritability, or slight speech changes may be a sign of cerebral disturbance.
2. Confusion may be caused by medication, dehydration, or excessive fatigue. Mild confusion may be the first indication of pneumonia.
3. Edema may result from prolonged sitting or it may be a sign of either a cardiovascular problem or electrolyte imbalance.

STANDARD IV

THE NURSE DIFFERENTIATES BETWEEN PATHOLOGIC SOCIAL BEHAVIOR AND THE USUAL LIFE STYLE OF EACH AGED INDIVIDUAL.

Rationale: In all human beings, there is a continuum of behavior which is within the range of normal. It is difficult to discriminate between that which is normal and that which can be dangerous to the individual or others, such as the right of the person for privacy and its extreme, which is withdrawal, and a person's right to independence and its extreme which may also be pathologic.

Assessment Factors:

1. The nurse visiting in the home may observe poor maintenance of the home and a lack of cleanliness. The nurse assesses the situation to determine whether this has always been the person's life style or whether his behavior has changed.
2. Many older persons who have been useful and needed throughout their lives may resent being given "busy work."
3. Withdrawal may or may not be a coping mechanism.
4. An older person who is used to independence and self-direction, may become mildly confused when placed in an institution. Such agitation may result in the older person making unusual demands. The nurse must not automatically see this as senility, but rather determine whether it might be an effort to maintain a life style that is being threatened.
5. The nurse provides for healthy outlet of normal sexual drives within the individual's life style and environmental settings, such as opportunities for heterosexual activities.
6. The nurse assists older persons to develop and maintain their social contacts, both inside and outside the institution or dwelling. This may take the form of telephone calls, birthday cards, etc. These activities may be provided by voluntary services.

STANDARD V

THE NURSE SUPPORTS AND PROMOTES NORMAL PHYSIOLOGIC FUNCTIONING OF THE OLDER PERSON.

Rationale: The nurse helps the older person to experience a higher level of wellness and seeks to prevent iatrogenic conditions.

Assessment Factors:

1. The nurse makes use of selected foods, fluids, exercise and habit training instead of cathartics, enemata and other artificial means for bowel regulation.
2. The nurse uses back rubs and gentle massage and other nursing measures as possible alternatives for medication to encourage sleep.
3. The nurse is aware of the increased dryness and fragility of an older person's skin so that less frequent bathing is indicated.
4. The nurse allows sufficient time for the client/patient to perform his activities of daily living at his own pace.

STANDARD VI

THE NURSE PROTECTS AGED PERSONS FROM INJURY, INFECTION AND EXCESSIVE STRESS AND SUPPORTS THEM THROUGH THE MULTIPLICITY OF STRESSFUL EXPERIENCES TO WHICH THEY ARE SUBJECTED.

Rationale: Aged persons have a decreased margin of compensatory reserve and, therefore, are more vulnerable to secondary problems as a result of stressful experience.

Assessment Factors:

1. Because the older person frequently has a variety of chronic illnesses, an acute episode will often exacerbate a chronic illness. When pneumonia occurs the older individual frequently develops cardiac decompensation or his diabetes becomes unregulated. The nurse must recognize early symptoms or even the potential for decompensation and provide the preventive rest and dependence.
2. The nurse uses appropriate precautions to prevent self-mutilation, suicide and assaultive behavior.
3. When an older person has a fractured femur, unless early mobility is provided, he frequently develops complicating conditions such as incontinence, confusion, social withdrawal and decubitus ulcers.

STANDARD VII

THE NURSE EMPLOYS A VARIETY OF METHODS TO PROMOTE EFFECTIVE COMMUNICATION AND SOCIAL INTERACTION OF AGED PERSONS WITH INDIVIDUALS, FAMILY AND OTHER GROUPS.

Rationale: Communication is essential to mental health and social well-being. Older persons need all kinds of sensory stimulation as well as a higher intensity of such stimulation. They frequently experience barriers to communication, such as language difference, aphasia, deafness, edentulousness or sensory loss.

Assessment Factors:

1. Older blind persons may be able to use talking books and other devices.
2. The nurse uses touch as a nonverbal means to communicate purposefully an idea or feeling.
3. The nurse makes a special effort to get and hold the older person's attention by eye contact, pitch of voice and/or objects which improve her communication with older persons.
4. The nurse uses clocks, calendars, newspapers, reading materials, thermometers and holiday decorations to assist in the orientation and stimulation of older persons to time and events.
5. The nurse plans and creates situations so that interaction is encouraged, such as placing an older person in a wheelchair near the nurse's desk so that he can observe, or thoughtfully selecting roommates and caring personnel.
6. The nurse is aware of obstacles that may interrupt the communication process between the nurse and an older person.
7. Music is a universal language; therefore, it may be used on an individual basis or as group activity to promote interaction.

STANDARD VIII

THE NURSE TOGETHER WITH THE OLDER PERSON DESIGNS, CHANGES OR ADAPTS THE PHYSICAL AND PSYCHOSOCIAL ENVIRONMENT TO MEET HIS NEEDS WITHIN THE LIMITATIONS IMPOSED BY THE SITUATION.

Rationale: The health of the older person is greatly influenced by his environment. The nurse uses this environment as a therapeutic tool. His environment may be monotonous because his mobility is reduced. The nurse, therefore, provides for variety in his environment.

The older person who has increasing dependence still has a need for maintaining a degree of mastery of his physical and psychosocial environment.

Assessment Factors:

1. The nurse provides a variety of materials for the older person's creativity, manipulation and sensory stimulation.
2. The nurse suggests the installation of hand rails in buildings used by aged persons.

3. The nurse changes the location of a client's/patient's bed so he may look out of the window.
4. The nurse provides the opportunities for learning which expand the horizons of older persons.
5. The nurse teaches the family to avoid many sudden changes in the environment. Often the most simple change of furniture is upsetting.

STANDARD IX

THE NURSE ASSISTS OLDER PERSONS TO OBTAIN AND UTILIZE DEVICES WHICH HELP THEM ATTAIN A HIGHER LEVEL OF FUNCTION AND ENSURES THAT THESE DEVICES ARE KEPT IN GOOD WORKING ORDER BY THE APPROPRIATE PERSONS OR AGENCIES.

Rationale: Devices are essential supportive measures to facilitate function. A nonfunctioning or defective device is potentially dangerous. To help older persons be more independent, the nurse teaches them to secure, to use and to maintain their devices.

Older persons have proportionately greater need for one or more assistive devices to facilitate functioning; therefore, the nurse needs to be well informed about resources for obtaining and maintaining these devices.

Assessment Factors:

1. If a hearing aid is required, the nurse considers the problem of cost and, if necessary, contacts a community agency. When a hearing aid is fitted for the older person, the nurse assists him in his adjustment to it by recognizing fatigue and that it takes time to get used to a hearing aid.
2. The nurse uses other resource persons to help design and fit wheelchairs and to adapt and maintain this equipment.
3. Following a cerebral vascular accident, the older person may need to adjust to using a cane, foot-drop brace, hearing aid and special eating devices.
4. The use of some devices, such as a hydraulic lift, may be primarily for the benefit of personnel and the older person may need a great deal of reassurance and instruction to perceive the mutual benefit obtained.
5. The nurse makes use of appropriate community resources, such as the Ileostomy Society, for additional assistance.

ITEM 8. LETTER FROM EILEEN M. JACOBI,* R.N., EXECUTIVE DIRECTOR, AMERICAN NURSES ASSOCIATION, INC., TO ARTHUR E. HESS, ACTING COMMISSIONER, SOCIAL SECURITY ADMINISTRATRATION, AUGUST 7, 1973

DEAR MR. HESS: The American Nurses' Association is pleased to have the opportunity to review and comment upon the proposed amendments to regulations for Skilled Nursing Facilities under Titles XVIII and XIX prior to their adoption.

We believe these proposed rules and regulations reflect an effort to upgrade the quality of care in skilled nursing facilities.

A common set of Standards for Skilled Nursing Facilities under Title XVIII (Medicare) and Title XIX (Medicaid) and uniform certification procedures are desirable because they will provide a framework for coordination and continuity of care over time among and beyond health care institutions.

Page 18624, No. 405.1122

(b) *Standard: Execution of patient care policies.*—The ANA endorses the concept of nurses assuming a major role for the execution of patient care policies. Among health care professionals, the registered nurse has the most continuous contact with patients and is in a unique position to provide coordination based on planning and recognition of the contributions of the several health disciplines involved in the development of patient care policies. However, delegating the responsibility for the execution of patient care policies to the registered nurse demands that there be adequate and continuing medical guidance and support.

Page 18625 No. 405.1124 Condition of participation—nursing services.

The ANA strongly urges that the services of the registered nurse be provided seven days a week. The title Skilled Nursing Facilities implies there is a con-

*See statement, p. 2574.

tinuing need for skilled nursing care. Patients' needs for skilled care cannot reasonably be limited to a time frame of five days out of every seven days.

Skilled nursing care is a complex process involving the systematic assessment of individual and group needs, formulation of nursing care plans, their implementation and the evaluation of care provided. Included in this process is a recognition of sudden or subtle changes and the exercise of professional nursing judgment to respond appropriately. The nursing process requires broad based knowledge and ability to make these crucial nursing judgments and to direct the activities of a variety of nursing personnel who possess diverse backgrounds in education, experience, ability, and motivation.

(c) *Standard: Twenty-four hour nursing service.*—"Nursing personnel, including at least one registered nurse on the day tour of duty five days a week, licensed practical nurses, nurse aides, orderlies, and ward clerks are assigned duties consistent with their education and experience, and based on the characteristic of the patient load and the kinds of nursing skill needed to provide care to the patients."

This Standard recognizes that personnel are prepared for different competency levels and that effective round-the-clock nursing care involves an appropriate blend of the competencies of nursing personnel and the needs of patients.

However, we believe that the number of registered nurses required to provide safe and effective nursing care and to direct the activities of the nursing staff is related to the number of patients cared for in the skilled nursing facility. For example, a skilled nursing facility with a capacity under fifty beds may fuction well with a registered nurse but there is an obvious need for more registered nurses in a larger skilled nursing facility.

Our primary concern with this Standard is that some proprietors of skilled nursing facilities will comply with the letter of the Regulations rather than its spirit or intent. There appears to be no mechanism to ensure that an adequate number of registered nurses will be provided when the proposed regulation specifies only "nursing service which is sufficient to meet nursing needs * * * " and further "including at least one registered nurse on the day tour of duty five days a week * * *."

A recommendation in support of more generous use of registered nurses is contained in the *Report of the Secretary's Commission on Medical Malpractice* published January, 1973. "The Commission recommends that physicians, hospitals, and nursing homes and other institutions increase the number of professional nurses giving direct care to patients in the interests of better patient care and of minimizing malpractice suits."

(d) *Standard: Patient care plan.*—Discharge planning should be included as an essential, specific component of the patient care plan. Discharge planning needs to be initiated at the time of the patient's admission to the facility. It must be multi-disciplinary in approach and include significant participation on the part of the patient and his family.

Page 18634, No. 405.191 Special hospital certification

(c) *Waiver of twenty-four hour registered nurse requirement.*—A waiver of this registered nurse requirement should be granted only when the facility can show evidence of having worked with the State Nurses Association to secure registered nurse coverage. Support for this endeavor is included in the report of the Committee on Finance, United States Senate, Russell B. Long, Chairman, accompanying public law 92–603.

"In recognition of the staffing difficulties of the rural skilled nursing facilities, the Committee amendment provides that, to the extent that law or regulation requires the presence of a registered nurse on one full shift seven days a week, a special waiver of the nursing requirement for these facilities may be granted provided that a registered nurse is absent from the facility for not more than two day shifts and the facility is making good faith efforts to obtain another on a part time basis. The American Nurses' Association has indicated that State Nurses' Associations would willingly cooperate in efforts to secure necessary nursing personnel; the committee expects that, to the extent such cooperation is extended, it will be utilized toward alleviating a skilled nursing shortage in a facility." (pp. 252–3, Committee report.)

(4) "The hospital is located in a rural area." The term "rural" needs to be clearly defined.

The American Nurses' Association thanks you for the opportunity to contribute to the proposed amendments to regulations for Skilled Nursing Facilities. We hope our recommendations will be helpful to you.

Sincerely,

EILEEN M. JACOBI, Ed.D., R.N.

ITEM 9. LETTER FROM EILEEN M. JACOBI,* R.N., EXECUTIVE DIRECTOR, AMERICAN NURSES' ASSOCIATION, INC., TO ARTHUR E. HESS, ACTING COMMISSIONER, SOCIAL SECURITY ADMINISTRATION, AUGUST 8, 1973

DEAR MR. HESS: The American Nurses' Association is compelled to point out a critical need for federal assistance in funding appropriate continuing education programs for professional nurses involved in Skilled Nursing Facilities.

The staff development Standard (page 18624, No. 405.1120 contained in the proposed amendments to regulations for Skilled Nursing Facilities) is not sufficient to provide for the breadth or depth of learning experiences which would enable registered nurses to provide appropriate support, counsel and direction to a variety of nursing personnel who possess diverse backgrounds in education, experience, ability and motivation.

Consumers' increasing awareness of quality and demand for service, a rapidly expanding technology, and a pressing requirement that the well prepared nurse systematically builds upon his/her basic preparation through lifelong learning all serve to make it imperative that the registered nurse be involved in activities that will upgrade and expand nursing practice.

It is grossly inefficient for widely scattered skilled nursing facilities employing small numbers of registered nurses to support and conduct quality continuing education programs. One example of a widely available continuing education activity has been made possible by a contract with Community Health Service, formerly in HSHMA, DHEW. The contract has provided for a series of conferences focusing on geriatric nursing practice for registered nurses working in nursing homes. In addition to expanding the knowledge and skills of the registered nurse participants, the conferences, conducted by ANA, have encouraged the continued development of other nursing home staff.

The American Nurses' Association is convinced that federal assistance in funding appropriate continuing education programs is a very significant contribution to improved patient care in nursing homes.

Sincerely,

EILEEN M. JACOBI, ED.D., R.N.

ITEM 10. NATIONAL COUNCIL OF HEALTH CARE SERVICES, POSITION PAPERS, SUBMITTED BY ROGER LIPITZ,** VICE PRESIDENT, NATIONAL COUNCIL OF HEALTH CARE SERVICES

1. INTRODUCTION

The following "position paper" is offered by the National Council of Health Care Services in support of the promulgation of high but fair standards for Intermediate Care Facilities, recently transferred to Federal jurisdiction by Public Law 92-223. The Council is aware that present State standards for such facilities vary widely. The Council is also aware that there exists some pressure to write ICF standards sufficiently lower than those in effect for skilled nursing homes so that a reimbursement differential may be put into effect.

The statement which follows is based on these basic premises:

1. The ICF patient/resident should be the primary concern of those who write and promulgate regulations for these facilities.

2. How individual patients are classified (i.e., skilled or intermediate) is the significant determinant with regard to the amount and type of care needed and, therefore, the amount of reimbursement which will be required.

3. Safety standards including fire safety for facilities which house elderly, sometimes confused, and ill patients/residents—whether they are bedridden or not, must be the same whether the facility is staffed as a skilled nursing home or

*See statement, p. 2574.
**See statement, p. 2588.

as an ICF. While some physical modifications may be in order, any cost savings for lower levels of care can come only through a justifiable reduction in both the amount and skill levels of personnel needed to care for the facility's patients.

The National Council of Health Care Services hopes that the regulations which are finally published will create uniformly high standards for Intermediate Care Facilities, which will assure the safety, comfort and well-being of patients within those facilities.

2. DEFINITION OF PATIENTS

The patient must be defined before setting standards and regulations for his care. The National Council believes that one of the major defects in the proposed regulations is the several different and sometimes conflicting definitions of the intermediate care facility patients which are embodied in various sections of the proposed regulations. Implicit definitions of patients describe patient/residents whose conditions range from ambulatory, mentally alert individuals capable of administering medications to themselves and participating in community activities outside the facility to blind, physically handicapped, non-ambulatory, mentally debilitated persons whose conditions range from mild illness to serious and incapacitating conditions.

If this broad range of patients is indeed envisioned as the typical patient mix in an intermediate care facility, then the National Council of Health Care Services strongly recommends that licensed nursing coverage for intermediate care facilities be required around the clock, seven days a week, rather than the limited coverage required in the proposed regulations, Section 249.12(a) (6) (1). Licensed personnel should always be present in case an emergency occurs, if they are available in the area at wage rates which are usual and customary in the area.

Further, we believe it is essential to more carefully define the ICF patient. Otherwise, the intermediate care facility could be almost anything.

2A. One must define the patient before setting standards and regulations for his care. Since several States now classify patients requiring constant skilled attention as "intermediate" patients, two classifications are defined below for patients who might be labeled intermediate. Optional positions on certain subjects were developed, based on how patients are classified. The starting point used is a definition of a skilled patient.

Skilled patient.—The skilled patient requires the supervision of or treatment by a professional or licensed nurse. In addition, he needs the professional evaluation or judgment of a nurse on a continuing basis, because the physician is not available on a day to day basis. It should be noted that this definition suggests that it is the judgment function of the professional nurse, rather than the specific tasks she performs, which should be most important.

Intermediate-skilled patient (ICF No. 1).—This patient requires a substantial amount of professional assistance with the activities of daily living, because of the complexity of the services required. He is unable in many instances to recognize his own medical condition. Because of his needs, this type of patient requires round-the-clock supervision by licensed personnel. This type of patient does exist. Where and how he is classified materially affects whether there will be a cost differential between intermediate and skilled care. If this type of patient is classified as an intermediate patient, there will be no cost differential in caring for him vis-a-vis the skilled patient. This type of patient represents a substantial percentage of the present patient load in nursing homes today. If these patients are classified intermediate, then the need for full time licensed personnel must be recognized and reimbursement should meet the cost of providing the care.

True intermediate patient (IFC No. 2).—The typical ICF No. 2 patient will be a person of advanced age who because of chronic infirmities and loss of strength and mobility needs assistance with daily living. Such patients generally will have some chronic illness, will be susceptible to accident and limited episodes of acute illness, and most will be regularly taking some prescription medication. Many of these patients may suffer occasions of mental confusion.

3. STANDARD—ICF VS. SKILLED—SECTION 249.10(b) (i) (a)

§ *249.10 Amount, duration, and scope of medical assistance.*

* * * * * * *

(b) Federal financial participation. * * *

(14) Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over

in an institution for tuberculosis or mental diseases. For purposes of this subparagraph:

(i) (*a*) "Inpatient hospital services" in an institution for mental diseases are those items and services which are provided under the direction of a physician for the care and treatment of inpatients in a psychiatric hospital which meets the requirements under title XVIII, section 1861(f) of the Social Security Act.

(*b*) "Inpatient hospital services" in an institution for tuberculosis are those items and services which are provided under the direction of a physician for the care and treatment of inpatients in a tuberculosis hospital which meets the requirements under title XVIII, section 1861(g) of the Social Security Act.

(ii) "Skilled nursing facility services" are those items and services furnished by a skilled nursing facility as defined in paragraph (b)(4)(i) of this section.

(iii) "Intermediate care facility services" are those items and services furnished by an intermediate care facility as defined in paragraph (b)(15) of this section to residents who have been determined in accordance with § 250.24 of this chapter to be in need of such care.

(15) Intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Intermediate care facility services may include services in a public institution (or distinct part thereof) for individuals determined to be mentally retarded or to have cerebral palsy, epilepsy, or other developmental disabilities as defined pursuant to Part C of the Developmental Disabilities Services and Facilities Construction Act. "Intermediate care facility services" means those items and services furnished by a facility which meets the following conditions:

(i) (*a*) It meets fully all requirements for licensure under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. Payments to a facility which formerly met all requirements of the State for licensure, but is currently determined not to meet fully all such requirements, may be recognized by the single State agency for a period specified by the State standard-setting authority, if during such period such facility promptly takes all necessary steps to meet such requirements. Institutions operated by a governmental agency may be considered to be licensed if they meet all requirements which are applied for licensure to the same type of facility in any other ownership category (i.e., nonprofit or proprietary) within the State;

COUNCIL POSITION

While it is obviously the intent of both the law which transferred intermediate care to Title XIX (P.L. 92-223) and the proposed regulations that state standards for licensure of intermediate care facilities should not be the same as those for skilled nursing facilities. the National Council recommends that Section 249.10(b)(15)(i)(a) be clarified to specifically state that state requirements for intermediate care facility licensure shall not be used as the determinant of eligibility to participate in the medicaid program as an intermediate care facility if those state standards require intermediate care facilities to meet the same standards as are required for skilled nursing facilities.

4. OWNERSHIP DISCLOSURE—SECTION 249.111(a)

A State plan for medical assistance under title XIX of the Social Security Act which includes intermediate care facility services must provide that:

(a) Any intermediate care facility receiving payments under the plan must supply to the licensing agency of the State full and complete information, and promptly report any changes which would affect the current accuracy of such information, as to the identity

(1) Of each person having (directly or indirectly) an ownership interest of 10 percent or more in such facility,

(2) In case a facility is organized as a corporation, of each officer and director of the corporation, and

(3) In case a facility is organized as a partnership, of each partner;

COUNCIL POSITION

The National Council of Health Care Services supports the mandatory disclosure of significant ownership interests for intermediate care facilities (as required by Section 299A of P.L. 92-603) as well as for other health care facilities. We would suggest, however, that the disclosure requirements in the proposed regulations be broadened to include other aspects which have just as significant potential effect on cost to the patient. In light of recent disclosures by the Washington Post, as well as many other documented cases of conflict of interest self-dealings on the part of directors and trustees of non-profit health care institutions, the National Council recommends that all health care facilities, whether proprietary or voluntary, be required to provide full and complete information to the state licensing agency on the names and business affiliations of their trustees and/or directors. We would further recommend that the full and complete disclosure of all business transactions between an institution's trustee's place of business and the institution be made a requirement. Requirements for this type of disclosure should be patterned after those required of publicly held companies by the Securities and Exchange Commission. Approximately 75 percent of the health care companies which are members of the National Council of Health Care Services are publicly held and already following this practice.

In addition, the National Council recommends that the above information be made available to the public in a convenient place.

5. ADMINISTRATION AND SUPERVISORY—SECTION 249(A)(6)

§ *249.12 Standards for intermediate care facilities (other than institutions for the mentally retarded or persons with related conditions).*

(*a*) *Standards.* The standards for an intermediate care facility which are specified by the Secretary pursuant to section 1905(c) of the Social Security Act and referred to in §§ 249.10(b)(15) and 249.11 are as follows. The facility:

(1) Maintains methods of administrative management which assure that:

(ii) An individual on the professional staff of the facility is designated as resident services director and is assigned responsibility for the coordination and monitoring of the residents' overall plan of service:

(iv) Written policies and procedures are developed by the administrator with the assistance of the resident services director and a registered nurse which govern all areas of service provided by the facility;

(6) .Provides health services under direct supervision of a health services supervisor in accordance with the following:

(i) Immediate supervision of the facility's health services on all days of each week is by a registered nurse or licensed practical (or vocational) nurse employed full time (exclusive of all other duties) on the day shift and who is currently licensed to practice in the State: *Provided that:*

(*a*) In the case of facilities where a licensed practical (or vocational) nurse serves as the supervisor of health services, consultation is provided by a registered nurse, through formal contact, at regular intervals, but not less than 4 hours weekly; and

(*b*) By January 1975, licensed practical (or vocational) nurses serving as health services supervisors have training that includes either graduation from a State-approved school of practical nursing or education and other training that is considered by the State authority responsible for licensing of practical nurses to provide a background that is equivalent to graduation from a State approved school of practical nursing, or has successfully completed the Public Health Service examination for waivered licensed practical (vocational) nurses;

(ii) The health services supervisor has the following responsibilities:

(*a*) The development and implementation of a written health care plan for each resident in accordance with instructions of the attending physician;

(*b*) General supervision, guidance and assistance for each resident in carrying out his personal health program to assure that preventive meas-

ures, treatments and medications prescribed by the attending physician are properly carried out and recorded; and

(c) The review and revision of resident health care plans, as needed, but not less than quarterly;

(iii) Restorative nursing care is provided to assist each resident to achieve and maintain the highest possible degree of function, self-care and independence;

(iv) Health services personnel are sufficient in numbers and qualifications so that:

(a) There is on duty, awake and fully dressed, a sufficient number of responsible staff members at all times immediately accessible to all residents and qualified by training and experience to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies;

(b) In the presence of minor illness and for temporary periods, bedside care under the direction of the resident's physician is available from or supervised by a registered nurse or licensed practical nurse; and

(c) All resident health needs are met and each resident receives treatments, medications, diet and other health services as prescribed and planned, all hours of each day and all days of each week;

COUNCIL POSITION

The National Council is in agreement with Section 249.12(a)(1)(i) of the proposed regulations which requires intermediate care facilities to be administered by a state-licensed nursing home administrator. We strongly recommend that the phrase "(or hospital administrator in the case of a hospital qualifying as an intermediate care facility)" be deleted from this section. Administration of long term care patients requires special training, which is not equal to the specialized training given to hospital administrators, who are oriented toward acutely-ill patients.

We believe, however, that the key staff person charged with overall responsibility for patient services and activities should be a Director of Nursing Services. We do not believe that a social worker or other professional in the field is the appropriate person to assume responsibility for the necessarily medical and health problems of patients.

Specifically, the National Council recommends, with respect to Sections 249.12 (a)(1)(ii) and (iv), that the regulations be clarified to allow the facility's administrator to serve as resident services director in certain cases as follows:

The resident services director will coordinate and monitor the resident's overall plan of services only if she (he) is also the health services director (licensed nurse)—as defined in Section 249.12(a)(6). Otherwise, responsibility for monitoring and coordinating patient services should be delegated by the resident services director (who may be the facility's administrator) to the health service director.

