TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-THIRD CONGRESS

FIRST SESSION

PART 22—WASHINGTON, D.C.

OCTOBER 11, 1973

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

25-842 WASHINGTON : 1975

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $1.65

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TRENDS IN LONG-TERM CARE

THURSDAY, OCTOBER 11, 1973

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

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

Present: Senators Moss, Percy, and Clark.

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 staff professional; Patricia Oriol, chief clerk; Gerald Strickler, printing assistant; and Betty Rose, clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The hearing will come to order.

This is a hearing of the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging.

We are here today because national organizations in the field of care for the aged have charged that the regulations for skilled nursing facilities have been substantially weakened by the Department of Health, Education, and Welfare.

The subcommittee received about 7 hours of testimony yesterday and heard from 20 witnesses.

These witnesses were unanimous in their conclusion that registered nurse coverage is necessary 7 days a week instead of 5 days a week; that a medical director and 30-day physician visits are desirable; that ratios between nurses and patients are necessary to insure that each patient gets the amount of nursing time he needs.

There was unanimity that the new regulations are vague generalizations of past standards which will be a nightmare to enforce and there was grave concern about the implementation of section 247.

With respect to section 247 and levels of care, it was charged that 50 to 75 percent of the present nursing home population does not fit in either the skilled nursing or the intermediate care category as defined by the proposed regulations.

There was also concern that these definitions will cause a wholesale declassification of patients and inevitable movement of patients.

These are the problems I would like to focus upon this morning.

We have some distinguished witnesses who will appear before us today, and we are looking forward to having their testimony. Because of the number, we hope that the witnesses will place their written

statements in the record and proceed to emphasize and highlight parts of the testimony that they wish to bring before the committee, and permit us time to question, which we will try to use sparingly, because of the need to hear from the many people that we have this morning.

Our first group of witnesses who will come and sit as a panel at the table are Dr. Charles Edwards, M.D., Assistant Secretary for Health, Department of Health, Education, and Welfare, and he is accompanied by Dr. John S. Zapp, D.D.S., Deputy Assistant Secretary for Legislation (Health), Department of HEW.

Would you gentlemen please come to the table, and I will ask my colleague, the Senator from Illinois, who is here with me, if he has any opening statement or any comment to make at the beginning.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator PERCY. Mr. Chairman, I have no opening statement, other than first to indicate that I did express yesterday my appreciation to you for the deep interest which you have taken in this subject over the years, in the field of nursing homes, health care, the aging, and for the personal trip you made to Illinois to unravel the facts about what we call the warehouses for the dying. That nursing home situation in Illinois was a scandal to the country. I just wanted to report to you personally that those hearings you conducted in Chicago made remarkable progress against many of the abuses.

Second. I am always honored to introduce Charles Edwards, an Illinois constituent, who I think has done a remarkable job in his public service in recent years. Dr. Edwards is one of our most notable citizens, and we are honored indeed to have him here this morning. I am pleased to introduce him to the committee.

Senator Moss. Thank you.

We are glad to have Dr. Edwards before us again in this committee. He has appeared before us previously, and we do welcome the other gentlemen who are seated here.

I introduced Dr. Zapp, and we have James Dwight and Thomas Tierney, and I see two other gentlemen, so we will ask Dr. Edwards to fill me in on whom I missed.

Dr. EDWARDS. Thank you, Mr. Chairman.

Thank you, Senator Percy.

Let me first change the lineup for you just a little bit.

To my immediate left is James Dwight, the Administrator of the Social and Rehabilitation Service, and to his immediate left is Howard Newman, who is Commissioner of the Medical Services Administration of the SRS, and to my immediate right is Ernest Michelsen, who is the Acting Director of the Office of Nursing Home Affairs within the Department of HEW; and to his right is Gorham L. Black, Jr., who is the Regional Director of our Region III in Philadelphia; and to his right is Morris B. Levy, who is Assistant Bureau Director of the Division of State Operations, Bureau of Health Insurance in the Social Security Administration.

Senator Moss. Thank you.

We welcome all of you here before us, and we look forward to hearing from you in the course of this presentation, and as I have indicated, we are very much concerned with the proposed regulations that have

been published in the Federal Register, and have not yet become effective, but are now being discussed.

Dr. Edwards, proceed in any way that you see fit.

STATEMENT OF DR. CHARLES EDWARDS, ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY JOHN S. ZAPP, D.D.S., DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH); JAMES DWIGHT, ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE; HOWARD N. NEWMAN, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION; ERNEST MICHELSEN, ACTING DIRECTOR, OFFICE OF NURSING HOME AFFAIRS; GORHAM BLACK, REGIONAL DIRECTOR, REGION III, PHILADELPHIA; MORRIS LEVY, ASSISTANT BUREAU DIRECTOR, DIVISION OF STATE OPERATIONS, BUREAU OF HEALTH INSURANCE

Dr. EDWARDS. Mr. Chairman and members of the subcommittee: I am appearing today in response to your request to the Department of Health, Education, and Welfare for a discussion of the proposed amendments to the title XVIII and title XIX regulations for skilled nursing facilities and intermediate care facilities, as they relate to goals of the Department for services of these institutions in the Medicare and Medicaid programs.

More specifically, we are requested to address certain proposed new requirements in the single set of regulations for skilled nursing facilities under both programs and the response to the document, as published respectively in the July 12 and March 5, 1973, issues of the Federal Register for public comment.

Responsibility for coordinating the review of comments received and the development of the Department's final SNF regulations was assigned to my office. My report and recommendations were submitted recently to the Secretary, who I am pleased to report, has approved them.

Before discussing the revisions in the SNF regulations, I would like to review with you their development.

Experience in both the Medicare and Medicaid programs has indicated that several areas in the current regulations need to be expanded and other new components added to insure the highest quality of skilled nursing facility services and to protect the health and safety of patients.

We believe that facilities of all sizes can meet these requirements, recognizing that they vary in size from under 50 beds to several hundred beds.

There are a variety of acceptable methods for meeting the intent of each of the requirements, and it has been our plan to explain this flexibility inherent in the requirements in interpretive guidelines for use by provider facilities as well as surveyors.

NEW AND EXPANDED REQUIREMENTS

The new and expanded requirements were originally included in the revised conditions of participation proposed for extended care

facilities under Medicare that were reviewed 2 years ago by national health-related organizations and Federal and State agencies that relate to the Medicare and Medicaid programs.

Responses from these sources fully supported the proposed efforts to upgrade and strengthen the program requirements for provider institutions.

The regulations for extended care facilities proposed at that time also were approved by the Medicare program's Health Insurance Benefits Advisory Council in early 1972, just prior to the development of the single set of standards for facilities under both programs by the interagency staff coordinating committee.

The July 12 proposed SNF regulations were the product of an interagency group organized in October 1972 and comprised of representatives of SSA, SRS, and HSA, under the direction of the Office of Nursing Home Affairs in my office.

The group's charge was to develop a common set of regulations for skilled nursing facilities participating in both programs, and a single approach for determining certification and compliance.

Enactment of Public Law 92–603 subsequently mandated the adoption of a single set of regulations for both programs.

Public comments on the July 12 proposed amendments were received during the subsequent 60 days. Over 300 organizations, individuals, and governmental units responded during the 60-day period. All the comments received during that period were reviewed by a multiagency staff group.

As requested, the Agency representatives also met with representatives of the American Nursing Home Association, the National Council of Senior Citizens, and the National Council of Health Care Services to discuss their formal comments.

The recommendations in my report to the Secretary encompassed several changes in the regulations for skilled nursing facilities under the Medicare and Medicaid programs as they were proposed in the July 12 Federal Register. Some of these changes will appear as final regulations to be effective on publication.

Two major policy changes are reflected in these changes—one related to medical direction in these facilities, the second to registered nurse coverage.

Inasmuch as these requirements were not included in the July 12 proposed regulations, their publication will be under a Notice of Proposed Rule Making to provide opportunity for public comment, however, they will appear in the same issue of the Federal Register in which the final regulations will appear.

Experience in both the Medicare and Medicaid programs has revealed that a major source of deficiencies in long-term care facilities has occurred in the provision of physician services—for example, too infrequent patient visits or outright abandonment, inadequate review of patients' drug regimens, incomplete records, and excessive length of patient stay.

Adequate Medical Supervision

Ensuring regularly available physician services is necessary to fulfill Medicare and Medicaid requirements for adequate medical supervision and direct physician care to patients, particularly to patients institutionalized for extremely long periods and in emergencies.

Although this requirement was not included in the July 12 notice, the concept of organized medical direction in the skilled nursing facility has the endorsement and full support of the American Medical Association's (AMA) Council on Medical Service as well as many other national health provider and consumer organizations.

In addition to meeting the statutory requirement that all patients in a facility must be under the care of a physician, the regulations will require all facilities to engage the services of a physician in order to comply with the requirements for patient care policies, emergency care, pharmaceutical services, utilization review, and the activities of the professional standards review organizations (PSRO).

The availability of a physician also has broad implications for the correction of deficiencies not limited to medical care services; that is, in other aspects of the facility's operation such as physical environment, infection control, and employee health.

Recognizing a scarcity of physician manpower in many parts of the country, time will be allowed for locating a physician able and willing to serve as medical director on either a full-time or part-time basis. Additionally, some facilities may find it impossible to establish a medical director position because of an absolute absence of physicians, geographic distances, and/or excessive workloads of available physicians.

In such cases a waiver of the requirement will be granted on an exception basis similar to that established for the waiver of 7-day registered nurse coverage in small, isolated, rural hospitals.

We believe that inclusion of the requirements for a medical director will denote a positive response to the strong recommendation made in public comments and the position adopted by the AMA and other health-related organizations.

We believe the requirement is justified on the basis of promoting better patient care and reduce waste, harm, and loss of life. Preventing the occurrence of deficiencies and the subsequent costly correction will be other positive benefits.

Registered Nurse Coverage

A second major policy change incorporated in the revised regulations concerns registered nurse coverage. 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 criticially needed than on the other 5 days. If the weekend were the 2 days during which a registered nurse was not on duty, the situation could be more critical 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 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, the overall, around-the-clock direction of nursing services requires the knowledge and experience of a registered nurse.

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, 7 days a week, is needed for prompt assessment of patient needs, delegation of duties, and initiation of the plan of care to insure safe and adequate services.

Although the requirement for registered nurse coverage was for only 5 days a week in the July 12 notice, public comments from many national health provider and consumer organizations strongly emphasized the need for daily presence of a registered nurse in all skilled nursing facilities.

In fact, we received more comments on this provision than for any other provision in the July 12 notice. We believe that adoption of this requirement represents a positive response to the large volume of comments supporting such action.

Enforcing fire safety in skilled nursing facilities and ICF's continues to be one of the most important responsibilities of the Department. As a result of enactment of Public Law 90-248, all skilled nursing homes participating in the Medicaid program were required by statute to comply with those provisions in the Life Safety Code—1967 edition—applicable to nursing homes.

The Department became committed to a vigorous enforcement of the code mandated by Congress and, pursuant to this commitment, the Life Safety Code was adopted by regulation for Medicare extended care facilities on October 28, 1971.

Thus, by legislation and regulation, compliance with the code is required of all skilled nursing facilities participating in the Medicare and Medicaid programs. The language in the new law as expressed in the final SNF regulations does not represent a compromise with current standards. No liberties have been taken by the Department in implementing safety standards stipulated in the statutes.

The present as well as revised fire-safety regulations contain a waiver provision and provide for the acceptance of State fire codes in lieu of the Life Safety Code; however, these options are specifically provided in the legislation. In applying the waiver, it has been granted only for existing buildings and only when it is documented that, as required by statute, the waiver would not adversely affect patient health and safety and that it would create an unreasonable hardship on the facility to make the necessary corrections.

To carry out the task of enforcing the Department's fire-safety requirements, we have entered into agreements with the most competent people in the State governments to do the job, usually the State fire marshal or State Hill-Burton agency.

Together with the National Fire Protection Association, which as you know, developed the Life Safety Code, we developed a training program on the code.

Approximately 600 fire-safety surveyors have attended this course. In addition, the Department conducts periodic followup sessions with State agency personnel.

To date, approximately 7,000 nursing homes participating as a skilled nursing facility in Medicare or Medicaid have been surveyed for compliance with the Life Safety Code. Many facilities have already been surveyed more than once.

NATIONAL BUREAU OF STANDARDS STUDY

After the tragic nursing home fire in Marietta, Ohio, in which carpeting was a principal cause in the loss of life, we went to the National Bureau of Standards and asked them to study the effectiveness of various tests to determine the hazards of carpeting. These studies concluded that the Steiner tunnel test is the most effective test method and this is the standard being applied to participating institutions under Medicare and Medicaid.

The existing requirement that patients be visited by a physician every 30 days has elicited numerous comments contending that not all patients need visits at that frequency. Institutional providers cite that they have little control over this requirement. Physician respondents viewed the requirement as interference with medical practice in that it allows no leeway for them to apply their medical judgment and knowledge of a patient's condition in the determination of the frequency of visits.

The July 12 notice would have required physician visits every 30 days for the first 90 days following admission, and thereafter at an alternate schedule developed and justified by the attending physician. Inasmuch as most Medicare patients would have left the facility by the 90th day, this flexibility was designed primarily for long-term care Medicaid patients. A significant volume of comments protested the open endedness of the period to the 90th day. This, together with a new requirement stemming from section 207 of Public Law 92–603, that the need for care in a skilled nursing facility under Medicaid be recertified at least every 60 days, persuaded us to amend the proposed regulation. The revised regulation will require patients to be seen by a physician at least every 30 days during the first 90 days following admission, and at intervals no greater than 60 days subsequent to the 90th day following admission.

Discharge planning is coordinative planning for the disposition of the patient. It is an integral part of a facility's procedures which are designed to promote economic and rational planning for utilization of facility services. It is initiated at the time of a patient's admission to any level of care and continues through other levels of care that he may need until he attains the maximum level of his recovery potential.

A common complaint leveled at virtually all inpatient institutions, especially long-term care facilities, is the frequent delay in beginning treatment of patients after they are admitted. Too often, no steps are taken to prepare for the care of an elective admission until the patient is received on the nursing unit. Discharge planning shortens to a minimum the time needed to initiate care, promotes continuity of care, and encourages facilities to utilize services to the greatest advantage, both economically and medically.

A requirement supporting a discharge planning activity already existed in the previous regulations for both Medicare and Medicaid and was connected to the social services requirement. Since Public Law 92–603 placed the requirement for social services on an optional basis, the provision to allow for discharge planning was lost as a mandatory requirement. Realinement of discharge planning under the utilization

review condition gives strength and viability to a vital aspect of patient care. Adoption of this requirement should not incur appreciable increased cost inasmuch as staff are already employed who can be assigned this responsibility.

We have included the requirement for discharge planning in the final regulations.

Qualifications of Administrators

A number of comments were received concerning the qualifications of persons serving in the dual capacity of hospital and skilled nursing facility administrator in a hospital-based facility. The comments tended to favor requiring that such a person be licensed as a nursing home administrator pursuant to State law. Notwithstanding this position, we believe that an administrator who is qualified to direct a certified hospital is adequately qualified under Medicare regulations to function as the administrator of a skilled nursing facility without the further assurance of State licensure as a nursing home administrator. Consequently, the revised regulations allow the administrator of a hospital-based, distinct-part skilled nursing facility to qualify either as a hospital administrator or a nursing home administrator.

The proposed regulations did not specify a minimum number of hours of consultant dietetic services, calling instead for visits at appropriate times and of sufficient duration and frequency to accomplish the desired results. Individual letters from many consultant dietitians and one State department of health recommended inclusion of 4 hours of consultation per week. This figure was also recommended by the American Dietetic Association. Because little or no substantive detail was provided to support the 4-hour period, the requirement will stand as published on July 12.

I would now like to review for the record the development of the SNF regulations and hopefully clarify several issues related to their development.

As stated earlier, a special ad hoc committee was established in October 1972 to draft proposed SNF regulations which would be applicable or common to both Medicare and Medicaid as provided in H.R. 1. Under the Department's rulemaking policy, nursing home associations and other interested organizations would be able to review and comment on the proposed regulations only after their publication in the Federal Register. Notwithstanding the committee's clear observance of departmental policy in this area, however, continuous progress reports of the work of the committee appeared in various health care industry publications.

Unauthorized Distribution of Draft

This was followed by unauthorized dissemination by unknown persons within the Department of both early working drafts as well as later drafts of the proposed regulations to at least several of the national associations in the nursing home field. These organizations in turn, as you know, made a wide distribution of these drafts within their respective State and local organizations and held numerous meetings around the country to critique them. Thus, some organizations had access to documents that the Department was developing, while others

who sought copies by direct request to the Department were unable to obtain them.

The latter organizations and groups were frequently hard-pressed to convince their members as to the equity of these circumstances. Certainly it was embarrassing to the Department because it suggested discriminatory treatment to favored organizations and produced ill-feeling toward the Department among many organizations.

The Secretary received letters from the chairman of this subcommittee dated July 10 and August 3, which made 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 regulations. This issue was also raised by the Republican Task Force on Aging. In his letter to the chairman of this subcommittee dated August 28, the Secretary stated that he did not approve nor was he aware of any advance selective distribution of draft regulations.

He reiterated that the policy of the Department was 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 rulemaking and comment period. He stated further that the Department takes the comment period very seriously and frequently makes substantive revisions based on the constructive advice and suggestions we receive from a broad variety of organizations and private citizens.

He added, finally, that in making the policy decisions on the regulations, he had not been aware of the views of nursing home organizations and consequently such views did not influence his decisions on the content of the regulations, adding that his decisions were based on what he considered to be an appropriate role for the Federal Government and on what he believed to be the most effective, equitable, and enforceable procedures from a management standpoint.

As discussed in his letter to you of August 28, the Secretary asked me to undertake a study to determine whether there was in fact a selective distribution of draft skilled nursing facility regulations to various nursing home organizations and a denial of access to consumer organizations who also requested such information. The Secretary asked me to report on what practices were followed, whether or not they were appropriate and if not appropriate, what action could be taken to insure that they do not recur.

Findings of Inquiry Detailed

I would like to take this opportunity to provide you with the findings of this inquiry. There was in fact a selective distribution of draft skilled nursing facility regulations to various nursing home organizations and a denial of access to other organizations, including consumer groups who requested these documents. It must clearly be noted, however, that such distribution was not authorized, encouraged, or condoned by the responsible persons concerned with developing the proposed SNF regulations, and that it was not the intent of the interagency committee or any departmental agency involved in this effort that these unfair practices should occur.

We believe, therefore, that the allegations of improper methods cited by the chairman of this subcommittee and others are not accurate. As far as I have been able to determine, the practices followed by staff developing the regulations were appropriate. Given the number of persons within the Department who at one point or another were involved in preparing, routing, reviewing, and other processing of these documents, there was no practical way that this group could have prevented the premature disclosure of the draft regulations.

In general, our thinking is that the Department should be able to seek outside consultation and advice on an informal basis from all interested groups prior to the preparation of draft regulations. Similarly, after draft regulations are approved by the Secretary but before they are published as final requirements, we should be able to discuss matters at issue with outside groups. Of course, these consultations should not take the form of a selective distribution of draft documents.

Now there may be limited occasions when it would be appropriate because of a statutory requirement or other special need for the Department to furnish draft materials to an outside group. We are now in the process of reviewing departmental practices to see whether such occasions may exist. We do not want to say today unequivocally that there would never be such a case until we have completed this study. But we can say without question that it is not departmental policy or in the spirit of fair play to share regulation proposals with any industry groups when we have not shared the same information with consumer and public interest groups.

We do share with the chairman of the subcommittee the goal that full and equitable disclosure be followed in the process of developing and issuing regulations. Leaking documents from whatever stage in the process is not only an inefficient dissemination practice, but discourages officials from putting their ideas into the record in a frank and open manner and weakens the entire public decisionmaking process.

The Secretary's office is currently preparing recommendations with respect to procedures which can be developed to insure equitable and timely consultation with organizations and individuals outside the Department during the preparation of regulations, and we will furnish this to you as soon as it is completed.

In summary, although the Department regrets the action which resulted in inequitable treatment of interested organizations, its position is that such advance review of the draft regulations has not affected the development of those regulations.

Because I cannot discuss at this time the final ICF regulations, inasmuch as they are still undergoing review and modification, I will be pleased at a later time to return to discuss these regulations with the subcommittee members.

Proposed Provisions of ICF Regulations

As you know, the Department's March 5 proposed ICF regulations set standards in the areas of health, safety, and patient care that include the following major provisions:

(a) Compliance with the requirements for institutions established in the Life Safety Code of the National Fire Protection Association.

(b) Adherence to physical standards designed to promote a sanitary and healthful environment appropriate to the ICF resident.

(c) Provision of rehabilitative services and activities programing for the aged in order to maintain or restore their functioning at maximal physical, mental, and social levels for as long a period as possible.

(d) Maintenance of a health care program under the supervision of a full-time profesisonal nurse (either RN or LPN) and periodic evaluation of the residents' health status by a physician.

(e) Provision of health or rehabilitative services, as needed, for the mentally retarded or persons with related conditions, to assist in development of independent living capabilities and return of the resident to the community, as appropriate and practical. The standards emphasize active treatment for each resident, defined to involve daily participation in planned activities and therapies which are part of a professionally developed and supervised program of health or rehabilitation services.

I would like to emphasize the Department's view with respect to the Life Safety Code requirement as it applies to ICF's. Because we could not condone any lesser fire safety standards to ICF's than we prescribe for SNF's, the Department is requiring in its ICF regulations that facilities participating in the ICF program also comply with the institutional requirements of the 1967 edition of the Life Safety Code.

In response to numerous requests from State agencies and mental retardation advocacy groups, the March 5 regulations permitted the application of the residental occupancy requirements of the LSC (rather than the institutional requirements) in instances where all the residents of an institution for the mentally retarded are ambulatory and currently certified by appropriate authority as capable of following directions and taking appropriate action for self-preservation under emergency conditions. This was done so that community based group homes for the retarded with less than 15 beds would not be precluded from participation in the program because of unreasonable and unnecessary structural requirements.

The above modification in the ICF regulations is based upon the 1970 edition of the Life Safety Code which provides that building or sections of buildings which house, or in which care is rendered to mental patients who are capable of average judgment in taking action for self-preservation under emergency conditions, in the opinion of competent authority approved by the State agency having jurisdiction, may come under the residential sections of this code rather than the institutional occupancies provisions.

2-Year Phase-in Period

Because the 1967 Life Safety Code is more stringent than many of the State codes now applicable to ICF's, the proposed regulations would permit a phase-in period of up to 2 years for facilities to fully meet the standards in the code. However, during the period provided for completion of corrections, facilities will be reevaluated every 6 months and will be required to demonstrate steady progress toward full compliance with the standards in order to remain in the program.

I would now like to discuss one aspect of the HEW regulations soon to be published which is receiving increased emphasis; namely, those

provisions which provide for aggressive programs of utilization review, medical review, and independent professional review of the necessity and quality of health care provided to both ICF and SNF patients. The effect of properly implemented utilization review (UR) and independent medical and professional review programs on ICF's and SNF's will be to substantially reduce or eliminate unnecessary admissions, shorten length of stays, curtail inappropriate health care service, as well as improve the effectiveness of the treatment provided.

An effective UR program would place an affirmative responsibility both on the State and the facility to assure the proper placement of ICF and SNF patients by reviewing admissions to the facility and periodically reviewing and evaluating the patient's need for continued care in an institutional setting. Alternate placement can be recommended by the UR committee. The purpose of the program is to promote the most efficient use of available facilities and services.

Independent professional and medical review, on the other hand, are more concerned with the quality of services administered.

The IPR and MR programs require that each patient and his/her medical records be reviewed by members of an independent professional team. The purpose here is to determine the adequacy, effectiveness, and appropriateness of the patient's plan of care and treatment, and whether the patient is receiving the care that he or she needs.

The intent of the IPR and MR programs is to ascertain that the patient's mental, physical, and social needs are being met in a timely and professional manner. The findings of the teams, however, could and should result in other benefits. If the ICF or SNF level of care is no longer necessary, consultation should ensue between the teams and the attending physician, guardian, and appropriate facility staff to determine the proper placement of the patient.

We believe that the UR, MR, and IPR programs will result in better management of health services, active treatment, and rehabilitative programs for ICF and SNF patients.

Mr. Chairman, that is our official position on this premature dissemination of these regulations.

Senator Moss. We are glad to have that explanation in the record, because it did cause great concern, and resulted in an exchange of correspondence to which you referred, and many of the consumer groups were considerably upset by the practice. Does that complete your oral presentation?

Dr. EDWARDS. Yes, Mr. Chairman.

Senator Moss. As I indicated before, your entire statement is in our record. I do have questions, and Senator Percy has indicated that although he had to leave for a few moments, he would have some questions when he returns.

NURSING STAFF RATIO

First I have a question on the nursing staff ratio, the HEW guidelines for the Medicaid programs suggested ratios for the number of nursing home personnel to patients.

Each patient was to receive at least 2.25 hours of nursing care per day. Does HEW intend to reinstate this and other ratios in the proposed guidelines?

Dr. EDWARDS. Mr. Chairman, with your permission, may I call on some of my colleagues to answer these questions?

Senator Moss. Certainly.

Dr. EDWARDS. Mr. Levy, would you like to speak on that?

Mr. LEVY. Mr. Chairman, when we were preparing the revised regulations, we gave very careful consideration to the question of a nurse-patient ratio. But we have found in our experience in talking with State agency people who have actually been conducting the surveys, and to such organizations as the American Nursing Association, they have found that in terms of actually making a judgment during the survey process on the adequacy of nursing, a nurse-patient ratio in many respects can be kind of a false benchmark. They have found that what you actually have to do is to look at such factors as the mix of patients in a facility, the actual needs of the patients, what type of physician orders have been given to those patients, and then make a judgment, based on these elements, as to whether the nursing staff is adequate.

They have found that applying a benchmark to a given facility may give a quite false impression, because in that facility you may even need more nursing than the benchmark gives.

In another facility, with a larger number of patients, or a different patient mix, more ambulatory patients, or where more patients do not need direct nursing services, you may not need quite what the benchmark says. It is a subjective type of judgment, and we felt in view of this experience and the advice we had obtained that we ought to allow the judgment of the surveyor who is onsite, and who is directly observing the patients in the nursing home, and the type of nursing care they are receiving, to make the decision.

Senator Moss. So the answer is you do not intend to establish this guideline as before of 2.25 hours?

Mr. LEVY. Not in terms of that specific figure; yes, sir.

Senator Moss. Is there any guideline at all, or is it totally left in the control of whoever makes the survey?

Mr. LEVY. Mr. Chairman, the nursing services condition in the regulations do contain various criteria, and various items that the surveyors are supposed to look at in terms of making the judgment of adequacy of nursing services, but it is not framed in terms of specific ratio of hours to patients.

Senator Moss. Is there any means of appeal of this decision by users of nursing home services?

Mr. LEVY. Well, yes; in addition to the survey, under the Department's disclosure provisions, the findings of all surveys are placed on record now and are available to the public.

In addition, any user or observer of a nursing home who has concern about the adequacy of such an item, the specifics of nursing services rendered in that home, of course has a right to bring that to the attention of the State health department, to make his concerns known, and that of course would be immediately looked into.

TRAINING OF PHYSICIANS IN GERIATRICS

Senator Moss. Dr. Edwards, what programs is HEW providing for the training of physicians in geriatrics and the care of nursing home patients?

Dr. EDWARDS. I cannot give you information on any specific training programs directed at the care of patients in nursing homes. I will be happy to supply such information.*

Of course, the whole subject of aging is becoming a more important issue in the education of physicians, and, of course, as you know, the Department spends many hours in medical education, so it is indirectly involved.

Perhaps Mr. Michelsen might be able to.

Mr. MICHELSEN. Yes, Mr. Chairman, the training effort that the Department has been undertaking has been reaching across a number of training approaches to reach professional personnel in the nursing homes.

Some existing contracts for a total of $1,935,000 have been negotiated to focus on nursing home personnel. Within that range of contracts, there has been a proposal that the Department is in the process of negotiating to provide for certain forms of geriatric training specifically for physicians. I am not at the moment aware of the precise status of the award of that contract, but I know it has been under negotiations as of this time.

Senator Moss. For some period of time we have been concerned about the lack of physicians interested in the field of geriatrics. It seems to occupy a very low priority in the training of physicians.

Under these circumstances, do you not think that HEW should do something to encourage the training of more specialists in geriatrics?

Dr. EDWARDS. I think, without a question, that is right, Mr. Chairman.

I think one of the interesting new areas that we are really getting involved in at HEW is the Institute on Child Care and Human Development, which is getting more and more involved in the whole process of aging.

I think this whole process of getting physicians interested in the process of aging is a very difficult one, and it takes far more than just HEW's interest in it.

As you know, one of the problems in getting physicians to be more responsive to the needs of nursing home patients is not so much a matter of their knowledge in the process of aging, as it is their interest in going to nursing homes and taking care of these particular individuals. I think we are just now moving into this area with some force, and we have not done an adequate job in the past. When I say we, I am speaking of the medical profession, and those interested in the medical profession.

LACK OF INTEREST

Senator Moss. Is the lack of interest by the medical profession because of the sort of undramatic situation of care for the aging? Is it because it is not as rewarding as other types of care for a number of people, surgery, and various other things of that sort?

Dr. EDWARDS. I think there is no question that there is a very real element, having been in private practice myself, and having been a surgeon, the acute conditions are of more interest, and there is more immediate interest in treating them.

Senator Moss. There is a challenge there of sorts?

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*See appendix 1, item 2, p. 2820.

Dr. EDWARDS. That is right. The challenge is greater. It is more readily apparent to those doing the treating.

The chronic diseases are less rewarding in that particular respect, but again, we have to face that issue, because as we move into a new era, in a sense of the health professions, I think chronic diseases are going to be more and more important in terms of the practices of the average physician, both surgical and otherwise.

Senator MOSS. Mr. Levy, in explaining the reasons for abandoning the ratio of care of the patients, the hours alloted, is really contrary to the testimony we have had from you before. Do you not consider this as a retreat by going back now and abandoning the ratio?

Mr. LEVY. Mr. Chairman, I really do not recall my testifying in favor of a ratio. The extended care facility conditions of participation, which of course are still technically in existence, and which have been in existence, do not contain a ratio.

Now, they do contain such requirements of course that there have to be 24-hour nursing services available, and there has to be a qualified nurse in charge of each shift.

There has to be at least an R.N. on one shift per day, and as I mentioned earlier, they contain criteria for assessing and evaluating the adequacy of care.

Senator MOSS. Dr. Edwards, does HEW have any programs which provide for the training of paramedical personnel who serve as medical assistants in nursing homes?

Dr. EDWARDS. I think, Mr. Chairman, I would like Mr. Michelsen to review that. We have had a number of contracts with outside organazations or groups for training and for refresher courses in various fields, and you might want to comment, Mr. Michelsen.

Mr. MICHELSEN. All right. If I might lay a little general background, the contracts cover a number of categories of nursing home personnel, for example, nursing home administrators, nursing personnel, and aides. Included are contracts with State-based programs, national professional groups, and a regional network of training centers served by some six long-term care facilities.

There are also contracts that have been funded by the National Institute for Mental Health for stimulating mental health training activities for nursing home staff as well.

First priority has been given in developing training approaches focused on physicians, on nursing personnel, on activity directors, and I believe on social workers.

The contract with the American Nursing Association to develop training materials, training strategies, and so forth, will cut across the various classes of nursing personnel including aides that are employed in skilled nursing facilities.

Senator MOSS. Can you tell how many medical corpsmen have completed the medex program?

Dr. EDWARDS. I am not familiar with the details of that program. We can certainly provide that for the record.*

Mr. DWIGHT. I would like to throw an added dimension in education up for consideration if the committee wishes to have it further elaborated; perhaps some of our educational colleagues in HEW might

*See appendix 1, item 2, p. 2820.

speak up further on that. Unfortunately they are not here today, but we could provide that kind of information for the committee, and for the record.*

Department Favors Broader Based Role

There is a general policy within the Department of Health, Education, and Welfare, which has been recently enunciated. The Department has wished to withdraw from institutional training activities in favor of a broader based role of providing financial assistance to individuals to seek and acquire training of their own choosing, so that the marketplace, that is, the need for practitioners in some of the areas you have indicated, will determine and draw persons into the educational system. So the policy of the Department relies primarily on individual training as opposed to providing the specific institutions for purposes as you have suggested. That is the process, a policy which is now in transition or evolutionary stage in many areas: We are moving toward the Federal role as being the financial role through the educational system, as opposed to the proliferation of training to the various bureaus in HEW or elsewhere.

Senator Moss. What I was concerned about, not only institutional training, but in-training of nursing home personnel, whether or not there was a program for that, and our hearings indicate that some 90 percent of all medical and nursing care in today's nursing homes is provided by unlicensed aides. They are usually paid the minimum wage, and most of them hired literally off the street.

Now, what sort of program do we provide for in-service training for nursing home personnel?

Mr. Michelsen. Mr. Chairman, as part of the President's eight-point plan for nursing home improvement—as you know, the Department has for the last couple of years been developing training programs for nursing home personnel of all disciplines across the country.

The overall target is to reach approximately 500,000 employees in the nursing home industry, and the initial concentration has been on developing model training programs, and training materials.

As I mentioned earlier, training activities were initiated dealing with four classes of personnel at the outset: These have been expanded to include other professional disciplines. I might add that during the course of fiscal year 1973 and the first quarter of fiscal year 1974, almost 22,623 persons representing all disciplines associated with nursing homes participated in training opportunities to upgrade their skills.

We can provide additional statistics to go along with what I have summarized, if you wish, for the record.

Senator Moss. We would like you to provide that for the record.**

Dr. Edwards, in a hearing we held before this subcommittee in October of 1971, we were talking about the Connecticut study showing an average profit of 44 percent was made by that State's nursing homes.

Under Secretary Veneman promised that HEW would conduct a study of nursing home profits. Has such a study been undertaken; and if so, what are the results?

*See appendix 1, item 2, p. 2820.
**See appendix 1, item 2, p. 2821.

Dr. EDWARDS. Mr. Chairman, I am not aware of Mr. Veneman's agreement and to my knowledge, unless one of my colleagues knows of it, I do not believe that study has been undertaken.

Senator MOSS. No study has been made?

Dr. EDWARDS. No, sir, not to my knowledge. I am sure if it had, one of the members at the table would certainly be aware of it.

Senator MOSS. Do you think such a study should be made?

Dr. EDWARDS. I think without any question it is appropriate.

Senator MOSS. Would you recommend then that the Department go ahead and conduct a study?*

Dr. EDWARDS. Let me, Mr. Chairman, suggest that we have some discussions of how best to go about a study of this kind, and get back to you as to how we would propose doing it, rather than to point blank say we are going to undertake a study.

I think we ought to think about it, about the methodology, about what we propose doing.

Senator MOSS. I would appreciate it if you would communicate back with us, say within 30 days what your proposal would be.

CUTBACKS IN NURSING HOME CARE EXPENDITURES

What I am concerned about is that the fact that we seem to be cutting back on expenditures for nursing home care.

On February 26, 1970, the President announced his intention to cut funds to Medicaid nursing homes by $235 million. Now comes the recent news that the administration's national health insurance proposal failed to give any consideration to the Nation's infirm elderly.

Since about 3 million people need some form of nursing or personal care, how can HEW in good conscience support cutbacks rather than new programs?

Dr. EDWARDS. Well, let me ask Mr. Dwight to speak to the Medicaid program and any cutbacks.

I would only add that in our deliberations for the development of a national health financing scheme, the issue of long-term care is not being ignored.

As a matter of fact, it will be included in the Department's package to some degree with the exact degrees yet to be determined.

Would you like to speak to that?

Mr. DWIGHT. Mr. Chairman, I think the facts would speak to the contrary as to any cutbacks in the provisions of long-term institutional care.

I have some information before me dealing with the title XIX Medicaid program which suggests not just expansion, but a substantial expansion in both the numbers of persons being cared for, the quality of that care being provided in hospitals, in skilled nursing facilities, and in intermediate care facilities over the last several years as projected into the future. What you may be referring to is a corollary attempt which is being made on the question of utilization, and that is to be better assured that a person is receiving care which is appropriate to that person's needs.

In other words, a person who requires intermediate care, is not provided with acute hospital care, and there is a major effort going on

*A 1972 study of costs, revenues, and profits of 750 nursing homes in the U.S. was supplied the committee. Retained in committee files.

in that area. That effort is based upon the provisions embodied in H.R. 1, which was passed by the Congress last fall.

Senator Moss. Well, thank you. My colleague, Senator Percy, will have some questions and I would like you, if you would like to go ahead, Senator, please do.

Senator PERCY. Thank you, Mr. Chairman.

Before I ask any questions I would simply like to commend HEW for the flexibility that it has shown in responding to public comments.

Certain people question public hearings as a charade.

I even heard the comment that the sealed envelope on the Presidential and Vice-Presidential decision is only going through the motions. You have certainly proven, however, that you are responsive, and by agreeing to upgrade requirements, and to register nurses and the medical director, I think you have proven the value of having public hearings by showing such responsiveness to them.

Yesterday we heard a good deal of criticism of the proposed regulations due to the fact that many elderly persons who need access to skilled nursing care do not need intensive care on a daily basis. Such patients will be forced out of skilled nursing facilities and into facilities which may not be able to provide the level of care they require.

Would you care to comment on this criticism?

Dr. EDWARDS. Senator, if you do not mind, I would like to have Mr. Newman comment on that.

APPROPRIATE UTILIZATION REVIEW

Mr. NEWMAN. It is difficult to respond in the abstract to a criticism of that kind. For one thing, the regulations permit a facility to provide both skilled and intermediate services so that the individual would not necessarily have to leave the facility if these services that he required were of the other level.

The general problem alluded to a moment ago by Mr. Dwight of appropriate utilization, of getting the person in the right place at the right time, is what we are trying to achieve. People are put on the street, I guess is the way the criticism is phrased, is not what any of us intend. I can only say, therefore, that the criticism is one that we, the issue is one that we are concerned about, and we think our regulations and our enforcement efforts reflect our concerns.

Senator PERCY. Dr. Edwards, we have had some complaints that HEW has consulted with the nursing home industry in drafting the proposed regulations, but not with groups representing the elderly.

Could you describe for the committee the process by which the Department prepared the skilled nursing facilities' regulations and the intermediate care facilities' regulations?

Dr. EDWARDS. Senator, in my testimony, some of which was submitted for the record, I went into some detail in this regard. We established an interagency task force within the Department, made up of representatives of the Social Security Administration, the Social and Rehabilitation Service, and from our bureau of what was then the Health Services and Mental Health Administration. All of this was coordinated out of the office of Assistant Secretary of Health.

This group worked from October until July of this year, approximately that length of time, in developing these regulations.

During this period, there was no question that some documents were leaked, and that they got into the hands of certain of the industry groups.

This was an unfortunate situation. We investigated it at some length. It was absolutely true. We were unable to find out exactly how it happened, but we are trying to come to grips with this problem. We are trying to develop some departmental regulations that can at least reduce this problem to a minimum. We do not believe, as I mentioned in my testimony, that there was any impact in terms of the ultimate regulations.

Senator PERCY. Do you feel it was made quite clear that you would welcome comments, criticism, suggestions, from all groups, not just industry groups, but all groups representing the elderly, for instance, and who are not in industry, but interested in the end results of delivery of health care?

Dr. EDWARDS. I think this is absolutely essential in the decision-making process, if it is going to be a meaningful one. We strongly recommend that groups like this get in touch with us and we are meeting daily with groups interested in issues such as this, and certainly our intent is in no way to exclude anybody from these discussion processes.

Senator PERCY. I think that is very important.

We have many groups well represented in the room today, and for the record, I would simply like to say in your custodianship of FEA, I have found that industry can have access to you. I have also found that you are most receptive to all consumer interest groups who have no axe to grind other than the best interests of the general public, and you also seem to be available. I think we ought to establish your record in this field and urge that that same policy be adhered to. I have heard some comments on what the intent of Congress was in H.R. 1, and that there was no presumption that it was the intention of Congress to agree, on a wholesale basis, to the existing regulations. Therefore, I would like you to comment on what the Department based its case on in deciding to rescind large sections of the existing regulations, and in preparing new ones. What grounds does the Department feel it had for taking out large sections of the existing regulations? I am interested in not only your understanding of the public authority you had to do this, but also the justification for the subsequent changes that were made.

JUSTIFICATION FOR CHANGES

Mr. MICHELSEN. Senator, in responding to that, I would also like to comment, that I think that there has been a general misunderstanding about the action of the Department in bringing the Medicare and Medicaid regulations together into a single or a common set of standards. I think there has been a misunderstanding that there were substantial deletions from the proposed regulations that were published in the Federal Register on July 12.

The basic foundation of the proposed regulations is the existing Medicare regulations to which the Department has made certain

additions and revisions which were developed over a period of approximately 2 years.

At the time that the proposed regulations were approved for publication—July 1973—there were some deletions of some of the additions to the existing regulations, but the existing regulations, plus those requirements that were mandated in Public Law 92-603 formed the basis for the proposed regulations.

As Dr. Edwards has testified to this morning, his recommendations to the Secretary include certain additional provisions to the regulations for final publication, upon his approval. I think, in general, that is the basic position that we would like to establish, and perhaps Mr. Levy or Mr. Newman would like to comment further on this.

Senator PERCY. Maybe I could shorten the question. Let's keep our eye on the objective—higher quality nursing care—and that is our objective for nursing home patients. Do we agree on the objective?

Dr. EDWARDS. We certainly agree on the objective.

Senator PERCY. We were out to achieve that goal.

Now in what way do the omissions that have been made contribute to that objective?

Mr. LEVY. Senator, let me comment on your question in this way. In developing the so-called combined regulations for titles XVIII and XIX, I believe if you compare these with the existing conditions of participation for extended care facilities, that the basic areas in the existing conditions for extended care facilities are accounted in almost every area in the proposed regulations for skilled nursing facilities.

FORMAT MODIFIED TO REMOVE "EXCESS VERBIAGE"

I think what may be misleading, and what may be causing part of the concern which was expressed to you yesterday is that in preparing these revised conditions we modified somewhat the format in an attempt to tighten up and remove some possibly excess verbiage in the existing conditions.

Now, the principal change which perhaps is causing some of the concern is that in the existing conditions we have a format which starts with the basic requirement; namely, the condition followed with several standards, and under each standard one or more factors.

What we attempted to do was combine the factors in with the standards, and attempt to make this more readily usable, and I think this is what has caused some of the concern, but as I indicated, as you look at this condition by condition, they are all there in the existing SNF conditions, and two very significant requirements that Dr. Edwards mentioned in his testimony, the medical director, and the nursing staffing, the use of registered nurses, will be issued under the proposed rulemaking procedure.

I do not know if that is what you want, if that is what you have in mind by your question, but I wanted to clarify what may be of concern.

Senator PERCY. Does anyone else want to comment?

Mr. DWIGHT. I think one of the points that I tried to bring into the discussions for the short period of time I have been involved in the development of these regulations is that approximately 75 percent of the care is provided not by the Federal Government, but by the States, and, therefore, the Federal Government is not an operator of the

program. The Federal Government is a partner with the States, and the States are the operators of the program.

Senator PERCY. What is the investment of the Federal Government in the program annually?

Mr. DWIGHT. The Medicaid investment would be upward of $2½ billion.

Senator PERCY. That is a pretty substantial partner.

Mr. DWIGHT. It certainly is.

Dr. EDWARDS. A greater reliance on the capability of the States to be responsive to the needs in a particular geographic location has been a factor that I have tried to bring to the consideration of the need for regulation, and I think that is an acute point when we go back to one of your earlier questions, and that is the expressed concern of the ability to provide care for people, that is, would people be put out on the street as a consequence of action by either the Federal or State government. As we increased the standards, and we have been increasing the standards over the last several years, as we became more and more concerned about the question of standards, we always have to temper the question of how fast can the facility respond to the needs of change, and the ultimate weapon of the Federal Government is to say we are not going to pay for the provision of services in that facility, and then the question that somebody has to answer is "well, where are those people going to be cared for?" so we have to temper our judgment in that context.

Senator PERCY. Mr. Chairman, I have a few more questions.

I would just like to comment that we are always aware of the problems of moving the Government to get something done when we see the apparent need for it. I think we are often caught in the situation where even the President of the United States wonders whether he can move the bureaucracy to get something done.

I think Dr. Edwards is familiar with the fact that the President and I were in Chicago in 1971 together to address the American Association of Retired Persons.

PRESIDENT ANGRY OVER FINDINGS

Coming back from Chicago with a captive audience, I had an opportunity to describe the findings of our committees, and I never saw the President so angry. I had legislation in to change regulations, but he wanted to do it by Executive order.

I said we could not be more pleased to have our work utilized and placed in effect by Executive order. The President called Arthur Flemming in, and we all conferred. I thought it was going to be done overnight, because the President said it ought to be done.

There is no question about the President's desire to see it done, and we have an obligation to move as rapidly as possible. We are simply saying that the legislative branch wants action.

The next question is based on one of the primary criticisms leveled at one of the regulations.

I cannot help but think of the tragedy we had in a city in Illinois, where we have some racial problems, and have had deep problems for years.

No white dentist in town will treat black patients, and there are no black dentists in town. The dentist comes over on Thursdays at 10 in the morning once a week to treat black patients. The motto is, if you are going to have a toothache, do not have it unless you have it Thursday morning at 10 o'clock.

Now, I just ask this question: Is there some inconsistency between the provisions limiting the need for a registered nurse to 8 hours a day, 5 days a week, and those limiting admission to a skilled nursing facility of persons requiring daily skilled care and attention?

Mr. LEVY. Let me just comment on the latter part, Senator. On limiting the admission to those requiring skilled nursing services, really, what we are getting into here is a coverage question under Medicare.

Of course, the facility itself, the nursing home itself would be able to admit those patients that it can properly treat, and have bed space, and so forth.

Under the Medicare provisions, in order for the patient to have services reimbursed under Medicare, he would have to be at a required level of care, namely, skilled care, that is perhaps what the illusion to this limitation is, but it is really what we are talking about.

The point I am trying to make is, that the nursing home itself would not be able to admit those patients it wishes to admit, irrespective of the level of care.

Many nursing homes, of course, which are providing a highly skilled level of care do limit the types of patients they wish to accept, that is, to those who have been hospitalized, and while they are very still seriously ill, but require a slightly lower level of care than hospital care. Others, of course, will admit a whole array of patients, from those needing custodial on up to those needing skilled nursing care.

Senator PERCY. Do I understand the Department has changed the regulation now to read 7 days a week instead of 5?

Dr. EDWARDS. That is correct. I did make the point in my testimony that that is one of the proposed changes.

TRAINING OF NURSING HOME PERSONNEL

Senator PERCY. Fine. I think that will take care of it.

Last, Senator Moss has touched on this point that I talked very strongly about, I have been a strong supporter of the concept of in-service training and orientation of nursing home orderlies and aides, and I would like to know if the requirement of this activity will be included in the recommendations.

Dr. EDWARDS. Mr. Michelsen reviewed that a little earlier. He might want to review the program as it exists over the past year, and some of our plans.

Mr. MICHELSEN. One of the things I had mentioned, Senator, is that the Department has been developing for the past 18 months to 2 years, an overall training program of in-service training for nursing home personnel, that provides forms of short-term training for all of the variety of disciplines employed within the nursing home.

In order to get the program launched, priority was given to four broad classes or disciplinary groups, so that the immediate focus of

letting contracts for developing programs and training materials, was focused initially on the training of nursing home administrators, nursing personnel, activity directors, and social workers.

The Department has been planning and developing additional training programs or training opportunities by letting new contracts to develop training guides and materials for other classes of nursing home personnel, so that as the program reaches its full momentum, it will cut across all of the specific staff categories or disciplines within the nursing home field. By way of general background for an earlier question on training for nurses, a contract with the American Nursing Association was awarded to develop a series of training experiences which can be used in the nursing home itself as the training site for nursing personnel, particularly for the aides and licensed nursing group.

Much of the concentration initially has been on developing of these training programs as models, so that specific training plans and materials can be provided to the States and to local organizations. Then the State agencies can come into the process, take these prepared training programs, and put them on themselves, so that by this augmentation, it is possible to reach into the more than 7,000 nursing homes across the country, and in so doing, bring a great variety of local resources into the training process.

Senator PERCY. The one thing that the elderly groups want assurance on is that regulations will require training as a condition for participation. Will it?

Dr. EDWARDS. Well, we get into the area here of State license certification requirements, Senator, and in many of the cases, for example, there are training requirements for nursing home administrators.

