BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

SATURDAY, MAY 25, 1974

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

The committee met, pursuant to notice, at 2 p.m., in the city council chamber, city hall, Hon. Pete V. Domenici, presiding.

Present: Senator Domenici.

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

OPENING STATEMENT BY SENATOR PETE V. DOMENICI, PRESIDING

Senator DOMENICI. The subcommittee will come to order.

I would like to thank everyone for coming to this hearing of the Special Committee on Aging.

I would like to give this audience an historical note. I have checked, and found that today's hearings are the first ones ever conducted by the Senate Special Committee on Aging in New Mexico, and I am proud to be here to instigate it.

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

Our subject is "Barriers to Health Care for Older Americans." We will keep a written record of all that took place in Albuquerque this morning and what will take place here in Santa Fe this afternoon. The facts we obtain here will thus become part of the published proceedings of previous hearings conducted in Washington and in four States, as well.

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

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

We know, for example, that Medicare—valuable and essential as it is—covers only a little over 40 percent of all health care costs of the elderly. Averages can be misleading, of course. Medicare serves many older Americans very well, and it prevents financial disaster when illness strikes. But it has many holes in its protection, and we are ex-

ploring them very closely. This kind of inspection is very much needed, particularly when there is so much talk about establishing a national health insurance program for all age groups.

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

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

But we are interested not only in problems but in solutions—and in proposed solutions. We're interested in getting the facts and then using those facts to insure that Congress does its part in building a better health care system for older Americans.

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

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

I would like to inform you that if you desire a printed copy of the transcript, please fill out a form at the back of the room, and we will see that you get a copy after it is printed.

Our first panel of witnesses this afternoon is headed by Anthony T. Arroyos, director, Santa Fe City and County Senior Citizens Program; he is accompanied by Mrs. Lucy Narvaiz, Outreach worker, Santa Fe County Senior Center, Remijio Lovato, chairman, advisory board, Santa Fe County Senior Center, Mrs. Matilda Solis, Santa Fe citizen, Mrs. Crucita Ortiz, Santa Fe County Senior Center, and Mrs. Charla B. Scott, Sante Fe citizen.

Mr. Arroyos, you and your panel members are welcome to this subcommittee. You may proceed in any way you wish.

STATEMENT OF ANTHONY T. ARROYOS, DIRECTOR, SANTA FE CITY AND COUNTY SENIOR CITIZENS PROGRAM

Mr. ARROYOS. Thank you very much, Mr. Chairman. I would like to welcome you to the city of Santa Fe, and I hope that whatever transpires today is fruitful, because we are all highly concerned about the senior citizen programs in Santa Fe and other northern parts of New Mexico, and I certainly hope that it all comes out like it is supposed to.

What I would like to do is just give you a history of our programs that is very brief. We started, basically, in the last part of 1969. We started the four basic projects that at the time was felt were good projects, and they are still with us. At that time we had four staff members and a limited budget, and they were sharing their funds with the title III of the Older Americans Act.

In 1973, it took a turn about, in that the county officials and city officials signed a joint powers of agreement. It brought the program into a comfortable situation, where you could expand the program on a countywide basis, and in doing that, the funding went up, and now we have 21 projects, 17 staff members in the program, 8 civic organizations, 43 business establishments, and the budget being proposed is that the city of Santa Fe is picking up $96,000 of the budget as compared to $36,000 of title III, so it has regressed quite a bit in the last year.

There was some foresight on that, and we would like to not be completely dependent on Federal funds, but rather start moving in the direction of easing out as well as we could under the circumstances.

Senior Citizens' Program

I want to give you some statistics on what we were doing, and I would like to give you statistics as to our senior citizens' program. We feel if it is comprehensive, it attracts more participation.

First of all, we have 2,890 registered members, and recreational, cultural, and social activities. We offer 249 different activities; we have had as many as 468 volunteers, participants in activities in the year's time is 15,000; transportation, 18,000; Meals-on-Wheels, 5,600; meals are served to 408 participants. Meals are served at five meal sites for 17,490; outreach is 521; escort services, 1,802; shopping assistance, 151; legal counseling, 89; consumer counseling, 480; HEW counseling, 1,347; home visits, 42; prescriptions issued, 4,928, of which 41 drugstores participated. We have a committee made up of druggists, doctors, and so forth.

We provided home maintenance for 52 individuals in our food for the elderly project. We have been able to help 255 individuals.

In home health care, we have helped 150 individuals. In our information and referral, we printed 31,500 newsletters, and in our telephone reassurance, we have contacted 3,600. In our 10-percent discount program, 2,890 participate, with 43 businesses participating.

I would like to make a brief statement on health for those not able to attend, which we are here for, simply because the others testifying today would like to express their feelings from the practical experience point of view.

This statement is reiterating the other statements that Mr. Oriol already has, as we see it here.

Our elderly in Santa Fe County and northern New Mexico face many barriers in supportive, preventive, and rehabilitative health care. These barriers include lack of health services, facilities, transportation, along with eligibility requirements, poverty incomes and accountability at all levels.

Facts point out that even with Medicaid, Medicare, and State health and social services, there still is a gap in providing assistance to the elderly poor. In Santa Fe County rural areas alone, there are approximately 4,000 persons classified as medically indigent people not eligible for any form of assistance from the local, State, and Federal Government.

When doctors, health care centers, clinics, hospitals, and long-term facilities do become available, they are quickly overloaded due to the

great demand of citizenry. Due to poverty, immobility, isolation, and transportation difficulties, the blind, handicapped, and shut-in elderly are denied the right of primary health care. In our day-to-day contact with the elderly, we run into senior citizens who have not seen a doctor in years. Not because they don't need one, but because of the health barriers stated here.

Finally, nursing and boardinghomes in northern New Mexico provide inadequate health care for their clients as has been shown by studies on nursing and boardinghome conditions. Proper monitoring and accountability is not enforced by either the Federal or State government.

The Federal and State governments have to increase their participation in financing programs which will lift the barriers currently facing the elderly desperately in need of supportive, preventive, and rehabilitative health care.

Pharmaceutical Program

I would like to describe very briefly the pharmaceutical program which we feel is having a big impact in Santa Fe, and on which we have had a lot of inquiries. Basically, the project is to offer purchasing of drugs to senior citizens who are not on any assistance whatsoever, but they need help with their drug purchases, and this is for those with acute or emergency conditions.

Chronic conditions requiring maintenance medication will also be considered, as the budget allows. Only nonassistance persons will be recipients. Exceptions are stated in the guidelines, but may include persons receiving Social Security benefits subject to the guidelines.

Basically, that is the description. The other health project description was based on a request to the city council for revenue sharing funds. The intent of the project was to go out into the community and seek out these people that have not been seen by doctors in years.

Its purpose is to provide the handicapped that are isolated, the opportunity for minor physical checkups on a regular basis at their homes. Thank you.

Senator Domenici. Is that last one a new program?

Mr. Arroyos. Yes, it is, Senator, we started it in February, the latter part of February, early March.

Senator Domenici. So the person in charge will have had just a few months of experience, but will tell us something about the program?

Mr. Arroyos. Yes, she is a witness here, and she has seen 150 beneficiaries and she has held some clinics throughout the county and in Santa Fe, and she can expand on that.

Senator Domenici. Before we go to the next witness, let me ask you a couple of questions.

If a senior citizen in Santa Fe is trying to find out what is available at any particular time, let us say next week in Santa Fe, and perhaps the individual is beginning to wonder about some kind of need, is there one specific place that she can go in Santa Fe to get information about available programs—broadbased, and then, specifically, those that concern themselves with health?

Mr. Arroyos. The feeling we would like to have is that in coming into our center, they can get just about any information they need.

Should we not have it, on Social Security, or on taxes, we will provide the transportation to the place where they can get the answers on anything. We will be with them until we satisfy them as best we possibly can to provide them with information.

Senator DOMENICI. Assume that the particular person I am referring to got very sick and was home, and a son or daughter or relative came into the house, and was trying to find out as quickly as possible what is available to senior citizens in this community. They were going to use the typical way to find out, the phone book, the Chamber of Commerce, some social agency. How would you propose to let them know that you are available as the principal source? How do you list yourself, and where do you give this information?

Mr. ARROYOS. The listing, first of all in the telephone directory, that is No. 1. No. 2, the Santa Fe Legal Women Voters put out a booklet called "Santa Fe" and the description of our program is in it.

The Community News also has a description of our program, and it has a short description. All senior citizens carry a membership card should they have to contact us, and it has the phone number, and so forth, on this.

If they are looking for a specific thing, I think information is pretty well scattered out. We have a program every morning over the air, where we inform them of what we are doing. Every Wednesday, we take different projects announced as we go along, and we have them often on the air.

We have another radio station that gives spot announcements. We do two or three television shows on a monthly basis, and the press release by the media is accepted very well in Santa Fe. We seem to be in the paper almost every day. So this type of dissemination, as well as outreach workers out in the field, and nurses out in the field. Drivers are also out there all the time, and they are answering questions.

Senator DOMENICI. One last question, with reference to your city government and your county government. Each has headquarters at city hall courthouse, in terms of their normal operation as a government unit. Now, is the senior program of Santa Fe considered to be part of the service that the city and county has for citizens? Is there something with some part of city hall itself, within its management role, that attributes to the city a role in senior citizens' problems?

Mr. ARROYOS. Mr. Chairman, when they signed their joint powers of agreement, the county agreed the city would be grantee. When the city took over and after we got the program squared away to their liking, they then made it a department of the city of Santa Fe.

This has greatly helped in fuel allocations, and in licensing, bonds, in all of these other things to assure you have a sound program, so it really has helped, and we have come a long way in the last year.

Senator DOMENICI. So the city of Santa Fe has a department which concerns itself with the problems of senior citizens.

Mr. ARROYOS. That is correct.

Senator DOMENICI. Would you introduce the next witness on the panel?

Mr. ARROYOS. We will start with Mrs. Crucita Ortiz.

Senator DOMENICI. Fine. We are delighted to have you with us.

STATEMENT OF CRUCITA ORTIZ, SANTA FE COUNTY SENIOR CENTER

Mrs. ORTIZ. Mr. Chairman, even though my project is the newest project for senior citizens, I have been in the health profession for 14 years, and I know the problems out there.

One of our problems that I find in my daily contacts with senior citizens is that some of our members have not been to a physician in 3, 5, 10 years.

In fact, a week ago I saw a senior citizen that had not been to a physician in 17 years. I asked him why he had not been, and he said, "well, I had no transportation." Because they feel, well, they do not feel ill, some senior citizens think they do not need to go to a physician.

One of our problems is on prescription drugs. We have people on medication, on four or five prescriptions from a physician, and can only get maybe two or three of them filled, because maybe two or three of their prescriptions are unaffective drugs, a combination of vitamins. Medicaid costs do not cover vitamins or laxatives, tuberculosis, or diet pills, and unaffective drugs. If they have problems that do not fall under prescription drugs, Medicaid will not pay for them, but they go to a pharmacist to get them filled. The pharmacist tells the patient they have to pay for the prescription, because it is an unaffective drug. Medicaid will not cover it, and in most instances, they will not get their prescription filled. I think that the doctor prescribes a supplemental vitamin because of their nutritional deficiencies.

Another problem is transportation. We have five vans, but the van that goes north for the senior citizens only goes up north twice a week, and that is at the end of the week; it is on Thursdays and Fridays. In the meantime, if they get sick at the beginning of the week, they do not have transportation to the clinic or to the doctor. If they get sick during the week, it is too bad.

Another problem that has come up with boardinghomes, I have seen some of the boardinghomes here in Santa Fe, and I have spoken with some of the boarders there, and they tell me they only eat maybe once a week, maybe not even once a week, they just have macaroni and potatoes almost every day, and they seldom eat an egg unless they buy it themselves. They have oatmeal for breakfast every day.

So there again, the nutritional deficiency comes into play, carbohydrates and starches for all three meals. Also, here in Santa Fe, to my knowledge, we do not have a visiting service, nursing service. We do have two agencies. One is the Santa Fe Family Services, and they do have nursing service and homemaker service, but they only service people that can pay, private patients. The other is the Santa Fe County Health; they only visit people with active tuberculosis, newborn babies, and patients that have delivered at a private clinic—maternal and child health—here in town that offer services to the indigent. Only those patients that qualify—low income—to use the services can be recipients. Health and social services do provide homemaker services, but only to Medicaid recipients.

Those are some of the problems that I have encountered in this 2½ months, I can tell you a lot about the other problems encountered throughout the year.

Senator DOMENICI. Let me try to talk with you just a little bit about what you are doing and some of the things you are finding out.

CARE OUTSIDE OF INSTITUTIONS

The Older Americans Act, and the White House Conference, which was held some 3 years ago, took an approach that we had to begin to deliver services to our senior citizens in places other than institutions. Preventive medicine, and nutrition, instead of following the established pattern of using hospitals, nursing homes, and the like, as the institution for care.