We find Section 249.12(a)(6)(i) not clear in stating whether the health service supervisor must be employed full time exclusively as a supervisor or to perform nursing duties. If the regulations are meant to require the health services supervisor to be employed exclusively as a supervisor, then this requirement should be related to the size of the facility. In many small facilities, it is appropriate for the licensed nurse who serves as health services supervisor to serve as resident services director as well as to pass medications. (Further, in many states, only licensed nurses are permitted to pass medications.)

The phrase "(exclusive of all other duties)" should be eliminated, to clarify the above point.

Consonant with the best interests of the patient, licensed coverage around the clock should be required. The National Council strongly recommends that Section 249.12(a)(6) be amended to require this coverage. In determining the need for round-the-clock licensed coverage, however, a distinction should be made between freestanding intermediate care facilities and ICF "distinct parts" of skilled nursing facilities. Our licensed personnel requirement recommendations for a freestanding facility are dictated, in some cases, by a concern over not having assistance available whenever needed. In an ICF "distinct part" such a consideration would not necessarily apply, since most skilled nursing facilities are required to have round-the-clock licensed nursing coverage, and therefore could provide needed assistance to ICF patients. The following is the Council's earlier position.

1. Regulations should require that all participating intermediate care facilities have a licensed nursing home administrator. The key staff person charged with overall responsibility for patient services and activities should be a Director of Nursing Services. The key staff person must be a licensed nurse. We do not believe that a social worker or other professional in the field is the appropriate person to be responsible for the necessarily medical and health problems of patients.

Requiring a licensed nursing home administrator would do away with the necessity of having a "Program Director" on the ICF staff. The PES examination used by most States in testing administrators for licensure does test the candidate on his ability to administer rehabilitative activities.

In those facilities serving only the second type of ICF patient, where it would not be necessary to have a registered professional nurse in charge, the facility should employ a registered nurse as a consultant, to be available for emergencies and for advice and assistance as needed.

6. STAFFING—SECTION 249.12(a)(1)(iii)

§ 249.12 Standards for intermediate care facilities (other than institutions for the mentally retarded or persons with related conditions).

(a) *Standards.* The standards for an intermediate care facility which are specified by the Secretary pursuant to section 1905(c) of the Social Security Act and referred to in §§ 249.10(b)(15) and 249.11 are as follows:

(iii) The numbers and categories of personnel are determined by the number of residents and their particular needs in accordance with accepted policies of effective institutional care and guidelines issued by the Social and Rehabilitation Service;

COUNCIL POSITION

The approach to ICF staffing requirements taken in the proposed regulations, Section 249.12(a)(1)(iii), is too vague. The National Council of Health Care Services recommends that minimum requirements for staffing of intermediate care facilities be determined by regulations, using the proper administrative procedure, with an appropriate time for comments on proposed regulations, rather than by "guidelines" issued arbitrarily by SRS–MSA. Too often in the past, "guidelines" issued in the Medicaid program have been interpreted by State agencies as mandatory minimums. This system benefits neither patient nor provider and should be changed.

The National Council's specific recommendations for staffing guidelines in intermediate care facilities, based on numbers and types of patients, as well as whether the ICF is freestanding or a distinct part, are contained in the following:

1. ICF No. 1.— If the patient described above as ICF No. 1 is classified as an intermediate patient, then a registered nurse should be on duty in the facility at least 40 hours per week. Licensed personnel should be on duty around-the-clock, and the total amount of nursing time or the total number of personnel should be the same as the requirements for skilled nursing facility patients.

As an aside, the typical skilled nursing home of any size, in our opinion, requires more licensed personnel than the minimum standard. Facilities caring for ICF No. 1 patients as intermediate patients may not require more than the minimum number and amount of licensed personnel required for skilled patients, but since that void should be filled by activities or rehabilitation personnel, there would still be no cost differential.

2. ICF No. 2.—In a freestanding intermediate care facility which cares for the second category of intermediate care patient, licensed coverage around the clock should be required. There can be no justification for the non-presence of licensed personnel in the case of an emergency. We would suggest that the State not be allowed to waive this provision except in cases where sufficient personnel are not available.

The minimum amount of personnel required should not be greater than 75% of the personnel requirements in a skilled nursing home of comparable size.

7. REHABILITATION—SECTION 249.13(a)(3)

(3) Maintains a rehabilitative program, either directly or through arrangements wth qualified outside resources, consisting of at least physical therapy, occupational therapy, speech therapy and audiology, which is designed to preserve and improve abilities for independent function, prevent

insofar as possible progressive disabiilties, and restore maximum function and which is:

(i) Provided in accordance with accepted professional practices by qualified therapists or by qualified assistants or other supportive personnel under appropriate supervision;

(ii) Provided under a written plan of care, developed in consultation with the attending physician and an appropriate therapist. The plan is based on the attending physicians' orders and an assessment of the resident's rehabilitation potential;

(iii) Continued only upon the written order of the physician, after a report of the resident's progress is communicated to the attending physician within 2 weeks of the initiation of the service; the resident's progress is thereafter reviewed regularly, and the plan altered or revised as necessary; and

(iv) Recorded in the resident's record and is dated and signed by the person ordering or providing the service;

COUNCIL POSITION

The National Council is in agreement with the emphasis on rehabilitation and maintenance embodied in Section 249.12(a)(3) of the proposed regulations. We would point out, however, that while most National Council members' facilities already provide the required services, the requirements in the proposed regulations are higher than those for restorative services for skilled nursing facilities. This section should be changed to require the facility to have a written agreement with a consultant therapist in the various specialties, rather than directly providing them or arranging to provide them for those patients who require rehabilitation therapy. Further, (ii) of this section should read "Provided under a written plan of care, initiated by the attending physician and developed in consultation with the appropriate therapist(s) and the nursing service. The plan is based * * * ."

Finally, separate funding should be provided for rehabilitation services, which are ofen too expensive to be included in the routine services which the intermediate care facility can afford to provide.

While we believe that rehabilitation should be required in the intermediate care standards, we do not believe that rehabilitation should be an element of the definition of the intermediate care facility. The vital concept here should be maintenance. While rehabilitative potential is important, it should not be the criteria for entrance into a program where even maintaining a patient's condition may be an accomplishment. In other words, we would agree with requiring the facility to make available rehabilitative services, but we would disagree with having rehabilitative potential to be a parameter used in defining the intermediate patient.

8. SOCIAL SERVICE—SECTION 249.12(a)(4)(i)

(4) Provides social services designed to promote preservation of the resident's physical and mental health and to prevent the occurrence or progression of personal and social problems; and:

(i) In the absence of a qualified social worker on the staff, who is a graduate of a school of social work accredited by the Council on Social Work Education, a designated staff member suited by training and experience is responsible for arranging for social services through health and welfare resources in the community, and for the integration of the social services with other elements of the resident's plan of care. Such staff member is provided consultation on a regular monthly basis by a qualified social worker; and maintains a written record of the frequency and nature of the qualified social work consultation and services provided or obtained; and

COUNCIL POSITION

With regard to Section 249.12(a)(4)(i), the National Council recommends that the second sentence, beginning with "* * * Such staff member * * *" be changed to:

Such staff member makes arrangements for referral to the appropriate health, social, or welfare agency and maintains a written record of the frequency and nature of the referrals made and services provided or obtained.

Such a change would bring the intermediate care regulations into conformance with requirements for skilled nursing facilities. Because many ICF's will be located in skilled nursing facilities, and because ICF patients will be intermingled with skilled nursing patients in some instances, the conformance of this and other such requirements is a logical step.

9. PATIENT ACTIVITIES—SECTION 249.12(a) (5)

(5) Provides activities programing with the resident's participation designed to encourage restoration to self-care and maintenance of normal activity through physical exercise, intellectual, and sensory stimulation and social interaction which assures that:

(i) A current written outline for group and independent activities of sufficient variety to meet the needs of the various types of residents in the facility is maintained under the direction and supervision of a staff member qualified by experienced and/or training in directing group activity or who has available consultation from a qualified recreational therapist, occupational therapist, occupational therapy assistant, or social worker;

(ii) Independent and group activities are planned for each resident as a matter of record and provided in accordance with his needs and interests and each resident's activity plan is reviewed with the resident's participation at least monthly and altered as needed with appropriate notations recorded describing his social functioning;

(iii) Adequate indoor and outdoor recreation areas are provided with sufficient equipment and materials available to support independent and group activities; and

(iv) Opportunities, as available, are provided for the resident's participation in activities of interest outside the facility through community educational, social, recreational, and religious resources:

COUNCIL POSITION

The National Council of Health Care Services supports Section 249.12(a) (5) which gives the ICF responsibility for emphasizing constructive care for each patient, directed toward restoring and maintaining the patient at his best functional level. We suggest, however, that the monthly review, with the patient's participation, of his individual "activity plan" in (ii) of this Section should be changed to an "as needed" basis. Our experience has shown that many ICF patients stabilize and do not require monthly checks of their activities regimen.

The intermediate care facility should be responsible for emphasizing constructive care for each patient, directed toward restoring and maintaining the patient at his best functional level. Special attention may be needed in remotivating the geriatric patient to prevent and overcome regression symptoms. This should be a major responsibility of the facility administrator and the Director of Nursing.

Each facility should have written plans for organized social and recreational activities with a range of possibilities suitable to varying needs, abilities, and preferences of the individual patients.

Unstructured activities should be provided for those who do not want to participate in organized activities.

In addition, the ICF should keep on hand a supply of newspapers and current periodicals, have arrangements for public library services such as through bookmobiles, and should provide recreation and social activities in space other than bedrooms and corridors.

10. DRUGS AND BIOLOGICALS—SECTION 249.12(a) (9)

(9) Maintain policies and procedures relating to drugs and biologicals which provide that:

(i) (*a*) If the facility maintains a pharmacy department, it employs a licensed pharmacist; or

(*b*) If the facility does not have a pharmacy, it has formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and recordkeeping of drugs and biologicals;

(ii) All medications administered to a resident are ordered in writing by the resident's attending physician;

(iii) Medications not limited as to time or number of doses when ordered are automatically stopped in accordance with written policies of the facility and the attending physician is notified;

(iv) Self-administration of medications is allowed only with the permission of the resident's attending physician;

(v) The health services supervisor (if a registered nurse) or the registered nurse consultant, reviews monthly each resident's medications and when appropriate notifies the physician. Medications are reviewed quarterly by the attending physician;

(vi) All medications are administered by medical and nursing personnel in accordance with the Medical and Nurse Practice Acts of the State; and

(vii) The facility complies with the Federal and State laws and regulations relating to the procurement, storage, dispensing, administration and disposal of narcotics, those drugs subject to the Drug Abuse Control Amendment of 1965 and other legend drugs;

COUNCIL POSITION

The National Council recommends that Section 249.12(a)(9)(v) be changed to require that

"The health services supervisor (if a registered nurse) or the registered nurse consultant reviews on an as needed basis, but not less than quarterly, with the attending physician, each resident's medications."

Further, Section (9)(vi) will cause some States to mandate round-the-clock licensed nursing coverage, because those States allow only licensed personnel to pass medications. (**Referring back to the Council's comments on the failure to require round-the-clock nursing coverage, this should provide added impetus to make that 24-hour coverage mandatory.) The Council's earlier position follows:

The facility administrator should be responsible for drugs and biologicals in the ICF, including seeing that (1) methods and procedures for obtaining, dispensing and administering drugs and biologicals are developed with the advice of a consultant pharmacist; (2) provision is made for obtaining drugs from community pharmacists promptly; (3) there is an emergency medication kit; (4) patients' medications are properly labeled and stored in a locked cabinet; (5) the facility complies with all Federal and State laws and regulations relating to handling of narcotics.

In addition, all medications administered to patients are ordered in writing by the patient's physician and the prescribing physician must review the patient's medication's either monthly or quarterly, depending on how often the patient's condition is checked by the physician.

11. FOOD SERVICE—SECTION 249(a)(10)

(10) Provides arrangements for professional planning and supervision of menus and meal service of both regular and special diets so that:

(i) In the absence of a qualified dietitian or nutritionist on the staff as defined under § 249.33(b)(4)(i), a designated staff member suited by training and experience is responsible for planning and supervision of menus and meal service. Such staff member is provided regularly scheduled consultation from a qualified dietitian or nutritionist. A facility having a contract with an outside food management company may meet this requirement if the company has a dietitian who provides on a regularly scheduled basis, consultant services to the facility;

(ii) A current diet manual recommended by the State survey agency is readily available to food service and health service personnel;

(iii) There is a sufficient number of food service personnel to meet the dietary needs of the residents and there are food service personnel on duty daily over a period of 12 or more hours;

(iv) Procedures are established and regularly followed which assure that the serving of meals to residents for whom special or restricted diets have been medically prescribed is supervised and their acceptance by the resident is observed and recorded in the resident's record;

(v) At least three meals or their equivalent are served daily, at regular times with not more than 14 hours between a substantial evening meal and breakfast;

(vi) Menus are planned at least 2 weeks in advance and sufficient food to meet the nutritional needs of residents is prepared as planned for each meal. When changes in the menu are necessary, substitutions provide equal nutritive value. Records of menus as actually served are retained for 30 days;

(vii) Individuals needing special equipment, implements or utensils to assist them when eating have such items provided; and

(viii) All food is procured from approved sources and stored, prepared, distributed and served under sanitary conditions:

COUNCIL POSITION

The National Council agrees with Section 249.12(a)(10) which requires the ICF to provide arrangements for professional planning and supervision of menus and meal service of both regular and special diets. However, if the "12-hour" requirement in (iii) of this section is meant to be 12 consecutive hours, we recommend that this be eliminated. The consecutive 12-hour requirement is actually meaningless and may conflict with new ideas in food service. Neither five-meal nor three-meal plans require food service personnel twelve hours per day. We do agree with the 14-hour requirement between meals.

Food in the ICF should be prepared and served under competent direction at regular and appropriate times. For general food service the facility should employ a dietician who (1) meets the American Dietetic Association's standards for qualification as a dietitian; or (2) is a graduate holding at least a bachelor's degree from a university program with major study in food and nutrition; or (3) is a trained food service supervisor, an associate degree dietary technician, or a professional registered nurse, with frequent and regularly scheduled consultation from a dietitian or nutritionist meeting the qualifications stated in (1) or (2). The facility may meet this requirement by subscribing to and following a menu planning service recognized by the appropriate State agency.

For special diets, the facility should employ a dietitian who meets the American Dietetic Association's standards for qualifications as a dietitian; or is a graduate holding at least a bachelor's degree from a university program with major study in food and nutrition. The requirement may also be met by using a consultant dietitian or nutritionist who plans special diet menus, or the attending physician may review and approve special diet menus.

12. ENVIRONMENT AND SANITATION—SECTION 249.12(A)(11)

(11) Maintains adequate conditions relating to environment and sanitation in accordance with the standards specified in this subparagraph; except that the single State agency may waive the application to an intermediate care facility of any such standard for such periods and under such conditions as are set forth in paragraph (b) of this section;

(i) The facility is constructed, equipped and maintained to provided a safe, functional, sanitary and comfortable environment. Its electrical and mechanical systems (including water supply and sewage disposal) are designed, constructed and maintained in accordance with recognized safety standards and comply with applicable State and local codes and regulations; and:

(*a*) The facility complies with all applicable State and local codes governing construction;

(*b*) Corridors used by residents are equipped with firmly secured handrails;

(*c*) Blind, nonambulatory or physically handicapped residents are not housed above the street level floor unless the facility is 1-hour protected non-combustible construction (as defined in National Fire Protection Association Standard #220), fully sprinklered 1-hour protected ordinary construction or full sprinklered 1-hour protected wood frame constuction;

(*d*) Reports of periodic inspections of the structure by the fire control authority having jurisdiction in the area are on file in the facility;

(*e*) An adequate supply of hot water for resident use is available at all times. Temperature of hot water at plumbing fixtures used by residents is automatically regulated by control valves;

(*f*) Laundry facilities (when applicable) are located in areas separate from resident units and are provided with the necessary washing, drying and ironing equipment; and

(*g*) Elevators are installed in the facility if resident rooms are located on floors above the street level;

(ii) Each major subdivision has at least the following basic service areas: workroom or area for staff, storage and preparation area for drugs and biologicals, storage space for linen, equipment and supplies, toilet and handwashing facilities;

(iii) Resident bedrooms are designed and equipped for the comfort and privacy of the resident. Each room has or is conveniently located near adequate toilet and bathing facilities which are appropriate in size and design to meet the needs of both ambulatory and nonambulatory residents. Each room has direct access to a corridor and outside exposure with the floor at or above grade level. Resident rooms have no more than four beds with not less than 3 feet between beds;

(iv) Provision is made for isolating residents with infectious diseases in well-ventilated single bedrooms having separate toilet and bathing facilities;

(v) Areas utilized to provide therapy services are of sufficient size and appropriate design to accommodate necessary equipment, conduct examinations and provide treatment;

(vi) The facility provides one or more areas for resident dining and diversional and social activities; and

(*a*) There is at least one dayroom area on each resident floor. Areas used for corridor traffic shall not be considered as dayroom space; and

(*b*) If a multipurpose room is used for dining and diversional and social activities, there is sufficient space to accommodate all activities and prevent their interference with each other;

(vii) The facility has kitchen and dietary service areas adequate to meet food service needs. These areas are properly ventilated and equipped for sanitary refrigeration, storage, preparation, and serving of food, as well as for dish and utensil cleaning and refuse storage and removal. Dietary areas comply with the local health or food handling codes. Food prepartion space is arranged for the separation of functions and is located to permit efficient service to residents and is used for only dietary functions;

(viii) The facility employs sufficient housekeeping and maintenance personnel to maintain the interior and exterior of the facility in a safe, clean, orderly manner; and

(ix) The facility has a written, rehearsed plan to be followed in case of fire, explosion, or other emergency. It specifies persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating residents, frequency of fire drills, and assignment of specific tasks and responsibilities to the personnel of each shift;

COUNCIL POSITION

We agree with and support the generally high standards embodied in Section 249.12(a)(11). We would suggest the following additions or modifications:

(1) The requirement under Title XVIII (20 CFR 405.1134) for flameproof cubicle curtains in multiple bedrooms should be incorporated into Section 249.12 (a)(11), as should the Title XVIII prohibition against locking doors to patient bedrooms.

(2) The requirement in (iv) for single bedrooms for patients with infectious diseases should be changed to require that

"Facilities should have adequate, appropriate facilities to isolate and care for patients with infectious diseases."

As an aside, the National Council does not believe that patients requiring isolation facilities belong in an ICF, and should be transferred to the appropriate facility, thus obviating the necessity for isolation facilities.

These extended care facility standards set forth under Title XVIII (20 CFR 405.1134) should be adopted as requirements, with some modifications described below.

For existing facilities, the elevator requirement could be waived for facilities of less than three stories; however, this waiver should not apply to new construction. The nursing unit requirement should be the same as for Title XVIII, with some allowances being made for the different types of furniture which might be appropriate. Ordinary rooms should have no more than two beds and in no case should have more than four beds.

The requirement for flameproof cubicle curtains in multiple bedrooms must be retained. The requirement for a special size bathtub or shower might be limited to floors where wheelchair patients are located. The prohibition on locking doors to patient bedrooms should be kept. The requirement for isolation facilities may be deleted. Patients requiring such facilities should not be in the ICF.

Under "examination rooms", require only that if the facility provides physical therapy, areas are of sufficient size to accommodate necessary equipment and

facilitate the movement of disabled patients. Lavatories and toilets designed for the use of wheelchair patients should be provided in such areas.

13. TRANSFER AGREEMENTS—SECTION 249.12(A)(12)

(12) Maintains written arrangements with one or more general hospitals and skilled nursing facilities under which such institutions agree to timely acceptance, as patients thereof, of acutely ill residents of the intermediate care facility who are in need of hospital or skilled nursing facility care; except that, as provided in paragraph (b) of this section, the single State agency may waive this requirement wholly or in part with respect to any intermediate care facility which is unable to effect such an arrangement with a hospital or skilled nursing facility;

COUNCIL POSITION

The National Council recommends that the skilled nursing facility transfer agreement requirement contained in Section 249.12(a)(12) be waived where the ICF and the skilled nursing facility are the same facility.

14. LIFE SAFETY CODE—SECTION 249.12(A)(13)

(13) Meets such provisions of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) as are applicable to institutional occupancies; except that the single State agency may waive the application to any intermediate care facility of specific provisions of such code for such periods and under such conditions as are set forth in paragraph (b) of this section; and except that the requirements of this subparagraph need not apply in any State if the Secretary makes a finding that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents in intermediate care facilities; and

COUNCIL POSITION

The National Council of Health Care Services supports the proposed regulations' requirement that fire safety standards in intermediate care facilities should be those of the Life Safety Code applicable to skilled nursing homes under Title XIX. We believe there can be no justification in terms of patient safety, for making fire safety standards any lower than those required for skilled nursing homes. In addition, of course, the facility staff should be well trained in emergency procedures.

Fire Safety standards in intermediate care facilities should be those of the Life Safety Code applicable to skilled nursing homes under Title XIX. The requirements of the Life Safety Code might be implemented in phases for ICF's—for example,

Phase 1—Immediate implementation for new construction, additions and conversions

Phas 2—(6–12 months) Building service equipment

Phase 3—(24 months) Partitions, construction standards, exits, sprinklers, etc.

15. PATIENT EVALUATION, UTILIZATION REVIEW 249.10(d) AND SECTION 250.24

PART 250—ADMINISTRATION OF MEDICAL ASSISTANCE PROGRAMS

6. A new § 250.24 is added to Part 250 as set forth below:

§ 250.24 Independent professional review in intermediate care facilities.

(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act which includes intermediate care facility services must:

(1) Provide, with respect to individuals eligible under the State plan who are admitted to an intermediate care facility or who make application while in such a facility, for an interdisciplinary professional review (covering physical, emotional, social and cognitive factors) of the need for the care in and the services provided by such a facility and for a written individual plan of care and service. Under this requirement, the following methods are followed in each case prior to admission or, in the case of in-

dividuals who make application while in an intermediate care facility, prior to authorization of payments:

(i) Each eligible individual receives a comprehensive medical, social, and psychological evaluation, which includes:

(*a*) Diagnoses, summaries of present medical, psychological and social findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs and amounts of care required;

(*b*) An evaluation by an agency worker of the resources available in the home, family and community; and

(*c*) An explicit recommendation by the interdisciplinary professional team with respect to admission or in the case of persons who make application while in an intermediate care facility, continued care in such facility. Where admission is not indicated, but must nevertheless be recommended or implemented because of current lack of appropriate alternatives, such finding is noted and plans are initiated for the active exploration of alternatives;

(ii) The individual plan of care and service is formulated in accordance with the findings and recommendations of the evaluation team and includes: written objectives; orders for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, and special procedures designed to meet the objectives; plans for continuing care (including provisions for review and necessary modifications of the plan) and discharge; and

(iii) Written reports of the evaluation and the written individual plan of care and service are delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

(2) Provide for redetermination at least semi-annually of the individual's continuing need for institutional care and consideration of alternate methods of care by medical and other professional personnel who are not themselves directly responsible for the care of the resident and who are not employed by or financially interested in any such facility.

(3) Provide for periodic on-site inspection to be made in all intermediate care facilities caring for individuals under the plan by one or more independent professional review teams which shall:

(i) (*a*) Include one or more physicians or registered nurses, and psychologists, social workers, or other appropriate health and social service professional;

(*b*) In the case of institutions for the mentally retarded, include one or more physicians or registered nurses, and psychologists, social workers, or other appropriate health, social service, mental retardation and special education professionals;

(*c*) In the case of institutions for mental diseases, include one or more psychiatrists (or other physicians knowledgeable about mental institutions) or registered nurses, and psychologists, social workers, or other appropriate health, social service, and mental health professionals; and

(*d*) Where there is no physician on the review team, assure availability of a physician to provide consultation to the team;

(ii) Function under the supervision of a team member knowledgeable about institutional care and services, and

(*a*) In the case of an intermediate care facility serving a geriatric population, be knowledgeable about the specific problems and needs of the geriatric resident;

(*b*) In the case of an institution for the mentally retarded, be knowledgeable about the specific problems and needs of the mentally retarded resident; and

(*c*) In the case of an institution for mental diseases, be knowledgeable about the specific problems and needs of the mentally ill resident; and

(iii) Have no members who have a financial interest in or are employed by any intermediate care facility, or who provide professional services to any intermediate care facility reviewed by the team of which they are members.

(4) Provide that:

(i) There are a sufficient number of teams, so distributed within the State that on-site inspections can be made in all intermediate care facilities caring for residents under the plan at appropriate intervals;

(ii) No physician member of a team inspects the care of residents for whom he is the attending physician;

(iii) At least one inspection by an independent professional review team is made in each intermediate care facility within 1 year from the effective date of these regulations and thereafter at intervals to be determined by the team and the single State agency for each facility on the basis of consideration of the quality of care being rendered in the facility and the needs of residents in the facility, but not less often than annually;

(iv) No facility is notified of the time of an inspection more than 48 hours before the arrival of the independent professional review team; and

(v) The independent professional review team inspection includes personal contact with and observation of each resident receiving assistance under the plan by a team member or members, and review of each such resident's records including the individual plan of care and service. Such reviews and observations are to determine the adequacy of the services available to meet the current health, rehabilitative, and social needs and promote the optional physical, mental, and psychosocial functioning of residents; the adequacy, appropriateness, and quality of services actually being rendered each individual receiving services under the plan; the necessity and desirability of the continued placement of such residents in such facilities; the feasibility of meeting their health and rehabilitative needs through alternative institutional or noninstitutional services; and in the case of institutions for the mentally retarded, whether the mentally retarded individual is also receiving active treatment. Under this requirement, such determinations may be based upon consideration of such items as whether:

(*a*) The medical, social, and psychological evaluation and the individual plan of care and service are complete and current, the individual plan of care and service is being followed, and all services ordered (including dietary orders) are being rendered and properly recorded;

(*b*) Prescribed medications have been reviewed by the attending physician at least quarterly, and tests or observations of residents indicated by their medication regimen have been made at appropriate times and properly recorded;

(*c*) Progress notes are made regularly by all professionals working with the resident and appear to be consistent with the observed condition of the resident;

(*d*) Adequate health services are being rendered each resident as evidenced by such observations as cleanliness, absence of signs of malnutrition or dehydration and apparent activity and alertness;

(*e*) Adequate rehabilitative services are being rendered each resident as evidenced by a planned program of activities to prevent regression, the progress toward meeting the plan objectives and the apparent maintenance of optimal, physical, mental, and psychosocial function;

(*f*) The resident currently requires any service not available in or actually being furnished by the particular facility or through arrangements with others; and

(*g*) Each resident actually needs continued placement in the facility or there is an appropriate plan to transfer the resident to an alternate method of care.