Many of the States are adopting so-called continuing education requirements for licensing or renewal of other professional classes, for physicians, nurses, and so on.

The regulations do not require this; they refer instead to the State requirements, in the sense of maintaining a certain type of education unit or course value requirements for renewal.

Mr. LEVY. I would just like to add a comment, Senator. In addition to the licensure requirements for a number of the professional people who bring services to the nursing home, there are specific educational and qualification requirements spelled out in the regulations, for example, for occupational therapists, recreation therapists, et cetera, in addition to the nursing staff, pharmacist, and so forth.

CERTIFICATION OF ICF'S

Senator PERCY. Mr. Chairman, with your indulgence, I have one question from Senator Javits.

It is my understanding that intermediate care facilities are certified for both the aged and mentally retarded.

Sometime back Senator Javits introduced a bill to require that to be certified as an ICF, the institution must be accredited by the Joint Commission for Accreditation of Hospitals.

I am told by Senator Javits that he was informed that his bill was unnecessary because its substance would be covered in the new regulations.

On behalf of Senator Javits, I will ask this question:

"Will such Joint Commission for Accreditation be required under the final regulations for ICF's serving the mentally retarded?"

Mr. DWIGHT. Senator, I cannot answer your question directly, because the decision has not been made.

Senator PERCY. Senator Javits was told that it would be, and I think the answer would be yes or no. If it is no, we wonder why.

Mr. DWIGHT. The notice of proposed rulemaking had the standards, which were developed by the Commission, included in it.

Subsequently, both the Commission itself, and the States who operate these programs, indicated to us that the standards were untried, and it would be inappropriate to require these to be mandated upon States as an element of the requirements that they have to meet in the operation of the programs. And let me restate, the Commission itself made that conclusion.

We are working with the joint council, and we have expanded their continuing role in working with us, by awarding a substantial grant so they can actually go out and review the facilities to determine whether they do in fact meet the requirements, and continue to refine their standards. Hopefully at some point in the future we will be able to put these out as regulations.

It is my best judgment that these would more appropriately be put forth as guidelines at this point in time to act as an indication of where we think we are, but without putting the States in a straightjacket, where we have no evidence whether that is good or bad.

The Joint Commission effort was an initial effort to establish standards, and it was a very superior effort, so there is no attempt to discredit that effort, but it just had to progress as far as it could, and apparently it was at a start when Senator Javits was proposing his legislation.

Senator PERCY. I might ask the staff to transmit this testimony to Senator Javits for his guidance as to what he might want to do to follow up.

Thank you very much.

Senator Moss. Senator Clark.

VIOLATIONS OF CIVIL RIGHTS CHARGED

Senator CLARK. Thank you Mr. Chairman. I just have a couple of questions for the panel.

As you know, the Civil Rights Act of 1964 states there can be no discrimination on the grounds of race, color, or national origin in nursing homes or in any other institution financed by Federal funds. Representative Don Edwards, the chairman of the House Subcommittee on Civil Rights and Constitutional Rights, has found what he calls de facto discrimination in Medicare and Medicaid facilities. Also, it is my understanding that the GAO has confirmed, to some degree, the existence of this situation. Therefore, why in the new regulations, in the July 12 regulations issued by the Department of HEW, has the mention of nursing home patients' civil rights been excluded?

And, do you have any particular suggestions on provisions that might take care of this area?

Mr. LEVY. Senator, there is an existing regulation in the Medicare program, which says that any facility, any hospital, nursing home or any other provider participating in Medicare must be in compliance of title VI of the Civil Rights Act.

This regulation appears in a different section than in the proposed conditions of participation for the skilled nursing facilities, and that is why it was not reiterated in those regulations.

Senator CLARK. So that is you feel it is adequately covered elsewhere?

Mr. LEVY. Yes, sir. Let me add that at any time the Office of Civil Rights were to advise us the facilities are out of compliance, then we would not have them down as being eligible for Medicaid and Medicare participation.

Senator CLARK. It is my understanding that section 1102(e) of the current regulations has been dropped. This particular section deals with title 6 of the Civil Rights Act of 1964, which requires that no person in the United States shall on the ground of racial discrimination, age, sex, or national origin, be discriminated against, specifically in regard to nursing homes receiving Federal funds.

Where it previously existed, it is no longer there, is that not so?

Mr. LEVY. My staff advises me it will appear in the final regulations.

Senator CLARK. Fine. That is the question.

It was pointed out yesterday, that it may be possible that patients will not be able to choose their own doctors. Considering the exclusion of that particular provision in standard (b) under section 405. 1123, which simply says, to the extent feasible, each patient or his sponsor shall designate a personal physician.

Why has it been determined that the patient would be better off not having a voice in that, where it is feasible?

Again, let me point out that this provision is included in the existing regulations.

MEDICAL DIRECTORS NEEDED

Dr. EDWARDS. I am informed, Senator, that is not necessarily a policy decision. It is more or less a fact of life. I think any patient, as far as we are concerned, can have his own personal physician, but you are certainly aware, as we are, of the difficulties of obtaining physician participation in nursing home health care activities, and we feel that there is a need for medical direction of the facility, not necessarily full time, but at least for a person who is responsible for the medical aid delivered in that institution.

We feel, in the final analsis, this will probably provide better medical care for these patients than trying to rely on individual care by their physicians.

Senator CLARK. It seems to me what you are saying and what I am asking for is a contradiction.

The old regulation says to the extent possible, each patient, or his sponsor designate, choose a personal physician.

Now, that means if it is not feasible, if it is not possible, if it is not practical, that this provision not be carried out. But it seems to me that the Department of HEW is directly saying no, we are not going to give patients any choice when it is feasible; you are going to drop

this provision. Knowing that older people have a strong feeling about this issue, a feeling many of us share, why does the Department want to drop this provision?

Dr. EDWARDS. I do not think that was the intent. I think you raise a good question, and one we will try to take care of.

Senator CLARK. My last question deals with mental and recreational care. Yesterday it was pointed out at these hearings that such simple items as books, magazines, newspapers, would not have to be provided to residents if the proposed regulations were enforced.

This has reference to section 405.131, standard (a)7.

This is the old regulation that has now been dropped. Let me read it for you.

The facility makes available a variety of supplies and equipment adequate for the individual. Examples of such supplies and equipment are books and magazines, daily newspapers, and games.

I am curious why you felt it was wise to drop that regulation.

Mr. MICHELSEN. What is the citation?

Senator CLARK. Section 405.1131, standard (a)7. I think particularly in view of the fact it was in the regulations, and now it is specifically dropped, that some people might interpret that to mean that such items are no longer required or important.

Mr. NEWMAN. I might try to respond to that, and in a way comment on an earlier question concerning the Department's efforts to respond to the intent of Public Law 92-603 with regard to nursing homes.

One of the most important things we thought was to try to bring about uniformity in both the standards in the Medicare and Medicaid nursing home programs, and in their enforcement.

With regard to the enforcement, I think it is in that connection I would like to try to respond to your question. We have moved from the concept of substantial compliance in which a nursing home would not have had to do those things that you specifically referred to, and still would have been able to continue to participate: that is, still be substantially in compliance.

I think what that means is that those requirements which are reflected in the regulations are in fact requirements.

NURSING STAFF RATIOS "ALMOST UNENFORCEABLE"

You make those standards which you plan to enforce requirements. In connection with a yet earlier question having to do with nursing ratios, there was some earlier discussion before you entered the room in which I think the point might have been made that a requirement dealing with nursing staff ratios would be almost unenforceable. To make it a regulation and not enforce it is, at least in my judgment, worse than not having the requirement at all. We have, therefore, taken the view that those kinds of things which we do not think should have the full force of a requirement, the absence of which should remove any Federal payment to the home, should be reflected in the guidelines. Those are the kinds of things we expect and hope, but do not require.

Senator CLARK. What you are saying, what you are suggesting, is that the various regulations I have been referring to with regard to magazines and televisions and so forth, are really only guidelines and

suggestions. Now we are going to have only those regulations that are enforced.

Mr. NEWMAN. No, sir. I am saying that those references in the earlier regulations were enforced by a system which accepted substantial compliance, and, therefore, a judgment was made which could have reflected the absence of those particular activities and the continuation of that home in the program. What we have tried to do in response to the direction of the Congress in Public Law 92–603, is eliminate the concept of substantial compliance. The regulations will be enforced to the letter. Those are the requirements, and they are absolute requirements. I apologize for the length of the response, but it explains the movement from certain of the specific requirements.

Senator CLARK. I understand your explanation. I would just say that it seems important to me that the provisions I have mentioned be included under the new regulations.

It seems entirely reasonable that a patient be allowed to select his own doctor, where feasible. These items certainly could be a part of the new regulations. Having other materials available, like daily newspapers, books, and magazines, would not be an unreasonable requirement, in my opinion.

Thank you, Mr. Chairman.

Senator Moss. A question from the associate counsel, Val Halamandaris.

Mr. HALAMANDARIS. Thank you, Mr. Chairman.

I just have a couple of brief questions. I will not delay you gentlemen too much this morning.

I understand that we are to have a medical director requirement. I simply would like to know what that means. If you are a nursing home operator, what do you do to meet that requirement? That is to say, is the doctor responsible for the overall care of the facility? Is there some requirement the physician would have to be in the facility a specific number of hours a day?

What is the shape of that requirement? Is it specific? What does it mean?

NEED FOR FLEXIBILITY DESCRIBED

Dr. EDWARDS. First of all, I think a fair amount of flexibility has to be given to the nursing home operator.

Certainly, in some of the cases of some homes, it would be a full-time director that would be probably appropriate.

In the majority of homes it obviously would not be. One morning the medical director might want to spend 5 hours, and the next day 15 minutes.

I think it would be totally inappropriate for us to attempt to define this with too much specificity, so we do not get into the exact amount of length of time.

We also address ourselves as I indicated in our testimony, to the problem of homes that cannot find medical doctors, either because there are no physicians in the area interested, or there are no physicians in the vicinity.

Mr. HALAMANDARIS. I am a little troubled by that response, Doctor, but let me go on. In your testimony, you note there has been testing by the National Bureau of Standards, and with respect to carpet, the

tunnel test has been certified as the most effective test, and this will be reflected in the new standards.

Am I correct that the old guidelines, 75 on the tunnel test, will be the demarcation line of the standards limiting the flamability of carpets in nursing homes?

Mr. LEVY. Mr. Halamandaris, there is both the present and proposed regulations, which do call for the application of the Life Safety Code to all facilities participating in Medicare and Medicaid.

This code does have provisions on floor covering which calls for the application of the tunnel test, where in the judgment of the fire authorities, floor covering does cause a potential hazard in the facility, and of course the application of the tunnel test would require the accepted cutoff point which in the code is 75 for an unsprinkled facility, and 200 for a sprinklered facility.

Mr. HALAMANDARIS. Thank you. With respect to your standards for intermediate care facilities, I believe that is pointed out in your testimony, Doctor, the standards, some of which were retained. We have information from some people within HEW that the standards have been significantly watered down. I do not know whether that is true. I would like to ask you if you know what the standard is for nursing coverage. I understand the standard is now a licensed practical nurse 5 days a week, and that all of the other consultants have been dropped.

To give you an example, the proposed regulations which were issued on March 5, pointed out that a dietary supervisor from a nursing home would be somewhat suitable by training or experience.

There would also be the necessity of consultation from the dietitian. The new standard purportedly reads anyone suitable by training and experience without further consultation would be suitable as a supervisor in an intermediate care facility. I understand what has happened all the way down the line, the consultant has been deleted, and the nursing standard has been cut back sharply.

Is that correct, or is that a false rumor?

Dr. EDWARDS. I would not say it was either. Number one, we just several weeks ago received the proposed final ICF regulations from Mr. Dwight's agency, and we are in the process right now of evaluating those, and I really cannot honestly say what has been deleted, and what has not, and I think it would be inappropriate to say at this particular point in time that we are looking at them in relation to one of the issues you brought up, and if some of these things are deleted, we will have to sit down and discuss it with the other appropriate groups in the Department.

LIFE SAFETY CODE REQUIREMENTS

Mr. HALAMANDARIS. We heard testimony yesterday that 50 percent of the intermediate care facilities do not meet the requirements of the Life Safety Code.

The gentleman from the State of Pennsylvania, Mr. Leopold, testified it was his guess that a large number of skilled facilities throughout this country could not meet the Life Safety Code, and he felt that the State of Pennsylvania was being singled out.

He felt that if this committee were to take a random sample of other States, we would find many, many other nursing homes do not

meet the requirements of the Life Safety Code, and I wish I could get a comment on that, if I could.

Dr. EDWARDS. I would like Mr. Black, our regional director for the area in which Philadelphia is located, to answer this question.

Mr. BLACK. I have a mandate from the Secretary to examine the procedures being used by the several States in my region to assure nursing home standard enforcement, as do my other nine colleagues in the other regions to do likewise.

This mandate insures that we see that the States involved in our regions—in our case, we are talking about Pennsylvania, Delaware, Maryland, Virginia, West Virginia, and the District of Columbia—that all of these States comply with the provisions of the Life Safety Code, and the minimum health standards that Dr. Edwards and other colleagues at the table have described.

Now, to the assertion that there is any persecution on the part of any one State, I can only say this is perhaps a function of numbers, as in the case of region III, because of the vast number of homes that Pennsylvania has as compared with the number of homes in other States within the region. Obviously, our No. 1 attempt is going to be to prevent and has been to prevent a reoccurrence of the tragic incident which occurred in the Washington Hill Home.

We are going to relentlessly see that standards are applied across the board. The fact that there are no physical means of bringing some of these homes up to a standard is a problem that we have met with the State authorities to reconcile, and we are not unreasonable in the application of these standards, and I might add for the record that the State of Pennsylvania has come up with an excellent plan to transfer some of the patients who are in homes that have been deemed by State authorities to be beyond rehabilitation, and I feel that is a necessary first step at the regional level in attempting to do what I understand the sense of the subcommittee's thrust is.

I hope that responds to your question.

WHOLESALE RECLASSIFICATION OF PATIENTS

Mr. HALAMANDARIS. Yes. There are two more questions.

With respect to section 247, which describes the levels of care, we had testimony yesterday that approximately 50 to 75 percent of the present nursing home population does not fit into either of the skilled categories, skilled or intermediate care. I wonder if that is true.

There was further testimony, if the standards are promulgated as proposed, that they will result in a wholesale reclassification of patients.

In fact, in some States there is already movement of large numbers of patients from one facility to another. We also have testimony about what happens when you transfer people from one facility to another, and indeed when you transfer patients from one part of a facility to another, people go through what is called transfer shock, and there is an incredible loss of life.

I wonder if HEW has taken precautions, I wonder if you are concerned about that at all. Do you see any possibility of wholesale transfers?

Mr. BLACK. I could use the Pennsylvania experience once again here.

In the plan presented by the Commonwealth of Pennsylvania to the regional office of HEW, these transfers were taken into account, numbers are being firmed at this point; indeed, today I have a group of people meeting with the Pennsylvania authorities on this very subject.

My particular persuasion is that the trauma associated with transfer is less painful than the tragedies of fire, and if given one or the other, I think we will have to move patients to a more safe location than was the case in the tragedy in Philadelphia.

Mr. HALAMANDARIS. I was not speaking of fire and of that situation, I understand that, but if the reclassification is necessitated by complying with the definition of what is skilled nursing and intermediate care, and the movement is occasioned as a consequence of saving dollars—if the decision is motivated by economics rather than something else, it is a different question.

Mr. BLACK. I would agree, but I thing you cannot separate out their compliance with just purely a regulatory classification. That is the point I would like to make.

Mr. HALAMANDARIS. Thank you.

I have one last comment, and that is, I am directing this to my friend, Mr. Levy.

DELETIONS FROM OLD STANDARDS

I really do not buy your statement that these regulations are old wine in a new bottle. This is pretty sour stuff as far as I am concerned. The committee has noted page after page of deletions from the old standards.

Every place you see yellow, that is a deletion. Some are pretty significant.

You say the deletions are not that significant, that the new generalizations will allow flexibility in enforcement. I learned something a long time ago from Amos and Andy. They said, with respect to contracts, "The big print gives it to you, and the little print takes it away."

With respect to nursing home regulations, you reverse that. The little print, the specifics, gives it to you and the big print, the generalizations, takes it away.

If the generalizations are all you have, you do not really have any standards.

If you are a lawyer, and you try to enforce these generalizations, you are going to have big trouble, and this is why I say to you, put the specifics back in.

It is almost impossible to enforce generalities. That is what we heard yesterday.

Mr. Traill, of the Michigan Department of Health, said if you promulgated these standards as you propose, it will be a bureaucratic nightmare to try to enforce them, and I believe that with all my heart.

I understand at the time of the adoption of the U.S. Constitution some people claimed that the protections inherent in the Bill of Rights were implied. I tend to go along with Jefferson. I believe protections should be specifically enumerated.

That is my comment. Thank you.

Senator Moss. We thank you very much for your appearance and response.

You can understand the concerns that we feel, and the people appearing before us underline as they feel, and we appreciate your being here today.

We kept you much longer than we expected, but we have many things that are on our mind.

Dr. EDWARDS. Thank you, Mr. Chairman.

Senator Moss. Our next witness is Mr. Don T. Barry, president, American Nursing Home Association.

Mr. Barry, proceed in any way that you see fit.

STATEMENT OF DON T. BARRY, PRESIDENT, AMERICAN NURSING HOME ASSOCIATION; ACCOMPANIED BY BRUCE D. THEVENOT, ASSISTANT DIRECTOR FOR LEGISLATIVE SERVICES

Mr. BARRY. Mr. Chairman, I am Don T. Barry, president of the American Nursing Home Association. Accompanying me today is Bruce D. Thevenot, assistant director for legislative services.

I would like to express our appreciation for this opportunity to present the views of the largest single nursing home organization in America.

The ANHA has long recognized and appreciated your efforts, Mr. Chairman, and the efforts of the Special Committee on Aging, to elevate public awareness of the needs of our elderly citizens. We have valued greatly the opportunities we have had on many occasions to work with the members and staff of this committee on our mutual efforts to improve and enrich the lives of our senior citizens, most particularly those who are institutionalized in long-term care facilities.

The Special Committee on Aging has consistently been in the forefront in proposing constructive legislative solutions to the problems of the aged.

Many of those proposals have been enacted into law. Many others that have not been enacted should and will be enacted in the future.

ANHA is proud of the real progress that has been made by America's nursing homes in recent years.

As you know, Mr. Chairman, nursing homes experienced a rapid and dramatic growth following the enactment of Medicare and Medicaid.

Many new responsibilities were placed on nursing homes with the introduction in Medicare of the new concept of the posthospital extended care benefit.

This concept created a whole new classification of patients based on the short-term, acute-care hospital model and grafted this concept upon facilities traditionally designed as long-term care facilities.

This unnatural situation created many problems for Medicare, for nursing homes, and for the patients that Medicare had promised to serve.

Fortunately, nursing homes have made considerable progress in recent years in upgrading facilities and expanding services.

Today, Mr. Chairman, good nursing homes almost always have long waiting lists. There is much that we can be proud of just as there is much progress yet to be made.

Recent changes brought about by the 1972 Social Security amendments were aimed at correcting many of the problems in Medicare and Medicaid in preparation for national health insurance.

These developments make us hopeful that the gains that have been made can be consolidated, and that we can now begin to talk seriously about a coordinated national policy with regard to the elderly and the infirm.

With this perspective, Mr. Chairman, the particular focus of these hearings is very timely indeed. The substance of regulations is of crucial importance—and so is the process by which regulations are developed.

There has been considerable discussion in recent months about the adequacy and propriety of HEW's rulemaking procedures as they have been applied in the formulation of new conditions of participation for skilled nursing facilities.

Absence of Consistent Policy

In a letter to Secretary Weinberger earlier this year, ANHA complained about the absence of a consistent policy with respect to public participation in the formulation of regulations. Other provider and consumer groups have likewise expressed grave concern over the inadequate opportunity for consultation and input.

Mr. Chairman, this problem is nothing new to America's nursing homes. We have experienced great difficulties in recent years in dealing with arbitrary bureaucratic powers, both in the areas of reimbursement policies of SSA and fiscal intermediaries and the regulatory authority of HEW under title XVIII.

Normally, the Department issues new regulations first in the form of proposed rulemaking in the Federal Register and invites public comment.

On many occasions, however, the Department has implemented arbitrary policy directives in the form of so-called intermediary letters and amendments to the reimbursement manuals.

There is no opportunity for comment on these directives.

This practice has been used to effect retroactive denials of claims and to authorize the recapture of accelerated depreciation payments made to providers.

Most recently, Mr. Chairman, the Department has manualized regulations governing the intermediary appeals process and in doing so declared that disputes over allowable owner's compensation would not be reviewable. This is the kind of capricious authority that must be challenged.

Fortunately, legislation has been introduced this year in both houses of Congress which would provide an effective solution to these problems.

S. 2308 and H.R. 8458, introduced by Senator Mondale and Representative Hugh Carey, would affirm to providers and to the Secretary of HEW the right of judicial review of contested reimbursement issues.

In addition, these bills would make the rulemaking authority of HEW under title XVIII and title XIX subject to the public notice and comment guarantees of the Administrative Procedures Act and subject as well to judicial review.

ANHA vigorously supported these bills. Favorable action on them in this Congress would go a long way toward insuring that regulatory actions are consistent with statutory authority and are responsive to the public interest.

Section 248 of Public Law 92–603 provided that standards for skilled nursing facilities participating in Medicare and Medicaid would be merged into a single set of requirements with one certification process to be applied for both programs.

While health professionals can agree on standards of care that we would all like to attain, there are two principal elements that must be taken into account in prescribing those standards: (1) The assurance of adequate funding, and (2) the availability of adequate personnel to provide necessary services.

Standards Being Met Now

In addition, it should be understood that the new standards which HEW has proposed are designed to be minimum requirements for participation in the program. Many State laws and regulations will be more stringent and will supersede these requirements. We feel certain that the overwhelming majority of ANHA member skilled nursing homes are meeting these standards now or will be able to meet them with a minimum of assistance.

Some have called for a substantial upgrading of minimum staffing requirements. Clearly that is the direction in which we should be headed. However, regulation writing cannot be done in a vacuum.

It has become clear to us by now, Mr. Chairman, that the name of the game in health programs is cost containment. The 1972 amendments were replete with cost containment and utilization control provisions, many of which, to be sure were justified and urgently needed.

Nevertheless, Mr. Chairman, it appears that the administration has interpreted the mandate of H.R. 1 as an occasion to effect large savings, particularly in the Medicaid program.

We are deeply concerned that this effort will be reflected in an attempt to move patients as quickly as possible down the ladder into intermediate care facilities where they are expected to be cared for at rates which are scandalously low in most States.

The current emphasis on cost containment is reflected in the SNF regulations. An illustrative example of this zeal can be found in the provisions which deals with utilization review. This provision calls for review by the UR committee of the facility of all Medicare and Medicaid cases of extended duration every 30 days.

The point is clearly to save money by moving patients out and into intermediate care status as quickly as possible. The fallacy of this requirement is that no apparent recognition was given to the basic differences between Medicare and Medicaid patients.

Medicare patients come into the system from a population group with a much healthier status, and often return to their homes after a period of convalescence.

Medicaid patients, however, come into the system from a different physical and psychological perspective. The Medicaid patient is poor and usually has deteriorated to the point that he must be placed in a skilled nursing facility in order to maintain a thread of life, with little or no prospect of ever returning to the community.

It would be completely pointless to require utilization review of the status of that patient every 30 days, and such a requirement would not result in a savings, but rather would add significantly to administrative costs which must be borne by the taxpayers.

It should be pointed out that this review mechanism is only one of three eventual levels of review. State agency review and PSRO review would be two other layers superimposed on the facility's own UR function. It is only a slight exaggeration to ask if there will be any time left to care for patients.

Maldistribution of Health Manpower

In addition to the uncertain prognosis for adequate funding, there continues to exist severe shortages and maldistribution of health manpower in many areas of the country. Even in areas where there is a potentially adequate supply of professional personnel, there continues to be a reticence on the part of physicians, nurses, and other specialists to serve in the nursing home setting. For this reason, ANHA has recommended deletion of requirements for experience over and above professional certification for nursing directors, dietitians, social workers, and pharmacists. As a minimum requirement, such a change would enable facilities in rural areas, for example, to enlist the services of new graduates who could not be hired otherwise.

We are pleased to note the leadership taken by you, Mr. Chairman, in offering legislation which would provide funding for curricula in the specialized field of geriatrics. There is a great need to establish a pool of qualified professional and paraprofessional personnel and to provide incentives which will induce qualified persons to go into geriatric service.

Similarly, Mr. Chairman, much has been said about the difficulty of getting physicians into nursing homes. One proposed solution has been to require the retention of medical directors in nursing homes which do not have an organized medical staff.

Whether this requirement should be part of the standards is only part of the question. The real issue is: What kind of medical component is required and how can we best provide that component?

There is no simple answer to this question. Such factors as the size of the facility, its geographic location, the ratio of skilled patients to intermediate care patients, and the proximity of the facility to a hospital must be taken into account. Another important question which must be addressed is which of the functions of the physician require his presence at the facility and which of his functions can be delegated to the nursing staff at his direction.

Mr. Chairman, I believe that Senator Church, with your cosponsorship, has come forth with a constructive solution to this problem in S. 2096.

Training nurse practitioners to assume many of the duties contemplated for a medical director would alleviate the difficulties nursing homes face in assuring an adequate medical component in the facility.

In short, Mr. Chairman, insofar as the substance of the proposed SNF regulations is concerned, the central issue would be this: It is not sufficient to simply propose higher standards for nursing homes without reasonable assurance that those standards will be adequately funded and that adequate health manpower resources will be available.

Our task is twofold: (1) To work toward the implementation of the best attainable standards, and (2) to take the necessary steps to remove the constraints that prohibit us from further upgrading standards.

There is no magic solution. The promise of better care must be matched by the commitment of the resources necessary to achieve it.

Fire safety in nursing homes continues to occupy much of the spotlight of public attention. ANHA continues to urge responsible enforcement of statutory requirements in the area of life safety from fire.

We have been distressed by the failure of State and Federal authorities to expedite certification procedures in a timely manner. The result of the failure has been to create uncertainty among providers and patients alike.

Threat of Decertification

Many facilities that have met all requirements have found that they face the threat of decertification because of delays and mishandling of paperwork by the responsible agencies.

Similarly, susbtandard facilities have been allowed to continue operation unlawfully because of delays, mistakes, and lax enforcement. This situation must not be allowed to continue.

An immediate priority for legislative action should be the enactment of an FHA-guaranteed loan program to assist facilities in the installation of needed fire safety equipment.

Such a program should not be directed toward keeping older substandard facilities in operation. There are, however, a large number of facilities which are providing quality care every day of the year, and which are relatively modern facilities in their own right, that lack specific items of equipment required to maintain compliance with Government standards.

Facilities that qualify should be assisted in obtaining necessary financing for sprinkler systems and other fire safety equipment.

We believe that it is in the public interest to provide this assistance through loan guarantees.

ANHA is grateful for your efforts to secure passage of this legislation, Senator Moss, and we urge you and your colleagues to do whatever is necessary to see this legislation through before adjournment this year.

Time is now of the essence as many homes will only be granted a limited phase-in period to achieve full compliance.

In point of fact, Mr. Chairman, our discussion of regulations for skilled nursing facilities is directed toward a minority of the patients and residents in nursing homes.

There are today approximately 1 million individuals institutionalized in long-term care facilities. By the year 2000 this number will double. The vast majority of these individuals will spend their remaining days on this planet in a nursing home.

Mr. Chairman, I believe it would be helpful to examine briefly the characteristics of these individuals because those characteristics are changing.

While we have constructed Government benefit programs based on a derivative of the acute-care hospital model, we are finding that most of our patients don't fit that model.

While the emphasis continues to be on establishing the nursing home as a less expensive alternative to hospitalization, we have forgotten that there is more to health than medical care.

Nursing Home Patients Statistics

The Public Health Service has developed some enlightening statistics on nursing home patients. Their characteristics are changing. We are getting more mentally ill patients, mental retardants, disabled patients, and stroke victims at an earlier age, and more post-hospital convalescents.

The average age of nursing home patients is 79 years, but more significantly, 70 percent are women—and they are alone; 62 percent are senile; 17 percent have other mental conditions. On the average, these individuals have three or more chronic conditions.

The social characteristics of these individuals are also unique. For example, while 9 percent of the general adult population have never married, 32 percent of the people in nursing homes have never married. Loneliness has been a major characteristic of their lives, and that problem becomes enlarged in old age. Fifty percent have no surviving next of kin.

Nursing home patients and residents are typically very poor.

Sixty to eighty percent are on some form of public assistance. As a group, these individuals have had a lifestyle characterized by a pattern of social and economic failure.

One-third of these individuals get better, leave, or die within 1 year after entering a nursing home. But two-thirds of them stay from 1 to 5 years or longer.

It is clear, Mr. Chairman, that the people we serve are not a cross section of the general population. They have very special needs.

Given the special characteristics of this population and considering that many will be institutionalized for long periods, our challenge becomes much more than maintaining life. Our greatest challenge is to fulfill it.

That is why the acute-care model is insufficient. The purpose of the acute-care model is to maintain life, not to fulfill it. Hospital practice is characterized by short stays; it is populated by specialists and experts; the emphasis is on intensive care.

The aged, infirm, and chronically ill of this Nation require a coordinated national policy based on a total assessment of their needs. It would be a tragic mistake to continue to force nursing homes into the acute-care model by virtue of uncoordinated benefit programs that emphasize medical care.

What is needed is a coordinated service system which can meet the needs of individuals in institutions, in their homes, in community centers and day care centers, through outpatient facilities, through nutrition programs and with assistance in providing necessary transportation.

Mr. Chairman, that is the basis on which ANHA has proposed the Chronicare program.

We are pleased that Chronicare demonstration bills have been introduced by Senator Humphrey and by Congressmen Burke, Pepper, and Staggers.

We believe this total delivery concept should be tested and we are hopeful that such a concept will lay the groundwork for the type of coordinated national policy which this committee has such an intense interest in.

We see a great potential for nursing homes to expand beyond the traditional services normally associated with long-term care facilities.

ANHA looks forward to the opportunity of serving an important leadership role in that process.

Thank you once again, Mr. Chairman, for this opportunity to present our views to the subcommittee. We will be delighted to respond to any questions you may have at this time.

Senator Moss. I thank you very much, Mr. Barry, for that fine statement.

I commend you particularly in the last summary part, of which you point out that the great challenge is how to have fulfillment for these people, not simply maintaining life, if they can just extend their life, and yet they receive no fulfillment, and we have not really accomplished much of anything, and I am very pleased to have you explain the philosophy of the American Nursing Home Association, and your philosophy as to what we ought to be doing with our elderly, when we find need to have them in nursing homes, and Chronicare may be closer to what we need than many realize.

Now, these hearings have focused on the adequacy or inadequacy of proposed standards for skilled nursing facilities.

While it is a proper function of HEW to set forth standards, the nursing home it seems to me can exercise a leadership responsibility in this area, so I believe it would be helpful for the committee to know what the American Nursing Home Association is doing specifically, on its own, to assure that its homes are providing good standards of care.

ICF and Skilled Standards Needed

Mr. Barry. There are two or three areas. First of all, in hearing the testimony this morning in regards to the standards being drafted, both the ICF and skilled, we believe that they are needed; we believe this is the best way and quickest way to provide continuity of services and quality of care across the country. The various States, with their various standards, are no longer adequate to provide for the public need. To provide good standards, and to get them issued so we can go to work with them is probably the No. 1 priority.

Next in reply would be also in regard to the testimony given earlier discussion about the number of staff that are needed in nursing homes, and how to determine the number of nurses and nurses' aides, that are needed. For years and years, it is a question nobody has been able to answer satisfactorily, and providing the figure does not really do anything. We feel a project currently underway through our association called our peer review program, probably is the best answer.

For example, in the State of Minnesota, the peer review program works with the State agency, and whenever a home is not meeting the requirements as determined by a surveyor, or if the home feels it is treated arbitrarily, then the review appeals committee, consisting of officials going in and making their examination, assists the facility in raising its standards. If it is an arbitrary decision made by a health

worker, we try to get it modified so the conditions are acceptable. It is not really difficult, though we have heard witnesses say a survey cannot determine this. A trained surveyor can go into a facility and quickly determine if the patients are well-cared for, and if the patients are satisfied. The other area would be the JCAH, which is another avenue of voluntary involvement in homes to meet higher than minimal standards.

Senator Moss. Thank you.

I appreciate being advised as to what the association itself is doing, to try to improve the standards.

What is your general feeling about the adequacy of the proposed conditions of participation that you have been talking about here?

Mr. BARRY. As I mentioned a moment ago, we feel that the standards are definitely needed, in order to move forward. Of course, we do not have access to some of the changes that have been made as related by previous testimony, so those we are not privy to, but the standards as we are aware of them, we feel we can meet. We are concerned about some areas, if pushed too high, that there will have to be consideration given to the funding of those programs.

In general, we feel the standards are adequate, with the reservation we have not reviewed the new proposals.

Senator Moss. Of course, without the review, you could not very well answer specifically.

There are a great many requirements, however, that have been dropped from the existing standards in the proposed revision, as Val Halamandaris said we felt there was an effort to try to cut down on the expense.

What you are saying is, as I take it, that you think you can meet the standards provided the funding is adequate?

SPECIALISTS NEEDED IN NURSING HOMES

Mr. BARRY. I do not think there is any question that we can meet any standards, if funding is provided, given the opportunity to gather the resources, if and when they are available.

I think what we are interested in is trying to establish standards that are going to be realistic within the framework of finances that the Government can afford, and then when it comes to the personnel, which is the big area, as I referred to in the testimony, the need is to begin to get specialists involved in nursing homes. This is really quite new, and to find those people with experience willing to come into long-term care institutions is really quite difficult.

We would like the opportunity to bring graduates, professionals under licensing, and so forth, and begin working with them through inservice training.

We feel we can contribute greatly toward the education of these people in their meeting the requirements of the patients in the institutions.

Senator Moss. As a result of Public Law 92–603, reimbursement under Medicaid will have to be on a cost-related basis.

What is the position of the American Nursing Home Association, as to what an acceptable cost-related reimbursement system should be?

Mr. BARRY. We feel that a proper reimbursement system, or we would like to use the phrase "payment-for-service system," is based

on a budget projection, in that this brings to bear good management requirements of determining how financially the operation is developed. From a budget approach, you can develop a prospective rate that can be established within an area, and the payments-for-services situation can be taken care of.

We also feel by using this approach, there can be built-in incentives for good performance and good management. Last of all, and certainly not least, we feel that consideration has to be given toward a factor, after all expenses, for return on investment of capital, profit, growth, surplus, new program expansions, whatever you want to call it. That has to be recognized and identified along with all of the other expenses of a good business operation.

Senator Moss. Thank you.

Senator Clark, any questions?

Senator CLARK. Just one very brief one in view of the time problems.

As I understand it, the new regulations defined skilled nursing care very narrowly, that the vast majority of the patients will not fall within that category.

In my own home State, and we double checked these statistics, they seem astounding to me, but out of the 11,000 patients, residents, only 100 will be considered skilled according to our State officials, that is less than 1 percent.

In fact, that ends skilled nursing care in our State as I understand it.

Now, what effect does this redefinition have on your whole industry?

Mr. BARRY. Well, we are finding that with the new standards—I am talking about physical plant standards, the Life Safety Code, and so forth—if you were going to contemplate the construction of a nursing home today, the standards are basically the same, so that when you get the building completed and ready for occupancy, it does not make much difference, as far as the building is concerned, whether you have intermediate care patients or skilled care patients.

DOWNGRADING OF SKILLED CARE

As we expressed in our testimony, the concern we had is downgrading of skilled care, and this led to the discussion of what skilled care really means. For a variety of reasons, some States have developed programs that we feel are of value for the Federal Government to consider in identifying what are the needs of a skilled nursing home patient, and what are the needs of an intermediate care patient. These need to be incorporated into the standards to assure the general public that there is a difference between the needs of these people.

We also feel in the intermediate section, where it calls for intermediate care, with nursing, or without nursing, that perhaps "without nursing" aspects are something aside and apart from the needs of the patient needing intermediate care, and that sometimes there are expenses that may not be warranted.

Senator CLARK. We have just 99 counties and we have 100 patients, so we are going to average about 1 patient per county.

That would mean the end of skilled nursing care. No one is going to provide for one patient per county. It seems to me it is no longer practical to have such a program.

Mr. BARRY. We have the same problem, though not so exaggerated, existing today across the country, in that the nursing homes met the skilled nursing home standards, which are the Medicare conditions, even though 10 or 20 percent of the patients living there are skilled care patients.

The rest of them are all intermediate. I have not seen the new standards to determine how they are going to make the change on the definition of determining which case is which, but careful guidance has to be given that the two programs continue to exist, or we will have a melting of a group of patients being taken care of in a facility. Economically speaking, I personally would not feel this is a wise move, because we are geared now, for example, in a 100-bed facility, with a certain number of skilled care patients, and a certain number of intermediate, to staff accordingly and best provide for the needs of those patients. Historically, one of the problems we had in nursing homes was that we had patients living there all the way from someone who wanted a place to stay to the terminally ill. Part of the bad image of nursing homes is that they tried to take care of the needs of all of these people, and ended up not taking care of any of the needs. So we feel that specialization is important, and that the skilled nursing concept must be retained in order to provide quality care at an economic cost.

Senator CLARK. Thank you.

STATEMENT OF BRUCE D. THEVENOT

Mr. THEVENOT. I would like to extend Mr. Barry's remarks here.

I was here yesterday, and in noticing, and listening to the testimony of a number of witnesses, I think the point has been raised again and again, which we would like to subscribe to, that when we are talking about the skilled level of care as defined by statutes, we are really talking about a coverage concept, and not a concept that has much concern to a patient or a group of patients. That is why, in our statement, we raised the point that we have to have more than just a series of isolated, uncoordinated coverage programs.

We have to have a service system in this country that is based on a total assessment of the patient's needs, whether that patient needs to be institutionalized, or can be cared for at home. We feel that the establishment of this kind of program will reduce the need for so many people to be institutionalized.

I think the typical Medicaid patient is a case in point.

It is clear to me that if the proper kind of health service programs were made available to low-income people, at an earlier age, perhaps we could avoid the ultimate need for institutionalization as a last resort. We are here representing the nursing home industry, whose primary function is taking care of institutionalized patients, but we would be the first to admit that, taking into consideration the whole problem, institutionalization is really the last resort that we want to commit a patient to.

Now, there will always be those among us who will require that kind of care, and I am sure many out in the community now are degenerating both mentally and physically in their homes, and are at the mercy of the community and should be institutionalized. Nevertheless,

we cannot talk seriously about providing the kind of services needed unless we take the totality of the concept, and have a coordinated approach both in terms of benefits government programs provide and the system by which services are delivered.

Senator Moss. Thank you very much for that addition to the testimony. We do appreciate it, and we do thank you both for being with us today and giving us this testimony for our record.

Mr. BARRY. Thank you for the opportunity.

Senator Moss. Our next witness is Marilyn Schiff, director, nursing home ombudsman program, National Council of Senior Citizens.

Marilyn Schiff, proceed in any way that you see fit.

STATEMENT OF MARILYN SCHIFF, DIRECTOR, NURSING HOME OMBUDSMAN PROGRAM, NATIONAL COUNCIL OF SENIOR CITIZENS*

Ms. SCHIFF. Mr. Chairman and members of the subcommittee: My name is Marilyn A. Schiff. I am associated with the National Council of Senior Citizens, a nonprofit, nonpartisan organization made up of 3,000 affiliated clubs throughout the country with a total of 3 million members.

I am employed as national director of the nursing home ombudsman program, a program funded by the Department of Health, Education, and Welfare to help improve nursing home care by providing patient advocates for nursing home patients. My testimony represents the views of the National Council of Senior Citizens and of its executive board and members.

The National Council of Senior Citizens is extremely upset by the Department of HEW's proposed regulations which lower the standards for skilled nursing home care. The national council urges that Congress pass legislation to require HEW to adopt standards that will assure high quality of care.

Since 1971, improvement of nursing homes has been a priority issue for both the administration and the Congress. In 1971, President Nixon made two speeches, in which he acknowledged that many substandard nursing homes were receiving Medicaid and Medicare funds and in which he promised to take steps to assure better nursing home care.

In his speech of July 25, 1971, President Nixon stated that there was:

> One issue that I have directed be given special attention (at the White House Conference on Aging), perhaps more attention than any other, if one issue has to have priority. I refer to the need to reform the regulation with regard to nursing homes in this country.

In 1972, Congress passed Public Law 92–603, which included some of the President's specific proposals for improving nursing home care, and included other provisions also designed to improve nursing home care. To comply with Public Law 92–603, HEW has had to revise its regulations for nursing homes. However, in direct contradiction to the intent of Congress and of the President, HEW is attempting to revise the regulations to comply with the literal requirements of the new law, but at the same time, is revising its regulations so that overall, the standards will be lower.

*See appendix 2, items 1 and 2, pp. 2827–2838.

No Justification for Change

Let me cite first the most flagrant example. The current regulations for skilled nursing homes require that each patient be visited by a physician every 30 days. The proposed regulations published in the Federal Register on July 12, 1973, state that after 90 days, a physician need not visit a patient at any specified intervals. We find no justification for the change.

To be eligible under Medicare and Medicaid for skilled nursing home care, a patient must need "on a daily basis skilled nursing care . . . or other skilled rehabilitation services."

A person who needs skilled nursing care on a daily basis is, by definition, sick enough to need frequent medical care. Another reason for requiring physician visits every 30 days is that under the regulations other services may be given only if ordered by a physician.

For example, a patient's diet may be changed only upon a physician's orders, and therapy may be given only upon a physician's orders. Without frequent visits, a physician cannot keep abreast of a patient's changing needs, and the nursing home is prohibited from revising a patient's treatment plan in the absence of physician orders.

Several groups, including the American Medical Association, have proposed that the new regulations for skilled nursing homes require each nursing home to have a medical director. Such a requirement was incorporated in an earlier draft of the proposed regulations, but was deleted from the formal proposal published in the Federal Register.

The national council would support a requirement for a medical director if it was made clear that the medical director would be legally responsible for the adequacy of the medical care in the nursing home.

I have seen some proposals that limit the medical director's function to consulting with the nursing home and to giving advice on overall procedures in the home. This would not be sufficient to assure adequate medical care. As an alternative, we strongly urge that HEW be required by law to retain the requirement in the current regulation that each patient be visited by a physician at least once every 30 days, and more often if necessary.

The other crucial area of nursing home care is nursing services, and here, also, HEW's proposed regulations offer no protection for the patient.

One of the deficiencies of the current regulations is that they require a registered nurse to be on duty only 5 days, 40 hours a week. During the remaining 128 hours each week, which generally includes weekends, when emergency care is difficult to obtain, there need only be a licensed practical nurse in charge of patient care. This requirement had long been criticized as inadequate.

Congress anticipated that HEW would require a registered nurse to be on duty 7 days a week and in Public Law 92–603, Congress included a provision (section 267) stating that if a registered nurse was required by regulation to be on duty 7 days a week, HEW would have to waive the requirement for a weekend nurse in rural areas of the country, if a nursing home could show that patient care would not suffer as a result.

Contrary to expectation, HEW in its proposed regulations did not require a registered nurse 7 days a week even in urban areas that have an adequate supply of registered nurses.

The National Council of Senior Citizens feels strongly that a registered nurse should be required in a skilled nursing home 7 days a week and 24 hours a day, subject to waiver in rural areas having an insufficient supply of registered nurses, and we urge Congress to enact such a requirement, since HEW has failed to adopt such a requirement by regulation.

Staffing Ratios Should be Specified

In addition to the requirement for a registered nurse 24 hours a day, 7 days a week, the National Council of Senior Citizens feels strongly that the regulations should specify staffing ratios for the nursing homes. Failure to set staffing ratios is one of the deficiences of the current regulations that would be perpetuated if the proposed regulations are adopted.

Under the proposed regulations, a nursing home, regardless of size, need employ only one registered nurse 40 hours a week. During the remaining hours, the home must employ a licensed practical nurse. (If the home has more than 50 beds, the home must also employ a licensed practical nurse during the same shift as the registered professional nurse.) Beyond this, the proposed regulations have no standards relating to staff size. The only purported standard is that the facility should provide 24 hours nursing service which is sufficient to meet nursing needs. As a result, a 400-bed nursing home could be staffed by one registered nurse 40 hours a week and by one licensed practical nurse on each shift. The number of nurses aides would apparently be left up to the nursing home.

Obviously, in a home of more than 100 beds, there would be insufficient licensed personnel to perform the skilled nursing services needed by the patients, or even to direct the unskilled nurses aides in providing these services.

The national council strongly recommends that Congress require by law that HEW prescribe specific staffing ratios for nursing homes. The staffing ratios should specify separately how many nurses would be required, how many licensed practical nurses, and how many aides. And the standards should be sufficient to assure enough licensed personnel to provide close supervision of the nurses aides in providing services directly to patients.

I have discussed the two most flagrant deficiences in the proposed regulations. I would like to discuss the regulations in general and the reason the HEW's proposals will necessarily result in poor patient care.

Until now, the chief cause of inadequate nursing home care has not been the absence of good regulations. Except for the absence of staffing ratios for nursing personnel, the current regulations are good.

The current regulations specify the care that is to be given and sets reasonable, high standards. The reason for poor care is that these regulations have not been enforced. Study after study has shown that many of the requirements in the current regulations are not enforced.

Nursing homes continue to be certified as Medicare and Medicaid providers despite the fact that they do not meet the specific standards of the current Federal Medicare and Medicaid regulations and they continue to be licensed by the States despite the fact that they do not meet the standards set out in the State licensing laws and regulations.

A study by the General Accounting Office in 1971 showed that in more than half the nursing homes visited, the requirement that a physician visit a patient at least every 30 days was not being obeyed. The report found one home where physician visits were as infrequent as 200 days apart.

Aides Had No Informal Training

Despite an explicit requirement in the current regulations for in-service training to be conducted at regular intervals for all nursing personnel (sec. 405.1124(i)(1)), a recent study in Detroit found that more than half of the nurses' aides had had no informal training since they began their current jobs.

And in terms of enforcement, too, we need only cite the situation in Pennsylvania, where it was recently revealed that the State was not enforcing the fire safety regulations.

Yet another example concerns requirement in the current regulations that telephone orders from a physician must be followed by a personal visit from the physician within 48 hours and the telephone order countersigned at that time. A study of two nursing homes in New York during 1971 showed that only 14 percent of the time when a physician gave telephone orders regarding a patient did he follow up his telephone orders with a visit within the 48-hour period.

I could give many other examples. The same GAO study that found insufficient physician visits also revealed that half the nursing homes did not meet State staffing requirements.

In the area of eye care, the current regulations require physicians to give attention to "special needs of patients, such as foot, sight, speech, and hearing problems" (sec. 405.1123(b)(3)).

Despite the requirement, a project to diagnose vision problems funded by HEW in the State of South Dakota found that about 30 percent of the nursing home residents needed eye care and had not been receiving it.

A survey of nursing home patients in need of dental care in Wayne County, Mich., revealed similar data.

The statistics may sound dry, but in each case failure to enforce the regulations has meant that a sick, elderly person has not received the care he or she needs and is entitled to.

The report of the South Dakota vision screening project illustrates the human dimensions of the problem:

> Often nursing home personnel failed to comprehend what a difference improved vision can make upon the amount of care required for a resident. Personality changes often occur when the individual feels more independent and self-reliant, and his safety is better assured with increased vision. One administrator went to the effort of taking an 83-year-old-man to an ophthalmologist for cataract surgery. . . . The gentleman's whole attitude and personality changed. It was the first time the resident had been able to see himself in 3 years. His anti-social, beligerent attitude reversed itself. He found new friends, and started helping around the home. He had a new self-image, and could function as a competent, friendly human being once again.

Many screenings ended with a discussion . . . concerning the relationship of blindness and senility. Is blindness a cause of senility? It would be doubtful as a cause, but it appears that the loss of visual stimulus is a highly decisive factor contributing toward senility. The same symptoms, that is, disorientation, failure to recognize familiar objects and persons, lack of interest in their surroundings would be exhibited in either the case of senility or the case of gradual blindness. All too often, it is assumed that these changes in behavior are due to senility and not blindness.

Identification of enforcement as the crux of the problem has been uniformly recognized.

President Nixon acknowledged it specifically in his speech on August 16, 1971, where he stated:

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

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

President Makes Four Proposals

The President then went on to enumerate seven steps designed to improve nursing home care. Four of those were directly aimed at improving enforcement of existing regulations.