Now, as I understand your testimony, by getting out into the field, you are performing a kind of medical service, be it preliminary, be it something that you can do, and certainly not a doctor.

Do you find that there is indeed a need out in the field that can be filled, if we have enough resources, and enough will to do it, without necessarily institutionalizing people?

Mrs. ORTIZ. Yes, sir; most definitely.

Senator DOMENICI. Do you have any problems relating to the kind of thing you are doing, to the medical profession in this city; are they involved in any way, giving you advice; do you get along with them as a professional group? Do they seem to have any objection to what you are doing?

Mrs. ORTIZ. I do not find any problems, because I work under the supervision of doctors that operate the two free clinics, one is the Santa Fe Health Services, the other is La Clinica De La Cente. The patients that are referred to me for home visits, I refer back to the two clinics, or to a private physician if they wish to go to a private physician.

Senator DOMENICI. In your short time in the field, specifically on transportation, have you found people that you consider to need transportation to medical or nutritional service centers that do not have transportation available?

Mrs. ORTIZ. Yes, sir, I have. Twice a week I round up patients from up north, and from other places, and I bus them in myself to the clinics. A drop in the bucket. There is a terrific need for transportation.

Senator DOMENICI. Now, you do have as part of the senior citizens' program in the city and county some transportation facilities; you have some minibuses or the like?

Mrs. ORTIZ. Yes, sir; we have five.

Senator DOMENICI. And do you relate the findings that you have in the field to the centers so they know what people need transportation, or how is that done?

Mrs. ORTIZ. Yes, sir; we have a coordinator of transportation, and I usually refer to him. If they have an appointment with a physician or at a clinic, or to any place else, that they need transportation for, I usually refer them to the transportation department, but usually if a clinic is scheduled, I usually take all five or six patients to a clinic. I stay with them, because they need an interpreter. Sometimes I have to take them to a hospital for EKG's, or lab tests.

Senator DOMENICI. Thank you very much. We will now hear from Mrs. Narvaiz.

STATEMENT OF LUCY NARVAIZ, OUTREACH WORKER, SANTA FE COUNTY SENIOR CENTER

Mrs. NARVAIZ. Mr. Chairman, I come here to share with you some of the problems and situations I have encountered during the time I have been with the program. I could not possibly discuss them all, but I am going to touch on those that I feel in my opinion are the most important.

Most senior citizens live on a fixed income, and with the high prices of food and clothing, they find themselves unable to meet their needs. When I have referred them to food stamps, some of them have not been very lucky. For some reason or not, they have been disqualified. I will mention a couple that I know whose income is less than $100 a month. Because their daughter works and is living with them, and has obligations of her own, cannot contribute very much to the family, so that the family, the couple are still not qualified for food stamps.

The next on my agenda is health. A lot of senior citizens are in need of glasses, hearing aids, and dental assistance. I have referred them to some proper agency just to find the right way. They somehow do not qualify.

In housing, I have seen some sad situations. I have in mind two elderly ladies, living in different homes, and I saw in one home where they have seen daylight only through the cracks of their home. I have suggested that should they wish to apply for low-income housing, and they have replied since they have lived there all their lives, they have roots there, they would not care very much to move into low-cost housing. They would appreciate much more if someone would repair that home, but because of their age or illness, they are not able to do it themselves.

Now, transportation; we do not have too much problem there. We have transportation. People are coming to do a lot of things that they were not able to do before. Because of their age, they do not own a car or cannot drive. They are participating in a lot of activities; they are enjoying it. They are participating in nutrition, in which they have at least a balanced meal a day. They are in fellowship with their neighbors and friends.

Now, with that, I think with nutrition, I think they are really benefiting by that. I believe with a little bit of easing on these regulations, the program would benefit everybody.

The staff, Mr. Arroyos, is very dedicated and so are his people. My director is a hard-working man, and I feel very privileged to be a part of this program.

Senator DOMENICI. Thank you very much. Mrs. Narvaiz, I would assume you agree as an Outreach worker that any plan for supplying health and nutritional needs for our elderly should include a transportation element, or should have within it the requirement that the local people provide something that concerns itself on transportation. You agree with that from your testimony, is that correct?

Mrs. NARVAIZ. That transportation is benefiting our citizens?

Senator DOMENICI. And that it is very much needed in the total plan.

Mrs. NARVAIZ. Yes.

Senator DOMENICI. You are very lucky to have what you have.

There are many communities barely getting any transportation, and your director sent us his strong position on it. We did take it to a committee that was talking about what should be included in plans for communities. We suggested it be mandated, that every community have a transportation plan.

You find transportation rather adequate at this point for your people?

Mrs. NARVAIZ. Yes. If they could get the other things that they need, then the program would be much better.

DO SENIOR CITIZENS PREFER HOME?

Senator DOMENICI. Let me ask you one last question. This morning in most of the testimony on this problem, barriers to health care, we have found that almost all Outreach workers, or those going into the homes, feel that the senior citizen would much prefer to be able to stay around home; that families would much prefer to try to care for them around the home, rather than to send them off to be institutionalized.

Now, I think it is part of our culture, that we like to keep our people in our homes. Could you just tell what you have found here in your city? Do they want to stay home? Do the young people want to care for them, or are we failing because we do not give them enough resources, money, or the like, in this effort?

Mrs. NARVAIZ. I believe if their incomes were a little higher, that they would be able to stay home and enjoy it. I think they would prefer to live at home than to be in an institution. Yes; I believe that.

Senator DOMENICI. Do you feel if we were able to take more of the services there instead of having them in institutions, that that might be a better approach to their well-being?

Mrs. NARVAIZ. I think they would be happier; yes. By that same token, they would be better.

Senator DOMENICI. Thank you very much.

Mr. ARROYOS. We will now hear from Mrs. Scott.

STATEMENT OF CHARLA B. SCOTT, SANTA FE, N. MEX.

Mrs. SCOTT. I am here to represent many members of senior citizens in Santa Fe. The major problem that they have is financial, because of the high cost of living. We have been given increases in our Social Security. However, it does not mean more money in our pockets. It is just enough to pay for increasing costs of food, medicine, and so forth.

We still cannot afford to pay for transportation. Perhaps people don't realize that a lot of us live alone and we must depend on others for transportation or just stay secluded at home.

Since the senior citizens program has been established, it has been like an answer to our prayers. Without the transportation their program offers, we would not be able to keep appointments, buy groceries, and so forth.

Not only can we depend on them for transportation, but their free medical program alleviates our burden of paying for the medicines.

I want to cite my own personal problem as an example of how the senior citizens program has been of great benefit to me. As I stated before, I have received an increase in my benefits. But because of this increase and because my income is bigger now, I am not eligible for food stamps.

My medical expenses include traveling to the Penrose Cancer Hospital in Colorado Springs every 6 months at my own expense.

This is just one of the many financial and medical problems you will encounter in our senior citizens membership. There are numerous problems we are burdened with and if it wasn't for the program the club offers, we would not be able to exist as independently as we would like to.

Senator DOMENICI. Mrs. Scott, let me ask you about the trips to Colorado for your treatments. What types of treatments are they?

Mrs. SCOTT. Cancer treatments.

Senator DOMENICI. Is this a special program that helps you?

Mrs. SCOTT. Yes.

Senator DOMENICI. What is involved in the cost? Is it transportation costs?

Mrs. SCOTT. The transportation, how much it costs me. Yes.

Senator DOMENICI. We understand that there is a special program that will help you with the cancer treatment, and my question is, Does that also take care of your transportation to the place you get the treatment?

Mrs. SCOTT. No.

Senator DOMENICI. You have been going to this place for treatment for some time?

Mrs. SCOTT. Yes; I have been going for 20 years.

Senator DOMENICI. And do you have a doctor in this community also?

Mrs. SCOTT. Well, yes.

Senator DOMENICI. Does he recommend that you go to the center in Colorado?

Mrs. SCOTT. Well, I went to the cancer clinic over here in Santa Fe, and then they have to use some other kinds of machines. They did not have it, so they tried to get me a closer place, so they got it in Colorado Springs.

Senator DOMENICI. So that this is done with your doctor's full approval?

Mrs. SCOTT. That is correct.

Senator DOMENICI. Thank you very much.

Mr. ARROYOS. We will now hear from Mrs. Matilda Solis.

STATEMENT OF MATILDA SOLIS, SANTA FE, N. MEX.

Mrs. SOLIS. Before I become involved with the senior citizens program, I was very lonely and quite at a loss as to what to do with my time. I don't drive and cannot learn now because of my poor eyesight. However, in 1972, I heard about the senior citizens program, and I decided to find out what senior citizens were doing, so I joined them in Pojaque. I soon became involved in arts and crafts and other projects that were going on.

If it were not for the senior citizens program, I would be very lonely. I would not get help for my medicines, and would not have met as

many nice people as I have. I would not keep myself busy, crocheting or doing other arts and crafts as I have learned.

I would not be able to enjoy the nice meals that are served at the school cafeteria or have transportation into town, or other things I need to do, such as obtaining information from Social Security, Medicaid, or Medicare.

I feel the senior citizens program has made great progress within the last year and a half, and I hope we can continue to enjoy these benefits for a long time to come. Thank you.

Senator DOMENICI. Mrs. Solis, you say you were in the senior citizens program in Pojaque?

Mrs. SOLIS. Yes.

Senator DOMENICI. Is that one of a number that you have in the city and county?

Mrs. SOLIS. There are more than one.

Senator DOMENICI. I take it that you really think we ought to have centers out where the people are, so you can get to them, is that correct?

Mrs. SOLIS. Yes; that is correct.

Senator DOMENICI. How far do you live from the center that you go to?

Mrs. SOLIS. Three miles.

Senator DOMENICI. How do you get there?

Mrs. SOLIS. In the vans they have for senior citizens.

Senator DOMENICI. So they even pick up people that are going to go for arts and crafts and the social activities at the center?

Mrs. SOLIS. Yes.

Senator DOMENICI. Let me depart from the next witness a minute and go back to you. Everyone has talked about drugs, more or less, prescription drugs. Mr. Arroyos, we understand that you have one of the finest and most innovative programs to try to fill the gaps where drugs are not available under Medicare. We are going to make your statement part of the record.[1] We understand that you do not have time to go through all of it, but that you recommend actual coverage for prescriptions where some are not covered now, is that correct?

PRESCRIPTION DRUG PROGRAM

Mr. ARROYOS. That is correct. This particular gap is really astonishing when you start to look at how many prescriptions are being filled a month, and the amount of money going into that particular program. There is a tremendous gap in this particular area in filling prescriptions, and it is my belief that should Medicare extend itself, and go into that area, we should make sure that the eligibility requirements, if nothing else, are really considered and looked at. This is why we are able to plug the gap, because of the requirements in that particular prescription program.

Senator DOMENICI. So your program, even though it is locally administered, has some fast rules to try to determine need, because it does cost a lot of money. You recommend that there be some Federal extensions, in spite of your program?

Mr. ARROYOS. Right; because it does cost about $24,000 a year, and you cannot do that year in and year out. Not only that, but in other

[1] Retained in committee files.

parts of northern New Mexico, they have none whatsoever, and I am wondering everyday, how they are getting medicine. So if it was extended, it would be a step in the right direction.

Senator DOMENICI. One last question on the drugs. We had some evidence this morning, that there was a rather large difference between the cost of drugs in the city in comparison to the small rural towns, or the rural drugstore, or the rural part of New Mexico. Has your experience indicated that there is indeed a big difference in price?

Mr. ARROYOS. No, sir, it has not. They are relatively the same. Well, what happens is that there was a lot of public relations done with the druggists to begin with, in putting this thing together, so we do get at least consideration in pricing when the senior citizens go in there, particularly in prescription programs. So this one step was taken, and we do not find a difference between what we are paying at that particular drugstore in the county, and what they are paying here in the city of Santa Fe.

Senator DOMENICI. Thank you. We will now hear from Mr. Lovato.

STATEMENT OF REMIJIO LOVATO, CHAIRMAN, ADVISORY BOARD, SANTA FE COUNTY SENIOR CENTER

Mr. LOVATO. Mr. Chairman, I think I can just finish my statement in a second at most. I think this group has said everything that should be said.

I have been involved in a program of the aged, the older people, since the beginning of this program. I have been involved in this as well as many other programs, and I think I know it.

At the present time, Mr. Chairman, I want to note, to talk not only for myself, but for the whole board itself. I think that we have been making great progress with the senior center for the whole community.

I see people that feel happy, they are contented, they get together, they are friendly, I think they enjoy life better than in any other place. So, therefore, this is exactly why this is an encouragement to me to do whatever I can, because I feel that I am maybe older than they are. But maybe I am lucky that I have got better health, so, therefore, this is what I intend to do, and I always have been content in doing what I am doing. So whenever I can help somebody in life, to enjoy their life, I will do it. This is the one thing that, when I retired, I joined the American Association of Retired Persons. I served as president. I served as vice president. And finally, I find myself wanting to be of further service.

I have been involved in many things, and, therefore, I have taken quite a bit of consideration about the people's needs, so I do try to do all I can.