(5) *Provided*, That:

(i) A full and complete report on each inspection visit is promptly submitted by the independent professional review team to the single State agency covering the observations, conclusions, and recommendation of the team with respect to the adequacy, appropriateness and quality of all resident services provided in the facility or through arrangements, as well as specific findings with respect to individuals;

(ii) The single State agency forwards a copy of each inspection report both to the facility involved and its functioning utilization review committee, to the agency of the State responsible for licensure and to the agencies responsible for certification or approval of the facilities involved for purposes of title XIX and to other agencies of the State which require the information in such reports in the performance of their official functions; and

(iii) Reports and recommendations are followed by documented corrective action on the part of the single State agency.

(b) *Coordination of medical review and independent professional review.* Periodic inspections by independent professional review teams as required by paragraph (a) of this section may be conducted by medical review teams (see § 250.23) where the composition of such a team meets the requirements of paragraph (a)(3) of this section or is modified or supplemented to meet

such requirements for purpose of its independent professional review activities, and where such medical review team is willing and able to undertake in addition to its regular medical review program the onsite inspection functions required by paragraph (a)(4) of this section.

(c) *Coordination of utilization review and independent professional review.* (1) Periodic inspections by independent professional review teams as required by paragraph (a) of this section may be conducted by noninstitution based utilization review committees where the composition of such a committee meets the requirements of paragraph (a)(3) of this section, or is modified or supplemented to meet such requirements for purpose of its independent professional review activities, and where such committee is willing and able to undertake in addition to its regular utilization review program the on-site inspection functions required by paragraph (a)(4) of this section.

(2) In the case of a facility which is not concurrently a provider of service under title XVIII of the Act, an inspection by an independent professional review team conducted according to the requirements of paragraph (a) of this section, whether or not performed by a utilization review committee as provided in paragraph (c)(1) of this section, may, at the discretion of the single State agency, be considered to satisfy the requirement for utilization review of long-stay cases for the next regularly scheduled meeting of the utilization review committee.

7. Section 250.30 is amended by revising paragraph (a)(6) and adding a new paragraph (b)(3)(iii) as set forth below:

COUNCIL POSITION

With regard to patient evaluation and development of a plan of treatment for individual patients, Section 249.10(d) (iv) through (vi) is written in a confusing manner where it defines a "resident" of an intermediate care facility and includes in that definition mental retardation facilities. For purposes of clarity, the National Council recommend that all references to mental retardation facilities, patients/residents, and definitions of standards for care, services, and plans of treatment be separated from those pertaining to intermediate care facilities. Specifically, we suggest that Section 249.10(d) (iv) through (vi) be reorganized to completely separate references to mental retardation facility requirements from intermediate care facility requirements. The regulations should be clarified to indicate clearly that an intermediate care facility is not required to serve as a mental retardation facility. Strong arguments have been postulated that geriatric ICF's and mental retardation facilities are not compatible.

In the area of patient evaluation and utilization review, the National Council believes that the proposed regulations, in Section 250.24—Independent Professional Review in Intermediate Care Facilities, are not consistent with similar requirements for skilled nursing facilities under Title XIX and should be modified accordingly.

First, on-site evaluations prior to admission or prior to approval for payment for an ICF patient, made by an interdisciplinary professional team composed of a physician or nurse, a psychologist and social workers, etc. should not be specifically required. In many cases, patients coming into a long term care facility will have to be evaluated to determine whether they belong in a skilled nursing facility or an ICF. The individual State should have the option to make that initial determination, consistent with its existing structure for evaluating skilled nursing facility patients. Any other system is duplicative, wasteful, and costly. Further, the patient will benefit from a coordinated approach and will be able to get into an ICF faster and leave the hospital sooner in some cases.

Second, neither a psychologist nor a social worker should be required to serve on an initial evaluation interdisciplinary professional team or an ongoing review team. The physician should be the key, in conjunction with the facility's existing utilization review team. The National Council recommends that the facility's utilization review team be charged with deciding whether the individual needs social or psychological evaluation. If the decision is "yes" then the facility must make appropriate arrangements to provide the evaluations.

Third, the National Council recommends that the State's independent review team be allowed to serve as the individual facility's interdisciplinary professional team, because the cost to an individual facility of providing such teams would be prohibitive.

Finally, we recommend that the independent review team be required to have a physician serving on it, rather than allowing a registered nurse to substitute.

16. DISTINCT PARTS

COUNCIL POSITION

The proposed regulations do not mention "distinct parts", implicitly leaving this question up to either the individual facility or the individual State. The National Council strongly recommends that language be added to the regulations specifically permitting the individual facility to determine whether or not to have distinct parts. This should not be a State option, but may become one if the regulations remain silent on this point.

Further, if the object of distinct parts is to avoid dilution of care for skilled patients, the National Council recommends that any nursing facility which meets staffing standards for a skilled nursing home should be able to care for any amount of intermediate patients and no distinct part categorization should apply. Obviously, no dilution of care would result. Where the intermediate care distinct part is located in a skilled nursing home, the ICF distinct part should be allowed to care for 10 percent skilled patients where the total staffing of all distinct parts, including the skilled, meets the requirements for skilled homes. If a facility containing a distinct part is able to meet skilled standards where considered as a whole, then its distinct part should be able to take skilled patients.

The Council's recommendations for an ICF "distinct part" differ slightly from those for a freestanding ICF because our personnel requirements for the freestanding facility were dictated in some cases, by a concern over not having assistance available when needed. It is recommended that in an ICF distinct part, one licensed person should be on duty between 7 a.m. and 3 p.m. where the size of the distinct part is from 0–25 beds. One additional hour of licensed coverage per week per bed should be required for distinct parts in excess of 25 beds.

The total personnel requirement in the distinct part ought to be the same as for skilled facilities or distinct parts if the intermediate patients are defined by ICF No. 1. In the case of the ICF No. 2 patient, minimum requirements should be 75% of skilled requirements.

* * * Any reduction in round-the-clock nursing personnel in the ICF distinct part should not result in the entire facility being unable to meet the minimum licensed personnel requirement for the licensure of the entire facility as a skilled nursing home.

NATIONAL COUNCIL OF HEALTH CARE SERVICES,
Washington, D.C., August 9, 1973.

COMMISSIONER,
Social Security Administration,
Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. COMMISSIONER: The National Council of Health Care Services has read and carefully studied the proposed regulations to provide a set of common standards for skilled nursing facilities under Title XVIII (Medicare) and Title XIX (Medicaid), which were published in the Federal Register July 12, 1973. In general, the National Council endorses the flexible approach taken by the proposed regulations and believes that its effects on both single state agencies and individual providers will be beneficial, if properly directed and administered.

Comments on specific sections of the regulations are given below.

405.1101 DEFINITIONS

405.1101(A) ADMINISTRATOR OF SKILLED NURSING FACILITY

Proposed Regulation

(a) *Administrator of skilled nursing facility.* A person who:

(1) Is licensed as required by State law; or

(2) If the State does not have a Medicaid program, and has no licensure requirement, is a high school graduate (or equivalent), has completed courses in administration or management approved by the appropriate State agency, and has 1 year of supervisory management experience in a skilled nursing facility or related health program; or

(3) If the administrator of a hospital-based distinct part skilled nursing facility, meets the requirements of § 405.1021.

COUNCIL SUGGESTION

405.1101(a) "Administrator of skilled nursing facility. A person who (1) is licensed as required by State law; or (2) if the State does not have a Medicaid program, and has no licensure requirement, is a high school graduate (or equivalent), has completed courses in administration or management approved by the appropriate State agency, and has 1 year of supervisory management experience in a skilled nursing facility or related health program."

RATIONALE

The National Council of Health Care Services is in agreement with Section 405.1101(a) of the proposed regulations which requires skilled nursing facilities to be administered by a state-licensed (or its equivalent where no Medicaid program exists) nursing home administrator. However, we strongly recommend that Section 405.1101(a)(3) be deleted from this section. Administration of long term and/or skilled nursing patients requires special training, which is not equal to the specialized training given to hospital administrators, who are oriented toward acutely-ill patients with specific illnesses.

405.1101. (E) DIETETIC SERVICE SUPERVISOR

Proposed Regulation

(e) *Dietetic service supervisor.* A qualified dietitian; or a graduate of a dietetic technician or dietetic assistant training program approved by the American Dietetic Association; or a graduate of another course that provided 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian.

COUNCIL SUGGESTION

405.1101(3) "Dietetic service supervisor. A qualified dietitian; or a graduate of a dietetic technician or dietetic assistant training program approved by the American Dietetic Association; or a person working toward ninety (90) hours of structured instruction or organized instruction in food service supervision to be completed within one calendar year and who has experience as a supervisor in a health care institution with consultation from a dietitian."

RATIONALE

The National Council supports the intent of this regulation, which is to ensure that dietetic service supervisors have some formal training in the specific functions they will be called on to fulfill. In actual practice, however, there are few dietetic technicians in existence, and even fewer with relevant experience. Therefore, in order to achieve the objective of this standard, a flexible approach is needed. On-the-job training, where structured and properly supervised, should be considered to fulfill the training requirements for this position.

In addition, the regulation does not define "experience" in terms of either content or length of experience. The National Council suggests that following consultation with skilled nursing facilities and the American Dietetic Association, some specific guidelines, recommendations, or regulations be promulgated in this regard.

405.1101(n) PATIENT ACTIVITIES COORDINATOR

Proposed Regulation

(n) *Patient activities coordinator.* A person who:

(1) Is a therapeutic recreation specialist qualified at least by way of definitions in paragraph (v)(4) or (5) of this section; or

(2) Has completed 36 hours (within a 3-month period) of a curriculum designed specifically to train patient activities coordinators; or

(3) Has 2 years of experience in a social or recreational program, within the last 5 years, 1 year of which was full-time in a patient activities program in a health care setting; or

(4) Is a qualified occupational therapist or occupational therapy assistant.

COUNCIL SUGGESTION

405.1101(n) "Patient activities coordinator. A person who:
"(1) Is a therapeutic recreation specialist; or
"(2) Is working toward the achievement of 36 hours (within a six-month period) of a curriculum designed specifically to train patient activities coordinators; or
"(3) Has one year of experience in a health care setting within the last five years; or
"(4) Is a qualified occupational therapist or occupational therapy assistant."

RATIONALE

While the National Council of Health Care Services is a vigorous supporter of stringent standards in health care facilities and requires that its member facilities be accredited (under the appropriate division) by the Joint Commission on Accreditation of Hospitals as a condition of membership in the Council, we strongly oppose setting advanced educational requirements and lengthy experience requirements for positions in nursing facilities such as a patient activities coordinator. Formal education, lengthy experience in the specific field and formal training programs are vital in such areas as physical therapy, speech therapy, etc. However, it is a disservice to patients, providers, as well as to many truly well-qualified potential job applicants to set unrealistic educational and experience requirements for positions such as patient activities coordinators and therapeutic recreation specialists. The widespread experience of National Council members unanimously indicates that the key attribute a patient activities coordinator or therapeutic recreation specialist in a skilled nursing facility must possess is an ability to relate to the patients within the facility. Advanced degrees, a high level of formal education "in the field" as well as overlong experience requirements are often found to be actual handicaps in relating to patients. Many nursing facilities, in our experience, have promoted persons to such positions from the ranks of non-professional or non-licensed employees of their facilities, after having evaluated their rapport with patients. Such individuals have proven to be a great success in these jobs.

In addition, the National Council recommends that training programs conducted by multi-facility organizations for patient activities coordinators be approved as meeting the educational requirements for this position. Many member companies of the National Council of Health Care Services operate sophisticated, well-conceived and executed in-service training programs for a wide variety of their nursing facility employees. These training programs are often superior to those offered by outside organizations.

405.1101(o) PHARMACIST

Proposed Regulation

(o) *Pharmacist.* A person who:
(1) Is licensed as a pharmacist by the State in which practicing, and
(2) Has training or experience in the specialized functions of institutional pharmacy, such as residencies in hospital pharmacy, seminars on hospital pharmacy, and related training programs.

COUNCIL SUGGESTION

405.1101(o) "Pharmacist. A person who:
"(1) Is licensed as a pharmacist by the State in which practicing, and
"(2) Preferably has training or experience in the specialized functions of institutional pharmacy."

RATIONALE

The National Council supports the concept of requiring pharmacists overseeing pharmacy services in skilled nursing facilities to possess specialized experience in institutional pharmacy, and in particular, experience in long term care institutional settings. However, most nursing facilities are served by community pharmacists; few have "in-house" or staff pharmacists as do most hospitals. Many of these nursing facilities are located in communities where there are no pharmacists with specialized experience in institutional pharmacy. Therefore, the Council recommends that training and experience in institutional pharmacy for the facility's consulting pharmacist be encouraged and recognized but not mandated.

The Council also suggests that the phrase in 405.1101(o)(2) suggesting specific experience in hospital programs be deleted. The practice of pharmacy in hospitals and in nursing homes differs significantly, both because of the difference in type of patient, in type of medication, in type of delivery system, in type of packaging, in type of payment, and the difference in type of pharmacist (in-house hospital pharmacists as opposed to community pharmacists who service nursing facilities).

405.1101(4) SOCIAL WORKER

Proposed Regulation

(r) *Social worker.* A person who is a graduate of a school of social work accredited by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.

COUNCIL SUGGESTION

405.1101(r) "Social worker. A person who is a graduate of a school or social work accredited by the Council of Social Work Education."

RATIONALE

An individual who is a graduate of a school of social work accredited by the Council of Social Work Education should be considered a qualified social worker. No further social work experience in a health care setting or elsewhere should be required of such an individual.

405.1101(u) THERAPEUTIC RECREATION SPECIALIST

Proposed Regulation

(u) *Therapeutic recreation specialist.* A person who is licensed or registered, if applicable, by the State in which practicing, and

(1) Meets the requirements for registration or certification of competency in therapeutic recreation from a national or State professional recreation society; or

(2) Possesses a masters degree, with a major in therapeutic recreation or in a general recreation or allied field (music, drama, physical education, psychology), and has 6 months of full-time experience in a therapeutic recreation program; or

(3) Possesses a baccalaureate degree, with a major in therapeutic recreation including a supervised internship, a general recreation major and has 1 year of full-time experience in a therapeutic recreation program, or an allied field major and has 2 years of full-time experience in a therapeutic recreation program; or

(4) Possesses an associate of arts degree, with a major in recreation and has 3 years of supervised full-time experience in a therapeutic recreation program, or an allied field major and has 4 years of supervised full-time experience in a therapeutic recreation program; or

(5) Has 2 years of supervised full-time experience in a therapeutic recreation program in a health care setting, and has 60 hours of specialized training in therapeutic recreation techniques.

COUNCIL SUGGESTION

405.1101(u) "Therapeutic recreation specialist. A person who is licensed or registered, if applicable, by the State in which practicing, and

"(1) Meets the requirements for registration or certification of competency in therapeutic recreation from a national or State professional recreation society; or

"(2) Has one year of supervised full-time experience in a health care setting, and is working toward achievement of 36 hours (within a six-month period) of a curriculum designed to train the individual in therapeutic recreation techniques."

RATIONALE

The Council's suggestions for this section depend on the same rationale as that used with Section 405.1101(n) "Patient activities coordinator." We believe that the key factor in establishing an effective recreation program is to have it directed by an individual who relates to patients effectively. Such individuals

cannot be identified by the amount of formal education, graduate degrees, or length of related experience they may have. In fact, such attributes, in this area, may indeed be hindrances to effective relationships with patients in the skilled nursing facility environment. The Council hopes that the legitimate educational, training, and experience requirements of some health workers, such as physical therapists, speech pathologists, etc. will not be confused with developing effective therapeutic recreational activities and patient activity programs for skilled nursing facilities.

405.1120 CONDITION OF PARTICIPATION—COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS

405.1120(b) STANDARD: LICENSURE OR REGISTRATION OF PERSONNEL

Proposed Regulation

(b) *Standard: Licensure or registration of personnel.* Staff of the facility are licensed or registered in accordance with applicable laws.

COUNCIL SUGGESTION

405.1120(b) "Standard: Licensure or registration of personnel. Appropriate members of the staff of the facility are licensed or registered in accordance with applicable laws."

RATIONALE

While the National Council is certain that the intent of this regulation is not to require licensure or registration of all personnel on the staff of an individual nursing facility, the language presently used could be so misinterpreted. Therefore, we suggest that the language be modified as suggested above.

405.1121 CONDITION OF PARTICIPATION—GOVERNING BODY AND MANAGEMENT

405.1121(d) STANDARD: ADMINISTRATOR

Proposed Regulation.

(d) *Standard: Administrator.* The governing body appoints a full-time qualified administrator who is responsible for the overall management of the facility, enforces the rules and regulations relative to the level of health care and safety of patients, and to the protection of their personal and property rights, and plans, organizes, and directs those responsibilities delegated to him by the governing body. Through meetings and periodic reports, the administrator maintains ongoing liaison among the governing body, medical and nursing staffs, and other professional and supervisory staff of the facility, and studies and acts upon recommendations made by the utilization review and other committees.

COUNCIL SUGGESTION

405.1121(d) "Standard: Administrator. The governing body appoints a full-time, licensed, qualified administrator who is responsible * * *."

RATIONALE

The National Council of Health Care Services supports the professionalization of the nursing home administrator and believes that all nursing home administrators ought to be licensed by their individual States. Further, addition of licensure as a requirement will conform these regulations with existing legislation for skilled nursing facilities under the Title XIX program (the 1967 Moss Amendments on nursing home administrator licensure). For those States presently without a Medicaid program which do not require nursing home administrators to be licensed, a waiver provision may be included, but they should be encouraged to adopt similar standards for nursing home administrators as those used by other States participating in the Medicaid program.

405.1121(h) STANDARD: USE OF OUTSIDE RESOURCES

Proposed Regulation

(h) *Standard: Use of outside resources.* If the facility does not employ a qualified professional person to render a specific service to be provided

by the facility, there are arrangements for such a service through a written agreement with an outside resource—a person or agency that will render direct service to patients or act as a consultant. The responsibilities, functions, and objectives, and the terms of agreement, including financial arrangements and charges, of each such outside resource are delineated in writing and signed by an authorized representative of the facility and the person or the agency providing the service. The financial arrangements provide that the outside resource bill the facility for covered services (either Part A or B for Medicare beneficiaries) rendered directly to the patient, and that receipt of payment from the program(s) to the facility for the services discharges the liability of beneficiary or any other person to pay for the services. The outside resource, when acting as a consultant, apprises the administrator of recomendations, plans for implementation, and continuing assessment through dated, signed reports, which are retained by the administrator for followup action and evaluation of performance. (See requirement under each service—§§ 405.1125 through 405.1132.)

COUNCIL SUGGESTION

405.1121(h) "Standard: Use of outside resources. If the facility does not employ a qualified professional person to render a specific service to be provided by the facility, there are arrangements for such a service through a written agreement with an outside resource—a person or agency that will render direct service to patients or act as a consultant. The responsibilities, functions, objectives, and the terms of agreement, including financial arrangements and charges, or each such outside resource are delineated in writing and signed by an authorized representative of the facility and the person or the agency providing the service. The outside resource, when acting as a consultant apprises the administrator of recommendations, plans for implementation, and continuing assessment through dated, signed reports, which are retained by the administrator for follow-up action and evaluation of performance. (See requirement under each service—Sections 405.1125 through 405.1132.)"

RATIONALE

The National Council *recommends requirements for the skilled nursing facility to assume total financial responsibility for vague and unspecified services be delegated from the proposed regulation.* Both the terms "outside resource" and "employ" should be specifically defined and clarified before the facility is asked to assume such financial responsibility. Further, the skilled nursing faciilty should not be required to assume financial responsibility for services which are not covered by the Medicare and/or Medicaid programs.

405.1123 CONDITION OF PARTICIPATION—PHYSICIAN SERVICES

405.1123(a) STANDARD: MEDICAL FINDINGS AND PHYSICIAN'S ORDERS AT TIME OF ADMISSION

Proposed Regulation

(a) *Standard: Medical findings and physicians' orders at time of admission.* There is made available to the facility, prior to or at the time of admission, patient information which includes current medical findings, diagnoses, rehabilitation potential, a summary of the course of prior treatment, and orders from a physician for immediate care of the patient.

COUNCIL SUGGESTION

405.1123(a) "Standard: Medical findings and physicians' orders at time of admission. There is made available to the facility, prior to or at the time of admission patient information which includes current medical findings, diagnoses, and orders from a physician for immediate care of the patient. Within 48 hours of the admission of the patient there is made available to the facility, additional patient information which includes rehabilitation potential and a summary of the course of prior treatment."

RATIONALE

Often patient records are held up in the hospital because information and evaluations on the patient's rehabilitation potential and/or his course of prior treatment are not immediately available. The National Council suggests, therefore,

that patient records made available to the skilled nursing facility at or before the time of the patient's admission be required to contain only that information necessary to begin immediate care and treatment. Additional information, which is also part of the complete patient record should be made available to the skilled nursing facility within 48 hours of patient admission.

405.1123 (C) STANDARD: PHYSICIAN VISITS

Proposed Regulation

(c) *Standard: physician visits.* Each patient is seen by a physician at least every 30 days, or more often as needed, except that, after 90 days following admission, this requirement may be deemed to be met in those specific instances where the attending physician has furnished adequate medical justification in the patient's medical record for an alternative schedule of visits, and provided that (1) the facility notifies the State Medicaid agency, when appropriate, and (2) the utilization review committee or medical review team has promptly reevaluated such patient's need for monthly physician visits as as well as his continued need for skilled nursing facility services.

COUNCIL SUGGESTION

405.1123 (c) "Standard: Physician visits. Each patient is seen by a physician at least every 30 days, or more often as needed, except that, after 90 days following admission, this requirement may be deemed to be met in those specific instances where the attending physician has furnished adequate medical justification in the patient's medical record for an alternative schedule of visits, and provided that the utilization review committee or medical review team has promptly reevaluated such patient's need for monthly physician visits as well as his continued need for skilled nursing facility services."

RATIONALE

The National Council recommends that the requirement that the facility notify the state Medicaid agency where appropriate be deleted because it is not a useful piece of information, would prove extremely difficult to carry out and should not be in the purview of the facility. This is a responsibility of the physician or medical director.

405.1124 CONDITION OF PARTICIPATION—NURSING SERVICES

405.1124(a) STANDARD: DIRECTOR OF NURSING SERVICES

Proposed Regulation

(a) *Standard: Director of nursing services.* The director of nursing services is a qualified registered nurse employed full-time who has administrative authority, responsibility, and accountability for the functions and activities of the nursing services staff, and serves only one facility in this capacity. If the director of nursing services has other institutional responsibilities, a qualified registered nurse serves as her assistant so that there is the equivalent of a full-time director of nursing services on duty each day. The director of nursing services is responsible for the development and maintenance of nursing service objectives, standards of nursing practice, nursing policy and procedure manuals, written job descriptions for each level of nursing personnel, methods for coordination of nursing services with other patient services, and for recommending the number and levels of nursing personnel to be employed.

COUNCIL SUGGESTION

405.1124(a) "Standard: Director of nursing services. The director of nursing services is a qualified registered nurse employed full-time who has administrative authority, responsibility, and accountability for the functions and activities of the nursing services staff, and serves only one facility in this capacity. If the director of nursing services has other institutional responsibilities, a qualified registered nurse serves as her assistant so that there is the equivalent of a full-time director of nursing services on duty 5 days a week. The director of nursing services * * *."

RATIONALE

The National Council suggests that the wording be changed to require a registered nurse to be on duty 5 days per week so that the regulation will be in conformance with the first sentence of the complete section (405.1124) which requires a registered nurse on duty 5 days per week.

405.1124(b) STANDARD: CHARGE NURSE

Proposed Regulation

(b) *Standard: Charge nurse.* A registered nurse, or a qualified licensed practical nurse, is designated as charge nurse by the director of nursing services for each tour of duty, and is responsible for each tour of duty. The director of nursing services does not serve as charge nurse in a facility with an average daily occupancy of 50 or more patients. The charge nurse delegates responsibility to nursing personnel for the direct nursing care of specific patients during each tour of duty, on the basis of staff qualifications, size and physical layout of the facility, characteristics of the patient load, and the emotional, social, and nursing care needs of patients.

COUNCIL SUGGESTION

405.1124(b) "Standard: Charge nurse. A registered nurse, or a qualified licensed practical nurse, is designated as charge nurse by the director of nursing services for each tour of duty, and is responsible for each tour of duty. The director of nursing services does not serve as charge nurse in a facility with an average daily occupancy of 50 or more patients. In such cases, the charge nurse may be a licensed practical (vocational) nurse who meets the requirements set forth in Section 405.1101(c) (2) and (3). The charge nurse delegates responsibility * * *."

RATIONALE

The above suggestion by the National Council is to clarify the eligibility of licensed practical/vocational nurses to serve as charge nurses in facilities with average occupancy levels over 50 patients. As written, it might be possible to interpret the regulations to require two registered nurses in such facilities—as both directors of nursing and charge nurses.