Those four proposals were:

(1) Institution of a federally funded training program for State nursing home inspectors.

(2) A proposal to Congress that the Federal Government assume 100 percent of the cost of inspecting Medicaid-approved nursing homes. This proposal was enacted by Congress in Public Law 92–603.

(3) Consolidation of all activities relating to enforcement in a single office within HEW.

(4) Request for funds from Congress to enlarge the Federal enforcement program by creating 150 additional positions.

All of these steps recommended by the President have now been implemented. Training programs have started; Congress has passed a law authorizing the Federal Government to pay 100 percent of the cost of State inspections of Medicaid-approved nursing homes; a single office was created within HEW to consolidate enforcement efforts; and additional positions were created in the Federal enforcement program.

These steps to improve enforcement of the existing nursing home regulations may have begun to have some effect. Then this summer, contrary to the prior emphasis, HEW issued new proposed regulations that were far weaker than the current regulations. In the proposed regulations, HEW has deleted most of the specific standards of the current regulations and substituted vague generalities.

For example, the proposed regulations require only "an active program of restorative nursing care" (section 405.1124(e)), and delete the current specific standards for restorative nursing.

Other similar examples are contained in our comments to HEW on the proposed regulations which we have appended to this statement.*

Under the proposed regulations, the functions of the registered nurse are vaguely stated, and encompass only administrative duties.

Under the current regulations, the registered nurse must "make daily rounds to all nursing units performing such functions as visiting each patient, reviewing clinical records, medication cards, patient care plans, and staff assignments, and to the greatest degree possible, accompanying physicians when visiting patients."

This requirement has been eliminated, so that the proposed regulations do not require any direct contact between a registered nurse and patients.

Turning to another area, the proposed regulations do not even purport to implement the revised definition of skilled nursing facilities contained in section 247 of Public Law 92–603 as institutions that provide "skilled rehabilitation services."

Instead of raising the standards to comply with the congressional mandate, the proposed regulations inexplicably delete the specific requirements of the current regulations that "therapists collaborate with the facility's medical and nursing staff in developing the patient's total plan of care" (current section 405.1126(c)(9)) and that "therapists participate in the facility's inservice education programs" (current section 405.1126(c)(10)).

Not Enough Therapy Provided

I know of no statistics in the area, but anyone familiar with nursing homes knows that therapy is not provided to nearly the extent that it is needed. To assure adequate therapy we need more stringent standards to make therapists focal figures in nursing homes and to prescribe a minimum number of hours for consultation by each type of therapist in relation to the size of the facility.

The proposed regulations are also deficient in the standards for training of nursing home staff.

President Nixon in his August 1971 speech recognized that "in too many cases, those who provide nursing home care—though they be generally well prepared for their profession—have not been adequately trained to meet the special needs of the elderly," and he directed the Department of HEW to institute training programs for nursing home employees.

In face of this, the decision by HEW to dilute the standards for staff training, and specifically to eliminate the current requirement for training in "simple restorative nursing procedures" (current section 405.1125(i)(3)) seems inexplicable.

Another area of serious concern to the National Council of Senior Citizens is the failure of the proposed regulations to require that information about the operation of nursing homes be made available to the public.

Congress recognized the need for public information and provided in Public Law 92–603 that inspection reports of nursing homes be made available to the public (section 299D) and that the names of owners of nursing homes also be disclosed (section 246).

*See appendix 2, items 1 and 2, pp. 2827–2838.

HEW has complied with congressional mandate, but has failed to require any public information beyond that specifically mentioned in the law.

There is much information about the operation of nursing homes that could be made available to the public without jeopardizing the privacy of patients. Specifically, the proposed regulations require that nursing homes prepare policy statements describing their methods of complying with the regulations. The proposed regulations state that these policy statements need be made available only to "admitting physicians and sponsoring agencies" (section 405.1122(a)) but not to the public.

We would like to recommend that Congress require, by law, that all information about the operation of nursing homes—except information about specific patients—must be made available upon request to any member of the public. If this were done, public pressure might become a powerful tool for improving nursing home care.

Some of our concerns may appear trivial and overly involved in detail. But good nursing home care is the result of many detailed procedures being properly performed. To assure good care, we need strong, detailed regulations that are strictly enforced.

For the many nursing homes that now provide good care, strict regulations will not be burdensome. And for the homes that do not provide high quality care, strict regulations and strong enforcement are the only way to bring about needed improvement.

Proposed Regulations Contain Vague Standards

We cannot overemphasize our concern with enforcement. Currently, the care provided by many nursing homes bears little relationship to what the regulations require. Vague standards such as those contained in the proposed regulations cannot be enforced and will not contribute to good care.

In closing, the National Council of Senior Citizens urges that Congress review the legislation relating to nursing homes. Both the President and the Congress have expressed interest in improving nursing home care. Their efforts appear to have been thwarted by the proposed regulations.

We urge that Congress consider amending the legislation if the Department of Health, Education, and Welfare will not adopt strict regulations on its own.

Mr. Chairman, I have several people here who wish to also address the committee.

Senator Moss. We are glad to have these people here to listen to our hearings and to address us, and we are glad you brought them along.

Ms. Schiff. Let me make some additional comments which relate to my prepared statement.

While I am pleased by the announcement this morning by HEW, that they are going to propose a registered nurse be on duty 7 days a week, that doctors visit the patients regularly, I am still very, very much concerned that the proposed new standards for nursing home care are still lower from the standards we have had in the past.

Senator Clark. Let me ask you if you were present when Mr. Newman talked about just exactly what you are talking about, the regulations, and what they meant to the Department up to this point, and in

fact now they expect to have people obey the letter of the law, and we have thrown a lot of light on why it is important that those regulations be enforced.

After all, they have no value if they are not enforced, and I am just a bit skeptical of the idea, that before we had regulations not enforced, and now we are going to have regulations that we will enforce, but I think the examples you cite are excellent in terms of the needs to do so.

Miss SCHIFF. I was interested in the comment before where he said before the standard was substantially in compliance. What I was citing was known to the Department, and anyone that reads the literature, it is far from substantial compliance.

President Nixon gave particular emphasis to the problem of enforcement. I quoted his statement in my prepared statement which I just read to you. In the comments to HEW on the proposed nursing home standards, we quoted this statement from the President, and said the President has promised not to subsidize substandard nursing homes, and the Department seems to be meeting this challenge by lowering the standards.

If enforcement is required, then good regulations are needed to provide that enforcement. How can you find out whether care is given, whether it is needed?

If you have a regulation, an inspector must go to the home, look at every patient's chart, must have a doctor come in to examine the patient. How do you know if it is needed?

To be able to enforce regulations, if we are going to enforce them, we need very, very specific requirements.

Without spending full time in the home, an inspector should be able to get an idea whether the home is meeting the standards. If you have specific staffing ratios, is the home meeting it?

I do not think it is as easy as some other people were saying, for somebody to come in a couple of hours, and find out whether a home is adequately staffed or not.

Specifically, it is the staffing ratios too. I would like to comment on the Department's decision to require a registered nurse 7 days a week.

REGISTERED NURSE—24 HOURS A DAY

I am pleased by that, but I do not think it goes far enough. I know that the council and its members are concerned about nursing care. We would like to see a registered nurse in the home 24 hours a day. Patients do get sick at night. Also, the national council is very concerned by having enough registered nurses.

If one registered nurse were required in the home, it means there would be one registered nurse in a 50-bed home, and also one registered nurse in a 400-bed home.

I am very concerned that in the 400-bed home, that one nurse will not be enough to provide for skilled nursing patients.

The Department seems to be recognizing the importance of having a registered nurse. I do not know how you can claim to recognize the importance of a registered nurse without giving some ratio:

How many patients can a registered nurse treat? I would like to give some examples of what the Department seems to consider as excess verbiage that was deleted in the proposed regulations.

Restorative nursing is something crucial to the care of skilled nursing home patients, many of them stroke victims.

The proposed regulations provide an active program of assorted nursing care. They delete the specific requirements in the current standards which state what restorative nursing is.

Restorative nursing is defined in the regulations, and I have it outlined in my prepared text. We do not think that language is excess verbiage. We think it is important to have it in there, what restorative nursing is.

There is another very curious omission. The current regulations require that the registered nurse make daily rounds to all nursing units, performing such functions as visiting each patient, reviewing clinical records, medication cards, and staff assignments, and to the greatest degree possible accompanying physicians when visiting patients.

The proposed regulations delete this requirement.

The functions of the registered nurse in the proposed regulations are totally administrative. The registered nurse need perform only administrative duties, and there is no requirement that the registered nurse have any direct contact at all with patients. She supervises other people, but she does not see patients.

I assume in most nursing homes, despite the lack of specific requirements, a registered nurse would have at least occasional contact with patients, but if there is insufficient contact, we need a specific requirement so that an inspector can say here is the requirement.

You have only a vague standard saying nursing care is needed. There is nothing specific if you want to cite a violation.

We are also concerned that various positions regarding therapists have been deleted in the proposed regulations. Specifically, one of the positions deleted is that therapists cooperate with the medical and nursing staff in developing the patient's total plan of care.

Also deleted is the position that therapists participate in the facilities of inservice education programs.

These are two very specific things. These would be very easy for inspectors to check up on.

Was there inservice training? Did the therapist participate? How many of the aides attended?

Even if you can claim this is encompassed in a general requirement for therapy, there is no way of checking up on whether it is being performed, or if citing it is a violation if it is not performed.

Training Requirements Deleted

Similarly the training requirements have been deleted. There is no longer any specific requirement for training and simple restorative nursing procedures.

I would like to shift to a slightly different area now; the area of public information about nursing.

The proposed intermediate care facility regulations have a provision in there requiring that all information regarding an operation of a home be made available to the public. The provision did not include patient information, but just what the home's policies are on carrying out the regulations

The proposed regulations for skilled nursing homes contain a requirement that the home have policies describing how it will meet each of the requirements in the regulations, but the proposed regulations for skilled nursing care said only that those policies must be made available to attending physicians, and to agencies that recommend people to the home. There is no requirement that those policies be made available to the public.

Congress in Public Law 92–603 recognized the public can be a powerful force in getting better nursing care, and it required that inspection of nursing homes be made available to the public.

Certainly the policies of the home itself should also be made available to the public, so that patients, families, and other members of the public can find out if the home is doing what it says it is doing, and, if not, they can be there to bring public pressure.

I would like to also discuss briefly the ICF regulations—the national council has heard, as you mentioned earlier, that the ICF regulations are being gutted, the way it was described, that all of the specific requirements are taken out. We are very, very concerned.

You have heard that there will be no more dietitians, consultants, and so on, as the Department is planning to issue them. We would hope at the very least that HEW would give the public an opportunity to comment on its new proposals for intermediate care facility regulations, before it comes out with them in final form, because what we have heard is that they are thinking of doing now is so different from what they proposed in the "Federal Register," that we did not comment on it, and had no opportunity.

If it is at all within the power of this committee, if they could make a similar request of HEW, we would certainly appreciate it.

I think I will close now, and just again would like to reiterate our concern with enforcement, and, therefore, our concern with detailed regulations. Only if we have them, can the care in nursing homes correspond to what the regulations say.

Thank you.

Senator Moss. Our next witness is Marilyn Rose, Washington counsel, National Health Law program.

Marilyn Rose, proceed in any way that you see fit.

STATEMENT OF MARILYN G. ROSE, WASHINGTON COUNSEL, NATIONAL HEALTH LAW PROGRAM*

Ms. Rose. Thank you, gentlemen, for the opportunity to address you today. My name is Marilyn Rose, and I am Washington counsel for the National Health Law program, which is the legal service backup center specializing in health problems of the poor.

For the past 4 years one of the major areas of our concern has been problems of the poor in receiving full benefits under the Medicaid and Medicare programs.

We have been made acutely aware of the problems of the destitute elderly who reside in nursing homes, and the inadequacy of too many of these homes to meet the health and safety standards which Congress intended them to meet, and for which millions of dollars have been appropriated.

*See appendix 3, p. 2839.

My comments shall be brief, in recognition of the limited time this committee has to hear the witnesses, and the fact that much of what I have to say has been stated.

NHELP fully endorses the comments of the National Council of Senior Citizens in this regard.

I would like to put into the record a copy of the comments which my colleagues in the Los Angeles office of NHELP sent to the U.S. Department of Health, Education, and Welfare, concerning the proposed regulations.*

Basically, those comments detail the areas covered by the current Medicaid regulations, and indicate the deficiencies in the proposed regulations.

Clearly there has been a diminution in health service standards to be required of skilled nursing homes.

Matters such as the frequency of physician visits, training of nursing personnel for provision of retroactive services, physician orders for therapy, and the formulation of a plan for the duration of care are either diluted or deleted from the proposed regulations.

Concern for Fire Safety

With respect to safety, specific requirements for fire safety existing in the current regulations are not set forth in the proposed regulations. The danger of fire in multistoried buildings for persons who are ambulatory is a general concern in our society.

For nursing home residents, it is a horror. Too long have nursing homes been able to escape their responsibility in this regard on the argument of "unreasonable hardship upon a skilled nursing facility" to use the language in the proposed regulations.

Aside from these defects, which have been quite adequately discussed by prior witnesses, and are covered in the comments which I am submitting for the record,* there is one additional matter which I would like to discuss. The underlying assumption of these proposed regulations is that specific standards should be deleted, and in their stead generalizations be substituted.

For example, instead of the list of services included in the current regulations at section 405.1122(a) (1) and (2) with respect to patient care, there has been substituted a generalization that nursing homes have patient care policies "which . . . reflect awareness of, and provision for, meeting the total medical and psychological needs of patients. . . ."

Let me state, that as an attorney with litigation experience, I would have great difficulty establishing in a court of law that such standard was violated by a particular nursing home.

I do not know how the administrative personnel in HEW or the State agency are supposed to judge compliance with this standard, or act with any type of uniformity.

In my experience I have found that HEW and Justice Department attorneys agree with my analysis. In a case where HEW as well as certain hospitals constructed with Hill-Burton moneys were defendants, in context of enforcing a commitment that Hill-Burton facilities

*See appendix 3, p. 2839.

would afford "a reasonable volume of service to persons unable to pay," HEW took the position that "prior to the promulgation of regulations which further define the scope of the obligations, the Federal defendant cannot determine whether any of the individual defendants is violating the obligation." (*Cook* v. *Ochsner*, pretrial order, app. 6M, par. (d)).

We submit that the enforcement of the generalizations which HEW has substituted in skilled nursing homes regulations are at least as impossible to determine, and thus enforce. In reality, there are no standards whatsoever.

Mr. HALAMANDARIS [presiding]. Thank you for that fine statement. Thank you very much.

Ms. ROSE. Thank you.

Mr. HALAMANDARIS. Let me interpose here, Betty Cox has an appointment with a train, and she just has a short statement.

STATEMENT OF BETTY COX, PUBLIC AFFAIRS COORDINATOR, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION*

Ms. Cox. Thank you. I am Betty Cox, public affairs coordinator for the American Occupational Therapy Association, and I am also an association representative.

Before joining the AOTA I served as director of occupational therapy and activity programs at the Stella Maris Hospital in Towson, Md., a 400-bed facility providing skilled nursing, intermediate, and custodial care.

I appreciate this opportunity to comment on the conditions of participation for skilled nursing facilities, and in the interest of time I will only mention two of the issues that are of greatest concern to the members of the AOTA.*

Our first concern, and one that is shared by many of our colleagues in other fields, is that the requirement for coverage by a registered nurse during the day tour, 5 days a week, is inadequate to safeguard the health and well-being of patients in skilled nursing facilities.

The incidence of unexpected medical crises of an acute nature is by no means limited to weekdays between the hours of 8 a.m. and 4 p.m.

Another matter of considerable concern to the AOTA is that skilled nursing facilities, irrespective of size, will only be required to have one registered nurse on duty on weekdays. Although the proposed regulations do not prevent a facility from hiring as many nurses as may be required to adequately meet patient needs, we recommend that specific staff-patient ratios be established and included in Medicare regulations.

PATIENT ACTIVITY PROGRAMS

Another AOTA concern is about some of the proposed qualifications for patient activities coordinator. We think it highly unlikely that a single, 36-hour course will be sufficient to prepare otherwise untrained personnel to plan and direct activity programs for the aged and infirm,

*See appendix 4, p. 2843.

let alone fully understand and appreciate the many safeguards and precautions that must be observed when working with patients who require skilled nursing care or other specialized rehabilitation services.

Patient activity programs should be a part of the patient's life in a skilled nursing facility. It is crucial that patient activity programs offer more than bingo, movies, and other diversional pastimes. If planned and implemented in such a way as to meet individual needs and interests, activity programs can help to create an environment for living in which patients can maintain a sense of self-esteem, usefulness, and competence that is all to frequently stifled in many long term facilities.

Activity programs can also help patients maintain and increase vital self-care and daily living skills such as feeding and dressing at a time when these skills are being jeopardized by the aging process, by the patient's removal from the company of friends and family and by the unfamiliar institutional environment.

Accordingly, we strongly urge that proposed regulations be revised so as to stipulate that, if graduates of 36-hour programs are utilized, they must be supervised by an occupational therapist, a certified occupational therapy assistant, or a therapeutic recreator.

Thank you for this opportunity to speak to you.

Mr. HALAMANDARIS. We will now hear from Elma Griesel, representing Ralph Nader's Retired Professional Action Group.

STATEMENT OF ELMA GRIESEL, REPRESENTING RALPH NADER'S RETIRED PROFESSIONAL ACTION GROUP

Miss GRIESEL. Thank you very much.

I have a statement here which I will read to the committee.

My name is Elma Griesel. I am the coordinator of the Retired Professional Action Group. With me is Nancy Wilson who for the past year has been responsible for working with retired persons who have volunteered their time to work on issues which relate to nursing homes. We appreciate the opportunity to appear today to make our statement to the committee. Our comments are brief. I think it is quite appropriate that several of the comments of Miss Schiff and Miss Rose are similar to our own.

In our statement today, we will not dwell on the many ways in which the current regulations have been downgraded by the obvious disregard of patient needs for skilled nursing service and an adequate amount of medical care and patient rehabilitation. Also by the lack of appropriate attention to discharge from a facility and adequate fire safety measures. These inadequacies and others have been appropriately cited and discussed by other witnesses.

Mr. Nader's nursing home task force appeared before this subcommittee in December 1970 to address the many problems which it had detected in the nursing home field. Our primary reason for being here today is that Mr. Nader continues to receive a significant number of complaints about nursing homes from citizens around the country—complaints which indicate that there is every reason for continued citizen action regarding nursing home problems.

We did join with other concerned groups, individuals, and Government workers in a positive response to the administration's focus on

nursing homes in August 1971. As Miss Schiff has pointed out, the President made clear in his address of 1971 that no nursing homes should receive Federal funds which did not meet the standards provided by Federal programs.

Status and Responsibilities Unclear

Although our consumer mail has kept us very aware of the continual need for monitoring nursing home activities and enforcement of current standards, we must admit that we achieved some satisfaction in knowing that the administration had organized one office to "coordinate" Government activities and to take steps to promote the upgrading of nursing home care through higher standards and enforcement. At the very least, this action seemed to provide some leverage through which the public could hold the administration accountable for its proposals. Now, however, even the status and responsibilities of that office are unclear.

Last spring we again joined in welcoming the upgraded regulations proposed for intermediate care facilities.

Congress took action to upgrade the standards of skilled nursing facilities by mandating that the highest level of care to be offered under both the Medicaid program and the Medicare program be defined as one and the same. There were no instructions for the administration to make substantial changes in the type of facility or care to be provided in these facilities. However, it seems as if legislative action is now being used to the disadvantage of the consumer.

A review of the proposed regulations for skilled nursing homes, makes it obvious that in order to carry out this mandate, the administration has chosen, for perhaps cost reasons, to accommodate the nursing home industry to make it easier for them to meet the standards.

As the majority of the other witnesses who have testified, we were astonished, when we reviewed the proposed regulations for skilled nursing home care to find that HEW had taken several steps backward in its purported goal to upgrade nursing home care.

It was shocking to find that not only had provisions which related to the quality of care for the patient been diluted and changed from the specific to the general, but also in many instances, specific requirements related to the physical environment of the facility were dropped or diluted to the extent that one finds in many of the bare minimal State standards for nursing homes.

Mr. Halamandaris. We will now hear from Nancy Wilson, Retired Professional Action Group.

STATEMENT OF NANCY WILSON, RETIRED PROFESSIONAL ACTION GROUP

Ms. Wilson. Thank you very much.

With regulations so vague that professionally trained people—familiar with nursing homes—don't know what is specifically required, one can hardly expect the consumer or his family to be able to choose or to evaluate a nursing home intelligently.

Our consumer complaints over the past 2 years clearly indicate that consumers still have no idea what to expect from a nursing home. For

this reason, the Retired Professional Action Group has been considering various ways that consumers can become more informed about what to expect and how to subsequently demand the services promised to them by, or required of, a particular facility. It is clear that these proposed regulations cannot serve as an effective guide or tool for consumers to use. We believe that the nursing home has specific responsibilities to inform the consumer of exactly what can be expected, and we think the proposed regulations should include a provision for this.

We are aware that most nursing homes provide some type of patient-nursing home agreement when the patient enters the facility. But this type of agreement actually tells the patient or his family little about what to expect or even what his responsibilities are—other than his financial involvement. For this reason, we have been experimenting with the concept of a model contract between the patient and the nursing home—a contract that would provide specific information about what each party to the agreement is expected to provide.

To take a fairly simple example: We have many complaints about food service—particularly the time that patients are fed their evening meal. If the patient and his family signed a contract which specifically states that the evening meal will be served at 4:30 and the patient is consistently served evening meals at 3, he has something he can use to keep the home accountable for its promised procedures. To take another example, the agreement between the patient and the nursing home could include the ratio of nurses and auxiliary personnel to patients.

Evaluating Effectiveness of Nursing Home

In the absence of specific requirements that the patient be provided with such information, perhaps the regulations could be amended to at least include a requirement that each patient, or his representative, be provided with a copy of the nursing care plan and the discharge plan developed for him jointly by his physician, a registered nurse, and a qualified social worker. Such information could provide a specific goal toward which everyone can work and should provide the motivation for the patient to return to the community. At the same time, it will provide a basis for the consumer to evaluate the effectiveness of the nursing home.

We have no new comments to add to those made by other witnesses before this committee. In particular, we strongly support the comments made by Ms. Schiff who is as concerned with all aspects of patient care as we are. If you have any questions we shall be glad to try to answer them.

Mr. Halamandaris. I take it that most of you agree with me that the new regulations are a bit too general, and that if they were specific, they would be easier to enforce, is that correct?

Ms. Rose. Yes.

Mr. Halamandaris. You in particular, Miss Rose, are taking this position from the point of view of a particular lawyer, trying to prove a case in court. It would be pretty difficult to handle these general requirements.

Ms. Rose. And I think it is also, like Marilyn Schiff pointed out in her testimony, that you have an investigator from a State agency in-

vestigating the nursing home, what are the standards he has to judge if something is appropirate or adequate, there are not any.

Mr. HALAMANDARIS. The next question again is rhetorical, do you agree with me that these are significant losses, not minor items, in the new regulations? For example, if the patient who is able and wishes to do so, a patient who requests to see their clergyman, should have a specific right to do so, and I do not think you cover it by pointing it out in a general regulation which says a nursing home should look to the religious needs of their patients.

I think it is necessary to enumerate. One thing that is missing, even from the old regulations, is some sort of a patient's bill of rights. I think it should be put in.

I think this is a very gray area of the law. We have not really decided what is the rights of a nursing home patient, and I think unless somebody makes an effort to pioneer and define what are the rights and duties of people in nursing homes, we are going to have a lot of trouble in the future.

Ms. SCHIFF. I certainly share your concern about that. I would have to at this point commend the District of Columbia, in which in its proposed regulations for nursing homes, does have a patient's bill of rights.

The National Council of Senior Citizens recommended to HEW that they include a bill of rights in their ICF regulations, and as far as we know, that is not a change that is being contemplated by the Department at this time.

Also in line with that, a patient's bill of rights should also include all of the services that the home is required to provide, is that the patient has a right to demand those, and the patient knows what those services are.

This is the same point that Nancy Wilson was addressing before, to tell the patient what the regulations require of the home, so if the home does not provide it, the patient or an ombudsman can then make the demand.

Often patients do not know what they are entitled to.

RATING SYSTEM FOR NURSING HOMES

Mr. HALAMANDARIS. I just want to comment the Nader task force report was the beginning of serious study on problems of nursing homes. The Retired Professional Action Group has provided a fine example of care and concern for the rights of older Americans.

One of the recommendations of the Nader task force was that there should be consumer groups, ombudsman groups organized, and that they should publish a rating system for nursing homes.

I wonder if groups such as NCSC that have wide geographic distribution in terms of chapters and membership, could be given the responsibility to collect information about nursing homes and publishing ratings, thus providing a guide to persons who want to put family members in nursing homes?

At the present time, there is nothing to guide the public. In the law we talk about the purchase of so-called "blind items", such as a watch, where you do not know what you are buying, a nursing home seems to be a classic example, you cannot tell what is a good or bad nursing home by looks.

Would you share that thought?

Ms. SCHIFF. I certainly do. It is a very sad situation. I think anyone in the field gets calls all the time from people who need to refer relatives to a nursing home.

Where can I refer them, who can I call? I said you just have to ask knowledgeable people in the area about what is a good home.

The nursing ombudsman program has considered the need for ratings, and the National Council of Senior Citizens, it is a very time-consuming effort, and something that requires cooperation by a lot of nursing homes, because right now we cannot get across unless the nursing home decides to give it either to the home itself.

There is no members of the public allowed in, and again, there is no requirement we have access about how the home runs.

We cannot as a matter of right ask to see what their policies are.

Certainly there are not insuperable barriers, but it would be far easier for consumer groups to get involved, if public information were made available, and consumer groups could make it available to the rest of the public.

Mr. HALAMANDARIS. I have one last question, and then our staff director might have one.

The question, it is often debated, is whether the for profit system is inconsistent with good care. Would you care to comment on that?

It is a loaded question, and everybody wants to stay away from it. Is there anything inconsistent in making a profit and giving good care?

Ms. WILSON. I do not think it is inconsistent. I think in lot of cases, the reimbursement system has not been thought out carefully enough to take into consideration all the factors involved in good patient care.

I think when a nursing home can just lump together patients requiring all levels of care, it may then decide not to admit a patient who requires a large amount of care. The patient who is largely bedridden, requiring a lot of care, costs more to care for than patients who do not need quite so much care.

When the nursing home obviously works less with the patient who does not need much care, and the reimbursement rate is the same as for a totally bedridden patient, it is not fair to the nursing home or to the patient.

If the Government sets a basic rate which allows for profit when a nursing home provides a full range of nursing care and rehabilitative services, nursing homes which cannot provide this full range of care would be excluded from participation.

CONSCIENTIOUS HOME PENALIZED

If the regulations do not require a high level of performance on the part of all nursing homes, a conscientious nursing home, which tries to provide complete care for its patients, is penalized in terms of profit while an unscrupulous nursing home might be making money hand over fist by cutting services—and therefore, costs.

As I recall, the Connecticut system bases the per patient payment level on facilities and services provided by the nursing home. I'd like to see that system combined with one—such as the Illinois system—which considers the specific elements of care required by each patient.

But, even under the present system, as long as the nursing home is conscientious about providing each patient with adequate and appropriate care, I don't see any problem with allowing that nursing home a profit.

Ms. ROSE. Well, I have a gut reaction that I am against profitmaking systems in the health industry.

I am very much against it in the hospital industry, but I think it is more complicated than should there just not be a profit in health care.

There could be an argument the nonprofit institutions also make a profit.

They just direct the profit into capital accounts for building expansion and other items like that.

I think the key is not so much the profitmaking, which I still am against, but what kind of regulations do you have, what kind of review do you have of services, who owns the profitmaking institution you are talking about, a hospital or a nursing home, and is there a built-in conflict of interest to give a lesser degree of care, because the owner may be the doctor, who owns the nursing home, he will be able to make a bigger profit.

Mr. HALAMANDARIS. Thank you.

I would like to introduce our staff director, Bill Oriol, who has a few questions.

Mr. ORIOL. I would like to join Val in thanking this panel in getting over so much information in such a brief period, and I would like to ask Ms. Schiff a few questions about the ombudsman program.

These hearings are in the nature of a wrap-up to years of hearings, and I think it is important that our final record has as complete a statement on what the ombudsman program has achieved, in what, about 2 years?

Ms. SCHIFF. Just slightly over a year now.

Mr. ORIOL. So for the hearing record, as quickly as you can give it to us, can you give us a written report, and for this occasion, can you just tell us about some of the significant trends or achievements that have occurred thus far in the program?

Ms. SCHIFF. The contract between the National Council of Senior Citizens and HEW requires that we get written permission from HEW before we discuss the results of our programs, so I will not be able to give you any specific results now, however, I would like to see——

Mr. ORIOL. Let me ask you, you cannot tell Congress what you are doing? Why not?

Ms. SCHIFF. I can say there is a concern about privacy with the things that we are doing in our function as ombudsman. It has a new function. It is a demonstration. The Department is concerned in keeping closely in touch with what the programs are doing.

Mr. ORIOL. We are not asking for final conclusions, or descriptions of your method of operation, and some of the findings, and if a written request will help, we will certainly make it.

Ms. SCHIFF. We will have to make the request. I am sure that there will be no problem in having it granted.

PROGRAM DERIVES FROM PRESIDENT'S SPEECH

First, I would like to say our program derives from one of the President's 1971 speeches, where he specifically recommended that

HEW establish a program to have people go into nursing homes and find out what was going on. Our program is doing that, we are operating in the State of Michigan now.

We collect complaints from the different people who call in, and we also send volunteer ombudsmen into nursing homes.

We have gotten permission from many nursing homes to have our ombudsmen go in, and we find out from the patients if they have any problems, and we do our best to solve them.

I think we are doing a very good job. The nursing home care is something given to individual people, and, however good a home is, however good the system, individuals will have specific problems, and we need ombudsmen for that.

What we have is that ombudsmen are not a substitute for good strong regulations.

Mr. ORIOL. It also strikes me if we had a patient's bill of rights, or if we had a contract for each patient as they entered, they would need an ombudsman, because the patient is in no position to see that that contract or bill of rights is really brought about.

Who speaks for the patient? You do need someone.

Ms. SCHIFF. Especially, because the patient is sick, he lives in the home, he has no power, and the patient is very fearful of reprisals, often needlessly, and adjusts the total dependency of the patient creates an unhealthy situation.

Mr. ORIOL. Like so many tenants in public housing, they are afraid to make a complaint, and there has to be a method to see that these promises are kept.

The Philadelphia Geriatrics Society, Elaine Brody representing them will testify later, but on this matter of explaining what services can be expected in a long-term care institution, what steps were taken in the Philadelphia Geriatric Society, we will hear from them on that.

Mrs. BRODY. The professional social staff there feels that this issue is one of the major responsibilities.

The first moment somebody is considering entering the nursing home, part of the worker's job is to advise the applicant what his entitlements will be, and what he can expect.

All through the period of his time in the home, he should have the right to certain services. This is a major function of the professional social worker by tradition, by training, by actual function on the job.

Mr. ORIOL. Do you feel that the patient himself has this complete understanding of his needs from the interview at the time of entrance?

Mrs. BRODY. I do not think an interview does it. I think it has to be a constant program of day-to-day orientation, of rights, responsibilities, and so on.

There are things that come up in the care of the elderly people on a long-term basis, every minute of every day, this way they require somebody to help them to obtain these services.

Older people have fewer resources of their own with which to do that. They are more fragile, sometimes they have brain damage, and they certainly require more of that than anyone of us.

Mr. ORIOL. How many social workers do you now have?

Mrs. BRODY. We have 10.

Mr. ORIOL. And what is your total of patients?

Mrs. BRODY. 340 people. But, of course, I would like to qualify that, because it is so important that people have service at the time of appli-

cation to avoid unnecessary institutionalization and to explore resources that may come into play. We therefore see many, many applicants and help them to make other plans. We do not want anyone to be admitted to the institutions unless it really is the place for that particular person.

Mr. ORIOL. Is the Philadelphia Geriatric Center unusual in the number of social workers that you have, and in the services that you offer?

TREND TOWARD USING SOCIAL WORKERS

Mrs. BRODY. I think we probably are. The trend has certainly been to use social workers more and more. There are, of course, many, many fewer proprietors who use social workers.

Mr. ORIOL. The voluntary workers, of those, are they volunteer nonpaid?

Mrs. BRODY. No; these are all salaried people. We also use volunteers who work under the direction of the social worker staff.

Mr. ORIOL. So you do get useful volunteer help?

Mrs. BRODY. Yes.

Ms. GRIESEL. I would like to respond to that.

I think you are familiar with Ms. Violet Bemmels, one of our staff associates who lives in the New York area. She acts as a consultant 1 day a week in a nursing home.

Her experience has been in a nursing home which is purported to be one of the better facilities in the New York area. They have on staff what they call social worker on a 5-day basis every week. She is not a trained social worker.

I think Ms. Bemmels started her consultation there last year. When she started that particular job, it was a requirement that the facility have a consultant social worker. When she went into the facility, she checked all of the patient records, and she found that the patients' records indicated they were very satisfied with the facility.

Yet when she started actually making the rounds of the facility, and talking with the individual patients, she found that the majority of them were very dissatisfied with their placement. She found that many of them should not have been in a nursing home at all. They should have been at home.

She confronted the administrator of the home with this fact and asked, what had been the social worker's responsibility in the home, and the administrator said that the responsibility of the social worker was to keep the beds filled. Ms. Bemmels found that amazing. Her orientation is that the social worker's function is not to see that the beds are filled, but to see that the patient does have the right place, and if not he should be transferred elsewhere.

After talking with Ms. Bemmels about her experiences, we were very concerned about the lowering of standards for social services in nursing homes.

Mr. ORIOL. Ms. Bemmels is a retired registered nurse?

Ms. GRIESEL. Retired social worker.

Mr. ORIOL. Did she visit many other nursing homes and get the same picture?

Ms. GRIESEL. Yes. She has worked in nursing homes for several years as a consultant, and this has been her experience in most of them.

Mr. ORIOL. Thank you. I would like to ask Ms. Schiff, you made the point before that your program springs from the President's 7-point program, and some of you have to have a close-working relationship with whoever is in charge of that program, and I would like to echo Senator Moss' question of yesterday, who is now in charge of that program?

Ms. SCHIFF. I am not sure. I called someone yesterday from the office of Nursing Home Affairs, and the telephone is still answered in Ms. Calender's office.

Mr. ORIOL. And Ms. Calender has moved to the Administration on Aging?

Ms. SCHIFF. Yes, so I have heard, and Mr. Michelsen is Acting Special Assistant for Nursing Home Affairs. I have never been able to figure out what it is.

NO WATERING DOWN OF COMMITMENT

Mr. ORIOL. The Commissioner of Aging has said from time to time there will be no watering down of the commitment to that 7-point program, but it seems from your comments, there is some uncertainty at the present time.

Ms. SCHIFF. The Office of Nursing Home Affairs which was one of the President's seven points, placed with HEW, would be primarily concerned with nursing home matters, that is somewhat of a static situation now, but I would like to add that Dr. Flemming does seem to be doing his best to assure that the Department does keep up its commitment to nursing home affairs.

That is not his position, but he has spoken to the National Council of Senior Citizens, and he is directly concerned with nursing home matters.

Mr. ORIOL. In addition to the Commissioner of Aging, Dr. Flemming also has an interagency coordinating function which should help us.

I would like to address one general question to anyone on the panel who wants to comment on.

Quite often, nursing home operators complain the level of reimbursement on the State level is too low for them to give good service.

What are your views on this? Do you think the levels are generally high, or just or what?

Ms. WILSON. I would like to make a comment on that.

I think until nursing homes adopt some standardized form of cost accounting and reporting, there is no way that question can be answered intelligently.

For example, a nursing home owner could have gotten a second, third, or even fourth mortgage from family members. The nursing home could own the pharmacy which supplies it with drugs and medical supplies at exorbitant prices. Or, it might have a superior—and very well paid—staff. Any one of these three nursing homes might find the level of reimbursement too low to show a profit.

However, it is pointless to speculate on whether the level of reimbursement is right until a standardized accounting form is adopted.

Ms. SCHIFF. I think in some States, it is clearly too low to provide good care.

Mr. ORIOL. How do you know that?

Ms. SCHIFF. I do not recall specifically what the reimbursement rates are, or what the specific States are, but I think in some of the Southern States, the reimbursement rates I have heard is such that you could not provide good care with that.

Perhaps an indication of whether the reimbursement rate is enough, is whether the profitmaking nursing homes are expanding in certain States, and if they are, they are making profit, and if they are not, maybe there is enough to provide good care, but there is not enough reimbursement to provide good care.

I think though to echo Nancy's comment, the auditing of nursing homes has not been done nearly close enough.

SOME ADMINISTRATORS GET FRINGE BENEFITS

I have heard of many, many administrators who get very valuable fringe benefits from their homes in addition to their salary, and I have been told by some these are not reported as fringe benefits to the administrator, but are accounted for in other ways.

I think like some of them are supplied home supplies, they have cars for their personal use provided by the home, and things like this, and that is not firsthand information, but it is from talking to a number of people that these things go into play.

Mr. ORIOL. Are you talking about nonprofit that are providing these fringe benefits?

Ms. SCHIFF. I have heard it both, profit and nonprofit.

Mr. ORIOL. What are the fringe benefits you are referring to?

Ms. SCHIFF. I have heard of cars and housing specifically.

Ms. WILSON. Some of the drug companies give premiums, such as cookware and things like that when the nursing home orders a certain quantity of drugs.

Mr. ORIOL. I have no further questions. Thank you.

Mr. HALAMANDARIS. I have no further questions for this panel. Are there any comments before we call our next witnesses?

Thank you all for appearing.

Ms. SCHIFF. Thank you.

Mr. HALAMANDARIS. Our next witnesses are Raymond J. Benack, M.D., founder of the American Association of Nursing Home Physicians, and J. Raymond Gladue, M.D., president of AANHP .

STATEMENTS OF RAYMOND J. BENACK, M.D., FOUNDER OF THE AMERICAN ASSOCIATION OF NURSING HOME PHYSICIANS*

Dr. BENACK. I am Dr. Benack, first president of the American Association of Nursing Home Physicians.

I am also medical director of Bel Pre Health Center in Silver Spring, Md., and a practicing physician in Silver Spring, Md.

Also with me is Dr. J. Raymond Gladue, who is the medical director of Jenkins Memorial Hospital in Baltimore, Md., and current president of the American Association of Nursing Home Physicians.

Today, rather than read my formal statement** on the subject to be

*See appendix 5, p. 2845.
**See prepared statement, p. 2788.

discussed, I am prepared to give a synopsis of the information I have submitted to this subcommittee.

In 1967, I introduced a concept of a medical director for nursing homes at a meeting of the Maryland Medical and Chirugical Faculty.

The reason for this concept, was the fact that after 40 to 50 years of existence, nursing homes were brought out of the shadows of medicine, and placed into an active role into the long-term care of the chronically ill.

This meant that the medical profession would have to assume a greater role in this program of total care.

The nursing home is the last institution of medical care that does not have formal medical staffs, and in fact, it had no formal medical program.

Up until 1966, most nursing homes had a physician who would be available for emergencies. His only compensation in most instances was first choice of those patients admitted to the facility without an attending physician. His compensation in other words was patient referral. This introduces a system of back scratching.

Furthermore, in 1966, we introduced the nursing home physical therapy, occupational therapy, regular physician visits, all of which have not existed previously.

There needed to be some medical supervision of all of these programs.

Responsibilities of Medical Director

Initially, the Maryland Association of Nursing Home Physicians, introduced some basic responsibilities that we felt a medical director should assume in his role as principal physician, primary physician, whatever his title might be, for that institution.

In 1971, all physicians in the State were advised by the medical disciplinary committee that we are responsible for filling these obligations, whether or not we have a contractural agreement with that nursing home, and that we would be held responsible for any deficiencies.

It became apparent to me at that time, that this compensatory mechanism of patient referral was not a very good system of reimbursement, if you want to call it that, of the medical director, if he was to assume these responsibilities.

It was on this basis that we developed the philosophy of a paid medical director in the absence of a formal medical staff.

Our recommendations were then submitted to the American Medical Association, and after a series of 10 to 13 meetings throughout the country, the American Medical Association, this year, recommended the concept of a medical director in nursing homes be approved in the absence of a formal medical staff.

The question has been asked repeatedly, "what does it cost, how much time must he spend, who is going to pay for it."

It is estimated that it will cost between 35 and 50 cents per patient per day to have a paid medical director in an institution.

The amount of time he devotes to that institution is proportional to the size of that facility.

We already have existing in certain facilities, primarily the nonprofit facilities, medical directors, who are paid on a full-time or part-time salary, and from this information, we were able to come up with at least an anticipated cost figure.

Furthermore, we also found out that in the 100-bed institutions, the medical director was spending 8 to 10 hours a week taking care of medical administrative duties.

These were not directly related to patient care of his own patients, but overall administrative duties for which he would not bill individual patients.

In the larger 200- to 250-bed facilities, there are full-time medical directors, who would be administratively responsible for assuring high quality medical care.

The fact remains that as the standards were proposed, on July 12, we stepped back almost 10 years in time, we removed the medical director concept, we removed the primary physician, all we required is that there be a physician that served in an advisory role.

The physician would not any way be actively involved necessarily in medical policies of the institution, or in insuring the allied medcal services were adequate.

Formal Medical Staff

It is our feeling that rather than step back, we should step forward and get away from this compensatory referral system for reimbursement of medical directors, and get into the philosophy of a formal medical staff, or a paid medical director, who would have definite duties to perform.

His role is not only in just making sure these things are done, but the very presence of a physician in a facility will help him in many ways. He would encourage the staff to take a more interested role in patient care.

A physician does not care about the patient, the staff does not care about the patient. If the physician is there, they know that the medical profession is interested in the patient, therefore, the nurse's aid, dietitian, physical therapist, will take an interested role, they will try to improve patient care. Without the guidance of a medical physician, they cannot do it.

Furthermore, this medical director can investigate and evaluate medical programs for nursing home patients. He can develop research medicine in nursing homes. He can develop new programs of individual care to certain illnesses.

In medicine today, we have a very poorly defined area of geriatric medicine, yet we have geriatric problems.

It has been mentioned today that nursing homes are getting more and more psychological problems.

This is true. Senility is not a reason to put people into mental institutions. Senility can be cared for in nursing homes.

It is a problem that can be handled for the nursing homes. It presents a whole new era of patient care in patient homes.

We need research on drug therapy for this problem.

By placing a medical director in these institutions, he has more to do than just sit there and make sure everything runs smooth.

He will have the opportunity to investigate, to evaluate, and propose new medical programs for the aged.

He will also stimulate a certain responsibility upon the other physicians in the community, to care for their patients in that institution.

As it existed in the past, many patients, and I say the past, prior to 1966, many patients were seen maybe once a year by their physician.

He came in only in an emergency. They were truly patients who came into the institution to die. Not much was done to prevent or to cure illnesses that may occur.

Preventive Medicine Necessary

The nursing home patient has not only the right to a useful life, he is also entitled to that medical care that will prevent the unexpected and unnecessary illnesses that might occur, such as bed sores, pneumonia, and urinary tract infections.

These can be prevented by regular physician attention. When the physician comes in after the bed sores are developed, he is accomplishing very little. If he is in there to make sure the patient is turned regularly and treated properly, he has accomplished a lot more.

The regular examining of the patient is the answer.

Physicians by nature are interested in acute illnesses.

They like the challenge. They sometimes, by and large, are not interested in what is ultimately going to happen, and they may not be interested in how that will happen, therefore, the chronic disease patient does not always attract the interest of the busy private physician.

We have a group of physicians who are actively involved in nursing homes, who are both in private practice, who are also medical directors, and who are not just interested in patients, but who are interested in the care of these patients, and who do try to develop new techniques and therapy. It is erroneous to encourage that physicians can come in every 90 days as they see fit. It is not a step forward, it is a very rapid step backward. Therefore, it is our recommendation that not only the medical director concept be incorporated into the skilled nursing home regulations, but that it includes at least the recommendations of the American Association of Nursing Home Physicians, and the American Medical Association. Furthermore, we recommend that they continue to require physician visits at periods of every 30 days, or sooner, if medically necessary, but not any less frequently.

Thank you, sir.

Mr. Halamandaris. Thank you. Your prepared statement will be inserted in the hearing record.*

Dr. Gladue, do you have any comments?

STATEMENT OF J. RAYMOND GLADUE, M.D., PRESIDENT, AMERICAN ASSOCIATION OF NURSING HOME PHYSICIANS

Dr. Gladue. Let me make some brief comments. These are supplemental to what Dr. Benack said. They refer to the medical director. There have been three arguments given why we should not add medical directors, and I think you have heard them all.

*See p. 2788.

One, they are not needed, the administrator or a social worker can do all of his functions; second, they are not available, and third, they cost too much.

Now, let me say something before I make any remarks. I practice geriatrics in Baltimore exclusively, and I am a medical director of a 100-bed nonprofit nursing home. I am a paid part-time medical director, I have been for the past 5 years.

First of all, skilled nursing homes are supposed to provide skilled medical and nursing services care. In other words, for sick patients, totally disabled who need medical and nursing care.

In effect, they are health facilities, and the person best qualified to supervise medical care is the physician.

Presently, let me say that care in nursing homes from my own observation is very important. It is either very poor, with a few exceptions, it is very poor, or it is scandalous, and I know from personal experience, and I was formerly a part-time medical supervisor to the nursing program for Baltimore City, in 1969, we conducted a survey of the nursing homes in Baltimore, about 40 of them, comprising of about 500 patients.

We tested, that was a 10-percent sample, we tested mostly the quality of care services there. We found that in all categories, that the care, the quality of care was very, very poor, unacceptable. This was so even with the most minimum standards there.

Inadequate Physical Examination

Let me name a few things. We found out that maybe 5 percent of the patients came in the nursing homes, brought any transfer summaries from some other institutions, and here is something that less than 5 percent of the patients came in had what is called an adequate physical examination.

Now, how can you give all the patients in nursing homes good care. To give good care, you have to find out what the patient's needs are and what his impairments are.

If you do not give him a good physical examination, I mean his social and psychological needs, a complete picture, which is necessary, you cannot treat him. We know there are a lot of patients in nursing homes that do not get good care.

Some have very poor eyesight, that they cannot enjoy the television or even read, or that their hearing is defective, and they cannot communicate.

If you cannot do a good physical, how can you correct those things, you do not even know about them?

We tested many other things, the frequency of physician visits, the nurses, the use of services by paraprofessionals, foot doctors and eye doctors, hearing doctors, and there was so little of that, that it is really scandalous the care that our nursing home patients are getting.

This survey was done in 1969, I am still in nursing homes, I go to them every day, I am a member of the geriatric evaluation service, and I do not see any change in the past 5 years. They are just as bad as they were. So we know they are poor.

Now, good care can be given at reasonable cost, and I think we have a lot of the examples of that, mostly, but not exclusively in the nonprofit homes.

The Hebrew homes for the aged give good care at reasonable cost, and so you asked me, what does it cost.

I know in our own home, which is a 100-bed nonprofit home, their per diem cost, and I know the care is good there, it is $22 a day, that is their per diem.

You asked me what does it cost, in a Baltimore, nonprofit home, which gives high quality care, it is $22 a day. I know the State rate in Maryland is $18, so it is not enough for that type of care, but we have many other examples of good care.

Now, one of the common denominators of those homes that give good care, they are not the only ones, but they have a medical director, the Hebrew homes, the other nonprofit homes, a few of the profit homes who have been shown to give good care, do have medical directors, and I would just like to point out, that 70 percent of our nursing home population is supported by the Government.

In this survey I did, it does apply itself to those homes in Baltimore, these homes in there are mostly homes that cater to the medically assisted patient, the one paid for by the Government.

I cannot say all of the profitmaking homes are exclusively private patients. Their level of care is at the same level as this survey I made shown, but in general, it is not the best care.

Now, I think what Dr. Benack said is that there is a need for a medical director. He is the best qualified person to lead the team. There are a lot of functions that only the medical director can do.

When you take the patient in, you have to find out whether he is eligible, whether he should be in the community, whether the care he needs can be taken care of by the nursing home.

Physician Makes Most Decisions

Only a physician can do that. Only a physician can supervise his ongoing care, only a physician can decide whether he is getting better so he can get some new services, he can be discharged from another facility, and there are many other facilities, supervising all kinds of committees, admission committees, patient policy committees, only a physician can do that well. He can do it better than anybody else here.