Senator DOMENICI. Could I stop you there and ask a question, Mr. Lovato?

Mr. LOVATO. Yes.

BOARDING FACILITIES CLOSED

Senator DOMENICI. Do you know of any boarding house facilities that have closed down, and if you do, do you personally know where the people that had been boarders and roomers went?

Mr. LOVATO. Some of them have gone to Las Vegas, and I suppose some of them maybe went to the Four Seasons, or someplace else. I do not know just where they went, exactly, but there were several that were closed, and the people have scattered.

Senator DOMENICI. When you say went to Las Vegas, do you mean to the hospital, or do you mean to the community of Las Vegas?

Mr. LOVATO. I believe, maybe, they went to the Mittle's home for older people, something like that. They went to that hospital, or whatever it is. This is the last thing that I found out. Others from homes that have been closed have maybe been picked up or been accommodated by their own children. I know that one or two had been picked up and taken to the homes of their sons and daughters.

Senator DOMENICI. Please proceed.

Mr. LOVATO. This is one of the things that has been of concern to me about this problem of the older people. I think that we would be improved if there was more money available, and if more encouragement was taken. And another thing, it has already been stated, that if a person owns a home, you could fix it so he could stay there, they would be happy to stay there.

There are very few that want to leave their home and move into a nursing home or any other place, if they can stay in their own place. So this is one thing we find out, that many people on the farms, they have sold their little homes, sold their little places, and they moved into town, with the understanding that they might find a better place to live. Many have gotten into trouble because the houses are not good. This is one of the problems that we went on and on with. This is exactly the way that it stands today, so in this program of social service, it is the volunteer work. We do have several men that go and fix things, like faucets—faucets that leak, those that are broken—and fix other things. This is another thing that can be improved upon.

FUNDS NEEDED FOR REPAIRS

If there were funds to repair these places, I think that these people would be happy to stay in their own homes, but there is not enough money to take care of these people that do not have the facilities, or the money, to do it. There is one new thing that has come up. If there were some funds, or some money to repair these people's places so they could live in them, so they could have heat in their places; a lot of these people are in danger of these faulty heaters, and once in a while you see that there are people that do get sick because of gas fumes or gasoline, bad ventilation, it is all the same. That is one of the things that can be improved.

Senator DOMENICI. Could I ask a couple of questions about living in one's home? Do you find that many of our senior citizens are living with their own family, either sons or daughters, or grandchildren?

Mr. LOVATO. There are quite a few, yes.

Senator DOMENICI. Do you find that most of them lack money or resources, that if they had enough, they would not be a burden on their family?

Mr. LOVATO. Yes, I think that is so, as long as they could move around. There would be a point, there would be time that these people would have to be nursed as they do in a nursing home, because whenever they cannot manage themselves, but as long as a person can move

around, or can cook their own meals or do something, they are happier in their own home than anywhere else.

Senator DOMENICI. Mr. Lovato, from the testimony that we have received, and some of the laws with which we are familiar, it seems that our Government makes it hard for senior citizens to live with their family, rather than giving the family some kind of advantage if they try to keep seniors at home and take care of them.

Now, without getting into specifics, would you think that it would be better for us to try to find ways and means of making it easier for a family to keep their elders at home, and help them, than a policy which would institutionalize them?

Mr. LOVATO. Yes, it would be better. I think I would put a very small percentage, I would say very few do not want to take care of their parents, but because they do have to work, they can only give limited attention. But if they can, these people will stay there in their homes, and I do not think that their children would object.

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

Mr. Arroyos, let me ask you, and then if any members of the panel have any views on this, I would appreciate hearing from them.

Your program has been going on now for about 5 years, and I can tell you honestly I believe you have initiated some very impressive new programs. Under the Older Americans Act, plans are developing to establish an areawide agency on aging.

How will this AAA, as it has been called, and I assume you are familiar with that, how will that work with your program, as you see it, and how can the AAA be encouraged to help develop coordination between health services for the elderly?

Mr. ARROYOS. Mr. Chairman, first of all, as far as working relationships with the AAA is concerned, I think their viewpoint could be one of a partnership type of situation, with senior citizens programs that have practical experience in the field. They have been out there working with these different communities, and in different counties, and a professional, technical assistance type of partnership developed, which hopefully will develop here in this district. Anyway, a lot more can be done in these areas.

The limitations of the State, and of the Federal Government, is in areas of providing adequate technical assistance in programing to communities that do not have anything whatsoever, even smaller ones.

LACK OF PROGRAM EXPERIENCE

There are a lot of gaps at the State level. Not having the practical experience in putting programs together, in realizing a lot of factors that we have gone through, in putting some of these projects together, a conference would be beneficial to them if they had experienced it, but in some cases, I guess it works at all levels of government in decisionmaking as we take it. We get people in there that are not actually trained, and doing this type of work. They are not experienced in putting programs together. They say they have conflicts that can arise in particular situations. Wherein you have one person, he tries to understand the problems of the elderly, and so forth. On the other hand, a new person has to be trained to do this. Yet one bureaucracy is over the other one, and so the relationships could be a problem. I think if compromise is put in there, and good understanding

between the programs in existence and the AAA's, and the Commission on Aging, if you can get them together in one room and share experiences and expertise, you are going to accomplish a lot more instead of division among the three of them.

I think that is very important, the AAA, in health planning or any other planning that goes on. You have to be a partnership. If not, we are going to be, we are not going to be able to accomplish what we must do. Counties are going to feel slighted, programs are going to be overlooked, and others will feel stepped upon.

With respect to the 5 years, I personally think, and I think within our county commissioners, the idea was to get a good senior citizen program working, and working very well, if possible, using the money we have.

I think it would be a fallacy, a definite fallacy, if the title III of the Older Americans Act would say that "you are not going to give any amount of money, because your x amount of years are up." I think while we are not looking for total support, or 50 percent or 25 percent support, I think local governments are looking for some support, because they have a right to share in these things.

I think that if there is this situation, where you have a 5-year program, and it is ready to go as far as title III is concerned, but the Federal funds are cut and we are sorry the local government must pick it up. I think that is a fallacy, because if you are going to build something and then pull the rug from under the seat of the local governments when the program is built, I think you are damaging the community much more so.

Another area of concern that we share here is that the State itself has got to start coming across to help communities that cannot generate general revenues or tax money in order to match title III.

This is a deep concern, it is expressed and brought up in smaller communities in northern New Mexico. They just cannot generate the revenue to match.

Now, the point is that if you do not have any money to match, you cannot have a senior citizens program.

That attitude has got to change. What is most important is that there must be more sensitivity by the State legislators when it comes down to providing some funds for these local communities, so they can in fact use these funds to match title III, and beginning programs for the elderly in communities which cannot generate their own revenue.

Senator DOMENICI. Thank you very much. Thanks to all of you. We very much appreciate your coming and taking your Saturday to be with us.

Mr. ARROYOS. Thank you, Mr. Chairman.

Senator DOMENICI. Our next panel is made up of Mrs. Epi Duran, San Miguel County director, New Mexico Social Services Agency; Mrs. Connie Sanchez, boardinghome operator, Las Vegas, and Mrs. Adelina Ortiz de Hill.

STATEMENT OF EPIFANIA DURAN, SAN MIGUEL COUNTY, DIRECTOR, NEW MEXICO SOCIAL SERVICES AGENCY

Mrs. DURAN. I am here to speak mostly about the boardinghome situation in the Las Vegas area. The poor quality of life of boardinghome clients in Las Vegas, N. Mex.

Most of the clients are isolated adults who are living away from their home communities. This is a profile of the people living in boardinghomes. The purpose of this is to make these people more visible, and to make their needs known to the public.

We have 168 adults living in 31 licensed boarding and shelter homes in Las Vegas, N. Mex., a community of approximately 16,000 people. Twenty-five percent or 42 case records from our file in Las Vegas were randomly surveyed for the following information, and I have some statistics here that I will give you.

This survey does not include clients living in intensive care facilities or extended care facilities that we have in Las Vegas.

We have a private nursing home which is a nice intensive care facility, and then we do have what Mr. Lovato referred to as Meadow's Home, which is an ICF, or intensive care facility.

The New Mexico State Hospital is located in Las Vegas, and, therefore, there is a high percentage of these people in boardinghomes. Approximately 88 percent of these residents are former patients of the New Mexico State Hospital.

As I previously mentioned, we reviewed a total of 42 cases of boardinghome residents. Of these, the average age is 57.95. The median age is 59.50.

We have 65 percent females and 35 percent males living in the boardinghomes. Patients are placed in boardinghomes from the State hospital. 78.6 percent of our boardinghome residents are from other communities and only 21.4 percent are from Las Vegas.

Of the sample taken, 11.9 percent of the boardinghome residents' length of stay was less than 1 year. Length of stay for 30.9 percent of the residents was from 1 to 5 years; 40.5 percent of the residents had a length of stay from 5 to 10 years; and 16.7 percent had a length of stay for 10 or more years.

We reviewed the records to check the number of interested families of these residents living in boardinghomes. 57.2 percent of the families are not interested in having these people live with them. 42.8 percent are interested. We have been very much involved in our county for the past 3 to 6 months in attempting to improve the conditions of the boardinghomes.

Improvements Sought for Boardinghomes

We have had several meetings with various people, including those from the health and social services, the licensing division, and boardinghome operators. The purpose of these meetings has been to improve the boardinghome situation.

If the conditions in the homes are improved, the people will remain in these homes. I think that some of the situations in the homes, or the conditions in the homes have been because the boardinghome operators did not fully understand the licensing regulations.

Mr. Libby, who is assigned to our area to inspect the boardinghomes, is very helpful in working with the boardinghome operators. During the last boardinghome meeting, Mr. Libby explained the regulations to the boardinghome operators, and what he expects of them when he goes to inspect the homes.

Senator DOMENICI. Let me ask you a couple of questions about this. If I understand your testimony correctly, you do acknowledge that many homes have a substantial number of those who occupy them and that the condition of those homes is not such that you approve of them?

Mrs. DURAN. Yes.

Senator DOMENICI. Is your agency in charge of finding out whether the boardinghomes comply with the law or not?

Mrs. DURAN. Not necessarily. The licensing division of the health department under the health and social service agency is in charge of seeing that the boardinghome operators comply with the regulations.

Senator DOMENICI. I understand that the licensing division law has been in effect for some time, has it not?

Mrs. DURAN. Since 1972. The boardinghomes were licensed in July 1972.

Senator DOMENICI. And is it your testimony to us that there are still a number of boardinghouses in the city and county of Las Vegas that do not comply with the laws of the State of New Mexico?

Mrs. DURAN. Yes; there are still a number of homes that do not comply with the regulations.

Senator DOMENICI. You have indicated a concern about what will happen to the people if they are closed down. I wonder, how long do you think that they should remain in operation if they are not in compliance?

Mrs. DURAN. As a result of our intensive work with the boardinghome situation, four boardinghomes have closed; two were closed by the licensing division and the other two closed on their own.

Three of the boardinghome operators said that they would not comply with the regulations.

BOARDINGHOME PROBLEMS WIDESPREAD

Senator DOMENICI. I want to state at this point, so there will be no misunderstanding, that the committee staff has not said that they found the boardinghouse situation here any worse than they found it in the slums of Washington, D.C., or in other cities, but that does not mean to say that they are telling this committee that this condition is a good condition. Rather, they are saying it is very widespread in the United States, and it is typically bad where we have institutions like Las Vegas.

We do not want to be part of mandating anything from the Federal Government. In fact, we think that a reading of New Mexico law would indicate it is a good law. I am not concerned with whether we have a good law, but rather I am concerned with how long is it going to take for changing the conditions the committee staff found, and that you have verified as well. We have heard at least five witnesses impartially indicate that they have also found problem conditions—not only in Las Vegas, but elsewhere, including the city of Albuquerque. Do you think there is anything that can be done about it?

Mrs. DURAN. Yes; I think that something can be done, and I think that one of the reasons is lack of staff in our agency, as well as in the health and licensing departments.

Senator DOMENICI. Let me ask you one other question on behalf of the committee staff. Based on your statement to us, you indicated that this licensing officer would license the place one time a year. Now, that is much like looking at a building to see if it still complies with the fire code of the city or State. Are you suggesting that all of the regulations needed to find out whether a place is healthy, sanitary, and feeding people properly, are judged by somebody only once a year?

Mrs. DURAN. No; I feel they should inspect at least three or four times a year. We do have people from the fire department visit these homes also, to see that they meet the fire code regulations. We also have the people from the environmental agency check the homes.

Senator DOMENICI. I want to ask you a general question, and if you do not feel you know the answer, that is all right.

I am interested in what the Federal Government can do, what we in the Senate might do, to see to it that we do our share to get rid of this kind of condition. Do you have any suggestions?

Mrs. DURAN. I think it is more money.

Senator DOMENICI. Where would the money go? Do you see it as a law we would pass or as something to get HEW to do? How do you accomplish that?