405.1124(g) STANDARD: ADMINISTRATION OF DRUGS

Proposed Regulation

(g) *Standard: Administration of drugs.* Drugs are administered in compliance with State and local laws. Procedures are established to ensure that drugs are checked against physicians' orders, that the patient is identified prior to administration of a drug, and that each patient has an individual medication record and that the dose of drug administered to that patient is properly recorded therein by the person who administers the drug. Drugs and biologicals are administered as soon as possible after doses are prepared, and are administered by the same licensed person who prepared the doses for administration.

COUNCIL SUGGESTION

405.1124(g) "Standard: Administration of drugs. Drugs are administered in compliance with State and local laws. Procedures are established to ensure that drugs are checked against physicians' orders, that the patient is identified prior to administration of a drug, and that each patient has an individual medication record and that the dose of drug administered to that patient is properly recorded therein by the person who administers the drug. Drugs and biologicals are administered as soon as possible after doses are prepared (with the exceptions of unit dose packaging and distribution systems) and are administered by the same person who prepared the doses (not to be confused with dispensing the drugs as defined in Section 405.1101(i)) for administration. Unit dose systems are acceptable methods for administration of drugs."

RATIONALE

The National Council recommends that the word "licensed" be deleted from the last sentence. The regulation already requires that drugs be administered in compliance with State and local laws. Therefore, requiring "licensed" personnel is

not necessary in the context of these regulations, which have as their objective allowing individual states discretion in specific implementaton.

In addition, use of the word "administered" and the phrase "the same licensed person who prepared the doses for administration" are confusing and may be misleading, unless the difference between dispensing and administering is made clear at this point in the regulations. Otherwise, unit dose systems of medications, which are recognized in other sections of the regulations, may be adversely affected when the regulations are interpreted by the individual state agencies.

The final sentence of the Council's suggested regulation has been added to clarify the acceptability of unit dose systems of drug packaging and distribution in the skilled nursing facilities.

405.1126 CONDITION OF PARTICIPATION—SPECIALIZED RESTORATIVE SERVICES

Proposed Regulation

In addition to restorative nursing (§ 405.1124(e)), the skilled nursing facility provides, or arranges for, under written agreement, specialized restoratve services by qualified personnel (i.e., physical therapy, speech pathology and audiology, and occupational therapy) as needed by patients to improve and maintain functioning. These services are provided upon the written order of the patient's attending physician. Safe and adequate space and equipment are available, commensurate with the services offered. If the facility does not offer such services directly, it does not admit nor retain patients in need of this care unless provision is made for such services under arrangement with qualified outside resources under which the facility assumes professional and financial responsibilities for the services rendered.

COUNCIL SUGGESTION

405.1126 "Condition of participation—specialized restorative services. In addition to restorative nursing (Section 405.1124(3)), the skilled nursing facility provides, or arranges for, under written agreement, specialized restorative services by qualified personnel (i.e., physical therapy, speech pathology and audiology, and occupational therapy) as needed by patients to improve and maintain functioning. These services are provided upon the written order of the patient's attending physician. Safe and adequate space and equipment are available, commensurate with the services offered. If the facility does not offer such services directly, it does not admit nor retain patients in need of this care unless provision is made for such services under arrangement with qualified outside resources."

RATIONALE

As stated previously in the Council's comments on Section 405.1121(h), a skilled nursing facility should not be required to assume financial responsibility for the provision of services unless there are corresponding assurances that Titles XIX and XVIII will pay the facilities for arranging for the provision of the care or service. In addition, the facility should not be asked to assume professional responsibility for the services of professional personnel, such as physical therapists who are not employees of the facility.

405.1126(b) STANDARD: PLAN OF CARE

Proposed Regulation

(b) *Standard: Plan of care.* Restorative services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapist(s) and the nursing service. Therapy is provided only upon written orders of the attending physician. A report of the patient's progress is communicated to the attending physician within 2 weeks of the initiation of specialized restorative services. The patient's progress is thereafter reviewed regularly, and the plan of restorative care is reevaluated as necessary, but at least every 30 days, by the physician and the therapist(s).

COUNCIL SUGGESTION

405.1126(b) "Standard: Plan of care. Restorative services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapist(s) and the nursing service. Therapy is

provided only upon written orders of the attending physician. A report of the patient's progress is communicated to the attending physician within 30 days of the initiation of specialized restorative services. The patient's progress is thereafter reviewed regularly, and the plan of restorative care is reevaluated as necessary, but at least every 30 days, by the physician and the therapist(s)."

RATIONALE

The Natinoal Council recommends that the initial progress report be required only after 30 days (rather than 2 weeks) have gone by. The initial 2 week limitation is not realistic in terms of either the geriatric or long-term care patient or in terms of dealing with the physician, in the experience of most National Council members.

405.1127 CONDITION OF PARTICIPATION—PHARMACEUTICAL SERVICES

Proposed Regulation

The skilled nursing facility provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility is responsible for providing such drugs and biologicals for its patients, insofar as they are covered under the programs, and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State, and local laws.

COUNCIL SUGGESTION

405.1127 "Condition of participation—pharmaceutical services. The skilled nursing facility provides appropriate methods and procedures for the dispensing and/or administering of drugs and biologicals * * *."

RATIONALE

Skilled nursing facilities using unit dose packaging systems, where the required medications are dispensed outside of the facility by the pharmacist or his agents should not be required to provide methods and procedures for dispensing drugs and biologicals, except on an emergency basis. As presently written, the proposed regulation could seriously inhibit the use of unit dose systems in many skilled nursing facilities.

405.1127(a) STANDARD: SUPERVISION OF SERVICES

Proposed Regulation

(a) *Standard: Supervision of services.* The pharmaceutical services are under the general supervision of a professionally competent staff for developing, coordinating, and supervising all pharmaceutical services. The pharmacist (if not a full-time employee) devotes a sufficient number of hours during a regularly scheduled visit to carry out these responsibilities. The phramacist reviews the drug regimen of each patient at least monthly, and reports any irregularities to the attending physician. The pharmacist submits a written report on the status of the facility's pharmaceutical service and staff performance at least quarterly.

COUNCIL SUGGESTION

405.1127(a) "Standard: Supervision of services. The pharmaceutical services are under the general supervision of a pharmaceutical services committee for developing, coordinating, and supervising all pharmaceutical services * * *."

RATIONALE

Because the term "professionally competent staff" is vague and not defined at all, and because Section 405.1127(d) mandates a pharmaceutical services committee with nearly identical responsibilities, the National Council recommends that the pharmaceutical services committee be in charge of supervision of pharmaceutical services in (a) as well. This would conform the two sections and eliminate a vague and confusing term.

405.1132 Condition of Participation—Medical Records

405.1132(g) STANDARD: INDEXES

Proposed Regulation

(g) *Standard: Indexes.* Patients' medical records are indexed according to name of patient and final diagnoses to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.

COUNCIL SUGGESTION

405.1132(g) "Standard: Indexes. Patients' medical records are indexed according to name of patient to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action."

RATIONALE

Requiring indexing of medical records by both name of patient and final diagnosis is unnecessary. Many skilled nursing facilities are unable to find medical records personnel in sufficient quantity to fulfill unnecessarily complex requirements.

405.1134 Condition of Participation—Physical Environment

405.1134(b) STANDARD: EMERGENCY POWER

Proposed Regulation

(b) *Standard: Emergency power.* The facility provides an emergency source of electricity necessary to protect the health and safety of patients in the event the normal electrical supply is interrupted. The emergency electrical power system must supply power adequate at least for lighting in all means of egress; equipment to maintain fire detection, alarm, and extinguishing systems; and life support systems. Where life support systems are used, emergency electrical service is provided by an emergency generator located on the premises.

COUNCIL SUGGESTION

405.1134(b) "Standard: Emergency power. The facility provides an emergency source of electricity necessary to protect the health and safety of patients in the event the normal electrical supply is interrupted. The emergency electrical power system must supply power adequate at least for lighting in all major means of egress; equipment to maintain fire detection * * *"

RATIONALE

The National Council supports the intent of this provision of the regulations, but is concerned that unless the language is changed as suggested above, the section may be interpreted by state agencies to require skilled nursing facilities to have sources of emergency electrical power which would provide lights in each patient room (if patient doorways are considered means of egress). Almost all affordable generators used to supply emergency electrical power do not provide enough power to provide an essentially complete patient room lighting system.

405.1135 Condition of Participation—Environmental Services

405.1135(a) STANDARD: INFECTION CONTROL COMMITTEE

Proposed Regulation

(a) *Standard: Infection control committee.* The infection control committee, composed of members of the medical and nursing staffs, administration, and other services, establishes policies and procedures for investigating, controlling, and preventing infection in the facility, and monitors staff performance to ensure that the policies and procedures are executed.

COUNCIL SUGGESTION AND RATIONALE

The National Council is disturbed that the "infection control committee", as do most of the many other committees established to oversee patient care and safety in these regulations, requires the services of a physician. It is common knowledge

that the services of physicians for nursing facilities are not easy to obtain. Therefore, requiring that a skilled nursing facility obtain physician services, even for committees such as this one, in order to be in compliance with regulations, seems unjustified. Importantly, infectious patients do not belong in skilled nursing facilities. Their presence there should be only a "holding action" until they can be transferred to more appropriate surroundings, such as the acute hospital.

The National Council of Health Care Services appreciates the opportunity to comment on the above proposed regulations. If we can be of further assistance, please do not hesitate to call on us.

Sincerely yours,

BERKELEY V. BENNETT,
Executive Vice President.

Enclosure.

NATIONAL COUNCIL OF HEALTH CARE SERVICES,
Washington, D.C., September 13, 1973.

COMMISSIONER,
Social Security Administration, Department of Health, Education, and Welfare, Washington, D.C.

DEAR MR. COMMISSIONER: The following is in addition to our previously submitted comments on the proposed regulations to provide a set of common standards for Skilled Nursing Facilities under Titles XVIII and XIX, which were published in the Federal Register on July 12, 1973. The National Council of Health Care Services represents a group of high quality multi-facility health care companies, and requires as a condition of membership that its members' facilities be accredited in the appropriate category by the Joint Commission on Accreditation of Hospitals.

We have noted that the proposed regulations, in several areas, require services of a physician in various capacities. This is most noticeable in the several committees, such as pharmaceutical services, infection control, utilization review, etc., in which a physician is required to participate. However, the regulations do not spell out any formal relationship between a physician and a skilled nursing facility. The National Council suggests that the physician requirements scattered throughout the proposed regulations be consolidated and that the regulations be restated to require that skilled nursing facilities have formal arrangements with "physician advisors" which would require that the physician advisors provide appropriate defined advisory and other services in those areas. We believe that this would more clearly define the physician's role vis-a-vis the skilled nursing facility itself as well as clarifying the role of the physician in defined areas and services.

We appreciate the opportunity to make a comment on these regulations.

Sincerely yours,

BERKELEY V. BENNETT,
Executive Vice President.

NATIONAL COUNCIL OF HEALTH CARE SERVICES,
Washington, D.C., August 8, 1973.

JAMES S. DWIGHT, JR.,
Administrator, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C.

DEAR JIM: The National Council of Health Care Services has read and carefully studied the proposed regulations on "Standards and Provider Certification" to implement Sections 239, 246 and 249A of P.L. 92-603 (Social Security Amendments of 1972) which were published in the Federal Register July 12, 1973. In general, the National Council supports the proposed regulations for uniform certification and inspection procedures for skilled nursing facilities under Titles XVIII and XIX. We believe that the flexibility which the proposed regulations offer to single state agencies, surveyors, individual states and individual facilities is a beneficial development, if properly administered. Further, the National Council strongly supports the use of a single agency for both Medicare certification and Medicaid inspection. The Council does, however, have some suggestions on specific sections of the proposed regulations, which follow.

SEC. 249.33 STANDARDS FOR PAYMENT FOR SKILLED NURSING FACILITY AND INTERMEDIATE CARE FACILITY SERVICES

§ 249.33 Standards for payment for skilled nursing facility and intermediate care facility services.

(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must:

(1) Provide that the single State agency will, prior to execution of an agreement with any facility for provision of skilled nursing facility services and making payments under the plan obtain certification from:

(i) The agency designated pursuant to § 250.100(c) of this chapter that the facility meets the standards set forth under section 1861(j) of the Act; or

(ii) The Secretary, pursuant to section 1910 of the Act, that the facility has been determined to qualify as a skilled nursing facility under title XVIII of the Act; or

(iii) The Secretary, pursuant to section 1905 of the Act, in the case of a facility located in the State on an Indian reservation that it meets the requirements of section 1861(j) of the Act.

(2) Provide that the single State agency will, prior to execution of an agreement with any facility (including hospitals and skilled nursing facilities) for provision of intermediate care facility services and making payments under the plan, obtain certification from the agency designated pursuant to § 250.100(c) of this chapter that the facility meets the conditions set forth under § 249.10(b)(15); except that in the case of an intermediate care facility determined to have deficiencies under the requirements for environment and sanitation (§ 249.12(a)(11) or § 249.13(a)(5) and (8)(v) or of the Life Safety Code (§ 249.12(a)(13) or § 249.13(a)(3)) it may be recognized for certification as an intermediate care faciilty over a period not exceeding 2 years following the date of such determination provided that:

(i) The institution submits a written plan of correction acceptable to the survey agency which contains:

(A) The specific steps that it will take to meet all such requirements; and

(B) A timetable not exceeding 2 years from the date of the initial certification after publication of these regulations detailing the corrective steps to be taken and when correction of deficiencies will be accomplished;

(ii) The survey agency makes a finding that the facility potentially can meet such requirements through the corrective steps and they can be completed during the 2 year allowable period of time;

(iii) During the period allowed for corrections, the institution is in compliance with existing State fire safety and sanitation codes and regulations;

(iv) The institution is surveyed by qualified personnel at least semiannually until corrections are completed and the survey agency finds on the basis of such surveys that the institution has in fact made substantial effort and progress in its plan of correction as evidenced by supporting documentation, signed contracts and/or work orders, and a written justification of such findings is maintained on file; and

(v) At the completion of the period allowed for corrections, the intermediate care facility is in full compliance with the Life Safety Code (NFPA, 21st Edition 1967), and the requirements for environment and sanitation set forth under § 249.12(a)(11) or § 249.13(a)(5) and (8)(v), except for any provisions waived in accordance with § 249.12 or § 249.13.

(3) Provide that any intermediate care facility receiving payments under the plan must supply to the licensing agency of the State full and complete information, and promptly report any changes which would affect the current accuracy of such information, as to the identity.

(i) Of each person having (directly or indirectly) an ownership interest of 10 percent or more in such facility,

(ii) In case a facility is organized as a corporation, of each officer and director of the corporation, and

(iii) In case a facility is organized as a partnership, of each partner;

Certification by the State licensing agency or the Secretary, as provided for in subparagraphs (1) and (2) of this paragraph shall be regarded as final evidence that the facility so certified meets the standards and requirements

except that the single State agency may, for good cause based on adequate and documented evidence, elect not to execute a contract or cancel a contract for participation by a facility certified under the State plan.

(4) Provide that the survey agency designated pursuant to § 250.100(c) of this chapter will:

(i) Review information contained in medical review and independent professional review team inspections made pursuant to State plan provisions under section 1902(a) (26) and (31) of the Social Security Act;

(ii) Review statements obtained from each facility setting forth from payroll records) the average numbers and types of personnel (in full-time equivalents) on each shift during at least 1 week of each quarter, such week to be selected by the survey agency and to occur irregularly in each quarter of the year;

(iii) Evaluate such reports and statements and take appropriate action to achieve compliance or withdraw certification as appropriate; and

(iv) Perform, with qualified personnel, on-site inspections at least once during the term of a provider agreement or more frequently if there is a question of compliance.

(5) Provide that the single State agency agreement with a facility for payments under the plan may not exceed a period of one year and that the effective date of such agreement may not be earlier than the date of certification. Notwithstanding the provisions of the previous sentence, the single State agency may extend such term for a period not exceeding two months where the survey agency has notified the single State agency in writing prior to the expiration of a provider agreement that the health and safety of the patients will not be jeopardized thereby, and that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services or that it is impracticable within such provider agreement period to determine whether such facility is complying with the provisions and requirements under the program. Execution of an agreement shall be contingent upon certification in accordance with the provisions of paragraph (a) (1) and (2) of this section and subject to the following conditions and exclusions:

(i) In the case of skilled nursing facilities not in compliance with all standards set forth under section 1861(j) of the Social Security Act, or in the case of intermediate care facilities not in compliance with all standards set forth under sections 1905 (c) and (d) of the Act, the single State agency and may enter into a provider agreement if:

(A) The deficiencies noted, individually or in combination, do not jeopardize the health and safety of patients and a written justification of such a finding is maintained on file by the survey agency; and

(B) The facility provides in writing a plan of correction acceptable to the survey agency;

(ii) In the case of a public institution (or distinct part thereof) for the mentally retarded or persons with related conditons, the single State agency will, prior to the execution of an agreement for the provision of intermediate care facility services, obtain a written agreement from the State or political subdivision responsible for the operation of such public institution that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under the plan, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its approved plan;

(iii) In the case of a skilled nursing facility not in compliance with all of the standards set forth under section 1861(j) of the Act or in the case of an intermediate care faciltiy not in compliance with all of the standards set forth under sections 1905 (c) and (d) of the Act, the term of an agreement shall be for the period of certification recognized by the survey agency; however, based upon such adequate and documented factors as medical review of independent professional review team reports, certification data, the nature of deficiencies and the degree of progress displayed by the facility in correcting prior deficiencies, the single State agency may elect to execute a provider agreement for;

(A) A term related to a facility's plan of correction; or

(B) The full certification period recognized by the survey agency but subject to a provision for automatic cancellation 60 days following the scheduled date for correction(s) unless the survey agency finds and notifies the State agency that all required corrections have been satisfactorily completed, or unless the survey agency finds and notifies the State agency that, on the basis of documented evidence derived from a survey, the facility has made substantial progress in correcting such deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency. Such notification is to be made a part of the contract and the facility so notified.

(iv) No second provider agreement under the condition specified in paragraph (a)(5)(i) of this section may be executed if:

(A) The standard found deficient was in compliance during the previous certification period, except where the survey agency has made a determination based upon documented evidence that the facility despite intensive efforts or for reasons beyond its control was unable to maintain compliance and despite the deficiency(ies) the facility is making the best use of its resources to render adequate care; or

(B) The standards found deficient are the same as those which occasioned the prior agreement except:

(1) In a case where a facility can document to the State survey agency's satisfaction that it achieved compliance with a previously unmet standard during the period of certification but for reasons beyond its control and despite, in the judgment of the survey agency, a good faith effort to maintain compliance with the standard, was again out of compliance by the time of the next survey; or

(2) In the case of a skilled nursing facility completing the second of two successive agreements under provisions for certification in effect prior to July 1, 1973 and having the same deficiency(ies) which occasioned the two agreements, the survey agency will review the performance of such facility (which may be limited to a review of the documentation of record) in providing safe and adequate patient care and in progressing toward correction of such deficiency(ies). On the basis of its evaluation, the survey agency will advise the single State agency that:

(*i*) No provider agreement may be executed with such facility,

(*ii*) A new provider agreement may be executed for a period related to the time required to correct such deficiencies, but not to exceed six months; or

(*iii*) A new provider agreement may be executed for a period of twelve months but subject to a provision for automatic cancellation 60 days following the scheduled date for correction unless the survey agency finds and notifies the State agency that all required corrections have been satisfactorily completed. If the facility continues to be out of compliance with the same standard's at the end of the term of the agreement, a new agreement may not be executed.

(v) Notwithstanding the foregoing provisions, in the case of skilled nursing facilities certified under the provisions of title XVIII of the Social Security Act, the term of an agreement shall be subject to the same terms and conditions and coterminous with the period of approval of eligibility specified by the Secretary pursuant to that title.

(vi) Upon notification that an agreement with a facility under title XVIII of the Act has been terminated or cancelled, the single State agency will take appropriate action to terminate the facility's participation under the plan. A facility whose agreement has been cancelled or otherwise terminated may not be issued another agreement until the reasons which cause the cancellation or termination have been removed and reasonable assurance provided the survey agency that they will not recur.

For the purposes of this subparagraph (5), waivers granted pursuant to section 1902(a)(28) of the Act or § 249.12 or § 249.13 are not considered deficiencies.

(6) Provide that facilities which do not qualify under this section are not recognized as skilled nursing facilities or intermediate care facilities for purposes of payment under title XIX of the Act.

(b) *Federal financial participation.* (1) Federal financial participation is available at 75 per centum in expenditures of the single State agency for compensation (or training) of its skilled professional medical personnel and staff directly supporting such personnel, which are necessary to carry out these regulations.

(2) Federal financial participation at applicable rate is also available for the single State agency to enter into a written contract (under the supervision of the Medical Assistance Unit) with the survey agency designated pursuant to § 250.100(c) of this chapter as necessary to carry out its responsibilities under these regulations. Such Federal financial participation is available only for those expenditures of the survey agency which are not attributable to the overall cost of meeting responsibilities under State law and regulations for establishing and maintaining standards but which are necessary and proper for carrying out these regulations.

COUNCIL POSITION

1. The phrase "good cause" in Sec. 249.33(a)(3) should be clarified for the benefit of both state survey agencies and individual providers/facilities. More specific guidelines are needed here to ensure appropriate application of this regulation.

2. Agreements, including conditional (with deficiencies) agreements, between providers and the Secretary of HEW (in the case of Title XVIII providers) should be of uniform duration to be determined on a national rather than a state-by-state basis. Section 249.33(a)(3) allows individual state agencies to execute agreements of up to one year with providers. The proposed regulation further stipulates that where conditional (with deficiencies which do not jeopardize the health and safety of patients) agreements are executed with providers, the state agency may not execute more than two successive such agreements (with limited exceptions). The National Council supports the intent of the proposed regulations to establish "clearly defined time limits" for correction of deficiencies, and further agrees that the number of conditional provider agreements should be limited. However, unless the duration of conditional agreements is mandated on a Federal basis, providers in some states might be given up to twenty-four months to correct the same deficiency which providers in other states must correct within four to twelve months. Such distinctions could be considered arbitrary and capricious since they would be based on geographical location rather than on the severity of the deficiency or any other reasonable indicator.

The National Council recommends that all provider agreements, whether conditional (with deficiencies) or not, be executed for a twelve-month period.

No six-month agreements (or lesser ones) should be permitted. On-site visits at least every six months for those facilities found to have deficiencies should be required, however. The on-site review team should be empowered to initiate decertification or cancellation of agreement proceedings against the provider, if its inspection reveals insufficient progress toward correction of deficiencies.

3. In Section 249.33(a)(5)(iv)(B)(2) the phrase "same deficiency(ies)" should be clarified to assure providers and surveyors alike that "same deficiency" means exactly that and cannot be interpreted to mean the same category or standard of deficiency. If this is not done, facilities may be decertified or have their provider agreements cancelled if they are found to have entirely different deficiencies in successive inspections which fall under the same standard.

The National Council hopes that facility surveyors, as they gain education and sophistication, will be able to exercise more reasonable judgment and discretion that has generally been the case in the past. The capabilities of individual surveyors will be crucial to the success of the new proposed regulations, which embody the concept of full compliance. Obviously, some deficiencies are more significant than others, and the determination of the degree to which an individual facility is in full compliance with a standard will require the exercise of sophisticated judgment by the surveyor.

4. Where the achievement of full compliance with standards is outside the control of the provider/facility, and deficiency (which does not jeopardize the health and safety of patients) resulting from the action or inaction of an outside source should not cause the provider/facility to lose or not be granted its provider agreement. For example, if a hospital transfers a patient to a skilled nursing facility and refuses to forward the patient's medical record after requests from the nursing facility, then the nursing facility should not be held out-of-compliance. However, the skilled nursing facility must maintain adequate written documentation of its efforts to obtain or maintain compliance with the standard in question.

5. Finally, consideration should be given by the single state agency to the number of occurrences of deficiencies within a particular skilled nursing facility.

The National Council of Health Care Services appreciates the opportunity to comment on the above proposed regulations. If we can be of further assistance, please do not hesitate to call on us.

Sincerely yours,

BERKELEY V. BENNETT,
Executive Vice President.

ITEM 11. REPORT AND RECOMMENDATIONS FROM INTERSTATE MEETING ON PUBLIC LAW 92-603, MARCH 2-3, 1973, SUBMITTED BY GEORGE M. WARNER,* PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS, NEW YORK, N.Y.

BACKGROUND AND DESCRIPTION OF MEETING

On numerous occassions in the last several years, directors and staff of State agencies have expressed increasing concerns about HEW's regulatory, policy and procedural moves in health programs and related areas. These concerns have been voiced by health, medicaid, mental health and other State agencies from a number and variety of States—large and small, industrial and rural, and from all regions of the country. Particularly sharp State reactions have occurred when HEW's actions in interpreting Federal statutes have seemed contrary to Congressional intent, impractical for State implementation, deleterious to health programs and services (and budgets for same) within States or, most important, potentially adverse in their effects on patients.

The passage and signing on October 30, 1972, of Public Law 92-603 has brought these multi-State concerns into ever sharper focus. Many Sections of Title II of this Federal statute have seemed to highlight the needs for conferral among States and for the development of State views on implementation that might eventually be shared among various States. Needs for closer Federal-State partnership on an equal basis also has seemed to escalate because of the many issues and problems posed by this legislation. State agencies involved in medicare, medicaid, maternal and child health, mental health and related programs have seemed particularly aware of being potentially affected, perhaps adversely, by key provisions of Title II.