Now, in the other argument, it was availability. It is true that perhaps in rural areas, there are not enough physicians, I accept that, but this is only a small part of our nursing home area, but we know in the large metropolitan areas, we know that all nursing homes have principal physicians.

If a physician is willing to be a principal physician, where he has responsibility for emergencies, and advice, he does not get paid for this, if he is willing to do this, if you can pay him for his administrative time, surely you can get physicians to do this.

If you can get him as a principal physician with no pay, that is fine.

Now, the last area of this is the cost, and Dr. Benack has mentioned a range of costs, 35 to 50 cents per patient per day. Now, this is the best package to improve the quality of care that you can possibly get.

Not only does the physician decide here that a patient should come in, he decides whether he should go out, he supervises the committee, he acts as ombudsman for the patient. A patient can talk to a doctor, not when he comes in once a month, and he is there daily, yes, they can talk to him then.

One thing that is important to remember as far as getting a medical director, an organized medical staff, that there should be some way where this medical director, or the organized medical staff can have some support from organized medicine, because the medical director has to be hired by the nursing home, he has to be paid by it, he is an employee of that home, subject to the administration, whether it is proprietory, or nonprofit.

So that we can establish some support for this medical director in case there is an ownership that does not care too much about medical care, the health committee of the Maryland Commission on Aging recommended to the Governor of Maryland about a year ago, that the medical director be not only appointed by a medical society, or a local hospital medical staff, but that ongoing supervision by this group continue for this medical director, just in case.

In case there is disagreement on medical aspects, between the administration of the home, the medical director will have somebody to go to, somebody who has some clout.

Homes Dependent on Recommendations

Nursing homes are dependent on their patients by recommendation from the medical people in the community, and if the community like a local medical hospital staff or a medical society felt the administrator was in some of his concepts, against the medical director, certainly he could influence the administrator strongly, and this would give the medical director some support to give good medical care.

Thank you.

Mr. Halamandaris. Thank you. That was an excellent statement.

I would like to go back and say one thing, that is, you mentioned 25 percent of the patients in this particular survey had any sort of transfer documents, had no medical histories, and so forth, then you mentioned that 5 percent of your patients in your survey had physical examinations, and you mentioned or went on to point out the importance of physical examinations.

I would like to point out in section 405.1123 of the regulations, it was required that a nursing home receive such transfer summaries within 48 hours.

The nursing home had the obligation of getting the patient's medical records, and bringing them to the facility within 48 hours. That has been deleted.

There also was a requirement the patient have a physical within 48 hours, and that has been deleted. The implications are obvious.

Mr. Oriol. Dr. Gladue, have you seen the Governor's committee on nursing homes in Maryland?

Dr. Gladue. Yes, I have.

Mr. Oriol. Have you evaluated that?

Dr. Gladue. I have not read it completely. I have read their major recommendations.

Mr. Oriol. Do you think that their recommendations—you said things have not improved in 5 years. Do you think that their recommendations would help make improvements?

Dr. Gladue. Yes, definitely. Have you read them?

Mr. Oriol. Yes.

Dr. GLADUE. Then you know the answer.

Mr. ORIOL. I want it from you.

Dr. GLADUE. There is no question, they did not spend too much time on medical directors, but they did improve.

Mr. ORIOL. Did I hear you say you are the chairman of the department of geriatrics?

Dr. GLAUDE. I am a practicing physician in geriatrics.

Mr. ORIOL. Yesterday I was speaking to Dr. Frederick Schwartz, the chairman on aging, I guess, for the American Medical Association, and I guess you have heard him speak from time to time, and one of his main arguments is that there is no such thing as death caused by aging.

In fact, he has some questions as to whether there is such a thing as aging, and he said death occurs to older people just as it does to younger people who fall victim to things like heart disease, and he seriously questions whether there can be a study of geriatrics in medical schools, and this is one of Senator Moss' major objectives to encourage more training in geriatrics.

DEFINITION OF GERIATRIC PATIENT

Dr. GLADUE. Let me say first of all, that 30 percent of our office visits, 30 percent of hospital time is spent on geriatric patients.

Mr. ORIOL. What is a geriatric patient?

Dr. GLADUE. Let's say 65.

Mr. ORIOL. Anybody 65 or over is a geriatric patient. Even if he is in good health generally for one element, it is strictly age that makes him a geriatric patient?

Dr. GLADUE. What I was trying to get to, Mr. Oriol, that the practicing physician, almost a third of his time is spent with older patients 65 and above, in the hospital, the office practice.

Now, let me say, although it is quite true that geriatric is a part of internal medicine, there are some peculiar things to geriatrics, in that it is still a branch of medicine that is not very clear.

We know in older people there are some changes that are peculiar. It is not consistent, but we know their kidneys do not function as well, we know their lungs do not function as well, we know their brain does not function as well.

We know their heart does not function as well. We know if your kidneys do not function as well, you give him an antibiotic, it does not act as in a younger person.

You almost have to be a psychiatrist to treat people who are senile, they are very difficult, they have all kinds of abnormal behavior.

Mr. ORIOL. What is your definition of senile?

Dr. GLADUE. Senile is a person I suppose who has developed, develops with aging, abnormal behavior, such as disorientation, or loses interest in things, his reaction time is much slower, you could go on and on, he gets disinterested in everything.

We are not sure yet whether this is due to arteriosclerosis, or it is due to other causes, but I think senility is something we have plenty of in our aging population, because we are getting older and getting more, and I feel very strongly about this, I feel there should be a specialty of geriatrics, for very practical reasons, not only because I know there

is a body of knowledge, but I picture a young physician as an internist, or as a general practitioner, or a family practitioner, and that man is in great demand, and you have patients come to you, and you have some old patients coming to you, you have some young patients coming.

Now, if you are very busy, you are going to have to make a choice, you are so busy, you can only take a certain number of patients. You take a geriatric patient, he is not a very desirable patient.

First, he is older, he has a lot of chronic problems, it is hard to get a history, it takes 25 percent longer, because he is slow. He has to have house calls, you cannot get physicians to make house calls, old patients need them, they are too sick, and they do not have transportation.

Further, he cannot pay as well as a young patient, so if you are a physician, and you have a choice of patients, so if you are a physician, and you have a choice of patients, you have to give somebody your time, and you have this young patient here, who has got an exciting illness, he pays well, he can come to your office, naturally you are going to choose the younger person, and the older patient will be left aside, and that is why old patients are not getting good care.

Nobody wants to treat them. If you get geriatrics, he will have to treat him, and that is all he does, and he will treat the patient, because that is his responsibility. That is all he is going to treat. There is great interest medically in young people.

Now, I am glad Senator Moss is sponsoring a bill for our medical schools. They do not teach much about chronic medicine, and there is a lot of chronic medicine in geriatrics. We have been trained to treat acute illnesses, dramatic illnesses, and not the chronic, maintenance and preventive, and we need it in that area.

Just the fact a third of our practice will be in this field shows we need it.

Cataract Removal in Older People

Dr. Benack. I would like to make some comments along that line.

The longer we are here on earth, the longer we exist, certain problems ultimately develop. Yet last night on television in one of the shows about a doctor, there was a discussion of cataracts in a young girl, a congenital disease.

We have this problem in old people, and quite frequently in young people.

The question raised in that show was is she going to see or not see after the cataracts were removed.

We have that same question in old people too, but the other question was that we have in old people, is not only will she see, but will she be oriented to time and place, or will she become what we currently classify as senile or the chronic brain syndrome.

The fact is that people grow old and suddenly develop a series of complications, of problems that need attention.

I have done a good deal of work, evaluating drug therapy in circulatory problems to the brain or senility.

There is one drug that we use which improves the chronic brain syndrome, not by increasing blood flow, but apparently by improving the circulation and use of the oxygen that reaches the brain.

This was an interesting fact that was only developed after we used it a long period of time, in that there was a whole different aspect

of the problem of chronic brain syndrome that we were not paying any attention to.

The point is that there is a period in life that the body undergoes changes, where there are not just one illness, but many illnesses which are intertwined.

There is a clearly defined area in medicine where there exists a group of people that have multiple illnesses, sometimes interrelated, sometimes separate, to which a physician must devote almost twice as much time as the average acutely ill patient. I can only compare, for example, in taking a history and physical on a 40-year-old man, and one on the 70-year-old man. I can assure you that the time to accomplish the physical on the 70-year-old man is twice as long, simply because there are more illnesses, and seeing a doctor and giving a history is a part of their life. They want to tell you everything they can. I think you should listen.

The fact is not just in age, but it is in that disease that is chronic in nature, and ultimately will create complications.

Mr. ORIOL. Thank you.

Dr. GLADUE. You made a note on profit and health care, I feel very strongly that nursing homes—it does not make sense to have profit motives in treating people's health, especially in the nursing homes.

It is only reasonable if you are making a profit, and you want to make your profit, it is understandable, and when you say 10 percent or 5 percent or 15 percent, if you are in a nursing home, and you are getting marginal money from your medical assistance patients, those are Government supported, and you know that is fixed by legislation, and maybe in a year, times change, your prices, the cost of living goes up, but the flat rate for the patient does not go up, it is only natural if you are going to make your profit, you are going to have to give on the quality of care, and some things happen, and even the best motivated profitmaking person, you are bound to reduce your quality of care, and that happens all the time.

If you are going to have consistency throughout the health area, you can have a profitmaking motive, but you have to give quality care, and there are some proprietors that are honest, but there are some making profit, that may be run by stockholders, that do not even know what is going on, and they do not care.

ADMINISTRATION OF DRUGS

Mr. HALAMANDARIS. Doctor, there are studies that indicate that the incidence of drugs administered in nursing homes may be 15 to 50 percent administered in error.

That is drugs given to the wrong person, or improper combinations, and we know that there are also severe adverse reactions that take place when patients are receiving sometimes seven different drugs at one time, and that can cause adverse reactions. I would like you to comment on that.

Have you seen many adverse reactions?

Dr. GLADUE. I think that sounds quite high. I can see the possibility in some nursing homes where the doctor comes in once a week, or sometimes there are substitute doctors, and they give a new drug for a symptom; they do not look at the other drugs, and in some nursing

homes, poor homes, you get a list of drugs, and sometimes you do get adverse reactions.

There are some very adverse reactions. I have seen it happen, where one gives a sulfur drug, and it goes on for months and months, and the patients die.

Mr. HALAMANDARIS. Have you had any experience where a patient takes coumadin and aspirin, and which has the same sort of effect?

Dr. GLADUE. No personal experience with these drugs. We do not use coumadin much.

Dr. BENACK. We have developed a method by which the pharmacy sends us an alert on interaction of drugs.

The question has been raised on occasional use of anti-Parkinson's drugs in combination with tranquilizers—which came first, the tranquilizer or the anti-Parkinsonism—but this is not an unusual dose, and last week in review, I wondered what a patient was doing with all of these drugs; I saw a whole page, and the nurse said the doctor comes in and orders something new, and does not discontinue the old.

The problem there lies in the fact that the nurses are insecure on whether they should call the doctor, and tell him he is on three different drugs; maybe he knows it, but if there was a medical doctor in the facility; she might have inquired of him, whether we should be giving all of these drugs, and he could have at least told her no, you better check with the doctor, but if there is no medical director, she has nobody to check with.

Dr. GLADUE. I know from my own homes, that the cost of our drugs are one-third of other similar homes, and our side reactions are much less, and that is because we do look carefully at our drugs, and there is a medical director there, so just from a cost area, it is a great savings to get good supervision here, and more quick visits to the patient.

Mr. HALAMANDARIS. I think an investment of 30 cents a day or 50 cents a day to get the physician in the nursing home actively involved, as you said, possibly is the best investment you could make. I cannot think of anything that would benefit the patient more.

I want to thank you gentlemen for your patience. You have served the record very well.

Dr. BENACK. Thank you.

[The prepared statement of Dr. Benack follows:]

STATEMENT OF RAYMOND T. BENACK, M.D., FOUNDER OF THE AMERICAN ASSOCIATION OF NURSING HOME PHYSICIANS

Mr. Chairman, members of the subcommittee on aging, I wish to thank you for the opportunity of appearing before this distinguished committee today. I am Raymond T. Benack, M.D., medical director of Bel Pre Health Center, Silver Spring, Md., founder and first president of the Maryland Association of Nursing Home Physicians and the American Association of Nursing Home Physicians.

I wish to speak to the question of medical director in nursing homes and the frequency of physicians visits to the nursing home patients. I might rephrase that statement by saying "are we to encourage that the best available medical care be provided to the nursing home patient or should we turn back the hands of time to where the nursing home becomes an institution of death to which we condemn a chronically ill patient." I say this because the recommended regulations for skilled nursing homes as currently proposed would in fact turn back the hand of time. In the time available, I would like to briefly present my views on these two subjects.

First let's consider the frequency of visits. The average nursing home patient is over 70 years of age and suffers from more than four major illnesses. He usually is admitted to the nursing home from an acute hospital. He has been in the hospital because of an acute illness. He has been admitted to the nursing home because his condition warrants either short term intensive rehabilitative therapy or long term medical care. It seems unusual that this patient who required daily hospital physician visits, suddenly upon transfer to the nursing home, requires an examination by a physician only once a month or once every 3 months.

It appears that the medical supervision of a patient is not dependent upon the medical needs of the patient but upon the facility he may be in. Furthermore if the patient is in the nursing home over 90 days, he may need very little or no medical supervision. This would imply that the long term care patient who suffers from those medical illnesses too severe to be cared for at home or in the physician's office, requires less medical superivision. This seems to be a paradox to me in that the sicker you are, the less medical supervision you need.

The nursing home is the last institution of medical care that currently exists in the United States that does not provide for a regular medical staff or supervisory physician. The hospitals require formal medical staffs; the chronic disease hospitals have paid medical staff, but the nursing home has only a physician who is available for emergencies. We must face the fact that nursing home are now an integral part of the total available medical services to the sick. The Medicare law has moved the nursing home out of the gray area of medicine into definite place in long term care. They are no longer the last living resting place on earth for the terminal cancer patient, the confused or the senile patient. They are, in fact, institutions of active medical care that provide not only nursing care but also physical, occupational, speech and respiratory therapy. Are such facilities to exist without any regular medical supervision? The current recommended regulations for skilled nursing homes would imply this. It must be decided now and forever whether we are to consider the nursing home as an institution of medical care or an institution leading to death. If we decide in the former then we must provide overall medical supervision either through a formal medical staff or through the use of a medical director.

Institutions of medical care cannot exist without medical supervision. However if we decide that the nursing home is an institution of death then we must keep the physician out of such a facility lest he do what he was trained for, namely prolong life.

It is my opinion that all people, regardless of age, are entitled to the best available medical services either to prolong their useful life or to provide them with a comfortable and respectable death. To accomplish this, the nursing home must have a medical director to insure that the patient in the facility receives not only the allied medical services to which he is entitled but also the medical supervision during his terminal period of life. Infrequent or sporadic visits by his physician and then only at times of extreme emergencies is not the answer.

The long-term care patient is entitled to regular medical supervision. He is entitled not only to receive emergency medical care but also preventive medical care. Regular medical supervision can detect anemia, congestive heart failure, skin ulcers and similar conditions before the illnesses become life threatening. To close the barn door after the horse does escape is a basic error in medical care. Early detection of illness is of the utmost importance. Removal of the requirement for physician visits to the nursing home patient every 30 days, only encourage physician inaction and rapid deterioration of the nursing home patient. I will state here today if the physician is not required to see his patient regularly he will never see the patient except at times of emergencies. If the recommendations for physicians visits as currently proposed in the regulations for skilled nursing homes is adopted, it will encourage not only improved medical supervision but the least possible and probably no medical supervision for the long-term care patient.

We must realize that the long-term care patient provides no medical challenge to the average physician and consequently he will not see the patient unless absolutely necessary. In other words the physician will not come unless required to do so. This is a basic fact of medical life.

The concept of a medical director for nursing homes was introduced by me in 1967 when speaking before the Maryland Medical and Chirurgical Faculty. In 1973, after nationwide conferences on the subject, the American Medical Association, approved the concept of a medical director for nursing homes and

recommended that the concept be adopted for all nursing homes. The Joint Commission on Accreditation of Hospitals will require the medical director concept in its accreditation of nursing homes. It appears that the medical profession believes that the medical director is a necessary concept for good medical care in nursing homes, but HEW feels that the medical profession, after 13 national conferences on the subject, does not know what it is talking about.

Rather than go through a detailed discussion on the subject at this time, I would like to refer you to the accompanying article * which adequately explains the medical director's philosophy. I would prefer to discuss what a medical director will provide for a nursing home other than administrative duties.

Above all, the medical director will stimulate an overall improvement of patient care by his presence and his interest in the patients. The medical director's interest in total patient care, regardless of whose patient it might be, will stimulate the staff to have a greater interest in the patients.

The medical director would improve medical communication by insuring adequate medical information prior to admission. He would encourage physicians to take a more active role in their patient's care. He would introduce improved medical care encouraging use of recent medical programs in the care of long term care patients. He would act as a communications between other long-term care facilities. This is only a few of the advantages of a medical director. There are many others too numerous to list.

Before we embark upon the costs of a medical director, we must consider what a medical director or principal physician does now and what he is expected to do. Since the enactment of the Medicare law, all skilled nursing homes have an agreement that a physician agrees to be available for medical emergencies for the nursing home facility and advise on the medical policies of the facilities. In other words, he agrees to be available or have suitable coverage in his absence to handle any emergency at the facility when the patient's attending physician is not available. Furthermore, he generally agrees to the medical policies of which the facilities which in many cases are drowning by the administration. In return for this service the medical director is compensated by having the first choice of patients admitted to the facility. No contractural agreement is signed but only a verbal agreement is reached. Either one can sever the agreement at any time. In other words, you scratch my back, I'll scratch yours. Or to rephrase it, if the medical director rocks the boat, he can be fired. If on the other hand the nursing home aggravates the physician, he can quit and leave them high and dry.

That is not all of the problems. Recently there have been major epidemics of salmonella infections in nursing homes. The one that prompted nationwide interest occurred in Baltimore, Md. As a result of this epidemic, the principal physician was reprimanded by the State medical society for not acting as a medical director by the standards outlined previously. Here was a physician reprimanded for not doing something he was never told to do or even allowed to do by the nursing home administration.

Today, we must assume that the primary or principal physician of the nursing homes is responsible for certain duties as the "medical director" of that facility. Whether he is compensated by patient referral or by a salary, he is still responsible. It would seem unwise that the physician who assumes the role of medical director to be compensated solely by patient referral. We feel that the physician who assumes the role of being the nursing home physician is medically and legally responsible to perform the duties of medical director. If such is the role of the primary principal physician or medical director in the nursing homes, then his compensation should never be in the form of patient referral but in the form of a contractural agreement. It is the decision of the Maryland Medical Society and I would assume every other State medical society, the nursing home physician is medically and legally responsible to perform all the duties of the medical director.

The final question is what will it cost to have a paid medical director in nursing homes? It is our estimate that it will cost between 35–50 cents per day per patient to compensate a physician to perform the duties of a medical director in nursing homes.

This is based on the formula that a 250 plus bed facility will require a full time medical director at $40,000 per year. If we presume a 100 percent occupancy. We realize that a 100 percent occupancy is the ideal but the fact remains that for 50 cents a day a nursing home patient receives optional medical supervision.

*See appendix 5, item 5, p. 2856.

In summary we would like to point out that the medical director in a nursing home concept provides optimium patient care at minimal cost and that reducing the frequency of physician visits encourage decreased patient care. We would urge that the committee, include in the regulations for skilled nursing homes, the requirement for a medical director and that the frequency of physician visits be limited to no greater than every 30 days.

Mr. HALAMANDARIS. We call Elaine M. Brody, director, social services, Philadelphia Geriatrics Society, representing the National Association of Social Workers.

Mrs. Brody, proceed in any way that you see fit.

STATEMENT OF ELAINE M. BRODY, DIRECTOR, SOCIAL SERVICES, PHILADELPHIA GERIATRICS SOCIETY, REPRESENTING THE NATIONAL ASSOCIATION OF SOCIAL WORKERS,* ACCOMPANIED BY GRANT LOAVENBRUCK, STAFF ASSOCIATE, NASW'S TASK FORCE ON AGING

Mrs. BRODY. I am here as representative of the National Association of Social Workers, an organization of almost 60,000 members. I am director of the department of social work at the Philadelphia Geriatric Center, and conduct research studies funded by the Administration on Aging and the National Institute on Mental Health. Accompanying me is Grant Loavenbruck, staff associate to NASW's task force on aging.

The center is a voluntary agency caring for almost 1,000 older people in a long-term care institution, a hospital, apartment buildings, and intermediate housing.

I am a fellow of the American Gerontological Society, chairman-elect of the social research, planning, and practice section of that organization, and cochairman of the NASW task force on aging.

I have written a book on social work and long-term care facilities under contract to the National Institute of Mental Health which is currently in press at the U.S. Government Printing Office.

The regulations governing skilled nursing facilities under Federal health insurance for the aged are a matter that goes beyond the well-being of many Americans to the issue of life and death.

About a million older people currently reside in long-term facilities, and many more are in need of such care. While the figure "1 million" represents 5 percent of the total 65-and-over population, recent research by Robert Kastenbaum indicates that there is at least a 20-percent chance of any aged individual entering a nursing facility of some type. The social implications therefore, are of even greater consequence than is generally thought to be the case.

The number of those who require long-term care will not decrease despite the current thrust to develop "alternatives." Those who may be enabled to continue to live in the community will be offset by the rapid proportionate and numerical increase in the oldest segment of the elderly—that is, the group that is most vulnerable to the mental and physical impairments requiring round-the-clock service.

In addition, there will be increased availability of such care to those formerly denied access to it, such as minority groups and the poor. The

*See appendix 6, p. 2860.

situations of these older people also have a direct impact on their families.

The proposed HEW regulations for skilled nursing facilities are therefore of immediate concern to many millions of citizens.

Regulations Compound Grave Error

The 1972 Social Security amendments took the regressive position that "the Secretary shall not require as a condition of participation that medical social services be furnished in any institution"—Public Law 92–603, page 122. The regulations, as written, compound that grave error.

The sections on the provision of social work services not only disregard the psychological and social needs of older people in need of long-term care, but threaten their sheer survival.

Psychosocial services are often regarded as luxuries dictated by humanistic views, but as secondary to the provision of shelter, food, and medical care. While humanistic views have a legitimate place in social policy, in this instance they have an underpinning of hard data.

Institutionalization of older people has been one of the most intensively studied subjects in gerontology. Scores of research investigations have been addressed to identifying the reasons for admission to long-term-care facilities, the characteristics of the people who reside in them, the paths they have taken to the institutions, the impact of the process of becoming institutionalized and of living as an institutionalized person. Other studies have explored the effects of various institutional environments on their occupants.

By now it is conventional wisdom in gerontology that the process of applying to an institution, waiting for admission, living in such facilities, and being inappropriately discharged to inadequate situations can be severely detrimental. It is well known that one of the broadest areas of neglect has been the lack of attention to psychosocial needs that results in increased dependency, depression, low morale, loneliness, anxiety, and other indicators of poor adjustment.

Research also has documented the phenomenon known as relocation effect or transplantation shock, that is, the deterioration and higher death rates that occur when older people are moved into, out of, and among institutions.

Particularly vulnerable to such negative reactions are those who are mentally impaired—both the functionally disturbed and those with chronic brain syndrome—the physically ill, the depressed, and those who are relocated involuntarily. Such fragile individuals constitute the group most affected by the regulations.

While we by no means advocate wholesale moves of older people, it cannot be concluded from such information that older people should never be admitted to institutions and should never be moved. It is self-evident that when an older person's condition is such that he requires long-term care, he must be admitted to an appropriate facility; that when he no longer requires skilled care and appropriate services and facilities are available in the community, he should be discharged. It is a fact of life that moves of older people occur not only into and out of institutions, but among various types of facilities and within them.

Fortunately, clinical information and research data are available regarding how moves should be managed and what institutional envi-

ronments should be like if physical and mental health and survival are to be protected.

In brief, research indicates that disastrous changes do not occur when older people move voluntarily; when they are given careful preparation for moving via counseling services; when they are oriented to the receiving facility prior to the move; when they participate in the decisionmaking and planning process; and when they have opportunities for choice.

Importance of Matching Individual and Facility

The professional literature strongly supports the importance of matching the individual to the facility that meets his particular personal and social needs as well as his medical needs. It documents the negative impact of moves to cold, dehumanized environments, and the beneficial effects of attention to psychological and social requirements.*

A number of research studies have successfully tested programs of psychosocial treatment designed to improve the functioning of the older people.

At my own institution, positive results were achieved even with a group which has in the past been written off—those in advanced old age—average 83—suffering from moderate to severe chronic brain syndrome—"sensility."

In other recent study at the Philadelphia Geriatric Center, necessary moves of a group of older people within the facility were planned carefully to utilize techniques that capitalized on knowledge of factors that mitigate the relocation effect. The data showed that with social-psychological preparation and post-move care, the residents' well-being improved after the initial negative impact and there was no increased death rate.

In short, available information points clearly to the fact that attention to psychosocial needs can make the difference between life and death. That knowledge should be utilized.

Unfortunately, the proposed regulations, by weakening the role of social work, will perpetuate neglect of the social aspects of care and will endanger not only the current population of older people, but also the one in every five of us who will at sometime require nursing home care.

If the goal is to implement Public Law 92–603's purpose of reducing "inappropriate institutional care" and to improve the quality of life in institutions, social work involvement is essential in the exploration and selection of possible placements, in the identification of appropriate facilities, in the preparation of the individuals involved, in attention to their social needs, in discharge planning and in the training of nursing home staff.

Professional social work is the key to the integration of the psychosocial aspects of care with other necessary services. Unless there is more than token involvement—and that is the case as the regulations now stand—there will continue to be inappropriate admissions and discharges and unnecessarily neglected older people, to say nothing of wholesale dumping.

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*Reviews of the literature are available in Lieberman, 1969; Blenkner, 1967; Lawton and Yaffe, 1967; Brody, 1970; Lawton and Nahemow, 1973; Brody and contributors, in press; and Gottesman and Brody, in press.

"WHO SPEAKS FOR THE PATIENT?"

I will take a moment to respond to Dr. Edward's statement this morning to the effect that realinement of discharge planning under the utilization review condition—rather than being connected to the social service function—"gives strength and visability to a vital aspect of patient care." Such procedures do nothing to avoid the simple mechanical determination of the medical need for care available in that particular facility. Such review does not insure that the patient will have the situation discussed with him that there will be thorough exploration and mobilization of other resources, nor that there will be developed an appropriate plan for care outside of the nursing facility. Mr. Oriol asked this morning "who speaks for the patient?" These functions, by tradition, training, and skill, belong to the social worker.

Time is running out. We cannot afford to go backward or to take such small incremental forward steps that the gap between need and action continues to widen. The regulations are vague and inadequate regarding both the quantitative and qualitative provisions of social work services. What, for example, are "satisfactory arrangements for identifying the medically related social and emotional aspects for care"?

As a first step, it is necessary to strengthen the regulations with respect to such matters as including certification in the social worker definition—section 405.1101—providing for social worker participation in the development, review, and implementation of patient care policies—section 405.1122—requiring social work as one of the professional disciplines delivering restorative services—section 405.1126—and spelling out social workers' qualifications and staff-to-patient ratios—section 405.1130. The particulars have been detailed in the letter from NASW's executive director, Mr. Chauncey A. Alexander, to the Commissioner of Social Security which is appended to this testimony.*

The National Association of Social Workers is deeply appreciative of the privilege of presenting these views.

Mr. HALAMANDARIS. Mr. Loavenbruck, do you have a statement you wish to make?

STATEMENT OF GRANT LOAVENBRUCK

Mr. LOAVENBRUCK. I do not have a prepared statement, but just briefly, I would like to expand on what Mrs. Brody has said, and refer to this morning's testimony of the HEW panel, in which they kept referring to their objective of removing excess verbiage.

Well, some of the excess verbiage that they removed is certainly pertaining to social worker services in the nursing home.

They removed social services as a mandated service, and instead put a lot of excess verbiage defining the social worker not mandated, not be mandated in that nursing home to be qualified to do what this training would be, and so forth, and so forth.

Even that excess verbiage fell far short of the standards of the National Association of Social Workers ascribes to.

*See app. 6, p. 2860.

The National Association of Social Workers is right now mandating their organization to go beyond the present level of certifying the competence of professional social workers in that it is going to the level of certifying the competence of social workers in various specialties, and functioning in the field of aging is to be one of these.

I just wanted to add that note. I thank you again for hearing us today.

Mr. HALAMANDARIS. Thank you.

They did take out a lot of "excess verbiage," did they not.

Some of these examples would be humorous if they were not so sad. No longer do nursing homes have to take into consideration the patient's home consideration, his financial resources, his community resources, and other information related to his medical and nursing requirements to be used in deciding when he should be discharged from the facility, and what sort of medical and therapeutic program to be set up for patients.

Your comments about relocation of transplant shock I think are very significant, and I believe we are going to have a terrible problem on our hands unless HEW realizes that you cannot arbitrarily superimpose insurance principles on human needs.

WHOLESALE RECLASSIFICATION OF PATIENTS

It just will not work. You have to decide what the individuals need, set reasonable levels for nursing care, and reasonable standards.

I am afraid we are going to have this sort of wholesale reclassification of patients from skilled nursing into intermediate care facilities. They will be the same nursing home we have had for the past few years, only the label will change.

The care in ICF's will be nonexistent. We are not going to have the personnel. We will have one licensed practical nurse 5 days a week, and in the same facility, we will have patients with multiple sclerosis, muscular dystrophy, people greatly physically ill, that do not fit the insurance definition of what will be called skilled nursing.

I think it is a serious problem, and I appreciate very much the fact you have come here to address yourselves to it.

I think it is significant that you mentioned utilization review, and the fact that HEW in its wisdom has decided to incorporate discharge planning into utilization review.

When you strip away the verbiage, utilization review, it is nothing more than a vehicle to insure that the Federal and State governments are not paying for patients which are not compensable under existing definitions.

Of course, HEW will have a time to decide what skilled nursing care is. Curiously, utilization review is required by the proposed standards every 30 days, but it is not required that a physician see patients every 30 days. So, when economics are involved, then the Federal Government will mandate the entry of these individuals in the nursing home every 30 days, but when the care and needs of the patients are involved, that is a different story, we do not need to see them every 30 days.

I am shocked and outraged really at the regulations. The more I see of them, the more I fear for the patients, past and future.

One last comment. After 4 years of reading 10 years of testimony in the field of long-term care, the best study I have read was by you, Elaine Brody.

Mrs. BRODY. Thank you very much, indeed.

Mr. ORIOL. I would like to note for the record that Val and I represent the majority members of the committee, and Margaret Faye is here representing the minority members.

I thought I saw Mrs. Brody's head nodding in agreement when Val was identifying the consequences of this trend toward intermediate care facilities.

Mrs. BRODY. Yes; I am terribly worried about the situation, Mr. Oriol.

I hope I am wrong, but I foresee the kind of wholesale dumping repeated that we experienced several times before in our history, notably when it was thought it was a good idea to dump mental patients out. What happened is that they went out of the State mental hospitals, into situations where they fared much worse than they had in the mental hospitals.

In Pennylvania we have not yet had sufficient experience to know what the ratio will be, but we have been hearing some vague rumors about institutions that have already had inspection review teams in, and they are telling us 1 in 15 patients currently residing are now being approved for the skilled nursing facility.

That is a pretty horrendous figure. If it means that 14 out of every 15 people in a nursing home will be discharged, because I know from experience that 14 out of 15 people in the nursing homes are not in such condition that they can be safely discharged to the community, and I know the community resources do not exist to take care of them.

It is a fiction that most people in institutions do not need long-term care. There may be some who have been inappropriately admitted in the past, but they are really far in the minority, and I am very distressed also at the guesses as to how many can be discharged.

We must develop the community resources. It is a very sadly neglected area in the United States.

PERCENTAGE OF ELDERLY INCREASING

Mr. ORIOL. You mentioned before, there has been so much talk about alternatives, and with that goes the motion that if you develop alternatives, you do not need the institutions as much as you do now. But I think the alternatives will enable the institutions to treat those people who do need insitutions, particularly as you point out, since the percentage of the so-called elderly is increasing at a more rapid rate than the overall elderly, so simply to get that foreseeable demand, institutions have to be relieved where it makes sense, as much as possible, but alternatives——

Mrs. BRODY. We must have the alternatives, but they will not take care of the bulk of the institutional population.

There are, in some European countries, where the rates of institutionalization are even higher than they are in the United States, even though community care services are more fully developed.

I think the main benefit to be derived from community care services is that they will take care of a lot of people now living way below standards in the community plus the minority who have been in the institutions inappropriately.

Mr. ORIOL. Another very significant point you made, most people who thought at all about this, say many people in long-term care institutions, most of them are elderly, it comes to about 4 percent of the total elderly population. Could you talk more about that?

Mrs. BRODY. I would feel more comfortable if you invited Dr. Kastenbaum to testify on his own research.

He is a gerontologist and a psychologist, who shook up the whole field recently by presenting a paper called "The Four Percent Fallacy," in which his message was that the 4 percent or 5 percent had been derived from cross-section data rather than longitudinal data—that is—from counting the people in the institutions on any one given day. But when the data was analyzed longitudinally, he found that many, many times the percentage of older people that died in the institutions were said to have lived in the institutions, and that, of course, puts an entirely different perspective on the whole question. Such data do speak to the social implications which affects many, many more millions of people than we had formerly thought.

Mr. ORIOL. May I request that a copy of that document be supplied for the record.

Mrs. BRODY. I will be glad to have Dr. Kastenbaum send you one. It was published in the issue of Aging and Human Development, of which Dr. Kastenbaum is the editor. It was published in volume 4, No. 1, International Gerontology Development. He gave the paper last year in Puerto Rico at the gerontological meeting.*

Mr. ORIOL. I would like to ask the same question I raised before about rates, whether rates generally are adequate to meet need. In Philadelphia, Pa., you have had a pretty low rate. Is it adequate to meet the need?

Mrs. BRODY. We do indeed have a low rate. Everybody knows that rates are very uneven regionally, that they are high in a few areas, and they are very low in others.

In Pennsylvania they have been very, very low. Until recently, we were getting a $15 a day per patient. Before that, for a very long time it was $11. I know that is not enough. We are a nonprofit organization, and we are running an immense deficit.

I think a general statement could be made that reimbursement rates are too low, there is no question in my mind about that in Pennsylvania.

Mr. ORIOL. I also wanted to ask you, you described before what your social worker procedure is in the Philadelphia Geriatrics Society is, what should be the ideal working relationship between the social worker and the medical director we heard so much about?

Mrs. BRODY. I am glad you asked that question. The gentlemen who testified this morning from the American Association of Nursing Home Physicians were very firm in their view that every long-term care facility should have a medical director, and I concur in that.

I think it is highly desirable for long-term care facilities to have a medical director who is responsible for the total overall medical care of every person in the institution, but beyond that point, my views differ very sharply.

ACUTE CRISIS-AND-CURE ATMOSPHERE

My opinion is that it is one of the tragedies of long-term care in the United States that it has gotten hooked so firmly to the purely medical

*Retained in committee files.

aspects of care. In institutions, as they get more and more of the medical care they need, what happened is that the personnel trained in general hospitals, tend to bring with them the acute crisis-and-cure atmosphere of the general hospital, in which the medical care is primary, and everything is subordinate to it.

People who live in long-term care institutions, live there for long periods of their lives.

I have known people who lived there for 10 or 20 years, and I think the philosophy of care is not making these people full-time medical patients, with the medical being primary, but to view the medical input as one of a number of necessary services servicing a whole human being.

Now, if I can use my own institution as a model, we do have a medical director and we also have other full-time medical staff. It is a large institution, but the administrator of the institution is not a physician. The physician as a medical director is the director of the major functional units of the institution, along with the director of nursing, the director of social work, and others. The administrator's task is, along with the others, to put the pieces together, so you can focus on a whole person.

I do not think it is necessary for the physician to be, and I am quoting the doctor this morning, to be the "leader" of the team. I think the medical care is terribly important, but it is only one of many necessary services for people living in a social environment.

Mr. ORIOL. You heard the discussion a while ago about geriatrics, as being a specialty for the physician. Should there be something for the geriatric social worker?

Mrs. BRODY. Well, that question does not have a simple answer.

You know, years ago, there were not any such specialty as social workers who worked with older people.

When I wanted to recruit people, I advertised that any experience they had would be valuable, whether it was family counseling, in psychiatric settings, in health settings, even people who had worked where they had handled adoptions, there could be something in common elements such as experience with separation of family.

There is no question but that there is some specific content that relates to older people, but particularly with the very old, because of their age-related losses, age-related diseases, and you do need some special knowledge in that, but I am not sure I would like to see a specialty called geriatric social worker at all.

Mr. ORIOL. What you would like to see is all social workers concerned about the entire lifespan?

Mrs. BRODY. I certainly would, and I think that regardless of what the setting is, inevitably he or she will be dealing with the problems of older people, no matter where they are, and also the families of the older people.

Mr. ORIOL. The question I raised before about who is in charge of the President's nursing home program, is that a question of concern to you?

Mrs. BRODY. I am sorry; I was not in the room.

Mr. ORIOL. There seems to be some uncertainty about the thrust of efforts to implement the President's seven-point nursing home program. I wonder if that is a matter of concern to you?

Mr. LOAVENBRUCK. It is of concern in that there is a lack of leadership, where the leadership is going to be, and it has got us worried.

Mr. ORIOL. I would like to add to what Val said about your work over the years, and I thank you for a fine statement.

Mr. HALAMANDARIS. I thank you both for a very fine statement.

Mrs. BRODY. Thank you.

STATEMENT OF EVELYN SOMMERS, ASSOCIATE DIRECTOR, AMERICAN SOCIETY OF CONSULTANT PHARMACISTS

Ms. SOMMERS. Mr. Chairman and members of the committee, my name is Evelyn Sommers and I am associate director of the American Society of Consultant Pharmacists, a nonprofit professional society concerned with assuring the delivery of professional pharmacy services to a particular class of institutions—mainly skilled nursing facilities.

Members of the society service some 300,000 nursing beds across the country and represent the foremost practitioners of the specialty of consultant pharmacy, a professional outbranch which grew from the Medicare extended care facility conditions of participation and which has become a more important and better recognized function through the transfer of these regulations to the new category of skilled nursing facilities.

Based in Washington, D.C., the society was formed to help establish and maintain the highest level of pharmacy consultant services attainable via professional training and experience. Thus, our association has sought to unite its members in a common effort to research, develop, and share new and emerging concepts, techniques, systems, and educational programs.

We believe these efforts will yield the benefits and protection of a learned profession to the nursing home patient, to the institution served, to the members of other health professions with whom the consultant pharmacist is associated, and to the pharmacy profession as a whole.

With me today to present the society's testimony is Dr. Allan M. Kratz, assistant professor of clinical pharmacy at Philadelphia College of Pharmacy and Science and president of Pharmicare Services, Inc., a corporation that provides pharmacy consultant services to a dozen skilled nursing facilities and operates six pharmacies in large retirement complexes in the Delaware Valley area.

Dr. Kratz also currently serves as project director for a short-term training program entitled "Pharmaceutical Services to Nursing Homes and Related Health Facilities." Funded by the Department of Health, Education, and Welfare, this is the third such program he has directed in the last 6 years.

In addition, he is on the editorial board of the Merck Manual and Hospital Formulary Management, is a section editor of Remington's Pharmaceutical Sciences, and makes frequent contributions to professional journals and periodicals.

Mr. HALAMANDARIS. We will hear from Allan Kratz, M.D., president, American Association of Consultant Pharmacists.

Dr. Kratz, proceed in any way that you see fit.

STATEMENT OF ALLAN KRATZ, M.D., PRESIDENT, AMERICAN ASSOCIATION OF CONSULTANT PHARMACISTS*

Dr. KRATZ. Thank you, sir. The American Society of Consultant Pharmacists appreciates this opportunity to discuss the proposed regulations for nursing facilities, particularly those sections relating to pharmaceutical services and their resulting impact on safe, quality patient care.

Informed consumer-interest groups and responsible Government and regulatory agency officials are expressing increasing and warranted concern about the so-called paper consultant pharmacist.

This is the individual who, by written agreement, is responsible to the nursing home administration for developing, coordinating, and supervising all pharmaceutical services.

In actuality, however, the paper consultant pharmacist often has never seen the nursing home, has no idea of the drug distribution system used there, has never spoken to the director of nurses and has no interest in working with the nursing home staff to assure safe drug therapy and medication administration. He simply supplies prescriptions to the nursing home and that is where his so-called contract begins and ends.

This paper consultant pharmacist cannot fulfill the urgent needs of the Nation's some 1 million nursing home patients. Drugs are the primary module of treatment in the nursing home and potentially constitute the most explosive and sustained threat to patient safety. There is a great increase both in the number and incidence of chronic diseases as people live longer. A 1969 survey of nursing and convalescent homes in California indicated that patients there have an average of 3.1 chronic medical conditions. Most chronic diseases require long term and multiple drug management utilizing a great number of modern drugs which are more and more potent and toxic in action.

Documented statistics verify that 18 percent of all medications given in acute care facilities are administered in error, and more recent statistics in medium and long-term care facilities range from 20 percent to over 50 percent. Moreover, although the average nursing home patient receives as many medications per day as does the acute hospital patient, the majority of nursing homes have neither pharmacists nor physicians on premises and must rely on nurses whose education in drug therapy and medication administration is sometimes outdated and often inadequate.

PHARMACIST SHOULD OVERSEE USE OF DRUGS

In view of this situation, who can be responsible for the rational and effective use of drugs? By virtue of his education, training, and experience, the pharmacist is the only logical choice to provide the knowledge necessary to oversee the entire spectrum of patient drug therapy. Although there is some ambiguity in wording that should be clarified, the proposed regulations recognize this fact by requiring that the nursing home pharmacist devote a sufficient number of hours during a regularly scheduled visit for developing, coordinating, and supervising all pharmaceutical services.

Beyond these generalities, which are much the same as those existing under the old conditions of participations, what can be done to assure

*See appendix 7, items 2 and 3, p. 2862.

that the paper consultant pharmacist cannot continue to operate and that the Nation's nursing home patients receive the level of care they are entitled to?

Step 1 is assigning all nursing home pharmacists definite staff responsibilities. ASCP urges that, if the pharmacist serving the home is not a full-time employee or staff pharmacist (and this is most often the case), the regulations should specify the act as a consultant with staff responsibilities. This would serve to draw a line of demarcation between a true consultant and a pharmacist who merely supplies prescriptions to a facility.

We believe the proposed SNF regulations are moving in this direction. In general, they provide the type of enabling regulations by which the nursing home pharmacist can more effectively practice the profession of pharmacy, rather than just the mechanics of dispensing. For instance, he can more fully exercise his professional competence in various aspects of executing pharmacy services, such as choosing to use unit-dose packaging and distribution systems. This particular allowance is especially meaningful in view of recent studies which indicate that lower incidences of medication error occur with unit-dose systems and that the life cycle cost of drug administration is lower than through traditional methods, thus freeing the nurse for more bedside patient care. Also, the new regulations require that the pharmacist do more than just dispense prescriptions, they require his physical presence in the facility and impose on him some conditions of accountability though documentation procedures are not always in counterpart.

This area of documentation is the second step toward assuring better patient care. As it stands now, by knowledgeable estimates, no more than 40 percent of today's nursing facility patients are exposed to appropriate and adequate pharmaceutical services—the other 60 percent of the patients receive inadequate services—less than that required by licensure or by current conditions of participation.

Some positive measures to correct this laxity have been proposed. The regulations do require that the pharmacist submit at least quarterly a written report as to the status of the facility's pharmaceutical service and staff performance.

To set up a specific check on this activity, ASCP feels it is imperative that: (1) The report be earmarked for submission to the pharmaceutical services committee, and (2) that the pharmaceutical services committee be required to meet at least quarterly. As it stands now, no minimum meeting schedule for this committee—so essential to the development and maintenance of safe drug policies, procedures, and controls—is delineated.

Review of Patient Drug Regimen

Another integral tool in achieving patient protection and better care is the pharmacist's review of the patient's drug regimen, and here again ASCP urges that this excellent requirement be documented by submission of a written report of the patients so reviewed.

Each of the procedures suggested will assure that services provided by the consultant pharmacist are subject to established procedures for verification.

Assign staff responsibilities to the consultant pharmacist, document the fulfillment out of these responsibilities and the paper consultant pharmacist will be out of business as enforcement of the regulations becomes operational and patient care optimal.

In view of this committee's interest in utilization review as a means of attaining quality care in safe, efficient surroundings, the society must point out the proposed regulations do not specifically include the pharmacist as a member of the utilization review committee. We strongly suggest that this omission be corrected. The nursing home pharmacist, as the drug specialist with clinical training, experience, and such responsibilities as monitoring patient records, can help insure proper patient care at reasonable costs.

This is borne out by a Government-funded investigation well underway in California which indicates that increased and expanded utilization of the pharmacist does improve the quality and cost effectiveness of drug therapy in long-term care patients. With greater clinical involvement by the pharmacist and his part in the prevention and early detection of possible complications in drug therapy, costs are reduced for the treatment of life-threatening and clinically significant adverse drug reactions, drug interactions, as well as medication errors.

The incidence of cost rehospitalization from nursing homes to hospitals also drops. The society, thus suggests that the pharmacist's role as a vital link in the overall, long-term care of the aged cannot be denied and his membership on the utilization review committee should be mandatory.

To assure that the pharmacist is able to handle his assigned responsibilities, the proposed regulations have set down a commendable and significant requirement: The nursing home pharmacist must have training or experience in institutional pharmacy.

ASCP would like to see this concept carried further to include educational programs directed specifically toward the nursing home long-term care environment. Nursing home pharmacy is different from hospital pharmacy, and the differences are decisive. Relevant factors are the types of patients, their ages, lengths of stay, the nature of their illnesses, and the resulting modes of medical treatment. Different reimbursement programs for the patients and the challenge of various drug delivery and distribution systems for facilities without in-house pharmacies also play a part. As previously mentioned, the nursing home pharmacist must carry out his responsibilities where highly skilled nurses are not on duty full time and where physicians are not often present or available, as they are in hospitals.

Certification of Consultant Pharmacists

These special requirements for serving nursing homes are being recognized through the process of certification. Certification of consultant pharmacists is being instituted by Florida, New Jersey, Mississippi, and West Virginia State pharmacy boards, and Arizona and California State pharmacy associations.

These efforts reflect the growing realization that specialties do exist in pharmacy, that consultant pharmacy is such a specialty, and that certification is a rational way to identify pharmacists as to their qualifications to practice in a specific area. Underlying these reasons, how-

ever, is the key motivating factor: The understanding that the nursing home patient needs the protection of the pharmacist and that certification helps insure professional competency in the fulfillment of this obligation.

ASCP feels so strongly about this need for certification patient insurance, we are initiating our own national voluntary certification program. Furthermore, we suggest that such a system at the national or State level be considered as a way to reinforce professional training by continuing education and bring into sharper focus those practices needed in the nursing facility which are either totally or partially new, such as patient medical profiles, clinical aspects, utilization review, geriatric drug interactions, and in-service pharmacological training for nursing personnel.

Up to this point, I have been commenting directly on the proposed regulations for skilled nursing facilities. Now I would like to touch briefly on the proposed intermediate care facility regulations, in particular those sections pertaining to pharmaceutical services, medication review, and the administration of drugs and biologicals. There should be no lowering of standards for the ICF in any of these areas.

Because presently an ICF patient is defined only as less than skilled, but in effect could be and most often is in need of treatment paralleling the time he was classified as skilled, this patient should not be any less safe than other patients who reside in the same facility.

Very often, in fact, ICF patients require as much, if not more, drug therapy. Thus, it cannot be assumed that they are not ill enough to need around-the-clock nursing services. These patients do need medications around the clock; yet under the proposed regulations, nonprofessional personnel—sometimes even an orderly—may pass needed medications without any supervision.

The probability for medication error in view of already documented statistics involving licensed personnel is staggering. Also, it is assumed that the ICF patient's drug regimen warrants a monthly medication review by only a registered nurse or registered nurse consultant. Once again, in actual operation, more than this is required. Geriatric patients may react differently to the effects of even an average dose of drugs because of the altered physiology in aging. Also patients on medications for many common chronic illnesses often need frequent adjustments in drug dosages; and if responses to drug therapy are not adequately monitored, clinically significant drug reactions and interactions may be overlooked. The regulations mandate the services of a licensed pharmacist and considering the medication situation outlined, he certainly should be the professional to monitor the dynamics of drug therapy involved.