Mrs. DURAN. I really don't know. I cannot say, but my boss is here, and he is going to be talking a little later and he can tell you.

Senator DOMENICI. All right. We will ask him. I think it would be good to have a boss like that. I am sorry I do not have one.

Mrs. Sanchez?

STATEMENT OF CONNIE SANCHEZ, BOARDINGHOME OPERATOR, LAS VEGAS, N. MEX.

Mrs. SANCHEZ. I am a boardinghome operator. Two years ago, my place was licensed, it passed all inspection, fire and State, all regulations. I got my license, and I thought that all of the businesses had done the same. Talking to my fellow operators, their places were licensed, and they were well pleased.

Now, about 4 months ago they started up this business, you know, that they were too dirty, they were not being fed right, that the places were just terrible, and ever since then, even last night, I looked at myself in the mirror, to ask "Am I the monster that they make out to be in New Mexico? Am I the one that is hurting these people?"

Going back on the feeding. In 1963, we were paid $63 per client. In 1970, we got a big raise, $86 per client. In 1974, it is $110 per client.

Senator DOMENICI. Now, when you say you got, or you received, you mean that is what the board and room pays you?

Mrs. SANCHEZ. Those are the rates. They were the set rates by the State.

Senator DOMENICI. Go ahead.

Mrs. SANCHEZ. On that, you can well imagine that you cannot feed a steak everyday.

Senator DOMENICI. What is the size of your boardinghome?

Mrs. SANCHEZ. I have six clients, female. I serve a normal nutritional meal. I consider my home to be very clean.

Senator DOMENICI. I want you to know it is not the purpose of this committee to individually make accusations about your home or any other home.

Mrs. SANCHEZ. No; what I am trying to do is defend all of the boardinghomes. We are trying to do our best for these people. I do believe there are some of them that are bad, but they take interest in this business.

I opened my home, it was pretty close to 14 years ago, and we took in the forgotten people. Nobody wanted the mentally ill. We took them in. We gave them a home, we gave them love and care, the best that we can give. I myself cannot give them any more, because I am not capable of any more. I wish I could have the Hilton Inn for them, but on $110 for room and board, who can afford it?

Senator DOMENICI. Now, let me make sure I understand what you are telling us. Again, I am not familiar with your boardinghome. The testimony we received this morning—the statistics that were given to us by the head of the agency—would indicate that under the strictest of rules, some homes are in compliance, but did I hear you state that you were coming before this committee, not only to talk about your boardinghome, but to defend the status of boardinghomes in the city of Las Vegas as being the kind of room and board that should be provided for the money that has been charged? Do I understand that is what you are telling us?

Mrs. SANCHEZ. Yes; a percentage.

Senator DOMENICI. So you do admit that some homes are not doing all of the wonderful things you are describing?

Mrs. SANCHEZ. That is true.

Senator DOMENICI. The investigations we have made of some of the facilities reveals that they do not have running water, or running toilets, the day around. Rather at a certain time of the day only can you use the toilet. If you do not use it then, you cannot use it the rest of the day.

If that exists, you would not say that that is reasonable treatment for anyone, regardless of what they pay?

Mrs. SANCHEZ. Definitely not. They should not operate a boardinghome.

YEARLY INSPECTION

Senator DOMENICI. How often do you get inspected?

Mrs. SANCHEZ. Once a year.

Senator DOMENICI. What does that inspection consist of?

Mrs. SANCHEZ. Well, the first major one, they measured the rooms, they measured everything, they made a sketch of my boardinghome. Then we had to have records, up-to-date records, up-to-date menus of what was being served to these people. We had to have our own personal checkups.

Senator DOMENICI. That is the extent of anyone passing judgment on your facility, once a year?

Mrs. SANCHEZ. Yes.

Senator DOMENICI. Do you think that is adequate? I am not speaking just for your facility, but for the operation and the kind of care that you know is given. Is once a year adequate?

Mrs. SANCHEZ. Well, maybe twice a year.

Senator DOMENICI. What happens to the Social Security, the SSI payment, does it go to the client, or to you? Do you know about all of the boardinghomes? Describe what happens.

Mrs. SANCHEZ. I can speak for myself. When the SSI payment comes in, the client finds they never have enough identification, and in Las Vegas, that is a problem. So what we do is take it to the bank where we trade. We cash it there, and we bring it back home, and from this they pay the room and board. Whatever is left is their personal spending money.

Senator DOMENICI. What is left?

Mrs. SANCHEZ. I charge $110 for room and board, and $30 is for their person.

Senator DOMENICI. So out of $140 of the check you cash, you keep $110 for room and board, and you give them back $30?

Mrs. SANCHEZ. That is it.

Senator DOMENICI. Do you know whether or not that is a typical arrangement in the community you live in?

Mrs. SANCHEZ. No; I do not, because in January, when the SSI took over the payment, we tried to get in touch with all of the operators to see if we could set our own rates, if they would all comply. So we all had the same thing, and so far they have all agreed to it. But underneath, I do not know if they are doing it, because some of the clients say they are overcharged, so I could not say.

Senator DOMENICI. How much help do you have in your facility?

Mrs. SANCHEZ. Just myself.

Senator DOMENICI. Who else lives there besides your boarders?

Mrs. SANCHEZ. My family, which consists of my husband, myself, and three children.

Senator DOMENICI. So you do all of the caretaker-type jobs for the $110?

Mrs. SANCHEZ. Yes, sir.

Senator DOMENICI. You cook the food?

Mrs. SANCHEZ. Yes, sir.

Senator DOMENICI. What are your arrangements with reference to this particular boardinghome? Do you change the sheets regularly, make the beds?

Mrs. SANCHEZ. Once a week, I change the bedding. They go over the bed, and then later on, I straighten out the room. They do their own dusting and helping to take care of the room on their own.

Senator DOMENICI. Do you feel that any of your boarders during the years were in need of care, attention from people that are professional, that are experts, for their mental condition, physical condition, or for nursing-type health?

PSYCHIATRIC CARE PROVIDED

Mrs. SANCHEZ. Whenever they are required; yes, they get psychiatric help once a month.

Senator DOMENICI. How do you work that out?

Mrs. SANCHEZ. We have a schedule through the doctor, who is a psychiatrist with the State hospital. He pays the girls a visit once a month. His name is Dr. Sears.

Senator DOMENICI. Does the group in Las Vegas call them operators?

Mrs. SANCHEZ. Yes.

Senator DOMENICI. Do they have an association?

Mrs. SANCHEZ. We have been trying to begin one.

Senator DOMENICI. But to this point, they do not have one?

Mrs. SANCHEZ. No; we are not fully organized.

Senator DOMENICI. And you are just sort of self-appointed spokesman for them today?

Mrs. SANCHEZ. Well, let me tell you this. We got together, and we decided we needed an organization, and I was elected their spokesman.

Senator DOMENICI. We will get back to you in just a minute.

Let us finish the testimony, and we will talk a little more.

Mrs. Hill?

STATEMENT OF ADELINA ORTIZ DE HILL, LAS VEGAS, N. MEX.

Mrs. HILL. My name is Mrs. Adelina Ortiz de Hill, and I am a specialist in aging. I am a coordinator for Pro Personas Mayores, an advocacy group for Spanish-speaking aging.

Their problems are the concern of this association. There are three coordinators. One in California, myself, and one in Massachusetts, to advocate on behalf of the Spanish-speaking aging.

I know the intent of Congress in allocating money on nutrition and for aging are those of the high-risk population of aging, and I do not think you can find a higher risk group than you find in boardinghomes. Some of these people have possessions that you can put in a shoebox. This is it.

The conditions of the boardinghomes have been a concern of mine for some time. I was employed by HSSD, and as an adult specialist did some work in this particular area.

I have taken all of the traditional steps of meeting in the community, and at the community level, and have made efforts at implementing programs at the State level. I have also assisted the AARP membership legislative group in their testimony before the State legislative committee on health and aging.

Their primary concern, and their priority, had been concern for the boardinghome recipients or residents.

Senator DOMENICI. When was this testimony?

Mrs. HILL. This testimony was about last August. I gave Mr. Oriol a copy of that testimony that was submitted.[1]

I am sorry Mr. Carmichael is not here, but we had also attended the hearings in Albuquerque, and had input from community people in Albuquerque about this. Perhaps many of the same people you heard this morning were very concerned about the conditions.

I believe I visited about 50 boardinghomes, not only in the State of New Mexico, but Kansas and California.

I realize that the role of the Federal Government is probably required, because apparently, from my experience in this State, there is a bureaucratic snarl of monumental proportions.

There are many agencies involved in this, and some of the things I can say about boardinghomes. While I realize Mrs. Sanchez has one of the better ones, that for the most part, from my experience, there is isolation, and isolation for the elderly. It is a deprived environment. There is overcrowding. All available space is used for beds. You have a

[1] See appendix 1, item 1, p. 1220.

vision of a boardinghome being a room where a person has his personal possessions.

You can convert a dining room, living room, and a three-bedroom house into an institution, and in many institutions there are 18 people. There is very little living space. There is very little activity areas in many of these boardinghomes. The diets are inadequate, drugs are administered, and I have mixed feelings about who administers these drugs, and what right boardinghome operators have to give them.

Many Residents Exploited

I think the residents are exploited. I have met many people who have had their total check ripped off. There are many mentally incompetent, not competent to manage their own money. Therefore, there is a dubious practice of whether they get any of it at all, and this may even happen in nursing homes where I believe that the person is too ill to spend his own money. I believe the practice is for the nursing home operator to keep it in a savings program, and collect the interest on it, and then who knows what happens to the money.

I would like to know myself. I am very curious. Then there has been cases of physical and mental intimidation.

I discussed some cases with the sheriff in San Miguel County, of residents having been beaten. I believe that this has happened in Albuquerque.

Social contacts are not encouraged. There are actually boardinghome operators who will tell people to stay away—social service workers, or just visiting persons—that they are not permitted to visit these people.

There are residents who probably need another level of care, higher or more independent, because many boardinghome operators are very controlling.

If you do not have any money, you cannot step out the door to be independent, and a great dependency level is maintained. I think it works to the advantages of boardinghome operators.

Often problems evolve around licensing standards for enforcement. I have met with representatives from the health department many times, and I have been told that there are not alternatives for these people.

If a boardinghome is closed, that is it. I think we need to develop alternatives. I developed a package of adult services which has not been implemented. I think that payment, the excuse of payment being insufficient, is not really always the case.

As an example, I used my own home and got a friend of mine who is an engineer to figure out how much I would make, with overhead, and this includes utilities and everything else, and my house happens to be a little better than average. I pay $175 a month, including the utilities, for my home, which is 1,600 square feet. I could have 18 people in there, and I figured in my overhead, with feeding expenses of $600, which is quite a generous estimate, my income would be $2,160 a month, and I subtract $600 from that, and I am making $1,100 a month.

Senator Domenici. Could you do that without any help?

Mrs. Hill. Without any help. They use the residents to do the work.

In fact, the sheriff told me that a woman had reported to him that she had been beaten. The reason given was that she was not carrying her own weight. They do some of the cooking, cleaning, and ironing. I do not object to their having any activity, but I know I would not be doing it alone, and even then, $1,500; I work pretty hard now.

Senator DOMENICI. What is the range of occupancy based upon the information you have?

Mrs. HILL. On my information, that would be a bed with at least 3 feet on either side, which is fairly typical of many boarding homes, with little personal space for storing.

You have a carton box under your bed, where some other patient might steal some of your things.

Senator DOMENICI. What do State regulations require in terms of space?

Mrs. HILL. I am not sure of the licensing regulations, but I know it is far more generous than that. The point is that it is not practiced. I don't know if they moved the bed in after the inspection or not, but in some that are quite crowded, the only place that the resident has to sit is on his own bed.

Senator DOMENICI. In terms of number of occupants; can you give us some idea of the range?

Mrs. HILL. I think that Mrs. Duran reported the average range was eight. There are homes that are as large as 23. I imagine eight would be more the case, because you have to figure that many of these are very small homes.

If you put them on the open market for rent, you could not get more than $80 a month, including utilities. They are not very big, fancy homes that they are using as boardinghomes.

I think this is the common picture the people have of a boarding-home. Would you like to ask some questions?

FEDERAL INTERVENTION: WHAT ROLE?

Senator DOMENICI. I have some questions that I would like to ask now. You have quite forcefully said that you see the problem as being one requiring the Federal Government intervention. Can you tell us how you perceive the Federal Government doing anything about it?

Mrs. HILL. I do know that moneys have been allocated to upgrade housing for elderly people. I would give this particular group of people a very high priority. I think there would be some subsidy for decent housing, and I think that this might be an area, I know that in the different communities I visited, like Tucson, and areas like that, many neighborhoods have been wiped out.

Older people wanted to live independently. For instance, one section in Tucson which became a model cities reclamation area, and people were moved.

Senator DOMENICI. I think that suggestion in the chain of thought you are talking about is more preventive in terms of how we cut down on the population available for this kind of need. I am asking more specifically. We know we have a problem, we know it exists in many cities in New Mexico. We know it is severe, and we know this cannot continue for very long. If I understand you, you are suggesting that the Federal Government has a role in curing it.