In response to these felt and recognized needs, representatives of agencies from ten States met informally at State initiative and expense, on March 2 and 3, 1973. This meeting had the official blessings of the sponsoring States and the Association of State and Territorial Health Officers. State staff participating included professionals knowledgeable about areas such as: State program administration and management; provider costs and reimbursement; health information storage and retrieval systems (including claims and payments); provider standards and certifications; health planning and budgeting; levels of care (including utilization review, periodic medical review, physician certification and related subjects); professional standards review organizations; health maintenance organizations renal dialysis programs and services; family planning; early and periodic screening, diagnosis and treatment programs; and other areas.

The ten-State group met both in general session and in smaller work groups. The various Sections of the law that seemed closely interrelated were reassembled into several major issue subjects for ease of consideration by smaller work groups, each of which concentrated on a specific issue or on several closely connected issues. Reports of the work group were reconsidered and amended in the final general sessions. Consensus was obtained on the general intent of the modified statements. The specific reports and recommendations on each of the issues are hereinafter reproduced with minor editorial and clerical changes and corrections.

In addition to reporting and recommending on subject matter in relation to PL 92-603, the interstate group also discussed: 1) next steps for disseminating this report; and 2) strategies for achieving closer State-Federal collaboration in the implementation of the provisions of the law most pertinent to the interests

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*See statement, p. 2603.

and roles of State health, medicaid, mental health and related agencies. A brief listing of steps and strategies is appended. Also, attached is the list of the States and their staff who participated in this interstate meeting.

MAJOR INTERRELATED HEALTH SUBJECTS AND ISSUES OF TITLE II, PL 92-603

Issue I—Levels of Care

Hazards of the liberalizing and limiting features of new levels of care definitions in Titles XVIII and XIX in relation to fiscal matters, patient care needs determinations, and patient placement.

Secs.

247 Level of care requirements for skilled nursing home services.

207 Incentives for States to establish effective utilization procedures under Medicaid.

225 Limits on payment for skilled nursing home and intermediate care facility services.

228 Advance approval of extended care and home health coverage under Medicare.

248 Modification of Medicare's 14 day transfer requirements for extended care benefits.

249 Reimbursement rates for skilled nursing homes and intermediate care facilities.

With regard to levels of care, Issue I of the agenda; the group agreed that:

1(a) In practice as well as in principle, the health care needs of institutionalized long term care patients (residents) are at two recognizable and somewhat different levels. For the sake of consistency with Federal statutory language, these may be referred to as needs for:

(1) Skilled nursing or skilled rehabilitative services.

(2) Intermediate care services.

(b) The categories of institutions which operate to meet health care needs at each of these levels are referred to, respectively, as

(1) Skilled nursing facilities (SNF's).

(2) intermediate care facilities (ICF's).

(c) The terminology used in 1(a) and 1(b) above omits mention of many other health and health related needs of users and of the services which are or should be furnished or arranged by providers to match users needs (e.g. in areas such as dietary services, rehabilitation or maintenance therapies, activities programs, social services, religious services and counselling, pharmaceuticals, physician care and treatment, the provision of safe healthy suitable environments and others); the terms used in 1(a) and 1(b) imply recognition of these other needs and provision of services appropriate to needs at either of the two primary levels of care.

2. HEW must permit each State to recognize and classify, should it choose to do so, sublevels of these two primary levels of users needs and subcategories of these two primary categories of facilities on condition that:

(a) Each State assures, through reasonable mechanisms, that determinations of beneficiaries needs for each sublevel of care and placement of beneficiaries in each subcategory of facility are consistent with that State's definitions of sublevels of needs and subcategories of facilities; and

(b) Federal Regulations, guidelines, conditions for F.F.P. or other Federal actions contain no Federal penalties for or serious interference with each State's use of its own sublevel and subcategory definitions and methods.

3(a) Needs for intermediate care services includes needs for at least two recognizable sublevels of ICF care which are referred to as needs for:

(1) A nursing or rehabilitative level of care up to but not including twenty four hour per day availability of nursing or rehabilitative services at the skilled nursing or skilled rehabilitation level of services such as are furnished or arranged ordinarily by a skilled nursing facility;

(2) A non-nursing or non-rehabilitative level of care which includes more than board and room but does not include nursing or rehabilitative services other than on an evaluative, "as needed" or similar basis.

(b) The subcategories of intermediate care facilities may be referred to as:

(1) Intermediate nursing or rehabilitative care facility (ICF with certain assured nursing or rehabilitative care or supervision)

(2) Supervised personal care facility (ICF without assured nursing or rehabilitative services or supervision other than on an evaluative, as needed or similar basis).

Each State should be permitted, without hazard of reduction in F.F.P. or other undue restrictions, to recognize users needs at this second ICF sublevel (3(a)(2)), to recognize facilities at this second ICF subcategory (3(b)(2)) and to arrange payments through either the Title XIX vendor payment avenue or the Public Assistance cash-grants to beneficiaries avenue, as it chooses, so long as that State can verify that beneficiaries are appropriately placed and receive services suitable to their medical, social and other health related needs in environments which are without hazard to their health and safety.

4. In a facility providing both SNF and ICF levels of care, the concept and practice of "distinct part" recognition and certification should be used (required) when the size of the subordinate unit in terms of numbers of patients/residents (beds) is such as to make determinations of "distinct part" cost center cost differences between SNF and ICF costs and rates practical. It is suggested that "distinct part" cost center differentials may be impractical at less than 25 patients/residents (beds). It is further suggested that facilities operating as combined SNF–ICF institutions be permitted to operate without "distinct part" designations in instances in which the SNF part is 80% or a greater percent of the total numbers of patients/residents (beds) and the ICF part is 20% or a lesser percent of the total.

5. State oppose the fixing by HEW of abritrary ratios or differentials between SNF and ICF costs, rates or F.F.P. for reimbursements that will be applicable to all States.

6. HEW should allow exceptions within and among States, at least for F.F.P. in reimbursement and/or other purposes, to differentials between SNF and ICF rates and costs, providing that the State can document that there are valid reasons for exceeding the ceiling set for ICF reimbursement on bases such as differentials in standards imposed on institutions or differences in identified levels of care, needs of users and of services furnished by providers.

7. As part of determinations of SNF vs. ICF costs, and of differentials intended to be proposed, States should be encouraged to obtain verified or audited cost data from providers, such data to be on the basis of State definitions of categories and subcategories of types of facilities and levels and sublevels of the health services needs of their users.

Issue II—Utilization Review and Related Functions in Relation to Professional Standards Review Organizations

Confusions and conflicts regarding utilization review and related areas (PMR, IPR, M.D. certification, etc.—roles of State health and Medicaid agencies, PSRO's, HMO's, U.R. committees, community based U.R. agencies, carriers and intermediaries, Federal agencies and others.

Secs.
207 Incentives for States to establish effective utilization procedures under Medicaid.
239 Use of State health agencies to perform certain functions under Medicaid and under maternal and child health programs.
237 Utilization review requirements for hospitals and skilled nursing homes under Medicaid and under maternal and child health programs.
249F Professional standards review.
223 Limitations on coverage of costs under Medicare.
247 Level of care requirements for skilled nursing home services.
249D Limitation on institutional care.
298 Independent review of intermediate care facility patients.

Plus pre-existing Federal statutes and regulations, such as 1861(j)(8) and 1861(k); CFR 405.1137, 1902(a)(30); CFR 250.20, 1902(a)(26); CFR 250.23, PL 92-223, PMR Guidelines from MSA 11/13/72.

1. PSRO'S—DELINEATION OF AREAS

Sec. 1152(a) page 102 provides that "The Secretary shall—establish throughout the United States appropriate areas with respect to which PSRO's may be designated * * *"

Sec. 1165 page 115 provides that "The Secretary shall by regulations provide for such correlation of activities, such interchange of data and information, and such other cooperation—between and among—public—agencies having review and control functions."

By reason of the above provisions, and for other reasons, the group agreed that the Secretary should incorporate in regulations pertaining to PSRO's a

provision that prior to designating areas for PSRO's the Secretary shall consult with the appropriate State agency and secure from such State agency its findings and recommendations as to the relevancy of such areas to areas for health planning, administration, or service as may have been or hereafter may be established in such State.

2. PROBLEMS WITH PSRO ESTABLISHMENT

(a) In States having three or more PSRO's, the Governor is to recommend only two of a minimum of eleven members of the Statewide PSR Council—this seems to be the only measure of State government-control provided for other than in the weak correlation requirements of Section 1165. The advisory group to the Statewide PSR Council (or, in States having only one or two PSRO's, to such PSRO) is to include any practitioners (other than physicians) and health care facilities serving as providers.

(b) Since each PSRO can establish its own U.R. criteria, larger States may have different standards for U.R. in different areas of the State.

(c) A PSRO may establish its own data system if it feels existing State system does not meet the PSRO's needs. Again, this can lead to a proliferation of separate and different data systems throughout a State.

(d) The authority of a PSRO in relation to existing health care facilities or organizations is not clear, leading to potential conflict between U.R. systems.

(e) The geographic areas delineated for establishment of PSRO's may conflict with geographic areas already delineated for other health care related purposes and result in a bureaucratic jungle.

3. IN RESPONSE TO THEIR DELINEATIONS OF PROBLEMS THE GROUP AGREED THAT

(a) If State has, by July 1, 1973, a U.R. system that meets with the approval of the Secretary, the PSRO shall adopt the criteria and system developed by the State.

If States do not have an approved U.R. system, PSRO shall participate with the State in the development of the criteria and system. The Secretary shall not contract with a PSRO unless the State has approved the U.R. system proposed.

(b) The appropriate State agencies shall participate in the contract negotiations with the PSRO and the Secretary, both in new and renewal contracts. The Secretary shall obtain full concurrence from the State prior to signing of contract. Implicit in this is the understanding that the State shall participate fully in evaluating the effectiveness of each PSRO within its boundaries.

(c) Each State shall have a single statewide data system that satisfies the needs of both the State and the PSRO's.

(d) The Secretary shall delineate only such geographic areas for the establishment of PSRO's within a State as have been approved by the appropriate State agency.

(e) In the case of "natural medical market areas" which include parts of two or more States, the Secretary shall designate for purposes of determination of PSRO geographic boundaries only such areas as have been approved jointly by the appropriate State agencies of the States involved.

(f) The Secretary shall designate and exempt from the jurisdiction of PSRO's only such health care facilities and organizations which are recommended/approved by the appropriate State agency as having acceptable U.R. systems of their own.

Issue III—Fiscal Implications

Secs.

225 Limits on payment for skilled nursing home and intermediate care facility services.

207 Incentives for States to establish effective utilization review procedures under Medicaid.

249 Reimbursement rates for skilled nursing homes and intermediate care facility services.

222 Demonstrations and reports; prospective reimbursement; extended care; intermediate care and homemaker services; ambulatory surgical centers; physicians' assistance; performance incentive contracts.

Plus numerous other Sections.

(1) Subissue relating to Section 225—Limits on Payment for Skilled Nursing Home and Intermediate Care Facility Services

(a) Principles involved. The group understands that the intent behind Section 225 is to influence the rising costs of nursing home and intermediate care and to maintain equity in Federal-State fiscal relations. The group suggests, as matters of economic and health care principles, that:

1. One segment of an economy cannot be burdened with an absolute control with no right of review;
2. Upgrading of facilities, operationally and structurally, is necessary for quality patient care;
3. State can suffer severe financial consequences as the result of a payment mechanism rather than inflated costs;
4. The Cost of Living Council established goals or standards for health care;
5. The limitation of reimbursement contradicts other objectives in PL 92–603 (for example cost related reimbursement);
6. Implementation would not only be detrimental to patient care but would be costly to administer equitably; and
7. This provision had been deleted at one time in recognition of possible effect on patient services and other controlling elements contained in the Law.

(b) Possible alternate solutions. The group agrees that there are very limited alternates and that one of these must be adopted:

1. Section 225 be deleted;
2. The Secretary increase the percentage to 106 percent and authorize increases in costs resulting from Cost of Living Council decisions; or
3. The implementation be made as simple as possible with the Secretary accepting cost increases resulting from expenditures necessary for the health and safety of patients or cost increases not within the providers control.

(2) Subissue relating to Section 207 (Incentives for States) and 247 (Level of Care)

(a) The group notes that Section 207 authorizes the Secretary to compute a reasonable cost differential for reimbursement purposes between statewide average costs of skilled nursing home services and statewide average costs of intermediate care facility services. Effective July 1, 1973, if such differential does not exist, the Secretary may reduce amount which would otherwise be considered as expenditures by an amount which he determines is a reasonable equivalent of the differences in expenditures had such reasonable cost differential been in effect.

(b) The group agrees as to the urgent need for H.E.W. to:

1. Consult with State before implementation of standards or cost differentials;
2. Consider and give full weight to non-uniform standards for patient classification among States;
3. Consider variances in economic levels and distributions of beds within States;
4. Take into account of peculiarities in a State's method of providing and paying for nursing home and intermediate care services; and
5. Provide States with a time and other flexibilities to restructure their programs to meet Federal requirements not precisely defined at this time.

Issue IV—Standards and Certification

Health facility standards, certifications and related matters—effects on patients and providers and on roles of State, Federal and other agencies.

Sec.	
239	Use of State health agency to perform certain functions under Medicaid and under maternal and child health programs.
249A	Medicaid certification and approval of skilled nursing facilities.
249B	Payments to States under Medicaid for compensation of inspectors responsible for maintaining compliance with Federal standards.
246	Uniform standards for skilled nursing facilities under Medicare and Medicaid.
299D	Public disclosure of information concerning survey reports of an institution.
249C	Disclosure of information concerning the performance of carriers, intermediaries, State agencies, and providers of services under Medicare and Medicaid.
244	Validation of surveys made by Joint Commission on Accreditation of Hospitals.
299A	Disclosure of ownership of intermediate care facilities.
297	Coverage under Medicaid of intermediate care furnished in mental and tuberculosis institutions.

298 Independent review of intermediate care facility patients.
299 Intermediate care, maintenance of effort in public institutions.
Plus pre-existing Federal statutes and regulations

With regard to standards and certification, the group agreed that:

1. (a) HEW officially and centrally (rather than through HEW Regional Offices), include equal representation and participation from State health (or equivalent) agencies with HEW in the development and review of standards for health providers (particularly health facility providers) and of standards for Federal and State administration of provider standards programs prior to the initial publications of any such standards in the Federal Register.

(b) Further, HEW should include such State health (or equivalent) agency participation in the reviews of responses to Federal Reigster publications, in the preparation of final Regulations (or amendments thereto) and in the preparation, finalization and amendment of Federal guidelines, policies and procedures for the implementation of Regulations.

2. The same format should be used in the Federal Regulations guidelines, policies and procedures applicable to SNF, ICF and other types of health providers in the several programs that are Federally sponsored, controlled or otherwise Federally affected (e.g., those covered under Titles V, XVIII and XIX).

3. The HEW concept of "compliance" with rigid six months limitations on periods of certifications and provider agreements must be terminated and the Title XIX Regulations containing such limitations must be deleted immediately from all Federal Regulations, existing and proposed. Further, the "compliance" concept must call for periods of certifications and provider agreements up to the Federal statutory limit of twelve months (with two months extensions permitted) with the State health agency having discretion to determine the period of such certifications and provider agreements in accord with its findings and its need to distribute the health facility survey, certification and related work loads on a reasonable year round or other suitable basis to be determined by the State.

4. HEW must press hard and quickly for reasonable uniformity of understanding and interpretation of the provisions of the various Federal laws, Regulations policies and procedures among its ten Regional offices, particularly with regard to those provisions of Medicare, Medicaid, Civil Rights, and other health programs that affect State Medicaid, health and related agencies.

5. State costs of performance of all functions required of the States by Federal laws and Regulations and otherwise requested by HEW of the States should be reimbursed 100% out of appropriate Federal sources. Such 100% reimbursement should include personal and nonpersonal costs and indirect costs of State functions Federally required or requested in programs such as Medicare, Medicaid, M.C.H., etc.

Issue V—Miscellaneous

1. SECTIONS 229 AND 290—TERMINATIONS AND WITHHOLDING OF PAYMENTS.

(a) Provisions of Sections 229 and 290 authorize the Secretary to terminate payment for services rendered by supplier of health and medical services found to be guilty of program abuses subject to the opportunity for hearing and judicial review of the Secretaries final determination. As a part of this, the Secretary upon 60-day's notice is authorized to withhold Federal financial participation in Medicaid payments by states with respect to those providers.

(b) The group urges that, where appropriate Federal, financial participation in payments to those providers by States should be continued until such time as the State's statutory requirements for hearing and judicial review have been satisfied as well. This principle should be applied to all other payment withhold problems between the States and the Federal government.

2. SECTION 299 I—RENAL DIALYSIS

(a) *The requirement.*—Section 299 I provides that fully or currently insured workers under Social Security and their dependents with chronic renal disease are deemed disabled for purposes of coverage under parts A and B of the Medicare three months after a course of renal dialysis is begun.

(b) *The proposed change.*—Since there is no logical or medical or social justification for a three month waiting period during which time a family may be financially ruined, the period should be reduced or the waiting period require-

ment should be deleted and a provision basing the eligibility and payment decision on medical-social necessity be substituted.

3. SECTIONS 299 E AND F—FAMILY PLANNING AND SCREENING

(a) *The requirements.*—Sections 299 E and F provide for a reduction of the Federal share of AFDC matching funds by 1% if a state fails to inform the adults in AFDC families of the availability of either family planning or child health screening services and fails to actually provide or arrange for such services.

(b) *The solution.*—The group urges that where a State, in good faith, informs recipients of the availability of those services and does in fact make them available, the State should not be penalized by the recipients failure to utilize the services.

To avoid the capricious application of penalties, the criteria by which the Secretary determines that a State is not meeting the requirements of Section 299 E and F should be specified in regulation.

4. GENERAL PRINCIPLES IN FISCAL LIMITATIONS

(a) *The problem.*—Some of the fiscal provisions of PL 92–603 are directed at cost containment. The group believes this generally is appropriate. However, adequate and accessible institutional care to all who need such care in facilities that meet State and Federal standards of health care and safety is essential. Undue constraints on payment for care, both in relation to facility operations and to capital needs, can adversely affect the provision of safe and adequate health care facilities in all areas. In particular, payment-for-care levels may effectively constrain efforts in States to replace existing sub-standard and fire hazardous long-term care facilities and to provide facilities to meet the needs of particular areas or populations less adequately served than others.

(b) *Ways out.*—The group believes that the law needs to be amended or that payment and other parts of regulations should be structured to meet these needs. The group urges that the Secretary consult with State Medicaid and facility licensure and certification agencies, comprehensive State health planning agencies and fiscal intermediaries and carriers in the various States to assess the extent of this problem and to seek administrative and/or legislative remedies.

SUGGESTED DISTRIBUTION AND NEXT STEPS WITH REPORT ON INTERSTATE MEETING ON PUBLIC LAW 92–603, MARCH 2–3, 1973, HOLIDAY INN O'HARE, CHICAGO (SCHILLER PARK), ILL.

1. SUGGESTED DISTRIBUTION

a. States involved in meeting—for corrections and comments
b. ASTHO Executive Committee, then membership of ASTHO
c. Through ASTHO members to other State agencies (e.g. mental health, CHP, Medicaid and others)
d. ASTHO affiliates as appropriate
e. Through ASTHO members and other State agencies to Governor's Office in each State
f. Congressional delegates (Senate & House) and/or their staff on a selected basis from each State
g. HEW Secretary
h. HEW Agencies—SRS, SSA, HSMHA
i. Council of State Governments
j. National Advisory Committees, Councils (HIBAC, CHP National Advisory Council, etc.)
k. National organizations of providers
l. Consumer agencies

N.B. The above suggestions (exclusive of the distribution to States participating in the March 2–3, 1973, meeting, ASTHO, members and circulation by ASTHO members to other agencies in their own States) were mentioned without necessarily referring to order of priority, method of distribution or other factors.

2. NEXT STEPS

The group suggested that, subsequent to appropriate clearance of the report itself, along with the suggested distribution and the method of followup, a delegation of State agency officials be formed to express and discuss views assembled in the report with H.E.W. Secretary Weinberger, Mr. Fullerton of House Ways and Means Committee, and Mr. Constantine of Senate Finance Committee and other appropriate Federal persons. State representation mentioned by the group included Michigan, New York, Tennessee and Virginia.

In addition the group suggested that appropriate State agency(ies) or the Governor's Office in each State might wish to contact Federal agency administrators directly to further confirm interstate reactions and unanimity on a number of the issues of P.L. 92-603. Named were the heads or appropriate representatives of BHI, MSA, CHS, OMB, Assistant and Deputy Secretaries, and the Special Assistant for Nursing Home Affairs.

ATTENDANCE (IN ALPHABETIC ORDER) AT INTERSTATE MEETING ON PUBLIC LAW 92-603, MARCH 2-3, 1973, HOLIDAY INN O'HARE, CHICAGO (SCHILLER PARK), ILL.

STATES REPRESENTED

California
Illinois
Kentucky
Massachusetts
Michigan
New York
Ohio
Pennsylvania
Tennessee
Virginia

PERSONS PRESENT BY STATE

Robert A. Bauer, Massachusetts.
William B. Beach, Jr., M.D., Pennsylvania.
Russel L. Bryant, Illinois.
Donald G. Dixon, Kentucky.
Paul X. Elbow, Illinois.
Jerry W. Green, California.
Roger Herdman, M.D., New York.
James B. Kenley, M.D., Virginia.
Lois Lamont, Michigan.
Edward A. Lentz, Ohio.
Thomas Lindsay, Michigan.
George A. Lindsley, Illinois.
William F. McCann, New York.
Harvey I. Remmer, M.D., Massachusetts.
Malcolm W. Schoenley, Pennsylvania.
Merle Shields, California.
Doris Soderberg, California.
Wendell P. Spurgeon, Tennessee.
Douglas E. Wade, Illinois.
George M. Warner, M.D., New York.
Hermann A. Ziel, M.D., Michigan.

ITEM 12. LETTER FROM MAURICE S. REIZEN, M.D., DIRECTOR, MICHIGAN DEPARTMENT OF PUBLIC HEALTH, TO ARTHUR E. HESS, ACTING DIRECTOR, SOCIAL SECURITY ADMINISTRATION, TRANSMITTING PROPOSED REGULATIONS FOR SKILLED NURSING FACILITIES, DATED JULY 19, 1973; SUBMITTED BY MR. FREDERICK A. TRAILL,* CHIEF, DIVISION OF HEALTH FACILITY STANDARDS AND LICENSING, MICHIGAN DEPARTMENT OF PUBLIC HEALTH

GENTLEMEN: Please find enclosed our analysis and comments with respect to proposed Subpart K—Conditions of Participation; Skilled Nursing Facilities published in the Federal Register July 12, 1973.

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*See statement, p. 2623.

It is our urgent and considered recommendation that the proposed new Conditions referred to above be rescinded at an early date and the current Conditions of Participation; Extended Care Facilities with appropriate modifications be retained as the standards for Skilled Nursing Facilities.

Modifications of the current Conditions would include but not be limited to:

1. Changing the term Extended Care Facilities to Skilled Nursing Facilities where appropriate.

2. Incorporating new statutory requirements mandated in P.L. 92-603.

Retention of the current but modified Conditions is justified by the following considerations:

1. The current Conditions in use since 1966 are reasonably well understood by all concerned; provide more detail and specificity regarding actual requirements thus insuring more uniformity in their enforcement; and are professionally more acceptable as the basis for assuring the quality of patient care.

We cite the following as examples of our concern with the proposed Conditions:

A. Current Conditions releated to the physical plant require elevators in multistory facilities; handwash lavatories in patient rooms and dietary departments; tempered water supply in appropriate areas; and minimum clearance around patient beds. These and numerous other specific requirements have been eliminated from the proposed Conditions.

The elimination of these and other such requirements, which are essential for patient welfare and safety as well as the proper functioning of the facility are not in the public interest. Such important requirements will be impossible to enforce under the proposed broadly worded and indefinite Conditions recently published.

B. The incorporation by reference of additional NFPA standards (other than fire safety standards) as well as standards for facilities serving the handicapped, on the other hand, will create many problems for existing facilities while they are not immediately essential to the proper provision of skilled nursing care.

2. The current Conditions in content and format are more appropriate in terms of Congressional intent and the requirements of the Social Security Act in that they offer the opportunity for needed administration and operational leeway to State agencies and facilities alike.

While it is true that Congressional intent was to embody the concept of full compliance in the administration and enforcement of requirements for Skilled Nursing Facilities, we sincerely doubt and find not one shred of evidence to suggest that the Congress ever intended SRS and more recently SSA to go as far as they have in implementing the full compliance concept.

The current Conditions, in content and format, permit implementation of the full compliance concept at the "Condition" level requirement while necessary administrative and operational leeway is possible at the "Standard" and "Factor" level requirements.

The rigid, uncompromising attitude of SRS and SSA with respect to the implementation of the full compliance concept will:

A. Result in administrative chaos, particularly at the State agency level.

B. Create unnecessary and undesirable hardships for patients resulting from unwarranted denial of certification to professionally acceptable facilities.

C. Offer inducement to State agency personnel to ignore deficiencies and items of noncompliance in the survey process as the expedient alternative to unreasonable Federal demands. (The broad, non-specific Conditions now proposed make this inducement even more attractive. It is also inconceivable to us that the proposed Conditions for Skilled Nursing Facilities should be less demanding than proposed requirements in Intermediate Care Facilities.)

It is further our recommendation that SSA and SRS take a more reasonable approach to implementing the full compliance concept at an early date for the reasons stated above. State agencies must be permitted some discretion in determining the acceptability of a skilled nursing facility since it is the unusual facility that absolutely complies with every requirement every day.