Maximum and Effective Use of Resources

In summary, the American Society of Consultant Pharmacists advocates that both the skilled and intermediate care facility regulations make maximum and effective use of existing resources.

One of these resources that has been grossly underutilized in our existing nursing home health care system is the pharmacist. He is the member of the health care team who has the most training and knowl-

edge in drugs. Moreover, the Nation's nursing home patients cannot afford the luxury of "paper" consultants.

The proposed regulations must define the responsibilities the consultant pharmacist professionally should assume, make sure he is qualified to assume, and fulfill the special pharmaceutical needs of the nursing facility, and finally, follow through with enforcement. Only then can the nursing facility "consumer"—the patient—be assured of a responsive national health care program with optimal protection afforded within the limits of sound economy and efficiency.

Mr. HALAMANDARIS. Thank you, Ms. Sommers and Dr. Kratz.

Dr. Kratz, the new proposed regulations call for automatic stop orders on medications, but there is no specific time for those stop orders to be in effect. The previous standard was 30 days. Now, we have the requirement of stop orders with no time limit prescribed.

Do you view that as a significant loss, is that a problem?

Dr. KRATZ. Yes, but under the new regulations the pharmacist is to review the patient's regimen on a 30-day basis, and that could seem as a stoporder.

Also the guidelines are important. There are situations where a patient has been started on a drug, and for some reason, because the physician has not been in contact with the patient, or the orders were renewed from one month to the next, and ultimately at the patient's cost, and possibly his safety, he has been taking drugs that he really does not need over a long period of time. The detection and correction of this situation will come from utilization review, and this is a very functional automatic stoporder.

Mr. HALAMANDARIS. The California study to which you refer indicates the average number of drugs taken by a patient in the sample of nursing homes is seven.

In other words, the patients on the average would take seven different drugs. If you take seven different drugs a day, I can forsee a very sharp possibility there can be an adverse reaction, or interaction of drugs. Is this a serious problem in your experience?

Dr. KRATZ. I have seen them to be a serious problem, causing the patient problems when two of these drugs can interact. Suppose this happened: The patient hemorrhaged, and maybe the facility does not have the capability of treating this hemorrhage. The nursing home would then have to hospitalize the patient, so there are drug-induced diseases as a result of taking drugs.

DRUG INTERACTIONS IN PATIENTS

Seven drugs per patient may be a little high. In my practice I have seen somewhere in the order of three to five drugs. This whole area of drug interactions is something new that everybody is looking at.

In our educational process, we are training the pharmacist to look for this, to recognize potentially significantly drug interactions.

Mr. HALAMANDARIS. Has this been neglected in the past as far as pharmacists are concerned?

Dr. KRATZ. Yes, it has.

Mr. HALAMANDARIS. For example, few pharmacists know that various antibiotics can be nullified by other drugs or foods, including aged cheese, would you agree with that?

Dr. KRATZ. Yes. This whole area is opening up. There have been books published within the past couple of years. In our nursing facilities, part of our standard procedure in getting a new order is maintaining a patient profile. When a new drug order is added to that patient's regimen, the first thing the pharmacist looks for is will this drug react with any other drug being taken and if it is a problem, discuss it with the physician, and make any appropriate changes before it can happen.

Mr. HALAMANDARIS. Is there any emphasis in schools of pharmacies at the present time to study geriatric drug interaction, taking into consideration the separate physiological needs, the reaction time of senior citizens?

Dr. KRATZ. Yes, there is a study in California where pharmacists are spending time in the facility, reviewing the patient-drug regimen, and looking for very specific geriatric drug interaction.

Another thing, in geriatric drug patients, you are talking of drugs taken day in and day out, and the minute you add another drug, there are definite changes of a drug interaction. For example let us say there exists a chronic drug use, any drug added to that might affect the body, so there is much greater potential for interaction.

Mr. HALAMANDARIS. And there would also tend to be a higher level of drug buildup in the patient's blood, because of reduced kidney function, and you could also state that larger doses of sedatives would be given. You could generalize and say some of the drugs given would have strong possibilities of side effects, which could be quite severe. I do not think this has been given proper emphasis.

Dr. KRATZ. I think there has been a trend to overutilization of drugs, particularly in the area of tranquilizers. Drugs are a major factor in the treatment of geriatric patients, but I realize they are not the total picture. The pharmacist is interrelated with other professions, like the social worker, physical therapist, the physician, and the nurse. The team approach is vital and I think in the past we have neglected the pharmacist.

I think he can be a very valuable member of the team in the nursing home. I know I feel I am.

Mr. ORIOL. In your statement, you say drugs are the primary module of treatment in the nursing home, more so than skilled nursing home care, for example. I would like you to elaborate on why you said that.

Dr. KRATZ. I think that if you look at a nursing home patient, you will find every patient is on some sort of medication, obviously to get this average of seven drugs per patient. And probably the patient is receiving it on a chronic basis.

CONCERNED ABOUT LOWERING STANDARD

The geriatric patient may have some infirmities that require a skilled degree of nursing care, but at the same time drugs are being used. Then when that patient goes from skilled nursing care requirement down to intermediate care requirement, he will still be using the same medication. This is why we are concerned about lowering the standard, because the drugs are very similar in both circumstances. The intermediate care patient may even be using more drugs, may be

ambulatory and walking around and still taking medicine for chronic disease.

Mr. ORIOL. I am just trying to determine whether you think it is undesirable; as you say here, drugs are the primary module.

Dr. KRATZ. No, I do not think it undesirable. I think it is a necessity.

Mr. ORIOL. You also say the pharmacist is the only logical choice to provide the knowledge necessary to oversee the entire spectrum of patient drug therapy.

Now, do you mean that the pharmacist oversees, or provides the knowledge to oversee, and if it is overseeing, what constitutes overseeing? Is he the person who blows the whistle when he thinks a person has a dangerous combination of drugs, and if so, how is that brought to his attention?

Dr. KRATZ. I think he is the person that blows the whistle, and how it is brought to his attention is by his participation.

He has got to be there. If he is maintaining a patient profile on that patient in his pharmacy, and he sees that drugs are being added to the regimen and there may be a problem, yes, I think he blows the whistle.

He has to tell the physician. I think one of the physicians testifying mentioned in his nursing home they have a mechanism for alerting potential drug interaction.

More of our pharmacists do this. They will not try to embarrass the physician, but I think they will bring it to his attention with some backup information.

Mr. ORIOL. Suppose it does embarrass the physician?

Dr. KRATZ. He should be embarrassed. Maybe he will not do it again if he is embarrassed.

I am trying to say we are doing it diplomatically. Most of the physicians have not been trained in the area of drug interaction; pharmacists have only been in the last few years. It is a very, very real part of our education. I know we are teaching patient care involvement, clinical pharmacy, drug interaction detection, and we hope we can carry this off into the community as well as into hospitals and nursing homes.

Mr. ORIOL. How do you arrive at the conclusion that this or that patient may be overtranquilized?

Dr. KRATZ. Looking at his chart, if you see a number of tranquilizers being used on him, where maybe one would work; if you see the dosage levels of either of these tranquilizers may be excessive; plus, if the nurses note the fact that the person is lethargic and not doing anything, just sitting there, not participating in physical therapy, whatever their normal routine is, then there is a good chance this person is oversedated.

OVERSEDATED "OUT OF NECESSITY"

Now, maybe the senile patient disrupting a whole floor requires a large dosage. In that case you would say yes the person is oversedated, but it is out of necessity. I think it is a question of interpretation, but also not just looking at the drug, but looking at the patient, the chart, and finding out the nurse's comments.

You get more clinically involved with the patient, you talk to the patient, and find out what the nurses are talking about with the patient.

Mr. ORIOL. Thank you.

Mr. HALAMANDARIS. I have one comment to make. You recommended and noted that the schools of pharmacy have stressed drug interaction to help pharmacists to detect something abnormal.

I am wondering if the average pharmacist on the street, and possibly one who has a vested interest in keeping their nursing home customers happy, would be willing to confront the nursing home administrator with the fact the nursing staff is prescribing medications on their own, or that the physician has been negligent in terms of what he has been prescribing.

Dr. KRATZ. First, I have seen practitioners who have been out of school for a few years coming back for courses. It is another area that the colleges are recognizing to be a definite need, and drug interaction is a big part of the continuing education programs of practicing pharmacists.

Second, I think part of this whole situation—the utilization of a pharmacist—involves education of the administrator.

I am generalizing but I do not think most administrators view the pharmacist as being anything but a supplier, and ASCP believes it requires some education of an administrator to the value of the pharmacist.

Mr. HALAMANDARIS. Thank you very much for your statement. We will excuse both of you.

Dr. KRATZ. Thank you.

Mr. HALAMANDARIS. We are quite anxious to hear the statement of Edward G. Krill, vice chairman, committee on legal problems of aging, American Bar Association.

STATEMENT OF EDWARD J. KRILL, VICE CHAIRMAN, COMMITTEE ON THE LEGAL PROBLEMS OF THE AGING, AMERICAN BAR ASSOCIATION

Mr. KRILL. Thank you very much.

In the interest of time, I am going to summarize a couple of the comments presented in my statement.*

I understand from the presentation of Dr. Edwards this morning, that HEW has represented that they will make certain changes in the regulations, and that these changes would relate to the specific areas to which I have addressed my comments.

My premise is that we have to assume that a portion of the patients which will be accepted by skilled nursing homes are acutely ill, and others are chronically ill. In both respects, the duty of the institution to concern itself with the quality of medical care I think is a developing legal duty.

The question of lowering standards is one against which I indeed would have to caution, and would have bad results. There has been a policy of transferring patients from the hospital, a much more expensive mode of care, to the skilled nursing home or the extended care facility. The liability in this situation is not very clear at this time, and I do not know if physicians woud come to fear for the welfare of their patients in a home supervised merely by licensed practical nurses.

*See p. 2810.

My conclusion, as I read the regulations the first time, was that an individual should not be very sick, should not require much medical supervision or care in the facility described.

If patients were to be accepted by homes described in the originally proposed regulations, frankly, I would not have advised as a private practicing attorney that any home merely meeting the regulations as originally described, accept an individual that had chronic or acute skilled nursing needs. I think that such a home would risk legal liability in doing so.

Emergency Requirement Deleted

In legal theory, when a nursing home undertakes to provide care for an elderly person or infirmed individual, and certainly the patient is helpless in many cases, the law takes this into consideration by providing that the patient shall have the opportunity, and is entitled to rely upon the facility as the only available source of medical care.

That goes to the emergency requirement which was significantly deleted in the proposed regulations.

The other requirement I have addressed in my comments, is that the nursing home must undertake responsibility to supervise the quality of medical care, and I frankly do not think that without the assistance of a physician, a home is in a position to do that.

The proposal of the American Medical Association, in testimony here today, I think addresses this problem quite well.

I am still not satisfied that the emergency problem will be taken care of, but I am satisfied that if the regulations as represented by HEW this morning were to be promulgated by the administration, if they are indeed promulgated, and do indeed result in firm regulations, it will have a solution to this problem, that is, the problem of institutional liability for care.

The last comment I wish to make is that I think that a physician's reputation needs to be of concern to an institution, and the physician's performance in prior cases needs to be of concern to an institution, as it is, of course, of concern to a hospital. With the assistance of a medical director in controlling the quality of care provided by attending physicians, he is possibly in a position to free the home from civil liability on this basis. I believe a home has a duty to refuse admission to any patient who had in the opinion of the institution, which opinion is formed with the assistance of a medical director, failed to provide adequate or good quality medical care on prior occasions, unless that patient would select a different physician.

I will be happy to answer any questions.

Mr. Halamandaris. Mr. Krill, thank you.

Let me ask you if you agree with me, that the new proposed regulations have deleted many specifics, and that being what I call vague generalizations, that it would be very difficult to enforce, indeed from a practicing attorney's point of view, if you represent a client that had a suit against a nursing home, would it not be more difficult to prove your case under the proposed regulations?

Mr. Krill. I find the proposed regulations to be of no assistance whatsoever, and I would have to rely on general principles of law.

I would have to prove negligence, I believe, and would find it very difficult to prove an individual was or was not receiving care to which

he was entitled as a beneficiary of the Federal program. The point being I would find it difficult to determine what the intent, what the entitlement was under the Federal program, under the proposed regulations.

I agree with Marilyn Schiff and Marilyn Rose.

Mr. HALAMANDARIS. Is it like saying there are no standards?

Mr. KRILL. I would have to agree with judicial opinion to that effect.

WHY ARE NURSING HOMES NOT SUED?

Mr. HALAMANDARIS. Let me ask you a question, I have worried about this for some time, hospitals have been exempt from legal liability for one or another reason, and principally, it is because they are nonprofit institutions, and nursing homes, most of them do not have this exemption, and I have wondered why is it that we see so few suits against nursing homes, what is your opinion?

Why are nursing home operators not sued to a greater extent, if all of these stories we hear are true, of the kind of horrendous care we hear by patients in nursing homes, could it be that nursing home patients do not have surviving family members?

Mr. KRILL. I think I can make several comments and explanations, some of which are highly critical of my own profession, some of which are highly critical of the state of the law at this time. In order to obtain a case, a lawsuit, one's complaints must come to the attention of a practicing attorney, and I have to say since there are few individuals in nursing homes on a routine basis concerned with the welfare of relatively helpless patients, that until family is advised of problems, or unless it comes to the attention of an attorney, nothing happens.

The group of attorneys most active in suing nursing homes and hospitals in the area of health care rights have been OEO lawyers, and they have to some extent solicited this responsibility with the aid of social workers. I would agree that that is correct in an ethical sense, and this is the way many complaints come to the attention of trained OEO attorneys. The other problem is that the law does not provide the volume of recovery in a case of older persons, injured, or indeed killed as a result of negligent activities of any kind. The measure of damages in law is lost income, the measure of damages in the case of a married older person is loss of income to the spouse. Recovery has to do with the economics of things and measurable damages has to do with the property rights of the individual, and older persons simply are not in an income-producing position. Rights to substantial recovery for negligently inflicted injuries do not exist under the civil laws as they are today for older persons.

WHO IS RESPONSIBLE IN NEGLIGENCE CASES?

Mr. HALAMANDARIS. Let me ask you this, in your experience, do nursing home operators carry malpractice insurance? The second question is, under the traditional law, civil laws as we know them, is it not the administrator that is responsible for the torts of the employees?

In other words, if the nurses commit acts of negligence against the specific patients in a nursing home, is not the administrator as well as the employee, responsible for the action of these employees?

Mr. KRILL. On the question of insurance; yes, I believe a general liability and casualty insurance is normally carried.

Second, with few exceptions, the institution's responsibility does extend to the acts of all employees.

At times there is question whether or not an individual in a home is an employee of that home.

For example, in the case of a private duty nurse hired by the patient or his family during a period of illness, that individual is not considered an employee of the home. The administrator is the one who has the responsibility with regard to liability, a distinction from the corporate liability in the home, in the event a nurse over a period of time exhibits negligent or careless conduct, and the administrator as the supervisor would have individual responsibility for this if he failed to discharge her. He is personally negligent to that extent, the administrator along with the nurse and the home, all would be individually and separately responsible for any particular injury to a particular patient.

Mr. HALAMANDARIS. I thank you for those answers, and for a very fine statement. Of course your entire statement will appear in the record, and we will excuse you.

Mr. KRILL. Thank you.

[The prepared statement of Mr. Krill follows:]

PREPARED STATEMENT OF EDWARD J. KRILL, ESQ., VICE CHAIRMAN, COMMITTEE ON THE LEGAL PROBLEMS OF THE AGING, AMERICAN BAR ASSOCIATION

I am appearing today to represent the views of the committee on the legal problems of the aging of the section of family law. These views do not necessarily represent the policy of the American Bar Association, but are my personal views as a private practicing attorney, and those of the committee of which I am vice chairman.

This committee should be commended for its continuing interest in the real difficulties faced by the aging, arising because of inadequate general laws for which my profession must somewhat answer, and the problem created by the inadequate administration and implementation of federal programs. This is possible the only federal forum of like concern.

In a sense, my statement is supplementary to a presentation to this committee by Norman J. Kalcheim on August 11, 1970. This covered a broad range of legal problems including the retroactive denial of benefits under Medicare and Medicaid, problems of involuntary commitment and estate administration and the effect of property taxes on the ability of the elderly to maintain a private residence. In reviewing that presentation, I find that most, if not all, of the legal problems then described remain. Some progress may have been achieved under Public Law 92–603, the Medicare amendments of 1972. Retroactive denials of benefits was cited in 1970 as a major shortcoming of Medicare.

In section 213, a waiver of beneficiary liability occurs where claims are disallowed through no fault of the beneficiary (which I would contend is true in every case where the beneficiary is not a physician). This section has not yet been implemented by regulations. This month marks the first anniversary of Public Law 92–603. The administrative inaction in this area should be of concern to this committee.

Today I wish to comment on one aspect of the proposed regulations implementing sections 239, 246 and 249A of Public Law 92–603, as published in the Federal Register of July 12, 1973 (Vol. 38, No. 133), to provide a common set of standards under Medicare and Medicaid for skilled nursing facilities. Specifically, I wish to review the proposed condition of participation, section 405.1123, "Physician Services." There are other areas of interest and concern in these proposed rules, but I believe that other witnesses have made the points of importance quite adequately.

I wish to concentrate on the question of whether this proposed regulation represents a requirement to conform to civil negligence law It is my opinion that

the least a Federal standard should require of skilled nursing facilities, as a condition of providing care, is that the facilities act in a manner which does not expose them to civil liability for careless, negligent or imprudent action.

The proposed rule requires "patient supervision by a physician." (Section 405.1123(b)). This is defined as requiring each patient to be under the supervision of a physician, who prescribes the proper regimen of care, and must revise this every 30 days. Physician visits are also required every 30 days (section 405.1123(c)) unless the attending physician, 90 days after admission, deems another period between visits to be appropriate and so notifies the State Medicaid agency and in the event this determination is confirmed by the utilization review committee or medical review team. A written plan for having a physician available to furnish emergency medical care must be at each nurses' station. (Section 405.1123(c)).

These regulations place considerable reliance on the nursing staff, which might include of only one registered nurse, during an 8-hour day, 5 days per week. (Section 405.1124(c)).

One wonders how the patient care regimen, required to be revised every 30 days (section 405 1123(b)), can be revised in the absence of a physician. One also wonders how it might come to the attention of a physician that a patient's condition has changed, after the 90-day determination not to see the patient has been made.

This committee has cited the problem of the physician's absence from the nursing home and the lack of institutional responsibility for medical care in connection with the salmonella deaths in Baltimore, which were the subject of hearings by this committee.

Rather than a responsive step toward meeting this problem, the regulation would indeed result in a "dilution (and) weakening of standards for skilled nursing facilities" contrary to congressional intent in enacting section 249. (S. Rep. No. 92-1230, 92nd Cong., 2nd Session, 1972, p. 282.)

The question I wish to raise is whether compliance with the standard proposed by section 405.1123 falls below that in effect by operation of the law of torts (liability for negligence) and possibly the law of contracts. It is my view that to do no more than required under these proposed regulations seriously risks a judgment of negligent action against a skilled nursing facility. I would so advise a client, and wish to explain this view to the committee.

When a skilled nursing home undertakes to provide care for an elderly or infirm individual, certain duties arise by operation of law. These duties are based in part on a recognition by the law that such persons, by their condition, give notice to the facility of their needs for adequate food, shelter, supervision, recreation, and assistance with the management of certain aspects of their personal lives. If a facility is not prepared to meet these known needs, or is unable to do so, it is legally required to refuse admittance, for admission constitutes a representation to the patient that the care required will be available. There arises, in my opinion, an unwritten warranty and legally binding commitment that the facility is ready, willing and able to provide the full range of care and services without the aid of additional arrangements by the patient. This means that a skilled nursing facility, must independently arrange for adequate medical care and supervision of each patient and cannot rely on the good graces of attending personal physicians to discharge its duties.

This view arises in consideration of recent developments in the field of hospital law, which I believe are substantially transferable in principle. In *Darling* vs. *Charleston Community Memorial Hospital*, (33 Ill. 2nd 362, 211 N.E. 2nd 253), the Illinois Supreme Court found a hospital liable for the negligent conduct of a member of its medical staff. The case represents a departure from the previously established principle that physician's were independent contractors and liable only directly to the patient, with the hospital having no authority to practice medicine and therefore, no liability for malpractice. The case established a duty to supervise members of the medical staff and created liability on the part of health care institutions for the acts and omissions of physicians in the care of patients.

In a recent case, *Karrigan* vs. *Nazareth Convent and Academy, Inc.*, 510 P. 2nd 190 (Kan. May 12, 1973), a hospital was found liable for a patient's injuries which resulted after an operation. Nurses on duty were unable to contact the patient's physician and made no efforts to find another physician. The patient had repeatedly said he was in great pain and asked for physician.

The duty to supervise physician care, based on the Darling case, and the duty to procure medical aid, represented by the Karrigan decision are not embodied in the proposed regulations.

In the Darling case, the court stated that the institution was liable for the injuries to the patient on either or both of the following bases:

(1) That it failed to have a sufficient number of trained nurses who would have discovered and adequately assessed the patient's condition as serious, and would have known to obtain proper medical attention, and

(2) The failure of the institution to require the attending physician to property care for his patient or obtain substitute medical care as it should have appeared to the nursing staff that the patient was being improperly cared for.

In my judgment, a licensed practical nurse does not have sufficient training to assess a patient's condition and make a determination regarding the need for medical care in a sufficient number of instances. The symptoms associated with salmonella poisoning, for example, closely resemble those of common flu. Should events occur on a Friday evening, such an outbreak might remain undetected until Monday morning, or until the first patient died. The standard prescribed for nursing services, section 405.1124, if merely followed, exposes the skilled nursing facility to liability for failure to provide adequate nursing care. It would seem axiomatic that if a patient by definition requires skilled nursing care, it should be a program requirement at all times. I know of no scientific evidence acceptable in law concerning a lesser need for nursing care and supervision at night or on weekends.

Supervision of the quality medical care in the hospital is a function of the medical staff and its committees. This is a requirement of Medicare, accreditation and civil law at this time. In the nursing home I believe the time has come to formalize a process which assures the institution that its patients do indeed receive adequate day-to-day medical care and will have a physician present in the event of an emergency.

The proposed regulations, part "C" merely require a "plan" for emergency care, theoretically this could consist of a listing of private attending physicians and their phone numbers. This regulation does not reflect the duty to actually succeed in obtaining the services of a physician in an emergency. A bona fide attempt which does not result in a physician being present within a reasonable period could be the basis of civil liability. Police and fire department rescue squads and ambulances should be called in the event a private physician cannot be quickly present. This should be part of any "plan."

The other aspect of formalized institutional responsibility for the quality of medical care, which should be a program requirement, is a substitute for the hospital medical staff function. The report of the council on medical service B (A–73) of the American Medical Association entitled "Guidelines for a Medical Director in a Long-Term Care Facility" describes a method for:

(1) Assuring that the institution's legal liability for the quality of nursing and medical care is met, and

(2) Assuring adequate response to patient medical emergencies as a function of the patient's rightful reliance on the home in this event.

This report has been discussed by American Medical Association representatives before this Committee. I would add only that this appears to be virtually the only method of obtaining proper review of patient care under the Darling principle, without actually organizing attending physicians into a medical staff, with all the committee work this implies.

In summary, I would advise a skilled nursing facility to:

(1) Maintain 24-hour registered nurse coverage.

(2) Require registered nurses to advise attending physicians of their patients' condition on a routine basis.

(3) Retain the services of a physician to supervise nursing care and review the quality and adequacy of medical care.

(4) Require the nursing staff to move immediately to alternative sources of physicians' services in the event the attending physician were unavailable within a very short time, in an emergency.

(5) Refuse admission to any patient attended by a physician who had, in the opinion of the institution, failed to provide adequate or good quality medical care on prior occasions, unless the patient will select another physician.

Mr. HALAMANDARIS. I will ask the very distinguished lady in the back of the room, if she would like to be heard. I am referring to Eleanor B. Baird, past president of the American College of Nursing Administrators.

If you would like to make a brief statement for the record, you are certainly welcome.

STATEMENT OF ELEANOR B. BAIRD, PAST PRESIDENT, AMERICAN COLLEGE OF ADMINISTRATORS, MEDICAL SOCIAL WORKER, TWIN PINES CONVALESCENT HOSPITAL, NEW MILFORD, CONN.

Ms. BAIRD. I would like to comment very briefly. Actually, I was here to tape Senator Ribicoff's acceptance of an award.

On some of the remarks I heard this afternoon, I agree with everyone's comments regarding the lack of standards. I would hope that if nothing else, these hearings would stop the publication of the standards until there is adequate input from the field, and by the field, I include the consumer.

I would also ask the committee to remember that as you add to the services that are necessary to make nursing homes truly part of the health care team, you are adding to the cost.

In our own facilities, a medical director adds 22 cents per patient day to cost.

A consulting pharmacist developing drug profiles, on the scene at particular facilities, incidentally needs the inservice training programs mentioned, adds 30 cents per patient a day.

Educational programs in our facilities which our staff must attend, are not voluntary on their part, both in and out of the facility, in the last 2 fiscal years, have added a cost of 28 cents per patient day.

These are services that are not directly rendered to a patient.

If you have a cost for direct patient care of $22 a day, and you add another $2 per day for services not directly given to patients, but which indirectly benefit patients, someone must pay for it.

The National Council of Senior Citizens, and the Association of Retired Persons, are concerned that nursing homes are not providing the services the law requires.

I believe it is their duty to get across to the senior citizen living on $250 a month, that $600 a month for adequate nursing care in a long-term facility is not too costly.

Everyone wants Cadillac service for Volkswagen prices. It cannot be accomplished, regardless of who sets the standards.

You have heard me say previously many times, I do not believe you can set a standard too high if you are willing to pay for it, and if someone will guarantee it is uniformly enforced across the country.

The average rate in nursing homes today ranges from $9.90 on the upper west coast to $68.52 in New York City for exactly the same standards.

Somebody is not doing something right.

Mr. HALAMANDARIS. Thank you. We appreciate that statement for the record, and with that, the hearing will stand adjourned, subject to call of the chair.

[Whereupon, the hearing was adjourned at 3 p.m.]

APPENDIXES

Appendix 1

ITEM 1. LETTER AND ENCLOSURE FROM SENATOR FRANK E. MOSS, TO HON. CASPAR W. WEINBERGER, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, DATED OCTOBER 30, 1973

DEAR MR. SECRETARY: At the request of several national organizations in the field of care of the aged, my subcommittee on long-term care recently conducted hearings on the proposed skilled nursing home standards. Dr. Charles Edwards appeared on October 11 on behalf of the Department of Health, Education, and Welfare. The transcript of these hearings will be available in the near future but until then we thought it important to write you on several matters.

First a reminder and a request. Mr. Edwards promised the committee that the Department would make good on the promise we received from Under Secretary Veneman that HEW conduct a study of nursing home profits. May we have details of your plans in this regard? Additionally, Mr. Michelsen promised specific figures on the Medex program and detailed statistics relating to the implementation of the President's eight-point plan. Finally, the Department has undertaken a cost comparison of 1,000 nursing homes under private contract which is nearing completion and which we would like to request on behalf of the committee at your earliest possible convenience.

With respect to the testimony of witnesses at the hearings, there was near unanimity among the over 30 witnesses that the new proposed standards were but vague generalizations—mere ghosts of the previous standards. This is particularly curious in view of the clear and obvious congressional intent. Section 246 of the statute, Public Law 92–603, is clear that a "skilled nursing facility" is an institution which meets the prior definition of an extended care facility and which satisfies certain other Medicaid requirements.

Department witnesses said that the retreat from specific standards and factors was: (1) To promote flexibility in enforcement, and (2) as a consequence of the abandonment of the in-substantial compliance criteria.

It is our view along with representatives of the American Bar Association, the National Center for Health Law, the Michigan and New York departments of health, that the proposed standards are so flexible as to be unenforceable from the point of view of either surveyors or litigants. We applaud the Department's abandonment of the insubstantial compliance criteria but we feel strongly that this move does not justify the wholesale emasculation of the existing standards.

For these reasons we request on behalf of ourselves and more than 20 major organizations who testified that you restore some of the important specific factors when the regulations are next published. While we appreciate HEW's turnabout on the R.N. and medical director concept, a list of what we feel are significant losses from the previous regulations is attached to this letter. Without the addition of these specifics the proposed regulations represent an unconscionable retreat from the rudiments of proper care for the infirm elderly.

In three instances the subcommittee requests the addition of a standard not presently existing in the present Conditions of Participation in an Extended Care Facility. This relates to the definition of an administrator, the inclusion of a ratio of 2.25 hours of nursing care per patient per day as recommended in the Medicaid guidelines and the incorporation of a paitent's bill of right.

The attachment, however, does not reflect the Subcommittee's most vital concern and that is the implementation of Section 247 by the Department. Representatives of several national organizations testified that some 50 to 75 percent of the current nursing home population does not fit into either skilled nursing or

intermediate care category as judged by the proposed regulations. Witnesses projected that HEW will define "skilled nursing" very narrowly, perhaps as it is presently construed in the Medicare program, which would necessitate the reclassification and transfer of thousands of nursing home patients now eligible for Medicaid skilled nursing.

In this respect, you well know the statistics reflecting high incidence of mortality and increased morbidity that results when patients are transferred from one facility to another. We trust that you will use the utmost caution in promulgating standards under section 247 to prevent the wholesale declassification of patients which is feared by so many.

Finally a word about HEW rulemaking procedures. Present rules require that when proposed standards are significantly *raised* by HEW action, such changes must be published in interim form. These is no similar requirement when HEW's change results in *lowering* standards. The present rules protect only one interest group. It is suggested that whenever HEW makes any *significant change* in the regulations from their interim status that these changes be again proposed as interim standards available for public comment.

With best wishes,

Sincerely,

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

Enclosure.

SIGNIFICANT DELETIONS FROM THE CONDITIONS OF PARTICIPATIONS IN AN EXTENDED CARE FACILITY (THE EXISTING MEDICARE STANDARDS CODE OF FEDERAL REGULATIONS TITLE 20, CHAPTER III, PART 405) AND SIGNIFICANT OMISSION FROM THE NEW STANDARDS FOR SKILLED NURSING FACILITIES AS PROPOSED IN THE FEDERAL REGISTER ON JULY 12, 1973

SECTION 405:1101

(a) The new standards require an administrator to be licensed according to State law but in those States that do not have licensure laws or do not participate in Medicaid, the standard is high school education plus one year's experience. Public Law 90-248, section 1908, requires administrator licensure. HEW rules should require State licensure of administrators without exception in skilled nursing facilities.

(e) The existing rules refer nursing home operators to title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color or national origin in U.S. nursing homes. This standard was incorporated by reference into the existing Medicare regulations. Deleted from the proposed standards. it should be reinstated.

SECTION 405:1120

III, Requires written patient care policies with respect to a list of 14 enumerated items from admission to utilization review. These specifics should be reinstated in the final regulations in lieu of substituted language which says only that patient care policies should insure "the patient's medical and psychological needs."

SECTION 405:1121

A new section (j) should be added incorporating a patient's bill of rights. The section should read:

"(j) Standard: Patient's Rights. The facility formulates and distributes to patients and prospective clients or their representatives a Patient's Bill of Rights. As a minimum, it includes the points enumerated below.

"Proposed Bill of Rights for Long-Term Patients

"(1) The patient in a skilled or intermediate-care facility has the right to the best health care available, without regard to his or her race, religion, color, national origin, or ability to pay.

"(2) Neither a patient's age nor sex shall be used for discriminatory purposes in the provision of care, nor shall certain age or sex groups be used for experimentation without full medical justification and informed consent.

"(3) Health care, including medical assistance, shall in no way violate the constitutional guarantee of privacy and of protection against self-incrimination; these rights shall prevail during examination, diagnosis, and treatment and shall govern the maintenance of all health records, verbal or written down.

"(4) Except in emergencies, each patient must be informed of the treatment he or she is to receive, of the persons who will provide that treatment, of the nature of the treatment (whether it is generally accepted procedure or experimental), and the expected risks and benefits of such treatment to the extent they are known. The patient has the right to give or to withhold consent to treatment.

"(5) Where an individual patient cannot give informed consent to recommended treatment because of medical disability, language barrier, or condition of confinement, such consent must be sought from next of kin, guardians, or others who would assume responsibility for the patient's legal and moral rights.

"(6) The relationship between the patient and the provider of care shall be free of any representatives of enforcement, investigative, financial, religious, or social agencies, except as specifically requested or approved by the informed patient and without duress.

"(7) No person in need of medical assistance may be turned away or abandoned by any individual or organization, public or private, capable of providing the assistance. (This shall not be construed to conflict with the principle of informed consent.)

"(8) The patient has the right to advocate and work for change in the provision of health care and to communicate his or her complaints or comments to officials, management, family or public; such activity shall not be used to deny access to or continuation of care at any time of need or to deny the protections of all patient rights and guarantees.

"(9) Every patient (or his representative) has a right to examine on the premises of the health-care institution as well as any other place designated by government regulation or law information bearing on the institution's performance, in terms of quality of care, safety of environment, qualifications of staff and administration, ownership, and costs of care. Specifically, statements of deficiency made by local, state, and/or Federal agencies shall be available routinely to patients and their representatives.

"(10) The patient has a right to representation on policy-making bodies of institutions drawing support in any form from public revenues. Given the long-term nature of their institutionalization, patients have the right to designate representatives from those among their ranks willing and able to represent them.

"(11) The patient has the right to considerate and respectful care, to have a written copy of the rules and regulations applicable to his or her conduct, to have an opportunity to contest those rules by orderly procedures, and to change his institutional residence.

"In addition, the facility has a procedure for receiving and acting on complaints presented in oral or written form, the records of which are available to the state agency and the public. The facility designates an individual to receive complaints and report on their resolution. Where a patient has a legally recognized guardian or representative, the procedure for making complaints shall be offered to that person. The facility does not retaliate against complainants.

"The facility may formulate its concept of obligations the patient has toward the facility. Statements of patient's rights and statements of patient's obligations are handed out following review and approval by the certifying agency. Statements of obligation are approved when found not to abridge any of the benefits, assurances, and requirementc imposed on facilities under title XVIII and XIX."

SECTION 405:1123 PHYSICIAN'S SERVICES

Each skilled nursing facility should have the services of a medical director who agrees to be on call in emergencies, to be legally responsible for the medical care offered by the facility and to spend a specific amount of time in the facility as determined by the size of the home and the number of patients. Sections to be reinstated:

(a) (1) Which requires that patient information be obtained by the facility within 48 hours.

(b) (1) Which requires that medical evaluation be completed within 48 hours of admission unless the patient has been examined within 5 days previously.

(b) (3) Which requires that attention be given to the foot, sight, speech and hearing problems of the elderly.

(b) (4) Which requires stop orders on medications and treatments after *30 days* should be continued. New regulations require stop orders without specifying a time limit.

(b) (6) Which requires that a patient should be seen by a physician at least once every 30 days. New rules allow the patient to be seen only every 60 days after an initial 3 months where the patient is to be seen monthly.

(b) (7) Which requires that a physician attending nursing home patients make arrangement with another physician to cover for him in his absence.

(b) (8) Which guaranteed, in so far as possible, the right of each patient to select his own physician.

(c) (2) Which requires that procedures established be followed in an emergency.

SECTION 405:1124 NURSING SERVICES

Subsection (b) should be amended to require that nurses should adhere to the standards established for an organized nursing practice by the American Nurses' Association with particular attention to the need to conduct orientation and in-service training (b) (7), and (c) (2) that the registered nurse, director of nursing service, make daily rounds of all nursing units visiting each patient.

(d) Requirements with respect to charge nurses should be changed to read "in so far as possible charge nurses should be registered nurses and that licensed personnel should be on duty at all times."

(d) (4) The requirement that the charge nurse be able to recognize significant changes in patient's condition should be re-entered.

(e) (2) The amount of nursing time available for patient care should not be less than 2.25 hours per patient per day.

(e) (3) (iv) The admonition that patients be treated with kindness and respect should be reinstated.

(f) Reinstate entire sections (1), (2), and (3) which spells out that restorative nursing should begin immediately after discharge from the hospital (2) that nursing personnel should be taught restorative nursing measures to maintain good body alignment; that they should encourage and assist bedfast patients to change positions every two hours night and day to prevent bedsores.

(g) (3) Reinstate requirement that adaptive self help devices are provided to contribute to patient's independence in eating.

(h) (a) Should provide that a nursing care plan accompanies the patient or is obtained by the facility within 24 hours.

(b) If the patient has no nursing care plan it should be established within 24 hours.

(c) The nursing care plan should be reviewed and revised as needed.

(i) The entire section on in-service education should be reinstated with the addition of a new factor (6) continuing education should be provided or authorized for the professional staff.

SECTION 405:1125 DIETARY SERVICES

(b) (3) Should be reinstated which presently precludes the possibility of dietary staff being assigned outside duties which may interfere with the sanitation or safety of their dietary responsibilities.

(c) (3) Existing language states that persons with communicable disease or open wounds *are not permitted to work.* New language says should not be permitted to work. Old language is preferable.

(g) The section relating to the planning of menus should be reinstated. It provides that menus are prepared at least one week in advance, that menus provide for variety in eating, that they are kept on file with records of foods purchased and that enough food supplies are on hand for a one week period.

(h) Related to the preparation of food should be reinstated in its entirety. It provides that where necessary food should be cut or ground to meet individual needs and that table services are provided for all who can and will eat at a table including those in wheel chairs.

SECTION 405:1126 RESTORATIVE SERVICES

The new regulations should make clear that the medical director, medical and nursing staff are jointly responsible for restorative therapies along with therapists. Such therapy should be ordered on an individual basis.

SECTION 405:1127 PHARMACEUTICAL SERVICES

The new regulations should be changed to state explicitly that unlicensed personnel may not set up or pass medications. Other sections to be reinstated are:

(c) (3) Which spells out that medication prescribed to one patient may not be given to another patient.

(c) (5) Requiring that medication errors are promptly reported.

(c) (6) That up-to-date medical reference texts are made available to personnel.

(d) (1) That each patient's medication container clearly indicate the patient's full name, physician's name, the prescription number, the number and strength of the drug, date of issue, expiration date, of all time dated drugs, the name and address and phone number of the pharmacist.

(d) (3) That medication is kept in the containers it was received in and that transfer from one container to the next is expressly forbidden.

(d) (9) Medications having an expiration date are removed promptly and disposed of after such date.

SECTION 405:1130 SOCIAL SERVICES

New regulations should begin, "While Social Services are not expressly required by law, participating facilities should make an effort to consider emotional and social factors in relation to medical and nursing requirements, and particularly knowledge of the patient's home situation, financial and community resources should be considered with any eye to returning the patient to the community as soon as possible." Sections (a) (1), (2), and (5), should be reinstated.

(c) Should be reinstated which mandates in-service training and orientation for staff directed toward understanding the emotional problems and the social needs of sick infirm or aged persons.

SECTION 405: 1131 PATIENT ACTIVITIES

(d) (3), (4), (5), (6) and (7) should be restated; they provide:

(3) Patients are encouraged but not forced to participate in activities.

(4) Patients who are unable to attend religious services are assisted to do so.

(5) Patient's requests to see their clergymen are honored and space is provided for privacy during visits.

(6) Visiting hours are flexible and posted to encourage visiting by friends and relatives.

(7) The facility makes available a variety of supplies and equipment to satisfy individual needs including books, newspapers, magazines, radio and television, stationery, etc.

SECTION 405:1133 TRANSFER AGREEMENTS

The facility has in existence a transfer agreement with a nearby hospital. New language should be amended to include a requirement that the family be notified at once if the patient is transferred. Also to be retained from previous regulations are excluded sections (a) (5), (b) (2) and (3):

(a) (5) That institutions provide each other with information about their respective resources to determine if care for the patient is available.

(b) (2) Medical information should accompany transferred individuals including medical findings, diagnosis, rehabilitation potential, a brief summary of the course of treatment in the facility, nursing and dietary information, ambulation status and pertinent administrative and social information.

(b) (3) The transfer agreement provides for the transfer of personal effects. Particularly money and valuables, and for the transfer of information related to these items.

SECTION 405:1134 PHYSICAL ENVIRONMENT

(b) (2) The new standard for emergency lighting should be amended as in (b) (2) here which specifically requires the electrical service to be effective 4 hours or more, covering lighting at nursing stations, telephone switchboards fire alarm system, etc.

(d) (1) Reinstate the language as in this section which specifies that nurses' call system which registers at the nurses station can be found over each patient's bed, in patient toilet room and in the bath, tub or shower.

(e) Reinstate this entire section except for factor number (1). New requirement shall read: (1) Single rooms for patients should have at least 100 square feet of space and in rooms with multiple beds each bed should be provided with not less than 80 square feet of space provided, however, that no room should have more than 4 beds.

SECTION 405:1137

Utilization Review Subsection (b) of the *proposed* regulations should be amended to state that no one with a financial interest in the facility should be a member of the utilization review committee and the membership of such utilization committee should not be limited to physicians.

ITEM 2. LETTER AND ENCLOSURE FROM HON. CASPAR W. WEINBERGER, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, TO SENATOR FRANK E. MOSS, DATED JANUARY 16, 1974

DEAR SENATOR MOSS: This is a follow-up to my interim reply of November 19 to your October 30 letter that outlined a number of concerns of the subcommittee on long-term care regarding the proposed final regulations for skilled nursing facilities (SNF's). I have also received your letter of December 28, and would like to reply to the concerns expressed in that communication.

The material you requesed in your October 30 letter, together with responses to your comments on specific sections of the proposed final SNF's regulations, are enclosed. If you have further questions, please do not hesitate to let me know. I shall be glad to furnish any additional information you may need.

The transcript which was returned to your committee by the Department included Dr. Edwards' statement as delivered to the committee and thus the portions which were not read to the committee were deleted. We have no objection to the committee's decision to include in the transcript any of the portions of Dr. Edwards' statement which were not read in their entirety.

The Department's policy with respect to the three items mentioned in your December 28 letter has not changed. The first item related to the 30-day physician visit rule has been revised and will be published in the final regulations. The second item, the requirement for a medical director or organized medical staff, and the third item, the requirement for 7-day per week registered nurse coverage, will be published as proposed regulations in the very near future. Although we had hoped to include items two and three in the January 17 issue of the Federal Register containing the final SNF's regulations, we will not be able to because of additional time needed to permit staff to do the necessary research and work out appropriate language acceptable to participating agencies in the Department of Health, Education, and Welfare. These two items could not be incorporated in the final regulations because they were not included in the proposed regulations published in the July 12 Federal Register. Publication of these two items under the proposed rulemaking procedure will allow ample opportunity for comments.

I would also like to point out that as a result of comments received, we are also planning to include in the proposed regulations a discharge planning program and a patient's bill of rights.

The Department with the assistance of the National Fire Protection Association has developed a training program for State fire safety surveyors and has provided this training to approximately 600 surveyors. Three 5-day sessions were conducted during September and October 1972 in Boston, Chicago, and San Francisco. An additional three 5-day sessions were held in July and August 1973 for those surveyors who were not able to attend the sessions in 1972 as well as for newly recruited surveyors. In addition, in April and May 1972, the Department conducted seven 2-day regional workshops for State surveyors on the application of Life Safety Code requirements and documentation of findings. Continuing training courses are planned by the Department for new surveyors as well as for updating those presently employed.

With respect to requirements concerning carpeting, the Department is currently considering requiring a stricter interpretation of this Life Safety Code provision. This stricter interpretation would require that all carpeting not meeting the Steiner tunnel test will have to be replaced within a 1-year period.

I appreciate your continued interest in health care for our elderly and look forward to your continued cooperation and support in our efforts to improve care and to insure a greater degree of safety from fires in the Nation's nursing homes.

Sincerely,

CASPAR W. WEINBERGER, *Secretary.*

Enclosure.

RESPONSE TO QUESTIONS ABOUT SKILLED NURSING FACILITIES RAISED BY THE SUBCOMMITTEE ON LONG-TERM CARE*

Costs and Profits Studies

During the past 2 years, the Department has initiated several studies of the complex area of nursing home costs and profits.

A Touche Ross and Co. study, supported by the Medical Services Administration, Social and Rehabilitation Service, due for completion in January 1974, includes pertinent material on the relative differentials in costs of care in skilled nursing facilities (SNF's) and in intermediate care facilities (ICF's). The study was conducted in five States—Colorado, New York, Massachusetts, Michigan, and Maryland—and was based on evaluation of cost reports from nursing home administrators in those States. Data from the study will include analysis of direct and indirect costs, as well as information on the effect of various reimbursement systems in the five States.

Another study completed in October 1972, under contract from the Office of Nursing Home Affairs, covered costs and profits in nursing homes. The report, "Estimates of Costs, Revenue, Profits, Manpower Utilization, and Patient Dependency in Skilled Nursing Homes," was written by Douglas E. Skinner and Donald E. Yett, who at that time were, respectively, associate director and director of the human resources research center, University of Southern California, Los Angeles, Calif. A copy of that report is enclosed for your information.

Grants to the American Nursing Home Association and the American Association of Homes for the Aged are in the process of being awarded by the Bureau of Health Services Research and Evaluation, HRA, to obtain data on nursing home care costs provided through a variety of reporting systems. The systems for analyzing the costs of long-term care will be based upon a set of uniform cost elements that relate services to costs. The product of this research will be consistent with and applicable to the provisions of Public Law 92–603, which mandates that States will, as of July 1976, reimburse facilities participating in the Medicare and Medicaid programs on a basis reasonably related to costs.

The National Center for Health Statistics, Health Resources Administration, is currently conducting a nationwide nursing home data survey which includes information on facility characteristics, patient characteristics, staff characteristics, and costs. This study will furnish important baseline data in all these areas which will be useful in future studies concerning costs and profits.

Training

Provider personnel training activities are conducted under contracts let by the Bureau of Health Services Research and Evaluation, Health Resources Administration, and the National Institute of Mental Health, Administration on Drug Abuse, Mental Health, and Alcoholism. Each has long-term care education coordinators in the Department of Health, Education, and Welfare's Regional Offices to monitor training contracts, and promote and help conduct provider personnel short-term training activities in the States.

The short-term training activities to upgrade personnel in skilled nursing homes participating in the Medicare and Medicaid programs originally were negotiated with national organizations of health care professionals and nursing homes for their members. Contracts with national organizations have provided training for activity directors, registered nurses, licensed practical nurses, medical directors, administrators, social workers and pharmacists. Future plans call for training contracts for dietitians and medical record librarians.

A recent approach has been to create centers for continuing education in each region of the Department, using a long-term care institution as the site. These training centers are developing their own capabilities for continuing the training programs after Federal funds are discontinued. The thrust of the program also has moved from training personnel in a single health care discipline to training several disciplines in a single course.

NIMH training activities have focused on the mental health aspects of nursing home care and the role of the nursing home in caring for the mentally ill. Through June 30, 1973, one national conference and five demonstration training projects have been conducted.

In all, approximately 30,000 people to date have received training through the provider personnel short-term training program.

*For Committee response to the Department of Health, Education, and Welfare statement, see: Developments in Aging, 1973; annual report of the Senate Special Committee on Aging.

During fiscal year 1973, a total of 642 survey personnel from State agencies were trained in 37 courses conducted at five universities. Forty-six indepth State surveyor training workshops, sponsored by the Department's regional offices, reached 2,062 State surveyors and consultants. Ten Regional Office orientation programs also were conducted for over 150 newly employed State surveyor personnel.

In response to your request for information on Medex: The Department is funding 40 primary-care physician assistant training programs. Eight of these are Medex programs which are primarily for training former military medical corps staff, and through December 1973 will have 212 graduates. The other 32 programs will have graduated 496 through December 1973, for a total of 708 primary-care physician assistants. The Medex program has not been directly related to the nursing home improvement program but the additional number of health personnel in scarcity areas has undoubtedly added to available manpower to assist in patient care.

PATIENTS' BILL OF RIGHTS

The Department, along with your subcommittee, is committed to incorporating a patients' bill of rights in regulations where appropriate. The final regulations for skilled nursing facilities, to be published in the Federal Register in January 1974, will include a preamble that states that a patients' bill of rights will be developed by the Department and will be published initially as a Notice of Proposed Rule Making (NPRM).

A number of elements pertinent to a patient's bill of rights can be found in several sections of the proposed SNF's regulations. The new regulations will require the facility to have and enforce rules on the protection of the personal and property rights of patients (section 405.1121, governing body and management), and to include training regarding these rights in the facility's staff development programs. A further requirement is that, except in a medical emergency, the patient cannot be transferred or discharged, nor can treatment be altered radically, without prior consultation with the patient (or with next of kin or sponsor if the patient is incompetent). To section 405.1122 has been added a requirement that the facility's patient care policies include provisions to protect these rights, and that such policies be made available to the public. Additionally, discriminatory treatment in SNF's is barred by the requirement that facilities must be in compliance with title VI of the Civil Rights Act.