Mrs. HILL. Yes.

Senator DOMENICI. Now, I am not speaking of curing the movement toward them. I am speaking of curing the problems of the hundreds that are in this condition. Do you have any suggestion with reference to what we can do?

Mrs. HILL. I believe there were low-interest loans available to seniors for housing. Many of them did not take them, did not apply for them, because they do not want mortgages beyond the time they expect to be able to pay them back. But perhaps to someone, or some church groups, or some nonprofit organizations, individuals that would want to go into this area, and develop decent housing for isolated individuals. In Las Vegas, we have the alcoholic council, a home for alcoholics, and it is a model home, and I might even use that as an example, because we have a boardinghome for alcoholics.

Senator DOMENICI. Whether I agree with the premise or not, let me tell you what information we are being given.

If the Federal Government, through the Secretary of HEW, was to issue a national mandate that SSI money would not be used for this kind of facility, and defined the minimum kind of facility, we are being told that there would be no facilities for these people.

Do you know whether or not the amount of money available for this is enough for us to expect better facilities from the private sector?

Mrs. HILL. Probably not.

Senator DOMENICI. So is it fair to assume—you are suggesting we must find ways to get more money into the hands of the operator, if we are going to demand more of them?

Mrs. HILL. No; because I envision more exploitation. I think unless you have some standards set for operators; yes, then possibly more money.

ALTERNATIVES SUGGESTED

I believe through HUD there was some housing money available for church groups, or any group that wanted to develop housing for seniors. I am just suggesting that perhaps this might be a priority area, rather than individual apartments, removed from the community, reclaim some of these neighborhoods, and fix up decent housing.

I do not believe institutions are an answer. I would not like such large ones that we have people stacked up, and we get into this depersonalized mechanical dispensation of assistance.

That concerns me, but I would like to see something done in this particular area.

Senator DOMENICI. The staff did talk to you about your observations and your thoughts?

Mrs. HILL. Yes; and I have submitted my testimony and recommendations.[1]

Senator DOMENICI. Now, might I ask the other two witnesses if they have any suggestions as to what the Federal Government might do to alleviate the situation?

Mrs. DURAN. Mr. Lovato mentioned that many of the senior citizens that he has to deal with, and I think members of the other panel, they

[1] See appendix 1, item 6, p. 1229.

would prefer to remain in their own homes. While we do have many residents in boardinghomes, I think that to try to get these people back into their own homes if possible, if we can work somehow with the relatives of these people, and maybe, it was suggested maybe make more money available to the client, or to the resident of the home, so they could help the relatives to stay in their own home.

Senator DOMENICI. However, your facts would indicate a substantial proportion in Las Vegas did not want to take care of them.

CAPABLE OF LIVING INDEPENDENTLY

Mrs. DURAN. Yes; but I do not know how much work has been done with this relative to really helping them see how important it is for these people to remain in their home, or stay close to their relatives.

This is what we are trying to do also, to work with these people, to see how many we can have live independently. I think a large number of them are functional enough to live independently, if they are given a little more money to pay rent, and so forth, if they do not own their own homes. I think that is one way of doing it.

Again, we do not have the staff to do all of this work, to render all of the services, to contact relatives in communities where they come from, and so forth.

Senator DOMENICI. Would you talk of the amount of money that is available, and tell us your views on the adequacy or inadequacy to give good care.

Mrs. SANCHEZ. If we had more money, would we do better for the client? I am sure they would. Another thing we need is more communication between the social services and all departments. You have to have many agencies, and none of them are communicating.

Senator DOMENICI. Communicating?

Mrs. SANCHEZ. With the operators. The departments with the operators for the betterment of the home, of her place. I have spoken to a lot of operators. I said, "How did your home rate?" "Nice." Some to them, it is just that. Maybe if they came out and asked our caseworkers, what do you think of my home, do you recommend a change, I am sure they would agree on doing better.

Senator DOMENICI. Well, there is some evidence there are five agencies authorized to inspect. Are you aware of that?

Mrs. SANCHEZ. To inspect?

Senator DOMENICI. Yes.

Mrs. SANCHEZ. Well, so far, the only inspection we have gotten is from the State.

Senator DOMENICI. Five State agencies have authority to inspect or regulate, or that are doing it?

Mrs. SANCHEZ. I did not know that. All I knew is that we are under the State standards of New Mexico, that is it.

Senator DOMENICI. Well, I want to thank the three of you for appearing. You certainly, Mrs. Sanchez. This is a very volatile and very serious problem for you.

I am not going to agree with you in the statements you made about the other operators, or the conditions, but I do want to tell you that I compliment you for coming down here and testifying.

Mrs. SANCHEZ. Thank you.

Senator DOMENICI. Our next witness this afternoon is Herman Agoyo, executive director, Eight Northern Pueblo Indian Councils, San Juan.

STATEMENT OF HERMAN AGOYO, EXECUTIVE DIRECTOR, EIGHT NORTHERN PUEBLO INDIAN COUNCILS, SAN JUAN, N. MEX.

Mr. AGOYO. I have with me Mrs. Cara Leon, community VISTA volunteer, Nambe Pueblo, N. Mex., which is in Santa Fe County. I feel she knows more about the problem of the aged among the Indian people, or at least in her community, than I do, because she works on a daily basis with them. I have a prepared statement, and after that we would be very happy to answer any questions, and then also we would like to have Mrs. Leon to give her the opportunity to briefly state what she does.

Senator DOMENICI. Fine. I am glad you are here and we will give you an opportunity also. Herman, you may proceed any way you wish.

Mr. AGOYO. As director of the Eight Northern Indian Pueblo Council, I represent the concerted efforts in social planning of Tesuque, Nambe, Pojoaque, San Ildefonso, Santa Clara, San Juan, Picuris, and Taos.

The eight pueblos have banded together in an organization which is a loosely formed association for their mutual benefit. This association is formed by eight self-governing entities. Each pueblo, by its self-governing powers, has authorized the creation of this association and has by their full governing authority given this association authority to negotiate with and conduct all transactions regarding the various Government programs. Going north from Santa Fe to Taos, we are rural communities situated alongside the Rio Grande. Our population is 6,037—446 which are 65 years and older.

As requested, I would like to speak today of our elderly. The programs, through the counties of Santa Fe, Rio Arriba, and Taos, which our old people take advantage of, those which they have not—and why not—and those programs which we believe should be developed in order to serve our elders.

FEW INDIANS DELIVER SERVICES

A full percentage of our people are eligible for some kind of supplemental security income, frequently VA benefits and those earned through previous employment. Food assistance is also commonly granted though Indian participation is dramatically low. We believe this to be the case because few Indians are employed to deliver these services and subsequent intercultural problems arise, in addition to what seems like endless paperwork. And when the effort is made to gain such benefits, it is often stymied by lack of transportation.

Within the pueblo we have attempted to deal with lack of State funding for transportation by supplying our own through the services of our Outreach workers, community VISTA volunteers, and community health representatives.

Needless to say, however, these people have greater talents to contribute than the ability to taxi to and fro, and the pueblo elderly wish these services. Yet, to date there has been no State initiated program

to supply transportation or to contract out—and therefore localize—State supplemented programs.

Instead, we find ourselves frequently belatedly informed of State operated programs or not informed at all. As a matter of fact, this is the reason there is no nutrition program; that is, "Meals-on-Wheels" under title VII, operating in our pueblos today though it was started on the State level almost 6 months ago.

Our old people continue to grow and teach, and to give a frame of reference to our life in the pueblo. Our tradition of extended families provides for the elderly person in the essentials of food, clothing, and shelter and companionship.

He also is an effective part of our work force, teaching one another and training the young in the old arts and crafts. Our lives and our economics are richer for their participation in Indian-initiated, pueblo-based craft cooperatives.

Those of the pueblo are quicker to recognize problems of the pueblo. Programs for Indian elderly will best work when they are designed by the Indian. We feel the greatest urgency to gain contract privilege so as to be able to restructure programs and funding of the State and Federal Governments to the situation of the pueblo and the demands of pueblo life, which necessarily have a cultural connotation.

Priority Usage of Funds

On a contract basis, we believe that we can make better use of funds because their allotments will appropriately correspond to the priorities of our elderly. In this way we could provide transportation where needed—as to the hospital, food shopping—better utilize the talents of our VISTA's and CHR's and develop home-based, Indian-initiated programs to suit our elderly.

I think, basically, what I am trying to say is that we have the Federal Government to deal with; we have the great State of New Mexico, which are supposed to serve all citizens of New Mexico. However, it has been our experience that we are not getting what we should get. That if we are getting services, they are very little, and one of the things that I feel that is lacking within the health and social services department in the State of New Mexico is that it has very little Indian employment. Consequently, our Indian people have a problem of communicating with the county welfare office.

For example, I think there is one individual that works—one Indian official that works at the county welfare office in Taos, that is Indian, and he is working with the Taos Pueblo.

I know of no person that works with the Española office, and within the region we have the San Juan Pueblo, and the Santa Clara Pueblo, and I know of no person in the Santa Fe County Welfare Office to deliver services to the Indian pueblos of San Ildefonso, Tesuque, Nambe, and Pojoaque. In Santa Fe County—it has four Indian pueblos—and no Indian person that works out of the welfare office to relate to the Indian people. Then also the State has not come up with any special programs to deal with the Indian communities whatsoever.

I feel that the only time the State wishes or wants to do anything for the Indian people is when the Federal Government wishes to give the State additional money to work with Indian people. I think what

we need in terms of not only serving the elderly people, but the rest of the Indian residents, is for earmarked funds, or special funding to Indian communities to address themselves to the social problems that the Indian people have. One good example of that is that traditionally the Indian people have been receiving services through the Bureau of Indian Affairs. It is a sad commentary on this United States of America that the Indians are the lowest rung of the ladder, and yet we have the great Federal Government trying to improve services for us. So I think, for example, the Bureau of Indian Affairs is there to perpetuate its own existence, and it took the Office of Economic Opportunity to break this fraternal relation that existed within the Bureau. So I think we were able to accomplish a lot with direct funding, or with funds going to the State, but earmarked for a possible formula basis to work with Indian people. Then I think another thing that might be considered is that, whether you like it or not, we have to create special departments within the State if it is not possible to give direct funding out of the health and social services department. Maybe within that department a special Indian affairs office can be established so that the State can do more for the Indians. I think maybe your staff can do a little bit of research as to how, and how much impact the Office of Economic Opportunity has made on Indian communities so this might be a worthwhile effort on the community's part to get some successful nest out of this approach.

Senator DOMENICI. Could I stop you and ask about a couple of programs? For instance, with regard to the dispensing of food stamps. There has been overwhelming testimony which we have received in this State of New Mexico. The State is doing a reasonably good job of dispensing the food stamps, including dispensing the food stamps to Indian people.

We have had some complaints about the remoteness of an office that certifies from a given pueblo, which has some very tough problems in terms of transportation, in terms of waiting in line, and the like. Is it fair to ask you for your feeling on that specific thing?

Mr. AGOYO. I think I can say publicly and for the record that the Eight Northern Indian Pueblos Council supports the bill to give Indian communities the opportunity to contract directly for such services. I think we are talking, you know, about more than inadequate services for the Indian people, when we say we are not getting the services we should be getting from the State, or from the Federal Government. I think we are talking about developing a group of people who have never been given the opportunity to do things for themselves.

Someone else was always doing the things, the planning, and the budgeting, and the hiring of people to service. We are talking about Indian communities who have recognition, and the right for self-government, so that when we ask for special consideration, we are not asking to be singled out. We just want the opportunity to grow like other communities do, and possibly we will experience the same problems that maybe the city of Santa Fe and the city of Española are facing today. We are talking more of just getting services. We are talking about developing such people like Cara here.

Senator DOMENICI. Internally?

Mr. AGOYO. Right.

Senator DOMENICI. We thank you very much, and we will have Cara talk about senior citizens programs she has experienced, if she would.

STATEMENT OF CARA LEON, COMMUNITY VISTA VOLUNTEER, NAMBE PUEBLO, N. MEX.

Mrs. LEON. I am a community VISTA volunteer from the pueblo. I have been working with the elderly, not only for the past 3 years since I have become a VISTA volunteer. I feel sorry for the people. We have, say, about 12 people, very old people, and I have to bring them in for the food stamps.

Senator DOMENICI. In for what?

Mrs. LEON. For the food stamps and for public welfare. I use my car, and I bring them in, and also to the hospital for treatment, or for their medicines, and I think that we need some money to pay somebody to bring these people in.

As a community VISTA volunteer, I am supposed to also be working with youth, but the elderly keep me very busy. There is one thing that I know the elderly people need—someone who is right there that can help them. I also feel that some of these people need help as far as a homemaker goes, right in the home, right in the pueblo, right in the community. I have spoken to several of our elderly people about coming to an old age home, and they feel very sad. So we feel that we want to make our elderly happy by bringing them, by keeping them right in our own community, where we can help them and make them happy.