We note with pride that the Michigan Department of Public Health has administered a very effective State health facility licensure program for many years. Since 1966, the monitoring and enforcement activities of the Department have been associated with the closing of more than 190 nursing homes, 110 homes for the aged, and 30 hospitals in the State. More important, the Department has assisted new facilities to begin operation with, for example, a net increase of more than 6,000 nursing home beds and an appropriate overall reduction of hospital beds in accord with community need.

We also wish to protest the plethora of bureaucratic, confusing and sometimes conflicting Federal program standards recently published in the Federal Register which are intended to guide states in the administration of their Medicaid programs and the fulfillment of delegated Medicare certification responsibilities. These standards defy interpretation by the average, competent State administrator and are so complex that they will create administrative chaos. We urge your consideration of this problem at an early date.

We apologize for the tone of this letter and sincerely wish that the obvious need for our critical comments could have been avoided. However, we believe it is essential to evidence our continuing concern and frustration over the fact that State agencies are regularly excluded from making meaningful input based on a wealth of experience to the development of Federal standards which they are ultimately called upon or required to administer and enforce.

Please let us know if we can be of assistance in carrying out your most important, difficult and complex responsibilities. We believe our "front line" experience in the licensure and certification of thousands of health care providers may be of use to you and your respective staffs.

Sincerely,

MAURICE S. REIZEN, M.D.,
Director.

Enclosure.

ANALYSIS OF PROPOSED SUBPART K—CONDITIONS OF PARTICIPATION—SKILLED NURSING FACILITIES*

[Published in the Federal Register July 12, 1973]

(Prepared by Bureau of Health Facilities, Michigan Department of Public Health)

The proposed new Conditions of Participation—Skilled Nursing Facilities are intended to implement the requirements of Section 246, Public Law 92-603, which mandates common standards for such facilities participating in the Medicare and/or Medicaid programs.

Once again, Federal agencies (SSA and SRS) have developed standards applicable to large numbers of provider facilities participating in the Medicare and/or Medicaid programs without significant input from State agencies charged with the application and enforcement of such standards through the survey, licensure and certification process.

While the new Conditions are similar in many ways to the existing Conditions of Participation—Extended Care Facilities currently used in the Medicare Program, they have been changed very significantly and represent a most regressive change that is not in the best interest of patients receiving care in such facilities, the provider facilities individually, or the nursing home industry generally.

This regressive change in the proposed new Conditions which weakens them substantially appears to have been justified in order to compensate for the unrealistic and impractical approach which SRS and more recently SSA have promoted in demanding "full compliance" with all requirements at the "Condition", "Standard" and "Factor" levels.

While it is entirely feasible and would, in our opinion, be in keeping with Federal law (Social Security Act) and Congressional intent to demand "full compliance" with requirements at the "Condition" level (including statutory requirements mandated in the law), State licensure and certification agencies as well as the individual facilities must be given certain adminstrative and operatonal leeway to employ the concept of "substantial compliance" at the "Standard" level in the proposed new Conditions. Furthermore, we urge the incorporation of at least some of the previous "Factor" level requirements, particularly in the area of physical plant, sanitation and environment where more specificity is required to govern multimillion dollar construction expenditures in a reasonable and more uniform manner.

It must be kept in mind that nursing facilities, when constructed new or having undergone extensive modernization or additions, will be in existence for at least twenty to thirty years. Thus, it is essential that the basic standards for construction be definitive and detailed enough to assure the quality of the physical plant, sanitation and environment as well as the functional design of the facility for a good many years into the future.

*Regulation No. 5 of the Social Security Administration as amended (20 CFR Part 405).

In addition, many of the proposed new Conditions would be enhanced by retaining selected requirements at the "Factor" level as long as application and enforcement at this level were on the basis of substantial compliance.

In addition to the above comments, we offer the following analysis of specific sections as outlined below.

405.1101—DEFINITIONS

1. *Deletions.*—Current section has been completely rewritten eliminating reference to and definition of "Extended Care Facility".

2. *Additions.*—New section includes 22 definitions, many of which also establish standards for various types of health professionals working in nursing facilities.

3. *Comments.*—None.

405.1120—COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS

1. *Deletions.*—None.

2. *Additions.*—New section recognizes the prerogative of the State to administer its licensing program and the enforcement of State laws and rules. An item of noncompliance with State requirements does not, therefore, necessarily become a matter of Federal noncompliance.

3. *Comments.*—The addition noted above appears to be desirable and eliminates Federal interference with State prerogatives.

405.1121—GOVERNING BODY AND MANAGEMENT

1. *Deletions.*—None significant.

2. *Additions.*—A. New emphasis is given to the role and responsibilities of the governing body.

B. New requirement for institutional planning which includes:

(1) Preparation of an annual operating budget which includes all anticipated income and expense items.

(2) Preparation of capital expenditures plan for at least a three year period with annual updates..

C. New requirement for governing body involvement in:

(1) Personnel policies and procedures.

(2) Staff development programs.

(3) Use of outside resources.

3. *Comments.*—The new requirement for institutional planning noted above will require considerable expansion of survey staff including individuals with specific competency in analyzing operating budgets and capital expenditure plans. While these requirements may be desirable from many points of view, there is a serious question that, as facility certification standards, they will result in an effective measure of control and have a positive cost-benefit relationship.

It appears far more feasible to establish requirements for the reporting of budget and cost information in conjunction with facility reimbursement requirements rather than as a facility certification standard. In addition, it also appears far more feasible to establish requirements with respect to capital expenditure planning in conjunction with the administration of Section 1122 of the Social Security Act rather than as a facility certification requirement. These changes would elminate overlap in the program.

405.1122—PATIENT CARE POLICIES

1. *Deletions.*—Much of the detail related to specific requirements for various areas of patient care policy has been deleted.

2. *Additions.*—None significant.

3. *Comments.*—The elimination of the above detail will make it difficult to require skilled nursing facilities to establish written policies in many areas of patient care where such policies are essential to the maintenance of quality patient care.

405.1123—PHYSICIAN SERVICES

1. *Deletions.*—Some detail regarding admission procedures has been eliminated.

2. *Additions.*—Physician visits beyond the first 90 days after admission may be less frequent than every 30 days.

A. An alternative schedule of visits must be justified in the clinical record.

B. The facility must notify the State Medicaid Agency.

C. The U.R. Committee or medical review teams promptly evaluates the patients need for monthly physician visits as well as his need for continued skilled care.

3. *Comments.*—The requirement that the facility must notify the State Medicaid agency in regard to an alternate schedule of physician visits should be changed to require that such notification be made to the State licensure and certification agency. It is inconsistent to have one agency enforcing standards which may be changed simply by reporting the change to a totally separate agency.

The continuing requirement for physician dominated and facility based utilization review in skilled nursing facilites remains an impractical requirement in skilled nursing facilities. The care of patients in skilled nursing facilities has and will continue to be primarily a nurse oriented and nurse directed type of care, particularly when physician visits to the facility are at intervals of 30 days or longer. The Michigan Department of Public Health has long advocated the substitution of a program of nursing audit and quality assurance as the standard approach to utilization review. The Department has demonstrated the effectiveness and value of such a program of nursing audit and quality assurance in a number of facilities in the State and urgently requests reconsideration of this matter in accord with earlier correspondence.

405.1124—NURSING SERVICES

1. *Deletions.*—A. Reference to "Supervising Nurse" is eliminated.

B. Details regarding the duties of nursing personnel have been partially eliminated.

C. Reference to "nursing care plan" has been changed to "patient care plan" in the interest of a broader approach to planning total patient care.

D. Federal requirements for "administration of drugs" have been eliminated and the new requirement is conformity with State and local laws.

2. *Additions.*—A. New standards related to the following have been added:

(1) Administration of Drugs (see above).

(2) Conformance with Physicians' Drug Orders.

(3) Storage of Drugs and Biologicals.

B. Roles of the Director of Nursing Services and Charge Nurse have been clarified.

3. *Comments.*—None.

405.1125—DIETETIC SERVICES

1. *Deletions.*—Much of the detail related to the various requirements has been eliminated, particularly detail related to the administration and sanitation requirements for the dietary department.

2. *Additions.*—None.

3. *Comments.*—Some of the detail at the "Factor" level related to sanitation requirements in the dietary department should be reinserted.

405.1126—SPECIALIZED RESTORATIVE SERVICES

1. *Deletions.*—Much of the detail related to the various requirements has been eliminated particularly detail related to the planning, organization and staffing of specialized restorative services. On the other hand, some of the detail related to the qualification of specific providers has been included in Section 405.1101—DEFINITIONS.

2. *Additions.*—A standard on "qualifying to provide outpatient physical therapy service" has been added.

3. *Comments.*—None.

405.1127—PHARMACEUTICAL SERVICES

1. *Deletions.*—Much of the detail related to the various requirements has been eliminated particularly with respect to the procedures for administration of pharmaceutical services. Primary emphasis is placed on compliance with "accepted professional principles and appropriate Federal, State and local laws".

2. *Additions.*—None.

3. *Comments.*—The deletion of the current requirement that medications be administered by "licensed medical or nursing personnel" represents a significant change in Federal requirements since many states permit the administration of medication by unlicensed nursing personnel under supervision or direction at this time.

405.1128—Laboratory and Radiologic Services (Previously Referred to as Diagnostic Services)

1. *Deletions.*—None significant.
2. *Additions.*—A. The skilled nursing facility providing laboratory and x-ray services must meet the requirements for those services as established for hospitals.

B. A new requirement for the handling, storage and transfusing of blood and blood products has been added which incorporates by reference the applicable standards for hospitals.

3. *Comments.*—The requirement that skilled nursing facility providing laboratory and x-ray services must meet the comparable standards for those services in hospitals is not totally desirable for the reason that the inducement to include sophisticated laboratory and x-ray services in skilled nursing facilities will make it just that much easier for such facilities to convert to hospitals at a later date.

405.1129—Dental Services

1. *Deletions.*—None.
2. *Additions.*—None.
3. *Comments.*—None.

405.1130—Social Services

1. *Deletions.*—Much of the detail related to the various requirements has been eliminated, particularly requirements for staff training in the area of social services and emphasis on a facility based social services program.
2. *Additions.*—None significant.
3. *Comments.*—None.

405.1131—Patient Activities

1. *Deletions.*—Some of the detail related to the various requirements has been eliminated.
2. *Additions.*—A specific standard has been added to require a patient activities coordinator and to require consultation in certain instances.
3. *Comments.*—None.

405.1132—Medical Records

1. *Deletions.*—Some of the detail related to the various requirements has been eliminated.
2. *Additions.*—A. Standard requiring the indexing of patients' medical records has been added to facilitate acquisition of statistical medical information and retrieval of records.

B. Standard related to location and facilities for a medical record library has been added.

3. *Comments.*—It will be exceedingly difficult for nursing facilities to comply with the requirement for indexing of patients' medical records. The quality of medical record personnel in nursing facilities is relatively low and the potential for obtaining consultation quite limited due to the lack of qualified consultants.

405.1133—Transfer Agreement

1. *Deletions.*—Some of the detail related to the various requirements has been eliminated and the section rewritten to set forth statutory requirements contained in the Social Security Act itself.
2. *Additions.*—None.
3. *Comments.*—None.

405.1134—Physical Environment

1. *Deletitions.*—Many significant and desirable standards, particularly at the "Factor" level have been deleted. In addition, the reference to Hill-Burton construction standards has also been deleted. This represents a serious and regressive change which must be corrected if the proposed new Conditions are to serve a useful purpose with respect to establishing standards for the physical environment of nursing facilities.

Nursing facilities regularly remain in operation for twenty to thirty years once they are constructed new or have undergone major remodeling or additions. Therefore, it is essential that standards for the physical environment applicable to such facilities be definitive enough to assure that the functional design and

available space, including that assigned to special purpose uses, will be conducive to the provision of quality patient care as well as patient care that can be delivered in an effective and efficient manner.

The proposed new Conditions are so lacking in detail with respect to standards for the physical environment, with the exception of those standards incorporated by reference, that they offer inadequate guidance to facilities as well as licensure and certification agencies involved in their application and enforcement through the survey process.

2. *Additions.*—A. The Life Safety Code of the National Fire Protection Association (21st Edition, 1967) has been incorporated by reference as well as certain statutory waiver provisions.

B. The NFPA 56B (Standard for the Use of Inhalation Therapy) 1968 and the NFPA 56F (Nonflammable Medical Gas Systems) have been incorporated by reference. It is not clear whether the statutory waiver provisions apply to these latter NFPA standards.

C. The American Standard Specifications for Making Buildings and Facilities Accessible to, and Useful by, the Physically Handicapped published by the American National Standards Institute, Standard No. A117.1 has been incorporated by reference.

3. *Comments—405.1134(a).*—There is serious question whether the NFPA standards for Inhalation Therapy and Nonflammable Medical Gas Systems should be made applicable to skilled nursing facilities. The incorporation of these standards is conducive to creating nursing facilities that are readily amenable to conversion to hospitals at a later date.

405.1134(b).—The proposed new standard for emergency electrical service makes no reference to the requirement that the emergency electrical service be effective at full load for four or more hours. This will encourage the use of a battery-operated emergency electrical service which is inadequate to assure the welfare and safety of patients in skilled nursing facilities. Furthermore, the proposed new standard does not specifically require that the emergency electrical service provide electrical power for the nurse call system; elevators; electrical controls for fans or pumps in the heating system; pumps in the water supply, sewage and sanitary systems; or the telephone communications system as well as the items mentioned.

405.1134(c).—It will be exceedingly difficult for existing nursing facilities to comply with the requirements of the ANSI standard No. A117.1. Most nursing facilities and even hospitals do not now meet such standards including but not limited to the requirements for braille keys for elevators; knurled hardware for exit doors and oversize toilet rooms in public areas.

405.1134(d).—The requirement that "the nurses station is equipped to register patients' calls through a communication system" is entirely too general. The present wording could readily be interpreted to find a "cowbell" at the patient bedside acceptable as a nurse call system. Furthermore, the new standard does not specify the need for a nurse call system to serve toilet rooms, bathing facilities and other critical patient areas that is absolutely necessary in the interest of patient welfare and safety.

405.1134(e).—The standard of 80 square feet per patient bed in multi-patient bedrooms will automatically eliminate a substantial number of nursing facilities in Michigan where the standard, until recent years, was only 70 square feet per patient bed. (Since 1969, the Michigan standard of 80 square feet per patient bed in multi-patient bedrooms has been applicable to new construction.)

The standard that "each patient room is equipped with or is conveniently located near adequate toilet and bathing facilities" is also subject to a great deal of interpretation which may not be to the advantage of patients. The present requirement in the existing Conditions of Participation—Extended Care Facilities for at least a handwash lavatory in each room or in an adjoining toilet room should be a minimum requirement for effective patient care.

In addition, a ratio of sanitary fixtures per patient bed should be specified in order to assure the minimum availability of such facilities.

The criteria for clearance around patient beds has been eliminated. This is an important requirement in terms of assuring the proper functional design of patient bedrooms.

405.1134(f).—No comment.

405.1134(g).—The standard should establish a minimum availability of day dining and activity space. This is essential if overcrowding of such facilities is to be prevented and facilities are to be able to function as other than "warehouses".

405.1134(h).—The standard for kitchen and dietetic service areas is so general as to be meaningless. One solution would be to include by reference the Food Service Sanitation Manual—PHS publication No. 934.

As a minimum, standards related to dishwashing, handwashing, food storage, disposal of solid waste and general sanitation must be included in this standard.

405.1134(i).—General reference to "comfortable lighting levels" and "limitation of sound at comfort levels" are exceedingly difficult standards to apply and enforce because of their lack of specificity.

In addition, the general reference to maintenance of a temperature level of 75°F. in the facility should be made applicable only to patient areas. This would not be an appropriate temperature in medicine rooms, office areas, maintenance areas, food storage rooms, etc.

In addition to the above comments, it is absolutely essential that standards be incorporated in the proposed new Conditions that will require elevator service in multi-story facilities; the availability of toilet facilities for personnel and the public in appropriate areas; and the availability of a tempered water supply where appropriate.

It is inconceivable that requirements for skilled nursing facilities are less demanding than published proposed requirements for intermediate care facilities.

405.1135—Environmental Services (Previously referred to as Housekeeping Services)

1. *Delctions*.—None.

2. *Additions*.—A. Standard requiring the establishment of an Infection Control Committee has been added.

B. Standard requiring the establishment of aspects and isolation techniques has been added.

3. *Comments*.—It will be difficult for many skilled nursing facilities to comply with the requirement for establishing an Infection Control Committee as well as the establishment of aseptic and isolation techniques. At the present time, many nursing facilities properly transfer patients with communicable or infectious diseases to hospitals simply because they are ill-equipped to handle them effectively and safely. The successful care of patients with communicable or infectious diseases demands the highest level of nursing direction, supervision and care which does not exist in the majority of skilled nursing facilities even though they comply with the current and proposed nurse staffing requirements.

In addition, there is a general reference to mechanical and electrical systems in standard (f) which might better be incorporated as one of the requirements under 405.1134—Physical Environment.

405.1136—Disaster Preparedness

1. *Delctions*.—None.
2. *Additions*.—None.
3. *Comments*.—None.

405.1137—Utilization Review

1. *Delections*.—Some of the detail related to the various standards has been eliminated.

2. *Additions*.—The section has been rewritten to conform with the statutory requirements of the Social Security Act.

A. Utilization review activity is defined to include at least the following:

(1) Procedures for medical care evaluation studies, and for dissemination and followup of study findings and committee recommendations.

(2) Definition of the period of extended duration and procedures for review of individual cases of extended duration.

(3) A method for identifying patients other than by name.

(4) Provision for maintaining written records of committee activities.

B. Specific requirements for utilization review committee records are set forth.

3. *Comments*.—See previous comments regarding the impracticality of physician dominated and facility based utilization review plans and programs in skilled nursing facilities under Comments, Section 405.1123—Physician Services.

SUMMARY

In summary, the most reasonable approach to establishing uniform Federal requirements for skilled nursing facilities would be to utilize the existing Condi-

tions of Participation—Extended Care Facilities with only name changes as is appropriate and other minor changes as suggested.

This will permit the continued use of standards which have been in effect since 1966 and have achieved broad acceptance in the nursing home industry.

ITEM 13. LETTER FROM MAURICE S. REIZEN, M.D., DIRECTOR, MICHIGAN DEPARTMENT OF PUBLIC HEALTH, TO ADMINISTRATOR, SOCIAL AND REHAILITATION SERVICE, TRANSMITTING PROPOSED REGULATIONS FOR INTERMEDIATE CARE FACILITIES, DATED MARCH 20, 1973; SUBMITTED BY FREDERICK A. TRAILL,* CHIEF, DIVISION OF HEALTH FACILITY STANDARDS AND LICENSING, MICHIGAN DEPARTMENT OF PUBLIC HEALTH

GENERAL COMMENTS

1. The Social and Rehabilitation Service should recognize two primary levels of long-term care in the Medicaid Program:

a. Skilled nursing care.

b. Intermediate care.

2. The Social and Rehabilitation Service should recognize that intermediate care includes at least two clearly defined sub-levels of care:

a. A nursing level of intermediate care.

b. A non-nursing level of intermediate care.

3. The Social and Rehabilitation Service should require, in order to prevent the dilution of hospital or skilled nursing care and to provide for the establishment of appropriate cost centers within a single facility necessary to the development of cost-related reimbursement procedures, that a hospital or skilled nursing care facility be required to establish a "distinct part" intermediate care unit when the number of intermediate care patients within the hospital or skilled nursing care facility exceed 20 percent of the total caseload.

Without a requirement for "distinct parts", hospitals or skilled nursing care facilities will have the incentive to provide care for more and more intermediate care patients at a higher overall cost to the public without actually providing care consistent will the patients' needs.

Furthermore, there will be dilution of the hospital or skilled nursing care for those patients actually in need of that level of care; difficulty in enforcing standards not consistent with the actual needs of patients or residents; and irresponsible dissipation of professional and fiscal resources. Cost-related reimbursement, required by law, for two levels of care provided within a single facility is feasible only when separate cost centers can be established in "distinct parts".

(It should be noted that the above comments with respect to hospitals do not have applicability in Michigan since only occasional intermediate care patients or residents will be cared for in hospitals. On the other hand, the above comments are entirely applicable to skilled nursing care facilities in Michigan.)

4. The Federal regulations for intermediate care facilities should be appropriately written so it is clear which standards apply to an intermediate care facility offering a nursing level of care and which standards apply to an intermediate care facility offering a non-nursing level of care where there are obvious differences in facilities or service programs.

5. The standards for intermediate care facilities and skilled nursing facilities should:

a. Be in the same format. The proposed format of Federal standards for skilled nursing facilities—Conditions and Standards—is preferable. These proposed standards, as we understand it, eliminate standards at the "factor" level incorporating the more important "factors" into the "standard" level requirements.

b. Be enforced in a comparable manner. "Full compliance" concept enforced at the "condition" level requirement only.

"Substantial compliance" concept be permitted at the "standard" level requirement.

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*See statement, p. 2623.

Full compliance with "statutory standard" level requirements can continue to be observed.

The above enforcement procedures are essentially comparable to the Medicare method of enforcement of the Conditions of Participation for Extended Care Facilities.

6. Intermediate care facility standards should realistically be correlated with the needs of patients and residents to be cared for in those facilities-medical/nursing, social and economic needs. Recognition must be given to the fact that the patients or residents in intermediate care facilities are quite elderly, have little potential for significant rehabilitation and are likely to remain in the intermediate care facilities for long periods of time, usually the rest of their life.

On the other hand, standards for intermediate care facilities should recognize the great need for a planned program of diversional activities in addition to day to day care consistent with individual care needs.

7. The standards for intermediate care facilities should be separated from extraneous administrative detail and other program requirements such as periodic medical review and nursing evaluation. Furthermore, the language of the requirements should be made more understandable with elimination of as much of the cross-referencing of requirements as possible.

SPECIFIC COMMENTS

Sec. 234.130.—No comment.

Sec. 248.60.—We strongly support the standards set forth in this section since:

(1) They permit recognition that public institutions may appropriately be certified and participate in the Medicaid Program as intermediate care facilities.

(2) They appear to recognize at least two levels of intermediate care—a nursing level and a non-nursing level of care.

Sec. 249.10.—(b) (15) This standard appears to be in conflict with Section 248.60(a) since it seems to limit intermediate care in public institutions to facilities for the mentally retarded and facilities caring for individuals with developmental disabilities.

It is our strong recommendation that these limitations be clearly eliminated.

Sec. 249. 20.—No comment

Sec. 249.11.—We strongly disagree with and urgently request consideration of the six-month limitation on certification of facilities determined to be in substantial compliance with correctable deficiencies and the limitation of no more than two sucessive six-month certifications for such facilities.

On the other hand, our objections to the above requirements would be significantly less if:

(1) Standards for intermediate care facilities are rewritten in the format of "Conditions" and "Standards" such as is currently being proposed in the standards for skilled nursing facilities.

(2) Six-month recertification requirements are applicable only to those facilities with deficiencies at the "Condition" level.

It is not administratively feasible to handle large numbers of facility recertifications based on complete facility resurveys any more often than annually. The number of personnel required and the cost incurred in such six-month recertification procedures cannot be justified on the basis that it will significantly improve patient care in individual facilities. Furthermore, such a requirement, if strictly adhered to, will result in the decertification of facilities that are entirely capable of providing a valuable and useful community service to recipients of medical assistance. Such rigid procedures will result in a considerable increase in the overall cost of care and from the State's point of view, result ultimately in the loss of Federal financial participation for care provided large numbers of Medicaid eligible recipients.

Moreover, there is no possible way that six-month recertification procedures can be administered in a satisfactory manner consistent with State law and regulations for the processing of administrative appeals resulting from changes in certification, denial of certification, and denial of issuance of provider agreements.

This problem has been called to the attention of Federal program personnel repeatedly. Unfortunately, these individuals seem to forget that the Medicaid Program is a State-administered program and must, therefore, be administered in accord with State law and regulations. When Federal requirements con-

flict with State law and regulations in a matter such as this, the result is a disservice to patients and residents in facilities and the potential retroactive loss of Federal financial participation in the cost of care provided to those individuals.

The requirement that an intermediate care facility be in full compliance with the Life Safety Code (NFPA, 21st Edition, 1967) is quite unrealistic. This requirement should be amended to substitute a requirement for compliance with individual State Fire Safety Codes. The alternative is the processing of numerous waivers in order to maintain a large number of intermediate care facilities as certified providers in the Medicaid Program.

Sec. 249.12.—The major problem in this section is the failure of the proposed Federal standards to clearly recognize two levels of intermediate care—a nursing level of intermediate care and a non-nursing level of intermediate care.

Comments on individual standards are as follows:

(a)(1)(i)—It is reasonable to require that an intermediate care facility providing nursing care be administered by a licensed nursing home administrator. On the other hand, it is not reasonable to require that an intermediate care facility providing non-nursing care be administered by a licensed administrator.

(a)(1)(ii)—Standards should be included for intermediate care facilities providing nursing care to provide for nursing direction and supervision as well as the establishment of an organized nursing service.

The standards for a non-nursing intermediate care facility may justifiably require the presence of an R.N. or L.P.N. in the facility to:

1. Advise the facility administration regarding the health program for residents.

2. Direct and supervise the health program that is implemented for residents.

3. Assure that residents receive needed medical care on either emergency or rountine basis by:

a. Resident visit to the physician's office.

b. Physician visit to resident in the facility.

(a)(1)(iii)—No comment.

(a)(1)(iv)—Standards should be amended to provide that written policies and procedures are developed by the administrator with the assistance of an R.N. in the case of an intermediate care facility providing nursing care or the resident services director in a non-nursing intermediate care facility.

(a)(1)(v)—No comment.

(a)(1)(vi)—No comment.

(a)(1)(vii)—No comment.

(a)(1)(viii)—No comment.

(a)(1)(ix)—No comment.

(a)(1)(x)—No comment.

(a)(1)(xi)—No comment.