We understand that Congressman William S. Cohen of Maine has introduced a bill to develop standards relating to the rights of patients in SNF's and ICF's. We plan to consider this proposal as well as the suggestions of your subcommittee, and to seek consultation from national organizations of provider institutions and consumers, in developing a meaningful and enforceable patients' bill of rights.

TRANSFER AND RECLASSIFICATION OF PATIENTS

The Department does indeed recognize the need for caution in implementing standards or policies that might result in unnecessary or inappropriate transfer of patients from one facility to another. Since many facilities provide more than one level of care, reclassification of a patient's care plan need not always result in transfer to another institution. Facilities will be required to develop discharge plans for all patients to ensure that transfers are made to the appropriate level of care needed by the patient and with minimum patient disruption.

The Administration on Aging has been assigned direct responsibility for developing the necessary related policies, and for taking the lead in implementing a coordinated program to ensure arrangements for adequate and appropriate alternative methods of care are made at the community level for patients who are discharged from substandard nursing home facilities. This effort will be coordinated with the Office of Nursing Home Affairs in H as are other activities in the Department's nursing home improvement program.

CONDITIONS OF PARTICIPATION—SKILLED NURSING FACILITIES

The conditions for participation for SNF's have been developed as performance-oriented standards to ensure that all facilities participating in the Medicare and Medicaid programs provide the highest quality of patient care. The omissions identified and changes proposed by your subcommittee have been reviewed by agencies involved within the Department. Every consideration has been given to your subcommittee's detailed comments, and many of the changes suggested

are included in the final regulations that will be published in January 1974. Other items, such as the requirements related to the medical director, registered nurse coverage, and patients' bill of rights, will be published as Notice of Proposed Rule Making in the near future. Some of the items that the subcommittee commented upon will be covered in guidelines to program for use by providers as well as State agencies. It should be noted that the transfer of some of the language in the existing titles XVIII and XIX regulations to the guidelines will state that such requirements are regarded as implicit in the standards. The guidelines will also be made available to the public.

The following pages provide comments to your subcommittee's suggestions regarding specific sections of the SNF's regulations.

LICENSING OF ADMINISTRATORS, SECTION 405.1101(a)

The Federal Government cannot force a State to establish licensing regulations for SNF administrators; it can merely withhold Federal funds for benefits in a Federal program such as title XVIII or a Federal-State program such as title XIX. For participation, title XIX requires that a State must have provision for licensure of nursing home administrators. Arizona is the only State that does not license its administrators. Furthermore, Arizona has chosen not to participate in title XIX. Conceptually we agree that all SNF administrators should be licensed where a State licensure program exists, and that it would be of benefit to skilled nursing facilities without exception. However, as related to the care of the aged, to currently require licensure would deprive title XVIII beneficiaries of their Medicare program benefits in a State not participating in title XIX.

CIVIL RIGHTS ACT OF 1964, SECTION 405.1101(e)

The reference to the Civil Rights Act of 1964 is now included in 405.1901(d), following changes in numbering of items when revisions were made.

PATIENT CARE POLICIES, SECTION 405.1122(a)

(Error in letter reference to patient care policies as 405.1120 III.) The proposed regulations provide that patient care policies will govern the skilled nursing care and related medical and other services furnished by the facility and will reflect provision for meeting total medical and psychosocial needs of patients, including admission; transfer, and the range of services available to patients. This text will cover all significant aspects of patient care, without specifically enumerating in the regulations those individual items that are implicit in the standards. The 14 subfactor items which were cited will be incorporated in interpretive guidelines for providers as well as surveyor agencies.

PHYSICIAN SERVICES, SECTION 405.1123

(1) Policy with regard to emergency physician services are covered under 405.1123(c) as a responsibility of the facility. Each attending physician is responsible for the medical supervision of his patients. It is his responsibility, when he is absent or unable to provide care for the patient, to inform the facility as to who will be responsible for his patients. The medical director will ensure the implementation of these policies, but will not be required to be the backup for all attending physicians. (2) No medical director would assume "legal" responsiblity for "all" the medical care provided in the facility, such as by the other physicians. Furthermore, the governing body of the facility has responsibility to see that all attending physicians are appropriately qualified. (3) The "size of the home and the number of patients" should not alone determine the amount of time the medical director will "spend . . . in the facility;" the proposed regulation on medical direction (to be published as NPRM) says "part-time or full-time, as appropriate to the needs of the facility," which relates to the needs of the varying types of patients admitted to different facilities.

PATIENT INFORMATION, SECTION 405.1123(a)(1)

On the basis of comments from providers and consumers to the July 12 NPRM, changes have been made to specify information required on admission and information required within 48 hours after admission.

DETAIL REGARDING MEDICAL CARE, SECTION 405.1123(b)(3)

The detail regarding medical care (attention to foot, etc., problems) is considered part of routine medical care as a physician's concern in the patient's total program of care, and will be expanded upon and included in the guidelines.

STOP ORDERS, SECTION 405.1123(b)(4)

The last sentence in proposed 405.1124(h) requires that the physician be notified of an automatic stop order prior to the last dose, which provides tighter surveillance of drug administration than does the existing regulation.

PHYSICIAN VISITS, SECTION 405.1123(b)(6)

Changes regarding physician visits as requested have been made (revised standard (b)) so that, under the final regulations, during the first 90 days physician visits are required every 30 days. Subsequent to the 90 days, an alternate schedule is permitted provided that the attending physician justifies in the medical record that the patient's condition does not require 30-day visits, and that the alternate schedule is approved by the facility's utilization review committee and reported to the State XIX agency. At no time may the alternate schedule exceed 60 days between visits.

EMERGENCY CARE, SECTION 405.1123(b)(7)

This will be added under 405.1123(b), "Patient supervision by physician: each attending physician is required to make arrangements for the medical care of his patients in his absence."

CHOICE OF PHYSICIAN, SECTION 405.1123(b)(3)

We agree, and have added a requirement to the condition regarding the patient's right to select his physician under 405.1123.

EMERGENCY PHYSICIAN SERVICES, SECTION 405.1123(c)(2)

Emergency physician services are covered under proposed standard (c). Inasmuch as a broad variety of emergencies is possible, details regarding information required and procedures to be followed will be included in interpretive guidelines.

NURSING SERVICES, SECTION 405.1124

(1) It would be inappropriate to specify a particular nongovernmental organization, such as the American Nurses Association, in the regulations. However, the intent of the ANA standards on nursing practice will be addressed in the interpretive guidelines. (2) All employee orientation and training are covered in detail under 405.1121(h), Staff development. (3) Responsibility for "scheduling of daily rounds to see all patients" has been added to proposed standard (a), Director of nursing services.

CHARGE NURSE, SECTION 405.1124(d)

Proposed standard 405.1124(b) requires that the charge nurse for each tour of duty be a registered nurse or a qualified licensed practical (vocational) nurse. This statement clearly indicates preference for a registered nurse.

CHARGE NURSE, SECTION 405.1124(d)(4)

Qualifications for the charge nurse, referred to in 405.1101(c) and 405.1124 (b), covers the desired capability—that the charge nurse be able to recognize significant changes in the patient's condition.

RATIO OF NURSING CARE, SECTION 405.1124(e)(2)

The proposal to require a specific *ratio of 2.25 hours of nursing care per patient per day* has been opposed by the Department as unfeasible since such numerical staffing standards tends to have a lowering effect on quality of care by becoming

the ceiling above which provider institutions will not increase staff even if patient requirements warrant more staff. Also, the 2.25 ratio proposed is not included in either title XVIII or XIX current regulations; it appears as a suggestion in title XIX guidelines.

PATIENTS' PERSONAL AND PROPERTY RIGHTS, SECTION 405.1124(e)(3)(iv)

References to patients' personal and property rights, and to the need for awareness of, and provision for, meeting the total medical and psychosocial needs of patients are included throughout the proposed SNF regulations; i.e., as a responsibility of the governing body in 405.1121, as part of all staff development programs in 405.1121(h), and as part of the facility's patient care policies in 405.1122(a). The specifics relating to patients' rights will be detailed fully in the interpretative guidelines.

REHABILITATIVE NURSING, SECTION 405.1124(f)

(1) The suggested details now in subfactors that relate to what constitutes rehabilitative nursing will be covered in the interpretive guidelines which also will include additional details regarding rehabilitative nursing practices and procedures. (2) Training of personnel in rehabilitative nursing has been added to 405.1124(e). (3) Use of consultation services by the facility is covered under 405.1121(i), Use of outside resources.

DIETETIC SUPERVISION, SECTION 405.1124(g)(3)

Details regarding specific ways to assist patients toward self-help in eating will be covered in guidelines.

DRUG ORDERS, SECTION 405.1124(h) (1), (2), AND (3)

A change has been made to use the term "total patient care plan" (rather than "nursing care plan"), the former incorporating the latter, and being initiated, developed, and maintained by the nursing service (proposed standard (d). Patient care plan).

INSERVICE EDUCATION, SECTION 405.1124(i)

All personnel, including nursing service, are required to receive orientation and onging training, appropriate to their functions, under standard (h), Staff development, under 405.1121. It is specifically stated in the standard that inservice training includes confidentiality of patient information and preservation of patient dignity including protection of his privacy and personal and property rights.

DIETETIC STAFF ASSIGNMENTS, SECTION 405.1125(b)(3)

The following is added to 405.1125(f) in the revised regulations: "In the event food service employees are assigned duties outside the dietetic department, these duties do not interfere with the sanitation, safety, or time required for dietetic work assignments."

HYGIENE OF DIETETIC STAFF, SECTION 405.1125(c)(3)

Personnel policies and procedures covering all employees are included in 405.1121(g) and are written to ensure that personnel with communicable diseases or infected skin lesions are not permitted to work. Additional strength to ensure overall infection control has been established with a new condition on Infection Control, 405.1135.

DIETETIC FUNCTIONS, SECTION 405.1125 (g) AND (h)

Details of procedures for menu planning and retention and for food preparation were deleted in the regulations and will be included in guidelines which also will expand upon the variations possible in these procedures.

REHABILITATIVE SERVICES, SECTION 405.1126 (EXISTING)

The suggested additions already are in the proposed regulations, and are further reinforced in the condition on nursing services, particularly the standards on patient care plan and rehabilitative nursing.

PHARMACEUTICAL SERVICES, SECTION 405.1127

A number of States permit unlicensed personnel to be specially trained for administration of drugs. Requiring licensing in such States would be acting counter to our professed support of programs designed to upgrade and expand functioning of health care personnel, thus to utilize their abilities to capacity and help to alleviate personnel shortages. The detail in the subfactors cited were deleted to be included in interpretive guidelines. The pharmacist's services requirement has been expanded and strengthened considerably, and a pharmaceutical services committee established to monitor these services.

SOCIAL SERVICES, SECTION 405.1130

Social services now described in existing factors (a)(1), (2), and (5) are covered in the proposed standard (a), and are reinforced under the conditions on Patient Care Policies (405.1122), the standard on the patient care plan (405.1124(d)), and the standard on discharge planning which will be introduced as NPRM. This should accomplish the same goal as those suggested in your comments.

PATIENT ACTIVITIES, SECTION 405.1131

(Third paragraph on page 6 of the attachment related in error to social services.) The detail of the specific activities arranged for patients cited, ((b)(3), (4), (5), and (6)), which are only a few among an array of patient activities that are being provided today, were deleted to be included in interpretive guidelines. The suggestion that factor (b)(7) regarding space and equipment be added was accepted, and it was added to 405.1131(b). This also is supported under 405.1134(g), Dining and patient activities room.

TRANSFER AGREEMENTS, SECTION 405.1133

Notification of the family is already included in 405.1121(j), Notification of changes in patient status. This is reinforced under social service functions and will be further reinforced under the requirement for discharge planning. Factor (a)(5) will be included in discharge planning. Factor (a)(2), is already included in detail in 405.1123(a), Medical findings and physician's orders on admission, and will be further supported by the requirement for discharge planning. A requirement that security and accountability for patients' personal effects are provided on transfer has been added, as requested.

PHYSICAL ENVIRONMENT, SECTION 405.1134

Emergency lighting, (b)(2), is now covered under both standard (a) which incorporates the Life Safety Code and standard (b) on Emergency power. The item regarding the nurse call system, standard (d) on Nursing unit, has been expanded as requested. The suggestion about space requirements for patient rooms is merely a rewrite of the language in NPRM standard (e) on patient rooms and toilet facilities. (This standard also has been expanded to cover facilities for the mentally ill and/or retarded and to explain the waiver relating to existing buildings.)

UTILIZATION REVIEW, SECTION 405.1137(b)

Standard (b), composition and organization of utilization review committee, requires that "no physician committee member has a financial interest, direct or indirect, in the facility," unless the Secretary finds significant reason for it. This standard relates primarily to decisions regarding medical necessity for extended duration, a decision only a physician is permitted to make. Nonphysician membership is optional but it is possible and it is encouraged. The actual composition of the utilization review committee is dependent upon the overall staffing, patterns of facilities which can vary greatly from facility to facility.

Appendix 2

NATIONAL COUNCIL OF SENIOR CITIZENS COMMENTS, SUBMITTED BY MARILYN SCHIFF,* DIRECTOR, NURSING HOME OMBUDSMAN PROGRAM

ITEM 1. LETTER TO THE ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICES, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, DATED APRIL 2, 1973

DEAR SIR: Here are our comments on the proposed regulations for Intermediate Care Facility Services published in the Federal Register on March 5, 1973. These comments reflect the views of the National Council of Senior Citizens, a non-profit non-partisan organization designed to promote the interests of the elderly, and the Nursing Home Ombudsman Program; a Program sponsored by the National Council of Senior Citizens and operating under Contract No. HSM 110–72–203 of the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare.

In brief, the National Council of Senior Citizens and the Nursing Home Ombudsman Program strongly support the proposed regulations, and particularly the requirements that intermediate care facilities provide all needed rehabilitative services and therapeutic activities. Strong regulations for intermediate care facilities are even more important now than in the past, since the number of such facilities is likely to increase. Public Law 92–603 requires for first time that skilled nursing homes meet the higher standards set for extended care facilities, so many skilled nursing homes may now choose to "down grade" and become intermediate care facilities, rather than to "up grade" and meet the new requirements for skilled nursing homes. For this reason, it is important to require that intermediate care facilities meet stronger standards and that they no longer be permitted to provide mere subsistence care that has earned them the label of "warehouses for the dying".

While we strongly support the proposed regulations, we are suggesting several ways in which the regulations should be strengthened. We are particularly concerned with the need for patients' rights, which is recognized in the proposed regulations but treated summarily, and with the issue of enforcement. It is well known that enforcement was the weakest aspect of nursing home regulation, and yet the proposed regulations indicate no awareness of the enforcement problem and contain no provisions designed to facilitate enforcement.

Our suggestions for changes are:

I. DEFINITION OF INTERMEDIATE CARE

There is a need for criteria to determine what conditions qualify a person for intermediate care. Criteria for skilled care eligibility appear in HEW's Medical Assistance Manual,[1] but nothing comparable exists for intermediate care. Intermediate care covers a broader range of conditions than skilled care. The proposed regulations set appropriate standards for the upper range of care needed by some intermediate care patients, but they do not indicate that patients also qualify under the law for intermediate care if they need services only slightly above the level offered in bed and board facilities.[2]

*See statement, p. 2757.

[1] The Medical Assistant Manual (MSA–PRG–25) (11/13/72) lists in Chapter III some of the services that necessitate residence in a skilled nursing home. These include the need for intravenous feeding and cylsis, levine tube and gastrostomy feedings, nasopharyngeal aspiration and tracheostomy care, colostomy or ileostomy care, and catheterizations, etc.

[2] Section 1905(c) of the Social Security Act states that: "the term 'intermediate care facility' means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the care and treatment which a hospital or skilled nursing home 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,. . . ." (Emphasis added).

While we strongly recommend retention of the requirements for rehabilitative services, we also recommend that the regulations also clearly specify that persons not in need of rehabilitative services may also qualify for medical assistance in an ICF. Defining the minimum standards for ICF eligibility would accomplish two objectives: First, it would prevent erroneous denials of eligibility—an important factor because a person denied entrance to an ICF has no effective way to challenge the denial. (If such a person enters a bed-and-board facility, there is no medical or other review to determine whether he needs a higher degree of care). Second, it would prevent states from establishing narrow standards of eligibility and defeating the Congressional intent that ICFs serve all people who need more care than provided in bed-and-board facilities.

It is therefore proposed that § 250.24(a)(1)(i)(c) be amended by adding the following after the first sentence:

"Admission or continued care shall be recommended as to persons who do not require the care and treatment which a hospital or skilled nursing home 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. This category includes people whose physical or mental condition prevents them from performing by themselves the routine activities of daily living, including bathing, dressing, grooming, etc., even if such people require no other nursing care"

II. RESIDENT CARE PLANS

The requirements for therapy and activities will, if enforced, constitute a major improvement in resident care. We are recommending several changes to promote enforcement of these requirements.

1. § 249.12(a)(3)(ii), dealing with the resident's plan for rehabilitation, should be amended to require that such plan include "measurable goals to be achieved" in therapy. The requirement for "measurable goals" appears in proposed § 249.10(d)(1)(v)(b) (dealing with ICFs in institutions for the mentally retarded) and measurable goals are equally needed in other ICFs to provide a focus for therapy and to permit an assessment of its effectiveness. That section should also require that a plan specify how frequently therapy must be provided to assure that the plan is carried out as intended. Therefore, § 249.12(a)(3)(ii) should be amended to read as follows (material to be added is in italic):

"(ii) [A rehabilitative program is] Provided under a written plan of care, developed in consultation with the attending physician and an appropriate therapist, *which sets measurable goals to be achieved and which specifically states the number of times per week that each type of required therapy shall be provided.* The plan is based on the attending physicians' orders and an assessment of the resident's rehabilitation potential;"

2. § 249.12(a)(3)(iii), dealing with the resident's plan for rehabilitation, should be amended to require that each such plan be reviewed by appropriate professionals no less often than quarterly, (rather than "regularly") and that notations of the resident's progress be recorded and that new goals be set. Other portions of the proposed regulations specify the intervals at which plans must be reviewed,[3] and with rehabilitation being an essential objective of intermediate care, review must be required at regular intervals to assure compliance. § 249.12(a)(3)(iii) should be amended to read as follows (material to be added is in italic):

"(iii) [A resident's rehabilitative program is] 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 *as needed but no less frequently than quarterly by the attending physician, the appropriate therapist, and the health services supervisor or other appropriate staff member, with appropriate notations recorded describing the resident's functioning,* and the plan is altered or revised as necessary *and new measurable goals are set.*"

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[3] The resident's activity plan must be reviewed at least "monthly" (§ 249.12(a)(5)(ii)); and an ICF without an accreditated social worker on its staff must consult "monthly" with an accreditated social worker (§ 249.12(a)(4)(i)); physician visits cannot be less often than "quarterly" (§ 249.12(a)(7)).

3. § 249.12(a)(5)(ii) should be amended to provide specifically that activities be provided daily. (The proposed regulations require *daily* activities in ICFs in institutions for the mentally retarded, and there is no reason that activities, which are intended to be therapeutic, should be provided less often in other ICFs.) The section should also be amended to require that the resident's participation in the monthly review of his activity plan be indicated by his signature on his record. A requirement for a signature would constitute the only way to determine whether the resident was in fact consulted. Therefore, § 249.12(a)(5)(ii) should be amended to read as follows (material to be added is in italic):

"(ii) [Activities programming is provided which assures that] Independent and group activities are planned for each resident as a matter of record and provided *daily* in accordance with his needs and interests and each resident's activitiy plan is reviewed with the resident's participation at least monthly and altered as needed with appropriate notations recorded describing his social, *physical and intellectual* functioning. *The resident's participation in the monthly review of his activity plan shall be indicated by the resident's signature on his record.*"

4. § 249.12(a)(3)(i) provides that therapy may be provided by "qualified therapists, or by qualified assistants or other supportive personnal under appropriate supervision". There is no elaboration about what constitutes "appropriate supervision" for therapy provided by "other supportive personnel", who may, and probably will be people with no training in the area of therapy.

We recommended above that "measurable goals" be established for therapy. To make those goals attainable, we recommend that only qualified therapists should provide therapy, unless it can be shown that qualified therapists are unavailable. (As the proposed regulations are drafted, facilities could use supportive personnel to provide therapy even in areas where qualified therapists are in adequate supply). We also recommend that where a qualified therapist does not provide therapy, there be at least monthly, documented consultation with a qualified therapist. (This is similar to the requirement in § 249.12(a)(4)(i) for monthly documented consultation with a social worker.) There should also be monthly training by each qualified therapist for all supportive personnel who provide "therapy". Even with these provisions, facilities should be discouraged from using supportive personnel for therapeutic services, and should be encouraged to develop time-sharing agreements so that qualified therapists could divide their time among several facilities.

Unless these recommendations are adopted, it is likely that meaningless activity of no therapeutic value will be provided by many facilities under the name of "therapy".

Therefore, we recommend that § 249.12(a)(3)(i), be changed to read as follows:

"(i) [Rehabilitation shall be] Provided in accordance with accepted professional practices by qualified therapists or by qualified assistants under appropriate supervision, which shall mean consultation at least once a month by a qualified therapist in each area where a qualified assistant performs therapy. The consultation shall be documented by a written record showing the frequency and nature of the consultation with each qualified therapist and the services provided or obtained. If a facility can document that after a good faith effort it has been unable to retain the services of a qualified therapist or qualified assistant for a specific type of therapy, such facility may permit other supportive personnel to perform therapy, provided that such personnel have previously received at least ten hours of documented training by a qualified therapist in the appropriate area (which may be part of the in-service training program provided for in paragraph (a)(1)(ix) of this section), and provided further that such personnel continue to receive at least two hours training per month (which shall be documented) by a qualified therapist in each area of therapy. In addition, where supportive personnel perform therapy, a qualified therapist in each area of therapy shall provide consultation with the health services supervisor at least once a month (in addition to the two hours of training for the supportive personnel), and such consultation shall also be documented by a written record showing the frequency and nature of the consultation and the services provided or obtained."

5. § 249.12(a)(4)(ii) requires that the plan for providing each resident's social needs be "periodically reevaluated in conjunction with the resident's total plan of care". We recommend, in order to conform with § 249.12(a)(6)(ii)(c), re-

quiring at least quarterly review of resident care plans, that § 249.12(a)(4)(ii) be amended to read as follows (material to be added is in italic):

"(ii) There is an evaluation of each resident's social needs, and the plan for providing such care is formulated and recorded in the resident's record, and re-evaluated *as needed, but not less often than quarterly,* in conjunction with the resident's total plan of care;".

III. ENFORCEMENT

Enforcement is generally acknowledged to be the weakest aspect of nursing home regulation. Despite exacting federal standards for skilled nursing homes, many homes that fail to provide required services continue to be licensed and to receive Medicaid payments. Assuring compliance with the new ICF regulations may pose an even greater problem, because the regulations require a major change in the focus of intermediate care—from providing mere subsistence care to providing rehabilitation. Unless strong enforcement measures are adopted, many ICFs may make only nominal changes in their operations (such as retaining consultants) but continue, in general, to provide only the current level of care. While we have no panacea, we propose several new sections, which, in combination with our other recommendations (particularly, the recommendations that therapy be provided by therapists and that "measurable" therapeutic goals be set), should facilitate enforcement.

1. *Cumulative statistics.*—We recommend that ICFs be required to maintain annual, cumulative statistics showing the number of residents who received each type of therapy and the number who received treatment from a dentist, podiatrist, and optometrist.

One of the difficulties in enforcing current regulations is that almost all records of a facility are maintained on the level of individual residents, so it is difficult to determine the overall adequacy of a facility's performance. (For example, a state inspector can easily find out (by looking at his record) whether a resident had been receiving speech therapy, but the inspector could not find out—unless he read the records of every resident—the number of residents in the entire facility who had received speech therapy.) Availability of facility-wide statistics, showing the number of residents who had received each type of service would fill this gap. Such statistics would indicate whether the facility was providing a reasonable quantity of services (and an inspector could look for extenuating circumstances if the statistics appeared low).

The record of nursing homes in providing dental and optometric services is particularly poor. A recent HEF financed study in South Dakota [4] found that more than half the residents of long-term care facilities had curable vision defects, and that the facilities were not providing opportunities for residents to visit optometrists or ophthalmologists. And a study in Oakland County, Michigan,[5] found that more than three-quarters of long-term facility residents needed dental care. Facility-wide statistics would be particularly valuable in these areas.

We are also recommending that the facility-wide statistics be made available to members of the public, so that prospective residents can exercise knowledgeably their right to free choice of facility, and to enable consumer groups and competitive forces to exert pressure for greater provision of services.

Although we hestitate to impose an additional record-keeping burden on facilities, the information would serve as an invaluable enforcement tool, and it would be more easily compiled by the facility than by a state inspector or review teams. We therefore recommend that a new paragraph (15) be added to § 249.12(a) to read as follows:

"(15) [The facility] Maintains and makes available to the public annual records showing separately:

(i) The number of residents who received—

(a) Physical therapy by a qualified physical therapist.

(b) Occupational therapy by a qualified occupational therapist.

(c) Speech therapy by a qualified speech therapist.

(d) Audiological therapy from a qualified audiologist.

(e) Physical therapy, speech therapy, occupational therapy and audiological therapy from a qualified assistant therapist or from other supportive personnel.

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[4] Final Report of Visual Screening of Residents of Nursing Homes in South Dakota, June 30, 1969–June 30, 1972, Older Americans Act, Title III, Grant No. 3–69–02.

[5] Citation unavailable at present time.

(ii) For each category in paragraph (i) of this section, the average number of hours per week that such therapy was received by each resident;

(iii) For each category in paragraph (i) of this section, where therapy is not given individually, the average number of residents in each therapy group; and

(iv) The number of residents treated or diagnosed by

(a) a dentist on other than an emergency basis

(b) a dentist on an emergency basis

(c) a podiatrist, or who received podiatric care from a physician; and

(d) an optometrist or opthamologist."

Use of cumulative statistics may also help enforcement in two other problem areas—abuse of tranquilizers (to control residents and to limit their requests for activity) and excessive economies in the purchase of food. If facilities were required to compile cumulative statistics showing total consumption of tranquilizers and showing expenditures on food, state inspectors might more easily spot violations in these areas.[6] Also, if these statistics were made available to the public, public pressure could be brought to curb violations.

We therefore recommend a new paragraph (viii) be added to § 249.12(a)(9) to read as follows:

"(viii) ((Facility's policies relating to drugs shall provide that)) Expenditures for tranquilizers used by all residents of the facility shall be recorded separately by the facility, and a report shall be compiled once each year, which shall be available for inspection by the public, showing the total expenditures for tranquilizers by all residents of the facility during the prior year."

We also recommend that a new paragraph (ix) be added to § 249.12(a)(10):

"(ix) The facility maintains figures showing the cost of food which it uses to compute once each year, in a report to be made available for inspection by the public, the average amount spent per day for feeding each resident."

2. *Resident evaluation of facility.*—Current practice in inspecting long-term care facilities does not include consultation with residents. While some types of care may require professional evaluation, no one knows better than a resident whether his overall needs are being met. We are recommending that states provide for evaluations of ICFs by residents. Obviously, the state need not accept definitively every assertion by a resident, but the resident evaluations might reveal otherwise hidden violations and would indicate conditions in the home that an outsider could never experience. Finally, evaluation by residents might prevent flagrant staff abuses (such as brutality) and would provide state agencies and review teams information on how to improve conditions in his home.

We therefore recommend that a new paragraph (17) be added to § 249.12(a) to read as follows:

"(17) Once each year, each state shall deliver to each ICF resident within the state a form on which the resident may, with the assistance of his family if he desires, evaluate the facility, the care and services offered and individual staff members. Provision should be made for residents to return the evaluation form to an agent of the state so that no staff member of the facility has an opportunity to see it. The information contained in the resident evaluations shall be considered by the state in conjunction with its annual inspection of the facility. Where appropriate, the state may show a resident's evaulation to a staff member of the facility, but in such case, notwithstanding anything to the contrary, the name of the resident shall not be disclosed unless the resident has specifically given his permission in writing."

IV. PUBLIC ACCESS AND PUBLIC INFORMATION

In the last two years, several lawsuits have been generated by attempts of long-term care facilities to deny interested members of the public access to such facilities. To our knowledge, it has been uniformly held that denial of access violates the First Amendment Rights of residents of such facilities.[7] To obviate the need for further lawsuits in other states, we are recommending that the ICF regulations include a specific requirement that access be granted at reasonable

[6] It should not require a Senate investigation, as it did in Chicago, for government to learn that a nursing home was spending only 58 cents a day per patient for food. "Trends in Long-Term Care," *Hearings Before the Subcommittee on Long-Term Care of the Senate Special Committee on Aging*, 92d Cong., 1st Sess., pt. 13, at 1251.

[7] *See Citizens for Better Care* v. *Alden Care Enterprises* (Wayne County Cir. Ct., Stipulation and Order, Aug. 17, 1972); Proposed regulations granting access to nursing homes, 3 Pa. Bull. 76. (Jan. 13, 1973).

times to anyone desiring to visit, or talk to residents, or to inform them of, or assist them in asserting their legal rights.

In other portions of our comments we recommend that certain information be made available to the public (in addition to the information that would be made publicly available under § 249.12(1)(a)(j)(x) of the proposed regulations.) To enable people to exercise their right to inspect we also recommend that the facility post a list of all publicly available information.

Therefore, to provide for access to the facility and for public inspection of available information, we propose that a new paragraph (16) be added to § 249.12(a) to read as follows:

"(16) [The Facility] Permits members of the public to enter the facility at least 5 days a week for no less than four hours each day between the hours of 9:00 A.M. and 5:00 P.M. for the purpose of—

(i) visiting or talking to residents or informing residents of their legal rights or assisting residents in asserting their legal rights, and

(ii) inspecting any information concerning the facility which must be made available for public inspection pursuant to this Section. Each facility shall keep posted in a prominent place in the lobby of the facility a list of all information concerning the facility that must be made available for public inspection pursuant to this section. Such list shall state the days and hours when information may be inspected and residents may be visited for the purposes set out in paragraph (i) of this section. The list shall also state that survey reports are, by law, available for inspection by members of the public, and shall state the address and time that a member of the public may inspect them.

V. RESIDENTS RIGHTS

The proposed regulations recognize the need for clearly defined rights of residents in ICFs (§ 249.12(a)(l)(x)). That section, however, does not go far enough, and we propose that a list of rights be included in the regulations.[8]

Clearly defined rights are essential to preserving the humanity and dignity of long term care residents, and their promulgation should not depend on the states or on the good will of nursing home administrators and owners. The rights that we recommend are taken, in large part, from Recommended Regulations for Health Care Facilities proposed by the District of Columbia in October, 1972. We therefore recommend that § 249.12(a)(l)(x) be amended to read as follows:

"(x) There is made available to interested members of the public and given to staff, residents and residents' next of kin, copies of all policies of the facility, including a written outline of its objectives and a statement of the rights of its residents. The statement of the rights of residents shall include as a minimum that:

(a) Facility staff members shall not handle the personal business affairs of residents without being requested in writing by the resident or duly appointed guardian.

(b) A written account is maintained on a current basis for each resident with written receipts for all personal possessions and funds received by or deposited with the facility and for all expenditures and disbursements made by or in behalf of the resident; funds deposited with the facility for use by a resident shall not be comingled with the general funds of the facility and should be drawn upon only with the full knowledge and written approval of the resident or his duly appointed guardian.

An accounting shall be provided for each resident no less often than monthly, and the resident shall indicate by his signature that the accounting has been given to him.

Any request for funds by a resident shall be honored within a 48-hour period, other than weekends or holidays.

The resident's account, at the time of his transfer, discharge or death, shall be concluded within 30 days, with refunds promptly rendered to the resident, his guardian, or estate, as appropriate.

(c) The facility shall provide for the safekeeping of possessions and valuables of residents if they request this service. In such cases the resident

[8] In this connection, it should be noted that the American Hospital Association has adopted a "Patient's Bill of Rights". Residents of long term care facilities are far more in need of defined rights, since their stay in the institution is of longer duration and their contacts with the community are fewer than those of hospital patients.

or his duly appointed guardian shall be provided with a receipt for these items.

(d) Residents' mail shall be delivered unopened.

(e) Residents shall have access to a telephone or the right to have his private telephone.

(f) Wherever possible, provisions shall be made for residents to bring their personal possessions and furnishings to their living quarters.

(g) Physical and mental abuse of residents is prohibited.

(h) Each resident shall have the right to retain the services of his personal physician.

(i) Provisions shall be made to meet the spiritual needs of the resident by:

(a) Advising the proper clergyman of a resident's admission to the facility if the resident so requests.

(b) Allowing residents to attend religious services of their choice in the community.

(j) No religious beliefs shall be imposed on any resident.

(k) A resident may request any services that he thinks are needed. (A list of all services that the facility must provide pursuant to these and other regulations, shall be attached).

(l) A resident may contact the nearest Social Security Office with any complaints about the facility. The address and telephone number of that office should be provided.

(m) A resident shall have the right to consume a reasonable quantity of alcoholic beverages, to be provided at the resident's expense, unless the resident's physician orders otherwise.

If the above recommendations for a list of residents' rights is adopted, a conforming amendment will be needed in § 249.12(a)(1)(vi).

VI. MISCELLANEOUS

1. § 249.12(a)(1)(xi)(c) requires that a resident and next of kin (in addition to attending physician and responsible agency) be "consulted in advance" of any transfer or discharge. To ensure enforcement of this section, we recommend, in addition, that a resident and next of kin be required to sign a statement indicating that they have, in fact, been consulted in advance of the transfer or discharge.[9]

Therefore, Section 249.12(a)(1)(xi)(c) should be amended by adding the following after the first sentence:

"Prior to any transfer or discharge, a resident shall be required to sign his record and indicate whether the transfer or discharge is being effected with or without his approval. His opportunity to indicate that the transfer or discharge is being effected without his approval shall be made clear to the resident."

2. § 249.12(a)(11)(iii), that sets standards for residents bedrooms does not specifically require that individual storage space be provided. We recommend that at the end of the section the following language be added (taken from the 1969 regulations for intermediate care facilities 34 Fed. Reg. 9784 (1969), formerly 45 C.F.R. § 234.150(a)(4)(viii)):

"and that individual storage facilities for clothing and personal articles be provided."

3. § 249.12(a)(10)(vii) requires that special implements for eating be provided when needed, but makes no provision for personal assistance in eating. We therefore recommend that the following language be added at the end of that paragraph:

"and that personal assistance in eating (feeding) shall be provided when needed."

4. § 249.12(a)(6)(iv) states that "health services personnel" be present in "sufficient" number to assure adequate care of patients. By way of contrast, § 249.13(a)(8)(iii)(a) prescribes minimum staff-to-resident for intermediate care facilities in institutions for the mentally retarded. We understand the reluctance to prescribe a minimum staff-to-resident ratio, and we would like to recommend a compromise between a rigid ratio and the overly vague require-

[9] Such a requirement might have obviated a recent California lawsuit (that has not yet been decided) where a patient sued a nursing home for having transferred him unwillingly to a mental institution. *David* v. *Nicholson* (Stanislaus County Superior Court, No. 120135).

ment of the proposed regulation. The compromise would be to specify a staff-to-resident ratio that would be "presumptively sufficient" to provide adequate resident care; but to permit states to specify lower ratios if they could establish that the lower ratio did not compromise the quality of resident care. In this way the regulations would avoid undesirable rigidity while establishing a standard for adequate care. A similar approach is taken in § 249.12(a)(7), which requires that a physician visit each resident "as needed and in no case less often than quarterly unless justified otherwise and documented by the attending physician".

We hope that you will give favorable consideration to these comments.

Sincerely,

WILLIAM R. HUTTON,
Executive Director.

ITEM 2. LETTER TO THE COMMISSIONER OF SOCIAL SECURITY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, DATED SEPTEMBER 12, 1973

DEAR SIR: Here are our comments on the proposed regulations for Skilled Nursing Facility Services published in the Federal Register on July 12, 1973. These comments reflect the views of the National Council of Senior Citizens, a non-profit, non-partisan organization designed to promote the interests of the elderly, and the Nursing Home Ombudsman Program, a Program sponsored by the National Council of Senior Citizens and operating under Contract No. HSM 110–72–203 of the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare.

We are gravely concerned about the disregard of patients' needs evidenced in the proposed regulations. We strongly urge that the Department reconsider its position and adopt final regulations that will foster decent care for patients in skilled nursing facilities.

President Nixon in two speeches in 1971 promised to eliminate Medicare and Medicaid subsidies to substandard nursing homes. The Department of Health, Education, and Welfare is apparently responding to this challenge not by raising the quality of care, but by lowering the standards.

In the face of Congressional mandate in P.L. 92–603 to improve quality of care, your Department has responded by:

—deleting the current requirement for physician visits every thirty days;

—failing to adopt reasonable staffing standards for skilled nursing personnel;

—deleting the current requirement that a registered professional nurse visit each patient daily;

—deleting the current requirement for training in restorative nursing;

—deleting the current requirement that therapists work with physicians in developing the patient's total plan of care.

Although enforcement has been the major problem in nursing home regulation, the proposed regulation seems purposefully designed to impede enforcement instead of measurable standards. The proposed regulations prescribe only such generalities as "an active program of restorative nursing care" (§ 405.1124(e)); "a sufficient number of qualified nursing personnel" (§ 405.1124); "appropriate orientation" for new employees (§ 405.1121(g)); "adequate space and equipment" for restorative services (§ 405.1126); and updating "as necessary" of patient care plans (§ 405.1124(d)). Standards of this nature are inherently unenforceable, and amount to no more than exhortations.

Officials of the Department have stated recently that guidelines (to be issued at an unspecified future date) will supply needed clarification. Guidelines, however, are of questionable legal status and it is unclear whether a facility could be de-certified for non-compliance with a guideline. The proposed regulations do not mention guidelines—the section dealing with certification of facilities, speaks only about "compliance with all standards contained in Subpart K of Regulation 5" (§ 405.1908(a)). If the Department considers guidelines to be binding, then issuance of regulatory material in the form of guidelines serves only to bypass the Administrative Procedures Act and its requirement for public participation in the regulatory process.

We find ourselves perplexed at the sudden about-face of your Department on the matter of nursing home standards. Since the Presidential directive of 1971,[1]

[1] "I am also directing the Secretary of Health, Education, and Welfare to undertake a comprehensive review of the use of long-term care facilities as well as the standards and practices of nursing homes and to recommend any further remedial measues that may be

(Continued)

the Department has been working to improve nursing home standards—an effort in which the President of the National Council of Senior Citizens was involved while a member of the Health Insurance Benefits Advisory Council. Apparently, efforts to improve nursing home standards were continuing within the Department until at least May 14, 1973—the date on a draft set of regulations that would have improved patient care by requiring each skilled nursing facility to have a medical director and requiring each facility, except those in rural areas, to employ a registered nurse seven days a week.[2] At some time after May 14, 1973, it seems that a decision was made not to impose higher standards, but, instead, to issue regulations that would implement new statutory requirements of Public Law 92–603 without promoting an improvement in care. If we are correct, the decision in May 1973, to discard the earlier draft was the cause your Department's inability to meet the statutory deadline of June 30, 1973 for implementation of the provisions of Public Law 92–603. While we can make surmises about the chronology, we can have no idea of why the Department abandoned its commitment to better patient care.

By proposing regulations that lower the standards from the present level and that are so vaguely phrased as to be unenforceable, your Department is also flouting the intent of Congress, as expressed in Public Law 92–603. In its report on § 249, requiring uniform standards for skilled nursing facilities, the Senate Finance Committee stated:

"The definition would incorporate the best features of the medicaid and medicare requirements.

The committee's amendment is not intended to result in any dilution or weakening of standards for skilled nursing facilities." (S. Rep. No. 92–1230, 92d Cong. 2d Sess. (1972) p. 282) [3]

Our comments on specific provisions of the proposed regulations are as follows:

1. Nursing Care

a. *Staffing*—Section 405.1124 of the proposed regulations should be revised to require the services of a registered nurse 24 hours a day, seven days a week. That section should also be amended to specify staffing ratios with separate categories for registered nurses, licensed practical nurses and for other nursing personnel.

It seems obvious that only round-the-clock services of a registered nurse can meet nursing needs of patients sick enough to qualify for skilled nursing care. It also seems obvious that minimum standards are needed for the number of nursing personnel in each category. Surely one registered nurse and one licensed practical nurse cannot provide directly or supervise skilled nursing services in a facility with more than 100 beds.

A recommendation for nurse-patient ratios was made as long ago as August 1969 by an SRS task force. According to a report by the General Accounting Office:[4]

"The task force stated that the terms 'adequate' and 'sufficient' nursing service as contained in the Federal regulations are 'difficult terms to deal with and must be clarified and defined.'"

Understaffing was cited as a problem by both the General Accounting Office in 1971 and by President Nixon in his 1971 speeches. In face of widespread reports, understaffing, it seems almost derelict to pointedly ignore this need in the new regulations.

Many states prescribe staffing ratios for nursing homes, but their ratios are often unenforced. By leaving this crucial aspect of regulations to the states, your Department is almost assuring that this requirement will continue to go unenforced—particularly since states bear the entire cost of inspections to determine compliance with state standards.

(Continued)

appropriate. Such review is badly needed. Study after study tells us—compellingly—that many things are wrong with certain nursing home facilities, but there is not yet a clear enough understanding of all the steps that must be taken to correct this picture;" (speech by President Nixon, August 6, 1971).

[2] The May 14, 1973, draft was sent to us by your Department in late July 1973, in response to our request for copies of draft regulations that had previously been obtained by members of the nursing home industry. We undestand that other similar drafts were obtained by nursing home industry members between December 1972 and May 1973, but the National Council of Senior Citizens has never been provided with copies of those drafts.

[3] Most of the provisions of Public Law 92–603 dealing with skilled nursing facilities originated in the Senate, so there is no legislative history on the House side.

[4] *Problems in Providing Proper Care to Medicaid and Medicare Patients in Skilled Nursing Homes*, May 28 1971, p. 11.

b. *Standards of Care*—We recommend retention of the provisions of the current Medicare ECF regulations that set specific requirements for performance of nursing functions. (These provisions are current §§ 405.1124(b)(1)–(9), and (c)(2)). One current provision that has been inexplicably deleted is the requirement that a registered professional nurse make "daily rounds to all nursing units performing such functions as visiting each patient, reviewing clinical records, medication cards, patient care plans, and staff assignments, and to the greatest degree possible, accompanying physicians when visiting patients." (Current § 405.1124(c)(2)).

Under the proposed regulations, there is no requirement that either the registered nurse or the licensed practical nurse visit patients. The registered nurse has overall responsibility for the facility's nursing program, and the charge nurse (who may be a registered nurse or a licensed practical nurse) is "responsible for each tour of duty," and "delegates responsibility to [other] nursing personnel for the direct nursing care of specific patients." We can find no rationale for deleting the current requirement for direct contact between patients and licensed nurses.

c. *Restorative Nursing*—The proposed regulation for restorative nursing reads in its entirety as follows:

"Standard: Restorative nursing care. The facility has an active program of restorative nursing care which is an integral part of nursing service and is directed toward assisting each patient to achieve and maintain an optimal level of self care and independence. Restorative nursing care services are performed and recorded daily." (§ 405.1124(e)).

This provision, which is weaker and less specific than the comparable provision in the current regulations, provides no impetus for the facility to provide adequate restorative nursing care. In citing "some examples of services which meet the definition of skilled nursing services," the Senate Finance Committee included:

"Restorative nursing procedures, including the related teaching and adaptive aspects of skilled nursing, which are part of active treatment and require the presence of licensed nurses at the time of performance, e.g., teaching the skills and facts necessary for understanding adherence to a regimen such as bowel and bladder training." (S. Rep. No. 92–1230, 92d Cong., 2d Sess. (1972) p. 283).

It is unlikely under the vague requirement "for an active program of restorative nursing care," that a home could legally be held to the standard intended by Congress. To assure provision of restorative nursing care on the level referred to by the Senate Finance Committee, the proposed regulations should be revised to require that such care be given either by licensed nurses, or by unlicensed nursing personnel only if the unlicensed personnel have been trained to perform such services and have demonstrated their proficiency and if the unlicensed personnel work under the close supervision of a licensed nurse. At the very least, the sections of the current regulations dealing with restorative nursing (§ 405.1124(f), and (i)(3)) should be retained.

(d) *Training of Nursing Personnel*—The proposed regulations lower the standards for training of nursing home staff. The only provision regarding training is § 405.1121(g) which states only in the vaguest terms what training shall be required. Absent from the proposed regulations are the requirements of the current regulations that in-service training "be conducted at regular intervals," and that training include "simple restorative nursing procedures."

It must be recalled that most of the people referred to in the statute and regulations as aides and orderlies frequently have no training, and receive the minimum wage for doing heavy physical work under unpleasant conditions. Thorough orientation is essential under these conditions. A vague requirement for "appropriate orientation" is scarcely adequate to protect patients from injury and death when being handled by previously untrained personnel.

We would further note that President Nixon in his 1971 speech in Nashua, New Hampshire recognized the need for training. He stated, "in too many cases, those who provide nursing home care—though generally well prepared for their profession—have not been adequately trained to meet the special needs of the elderly." By failing to provide adequate standards for staff training, your Department is ignoring one of the President's major concerns.

2. PHYSICIAN SERVICES

We recommend that § 405.1123 dealing with physician services be revised to reinstate the requirement for a medical director which was included in the drafts

of the proposed regulations made available to nursing home industry during the early months of 1973. We also recommend that the requirement in the current regulations that each patient be seen by a physician at least every 30 days be retained in the new regulations.

The medical care of nursing home patients is known to be inadequate, so efforts should be directed toward enforcing current regulations and not toward weakening them.[5] If mandatory monthly visits by physicians are discontinued, the nursing home will be required to take the initiative in requesting physicians to visit when needed. This may be an onerous burden—particularly in areas with a shortage of physicians—and will almost surely lead to medical neglect of patients. It seems axiomatic that patients who qualify for skilled nursing care have health problems requiring the services of a physician at least once a month.[6]

Monthly physician visits are also essential because other services of skilled nursing facility—including rehabilitative services, medication and diet—may be provided only pursuant to physician orders. If a physician does not visit patients, the facility is prohibited from making any changes in the patient's plan of care.

3. Rehabilitation

The proposed regulations do not even purport to implement the revised definition of skilled nursing facilites (§ 247 of P.L. 92–603) as institutions that provide "skilled rehabilitation services." Instead of raising the standards to comply with the Congressional mandate, the proposed regulations inexplicably delete the specific requirements of the current regulations that "therapists collaborate with the facility's medical and nursing staff in developing the patient's total plan of care" (currrent § 405.1126(c)(9)) and that "therapists participate in the facility's in-service education programs" (current § 405.1126(c)(10)).

Congress was explicit in its intent that skilled nursing facilities be centers for rehabilitation. The Senate Finance Committee stated:

"The types of services which would be covered under both medicare and medicaid 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.

The recognition of a patient's need for skilled rehabilitative services as a basis for meeting the level of care requirement is intended to cover situations such as the following: (1) non-ambulatory stroke patients who need daily skilled rehabilitative services such as speech therapy, but who do not necessarily need skilled nursing services; and (2) hip fracture patients who need daily physical therapy services after the fracture has healed to the weight-bearing stage." (S. Rep. No. 92–1230, 92d Cong. 2d Sess. (1972) p. 284.)

To assure that skilled rehabilitation services are provided, the proposed regulations should be revised to require that qualified therapists participate in developing and executing the facility's patient care policies under § 405.1122; and that appropriate qualified therapists participate in developing individual patient care plan under § 40.1124(d). The proposed regulations should also set a minimum number of hours for consultation by each type of therapist, in relation to the size of the facility.

Finally, we are concerned by the fourth sentence of § 405.1126 which seems to state that a facility need not provide all types of therapy, but should not admit patients whose rehabilitative needs it cannot meet. This sentence should be clarified and amended to require the facility to make known to physicians, sponsoring agencies and members of the public, which rehabilitative services it cannot provide.

4. Patient's Rights

The proposed regulations require that skilled nursing facilities develop policies for protection of patient's personal and property rights, but there are no specific provisions such as were contained in the proposed Intermediate Care Facility regulations published in the Federal Register of March 5, 1973.