We have had several little parties for them, sort of get-togethers and they love it.

Senator DOMENICI. So that based on your experience, you would feel that all kinds of outreach programs, whether it be home delivery of nursing care, bringing service to them, rather than bringing them to institutions, would be a welcome change in the program?

Mrs. LEON. I think so, yes, sir. Like I said, when I mention the old age home, they do not like it at all, and I do not blame them.

Senator DOMENICI. Is it a practice of the people that you work with, that they try to take care of their older people?

Mrs. LEON. Right, yes. Of course, there are families in which they do have children—they have their own family. This kind of makes it hard on their families, because they are family people also. That is where I come in, and I try to make them happy, and clean them up a little bit. This is where the homemakers should come in, I think, and also, transportation to haul them around.

Senator DOMENICI. Herman, you heard the questions that I have asked, and I think later in the day we will have some witnesses that are familiar with the new approach to AAA, and regional planning for senior citizen problems.

Are you involved in present planning in this area, in the pueblo that you represent? How does it fit in?

Mr. AGOYO. I am not aware of it. I have not heard anything about it, and I am sure we would be glad and happy to participate, but we are not aware of any planning of that sort.

I do not know whether it is coming through NorCHAP, or what other vehicle, but I am not aware of anything of that sort.

Senator DOMENICI. I know of the general thrust of the Indian people who want to continue direct funding relationships with the Federal Government, not the ancient Bureau of Indian Affairs, of course, but almost every new program including those that have to do with senior citizens.

We are getting the Indians feeling that they ought to deal directly with the Federal Government. I take it that your answers here today indicate that you personally agree, and those that you represent, favor that approach?

Mr. AGOYO. Yes, sir, and we have been able to grow a lot since 1965, because of this approach through the Office of Economic Opportunity.

TRANSPORTATION PLANNING

Senator DOMENICI. One last question, Herman. Whether I agree with or disagree with direct funding, it seems to me that there are some areas of service within a region, aside from wanting to train your own people. Transportation, for instance, in a region for senior citizens, certainly ought to be included within the region in planning the transportation.

This is the only one that comes to my mind, but it seems to me that there would be a number. Are you suggesting that each phase be handled independently, indirectly, or that you be part of the planning, and end up deciding which ones you can handle best, and which should be handled on an areawide basis?

Mr. AGOYO. We are hoping to do whatever recommendations that might be made out of something like this. We hope it will just give us the opportunity to sit in on the planning. As I said, we can and are coming to grips with some of these problems, but we need more time.

Senator DOMENICI. One last question, Herman. Do you know—within the eight pueblos that are part of your group—the facts as to the number of senior citizens, or elderly who live in these pueblos?

Mr. AGOYO. According to the 1974 census, the eight pueblos have a total population of a little over 6,000, and of that, 446 are 60 and older, and I think for the most part, they are all in the community.

Senator DOMENICI. They would be spread within all eight pueblos?

Mr. AGOYO. Right. Before you let us go, I would like to make one point here. Because of lack of funding, or lack of imagination on somebody's part, we have to resort to the VISTA volunteer program to provide services for our elderly. Cara is just one of nine community volunteers who are working with the elderly and youth in our communities.

We have no other funds to employ people to directly address themselves to the problems of the elderly. I just returned from a conference in Dallas, at which time we were informed that the wages or stipends, whatever you want to call it, for the volunteers, was raised from $140 a month to $165 a month, and we had a contract for transportation to reimburse Cara and the others to take people to the various agencies, and that was canceled, because we are too big of an agency, as we cannot qualify for our transportation contract services. Cara here averages about $70 per month taking people to various places, and I have to find moneys within our own program to reimburse her for the

miles she puts on her car. We just cannot even afford to pay, to reimburse Cara $70 a month.

Thank you very much.

Senator DOMENICI. Herman, with reference to the eight pueblos that you represent, the only senior citizen personnel that you have directly relating to each of the communities are the VISTA volunteers that you described?

Mr. AGOYO. That is right.

Senator DOMENICI. You have none within your pueblos as community workers that work for senior citizens?

Mr. AGOYO. Yes, that is correct.

Senator DOMENICI. That is the total extent of the available help?

Mr. AGOYO. Yes.

Senator DOMENICI. We thank you very much for appearing.

Our next panel is made up of five witnesses, and they are: Clifford Whiting, chairman, New Mexico Commission on Aging, Mrs. K. Rose Wood, director, New Mexico Commission on Aging, Thomas Shinas, deputy director, New Mexico State Health Agency, John Glass, executive director, North Central New Mexico Comprehensive Health Planning Council, and Charles Lopez, director, Public Assistance Agency.

I understand Larry Brown will join the panel. Let me just say before the panel begins: Mr. Whiting was present in Albuquerque this morning for the entire hearing. I hope everyone understands that we did not come here exclusively to hear and talk about the problems of the boardinghomes. However, it has become a very prominent issue.

I think Mr. Whiting will attest to the fact that we heard, this morning, a wide variety of witnesses on a wide variety of subjects as it concerns senior citizens.

Certainly, before you leave, I want to inquire of you, who are experts and knowledgeable on boardinghome regulations in New Mexico, but we do not want you to limit your remarks to that particular phase.

Mr. Whiting, I assume you would like to lead off. We will turn it over to you for the sequence of witnesses.

Mr. WHITING. Senator, I would like to change the setup. I would like to ask Mr. Lopez to lead off.

STATEMENT OF CHARLES LOPEZ, DIRECTOR, STATE PUBLIC ASSISTANCE AGENCY

Mr. LOPEZ. Thank you, Mr. Chairman. My name is Charles Lopez and I am director of the Public Assistance Agency of the New Mexico Health and Social Services Department. I am pleased that you have invited me to present information with respect to the New Mexico Medicaid program.

During the 61st fiscal year—July 1972–June 1973—the Health and Social Services Department made payments totaling $20,027,583 to providers of Medicaid services in behalf of 64,726 eligible individuals. Of this amount, $4,666,700 was paid in behalf of 8,421 eligible individuals that were age 65 or older.

Although we are proud of our accomplishments in managing the Medicaid program, we recognize that much is yet to be accomplished, especially in the areas of expanding coverage to New Mexico citizens as well as expanding the scope of Medicaid-covered services. Briefly, I would like to describe our efforts, and to some extent our frustrations in working toward these goals.

First, it should be pointed out that with the high cost of medical services, the Health and Social Services Department has endorsed mostly those programs in which Federal financial participation is available. Our efforts in establishing State-funded medical programs has thus been severely limited.

Recent Developments in Medicaid

Some recent significant developments in our current Medicaid program include:

(1) Extension of Medicaid coverage to all individuals eligible for the Federal program of Supplemental Security Income.

(2) Extension of medical assistance to individuals requiring skilled nursing and intermediate care that would be eligible for SSI benefits if they were not in the facility.

(3) Implementation of a now completely State-funded program to provide medical assistance to seriously ill persons with income less than $240 per month—Special Needs Act passed by 1973 legislature.

(4) Implementation of the federally mandated program of early, periodic screening diagnosis and treatment for eligible children under age 21.

(5) Expansion of family planning services.

(6) Payment of part B Medicare premiums for Medicaid eligibles.

From a program point of view, the following are seen as barriers to providing health care for many Americans:

(1) By and large, eligibility for Medicaid services is based on eligibility for financial assistance programs such as Supplemental Security Income or Aid to Families With Dependent Children. Only in those States which can afford a medically indigent program can an additional group of individuals requiring medical services be covered for Medicaid. Too many times have we seen persons in dire need of medical services denied medical care simply because their income happened to be $1, $2, or $3 above the income limits for Supplemental Security Income or Aid to Families With Dependent Children eligibility. The recent 7 percent Social Security increase and the additional 4 percent increase places the Health and Social Services Department in the position of having to terminate Medicaid assistance to many older Americans, some of which find themselves in skilled nursing or intermediate care facilities. The Public Assistance Agency will be recommending to the Health and Social Services Board that the "standard" for nursing home or intermediate care be increased so that no one will be forced out of the institution. But what about the next Social Security increase? Will we face the same problem? Although present law permits establishing a higher standard for individuals requring institutional care, I submit that what this country needs is a law which provides that any American in need of institutional care, and not having sufficient income for payment, should, by right, be eligible for this care.

(2) Effective January 1, 1974, aged, blind, and disabled individuals in need of financial assistance began receiving money payments from the Bureau of Supplemental Security Income. New Mexico chose to extend Medicaid coverage to all aged, blind, and disabled persons receiving Supplemental Security Income. The Health and Social Services Department signed an agreement with the Social Security Administration in which they agreed to provide information on eligible aged, blind, and disabled persons on a timely basis so that we could extend Medicaid coverage. Our experience to date is that the Social Security Administration has failed to live up to their obligation under this agreement, thus, creating difficulties for aged, blind, and disabled individuals to receive medical care. Although this situation has been partly eliminated by the development of a system to identify eligible individuals through a manual operation rather than the agreed upon computer system, it is our understanding that other States are experiencing extreme difficulty in this regard.

(3) In an attempt to provide medical assistance based on medical need rather than financial need, a proposal for a limited medically indigent program was developed and presented to the legislative committee on health and aging who would consider sponsoring legislation to enact such a program. The Health and Social Services Department felt it could not request an additional $3.1 million to implement this program since our first priority was an increase in the standard of need paid to families receiving Aid to Families With Dependent Children. Although the medically indigent program was not considered for legislation, our experience in developing the proposal pointed out numerous other problems, not only in program development, but in the ultimate utilization of the program by eligible individuals. The most significant of these problems was the fact that the regulations allowing Federal participation in the cost of the program also included provisions for a mandatory enrollment fee, thus putting an additional burden on the individual applying for the program and greatly increasing the cost and complexity of administering the program.

(4) In certain areas of the State, physicians are reluctant to accept as their patients persons whose medical care will be paid by Medicaid. Continuously, we hear that there are too many forms and too much redtape in receiving remuneration for their services.

In conclusion, I have identified a few examples of the problems and difficulties that arise daily in the development and administration of these most complex programs. We are hopeful, however, that through our continuing efforts and the meaningful legislation at the Federal level, that the barriers of the bureaucracy can be eliminated from health programs and the obtaining of essential health care can be an attainable goal for all people.

Senator DOMENICI. Let me ask you, Mr. Lopez, about your statement concerning the amount that was for prescribed drugs for Medicaid people that are over 65. It does not necessarily mean that prescribed drugs include what some of the witnesses were complaining about, does it?

Mr. LOPEZ. You are correct, sir, although we are satisfied in our accomplishing, in managing the Medicaid program. We recognize that much has to be accomplished, especially in the area of expanding

coverage of New Mexico citizens, as well as expanding the scope of covered services.

Build Upon Existing Programs

Senator Domenici. Also, you basically said in your statement, with regard to considering a national health insurance plan, that the plan should build upon existing programs. We have to be awfully careful that we replace those existing ones. We ought to get rid of the kind of criteria in the new plan, that are built into such things as Medicaid which you had described as not desirable.

If we use it as the basis, we will be many years finding out who is left out, is that not correct?.

Mr. Lopez. I submit to you, sir, of the little I have read on the proposed legislation for the national health insurance, there is much of the same bureaucratic processes built in that system which makes it very, very difficult for individuals requiring, especially at that age, when income, when resources are insufficient, and when you have a State like New Mexico, which has abolished its responsibility law. If you are going to make it available, then do it simple, and do not come up with that kind of redtape that provides for enrollment fees, that provides for income standards, that provides for many other factors related to the real importance.

Senator Domenici. Let me ask you one more question. With reference to your manual determination of the people that you should have gotten through the machines which broke down nationally and in New Mexico, how well are you moving in that program you described?

Mr. Lopez. Very well, sir. We have had excellent cooperation from the local Social Security Administration. The district manager is here in the audience. He is aware of some of the problems. He recognizes it is not a conflict between State agencies, or that we do not communicate as many alleged earlier in the afternoon. But rather that the problem is at the Federal level.

Senator Domenici. I wanted to say that perhaps we do not always have the resources that you people would like us to have, but in terms of understanding the programs, New Mexico agencies are ahead of many States in meeting the needs of the people. We are, generally, as progressive as any we find in terms of taking care of the problem on our own. We do find people that are out of the programs.

Two or three of your programs are among the best in the country. If the moneys are there, you can fill those gaps. I think that is what you are saying, that you could not within the budget constraints.

I do not have any further questions to ask of you, but I would appreciate it if you would stay in case something else comes up with regard to the other programs.

Mr. Whiting?

Mr. Whiting. Mr. Glass.

STATEMENT OF JOHN GLASS, EXECUTIVE DIRECTOR, NORTH CENTRAL NEW MEXICO COMPREHENSIVE HEALTH PLANNING COUNCIL

Mr. Glass. Thank you very much, Mr. Chairman. Senator Domenici, members of the Committee on Aging, I am John Glass, director of the

North Central New Mexico Comprehensive Health Planning Council, known in the state as "NorCHAP." This is an areawide comprehensive health planning council which has been in existence for 5 years, serving the seven counties of Santa Fe, Los Alamos, Rio Arriba, Taos, Colfax, Mora, and San Miguel, with a population of somewhat over 150,000.