(a)(2)(i)(a)—No comment.

(a)(2)(i)(b)—No comment.

(a)(2)(i)(c)&(d)—Standards should be amended to clearly differentiate between the records required in an intermediate care facility providing nursing care dependent in large part upon the proper maintenance of a clinical record for each person and the records required in a non-nursing intermediate care facility where an individual clinical record is not indicated.

(a)(2)(ii)—No comment.

(a)(2)(iii)—No comment.

(a)(2)(iv)—No comment.

(a)(3)—The standards for a rehabilitative program provided directly or through arrangements with qualified outside resources place far too much emphasis on the availability of such services. There is failure to recognize that the majority of patients and residents in intermediate care facilities are quite elderly, have little potential for significant rehabilitation and are likely to remain in the intermediate care facility for long periods of time, usually the rest of their life.

Such standards also offer the incentive to provide rehabilitation services on a broad scale to all patients or residents in the intermediate care facility as a "money making scheme".

(a)(4)—The standards for social services are overly-complex and comprehensive and far beyond the needs of the majority of patients in intermediate care facilities.

(a)(5)—The standards for activities programming (diversional activities) appear to be appropriate. On the other hand, many intermediate care facilities will be unable to obtain the consultation of a qualified recreational therapist, occupational therapist, occupational therapist assistant, or social workers in the development of a diversional activities program.

(a)(6)—The standards for health services should be amended to be appropriate to the two levels of intermediate care. (See comments above)

(a)(7)—No comment.

(a)(8)—No comment.

(a)(9)—The standards for pharmaceutical services should be amended to make them appropriate to the two levels of intermediate care.

We concur in the requirement that "all medications are administered by medical and nursing personnel in accordance with the Medical and Nurse Practice Acts of the State".

(a)(10)—No comment except that facilities should be required to plan menus at least 30 days in advance instead of two weeks.

(a)(11)—The standards for environment and sanitation are generally acceptable with the following exceptions:

a. Many existing intermediate care facilities do not have elevators and would be eliminated from the program by this requirement. We recommend as an alternative that elevators be made a requirement for new construction only.

b. The absolute limitation on patient or resident bedrooms to four individuals should be limited to new construction although it could be made a strong recommendation for existing facilities.

c. The requirement for "one day room area on each resident floor" is overly-restrictive. There is some merit to this requirement if it is made applicable to new construction.

d. A requirement for a nurse call system in intermediate care facilities providing nursing care has been omitted. This requirement should be included in the interest of patient health and safety.

(a)(12)—No comment.

(a)(13)—The requirement for compliance with the NFPA Life Safety Code is not realistic for intermediate care facilities and should be amended as recommended above.

(a)(14)—No comment.

(b)(1)(2)—The waiver provisions of this section are absolutely essential if the above recommendation for change are not implemented. On the other hand, every effort should be made to eliminate the need for waivers wherever possible since they will be a continuing administrative problem which is out of proportion to the benefits to be anticipated for patients or residents.

Sec. 249.13—Standards for intermediate care facility services in institutions for the mentally retarded or persons with related conditions should, as with other intermediate care facilities, recognize a nursing level of care and a non-nursing level of care. In either instance, appropriate services for the mentally retarded and persons with related conditions can and should be provided.

(a)(1)—Licensure of the administrator should be limited to intermediate care facilities providing nursing care.

(a)(2)—No comment.

(a)(3)—See above comments regarding compliance with NFPA Life Safety Code.

(a)(4)—See above comments regarding health services supervisor. This should be a registered nurse in a nursing care facility. The potential for other trained personnel to head up non-nursing units as a resident services supervisor should be permitted.

Futhermore, a non-nursing intermediate care facility may justifiably require the presence of an R.N. or L.P.N. in the facility to:

1. Advise the facility administration regarding the health program for residents.

2. Direct and supervise the health program that is implemented for residents.

3. Assure that residents receive needed medical care either on an in-residence or out-of-residence basis.

(a)(5)—See above comments regarding environment and sanitation.

(a)(6)—The requirement for a "qualified mental retardation professional" is far too complex with these "ideal" standards.

(a)(7)—No comment.

(a)(8)—It is unrealistic for governmental standards to incorporate by reference the standards of nongovernmental agencies.

Futhermore, the standards established by the Accreditation Council for Facilities for the Mentally Retarded with respect to staffing are excessive in terms of minimum standards for facility certification. Minimum standards should be in terms of hours of nursing or resident care per patient or resident per day rather than in an overall ratio of "staff to resident" ratio.

In addition the requirements for special services (physical and occupational therapy, psychological services, social services, speech pathology and audiology services, organized indoor and outdoor recreational activities) represent the "ideal" rather than the minimum standards acceptable. It will again be almost impossible for most facilities to meet these standards for special services.

(a) (8) (ii)—The standards related to methods of administrative management are excessive, impossible of compliance in most institutions and extremely costly as they relate to the admission procedures outlined. The same is true of the complex record system requirements set forth.

(a) (8) (v)—The standards for "resident living areas" provide a minimum requirement of 60 square feet of floor space per resident in a multi-resident room. This space is inadequate and should be increased to at least 70 square feet of floor space per resident room.

There should also be a specification that in new construction the standards should be 80 square feet of floor space in a multi-resident room and 100 square feet of floor space in a single resident room.

See above comments related to environment and sanitation as also being applicable to this section.

Additional comments on Section 250.25 Independent Professional Review in Intermediate Care Facilities will follow.

ITEM 14. MINNESOTA HOSPITAL ASSOCIATION 1973 RAY AMBERG MEMORIAL LECTURE "WILL OUR SYSTEM OF HEALTH SERVICE SURVIVE"? SEPTEMBER 20, 1973, SUBMITTED BY JOHN M. MASON,* DIRECTOR, DEPARTMENT OF SERVICES TO THE AGING, DIVISION OF SOCIAL SERVICE, THE AMERICAN LUTHERAN CHURCH, MINNEAPOLIS, MINNESOTA

Will Our System of Health Service Survive?

It is indeed an honor to have been invited to present the Ray Amberg Lecture by the Minnesota Hospital Association. Those of you who knew Ray will understand when I say that often during a lengthy presentation before the Minnesota Advisory Council on Hospital Construction, just one of many Boards and Councils on which Ray Amberg served with distinction, it would appear that he was almost asleep or at least inattentive. The illusion was quickly shattered when the presentation was completed and Ray in a quiet, yet cogent, manner would analyze what had been said, taking apart some points and giving added emphasis to others. He was indeed Minnesota's "Mr. Hospital," his contribution will be recognized for many years.

The program committee for this annual meeting of the Minnesota Hospital Association, with its affiliate, the Minnesota Conference on Geriatric Care, has chosen a good theme, "Challenges to Survival." No subject could be more timely, for in the opinion of many in the field, the health system in the United States is in danger of suffocation from layer after layer of bureaucratic regulations that have been imposed upon it. While these may be meant well, the governmental regulations appear to be more concerned with saving buildings than saving lives, more occupied with multicopy reports than dealing with human problems, more concerned with a systems operation than with a caring service. In my opinion, too many decisions on medical and health problems are being made by non-medical people and persons who by experience and training do not have an expertise in the field of health care.

It is very important, according to building code regulations, that in a patient's room we have the proper ratio of square inches of glass area in the window to the number of square feet of floor space! It is of great importance that the corridor of a building be 96 inches wide rather than 94 inches. If we were to study the regulations in the various states on locks on patient's doors, we would

*See statement, p. 2627.

be astonished. I attended a meeting in one state where several hundred administrators were present together with some government inspectors. About two hours of precious time were taken up debating the merits of having the lock on the inside of the door, the outside of the door or not having a lock! In that state, there were three contradictory regulations: by Medicare, by Medicaid, and by the State Board of Health, about locks and their locations. The tons of paper being used to make reports, in multicopy, is scandalous in the light of present paper shortages. Of greater significance, however, is the waste of man-woman power used to make reports, to review reports and to file them out of sight. If some of this time and effort were used to give person-to-person services to people, it would likely help many people recover from illness or perhaps live with just a little more comfort; program costs would be cut substantially.

Thus you sense the direction this paper will take. I want to discuss briefly a number of dehumanizing regulations which must be complied with if reimbursement for service is to be received. I would like to review for you some of the frustrating experiences you all have had in seeking to provide the best possible care at the most reasonable cost in light of the great number of obstacles that have been placed in your way. I do not want the paper to be negative but positive. At the appropriate time, I want to ask a question that has been on my mind for a long time and in giving my answer to the question, I hope we can come to an understanding of our problem that will help us continue to serve people, and thus, win the struggle for the survival of our health system. In the interest of brevity, the items that I discuss will not be dealt with exhaustively, but sufficiently so that a point can be made. No doubt there will be those in this group who will disagree with some of my positions. This will not be a new experience and I welcome criticism, for by meeting differing opinions we grow in our understanding.

As my experience in the past twenty years has been mostly in the field of long-term-care for the elderly, most of my material will be drawn from this field, but will apply almost as directly to the acute hospital field as these institutions must live under similar regulations and systems; we will begin by discussing several more or less unrelated items. Then we will attempt to show what these mean in the light of the efficacy of our health delivery system and then we will ask our question. From that point on, we may be treading briefly a new path which possibly will lead us back to some fundamental truths that have all but suffocated under the systems approach which has been developing in our country.

THE AREA HEALTH SCREENING TEAM

We are all concerned with the costs of health care. In the United States, we spend about $90 billion dollars a year buying the health services we receive. Recently a publication out of Washington, D.C. predicted that we soon will be spending double that amount. We need to be sure that we get what we pay for!

There are many facets to this problem, but the one which concerns us most at this point is the cost of health care for the aged. This care is provided basically to our older people in hospitals, nursing homes, home health agencies and other programs such as visitation nurses and day-care centers. Demographic specialists predict that by 2000 A.D. our population will show 35 percent in the 65 and over category. Think what this will do to the utilization of health care facilities.

In 1967, the Medicare program was made operative. Hospitals and skilled nursing homes were generally certified as "providers-of-service." To begin with, the general public was of the opinion that the problems of health care for the aged were solved. The payments made through Social Security and through deductibles and charges for doctors services, were accepted with good will.

As the program developed, however, it was soon learned that the cost to the old person was still rather high and as each year passed, this cost has increased so that we have recently learned that the average annual out-of-pocket expense for health care for old people is more than it was at the time of the enactment of the Medicare program!

Also, as the program developed, there were drawn up by the persons who in HEW set the standards and regulations for the implementation of Medicare, a catalog of "non-covered cases." This catalog is so large that only a very unusual case is actually covered in an Extended Care Facility. Among a number of criteria used to determine the eligibility for coverage of a person discharged

from a hospital to an Extended Care Facility is the rehabilitation potential of the patient! Thus, if a person is diagnosed as being incapable of rehabilitation and possibly a terminal case, it is highly unlikely that the care will be covered in the ECF. When the implications of the Title 19 program began to show up, the problem for the old people who were not able to pay for their care became real. Title 19 covers the persons who are not financially able to carry their health care costs and who generally require long-term care which in many cases should be classified as "skilled" care. Title 18, which is basically a program to cover the costs of care in hospitals and for a very limited period, the costs of care in an Extended Care Facility, really a skilled nursing home, proved also to be far more expensive than had been anticipated. Thus, in both programs there began a process of attrition, that is, cutting back of benefits originally promised and an increase in the costs to persons able to pay their own way and an increase in the costs to the state agencies responsible for the care of the old people who were unable to pay their own way. The success or the failure of the health care system was judged on the basis of its cost, rather than on what was happening to old people who were patients.

In this paper, while we will deal mainly with the nursing home problem, as it has developed in the six years since Medicare and Medicaid, Titles 18 and 19 were adopted, we also will bring in some information from hospitals. Thus in 1965–1966 the skilled nursing care homes began to tool up for certification as providers of services. It is interesting to note that the CPA audit summaries of one national church body that has for more than one hundred years provided care for the aged and the infirm, show that during the "tool-up" stage, the costs per person per day rose at the following rate: 1963 6.5%, 1964 8.8%, 1965 9.4%, 1966 11.4%.

When Medicare became operative, the costs continued to rise as follows: 1967 11.6%, 1968 9.4%, 1969 10.7%. By 1968, however, it was evident that Medicare and Medicaid had many faults. In fact, most of the homes of this church began to drop out of the Medicare program because it was realized that the program did not serve the best interest of old people and that the reimbursement for services provided, forced the homes into a deficit operation so great that they could not continue the program. In the State of Minnesota, more than 60% of the counties do not have a single Extended Care bed. This means that more people are kept longer in the hospitals where the care provided cost much more but is still covered. This is an unnecessary cost with no real benefit to the person needing care. It is of further interest to note that in this particular program the cost increase per person per day began to decrease as the homes dropped out of Medicare. Thus in 1970, the cost increase was 9.5%, in 1971 4.6%, and in 1972 6.8%. At the present time, as of the end of 1972, the cost increase per person per day is at about the same rate as before the inception of the Medicare system. What will happen in 1973–'74, due to the form the Economic Stabilization Program has taken, is still a question but the situation looks serious. The homes, however, are still providing the same skilled nursing care which they did under the Medicare program. An interesting comparison may be drawn with respect to the increase in program costs in hospitals. The increase in patient costs per day in one large hospital in Minnesota was $51.34 from 1963 through 1972, a change from $43.59 in 1963 to $94.93 in 1972. This indicates an increase of 117.77%. This would mean an average increase of 13.08% per year. The homes mentioned earlier showed a per resident cost of $4.77 for program service in 1963 and $10.46 in 1972, an increase of 119.28%. The average increase over the same nine year period was 13.25%. There thus is a striking correlation in the percent of increase in cost between the nursing homes and this hospital. Should this kind of increase in costs continue, the danger of collapse in our health care system is very real.

Those in charge of the administration of Medicare were well aware of what was happening. They attempted a number of strategies to cope with the deteriorating situation. The first strategy has been mentioned, the development of a catalog of "non-covered" cases. Along with this it was decided that specific "levels-of-care" should be set up so that a person could be classified as needing care in a "separate-and-distinct-part" of a home in accord with the level of care the person required at given time. The concept that all people should be capable of rehabilitation shows up in this item. The fact that old people are not about to become young does not seem to have been understood. This led to the absurd situation which is referred to as the "60 day corridor problem" which means that a 65 year old or any Medicare covered person could have only one benefit period unless he or she lived 60 consecutive days in a non-health-related facility after dis-

charge from the Extended Care Facility, or after having used up the Medicare benefits. A young, old person, who returned to his own home after a cardiac disturbance would qualify for a full Medicare benefit if a second episode of illness would not occur until 60 consecutive days had passed. The old person, however, who lived in a health-related facility, whose home was there, could never qualify for a second Medicare benefit! There were the following categories:

1. The Extended Care Facility—covered in the main by Medicare for a limited period of time and with certain payments required of the recipient of care, but only after a three day stay in an accredited hospital;

2. The Skilled Nursing Facility—covered by the Medicaid program, which means that this was the public assistance program which cared for people unable to pay for their own care. Persons who could pay their own way, or who had used up their benefits under the Extended Care Facility program, could also, at their own expense, be cared for in the Skilled Nursing Home Facility;

3. The Intermediate Care Facility—which provided no reimbursement from Medicare, no reimbursement from Medicaid, except for those on public assistance (Welfare); no nursing care was to be paid for; the staffing pattern allowed, did not qualify this kind of facility for licensure to provide nursing care nor for adequate reimbursement of the costs to pay for the care provided.

4. The Custodial Care Facility—which was not licensed for health services and was designed to care for people whose "prognosis" was negative, that is, people who were really beyond hope of rehabilitation and were to be cared for until taken by death! Payment for care was to be provided by the person receiving care, the family, or if these sources were not available, by public assistance. The level of reimbursement was very low. Also, in the Custodial Care Facility were the people who had no other place to live but who needed some supportive or protective services and who may or may not be able to pay for their care.

This "Separate-and-Distinct-Part" classification for levels of care for old people was devastating to the well-being of the people involved. No old person enjoys breaking up housekeeping to move into a home for the aged. To do this under the best of circumstances is traumatic. To do this with the knowledge that there was no security in the new situation, that a change from one type of facility to another was dependent upon their state of health or state of finances was enough to cause many old people to deteriorate rapidly.

The administrators of the Medicare-Medicaid programs have recognized the fallacies of this approach and are now seeking to correct the situation. The cure, however, may be worse than the disease! The new system calls for making the physical standards of Medicare and Medicaid identical. Thus the level of care for both Extended Care Facilities and Skilled Nursing Facilities are to be identical and the Extended Care Facility name will be dropped. Only the method of reimbursement is different, Title 18 recipients being eligible for greater coverage than Title 19 recipients! In making this change, however, the Intermediate Care Facility has come into a new prominence. In some manner, not yet quite clearly defined, the Intermediate Care Facility, the ICF, will be looked upon as a "Health Facility," but the rate of reimbursement is not related to the cost of the care provided, even though it may be shown that a disoriented old person, incontinent and requiring medical services may cost more to care for than a person discharged from a hospital to a skilled nursing facility for a period of convalesence under Medicare! It is greatly feared by many that the ICF may become a "dumping" place for old people in order to cut costs. The position of the Custodial Care appears to remain unchanged. To this facility the people, for whom the prognosis is poor, the people who are not expected to be rehabilitated, will go to await death. With these people, will also be found those mentioned above who cannot cope with the problems of living alone and need service provided in a congregate care or group-living facility.

The inequities of this new system are enormous and as yet have not been recognized by the general public, although the providers of service are very much aware of the problem. To use the potential of rehabilitation as a criterion for determining the level of care to be provided is a disgrace to our nation and is a cause of abuse and poor care that is found in many homes where the motive is profit and not the well-being of the person. Nevertheless, such a person cannot be moved to a facility that will call for a higher reimbursement for the care they require!

The major responsibility for the determination of the level of care a person is to receive will be given to the "Area Health Screening Team," which has been

set up under the auspices of Medicare-Medicaid. This team will come into a home at regular intervals to "evaluate" the residents and to determine which category of care applies to those evaluated. In the short period in which this system has been operative, it is very apparent to the administrators of homes that the purpose of the team is to move people who are in the more expensive Skilled Nursing Facility into the ICF or even the Custodial Care Facility, which will automatically reduce the reimbursement provided for the care of that person.

It is a demonically dehumanizing system! We may just as well place these poor old people on a cake of ice and shove them off into the Arctic Ocean! This would be more humane, for their period of suffering would be much shorter.

When a person is "evaluated" and it is determined that "at this point in time" he or she does not need the level of care which under good rehabilitative programs has enabled that person to come out of a semi-comatose state to a relatively stable state, he or she must be transferred to a lower level of care category and the almost inevitable result is a regression. In a short period of time the patient may need not skilled nursing care, but hospital care at an enormous increase in cost!

One director of a health screening team, when questioned by an administrator on this system said, "We know it is wrong, but we have our regulations to go by. We must reclassify this patient even though we know that the inevitable result will be a regression on the part of the patient."

Later, this person applied for the position of "Charge-Nurse" in this home because as she said, "I want to work in an institution that places the well-being of the patient in first place!"

So, we must look at what is happening. Our present system is not reducing costs but increasing them, while at the same time, the quality of care provided, steadily deteriorates because people are not provided the care they need and because staff who could otherwise be deployed in providing personal services are busy with paper work, health screening teams, surveyors of programs, utilization review committees and the like!

THE LIFE-SAFETY-CODE

Certainly, no one is unaware of the tragic fires which have taken the lives of helpless old people in homes and sick people in hospitals. That these happen rarely is a matter often overlooked by the press, the public and the legislators. More people are needlessly killed on our highways each month than have died in fires in homes and hospitals in many decades! After such a fire occurred in Marietta, Ohio, there was a loud outcry for more stringent regulations on nursing homes so that such a tragedy would not be repeated. Again, after the fire at Homesdale, Pennsylvania, the attention of the public was focused on an event which surely should not have happened. A number of years ago, a fire in a multi-story frame building in Council Bluffs, Iowa, which took the lives of a dozen people shocked the nation. There have been other fires and no one defends them. As each occurrence has made itself felt in the consciences of the citizenry, there has been a demand for stricter laws for fire-preventive construction material and automatic devices to prevent a repeat of such tragedies.

We now have a Life-Safety-Code which is being enforced in all health related facilities. At the risk of sounding facetious, I would say that it could better be called, "The Building-Safety-Code," for it is quite evident that the code will be more effective in saving structures than in saving lives.

For instance, one home which I visited recently must replace a number of beautiful plate glass windows which not only are attractive, but which add much to the quality of life in this well built home. The inspector explained to the administrator that in case a fire broke out, the heat, likely to be generated, would blow out the glass and the fire and smoke would spread. This sounds reasonable until you realize that if such heat is generated, the glass may as well blow for if the residents have not been evacuated from the building they will be dead before that happens!

Another example: The home has exposed steel girders which have been beautifully worked into the structure. These girders, the code states, must be covered by a plaster-board material, because if a fire breaks out in the building the heat will cause the girders to buckle and the roof will cave in. So what, if such a temperature is reached, the people who still are in the home will be dead before the roof comes down! There is an ironic twist to this particular regulation. It was after the fire in Council Bluffs that the steel-girder was introduced to

protect the building. Now it is declared to be unsafe without protection. We used to build with laminated wood beams which tests show can stand intense heat and even burn for hours without collapsing!

Is it not time to think more about the safety of the people? The best fire detector is a human being, a properly trained staff person on duty with a fire drill routine that has been carefully worked out. These staff persons will discover fires before they get out of control and residents will be evacuated before glass panels blow or roofs cave in.

On February 28, 1973, the Subcommittee on Housing for the Elderly of the Special Committee on Aging of the United States Senate, held hearings on fire-safety. A number of witnesses testified. If you will examine the testimony, you will find not one word on the need for well trained staff on duty with a fire-safety plan coordinated with off-duty staff, the fire department, police and the state highway patrol! The testimony deals exclusively with automatic smoke and heat detection systems, sprinkler systems, and other construction items. An example is quoted of an old woman who ran out of her room leaving the door open because the room was on fire! I don't blame the old lady, I think I would run too! But, where was the staff to sound the alarm and to begin the evacuation system?

The American Lutheran Church has served tens of thousands of old people in the past 125 years. We have had several fires which partially or completely destroyed the structures, but we have never suffered the loss of a single life. Why? Because we believe that we must not only have well designed and protected structures but that the most effective life-safety device is a human being on duty and trained to react responsibly in an emergency.

Let me cite a few examples. At Stoughton, Wisconsin, the Skaalen Home burned to the ground, but no one suffered a burn. At Lake Park, Minnesota, The Home for the Aged was totally destroyed, but no one was injured or burned. At Wolf Point, Montana, a senile couple deliberately set fire to their room, closed the door and went out into the lounge to wait for the excitement to begin when the fire department with its sirens would come to put out the fire! The modern, well constructed building was damaged but no loss of life nor injury due to smoke inhalation occurred. At Williston, North Dakota a 78-bed home was set on fire by a faulty electrical connection in the oil storage room. Immediately, the trained staff put their fire routine into action. In a matter of minutes, all residents were ready to be evacuated, the police and highway patrol had filled the parking lot with passing cars—at 2 A.M.—and the fire department was at work. The fire was contained and the residents were brought back to their rooms, excited but unharmed.

There is no such thing as a "fire-proof" building, as witness, the incident at Wolf Point, Montana. Automatic devices and good construction are necessary, but nothing will replace trained staff in times of emergency. Yet, not a single witness at the hearing made mention of this. When you read the proposed staffing regulations for skilled nursing homes as published in the Federal Register, July 12, 1973, you will note that staffing requirements are actually lowered! This does not make for a good life-safety system.

THE CERTIFICATE OF NEED LAW

Under recently established federal law, each state has been required to pass legislation which makes it necessary for a sponsoring group to secure from the State Board of Health a Certificate of Need before commencing construction of a home that is to provide any kind of health services to people. The intent—to prevent over-building of facilities—is good. There is, however, another side of the picture that must be looked at. In adopting this stance, the state may very well be protecting undesirable programs and supporting high cost, for-profit operators; it may be preventing progress in the development of innovative and improved facilities by the non-profit sector. A specific example will be cited.

In St. Paul, Minnesota, a fine home with more than sixty years of experience behind it, caring for more than 200 old people and with a long waiting list of persons who are in need of the kind of housing and health care that this home provides, was denied a Certificate of Need by the Minnesota State Board of Health. This was done in spite of the fact that the Area Health Planning Council had recommended the granting of the Certificate and in spite of the fact that the same Board of Health had approved, upon the recommendation of the Advisory Council to the Board of Health on Hospital Construction, both a Hill-Burton grant and a Hill-Burton loan for the construction of the proposed additional facilities.

The reason given for the denial was that in the metropolitan area there are at present about one thousand empty beds. Therefore no new construction should be allowed. Obviously the Board of Health has a point, but questions need to be answered. Why does this home have such a long list of people desiring to enter? Why do a number of similar homes offering high quality care at relatively low cost have long lists of people desiring entrance. Why do some homes in the area have empty beds?

To those who are familiar with the situation, the answers are easily seen. The good homes have lists of people who desire to enter; the homes that are of substandard quality have empty beds. It should also be said that some homes where profit is the motive take no welfare cases and charge high rates; possibly because of this they have empty beds. In the light of these facts, the action by the Board of Health in denying the Certificate of Need tends to protect the substandard home and to aid the high cost, proprietary home.

Senator Frank Moss, Chairman of the Subcommittee on Long Term Care of the U.S. Senate Special Committee on Aging, said at a special committee hearing on nursing home abuses held in Minneapolis, Minnesota, November 29, 1971: "There is growing evidence that 50 percent of the nursing homes in the United States are substandard." Exposés in a number of major cities in the last few years support this statement. Yet, a good program is denied the opportunity to expand and thus to provide many people with the kind of care they want and need. Improvement of the program of health services for the aged will be set back severely if the present ruling is permitted to stand.