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[5] Utilization review is not an appropriate means for assuring adequate medical care of nursing home patients. Utilization review is generally accomplished through scrutiny of records, which cannot substitute for direct examination of patients. Moreover, the purpose of utilization review is to determine the level of care and not the quality of care.

[6] We note in passing President Nixon's comment during the speech in 1971: "I have even heard of doctors who refuse to visit some nursing homes because they get too depressed." Under the proposed regulations, such doctors could nonetheless remain responsible for the care of nursing home patients.

We recommend incorporation of the substance of § 249.12(a)(i), (v), (vi), and (x) of the proposed Intermediate Care Facility regulations. These provisions require establishment of a system "for the registration of resident complaints without the threat of discharge or other reprisals," maintenance of a written account "for each resident with written receipts for all personal possessions and funds received by or deposited with the facility and for all expenditures and disbursements made by or in behalf of the residents," and the public availability of a statement of the rights of residents. We also recommend incorporation of the patients' bill of rights that we recommended in our comments on the proposed Intermediate Care Facility regulations.

5. Public Information and Access

Several sections of the proposed regulations require skilled nursing facilities to prepare policy statements describing their methods of complying with the regulations. For example, facilities must prepare patient care policies (§ 405.1122); personnel policies (§ 405.1121(f)); staff development programs (§ 405.1121(g)); and policies for notification of changes in patients status (§ 405.1121(i)).

There is no provision in the proposed regulations for any of these policies to be made available to the public.

We recommend that a new provision be added stating that all policies prepared by the home and all other information about the operation of the facility—except information relating to specific patients—must be made available on request, to any member of the public.

We would also like to repeat two recommendations that we made in our comments on the proposed Intermediate Care Facility regulations—that members of the public be afforded access to nursing facilities and that nursing facilities be required to prepare for public dissemination reports showing the number of patients who received each type of therapy and the number who received treatment from a dentist, podiatrist, and optometrist.

Public pressure is potentially a powerful tool for improving nursing home care. Public pressure can only be applied if the public is supplied with information. Congress recognized the need for public information when it adopted § 299D of P.L. 92-603, making available to the public inspection reports of health facilities. The same rationale applies to policies developed by facilities for compliance with the regulations, and to statistics showing services rendered to patients.

SUMMARY

We strongly urge that the regulations be completely revised prior to adoption. If adequate patient care is in fact a goal, the regulations should provide:

—24 hour a day, seven day a week services of a registered nurse;

—specific staff patient ratios for each type of nursing personnel;

—mandatory physician visits every 30 days;

—specific, detailed methods for providing rehabilitative services;

—specific, detailed methods for providing restorative nursing care;

—public access to nursing homes and public disclosure of all policies and other information regarding the nursing home, with only information pertaining to individual patients being exempt from public disclosure; and

—a strong bill of rights for patients.

We hope that you will give favorable consideration to these comments.

Sincerely,

William R. Hutton, *Executive Director.*

Appendix 3

NATIONAL HEALTH LAW PROGRAM COMMENTS, SUBMITTED BY MARILYN G. ROSE,* WASHINGTON COUNCIL

LETTER TO ARTHUR E. HESS, ACTING COMMISSIONER, SOCIAL SECURITY ADMINISTRATION, AND JAMES S. DWIGHT, JR., ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE, DATED AUGUST 10, 1973

DEAR MR. HESS AND MR. DWIGHT: The National Health Law Program is an OEO-funded legal services back-up center specializing in the health problems of the poor. We have been assisting legal services offices with Medicaid and Medicare problems for four years, and have been much concerned with the plight of the many destitute elderly who reside in nursing homes and other institutions. We are hereby submitting comments on your proposed regulations for skilled nursing facilities under both the Medicaid and Medicare programs.

We are sorely disappointed that the regulations consistently retract from the position of those currently in effect by changing specific requirements to more general ones on every standard relating to high quality patient care. We understand that this was done at the urging of national associations or proprietary nursing home administrators—all of whom have a distinct fiscal incentive to see lower quality standards which mean lower patient care costs and higher profits. We protest both the manner in which the Department permitted pre-review and comment on the regulations by the affected industry without affording an equal preliminary voice by consumers and their representatives and the many regressive provisions of the proposed regulations which can only assure that Medicare and Medicaid patients will receive worse care.

In addition to specific comments on your proposed regulations, we are expressing our concern that the intent of Public Law 92-603 will not be carried out by a shift in emphasis in the new regulations away from restorative nursing procedures. Section 247 of that law in referring to post hospital extended care services defines the care requirements as including: ". . . on a daily basis . . . other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility in an inpatient basis. . . ." The legislative history of this section reveals that Congress recognized the need for providing rehabilitation services. In defining care in skilled nursing facilities, the Senate Finance Committee Report on the Social Security Amendments of 1972, cites "restorative nursing procedures, including the related teaching and adaptive aspects of skilled nursing" as an example of a service which meets the definition of skilled nursing services. (Senate Report No. 92-1230, 92nd Congress, 2nd Session, page 283.) That report, on page 284, states:

The types of services which would be covered under both medicare and medicaid 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.

The same report, also on page 284, also expressed the Senate's concern that "services received in skilled nursing facilities by patients who are in regular need of skilled rehabilitation services (other than nursing)" be covered by Medicare. Thus it is clear that Congress intended that restorative services be an integral part of skilled nursing care. As our discussion below indicates, that emphasis on restorative care has been emasculated by the proposed regulations. And, in fact, the emphasis, based upon Congressional intent, should have been *strengthened.*

For clarification, all citations to the regulations in each heading refer to the proposed regulations while all citations within the body of each comment refer to the current regulations.

*See statement, p. 2766.

405.1121—ADMINISTRATIVE MANAGEMENT

The proposed regulations do not incorporate 405.1124 (1), (3), (4), and (5) of the current regulation which require the administrator to be at least 21 years old and without physical or mental disabilities or personality disturbances; that his duties be clearly defined; the designation of a competent individual to act in the absence of the administrator; that the administrator may be a member of the governing board. The new regulations merely define the administrator of skilled nursing facility as "licensed as required by State law" or having one year of supervisory experience.

405.1122—PATIENT CARE POLICIES

The proposed regulations fail to incorporate the list of services included in the current regulations at 405.1122(a) (1) and (2). Instead the new regulation requires policies to be developed which meet "the total medical psychosocial needs of patients, including discharge planning and the protection of their personal and property rights." This section reflects the scheme of the new regulations, which replaces the detailed requirements of the old regulations with vague general all-purpose statements.

405.1123—PHYSICIAN SERVICES

The proposed regulations do not require a physical examination to be made within 48 hours of admission. The current regulations require attention to be given to the special needs of patients such as foot, sight, speech and hearing problems. Under the current regulations a doctor must visit each patient at least every thirty days. Under the proposed regulations, after a patient has been in a nursing home for three months the doctor may decide to visit the patient less frequently.

405.1124—NURSING SERVICES

The current regulations spell out the responsibilities of the charge nurse described in 405.1124(d)(3-5). The proposed nursing regulations omit the requirement of patients to be treated with "kindness and respect" 405.1124(e)(3)(iv). The current regulations require that nursing personnel be taught restorative nursing practices, including maintaining good body alignment, assisting patients to use prosthetic devices and assisting patients to carry out physical therapy exercises 405.1124(f)(2). The proposed regulations contain no requirement for training in restorative nursing.

Other omissions from the current nursing care regulations include: providing adaptive self-help devices to contribute to the patient's independence in eating 405.1124(g)(3); providing a personalized daily plan for each patient which includes how he or she likes things done, what approaches are most successful and what modifications are necessary to insure best results 405.1124(4)(1).

405.1125—DIETARY SERVICES

The proposed regulations fail to spell out the minimum servings of food that each patient should eat as do the current regulations 405.1125(d). They fail to require those responsible for therapeutic diets to be qualified to make substitutions when necessary 405.1125(3)(1). They omit specific standards for food preparation included in the current regulations 405.1125(h) (1), (5), (6). They do not provide for specific sanitation standards 405.1125(1-6). For example, while the current regulations contain standards for waste disposal, the proposed ones merely state that "waste is disposed of properly."

405.1126—RESTORATIVE SERVICES

The proposed regulations do not mention ambulation and therapeutic equipment 405.1126. The current regulations require a physician to make specific orders for therapy—including goals to be achieved, devices to be used, and the frequency of therapy services. The proposed regulations fail to guide the physician in this task.

405.1127—PHARMACEUTICAL SERVICES

No comment.

405.1128—Laboratory and Radiologic Services

Arrangements for transportation of patients is not provided for under the proposed regulations 405.1128(h)(3).

405.1129—Dental Services

The proposed regulations do not provide for an advisory dentist to be available in case of emergency 405.1129(b)(1).

405.1130—Social Services

The current regulations require an evaluation of the probable duration of the patient's need for care and the formulation of a plan as soon as possible after admission 405.1130(a)(2). Neither are included in the proposed regulations. The proposed regulations replace the very detailed provision requiring confidentiality of social data with the mere statement "Policies and procedures are established for ensuring the confidentiality of all patients' social information."

405.1131—Patient Activities

The current regulations specifically call for each facility to make available a variety of supplies and equipment including books, television, games, etc., adequate to satisfy the individual interests of patients. They also require the facility to establish flexible visiting hours, and opportunities for religious services. The proposed regulation merely calls for a "program of meaningful activities."

405.1132—Medical Records

The current regulations spell out with more detail than the proposed regulations, the content required of each patient's medical record 405.1132(a)(1–12).

405.1133—Transfer Agreement

Again, the proposed regulations replace a provision which details requirements and procedures with a provision that merely recites general goals and purposes in vague language, leaving it to the complete discretion of the facility administrator to determine what actually is required.

405.1134—Physical Environment

The current regulations require: a fire authority to submit a statement on any waiver of provisions of the Life Safety Code; that the facility comply with all applicable State and local construction and fire codes; that inspection reports by the fire authority be on file in the facility; that corridors be equipped with hand rails; that unsafe occupancies or activities not be located in the facility; that candles, kerosene oil lanterns and other open flame methods of illumination not be used; that hot and cold running water be installed in the nursing unit 405.1134. None of these protections is specifically mentioned in the proposed regulations, which also omit any discussion of standards for elevators and examination rooms, 405.1134(g), use only general language for describing patient bedroom facilities, 405.1134(e), and fail to specifically require dietary areas to comply with the local health or food handling codes.

405.1135—Environmental Services

The sections on housekeeping, linen, and pest control are all inadequate compared to the detailed provisions in the current regulations 405.1135(a), (b), and (c). The proposed regulations merely require "a safe, clean, orderly, and attractive interior." The current regulations spell out housekeeping requirements in regards to floors, walls, ceilings, deodorizers, storage areas and grounds. The proposed regulations call for a pest control program to keep the facilities "free from insects and rodents." They fail to explicate what this program consists of and omit any requirements that the least toxic and least flammable effective insecticides should be used. While the current regulations require soiled linen

and clothing to be stored in *separate* areas, the proposed regulations only mention that they should be handled and stored in such a manner as to prevent the spread of infection.

405.1136—DISASTER PREPAREDNESS

The current regulations require at least simulated drills every year, 405.1136(a)(3) while the proposed ones do not provide for any minimum.

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In addition, the proposed regulations fail to include the following provisions from the Medicaid regulation § 249.33—concerning services and payment of skilled nursing facilities:—249.33(b)(4)(ii)—special and restricted diet menus are kept on file for at least 30 days with substitutions noted.—249.33(b)(9)(c)(1)(iv and v)—conditions of waiver of fire and safety code provisions are redetermined at the time of each survey and waiver is rescinded at any time conditions no longer require waiver.

P.L. 92-603 gives the Department the opportunity to improve nursing home standards and the quality of care that homes provide. We urge the Department not to ignore its responsibilities to the hundreds of thousands of aged and disabled by regressing in its administration of the nursing facility program, but rather to improve the quality of patient care by issuing higher and more rigid quality standards, a process to which this Program would gladly lend its support and assistance.

Very truly yours,

PATRICIA A. BUTLER, *Senior Attorney.*
BOB ZWIRB, *Research Assistant.*

Appendix 4

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION COMMENTS, SUBMITTED BY BETTY COX,* PUBLIC AFFAIRS COORDINATOR

We believe that the proposed regulations, with appropriate changes and if fully enforced, should help to improve the quality of care provided in many skilled nursing facilities. The proposed definition of supervision (Section 405.1121(t)) as well as the new standards governing the use of outside resources (Section 405.1121(h)) and requiring medicare evaluation studies (Section 405.1137(c)) seem to be particularly constructive additions to current regulations.

We are concerned, however, that the definition of occupational therapist in Section 405.1101(1) of the proposed regulations will permit the employment of less than fully qualified personnel while preventing the employment of well qualified foreign trained therapists. Graduation from an accredited occupational therapy curriculum is only the first of a three part credentialing process that also includes successful completion of supervised clinical affiliation and a nationally administered certifying examination, nor are the many high quality educational programs in member countries of the World Federation of Occupational Therapists accredited by the AMA's council on medical education. We urge, therefore that the following definition be used in Section 405.1101(1).

(1) Occupational therapist. A person who:

(1) Meets the requirements for certification as an Occupational Therapist Registered (O.T.R.) established by the American Occupational Therapy Association; or

(2) Has filed application for the first scheduled certifying examination administered by the American Occupational Therapy Association subsequent to successful completion of the education and experience requirements for certification as an Occupational Therapist Registered.

Similarly, Section 405.11.1(m) should be changed so as to read:

(m) Occupational Therapy Assistant. A person who:

(1) Meets the requirements for certification as a Certified Occupational Therapy Assistant (C.O.T.A.) established by the American Occupational Therapy Association.

Until such time as proficiency examinations for the occupational therapy field have been developed and it has been determined that such examinations are valid and reliable indicators of an individual's ability to provide acceptable occupational therapy services, the Association is reluctant to endorse the inclusion of Item (1)(3) or Item (m)(2) of Section 405.1101 in the Conditions of Participation for Skilled Nursing Facilities. If these items must be retained, we suggest that they be revised somewhat, primarily for the purposes of clarification.

As presently written the proposed definitions call for "two years of appropriate experience as an occupational therapist," or, ". . . as an occupational therapy assistant." We submit that a person cannot accumulate experience as a therapist or assistant until he or she is a therapist or assistant. It would be much more preferable to use the phrase "meets an appropriate experience eligibility requirement" in lieu of the present "has two years of appropriate experience as an occupational therapist . . . (or occupational therapy assistant)."

We would also recommend that the phrase "in collaboration with the American Occupational Therapy Association" be inserted after the words U.S. Public Health Service in subsections (1)(3) and (m)(2). Our concern here is that the proposed regulations as presently written do not clearly reflect the intent of Congress as expressed in PL 92–603 which was that the Secretary, in developing and conducting a program to determine the proficiency of individuals who do not otherwise meet educational and other specific qualifications, do so in consultation with appropriate professional health organizations.

*See statement, p. 2768.

With these changes, the two items should read:

Meets an appropriate experience eligibility requirement and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service *in collaboration with the American Occupational Therapy Association,* except that such determinations of proficiency will not apply with respect to persons initially licensed by a state or seeking initial qualification as an occupational therapy assistant after December 31, 1977.

The A.O.T.A. is most concerned about the proposed qualifications for patient activities coordinators that presently appear in Section 405.1101(n)(2). We think it highly unlikely that a 36-hour course can provide otherwise untrained personnel with the knowledge and skills needed if they are to assume responsibility for planning and directing activity programs that meet the standards set forth in Section 405.1131 nor can a person with the qualifications currently described in Section 405.11.1(n)(3) be expected to have the competencies required to perform these functions.

If "patient activities programs" are to meet the standards described in Section 405.1131, the personnel charged with overall responsibility for their planning and direction must possess considerable knowledge and skill and fully understand the many safeguards and precautions that are required in programs for individuals who need the skilled nursing care or other skilled rehabilitation services.

For the above reasons, we recommend that Section 405.1101(n) be revised to read as follows:

(n) Patient activities coordinator, A person who:

(1) Is a therapeutic recreator qualified at least by way of definitions in paragraph (u) (1), (2), (3), and (4) of this section;

(2) Is a Certified Occupational Therapy Assistant (C.O.T.A.) qualified at least by way of the definitions in paragraphs (m) (1) and (2) of this section, or

(3) Has completed 36 hours (within a three-month period) of a curriculum designed specifically to train patient activities coordinators *and works under the supervision of, or with frequent, regularly-scheduled consultation from persons meeting qualifications established in Sections (1) and (2) above.*

We have purposely omitted the O.T.R. from the list under the assumption that more highly-qualified personnel would automatically be eligible to serve in this capacity. If this is not understood, then an O.T.R., qualified at least by way of the definitions in Paragraph (1) (1) (2) of this Section should be listed.

Many of our members have expressed serious misgivings about the adequacy of the staffing requirements outlined in Section 405.1124, Condition of Participation—Nursing Services. In view of the level of care requirements for skilled nursing home services mandated in Section 247 of Public Law 92–603 we recommend that the services of a registered nurse be provided at least during the day tour, seven days a week, rather than only five days a week as presently proposed. Restorative nursing care services should be performed and recorded daily by a qualified member of the nursing staff (Section 405.1124(3)).

In Section 405.1137, Condition of Participation—Utilization Review, Part (b), we strongly recommend that you strike the work "optionally" from the sentence, "The Committee or group responsible for utilization review is composed of two or more physicians, and (optionally) other professional personnel." Only by making the participation of "other professional personnel" mandatory will broadly-based utilization review committees be established. Physicians cannot and should not be expected to assume sole responsibility for evaluating the quality and effectiveness of services provided by other professional personnel.

Finally, in view of the magnitude of the public financial contribution to the income of skilled nursing facilities, there should be explicit provisions in the conditions of participation for public access to 1) pertinent information about the degree to which participating facilities are in compliance with Federal, State, and local laws (Section 405.1120) and 2) the administrative and patient care policies and bylaws that are called for in Sections 405–1121 and 405.1122.

Appendix 5

AMERICAN ASSOCIATION OF NURSING HOME PHYSICIANS, RECOMMENDATIONS AND PROPOSALS, SUBMITTED BY RAYMOND J. BENACK,* M.D.

ITEM 1. RECOMMENDATIONS FOR IMPROVEMENT IN PATIENT CARE IN NURSING HOMES AND EXTENDED CARE FACILITIES**

Background of the Association

The American Society of Physicians in Chronic Disease Facilities originally was founded in 1966 when the Maryland Association of Nursing Home Physicians was organized by the principal physicians and medical directors in nursing homes within the state of Maryland. In 1968, the Maryland Association of Nursing Home Physicians incorporated and formed the national organization, the American Association of Nursing Home Physicians. In 1969, the American Association of Nursing Home Physicians and the International Society of Medical Directors in Chronic Disease Facilities which was formed in 1968 merged to form the American Society of Physicians in Chronic Disease Facilities. The first president of the new society was Dr. Thomas Kalkoff, Medical Director of Iroquois Nursing Home in Erie, Pennsylvania. Its current president is Raymond T. Benack, M.D., Medical Director of Bel-Pre Health Center, Silver Spring, Maryland, and current president of the Maryland Association of Physicians in Chronic Disease Facilities. The association consists primarily of physicians who are medical directors or principal physicians in nursing homes, extended care facilities, chronic disease facilities and related facilities, and those physicians who devote a substantial portion of their time to the care of the nursing home or chronic disease patient.

The purpose for which our association was founded is to further the general health of the chronically and/or aged peoples through the acquisition and dissemination of useful and accurate knowledge regarding the medical management and treatment of such individuals and to undertake in their interest those activities that will improve the welfare of these individuals. To these ends it is the purpose of this association to promote among the physicians the free exchange of knowledge with respect to this subject, to improve standards of treatment of the nursing home residents, to develop methods of medical supervision and to set up standards of medical care acceptable to this association.

The society has held its meeting in conjunction with A.M.A. clinicial meeting and also other medical organizations. In 1969, the association held a meeting as part of the Second International Congress on Gerontology held in Washington, D.C. The society has also supported the activities of the A.M.A. Commission on Aging and its conferences on long term care held in November 1970 and April 1971. The Maryland Chapter of the American Association has worked with the Medical and Chirurgical Faculty of the State of Maryland in the development of responsibilities for medical directors in extended care facilities, nursing homes and related institutions. These responsibilities were adopted by the State Medical Society and are also the nucleus of similar responsibilities under discussion by the A.M.A. Furthermore, the Maryland association worked with the Maryland Medical and Chirurgical Faculty to develop medical standards for nursing homes. These standards are recommended to be the minimum medical policies in all extended care facilities and skilled nursing homes.

** See statement, pp. 2778 and 2788. Submitted to the 1971 White House Conference on the Aging by the American Society of Physicians in Chronic Disease Facilities, 10400 Connecticut Avenue, Kensington, Maryland 20795.

Problems of Medical Care in Nursing Homes

Nursing homes have existed only during the past 40 years and their greatest growth has been since the second World War. Many of the initial facilities were converted homes which offered a good deal of tender loving care but inadequate and incomplete medical care. Until the passage of the Medicare Act in 1965, the nursing homes were at the periphery of medicine and had poorly identified roles in the total medical care of patients. Gradually structures of steel and brick replaced the old dilapidated and often overcrowded homes. But the new facilities did not necessarily bring with them improved patient care or make them an integral part of medical programs.

First we must approach the problem of who is the nursing home patient. In the past most of the patients were admitted to nursing homes primarily for terminal care and who for all practical purposes had been written off medically. With the passage of the Medicare Act, many nursing homes were upgraded to an extended care facility. It was intended to provide intensive, short term rehabilitative therapy to the recently hospitalized patient. This created a complete change in the nature of the patients admitted to these facilities. Patients though elderly were more acutely ill, having been recently hospitalized with an acute illness. Furthermore, they continued to need regular skilled nursing care but not as intensive as in the hospital setting. However, the number of extended care patients in a nursing home has gradually diminished to probably less than 5% of all patients in the nursing homes. However, it did open the eyes of the public to the existence of nursing homes and that in many instances they were not necessarily institutions of death. More and more families admitted their parents and relatives to nursing homes because of the convenience of providing regular care and relieved the family from the responsibility of providing satisfactory care to their parents while at home. Patients today in skilled nursing homes tend to be elderly with average age of about 80. The patient is more often a female and the patient will probably have at least seven or more major illnesses warranting regular medical treatment. Many of the patients are debilitated, frequently incontinent, and often requiring a good deal of assistance even to carry out the minimum daily activities.

Medical Supervision

Prior to 1966, most nursing homes had a physician who would be available for emergency care and who would occasionally advise the administration on patient care policy. In many facilities this physician existed on paper alone to comply with the state regulations. Many regulations stated that there must be medical policies but failed to define what should be included in the medical policies. Passage of the Medicare Act and the upgrading of skilled nursing homes under the 1967 Medicaid revisions still did not define in any greater detail what medical policies were needed in these facilities. The laws did require that the physician make at least one visit per month to the nursing home patient. This was a step forward since many patients in the chronic disease facilities were seen infrequently and at times only once a year.

Many patients in the nursing homes received inadequate medical supervision because most physicians were reluctant or disinterested in traveling to the nursing home or in caring for the elderly patients. Many factors contribute to this problem. Selection of nursing homes was often done by the family based on economic reasons, or proximity to the family's place of residence. The physician had rarely designated a particular facility. If the patient was admitted to a facility far removed from his offices, he either failed to see the patient or after prompting by the facility asked that the principal physician take over the patient's care. For economic reasons the nursing home was frequently located a distance from the hospital and the physician. This discouraged physicians from seeing their patients regularly since it often entailed a long trip to see a patient during his regular working day. Consequently the nursing home visit was delayed to more convenient times which were infrequent.

Since the passage of the Medicare Act certain changes have occurred that have improved at least some of the physician's role in providing his patient regular medical care. Now the physician will often designate those facilities which he is able to go regularly. The patient is then given the opportunity to select a facility where he knows he will be seen regularly. Furthermore, in many facilities there had developed a nucleus of physicians who generally take care of the majority of patients in the facility. These physicians assume the care of patients of other physicians at the request of other physicians simply because the "house physician" is better able to see the patient regularly.

However, most of these physicians work alone and rarely meet in the facility. Generally there is no communication concerning patient care policies or problems in the facility. Rarely is there any formal medical staff. Consequently, the medical director exists as the only physician who will be familiar with most of the problems in the facility. Even though the Joint Commission on Accreditation of Hospitals which also accredits nursing homes and extended care facilities requires the presence of a medical staff with a formal constitution and by-laws, very few facilities have such an accreditation. The state of federal regulations have no similar requirement. Consequently very few nursing homes have any formal medical staff or even meetings at which they can communicate.

Most long term care facilities will have minimum medical policies which occasionally are reviewed and agreed upon by the medical director. The medical director when requested may advise on a medical policy but his primary role mainly is to be available for emergencies. The medical director has no authority to enforce his medical policy nor does he have any responsible agency to which he may take his complaints. As long as the facility abides by the minimum standards required by state and federal law, they cannot be found guilty of neglect or deficiencies. As the situation now stands, most facilities have a medical director who exists on a non-contract basis free to leave at will or free to be fired by the facility regardless of reasons.

To resolve this problem we recommend that all chronic disease facilities, skilled nursing homes, extended care facilities be required to have minimum medical policies similar to those recommended by the Medical and Chirurgical Faculty of the State of Maryland. Furthermore, we would recommend that the facilities be required to have a medical director with the responsibilities as recommended by the Medical and Chirurgical Faculty of the State of Maryland and that the medical director have a contractual agreement with the facility which would include arbitration of differences.

Another problem in medical care is the restrictions placed on physicians in providing regular medical care to the nursing home patient. The Social Security Administration has ruled that visits to nursing home patients could be considered medically necessary if they are once per month. Any visits of frequency greater than one per month must be substantiated as being medically necessary. With the already existing load of paper work for the physician it would seem improbable that most would desire further paper work to receive payment for services rendered to a nursing home patient particularly when it is required for visits greater than one a month. This ruling discourages regular physician visits and if anything will drive a physician from nursing home care rather than closer to the nursing home patient. It is recommended that these restrictions be removed and that Peer Review Committees be used to determine physician over utilization.

Nursing Care in Nursing Homes

One of the prime problems in nursing care in nursing homes is the marked turnover in personnel. It is a serious problem among nursing aides. There is a constant turnover among aides who tend to move around for slightest difference of salary. Yet most of the patient care in nursing homes is provided by the aide. However, the aide is frequently untrained, generally has a high school education, and no formal training beyond that level except what experience he learns while on the job. Although most facilities are required to have some form of in-service education program, very few have any regular or complete program. Often when aides have received enough training or experience they will leave the nursing home for a high paying salary in hospitals. Constant changing of nursing staff leads to breakdown in nursing care. There must be some change from this system to insure more regular patient care and the encouragement of regular aides in the facilities.

Some of the problems in nursing care are not solely caused by the nursing staff. The physicians must also share the blame. Physicians see their patients infrequently, discuss very little with the nurses and do not necessarily practice the same high level patient care in the nursing home that they would provide in the hospital. Many physicians will only come in to sign the death certificate or to fulfill the required obligation of a monthly visit and then leave as rapidly as possible. There is no encouragement to the nursing staff to become interested in a particular patient's problem. Regular visitations by the physicians would encourage a greater interest on the part of the nursing staff and would upgrade the quality of care throughout the facility. Too many physicians are interested in the

problems of the acute, problematical or the curable patient. Few are interested in the problems of long term care.

The problem of physician distinterest begins in medical school and is perpetuated during his subsequent training. Very few medical schools provide any formal programs or courses in care of the chronically ill or geriatric patient. Rarely do internships or residences incorporate any training in a chronic disease facility or nursing home. Consequently, the care of the geriatric patient is developed through the trial and error experience of the physician.

Educational programs on geriatric care should be included in the medical schools and during the internships and residences. This could increase the number of physicians interested in geriatric care. It should also stimulate improved long term care and increased research into the problems of diseases of age.

Physical Therapy

The physical therapy in nursing homes was almost non-existent prior to the Medicare law. Subsequent to the Medicare law many facilities included some space, although frequently small, for the physical therapist to provide some therapeutic programs for its patients. The physical therapy was primarily limited to the extended care patient who was in the facility under Part A of Medicare benefits. As the number of ECF beneficiaries declined the use of physical therapy gradually decreased. Many facilities have patients that would benefit from physical therapy but because of economic reasons are unable to do so. Many physicians would only order physical therapy when the family had the economic means to pay for it. Many more patients would benefit from physical therapy if these services were covered under Medicare in the nursing home other than under Part A.

X-Ray Therapy

The availability of diagnostic x-ray equipment in nursing homes is grossly inadequate. Most facilities of a 100 beds or less do not have any diagnostic x-ray equipment. A few facilities of a 100 beds or more have minimal equipment. As a result of these inadequacies, many problems have occurred. One is the delay in obtaining necessary x-rays after falls or other injuries. Another includes the high cost of transportation of patients to hospitals by ambulances for x-ray diagnoses. Also many physicians will depend upon clinical impression in the treatment of patients when x-rays would have been more informative and helpful. When there is some doubt on the nature of a patient's illness or injury, the physician is reluctant to send the patient to the hospital because of the substantial cost and inconvenience to the patient in transporting them. Furthermore, if the x-rays were negative it would be an added expense to the patient while suffering the inconvenience of being transported to and from the nursing home. It is not unusual for a patient to be sent to the hospital for an x-ray which may take only 10 minutes but will have to wait three to four hours for transportation back to the nursing home. It would seem far more realistic if at least some minimal but adequate diagnostic x-ray equipment were available at the facility.

Even though there may be a substantial initial investment for the installation of x-ray equipment into a nursing home, there are many sources of financial return for the investment. Routine and annual chest x-rays could be taken both on patients and employees. X-rays of potential fractures could be done. Upper GI Series, Barium Enemas, Gall-Bladder x-rays and IVP's could be done in the facilities. Since many nursing homes are far removed from the hospital and spread throughout the community the x-ray facilities could be offered to the local physicians in the community to obtain x-rays on their patients rather than overloading the hospital's x-ray facilities.

Other possible solutions to the problem could include a central location of one facility for x-ray equipment to which satellite nursing homes would send their patients for x-ray diagnoses without undue delay. Also a solution could be a mobile van which would circulate through the community going to different nursing homes taking x-rays as needed at the different facilities. The x-rays could be developed at a central x-ray department such as one of the local hospitals and reports returned the same day to the facility.

The question of need for x-ray diagnostic equipment in nursing homes must be explored. It is recommended that studies be undertaken to determine the feasibility of installation of x-ray equipment in nursing homes.

RECOMMENDATIONS

The recommendations of the American Society of Physicians in Chronic Disease Facilities are as follows:

1. All nursing homes should be required to have a medical director who would be responsible for the medical administrative duties in the facilities.

2. That the duties of a medical director contain at least the responsibilities recommended by the Maryland Medical and Chirurgical Faculty and the American Society of Physicians in Chronic Disease Facilities.

3. All nursing homes have at least the Minimum Medical Standards for Skilled Nursing Homes recommended by the American Society of Physicians in Chronic Disease Facilities and the Maryland Medical and Chirurgical Faculty.

4. That studies be undertake to determine the number and training of nursing personnel needed to care for patients in nursing homes of different sizes, architectual patterns and level of care provided.

5. That physical therapy benefits under Medicare be expanded to include not only patients receiving benefits under Medicare as extended care facility patients but also to include all patients in the nursing home who would benefit from such services. Those potential abuses of physical therapy be reviewed by the Peer Review Committees.

6. That all restrictions on frequency of visits by physicians to nursing homes and extended care facility patients be removed, that the possible abuses of physicians in providing care to their patients under the Medicare or Medicaid program be referred to the Peer Review Committees.

7. That pilot projects be undertaken to determine the cost and effect on patient care in nursing homes by physicians when their services are underwritten on a per capita basis rather than on a per visit basis.

8. That studies be undertaken to determine the feasibility of installing diagnostic x-ray equipment in skilled nursing homes and ECF's or possible alternatives to correct the existing problems in providing x-ray services to nursing home patients.

9. That geriatric and long term care courses be included in medical school curriculums.

10. That geriatric and long term care programs be included in internship and residency programs.

ITEM 2. RECOMMENDED MEDICAL STANDARDS FOR SKILLED NURSING HOMES

The Medical Standards recommended here were initially developed by the American Association of Nursing Home Physicians and the Maryland Association of Physicians of Chronic Disease Facilities. They have been selected from the Conditions for Participation in Extended Care Facilities; Regulations for Licensure of Skilled Nursing Homes in Maryland; and from the Standard for Accreditation of Skilled Nursing Homes and Extended Care Facilities by the Joint Commission on Accreditation of Hospitals. It is an attempt by the Medical profession to provide some guidance to other physicians in the field of skilled nursing homes through the development of minimal standards of care. Obviously as the trends in medical care change, there need to be some deletions, additions and possible rephrasing of the standards. It is with this in mind that the following standards have been developed.

1. MEDICAL DIRECTOR AND MEDICAL STAFFS

(a) Each Extended Care Facility, Nursing Home, or related facility shall have a Medical Director who will be responsible for the development and implementation of the medical care policies of the facility. His duties and responsibilities are defined elsewhere.

(b) Whenever possible there should be a formal medical staff with by-laws and rules and regulations.

(c) Patients should have the right to be cared for by the physician of their choice.

(d) All physicians caring for the patients in the facility should be advised of the medical policies of the facility.

2. Admission of Patients

(a) Every patient admitted to the facility must have a primary attending physician responsible for the general medical care for the patient from the time of admission.

(b) No patient should be admitted to the facility without adequate information, including current medical and nursing care, being submitted to the facility prior to or at the time of admission.

(c) If there is any doubt concerning the admission of a particular patient, then the pre-admission information should be reviewed by the Administrator, Medical Director and the Director of Nurses. No patient should be refused admission for medical reasons without prior discussion with the referring physician.

(d) Every patient must be certified by his attending physician prior to admission as being free from active tuberculosis or mental disease warranting care in a mental institution.

(e) There should be a written list of the types of medical conditions that cannot be admitted to the facility.

3. Patient Records

(a) Each patient must have a history, including present illness, past history, review or systems and a physical examination recorded on the chart within 48 hours.

A hospital discharge summary containing the above information, or a history and physical done within one week prior to admission, if done by primary attending physician may be used.

(b) Upon the admission of the patient, his primary attending physician will become responsible for the evaluation of the patient's immediate and long-term needs. Based on this evaluation, the physician must prescribe the regimen of medical care which will cover medications, treatments, restorative services, diet, special procedures, and plans for the patient's continuing care.

(c) Each patient should have a chest x-ray within 90 days prior to or as soon as possible after admission. A complete blood count and urinalysis must be done on admission. A Fasting or Post Prandial Blood Sugar, Blood Urea Nitrogen and Electrocardiogram are strongly recommended.

(d) Patients should have a comprehensive re-evaluation including a physical examination and suitable laboratory studies at least once a year and more frequently if necessary.

4. Frequency of Visits

(a) Patients should be seen as frequently as deemed necessary by the primary attending physician, with suitable progress notes recorded on their charts at the time of each visit. All patients should be seen by the attending physician at least once a month.

5. Medical Orders

(a) All orders must be renewed in writing every 30 days.

(b) All telephone orders must be countersigned by the physician within 48 hours.

(c) Policies regarding stop orders should be developed by the medical staff.

(d) If a drug formulary is developed and adopted by the facility, the private physicians are urged to use it.

6. Utilization Review

(a) All medical records become the responsibility of the facility and may be reviewed by the Medical Director, Medical Staff or Utilization Review Committee.

(b) Patients' records will be reviewed by the Utilization Review Committee with the frequency prescribed by law unless otherwise specified by the Committee. All records and recommendations of the Review Committee should comply with the policies outlined in the Utilization Review policies of the facility.

(c) When a patient is scheduled for Utilization Review, the primary attending physician will be advised of the impending review.

7. Ancillary Medical Services

(a) Private physicians are urged to utilize the ancillary services in the care of their patients, such as physical therapy, occupational and speech therapy and podiatry care.

8. Medical Emergencies

(a) If, in the opinion of the nursing staff, a patient is in need of immediate medical attention and the private physician cannot be contacted, or fails to comply with the request, the Medical Director or his designate is to be contacted.

(b) There should be a specific routine to follow in case of medical emergencies; including communicable disease outbreaks.

(c) There should be a specific policy for the transfer of patients to a hospital in emergencies. A copy of the transfer form must accompany the patient to the hospital.

(d) If, in the opinion of the Medical Director, in consultation with the Administrator and the Director of Nurses, a patient should be removed from the Home because of behavior, repeated failure to abide by the regulations, or because of a medical emergency, the primary attending physician should be requested to remove the patient from the facility.

9. Suspension of Privileges

(a) Physicians who fail to comply with the medical policies should be advised in writing of their delinquency.

(b) When physicians fail to comply with the facility's Medical Policies, the Medical Director or his designate should assume the patient's care.

10. Diets

(a) Therapeutic diets must be prescribed within the limitations of the diet manual recommended by the State Licensing Body, or as determined by the individual institution if it incorporates the recommendations of the state. A licensed dietitian should review special diets at least once a month.

11. Inhalation Therapy

(a) Intermittent positive pressure therapy will be administered to patients only upon the written order of the physician. It may only be administered by a nurse trained in the use of the apparatus, or by an oxygen therapist. Patients who have demonstrated their competency in the use of the apparatus may administer their own therapy.

12. Review

(a) There should be periodic check of patients' records to ascertain compliance with the medical policies.

(b) The Medical Director or the medical staff should meet with the Administration and the Director of Nurses regularly to review problems in patient care or medical policies.

13. Drug Policies

(a) There should be definite written drug policies which are reviewed periodically by the pharmacy committee.

ITEM 3. PROPOSED MODEL CONTRACT FOR MEDICAL DIRECTOR IN NURSING HOMES, ECF's AND RELATED FACILITIES

This model contract is based upon the provisions and recommendations as provided by and supported by the Maryland Association of Physicians in Chronic Disease Facilities and the Medical and Chirurgical Faculty of the State of Maryland. The contract is meant to be a general outline on the agreement between the Board of Trustees and the Medical Director of the nursing home, ECF or related facility. It covers those factors which the Maryland Association of Physicians in Chronic Disease Facilities feel are necessary to provide medical care and protect the rights of the parties concerned in the contract.

It is not meant to cover all factors that may be of interest to various parties in a variety of different facilities. We suggest that the physicians consult their attorney when they contemplate such a contract. The responsibilities outlined are based on a 100 bed facility but may be modified to fit a facility from 25 to 400 beds.

AGREEMENT

THIS AGREEMENT, made this ——— day of ———————— 19—— referred by ———————— Nursing Home, Party of the First Part, hereinafter referred to as "Facility" and ———————— M.D., Party of the Second Part, hereinafter referred to as "Medical Director".

WITNESSETH THEREOF, that the Facility hereby employs and the Medical Director hereby accepts employment as Medical Director of ———————— Nursing Home, for the term of One (1) Year beginning on the ——— day of ——— ——— 19 ——, and ending on the ——— day of ———————— 19 ——, at a total Salary of ———————— hundred dollars ($ ————) for said term, payable in twenty-six (26) installments of ———————— hundred dollars ($————) beginning two (2) weeks from the date of this Agreement and every two (2) weeks of said term.

MEDICAL DIRECTOR COVENANTS AND AGREES

1. The said Medical Director agrees to devote his time and best efforts in the performance of his duties which carry with them the primary responsibility for the quality of the medical program and its administration.

2. The said Medical Director agrees to utilize the most modern methods in the care of the aged and chronically ill including prevention, treatment and rehabilitation.

3. The said Medical Director agrees to provide an average of ———————— hrs/wk (eight hours per week per 100 beds) for the administrative duties connected with his position.

4. He shall develop and have supervision of personnel health programs.

5. He shall be responsible for planning, directing and supervision of all overall health and medical services and programs for the facility which shall include medical service, nursing service, physical medicine, drug handling policies, dietary therapy, occupational therapy, etc.

6. He shall be responsible for the development and implementation of medical care policies of the facility including procedures insuring physician responsibility in fulfilling his obligations for regular patient care.

7. He shall evaluate all applications for admission to determine that the patient is medically eligible for admission. A report of the evaluation shall be submitted to the Admissions Committee, Administrator or Intake Officer.

8. He shall see that the facility maintains complete medical records on each patient.

9. He shall be on call for all emergencies or make arrangements to have another physician cover for him during such periods of time as he may be unavailable.

10. He shall notify the administrator and attending physicians of any change in the condition of a patient which might make the removal of a patient from the facility necessary or desirable such as mental illness.

11. He shall advise the administrator and the attending physicians of any situation or condition that might affect the health or well being of the patients.

12. He shall assist in the training of personnel in the use of specialized or new medical equipment.

13. He shall continually evaluate the facility's equipment and services and make recommendations to the administration whenever patient care might be improved.

14. He shall develop programs for emergency treatment of patients and setting up emergency drug trays.

15. He shall participate in staff meetings, staff training and meetings of Medicare review or similar review meetings within the facility. He shall interpret the medical program to community groups.

FACILITY COVENANTS AND AGREES

1. The facility agrees that when necessary the Medical Director with the approval of the Board of Trustees may appoint an assistant to assist him or carry out his duties and said assistant shall be compensated by the nursing home.

2. The Medical Director shall be entitled to have four (4) weeks of vacation per year and leave of absence to attend scientific courses and meetings. The Medical Director shall notify the administrator of the facility in advance concerning such absences. It shall be the responsibility of the Medical Director to insure that there is sufficient coverage during his planned absences or the absences of his associates for their vacation.

3. The facility agrees to defray expenses for the Medical Director to attend meetings provided such expenses do not exceed _____ hundred dollars per year from the anniversary date of this Agreement nor extend beyond _____ weeks in any one (1) year.

4. The nursing home further agrees to provide and be responsible for the payment of the malpractice coverage for the physician in the usual and customary amounts of the coverage.

5. The facility also agrees to defray expenses incurred by local travel on the facility's business.

MEDICAL DIRECTOR AND FACILITY MUTUALLY COVENANT AND AGREE

1. This agreement shall be for one (1) year's duration and may be renewed automatically from year to year by the facility. In the event that the Medical Director or the facility should wish to terminate this contract the moving party shall provide written notice at least thirty (30) days prior to the desired date of termination. Nothing herein shall prohibit either party from requesting a review of the terms of this contract at any time with the view towards modification of said terms during the next annual renewal.

2. The facility will provide the Medical Director with adequate secretarial assistance, office space and equipment in order to carry out the duties of his position.

3(a) The Medical Director agrees that the facility may terminate his employment in the event that the doctor shall conduct himself in such a manner as to impair substantially his ability to discharge his duties as required under terms of contract.

3(b) In the event that the Medical Director is rendered incapable by reason of illness for carrying out his duties for consecutive period of three (3) months, the facility may discontinue payment to the Medical Director. If the Medical Director's incapacity should continue for a total of six (6) months the nursing home may cancel and terminate the contract.

4. In the case of disagreement concerning the medical administrative policies of the facility or in the interpretation of the agreements entered into in this contract between the doctor and the administrator or the Board of Trustees of the facility, they thereby agree that the Chairman of the Board of Trustees appoint a Review Board which shall consist of at least three (3) persons knowledgeable in the medical affairs, two of whom shall be physicians who shall be acceptable to the Medical Director. The dispute shall be referred to the Review Board for recommendations to the facility.

IN WITNESS THEREOF, the parties hereto have set their hands and seals on this day and year first written above.

ITEM 4. ROLE OF THE PRINCIPAL NURSING HOME PHYSICIAN AND UPGRADING OF CARE

[Reprint from Maryland State Medical Journal, August 1967]

By RAYMOND J. BENACK, M.D.

What I will say today will provoke some anxiety in a few and great concern in many. However, we are entering a new era of patient care, and because of this, changes must be made, new responsibilities delegated and new roles assumed in the continuing care of the chronically ill.

In my short life span, and in my even shorter period of medical practice, I have seen nursing homes change from old, dilapidated, overcrowded, unsanitary and unsafe buildings, where patients were sent to die or be forgotten; to homes which are magnificent modern edifices with carpeted halls, beauty salons, and the latest in rehabilitation equipment. Unfortunately, I have not seen the physician's interest in the nursing home patient keep pace with the improved facilities.

We must now meet because of federal and state legislation to better define the role of the private physician and his relation to the nursing home patient. But before one can do that we must first clarify the role of the Principal Nursing Home Physician who will act as consultant to the private physician and the nursing home administration.

We cannot blame the physician alone, nor the nursing home administrators, nor even the federal or state governmental agencies. The problem is bigger than any one of them can resolve alone. So let us recognize from the beginning that every human being in need of, or receiving care in, a nursing home, is dependent upon all of us working together. If the physicians, nursing home administrators, or the governmental agencies fail in their respective role in the upgrading of the quality of patient care in nursing homes, then we will all fail.

When we fail the patient suffers. When the patient suffers, we must answer not only to ourselves, to our fellow physicians, or even to civil courts, but above all we must answer to God. We are given the opportunity to work together towards the ideal in nursing home care. If you fail to make the most of that opportunity, you violate the natural law. Violation of the natural law is answerable only to God.

During the past year I spent over three hundred hours seeing patients in nursing homes. When you are in a nursing home for that much time, you have to see and hear things. Much of what I have seen and heard would make you wonder how some people continue to survive. It is difficult for me to understand how the average nursing home patient can suffer from eight or more diseases, and still be seen once every three or four months.

Would a physician who is a patient in a nursing home be expected to be seen every three or four months? Would he accept the same care for his parents? Each patient must be considered as our own parent, and we should provide him with the same care we would expect or desire. The family and relatives have entrusted to us the care of that patient, expecting the best possible care, that is, the care you would expect for yourself or your own relatives.

It is now necessary for the principal physician in the nursing home to assume a new role, and new responsibilities to accomplish these goals. In assuming this new role, we must also give him a title which would more adequately clarify his position. I would prefer to call such a physician the *Medical Director* of the nursing home. The reasons for this will be amply demonstrated in the subsequent discussion. Most obvious will be the fact that the principal physician will not only be responsible for the care of those patients without attending physicians, or for emergencies, but also will be expected to develop, revise, enforce and continually evaluate medical policies for the institution.

What then is the role of the principal physician. The *Medicare* law states that the extended care facility must have a physician responsible for the execution of patient care policies, and that the facility have a physician available to furnish necessary medical care in case of emergency.

The new State of Maryland regulations governing nursing homes define the duties of the principal physician as "responding to calls at times of emergency, and being available as needed to advise the administrator on medical questions. He shall also provide guidance on the execution of patient care policies and the health program of employees."

If we develop these brief guidelines into the more specific responsibilities which they encompass, we will find that they require a great deal of time and effort on the part of the principal physician. The principal physician must develop medical policies in conjunction with the administrators and director of nursing. These policies must include not only a guideline for physicians, but also those policies necessary to insure optimum and continued use of the facilities.

The *Medicare* law and the State laws clearly define the frequency with which a patient must be seen, and what information must be available and when. My concern is what happens during the first 48 hours, or when the physicians fails to provide the necessary information, or to see the patient with the frequency required. Therefore, the medical policies must not only include the listing of information already prescribed by law, but also include a description of the absolute minimum of information about the patient's illnesses, drug and other allergies, idiosycrasies, unusual behavior, therapy, diet, and what particular care problems he or she might have.

It is not sufficient to know only that a patient has a hip fracture, particularly if he has heart disease or mild diabetes, or is disoriented at times. Any one of a number of emergencies can occur within the first 24 to 48 hours for which the

physician may be called. Lack of basic information about all the patient's illnesses may lead to a patient's discomfort or even death. The physician should not depend upon the family or the patient; they may be no more informed, or equally as confused as you.

We must remember that most of the regulations spelled out in the *Medicare* law should not only be applied to *Medicare* patients, but should also include all nursing home patients. Therefore, the policies you outline should be applicable to all patients. For this reason you must develop a system to advise physicians when they are delinquent or fail to abide by the regulations. How would you go about this?

There is one method in which an initial telephone call is made to the physician. If he fails to follow up on that, then a letter is sent, with a check-off system whereby the administrator advises the private physician of what regulation he has failed to follow. Also, it should be clearly written down what steps must be followed by the administrator when the attending physician has failed to fulfill his obligation, after adequate notification.

I do not believe that the medical director should be responsible for informing the attending physician. Even though it is a medical policy, it is also a law which must be followed by the nursing home in order for it to retain its license. Also, many patients select the medical director as their private physcian when their private physician cannot see the patient. Consequently, it would be unwise for the medical director to advise the private physician of his loss of privileges, when the medical director has an excellent chance of being asked to assume the patient's care. This obviously opens the door to many accusations and potential unethical practices.