The area, covering 20,000 square miles—larger than the combined States of Maryland, Delaware, and New Jersey—is highly rural and sparsely populated; 46 percent of the population live outside of the six urban centers and the population density of the rural portion of this area is approximately 3.5 persons per square mile. The population is 68 percent Spanish surname or speaking and four of the counties have economic and education indicators among the lowest in the State.

Aging persons in our area experience the same barriers to health service that others of our population do; however, for them these barriers are accentuated due not only to reduced mobility, slowing mental processes, and a generally lower economic status, but also due to unfamiliarity with the health delivery system, the distance to health services, and cultural factors relative to health.

I will comment briefly on three barriers which have a particular impact on our predominantly rural, Spanish, aged population of north-central New Mexico. Although obviously not Spanish myself, I have worked for over 5 years in this area with a health planning council and staff that are highly representative of our population and have come to appreciate the significance of these barriers to health services.

The Spanish culture puts a premium on self-sufficiency. In the area of health care much of the population has relied throughout their lives on folk medicine—prescribed through the curandero or someone in the family knowledgeable in home remedies. If reasonably healthy, they have not had to seek professional medical care. As they grow older the folk remedies are no longer sufficient and a real need exists to obtain more professional attention. The aged person clings to the self-sufficiency, the independence, and is reluctant to give it up. They put off seeking professional help until their condition deteriorates to the point where recovery is more difficult than if they had sought attention early.

Other cultural concepts reinforce this reluctance to seek professional health services early. The concept that pain or "feeling sick" is the only indicator of poor health and that if you feel well there is no need for health care also works against a health maintenance or preventive focus on health care.

"Pride"—A Barrier?

The financial barrier has been well discussed today—but one aspect of that barrier needs reemphasis—the pride of the Spanish aged prevents many who are fully eligible to receive subsidized services from seeking them; they do not want to be identified as paupers, and they fear the loss of small dwelling or land holdings. I heard an interesting example of this pride just this week—a member of our council told me that he took over the business affairs of his new father-in-law following his marriage a number of years ago. The father-in-law was a sheepherder and our council member filed Social Security payments for him for years as a self-employed person. When he reached the age where he had to stop work, the son-in-law told him he would put in for Social Security. The old man refused, saying that he didn't need "welfare"; not

until he understood that he had paid for these benefits through years of payment of FICA taxes would he file for his Social Security benefits.

These cultural factors all work to prevent early use of health care services and represent a significant barrier to care.

One other cultural feature needs mentioning—the close family ties within the Spanish population. These ties foster a reticence to leave home for institutional care—and a like resistance of a family to place an aged parent in an institution.

The ratio of long-term care beds per population is much less in our area than in many other parts of the United States. This increases the need for home health services and for liberal benefit programs covering these services for the aged. Home care is not only better for the patient—prolonging his useful life—but it is also much less costly.

The distances one must travel to get health services require the availability of a means of transportation for the rural aged in our area. Sources of transportation are needed to get persons from home to the primary care provider and to the more sophisticated services to which they may be referred.

The scarcity of rural health services has been significantly reduced in north central New Mexico, however, even with the increased accessibility some persons still must travel up to 60 miles to get to the nearest health care provider during nonbusiness hours.

Many aged living alone do not have a car; they may have given up driving, never had a car or can't afford one. Public transportation does not exist in the rural areas except along major highways. Vehicle owners in the area often take advantage of the situation and make unreasonable charges for rides to any type of service; the cost of transportation is thus a deterrent to making the trip and to getting health care.

The fact that many rural roads are not maintained during the snow season is an added transportation barrier; and winter storms and mountainous terrain are deterrents to travel even when roads are maintained clear. Transportation is the barrier to health services almost always mentioned by our aged population.

Even if the aged patient can get to the health service and has no problem with payment he may not seek the service for reasons relating to the complexity of the system and the manner in which the health service is provided.

Many persons do not know what services are available to them in their areas and do not understand how the health care system ties together or how to enter it. In addition, the paperwork procedures involved are a source of confusion. These conditions can cause patients to feel "ignorant" and stay away rather than suffer embarrassment.

Confusion Compounded by Language Barrier

Once the person does contact the health care provider the impersonal climate in which care may be provided can cause him to refuse to return. In our area this problem for the aged Spanish patient may be compounded by poor communications with health personnel due to language problems that may cause him to feel self-conscious. Health care providers who are not "people oriented" do not enhance the delivery system.

The reticence to obtain needed health services, born of fears accompanying health problems, must not be increased by complex system demands and insensitive impersonal relationships. Health services should be delivered in a humanitarian manner, understandable to the public.

Senator DOMENICI. Doctor, could I ask you a couple of questions? I recall your visit to my office, and our very enlightening discussion about the new national health planning bill, which is not be confused with health insurance.

As I look at your statement, you speak of what we have been hearing all day. The idea of moving toward the alternative of supplying the service, where feasible, in the home instead of the institution. Maybe I do not understand the problem, but might I ask—assuming we had the best of the national health planning bills that you recommend, and assuming it was adequately funded—is it fair to think that in such a comprehensive planning program, someone would take a hard look at delivery and services to the elderly in the home, as it relates to health care as part of the plan?

Mr. GLASS. I would hope that the plan would foster the minimum utilization of institutional care, and that is to make the most liberal benefits for other institutional care.

Senator DOMENICI. We did not discuss, in my office, the substance of the bill as it might thrust one in the direction that you described, or at least require it be looked at, versus what seems to be intentionally or otherwise, thrust toward institutions in the recent past, because of the money that went there, most of the programs paid for that. Does the bill that you recommend on health planning have enough substantive language in it to encourage just what you said, or might some consideration be given to include such a mandate in any national bill, not a mandate for the thrust, a mandate for everyone to look at?

Mr. GLASS. Senator, that bill does focus highly on the factor of cost of services.

Senator DOMENICI. All right.

Mr. GLASS. And it is recognized by certain health planners, that providing services outside of institutions, particularly when that coincides with the wishes of patients, is by far the better course of action. I believe that that focus is adequately represented in that health planning legislation.

Senator DOMENICI. As an absolute minimum, so long as you have anything to do with preparation of the plan for a region of the State, you are telling me that you are going to take a look at that aspect in any planning, unless prohibitive?

Mr. GLASS. Absolutely.

Senator DOMENICI. All right. We appreciate your statement very much. Mr. Whiting?

Mr. WHITING. We will now hear from Larry Brown.

STATEMENT OF LARRY BROWN, DIRECTOR, SOCIAL SERVICES AGENCY, HEALTH AND SOCIAL SERVICES DEPARTMENT, SANTA FE, N. MEX.

Mr. BROWN. Thank you very much, Mr. Chairman. The social services agency of HSSD provides supportive social services to eligible

aged, blind, or disabled persons—as well as families with children—who need assistance in finding or getting to a health care resource. In addition, we provide homemaker services to assist clients to remain in or return to their own homes or communities. We have a direct service staff of 130 caseworkers, and 20 social service aides, and 140 homemakers for the provision of social services statewide. In a fairly typical month, we provide, in response to client requests, 1,394 health related services to aged, blind, or disabled persons, and homemaker services to 2,906 aged, blind, or disabled individuals.

We cite these statistics not as an illustration of how busy we are, but as an indication of the dimensions of the need for health care and the more general area of care for the aged, blind, or disabled who are unable to care for themselves.

I welcome this subcommittee's inquiry into boardinghome care, as I share your concern about what happens to persons who either have no family to care for them or whose families are unable or unwilling to provide needed care. The State of New Mexico has not developed a variety of publicly owned and financed institutional and sheltered care facilities aside from those traditional institutions of department of hospitals and institutions; and consequently private, profitmaking organizations and individuals have developed who offer nursing home, sheltered or intermediate care, or boardinghome care. There are quite strict and expensive-to-meet licensing requirements as to physical, health, and safety standards for facilities offering the better kinds of care; however, boardinghome standards are more easily met. Thus, the growth of sheltered and long-term care facilities has been minimal and insufficient to meet the ever increasing need for such resources.

And, consequently, boardinghomes have played an increasing role by taking in confined, disoriented, helpless people and supplying not just room and board, but supervision and assistance in personal care and daily living. Although the position of HSSD has been that only competent individuals should be referred to boardinghomes, when approached by families seeking placement for a relative, in the absence of any other resources, such placements have been made.

In addition, the State hospitals at Las Vegas and Los Lunas furlough or discharge patients to boardinghomes in the expectation that supervison and assistance in daily living activities will be provided.

Regulation for 2 Years

By and large, most boardinghome operators are conscientious, responsible people who do a good job of caring for these "boarders" in their homes; however, some are in it for whatever profit they can make with little regard for the welfare of those dependent upon them, and there have been abuses. Prior to 2 years ago, boardinghomes in New Mexico were unregulated, except by local fire and health ordinances. At that point, after enabling legislation was passed, the HSSD board established policies setting statewide licensing requirements regarding physical health and safety standards and some improvement has occurred, but not yet enough.

As we all know, physical and safety standards alone do not prevent personal abuse or institutional management which adversely affect helpless people.

The social services agency responds to complaints regarding persons needing protection; but the alternatives we can offer, aside from legal redress through the courts, are often limited to placement in another boardinghome.

During the past 8 months, we have had a social worker visit each welfare client living in a boardinghome in New Mexico. The purpose was to establish the client's ability for self-care and to assess the adequacy of the personal care he receives in the boardinghome. We are tabulating the results, which I will submit for the committee record when all the data are analyzed.[1] A sample, however, from three counties—Bernalillo, Santa Fe, and Luna—indicates the following:

(1) Eighty-six percent were judged able to provide adequate self-care and the care provided by the boardinghome operator was also adequate.

(2) Eleven percent were unable to provide adequate self-care and most were living in a room and board relationship with relatives where no change in living arrangements was recommended.

(3) Three percent do not receive adequate care. Most were reported to be content with their living situation. It is not yet known how many of this 3-percent group would accept a change in their living situation if the option was made available to them. No question, living one's life out in a boardinghome is not exactly an ideal situation for an old person.

Plans for a foster care program for adults have been approved by the State board, but implementation delayed because of restricting effects and uncertainty of changing Federal social services regulations over the past year, with subsequent funding implications.

Providing care and personal services for people is expensive, time consuming and demanding work, and requires appropriate compensation. HEW regulations regarding foster care vendor payments for both adults and children place the full burden for such payments totally on the States and provide no matching with Federal funds, as is the case in all other social service programs. In a State like New Mexico, this HEW regulation has disastrous effects on our ability to meet an important unmet need.

Further Recommendations

My further recommendations are:

(1) Doubling the ceiling of Federal social services funds—from $12.7 to $25.4 million—imposed in New Mexico by the Revenue Sharing Act of October 1972, with the condition that 75 percent of the increase be expended for adult social services.

(2) Deleting the HEW regulations prohibiting Federal match at 75/25 rate for foster care vendor payments.

(3) Finally, I recommend that State and/or Federal laws be developed to establish cost and personal care requirements for the many BSSI recipients who live in boardinghomes in New Mexico. We now have health and safety regulations and plans for increasing their enforcement. Cost and personal care regulations must now be enacted.

The statistical data on my agency's analysis of the problems are being prepared for submission to the committee.[2]

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[1] See appendix 1, item 8, p. 1232.
[2] See appendix 1, item 8, p. 1234.

Senator DOMENICI. Mr. Brown, could I ask you, not at all questioning your observations, but the observations of many witnesses. Do you believe that many of those in the licensing process have been closed?

Mr. BROWN. Yes, sir.

Senator DOMENICI. Might I ask, would it not be possible to prove that one way or another?

Mr. BROWN. Yes, sir. My agency was very involved and concerned in the conditions that led to the passage of the licensing regulations. I also talked to a gentleman this morning who testified earlier, and we discussed the situation here in Santa Fe, which he was aware of where persons were seriously abused because of the facility. In our discussion, he agreed that that facility has been closed, and is no longer in business in Santa Fe.

Senator DOMENICI. Mr. Brown, who prepared the format for the personal visits?

Mr. BROWN. This was done with the assistance of Mrs. Hill, who testified here earlier, when she was a member of my staff, and also other planners of my agency in the public assistance agency, and arrangements were made at that time to develop a process to prepare referral from public assistance service, and of the social workers that go out.

There will be a lot of analysis in the final report but we are sure we can give you some significant information on each of these individuals.[1]

Senator DOMENICI. Will the information include what objective analysis was expected to determine adequacy?

Mr. BROWN. Yes, sir; it is a fairly detailed form which is filled out on each client.

INSPECTIONS SURPRISE?

Senator DOMENICI. One last question. Are you satisfied that the interview and observation was done in such a manner that it could not have been prepared for by the operator? You did not advise them a week in advance that you were going to be in next Monday morning at 9?