A second objection to the concept of the Certificate of Need requirement is that it constitutes an infringement on a person's right to choose the place of his or her residence. If the Board of Health of any state denies a Certificate of Need to a good home it, in effect, tells the old person that he must accept an inferior home and his right of free choice is denied. The Supreme Court of the State of North Carolina has declared the law unconstitutional.

A third objection to the Certificate of Need requirement is the fact that it disregards a person's ethnic and religious preferences. Conceivably an orthodox Jew might have to live in a home where no kosher food is served or a Lutheran might have to live in an orthodox Jewish home. The damage to old people who thus would be deprived of cultural and religious preferences would be impossible to measure.

(A postscript must be added. Since the above was written, the governor of Minnesota, after a six month delay, appointed a review committee in accord with the provisions of the law. The Appeal was filed on October 11, 1972, but the Appeal Committee was not appointed until March, 1973. The hearing was held and four months later, in August of 1973, the decision was handed down ordering the Minnesota State Board of Health to issue at once the Certificate of Need. In the meantime, the $250,000 Hill-Burton Grant appears to have been lost and the $1,800,000 Hill-Burton long-term loan has been reduced to about $600,000. A tragic happening and entirely unjustified.)

THE HOUSING FOR THE ELDERLY PROGRAM

Alongside of the health care program for the elderly there has developed a housing program which in my opinion is creating hazardous living conditions for people 65 and older. Again, the intent of Congress was good, but the program fails to do what ought to be done because it fails to recognize that if a person does not die he grows older. As he grows older he will inevitably arrive at a time when chronic ailments make it necessary that health care or nursing care be provided.

These programs, wherein the Federal Government either extends direct loans, or issues mortgages or subsidizes interest rates, do not allow for the providing of health services. One program, FHA 231, allows for a very limited temporary care in an infirmary, the other programs, FHA 202 and 236, do not allow any health care. A fourth program, FHA 232 goes to the other extreme and provides care for only those who need nursing care!

Why should it be so difficult to understand that as people become old they will also gradually become infirm? Why cannot we realize that in placing old people in situations where they cannot obtain nursing services they will tend to hide illness until it reaches an acute stage and hospitalization is required? Why cannot we understand that insecurity and fear is a causative factor in the development of illness among old people? If we had a housing program which would provide whatever kind of care a person might require, there would

be less illness, more happiness and fewer costly hospitalizations. The goal of cutting costs of health care would be achieved, not at the expense of suffering and anxiety on the part of old people, but because they would be provided the kind of care they need at the time required.

Last December, I visited a high-rise 236 project which housed about 300 old people. I spent two days studying the program and much of my time was spent helping old people get on or off the elevators because they were either too infirm to help themselves or too confused to know which way to turn! Yet these people were supposed to be living on an independent basis, buying their own food, preparing it in their own apartments, and eating it in the loneliness of a room with a table and three chairs, two of which were empty. No health care, no group activity, no common space were provided; only a staff that consisted of a manager, his secretary and a custodian!

The tragedy of our Federal Housing program goes beyond anything that I have observed. In my files are dozens of copies of bidding documents for FHA housing for the elderly projects which have failed and are now on the market seeking a bidder.

I bring this into this paper because no housing for the elderly project should be thought of out of context with health care for the elderly. The average age of people coming into these programs is in the high seventies which means that if chronic illness is not already present, it soon will be. This program, too, is beset by layer upon layer of bureaucratic regulations that astound all who seek to operate under them. To state that these people should be moved to a health providing facility when they cannot cope with the problems of living independently is too simplistic an answer. In the first place, the old people do not want to be moved and will fight to stay where they are. In the second place, there are not enough long-term-care facilities to meet the need.

However one looks at it, the system of housing and health care for the aged in the United States is not working well and is, in fact deteriorating. Why should this be so in an affluent society that has always prided itself on its generosity toward people in need? Why are we unable or unwilling to provide for the real needs of our own elderly people when we can spend what it takes to land men on the moon? The answer is to be found in the fact that the United States does not have a sound philosophy toward the aged. We tend to be youth-oriented. We are either frightened by the thought of old age or death or we don't believe people are worth our concern, time or money! The latter is surely not the case. There really is no evidence to the effect that there is not concern for and willingness to help the aged. Seldom, if ever, has any nation provided as many "programs" designed to be of help to the aged. One session of Congress after another has come up with new programs or amendments to old programs with the purpose and intent to improve what is being done. No candidate for office would dare run for election if promises were not made to help old people. Good intentions, however, are not a substitute for wise action based on sound knowledge and good philosophy. Out of the latter will flow good programs, but without a unifying common understanding of the needs of older people and attitudes which reflect an acceptance of such philosophy, the country cannot expect to find the proper solutions to the difficult situation the elderly people find themselves in today. That is our problem! To arrive at a philosophical point of understanding and an acceptance of concepts which speak to the various needs of our elderly people, is the goal that must be achieved if our problem is to be solved.

THE RISE OF THE "FOR-PROFIT" HEALTH INDUSTRY

Apart from the old "Ma and Pa" homes which cared for a few old people and were generally under no regulative standards, the For-Profit Industry in health care came into being at about the time that state and federal payments for the care of old and sick people were developed. The for-profit nursing home was first on the scene and in these latter years there have come into being a substantial number of for-profit hospitals. This is a problem that is of great concern to those in the non-profit sector and should be a serious concern for the whole public. These groups are motivated by personal gain which casts their programs in an entirely different setting. The first priority must be a profit, the welfare of the person must come second. This has far-reaching implications which we will touch on as briefly as possible.

The rapid growth of the for-profit industry in the health field should prove that the need for health facilities is far greater than the supply. This has not always been understood in certain governmental circles where one Secretary of

HEW stated publicly that we must stop railroading people into nursing homes. The only evidence of this type of practice that I have observed has been the practice by governmental agencies who have sought to empty state hospitals by dumping people into nursing homes, mostly for-profit homes, regardless of the standards of care that could be provided. When I commented to an HEW official on the great burden being placed on the health care facilities because of the growing number of regulations, the reply was that they were necessary in order to police the for-profit industry. If it were not for the practices of this group, I was told, we would not need all of these regulations. This may have been an overstatement of the situation, but when we examine some of the practices which are not uncommon among the for-profit programs, we are of the opinion that a major cause for the development of the strict regulatory system no doubt was grounded in the fact that the proprietory facility had to show a profit or go out of business.

People have a number of misconceptions about the for-profit system in health care that need to be corrected. We will point to some of these.

It is commonly held that as the non-profit home is not taxed for the real estate value of the facility, the for-profit owner should be allowed a higher rate of reimbursement for services provided. An alternative, of course, could be the removal of the non-profit home from the tax exempt list. People, and this also means legislators, do not seem to realize that you cannot tax a non-profit home. All that can be done is to tax old people for living too long! The for-profit owner does not personally pay any property taxes; he merely passes them on to the old people in his home or to the general taxpayer in the cases where the old person is on public assistance.

Perhaps the for-profit homes should be tax exempt. If this were to be tried, however, it would have to be done under a system wherein the for-profit homes would also be required to make full fiscal disclosure of all income and expense on a cost accounting system with the costs identified with the services provided. It would be necessary that costs of care be proven through CPA audits of the annual reports submitted. Senator Frank Moss also said on November 29, 1971, that:

"Currently Medicaid payments to nursing homes typically provide a flat rate of perhaps $14 a day. This amount is immediately cut back when the patient becomes ambulatory. The incentive is thus to keep the patient in bed. Further, this $14 a day is not enough to provide the kind of care that is needed. Thus we employ a system where 80 percent of the nursing homes are for-profit institutions, and tell them that the only way that they can make money is by cutting care and services. Each individual operator can decide for himself how much to allocate to care and how much to profit. There is absolutely no accountability. If you cut back on food and nursing staff, you can make a fortune on $14 a day."

The same cost accounting requirement should also apply to the non-profit sector. Only when this is required of all homes will it be possible to learn what true costs are and payments for service be made accordingly.

Under the present system the poor program is rewarded for providing sedation therapy while the good home is penalized for providing physical and occupational therapy which helps to rehabilitate most residents and to maintain others on a relatively stable health plateau. Another factor not understood by most of the people in our society is the policy of reimbursing the for-profit owner in a manner that allows him to recover the cost of his investment plus a reasonable profit. The question needs to be answered: Is the benevolent dollar contributed by a person for the purpose of constructing and operating a non-profit home not deserving the same treatment? The donor is investing his money in a program to serve people; he does not expect or desire either a return of his investment or an interest earning on it. Surely this type of investment should be encouraged and the reimbursement to the non-profit provider would then be used for improvement of program and replacement of equipment. Under our present system where the non-profit home and hospital is being discriminated against in reimbursement schedules as compared to the for-profit home and hospital, we may soon see many non-profit organizations going bankrupt.

An example of what is happening in the hospital field is reported in a national press release by the American Hospital Association.

According to William Lane, administrator (of a 282 bed hospital in Massachusetts), the hospital is presently having considerable difficulty in paying its creditors and recently had to borrow $350,000 which is being used to keep up with its bills. It is currently paying $1,327 a month in interest payments on the

loan, and it has been unable to open a pediatric health center for the children of indigent parents because of the money crunch.

He has also had to tap his $223,000 depreciation fund meant for the purchase of new replacement equipment to meet daily expenss. He has had to forestall indefinitely the purchase of needed diagnostic equipment in both his X-ray and laboratory departments.

Since the first of the year, his food costs have risen 18 percent and he has had to cancel regularly scheduled pay raises for his employees three times.

"In addition to all of this." Lane said, "we are literally losing $18,000 a month on our Medicare cases because the government is only reimbursing us 78 cents on every dollar they owe us for treating their patients. They are using a cost formula from 1971 figures, which obviously are well below the inflationary figures of 1973 standards."

Lane says that all of his problems can be traced to the inconsistent regulations covering the health industry under the stabilization program. They are presently appealing their case before the Cost of Living Council.

"If we are denied, then this hospital could go bankrupt in a minute or if that didn't happen we would probably have to lay off large numbers of employees and curtail services. Even if we didn't go bankrupt, I would close first if I could not give quality care." Lane said.

Many examples could be cited. My office has recently received requests from home administrators asking that they receive a moratorium on the payment of interest and principal on capital loans because with rising costs and inadequate reimbursements they simply do not have the money to pay their bills. The situation is not serious, it is critical.

The time has come, in my opinion, that the people of the United States must face up to the question which other nations in the world have answered long ago. Does any man or group of people have the right to exploit the disadvantaged person who is sick, old or both? Should we not take the profit out of health care? When this question is answered in the affirmative, we can expect to see a change in our system that will provide better care at lower costs. If we do not come to grips with this situation our present system of health care may well go under, to the disadvantage of those who need health care and at great cost to the taxpayers of our society. One final statement on this point, and it concerns the priority system of our society. We think nothing of paying $15 to $18 a night for a bed in a hotel, paying extra for all meals and other services, tipping everyone who serves us. But we object to paying half that amount for a more expensive room, plus three meals per day with two snacks, plus round-the-clock nursing care, plus activities programs, physical and occupational therapy and a full chaplaincy program in our long-term-care homes. Does this make sense?

THE PROPOSED REGULATIONS FOR A SKILLED NURSING FACILITY

Early in August of this year, I met with seven other men in Washington to study the proposed regulations for skilled nursing facilities as they were published in the Federal Register. Meeting with us was a fine gentleman, well known to us all, a man who works in HEW and who had written a part at least of the regulations. He is one of the ablest and most knowledgeable persons in the bureaucracy and for years has worked diligently to interpret, by way of regulation, the laws pertaining to health care. Nevertheless, he has not had training in the medical field nor has he had experience working in the field of health care in a nursing home or hospital. I'm sure, however, that he does his best to listen to those who work in the field and to put into writing what to him appears to be reasonable.

In our discussions, we looked at definitions which described a skilled nursing facility. Remembering that the same regulations are to be used for Medicare and Medicaid with respect to standards for the facilities certified to provide skilled nursing care, we were shocked to see that such a facility would be required to have only one registered nurse on duty, on the day shift and for only five days a week! How can you explain such a regulation? Are there two days out of seven when patients do not need skilled nursing care? Is it not possible that an acute need for the presence of a registered nurse might well occur during the 3–11 shift or the 11–7 shift? And how about the large skilled nursing facility with several hundred persons to be cared for?

Administrator Paul De Preaux of Church Homes, Inc., Hartford, Connecticut has written: "Consider the number of groups and committees of which the Director of Nurses will be a member if the proposed regulations are adopted.

1. Utilization Review Committee
2. Pharmacy Committee
3. Patient Care Policies Committee
4. Social Services Committee
5. Restorative Services Group
6. Infection Control Committee
7. In-service Training Committee

"And this she does in a 40 hour week in addition to dispensing medications: treatments; supervising nursing personnel; checking the housekeeping and dietary personnel; notating each patient's chart each shift; reminding doctors of the 30 day visitation requirement; consulting with the physicians, families, administrators, dentist, podiatrist, laboratory and X-ray services and last, but not least, conducting indoctrination lectures and supervising in-service education. Why do I list all these items? Because I wish to emphasize that the new regulations only require one RN on duty on the day shift, 5 days per week. She is also, I might add, responsible for the development and maintenance of nursing service objectives, standards of nursing practice, nursing policy and procedure manuals, written job descriptions for each level of nursing personnel, methods for coordination of nursing services with other patient services, and for recommending the number and levels of nursing personnel to be employed.

"The new regulations applicable to reviews of patient care are patently absurd. To subject a physician to seven or eight reviews of his treatment of a patient is an unwarranted intrusion by bureaucracy into the profession of medicine. A single review by his peers the (PSRO) is sufficient to guarantee good patient care and properly document the necessity for that care. The other six or seven reviews are exercises in bureaucratic overkill. In small towns with one or two physicians, how could they even conduct the number of reviews required without conflicts of interest? In large communities with many physicians, how many will take the time from the care of their own patients to review another physician's methods of treatment?"

As we discussed this portion of the regulations the question was raised as to the use of the term "skilled" nursing care. Is there a good kind of nursing care that is "unskilled" and do some people need this kind and not another? I would object strenuously if I were assigned to work in a health-related facility that did not require skilled nursing care, if I were a nurse! And, if I were a patient in a facility and discovered that regulations did not allow for skilled nursing care to be practiced, I think I would want out! All too often people who are in such situations are not able to do anything about what happens because they are personally helpless and because a multitude of regulations stand in the way of those who would like to help.

I do not mean to be facetious, but why cannot we understand that the health conditions of sick or old people change from day to day? This is particularly true for old people but any person in a hospital, young or old, should have the right to receive the best of care on each shift and seven days a week!

The whole concept of "separate and distinct parts" of facilities designed and staffed to provide for differing levels of care is absurd. Our jobs as providers of health services is to take care of people at whatever level of health exists. Every institution, hospital, or home, should be prepared to provide the care a person requires regardless of the geographical location of the person. It appears that the present concept has been developed primarily to hold costs down, which it does not do, and without consideration of the true needs of the person. This comes about because a non-medically trained person or a committee that is not experienced in the field of actually providing on-floor service to sick or old people, has decided that if persons can be classified by regulation to fall into this or that level of care category at the time of the screening, staffing can be cut down and cost of care reduced. What does not seem to have been understood is that this system by its very nature requires a great amount of supervision by many different inspection teams, all of which becomes very expensive. More important, however, is the fact that treating people as things and moving them about to fit arbitrarily designed categories, will cause more serious illness and often hospitalization and death. The costs of this system, as has been indicated, are the basic reason for the rapid escalation of health care costs and the tragic truth is that the ill person suffers and the general public pays the cost for inefficiency that has been built into the system. Thus each state under Medicaid, the program that cares for people who are poor and perhaps have little political influence, defines the level-of-care categories for which it will pay and sets the reimbursement level accordingly. Some states have three levels, some five, or seven and I have heard of one state with 13 levels of care!

It is a psychologically damaging experience for persons to be moved about due to changes in their health condition. This is very true for the old people. To be moved causes anxiety not only in the person moved but in the friends and neighbors of the resident who fear they may be next in line for St. Peter's row! Old people tend to hide illness in a home that moves people about because of changes in their health condition. This fear of being moved aggravates the hidden illness and persons who could be treated in an early stage of disease suddenly are found to be in need of acute hospital care at greatly increased cost. It has been my observation over the years that those facilities that seek to provide whatever care a person requires where he is, without unnecessary movement, show a lower incidence of hospitalization and a lower total cost of care than is the case where no person is secure, but is constantly on guard lest a change of room or building may be the result of a change in health conditions. In other words, it is less expensive to bring care to the person than the person to care. This, of course, must be understood: there are emergencies when a person must be moved, but we should not design into a system an almost certain transferring of people because of a multitude of levels of care which call for different levels of reimbursement and different placements in a home. We must also understand that older institutions may be so constructed that it is not possible to follow this philosophy completely, but simply being aware of the problem created by movement of people will help alleviate some of the trauma.

Another item in the proposed regulations for skilled nursing facilities which indicates the low level of understanding of the problems faced by old people who need long-term care is that part of the regulations which requires that the policies of a facility, available to admitting physicians and sponsoring agencies must, among a number of items "include discharge planning." It is not easy to react responsibly to the concept that upon admission of a person to an institution a plan must be set up for the discharge of the person! Most people who come into the long-term-care homes, licensed and staffed as skilled nursing facilities do not leave except by death. To immediately set up a program of discharge planning is a waste of time and energy of staff, is a cost producing factor, and is simply meaningless to the great majority of persons admitted. It appears that this provision overlooks entirely the fact that there is any such person as a long-term-care patient. It further reinforces the opinion that the basic concern of HEW is to move people out of skilled facilities into intermediate or low cost facilities regardless of the needs of the persons. The fact that this practice likely will prove to be far more costly over the long term has not been understood or accepted. Overlooked, possibly, is the fact that many persons are staying longer in expensive hospital beds because they still have medicare coverage rather than being moved to an ECF where they would have no coverage!

In the document proposed by the group of persons mentioned earlier in this section the statement is made that "Ironically, the SNF regulations require an inordinate amount of time-consuming and costly record-keeping and medical evaluation studies, whose value is questionable, while at the same time they impose utilization reviews aimed at cost containment."

One member of the group, Mr. Paul De Preaux, seriously presented the following statement:

"These regulations represent the ultimate in bureaucratic overkill. They require that the work of a physician is to be reviewed by the Medical Director; that the work of the physician and the review of the Medical Director is to be reviewed by the Medical Care Evaluation Studies Committee; that the work of the physician and the Medical Director is also to be reviewed by the Utilization Review Committee, that the work of the physician, the Medical Director, and the Utilization Review Committee is to be reviewed by the Medical Staff, if applicable: that the work of the physician, the Medical Director and the Utilization Review Committee is to be reviewed by the Medical Department of the fiscal intermediary; that the work of the physician, the Medical Director, the Utilization Review Committee and the Medical Care Evaluation Studies Committee is to be reviewed by the PSRO; that the work of the physician, the Medical Director, the Utilization Review Committee, the Medical Care Evaluation Studies Committee, the PSRO and the Medical Staff is to be reviewed by the State Department of Health Surveyor and finally, all of the above is to be reviewed periodically by the Health, Education and Welfare Surveyor!"

He must have left something out! Could it have been the welfare of the resident or patient?

Enough has been said to indicate that we are in real trouble with the proposed regulations for the Skilled Nursing Facilities and we have not mentioned the regulations that will become effective for the Intermediate Care Facility which is now to be classified as a health care facility, even though it need not have on its staff a registered nurse!

At this point, I would say that if the present trend continues and if each year finds new laws and regulations being added to what we already have, our health delivery system will not survive, it will collapse under the weight of a super-bureaucracy which feeds upon itself and grows heavier with each passing year.

Our nation will be forced into a national health insurance program, how soon, I do not know, but I am sure it is coming. It will be looked upon as a way of saving our health delivery system, but I am afraid that it may do just the opposite unless groups like this one, and others across the country get through to the general public and the legislators on both state and federal levels, the truth about the reasons for the escalation of costs, the evidence of inadequate care, and the unreasonableness of the bureaucratic overlay under which we all suffer.

IS OUR HEALTH SYSTEM BASED ON A FALSE PREMISE?

And so we come to our question: Has our health delivery system been founded on a false premise? Have we looked upon the health profession from a wrong point of view, one that has over centuries brought us to a point of a dead end? What I am referring to is the whole concept that nursing homes and hospitals are "houses of healing," that the medical profession is made up of men and women who are "healers." Thus, when a person dies, the hospital or home has failed to be a "house of healing" and the doctor has failed to be a "healer." Failure cannot be tolerated, so death has become very frightening. We must protect ourselves with a fail-safe system or hide from reality!

Pick up almost any newspaper and you will read the lists of people who entered the hospital in a given week and below this will be the list of the "Departures." When you study the latter you will soon realize that often a departure is a euphemism for death! The person died, he was carried out of the hospital, a corpse, and in due time he was buried!

Could this be why it is so commonly stated, in the prolific writings on the subject of death and dying which have flooded the paper-back market in these last years, that the doctors are afraid of death, that they do not tell their patients or the families of patients that the end is about to come? Is this the reason why administrators of both hospitals and homes state so often that in the terminal stages of life it is almost impossible to get a physician to visit a patient? Yes, he will call by telephone to authorize a stronger dosage of a sedative, so that the person will not suffer pain—and also will not be aware of what is happening. Is this fear of failure as a house of healing the reason why a hospital or home often seeks to move a dead person out quickly and quietly so that others may not be upset at the failure of the hospital or the home to keep the person alive?

I remember a home that almost closed its doors a few years ago. The community had worked long and hard to raise the money to build. Many families waited anxiously to enter their loved ones in the beautiful home. But what happened? In the first two weeks almost all the persons entered, departed in death! They should not have been moved from the hospital in the first place, but the hospital was glad to have them go, for their deaths then would not be a reflection of failure on the part of the hospital. The home almost came to be known as the "house of death" and my office received questioning letters asking if there were competent staff at that home!

What about it? Do we not have a wrong concept here that health practioners are really not that, but healers and that hospitals are not hospices where help is given but houses of healing and that nursing homes also are really not that but places where people go to be remotivated after a stroke or heart attack and brought back into the stream of active life?

Perhaps this false premise lies at the root of the inhuman practice of our Medicare system that uses the prognosis or potential for getting well again as a criterion for classifying a person as one whose condition is eligible for coverage.

Looking at the problem from another vantage point, I have a feeling that if there is an inquisitive society on this earth a thousand years from now and if a study is made of this period in the life of man, one characteristic that will be noted is that this society was beset by the fear of death, that it did not understand that the normal end of life on this planet is death, that nothing in life is more natural than dying! Therefore this society would be classified not only as naive

and fearful but cowardly, for it would be discovered that we were a highly drugged society, that we used every chemical means possible to protect ourselves from facing reality of death and failure!

I do not mean to belabor the point, but now ask yourself another question. If we were to change our premise and think of the health profession, the doctors, the hospitals and homes as a loving and caring profession, dedicated to relief of suffering, yes even helping people get well from disease when this is possible, but not being captive to that, would it not be easier for doctors to sit with a dying patient and the family to help them face what soon was to be reality, that a life was about to leave and enter eternity? Would it not be easier for a hospital and nursing home to minister to the needs of the person without casting the happening in a setting of stillness, quiet and gloom. Could not the passing of a person from this life be looked upon as an achievement, even a victory? I remember hearing Dr. John Brantner of the University of Minnesota say that he hoped the day would come when he could lead a triumphant procession down the corridor of a hospital, with the body of the deceased person on a cart behind him as a symbol of victory! Should such a change come to our society by way of the loving, caring health profession, then indeed we would realize the truth that "We are but pilgrims here and heaven is our home."

It is my conviction that if such a change could occur in our concepts, so that doctors would not fear that failure stalked them when a patient died, and homes and hospitals could rejoice in the fact that it had been their privilege to care for a person during the terminal stage of life, we would find a change would come over the entire health delivery system. We would no longer be locked into the kind of system that now forces us to the position that people must be kept alive or we have failed. We have been caught up for centuries on what I believe to be a false premise, that the health delivery system must succeed in keeping people alive or be classified as failing. Rather than thinking in terms of the system being dedicated to helping people be persons with meaning and value up until the time of death, we have been seeking to develop systems that protect us, no matter what!

Think of the layer upon layer of bureaucratic controls that have been placed upon the health profession, to make sure that it succeeded in keeping people alive and buildings from burning. Think of the needless red tape, the endless forms, the thousand-and-one inspections and reviews that could be done away with if our premise could be changed, if we could be set free from the shackles that bind us to the concept that the human heart beat or the functions of a brain pattern are the marks of life and that the success or failure of our health system depends on keeping one or the other functioning. If we could simply use our talent, time and magnificient technocracy giving loving care to people who are ill, and not feeling guilty when life ceases, our health delivery system, now suffocating almost unto death, could come alive itself and fulfill its mission in the lives of people and rejoice with the person who comes to the time of victory. We also would likely be surprised to find that the cost of providing this better kind of care would be much lower than is the case presently with our highly over-supervised system which tends to dehumanize the patients and to make the system an end in itself.

Such a radical change in concept would be healthy for the whole of society. The guilt feeling, which now haunts children (who themselves may be grandparents) because they have placed their parents in a home, possibly could be removed. We could come to accept new life styles for the elderly, so that in a natural manner people would move through the normal stages of life, from childhood, to parenthood, to grandparenthood and beyond, all the time realizing that life is an ever expanding experience and that when a person has become old he is not alone but can join a host of others in a new social setting where all the amenities for good living are provided. And in addition, all the staff and equipment to give loving and professional health care is at hand, together with spiritual counsel which will help each person move on into the great life which will come when today ends and tomorrow is forever.

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