The medical director should evaluate the facilities, equipment and services. He should make recommendations to the administrator wherever patient care might be improved. This includes even improvements in the building or maintenance policies, since these are often important to patient care. Inadequate physical therapy space, or lack of adequate light, even unusual odors, excessive heat, poor ventilation, insufficient recreation areas, are all an integral part of patient care. What good is a physical therapist if he has no room or equipment to work with? What good is an occupational therapist if she has no equipment?

The medical director also should insure proper diet therapy. He should check the kitchen, check diets, check the distribution of food. I have seen regular coffee, fried foods, given to patients on a bland diet. I have seen trays of food sit in corridors, becoming cold, while waiting for staff to distribute them. I have seen dirty kitchens, food stored in dirty storerooms, and disheveled, unkempt and occasionally drunk staff preparing meals.

Take an occasional trip through the kitchen, check the quality of food being prepared, walk into a patient's room at meal time, and see if the food served corresponds to the diet prescribed. If you have the intestinal fortitude, sit down sometime and eat the food. (You might be surprised; it might be good or bad.)

With the cooperation of a pharmacist, prepare guidelines for drug control. This includes not only the standard regulations as they pertain to identification of patients' drugs, but also such policies as they may pertain to drugs to be included in the emergency tray, such as digitalis, coumadin, promestyl, adrenalin and similar drugs. Make sure that it contains drugs for all emergencies, not only cardiac emergencies.

There should be drugs for treatment of insulin shock, blood loss, acute pulmonary edema, regardless of cause. This tray should be on every wing or floor. Only one tray for the home with a few wings or floors is impractical. When an emergency occurs you don't have time to run around for drugs.

In connection with the emergency drugs, you should have clearly defined procedures to follow in case of emergencies. This should include not only immediate nursing procedures, but also procedures to be followed in contacting private physicians, or in their absence, the medical director. Delay may mean the difference between life and death. Waiting for a physician who is attending a meeting to call you back may take too long. It may be easier to contact the medical director or his alternate.

Despite what some may say, there should be a group of drugs available in the home which can be used when pharmacies are closed, or when delivery will be delayed. If I prescribe a drug stat, I mean stat. When I prescribe an analgesic or anti-emetic stat, I don't mean one or two hours later. Have you ever tried to get cough medicine, and injectable tranquilizer, analgesic or sedative at three o'clock in the morning?

Take time to look at the nurse's notes and see what time a drug was given in relation to the time is was ordered. I don't agree with borrowing a drug from one patient to give to another. I would much prefer a supply of cough medicines, analgesics, tetanus toxoid, and tranquilizers, available for use, regardless of the hour. The consultant pharmacist can check these supplies weekly and replace them when necessary. This is a within the limits of the law, and it is not difficult to accomplish, and certainly it is much more convenient.

The attending physician should be aware of all seriously ill patients, and review their charts. He should review all charts of *Medicare* admissions to see if they have adequate admission information, orders, and a planned program of therapy. He should also help prepare the utilization review plan when not done by some outside agency. He should be present at the review committee meetings. He should review prior to the utilization review meeting all patients to be reviewed.

I might add that utilization review will ultimately involve not only *Medicare* patients but, must be applied to all recipients of Public Law *89–97*, which I believe would include Title 19 patients, those receiving benefits under the medicaid program.

Other responsibilities of the medical director include training of the nurses in the use of specialized equipment, such as intermittent positive pressure suction and even pacemakers which might be implants in patients, then transferred to the nursing home.

He should train the staff in emergency procedures. He should give special lectures to the staff on particular care problems.

He might develop a transfer form or referral form for use at the nursing home.

He should constantly evaluate the progress of patient care and improve where deficient. He should be known to, and have a direct line of communication with, the hospitals with which he has a transfer agreement, and with all homes in the area.

He should be familiar with the services available in the community, either through the Health Department or the voluntary agencies. He should be familiar with the State and Federal legislation as it pertains to the nursing home.

He should develop and carry out employee health programs.

What has been said pertains to extended care facilities and skilled nursing homes, but there is very little that could not easily apply to personal care homes. It is all good medicine, and anything less could be detrimental to patient care. It cannot all be accomplished at one time, but can be gradually introduced over a period of time, but hopefully not longer than a year.

We must realize that the interested medical director can accept and understand the new rules, regulations and responsibilities, but it will take a massive physician education program to inform all the practicing physicians in the community, and to have them accept the changes. This will take time, and we must be understanding, but at the same time we must enforce the law and not back down. If we give in now, we give in forever.

Obviously the job description for a medical director is more extensive than before. He will be required to spend more time at the home performing services not directly related to a patient's care and for which he cannot charge any particular patient. Therefore, I believe the medical director should be compensated for his services, and this could easily be accomplished on the basis of either a consultant's fee or included in the cost of patient care. To expect a physician to be this active, and assume so much responsibility in a nursing home without suitable compensation, would be foolish. We would end up where we started, and all I have said would have been said in vain, and I hope that this is not the case.

ITEM 5. THE ROLE OF THE MEDICAL DIRECTOR

By Raymond J. Benack, M.D.

"Why do we need medical directors when our principal physicians are already doing everything that is expected of a medical director."

This statement has been frequently made whenever the subject of medical directors in nursing homes is discussed. Today I would like to speak about the role of the medical director as it relates to that statement.

Five years ago principal physicians were fired when they tried to fulfill even a few of the duties as outlined in the responsibilities of a medical director. Two years ago physicians were reprimanded by their medical society for not doing what they were expected to do regardless of whether he was allowed to do it. Obviously the principal physician is the fall guy between the nursing home administration and the medical societies. No matter how he moves he can be in trouble. Therefore the "initial" statement can not be completely accurate since the medical society feels that the principal physicians are not doing what is expected of the medical director while the nursing home administration feels that he is doing more than is overstepping the role of the medical director and therefore he should be fired.

I am not only a medical director but also an attending physician. I am also a member of the Montgomery County Medical Utilization Review Committee. In all these roles I have been involved in patient care in at least twenty nursing homes. I can honestly say that in those nursing homes where there is an interested and active principal physician with a cooperative administration, the quality of care is superior. However where there is a disinterested or inactive principal physician the quality of care is poor. Generally where the latter exists there is an uncooperative or disinterested administration. It can be generally stated that poor administration attracts poor physicians. I know of facilities where principal physician is seen for about one hour a month; where physicians orders are rarely if ever reviewed or renewed; where telephone orders are never countersigned; where there are no histories or physicals; where the administration would never think of consulting the principal physician. Unfortunately there are too many nursing home administrators and/or owners who do not wish to give the medical director any authority or to relinquish control of patient care policies to any physician. It is in those facilities that the physician does not do what is expected of the medical director.

It can also be said that an active and interested medical director upgrades the whole patient care program in the nursing home. When the medical director regularly spends time in the nursing home not only with his patients but also meeting with the nurses and administrators, he could only but stimulate the staff to provide improved care. It has been amply demonstrated that in those hospitals where there is an actively involved medical staff, the quality of care tends to be superior. The same can be said of nursing homes where there is an actively involved medical director. The very presence of a physician who can answer questions to the nursing staff or to assist the directress of nurses with inservice education will be a great boost in total patient care. The medical director by his interest will prompt inproved patient care because the whole nursing staff will see that he is not only interested in his own patients but also is interested in the well-being of all the patients.

One of the problems in the past has been the disinterest in nursing homes by physicians both attending physicians and principal physicians. Their disinterest had carried over to the nursing staff and the administration. There was no stimulant to the nurses, staff or administrator to improve patient care or to upgrade medical policies. Status quo has always been the philosophy in nursing homes unless there was a stimulant from outside to upgrade the quality of care such as a fire or epidemic. However, today with improved medical techniques, increased longevity, increased number of elderly citizens, status quo is no longer acceptable. We must not only upgrade the quality of care in hospitals in our private practice but we must also do it in the nursing home. The nursing home is no longer sitting at the perimeter of medical care. It is playing an active role in the health programs for the elderly and for the chronically ill. It is because of this advance of medicine, that the medical director is a must for nursing homes. I am certain that there are sufficient number of interested physicians within this state and within the country who would actively devote some of their time to being a medical director particularly if given adequate renumeration for the time spent as a medical director. This is necessary since the times spent in nursing home will reduce their office practice time to detract and that loss of income from the office practice must be in some way compensated.

In summary it can be said that the principal physicians are not already doing what is expected of the medical director. If they were, we wouldn't need meetings such as this.

ITEM 6. LETTER FROM JOHN M. DENNIS, M.D., CHAIRMAN, COMMISSION ON MEDICAL DISCIPLINE, BALTIMORE, MD., TO ALL PRNCIPAL NURSING HOME PHYSICIANS IN MARYLAND, DATED AUGUST 1, 1971

To: All principal nursing home physicians in Maryland.

DEAR DOCTOR: The Commission on Medical Discipline recently considered a case involving the responsibilities of a Principal Nursing Home Physician. Part of the plea in this matter dealt with the physician's alleged inability to do anything about conditions in the nursing home. In addition, it was indicated that the responsibilities of a Principal Nursing Home Physician are not clearly defined either in regulations, the signed agreement that must be on record with the Department of Health and Mental Hygiene, nor in the law.

The Commission is extremely concerned over the lack of understanding that many physicians profess to have when they assume this responsibility. As a physician, the responsibility is quite clear—you are responsible for the medical care of the patients in the nursing home, including the assurance that instructions or orders given by you are carried out.

The Council of the Medical and Chirurgical Faculty recently adopted the attached statement of Responsibilities of a Medical Director in an Extended Care Facility, Skilled Nursing Home or Related Facility. While these are only generalities, they make it adequately clear what is expected of you when entering into a contract as Medical Director of a nursing home.

Should you have any criticisms or complaints regarding the lack of response to your medical instructions or orders, they should be addressed to the Board of Examiners of Nursing Home Administrators, or to the Division of Licensing and Enforcement within the Department of Health and Mental Hygiene, 301 West Preston Street, Baltimore, Maryland 21201; Telephone (301) 383-2600.

JOHN M. DENNIS, M.D., *Chairman.*

[Enclosure.]

RESPONSIBILITIES OF A MEDICAL DIRECTOR IN AN EXTENDED CARE FACILITY, SKILLED NURSING HOME OR RELATED FACILITY

DEFINITION OF A MEDICAL DIRECTOR

The Medical Director shall be the physician designated by the extended care facility, skilled nursing home, or related facility as the principal physician. He shall be chief of the medical staff and senior house officer of that facility. He shall be responsible for arranging coverage of medical emergencies, for the development of employees' health programs, serve as medical advisor to the administration of the facility, and perform those administrative duties necessary to insure the highest quality of medical care for the facility.

TIME DEVOTED AS MEDICAL DIRECTOR

The Medical Director shall spend the necessary amount of time as negotiated between him and the nursing home, proportional to the size of the facility, devoted to fulfilling his duties as a Medical Director. This time shall be independent of the time used to provide care for his private patients. The amount of time devoted to his duties as Medical Director, and the compensation for the time, should be reached by agreement between the Medical Director and the Administration of the facility.

ADMINISTRATIVE DUTIES OF THE MEDICAL DIRECTOR

1. Develop employee health programs.
2. Develop medical policies.
3. Responsible for patient admission policy.
4. Develop procedures for insuring physician responsibility in fulfilling his obligations for regular patient care.
5. Continually evaluate the facility's equipment and services and make recommendations to the administration whenever patient care might be improved.
6. Insure proper diet therapy, including evaluation of quality and preparation of food.
7. Arrange for continuous physician coverage for medical emergencies.
8. Develop suitable drug handling policies in cooperation with the administration and the consultant pharmacist.

9. Develop programs for emergency treatment of patients and setting up emergency drug trays.
10. Be responsible for training personnel in the use of specialized or new medical equipment.
11. Assist in the continuing education programs for the staff and cooperate with the director of nursing in preparation of any inservice training programs.
12. Advise and develop satisfactory communications and relationship with acute hospitals and other extended care facilities, home care and related facilities.

OTHER RECOMMENDED ACTIVITIES

1. Attend meetings related to nursing home activities.
2. Be acquainted with the various voluntary and governmental agencies active in nursing home programs.
3. Work through local and state medical societies for changes or need for changes in nursing home policies and be familiar with changes in federal, state and local legislation relevant to nursing homes.
4. Work with local and state agencies to upgrade the status of the nursing homes and related facilities.
5. Participate in continuing education programs which would improve his skills as Medical Director.

COMPENSATION OF A MEDICAL DIRECTOR

A. Compensation of the Medical Director for the performance of his administrative duty shall not be in the form of patient referral or consultation.
B. Where emergency care has been provided by the Medical Director or any other physician on the medical staff, the patient should be billed directly.

ARBITRATION

It is recommended that a mechanism be established for arbitration between the Medical Director and the Nursing Home Administration.

Appendix 6

NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC., LETTER TO COMMISSIONER OF SOCIAL SECURITY SUBMITTED BY ELAINE M. BRODY,* DIRECTOR, SOCIAL SERVICES, PHILADELPHIA GERIATRIC SOCIETY

DEAR COMMISSIONER: In response to the proposed amendments to 20 CFR Part 405, (regulations governing skilled nursing facilities under Federal Health Insurance for the Aged) which were published in the Federal Register, Vol. 38, No. 133 on July 12, 1973, we recommend the following modifications:

405.1101 Definition—The definition for "social worker" (r) should be revised to read:

(r) *Certified* social worker—A person who is licensed or registered, if applicable, by the state in which practicing, and has a masters degree from a graduate school of social work accredited by the Council on Social Work Education and certified by the Academy of Certified Social Workers, a unit of the National Association of Social Workers. Such certified social worker must also have a minimum of 2 years of social work experience in a health care setting.

Rationale.—The term, "certified social worker" is consistent with NASW's *Standards for Social Service Manpower,* a policy statement on standards for the profession. The definition sets forth the minimum standards of training, competence and experience needed to ensure qualified provision of services, supervision, consultation, planning and administration of social service activities within the skilled nursing home facility.

405.1122 Condition of participation patient care policies.

(a) Standards: Development and review of patient care policies.

The term "one or more certified social workers" should be inserted in the middle of the first sentence following, ". . . registered nurse."

Rationale.—A certified social worker should be part of the professional team responsible for developing policies, especially insofar as such policies relate to meeting "the total medical, and *psychosocial* (emphasis supplied) needs of patients . . ." Certified social workers are uniquely trained and equipped to plan for, deal with and otherwise address the psychosocial needs of patients and their families.

405.1126 Condition of participation—specialized restorative services.

The term, "social services" should be inserted within the parenthetical portion of the first sentence.

Rationale.—Social services are a specialized and essential component of "restorative services", as contemplated by section 405.1126.

The following should be inserted in subparagraph (6) Standard: Staffing, following the second sentence of that subparagraph:

A non-qualified person, to be designated as responsible for social services, must have at least one year's experience in a health care setting, and a certificate for at least 32 hours of training obtained within 12 months of the effective date of this regulation, from a program approved by the Department of Health, Education & Welfare or from an accredited university extension or educational center approved by the State health standard setting authority, and annually reviewed.

*See statement, p. 2791.

The designated person(s) must work in social service full-time in facilities with 100 or more beds, at least half-time in facilities of 35–99 beds, and at least one-third time in facilities with less than 35 beds. The non-qualified designee works under the direction and regular (one day a week or more frequent) supervision of a qualified social worker consultant to the facility to whom the designee is accountable for his social service work.

The non-qualified social service designee who meets these conditions is designated by the administrator of the facility with the concurrence of the qualified social work consultant.

Rationale.—Even a non-qualified person, to be designated as responsible for social services, should be expected to meet certain minimal standards relative to training, supervision and availability to perform the social services needed. The foregoing paragraphs are addressed to this issue.

Sincerely,

CHAUNCEY A. ALEXANDER, ACWS,
Executive Director.

Appendix 7

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER FROM THE AMERICAN DIETETIC ASSOCIATION, CHICAGO, ILL., TO SENATOR FRANK MOSS, DATED OCTOBER 19, 1973

DEAR SENATOR MOSS: The American Dietetic Association, representing its 24,000 members, is pleased that you have held hearings concerning the proposed Skilled Nursing Home Regulations published July 12, 1973, in the *Federal Register*.

We are concerned because under dietetic services there was not a standard for "Patient nutrition care" which should include the following points:

a. Meals and nourishment should be served to all patients in accordance with a written plan of care based on:

1. Attending physicians orders;
2. The assessment of the patient's food practices and nutritional needs; and
3. All aspects of the patient's care.

b. The patient's intake should be regularly observed and noted in the medical records.

c. Diet counseling is provided as required to assist the patient to meet his nutritional needs.

This inclusion would provide a guide in planning and evaluting dietetic services. When this type of service is provided all patients benefit, and maintenance of the patient's optimum health is better assured through direct communication with all patients and those involved directly with dietetic services.

We are also concerned that there is no requirement that a dietitian provide 4 or more hours per week of service which we understood would be included in these regulations. The American Dietetic Association's "Guidelines for Part-time and Consulting Service—Dietitians Role in Nursing Homes and Related Facilities" states that: "To reach reasonable goals, it is recommended that the dietitian provide at least 4 hours service in the facility each week." Experience has shown that without a minimum time requirement many skilled nursing facilities employ the dietitian for an inadequate time to accomplish their goals. It is difficult for the dietitian to make more than a superficial impact on the nutritional care of patients unless at least 4 hours or more per week are spent in the facility.

Thank you very much for considering our remarks as your committee makes its report of its findings.

With best wishes, I am

Sincerely,

ISABELLE A. HALLAHAN, R.D., *President.*

ITEM 2. "THE CHANGING COMMON LAW IN THE UNITED STATES IN RELATIONSHIP TO THE DRUG DISTRIBUTION PROCESS IN HOSPITALS AND OTHER HEALTH INSTITUTIONS,"* SPEECH BY GEORGE F. ARCHAMBAULT,** PHARM. D., LL.D., FROM HOSPITAL FORMULARY MANAGEMENT, MARCH–MAY 1973

This presentation covers Court cases indicating recent *changes* in health care law—changes from the established *common* law of this country. It has been reported that each year, of the some 40,000 court decisions "handed down,"

*Presented at Seminar on Administration Approaches to Medication Distribution Systems, San Juan, Puerto Rico, January 26, 1973—sponsored by Department of Health of Puerto Rico, Pharmaceutical Association of Puerto Rico, Hospital Association of Puerto Rico, Association of Administrators of Hospitals of Puerto Rico, Association of Graduate Nurses of Puerto Rico and the College of Pharmacy of the University of Puerto Rico in cooperation with Health Care Facilities Service, HSHMA, USPHS, HEW.

**Editor, Hospital Formulary Management, also Pharmacy and Drug Distribution Systems Consultant, UMWA Welfare and Retirement Fund (Medical Health and Hospital Services), Washington, D.C.

about 4 percent (1,600 cases) make "new" law. We need to know of these changes and their impact on hospitals and drug distribution systems. Many changes are also taking place in statutory or code law in the states and the federal government, such as changes by the Federal Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs, but these changes are not within the scope of this paper. For example, there is no longer a federal Harrison Narcotic Act—a "Controlled Substance Act" has taken its place.

We now enter a brand new "ball game" in hospital and health care institution law as these new "leading cases' (*stare decisis*) blaze new legal concepts and bring new concerns and anxieties to hospital attorneys, trustees and administrators and others.

A brief discussion, such as this, of the legal considerations involving drug distribution systems in health care institutions must of necessity *cover only generalities* and limit itself to basic considerations.

One needs to bear in mind, therefore, in a discussion such as this, the U.S. law is a *complex specialty*, made so by the existence of federal, fifty-state, and many county and municipal laws, codes, statutes and regulations. This presentation deals with common law *principles in general*, pointing out trends or changes taking place or that have taken place. One need not be reminded that, when a *special legal problem* arises, one needs to consult an attorney, one *competent in hospital law*—common and statutory, in the jurisdiction of the hospital, i.e., its city, county and state. It is for this reason that an attorney well versed in the Puerto Rican laws and regulations in this field, joins with me in this presentation and the workshop discussions.

In the time allotted, we'll examine the changes taking place in the following areas that directly affect the drug distribution process in hospitals:

1. The hiring of pharmacists.
2. The degree of care and skill legally expected of a hospital pharmacist.
3. The utilization of nonpharmacists as pharmacists.
4. The liability of health institutions and health practitioners (physicians, dentists, nurses, pharmacists, hospital administrators and others) in situations involving charges of (a) *criminal* negligence; (b) *tort* negligence including strict tort liability and the new interpretation being applied to the "tort benefit" rule and (c) the implied warranties of fitness for use of medications in states where the strict tort liability is not law. (Contract law vs Tort law).

Let us glance first at *one general principle of law*, a principle quite likely familiar to all of us, and then lead *into the changes in the common law now developing* in the United States. Basic, of course, is the proposition that an individual is liable for his own acts—criminal, tortious or contractual—with certain exceptions such as are applied to minors, insane or corporation (*ultra vires*).

Also basic is the fact that an employ*er* is normally responsible for the acts of his employ*ees*, that is, *acts* performed within the scope of the employees' employment. This rule of law applies to health institutions in all states with the exception of the few still holding to the Charitable Trust Immunity Doctrine, such as Massachusetts. As to the Charitable Trust Immunity Doctrine, it *needs* to be said that reliance on the Doctrine, if such exists in one's state, is indeed a dangerous practice. The trend is definitely away from this principle of law and one *needs to be insured* against the possibility of negligence suits in *all* states today.

In mentioning insurance it might be of interest to indicate that records should be *maintained* of insurance *carriers* and the *periods of coverage* and that such records should be kept for at least 23 years. Unless state statutes exist to the contrary, infants have the right to institute suits afer they reach majority plus the statute of limitations period—usually two years. One such case was instituted in Maryland with the plaintiff losing, however. Another case "came down" last year. During 1971, in Los Angeles, a retarded youth was awarded $225,000. His parents claimed his affliction was caused by a vitamin deficiency in *infancy* as a result of the drug company's baby food formula not containing essential vitamins. The case contended the product was low in Vitamin B and C. The suit filed 15 *years* after the child's birth, *was possible*, because the Statute of Limitations did not apply to a minor or mentally incompetent *person*. (*Washington Daily News, p.* 52, 2/4/71 (*Kloss, E.F. & Wife vs. Amer. Homes*).)

NOW TO THE FOUR ISSUES

1. *The hiring of pharmacists*

It goes without saying that an employee selected for a particular professional assignment must be competent to handle the duties of the position. The rule is

simple enough but how does one determine such competency? From a practical point of view, the employer-to-be needs proof of (1) *current state* licensure of the prospective employee (by presentation of current certificate of licensure); (2) proof of *current* professional competency as indicated by previous employers and medical, dental and pharmacy associates to have *recent* personal knowledge of the professional capabilities of the applicant; and (3) proof of good moral character (not a drug addict), and no unprofessional conduct such as running lotteries or selling illegal lottery tickets or evading BNDD and/or Boards of Pharmacy regulations.*

Hospital pharmacy practice, as you know, differs in many ways from community or retail pharmacy, and it is advisable to give preference to an applicant with hospital pharmacy experience or practice, especially if the individual is to be the *sole pharmacist.* As to good moral character, this definition is slowly changing as you well know. The mores of a country do change—"Nothing is permanent," it is said, "except change." How true.

As to professional competency, The American Association of Colleges of Pharmacy and the American Society of Hospital Pharmacists have issued a "Statement on the Abilities Required of Hospital Pharmacists" (1962). These are abilities and characteristics above those of licensure, character and references of a current nature. This Statement is worthy of consideration by potential employers of pharmacists for institutional duty and might well be kept in a ready reference file. Also, recent hospital pharmacy experience or completion of a formal one-year ASHP residency is highly desirable.

A three- to six-month *probationary period* as part of the employment contract would be a further safeguard against charges of administrative negligence in the selection and employment of the pharmacist.

Institutions requiring the services of *part-time pharmacists* only would be well advised to insist that such pharmacists be participants in the ASHP & *Medicare recommended* pharmacy indoctrination programs for hospital and extended-care-facilities.

To depend upon a charitable trust immunity doctrine, as a defense against negligence, *including negligent charges in the selection of the employee,* in indeed today a dangerous practice, sort of playing Russian roulette, inasmuch as most states have seen fit to discard the doctrine and others appear to be in the process of doing so, as indicated by the recent Carney Hospital, Massachusetts case. (1969).

2. *The degree of care and skill to be expected of the hospital pharmacist*

The old common law rule was to the effect that the degree of skill and care need be equal only to the degree of care and skill of the *average* practitioner in the same field of work in the *same geographic area.* Today, *Brune vs. Belinkoff*—1969 (Fall River, Massachusetts) rules that the degree of care and skill should be equal to that of the average practitioner, practicing according to national standards, *without reference to geography.* Also in the Illinois Darling case (leg amputation), the court referred to a *national* Standard for Accreditation. The court went further here and quite clearly indicated that the medical profession and other responsible authorities *regard it as both desirable and feasible* that a *hospital* assume certain responsibilities for the care of the patient. Following this line of reasoning, one applies to the institutional situation the same rule in determining the degree of care and skill that is used to judge the individual health practitioner.

To restate, the degree of care and skill of an institutional pharmacist is to be judged by national standards and no longer on a purely local standard basis, at least in Illinois and Massachusetts. The same, of course, applies to physicians, nurses and other health professionals. By dicta, the same point could be made for other jurisdictions.

While the Darling (Ill. 1965) case was against a hospital (Charleston Community Memorial), it is pointed out that the physician involved settled out of court for $40,000 (verdict against the hospital was for $150,000) and that the basic dispute involved the effect to be given to evidence (1) concerning the *standard* of care and diligence *of the hospital* and (2) the effect to be given to

*A pharmacist's failure to keep adequate records was not sufficient to prove "unprofessional conduct"—Miller vs. State Board of Pharmacy, 262 So. 2d 188 (Miss. Superior Court 1972) and dispensing prescriptions for large quantities of an addictive drug after checking with the prescriber was held to be *not* a cause of unprofessional conduct. (Nevada State Board of Pharmacy vs. Garrigus 496 PL 749 Nevada Superior Court, May 1972). In both cases, the decisions were probably based on the lack of a definition for "unprofessional conduct."

hospital regulations adopted by (a) the State Department of Public Health under the Hospital Licensing Act, (b) the *standards* (national) for *Accreditation of Hospitals* and (c) the by-laws of the hospital itself. Note that a *national standard* of care was involved among others. Hull vs. North Valley Hospital, No. 12102—June 1972 (Montana) bears out this *new* point of law, even though the hospital was not held liable on the facts (J. C. standard had changed). The facts of this case indicated no vicarious liability (secondary liability) was present for the hospital for a private physician's negligence.

At this point, we might inquire *what* national standards are in existence concerning hospital and institutional pharmacy practice. We have already mentioned the Statement on the "Abilities Required of Hospital Pharmacists." In addition, one should be knowledgeable as to:

(1) "Minimum Standards for Pharmacies in Hospitals" of the ASHP
(2) The ASHP–AHA Joint Statement on Drug Distribution Systems
(3) The revised Joint Commission Standards
(4) The revised Medi*care*, and
(5) The new (1971) Medi*caid* Conditions of Participation as pertaining to pharmacy and drug distribution service, (for example—the latter conditions, among other things, require or recommend that the prescription label carry (a) name and strength of drug, (b) number of units dispensed, and (c) the manufacturer's name and lot number).
(6) The Statement on the "Safe Use of Medications in Hospitals" by the National League of Nursing and ASHP, now under revision, is *another valuable document* that should not be ignored by hospital administrators and nursing and pharmacy personnel in reviewing their activities.
(7) The ASHP Statement (1970) "Guidelines for Single Unit Packages of Drugs."

The AHA's *Manual on Hospital Pharmacy Service* is also a most helpful reference. We would point out that in addition to the above cited references, one needs to include the hospital's policy and procedure manuals and by-laws.

However, take notice, that when these documents become standards or norms of practice by their general enforcement and acceptance and the passage of time, they also become *tools* to be used by attorneys of plaintiffs in determining the degree or standard of care, *below which* a hospital might conceivably be found guilty of negligence. Failure to meet these standards, often thought of as minimum requirements, could mean having damaging evidence introduced that tends to substantiate the negligence claims; and further, administrative negligence could be alleged against management if periodic checks are not made by department heads such as pharmacists and nurses as to compliance with standards and with in-hospital policy and procedures as spelled out in the hospital's manuals.

3. *The utilization of non-pharmacists in the delivery of pharmacy and drug distribution services.*

The use, as *pharmacists,* of nurses, pharmacy aides or technicians, quite likely, is *one of the most disturbing legal problems* in the hospital drug distribution process today. The problem is not unique to pharmacy. Medicine and nursing are also involved in their sphere of patient care. Most of the health practice acts were placed on the books in the early 1900s or before, and regulations within the acts have been made, piecemeal, through the years, for the protection of the public health and safety and, in some instances, some claim, for the economic protection of the practitioners.

Today, we are confronted with this dilemma—Some hospitals, especially those in the research educational environments, to conserve highly trained manpower in short supply or for economic reasons, are utilizing nurses and training ex-military hospital corpsmen and others, *in areas* considered to be within the medical practice act. L.P.N.'s are being utilized as R.N.'s and, in the drug compounding and dispensing areas, nurses, technicians and aides are being utilized in roles designated by state statutes as restricted to licensed pharmacists.

Further, we note from the HEW's Task Force on Prescription Drugs Report, federal recommendations to the effect that the use of aides and technicians be considered for the "count" and "pour" activities now restricted by law to licensed pharmacists. The report further recommends that a "pharmacy aide curriculum" be considered by junior colleges and other schools.

Recently a $300,000 HEW grant was awarded to the University of Cincinnati College of Pharmacy to study the proper role of *pharmacy technicians.*

I mention these facts to indicate that, as a nation, we are moving in the direction of utilizing lesser talents in certain areas that are today, by law, considered

the sole provinces of medical, nursing and pharmacy practitioners. Until legislation catches up with this trend (as for example, New York now has legislation permitting some of this activity to physician assistants) one should not if one's state has a favorable "advisory opinion" from its Attorney General on this issue. His opinions are not "law" but indicate what action, quite likely, would be taken on criminal (*not tort*) charges involving such acts. Today, hospital administrators and pharmacists involved in the drug distribution process find themselves confronted with two very real possibilities in the event of an injury to a patient as a result of a negligent act in this area by a sub-professional—(1) criminal charges of violation of state practice acts and (2) charges of criminal and/or tort negligence. To date, to our knowledge, no one has been challenged directly in court on these issues in grant study situations. However, we do have cases, both on the criminal and tort side, that indicate the current thinking of the courts in this matter.

Let us look at a few such cases:

A CRIMINAL NEGLIGENCE CASE

An Inquest Report, 1956, *Northeastern U.S.* This is a case involving *two deaths* as a result of sodium nitrite being dispensed for "Phospho-Soda." The wrong solution was taken from the pharmacy by the helper on a quiet Sunday morning. He was not under direct and immediate supervision. The judge stated: "Suffice to say, however, a study of the evidence reveals acts of carelessness, carefree abandonment of responsibilities, the delegation of responsibilities to others, certain omissions to act, and wanton and reckless acts, as well as incompetence and the failure to qualify for the jobs they were intended to do on the part of the director of the hospital, the chief pharmacist of the hospital, and the pharmacist helper so as to warrant and justify a finding of *criminal negligence* on the part of the above named individuals and, by reasons thereof, that is the finding of this court." The case terminated, however, with (1) a $500 fine against the hospital for violation of a Massachusetts public health regulation—that "external use" medications be kept apart from "internal use" medications and (2) adverse front-page publicity. Concentrated Solution of Sodium Nitrite is obviously a "killer drug" in a hospital. So also are Concentrated Solutions of Boric Acid (Infant feeding formula mix-up cases), Camphorated Oil (dispensed for Castor Oil), Fluid extract Ipecac (dispensed for Syrup of Ipecac) and Formaldehyde (dispensed for Paraldehyde) among others.

Where are these "killer drugs" kept in your institution, at your nursing station medication centers, drug carts and in the pharmacy? Remember, "external use" drugs must be kept apart and separate from "internal use" medications.

DRUG CASES ON ADMINISTRATIVE TORT NEGLIGENCE

Morton vs. Argonaut Insurance Co., 144 So. 2nd 249 — *La. June 1962*

Here is a good illustration of an administrative tort situation. This is a case where a three-month old died from an overdose of Lanoxin. An assistant director of a nursing service administered a parenteral solution where an *oral* solution was intended. The parenteral solution was five times as potent as the oral solution. Judgment against the physician, nurse and hospital was affirmed. The nurse had been utilized for some time as an administrative nurse and was not aware that an oral form was on the market. Administrative tort negligence was held on the part of the hospital for allowing an administrative nurse to function in a clinical setting.

Sullivan vs. Sisters of Saint Francis, Texas Court of Appeals—December 1963 is another case in point.

A judgment was returned against the hospital (Refugio County Hospital) on the grounds of administrative tort negligence, i.e., failure to employ a licensed pharmacist and the use of a non-pharmacist as a pharmacist. In this case Fluid extract of Ipecac was dispensed for Syrup of Ipecac by a non-pharmacist with fatal results.

TORT NEGLIGENCE INVOLVING "INVESTIGATIONAL" DRUGS—TWO CASES

1. *The methotrexate Maryland case* (1970) with a $600,000 judgment against the physician (decision no doubt will be appealed to a higher court or new trial requested). The patient is alleged to have developed aplastic anemia. Note the acts of alleged negligence introduced in this case:

(a) Although the drug is used in the treatment of psoriasis by dermatoligists and others, it had not been cleared by FDA at the time for use for this purpose

and the package insert contained no reference to this use. (The drug is now covered by FDA as a drug of "last resort" for psoriasis). (See Federal Register, Aug. 15, 1972, and Oct. 1972 issue of "FDA Drug Bulletin" for latest discussion on "Use of Drugs for Unapproved Indications—Your Legal Responsibility.")

(b) No blood tests were made during use of the drug.

(c) Patient's consent was not obtained.

(d) The patient was not warned of all possible ill effects.

Note *here*, that the failure to meet federal requirements for the use of a drug in investigational status (an *old drug* with a *new* use as in this situation) was introduced as evidence of alleged negligence.

AMA's "Drug Evaluation—1971" (AMA–DE) states that an M.D. is "well advised to be aware of" package insert contents and to "give it due weight. However his decision on how to use a drug must be based on what is good medicine and what is good for his patient." This statement is legally sound. In a *malpractice suit*, such drug labeling information (package inserts) *may* have evidentiary weight for or against a physician, but the evidence is subject to refutation. Drug labeling information (package inserts) *per se*, does not set the standards for what is good medical practice. However, "beware" and be cautious in going beyond these stated uses.

2. *McCord vs. State of N.Y.* (1969)—*Court of Claims* (43405, 43406 & 43407) is another case involving an investigational drug.

A $228,000 judgment was rendered against the State—the case is under appeal. The elements introduced to prove alleged negligence included a mentally ill patient who killed her two children and attempted suicide. When her supply of medication was exhausted she had not been given a new supply of the drug by the research department of the hospital. In this situation:

(a) The drug was controlled by the hospital's research department and not by the pharmacy service.

(b) The patient had attempted to obtain the drug without success—the department was closed for a long weekend holiday.

(c) The Court stated: "The state had the duty to supply her *immediately* with the pills (investigational drug—not yet on the market) or a tested substitute—or to make a medical judgment as to the advisability of her release without pills or whether it was necessary to return her to the hospital."

In this connection, it is interesting to note that the 1957 AHA–ASHP statement on the "Use of Investigational Drugs in Hospitals" contains this statement: "*The pharmacy department is the appropriate area for the storage of investigational drugs, as it is for all other drugs. This will also provide for the proper labeling and dispensing* in accordance with the investigator's written order."

Finally, let me present two recent *unusual Tort Negligence Cases where the Benefit Rule in defense was not applicable.*

Troppi vs. Scarf—Michigan Court of Appeals 2/71.

This case, involving the dispensing of a "tranquilizer" drug for a "birth control" medication, follows usual tort law except defendant attempts to mitigate his damages by claiming that the birth of a healthy child is a benefit or if *not* wanted an abortion or "place out for adoption" could have been arranged, therefore, damages should be mitigated. The Court held "No."

The lower Court held that the benefits of having a healthy child offsets any damages. The "Benefit Rule" is not applicable, stated the Appeal Court (Restatement—Benefit Rule—"Where the defendant's tortious conduct has caused harm to the plaintiff or to his property and in so doing has conferred upon the plaintiff a special benefit, the value of the benefit confirmed is considered in mitigation of damages when this is equitable. Restatement—Torts. Sec. 920, p. 616). The application of the "benefit rule" to prevent recovery for the expenses of rearing an unwanted child *is unsound*, in the opinion of the Court of Appeals.

One case leads to other similar cases—and so it is with the "Birth Control pill" situation. In 1972, a year later, a March 11th *New York Times* news article reported "A Brentwood, Long Island (note first case was in Michigan) woman and her husband were awarded $31,000 in damages by a Suffolk County jury because a druggist misread a prescription for birth control pills and gave the woman *nasal* decongestant tablets. A year later she had a baby." The pharmacist, was sued for $6,000,000. The jury awarded the woman $8,000 for pain and suffering, her husband $8,000 for the loss of his wife's services and the couple $15,000 to cover the cost of raising their son, now 5 years old, to adulthood. The prescription called for Norlestrin; the pharmacist dispensed Novahistine. The case may be under appeal.

Another similar case is Jere D. Souter and Joan D. Souter vs. Hans G. Engel, Owl Rexall Drug et al (case No. 865489) County of Los Angeles, State of California. Considering the handwriting of physicians on prescription orders, it is not too difficult to see how "Norlestrin" could be interpreted as "Novahistine." This situation illustrates quite strongly one of the reasons why the *diagnosis* should be on the prescription order, as is required by at least one union's health and welfare fund prescription program (United Mine Workers of America Welfare and Retirement Fund).

I might add that the placing of the diagnosis on the prescription order might be the saving factor in preventing a negligent tort law suit because the dispensing pharmacist, in *monitoring* the prescription order, quite likely would detect the error.

A case reported in *Resident Physician* (May 1967) also illustrates the point. A patient was treated for fulminating pyelonephritis with several antibiotics. The therapy proved successful but the occurrence of total deafness prompted the patient to sue the physician. Evidence showed that one of the prescribed antibiotics (Kanamycin) had been reported by the manufacturer as ineffective against against the organism and had been known to cause ototoxicity. The drug order had been written after the physician had read and interpreted the antibiotic sensitivity report. In this instance, diagnosis on the prescription order might well have alerted the monitoring "clinical pharmacist" that something was amiss.

Product Liability Cases—Strict Tort Liability. This brings us to *the most recent change* in hospital law in Illinois—the application of the rule of the *strict tort liability doctrine* to blood cases—the case, probably as well known now to hospital administrators, as the famous Illinois Darling case, is *Cunningham vs. MacNeal Memorial Hospital (Sept.* 1970).*

Cunningham established in Illinois the principle of a hospital's legal responsibility for the harmful contents of transfused blood. Cunningham established the point that transfused blood was a *product* and not a "service" and as such the *doctrine of strict liability in tort* would apply as when hepatitis results from the transfusion.

Strict liability in tort, as a general rule, can be applied where a product is found to be in *a defective or impure condition* and *unreasonably dangerous to the user.*

The *Illinois Court has indicated* in the Cunningham Case that the *dispensing and administering of drugs* to hospital patients is *also* similar to transfusing blood and that the use of contaminated drugs "most assuredly" would lead to *strict liability* if the patient was harmed as a consequence. The Cunningham case clearly *affects* the *potential liability* of Illinois hospitals for other products besides blood that are passed on to patients *without processing*, such as *medications, injectables*, and *intravenous solutions* (a national problem recently, with the I.V. solutions recalls because of alleged contaminated liners of the caps). States not following the "Strict tort liability" principle as enunciated by the Illinois Cunningham case, quite likely will follow the "implied warranty of fitness for use" doctrine as used in the famous California Cutter polio cases.

We have attempted to weave into this discussion drug distribution cases of criminal and tort negligence, the strict tort liability and implied warranties of fitness for use doctrines. Let us conclude by listing the current specific changes taking place in hospital drug distribution systems. *As these new systems* and practices *become standard practices*, they too will *become "norms"* on which drug distribution systems will be evaluated by the courts in drug and drug distribution cases involving negligence, strict tort liability and implied warranty of fitness for use.

These changes involve the following 15 situations:

1. The preparation of I.V. additives by the pharmacy service and not the nursing service.
2. The use of the *original* physician medication orders vs. copied orders sent to the pharmacy.
3. The use of the single-unit drug system (unit dose) vs. floor stock containers as recommended in the recent GAO report. or, to restate, the use of the new pharmacy-controlled drug distribution system versus the old nurse-controlled drug distribution system.

*This doctrine of liability without proof of negligence was again exercised in a blood transfusion case (Brody vs Overlook Hospital and the Essex County Blood Bank)—in New Jersey, Union County (N.J.) District Court.

4. The broader use of pharmacy technicians and physician assistants.
5. The use of pharmacists as medication experts (generalists) or applied pharmacology experts (clinical pharmacists) in admission and exit interviews with "in" and "out" patients and as consultants to physicians and nurses.
6. The use of quality control prepackaging and bulk compounding programs *with* drug coding referring back to manufacturer's lot control numbers (for example, 11–71–109 for item 109 in prepackaging log of Nov. 1971) to *rapidly* recall "in-stock" and dispensed FDA or industry recalled lot numbers of "prepackaged" medications.
7. The involvement of computers in the drug distribution process including drug-drug interactions and allied information.
8. The handling of investigational drugs (ability to "break the code" immediately, when necessary, at locus of the patient; the consent of the fully informed patient, and the "new use for old drug" problem, etc.).
9. The ability to handle promptly all FDA drug recalls including dispensed medications. (NDC–ASHP code numbers).
10. Patient-Drug Use Surveillance (Clinical Pharmacy—The patient-pharmacist-medication profile.)
11. Adverse drug reactions and drug-drug interaction monitoring activities including contraindicated foods, beverages, and clinical laboratory tests.
12. The formulary system or "Basic Drug List" approach—the substitution question—and the "blanket" and "current" *consent* of prescriber for use of generics.
13. The replacement of nursing station drug centers by the *mobile drug cart.*
14. The use of single dose throw away sterile injectables.
15. The use of prescription containers (amber) with child-proof safety closures and the exemption waivers on the latter.

SUMMARY

There are three events transpiring that one needs to be cognizant of (1) the increase in the number of negligence cases involving medications; (2) the changing laws, that *more and more* are holding the sellers, including hospitals, of medical services and products liable without proof of negligence (the strict tort liability principle); (3) the changing methods of drug distribution systems in hospitals involving *unit dose*, mobile carts, nonprofessional personnel; and patient-drug use surveillance by pharmacists.

Finally, as most of us are aware, the five leading causes of accidents in hospitals, as cited by insurance companies several years ago, were:

1. Bed falls
2. Hot water bottle burns.
3. Medication errors
4. Improper blood typing
5. "Lost" sponges

Although medications errors were in *third* place as to the *number* of accidents, they were cited *first* as to dollar judgments.

Finally, there are 14 drugs that one should be especially alerted to because of adverse reactions that may occur when they are apparently improperly prescribed. These are, today, of greatest concern—litigation wise.

1. *Birth Control Oral Medications*
Numerous Brands [arteritis, clotting (brain, lung, legs), cancer, baldness, chromosomal damage to mother].
2. *Chloramphenicol*, U.S.P. XVIII
Chloromycetin (aplastic anemia)
3. *Chloroquine*, U.S.P. XVIII
Aralen (retinopathy)
4. *Diethylstilbestrol*, U.S.P. XVIII
Numerous Brands (fatal cancers of the vagina of teenage girls born of mothers while on the drug)
5. *Fluothane* N.D. (1967)
Halothane (liver necrosis)
6. *Hexachlorophene*, U.S.P. XVIII
Numerous Brands (nerve damage)
7. *Imipramine*, U.S.P. XVIII
Tofranil (suspected of liver damage to fetus)
8. *Iodochlorhydroxyquin*, U.S.P. XVIII
Entero-Vioform (SMON—subacute-myelo-optic neuropathy)

9. *Methoxyflurane* N.F. XIII
Penthrane (kidney and liver failure)
10. *Methotrexate*, U.S.P. XVIII
Amerthopterin (aplastic anemia)
11. *Nitrofurantoin*, U.S.P. XVIII
Furadantin (peripheral neuropathy)
12. *Phenylbutazone*, U.S.P. XVIII
Butazoldin [Stevens-Johnson Syndrome (ectodermosis erosiva pluriorificialis)]
13. *Tetracycline*, U.S.P. XVIII
Numerous Brands (kidney damage)
14. *Trifluoperazine*, N.F. XIII
Stelazine (neurological changes)

Let me conclude with this gem reported in the literature: "A surgeon examining a minor's hospital record prior to an operative procedure discovered that only the mother had signed the consent, although the father had been present at the time of signing. When questioned, the father admitted he had not signed the consent so that—if the operation was not a success—he could sue the doctor."

ITEM 3. "WHY?" EDITORIAL FROM HOSPITAL FORMULARY MANAGEMENT, AUGUST 1973, BY GEORGE F. ARCHAMBAULT

Practitioners of medicine and pharmacy need to question:

(1) Why certain acts must be performed *personally* by pharmacists in some states.

(2) Why Skilled Nursing Facilities in some states cannot have pharmacies on the premises as do hospitals.

All recognize that certain laws and regulations were needed to protect the consumer patient back in the early 1900s when pharmacy was essentially a "cottage industry." In those days pharmacists were primarily concerned with the *compounding* and dispensing (as distinguished from simple dispensing) of the prescriber's medication orders (the prescription order). However, today little "compounding" is done; prefabricated or manufactured medications have for the most part replaced the prescription of old with its "inscription" parts (i.e., base, corrective, adjuvant and vehicle).

Today, some who regulate pharmacy practice in the states (Boards of Pharmacy), in their *over*zealousness to protect the public health and patient (or as some say for the economic interest of the practitioners), still insist that pharmacists personally "count and pour," "Hunt and peck," and "lick and stick."

Can one picture a Board of Law Examiners requiring that attorneys *personally* "longhand" or type briefs, incorporation papers, wills, and similar legal documents?

Can one picture a Board of Registration in Medicine forcing physicians to *personally* "longhand" or type medical histories on patients—or CPA's being required to *personally* perform routine bookkeeping duties such as "debits" and "credits" of accounts?

Yet, in 1973, some State Boards of Pharmacy prohibit Pharmacy Technicians, Aides, Supportive Personnel, etc., from performing these time consuming tasks that any trained high school graduate, under the supervision of pharmacists, can do well.

Some are saying that such non-professional tasks constitute pharmacy's "security blanket."

Where prescription dispensing workloads are high as in many hospitals, SNF's and community pharmacies, the use of supportive personnel for these tasks is an economic must. Pharmacist salaries are rising and, as a result, prescription prices; such a waste of pharmacists' time is part of the cause.

Further, State regulations that require *all acts pursuant to the practice of pharmacy* be performed *personally* by pharmacists or pharmacy interns supervised by a pharmacist are—in 1973—archaic and not in the best interest of patient care, safety and economic welfare.

It's time for pharmacy and medicine to protest nationally and state-wide against such laws and regulations. Let's give the pharmacist, this professional who gives five years to formal education to become a "medication expert," the needed time to properly monitor the prescription orders he dispenses. It is essential today that such orders be monitored for possible significant drug-drug

interactions, "physician shoppers," under- and over-drug usage situations, and kindred problems of dispensing.

The knowledgeable physician not only appreciates this service, but more and more, expects it, providing he is properly consulted.

Some tell us pharmacy schools could be helpful by instituting typing courses to replace the "hunting and pecking" of pharmacists. All colleges have "typewriter label training" at the dispensing lab. Seriously, shouldn't we move now to correct this situation via resolutions at county, state and national association meetings. To wait much longer will surely bring consumer criticism on pharmacy for such a waste of professional manpower.

As to the states that by law or broad regulation *prohibit pharmacies on the premises of Skilled Nursing Facilities (SNF's)*—when such are sanctioned by the Joint Commission and Medicare—we can only again ask "Why?" *Both* "in-house" and community pharmacies are needed, depending upon the volume of medication distribution service generated by the SNF.

We note that the Pharmacy Consultant for the Bureau of Health Facilities in one state comments on this problem: "It would seem that the ultimate situation is a pharmacy on the premises of the facility. However since the laws of . . . prohibit this, the *next best* system of providing good pharmaceutical service is the community pharmacy utilizing the services of a legally and professionally competent pharmacist consultant." (Italics supplied.)

Care to write HFM your opinion on this subject?

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