Mr. BROWN. I am not sure. I will check that out and include it in the report to you.

Senator DOMENICI. I think it would be important. There is some evidence the places were spruced up and gotten nice and ready for the observer, only to have a casual person walk in next week and find it completely different.

Mr. BROWN. I understand, but it is our practice to make appointments wherever possible. We really are not going out for the investigative purpose, but this was merely an effort to contact clients, and determine how adequately they were able to care for themselves.

I know of the information that was in the press recently, and I can say that I do not know where the possible variables are at this point. I have talked to persons before the hearing, and we agreed that there is no question that spending one's last years in a boardinghome is not a desirable situation, even if the facility is an excellent one, or an

[1] See appendix 1, item 8, p. 1234.

outstanding one. There is a great deal of impact on persons going into these facilities, seeing the old people in their final years, living alone in isolation, in the care of a stranger.

Senator DOMENICI. I think that one of the most important random statistics you have given us, if it is true—it is inconsistent with individuals' observations—is the percentage that are able to care for themselves.

That is a very important statistic to the development of the plan, because obviously, we are talking of people who do not have these kinds of facts. We are talking about the fact that there is no way to help them provide for themselves, because they cannot provide for themselves. Your statistics would indicate that a large percentage could, if they had a way.

Mr. BROWN. Yes, sir, I think that is right. We do have plans for a foster care program for adults, which was approved by our State board several months ago, but implementation of that plan was delayed because of what I believe to be restricting effects, uncertainty of changing effects of social service regulations in the past year, with subsequent funding implications, and I would like to urge swift action by the Congress on H.R. 3153, which would break the logjam on restrictive regulations for social services for the elderly.

This bill, you will note, was approved by both Houses and scheduled for conference by the Congress.

MORATORIUM ON HEW REGULATIONS SOUGHT

If agreement on this bill cannot be reached this year, I would also like to request that the Senate consider a new moratorium for another year on the pending social service regulations from HEW, which are restrictive, and will continue to restrict the ability of a State plan for adequate care and to utilize the Federal resources which are available by the Congress.

It is very difficult to plan with the specter of those regulations hanging over our heads for January of next year.

Also, I must say at this point, the administration's strategy to control expenditures by regulation, is without doubt contributing to the difficulty for many older Americans in this country who need help. I think there are far better places for our Government to save money, and to hold back, rather than on the social services for the elderly.

Senator DOMENICI. Thank you very much. I want you to know that on this point, I have done what I can about the bill. I voted for it. I do not know what is happening in conference, but I think I understand the problem. We will do what we can with reference to that bill, as you have recommended, for that was my approach in any event.

Mr. BROWN. We have heard, Senator, the conference might possibly not take place because of the other pressing events of this Congress. If that is true, we would certainly like to recommend a further moratorium on those regulations slated to go into effect in January of 1975.

Senator DOMENICI. Let me ask you, just from a technical standpoint, is the room and board type facility that we are talking about definable in terms of the other kinds of care that we have? We know what a hospital is; we know what a nursing home is. If we were trying to

define the kind of foster homes that you have spoken of, could you talk a little bit about how you would define it?

Mr. BROWN. Senator, my colleague, Thomas Shinas, does have a prepared statement about that. I can comment about it, but I think it would be better for him to answer that.

Senator DOMENICI. Fine. Thank you very much. One last question. Your total survey will include Las Vegas eventually?

Mr. BROWN. It does include Las Vegas.

Senator DOMENICI. But your random sample did not?

Mr. BROWN. That is correct.

Senator DOMENICI. Mr. Whiting?

Mr. WHITING. We will now hear from Mr. Shinas.

STATEMENT OF THOMAS SHINAS, DEPUTY DIRECTOR, NEW MEXICO STATE HEALTH AGENCY

Mr. SHINAS. Thank you. Mr. Chairman, I am going to have to give you an apology. On the plane last night, running on a trip to HEW, I wrote the notes rather hastily, and I would want the opportunity, however, to give you a much more detailed written statement.[1]

Senator DOMENICI. This hearing record stays open for 30 days, so we would greatly appreciate that.

Mr. SHINAS. I did go around into the license mechanism of the agency, whereas in my total statement, I would have liked to discuss a number of things around public health and the agency, and spend some time on those programs that do exist, and to know what we now have ready to go in the next fiscal year.

Prior to the licensure law effective date of July 1972, there were some 150-plus boardinghomes identified in the State, on a statewide basis, but by November, by the time regulations were put together, and applications were sent out, and notices submitted by radio, television, newspaper, we received application from 86 facilities; 76 of them were licensed. A number of those 72 identified correctable deficiencies, and were therefore given as provided for in the law, temporary licenseship.

Upon receipt of a plan of correction, and then a followup visit to those facilities to inspect for those corrections, an annual license was issued.

During the period of November of 1972 to this date, 15 homes have been denied their license, suspended, revoked, or not renewed. Six of them, additionally, voluntarily relinquished their license, because they were unable to meet the conditions of the standards set forth.

Since January 1974, licensure personnel have made 659 inspections on a statewide basis, and by June 30, which is the new licensure date, we will have contacted at least 30 more.

BUDGET INCREASE PERMITS STAFF ADDITIONS

Some calls in the past 5 months were on a routine basis, others were on a followup basis, and then yet others were upon receipt of a complaint, and I might say here that we are very, very pleased to have people like Mrs. Hill and Mrs. Duran, and various other interested people around the State who will call us when they find something wrong, because we try to respond to that call immediately. There are four

[1] See appendix 1, item 9, p. 1237.

licensure representatives on the staff in the licensing section, plus the chief of that unit.

I am happy to say that we were granted a budget increase commencing July 1, 1974, to secure two additional representatives, and we will be adding a full-time nutritionist on the staff for dietary consultation to these facilities on a statewide basis.

We recognize that our staff is small. We have a great deal of work to do, and have a big State to cover, and it has been very difficult for them on the road, 4 or 5 days every week. We hope with this additional staff, we are going to be able to do a better job than we have been doing, and we recognize that we need to do this better job.

Senator DOMENICI. Could I ask you about resources in this manner, does the law to which you are speaking envision any local enforcement with regard to licensing regulations?

Mr. SHINAS. We utilize continually local government representatives, sanitarians who regularly visit in their communities. We use the local building and construction people of the city government. We use local fire preventive specialists. We use local social service people, casework people, which we depend on to give us feedback. We do rely a great deal on some local input.

Senator DOMENICI. But the actual licensing itself is reserved exclusively to the State by the law?

Mr. SHINAS. True, with the exception of Bernalillo County, which has their own law, I forget the term they use, on a local level, but they do have their own ordinance to close the facility that does not meet their standards.

The boardinghome industry, though I may be using this in a rather broad term at this point, was for years really—and this is part of our problem—it was for years just a family way of using an extra room in the house, so to speak. A widow or a couple would use the extra bedroom and take in boarders. Then came what I considered the error of rather massive unloading of institutional patients.

Some of them were quite backward, if you know what I mean. Some of them were with mental health problems over many years. Some of them were mentally retarded, plus the fact that people are living longer. I am sorry to say, all people sometimes are not wanted. All of the aged are not wanted.

HOME SELECTION—PERSONAL CHOICE

The indigent and the homeless individual, he tries to find a home as a result of this with his welfare check. The public assistance agency cannot tell him where he will live. This is a choice of his, and that is what he uses to help him find a home, and those who are merely old, I am not being facetious, but who have no severe handicap, they did much better. They found a place that for the most part responded to their needs. But those who were handicapped, with strokes, or diabetics, or arthritics, or mental problems, or other debilitating diseases, they had a hard time, because the boardinghomes, as we know them, and as the law provides, have to provide board and room for independent living situations. That is the problem—that a person with a handicap has no place to go. He does need room and board, so the existing boardinghomes today are not equipped or staffed really to take care

of this type of need, the handicapped need, or the need of additional services. Interestingly enough, in my opinion, many of them assist these people in any way, and today I grant you that a large measure of some 1,500 welfare clients are in boardinghomes, and they really need something more than board and room.

Now, this may sound conflicting to what was said a moment ago, but do remember, I am talking strictly now about room and board, and what the law says. I know that additional services are necessary, and in some of these boardinghomes, they are getting this. I might say here in defense of many good boardinghomes, that they have accepted a responsibility above and beyond for care at a rather minimal amount of money, starting off with some $66 a month 2 years ago, jumping up to $88 a month, and now with the SSI program, we have kind of a wide open affair. I would like to kind of speak to that a little bit.

If, however, a large percentage really do need additional services, it seems obvious that it becomes necessary for someone to identify the proper level of need to accommodate the client.

The trip I mentioned a moment ago, the HEW trip, one of the purposes for my trip to Washington was to help them develop guidelines for intermediate care facility category. I am happy to say, tone it down, because there is too big a gap between the basic room and board category and the intermediate care level. So they are going to adjust it downward to meet more needs—both in the custodial sense, or residential sense—with some intermittent kinds of nursing, recognizing the outside consultant who can come in, the homemaker, the home nurse, and so forth. This program would also include medication.

Senator DOMENICI. Tell me in what stage of development is this new regulation, and who are you dealing with?

Mr. SHINAS. I am dealing with the medical services administration of social and rehabilitative services. They are responsible for the program in working with the associate director, Tom Laughlin, and these guidelines are in their final stage. They are in their final stage right now, and we were polishing them off in the last 2 days.

Senator DOMENICI. We are told that he used to be a member of your committee staff.

Mr. SHINAS. Right. I think that is a move forward. As for the boardinghomes who cannot meet a reasonable standard, we will have to work harder. We will have to help them improve, and if that cannot be accomplished, we have no other choice but to revoke their license.

Without additional staff in July, and the assistance of a full-time nutritionist, we fully intend to launch certainly an all-out effort.

DISTRICT INSPECTORS TO BE PLACED

We are also planning on another move, the placement of inspectors on a district basis. I feel that this would allow for much easier follow-up visits, rather than attempt to maintain a central location.

This is a large State, and there are long distances to travel. We feel this would assure accessibility and on a long-term basis to boardinghomes and others.

One final element that came to mind in reviewing the boardinghome situation, sir. Since the intermediate care facilities are paid based on a cost for service, plus the fact that the agency has the right of audit of

that cost, it would appear to me at least reasonable to make similarly some type of procedure around the room and board program, making it a vendor program. In other words, if it is a business, let it build like a business.

I think in the final reality, I believe boardinghomes would welcome this. It would certainly provide for a stronger enforcement of standards as we have seen the "mom and pop" nursing home evolve over the last 5 or 6 years.

There is a problem with Federal regulations right now. I would have to refer to Charlie Lopez, but I think Federal regulations prohibit making a boardinghome a vendor-type payment deal. That could be overcome, I see this as a possibility.

Senator DOMENICI. The quality of service would be taken into consideration?

Mr. SHINAS. Right

Senator DOMENICI. I understand that when a client goes into a boardinghome, regulations of the USDA prohibit him from continuing to benefit from any food stamps.

I could see the possibility of a judicious use of food stamps for that individual to assist in supplementation. I am talking about the food part. Granted he goes to the boardinghome expecting to get the food, but nevertheless, because he is living in this environment, he is denied food stamps.

Mr. SHINAS. In my opinion, we could supplement his nutrition with food stamps, we should do this whether he is living in a home or not.

I think that could be something that could be worked out. Hopefully, the combination of the standard-setting authority, the service clauses that we talked about a moment ago, a vendor payment to the operation would go a long way to maybe cure or at least get at the root of some of the problem. This might in the end encourage the development of more sound programs for services to the aged.

I will end there, Senator. I hope to have a more detailed statement covering the broader aspects of public health which will be more responsive, and give you more information about our program.

Senator DOMENICI. We are running behind again, so rather than ask questions now, let us go to our next witness.

Are you going to speak now, Mrs. Wood?

STATEMENT OF K. ROSE WOOD, DIRECTOR, NEW MEXICO COMMISSION ON AGING

Mrs. WOOD. Yes, Senator.

Senator Domenici, members of the Special Committee on Aging, I am K. Rose Wood, the director of the New Mexico Commission on Aging. All I would like to say is that you have heard some of the problems and you have heard something about the frustrations. For a small agency to be designated by State law as the "single State agency" responsible for advocacy for the older population, I would like to say that we have quite a responsible job.

Without the support of health and social services agencies, hospitals and institutions, and the various other resources that elderly people should, and do have access to, a small agency on aging which does not deliver any direct services could not do its job. The agency collects

and disseminates information, and is responsible for something called interagency agreements and linkages to make certain that available services are delivered to the older population.

When you think of New Mexico even 10 years ago, in 1964, we had less than 50,000 older people. Today, we have over 116,000 people aged 60 and over. Through the allotments of Federal moneys made to the Commission on Aging, under titles III and VII of the Older Americans Act, we are responsible for planning for the delivery of comprehensive community services to the majority or our older people. At one time, under title III of the Older Americans Act, this looked like a "fun and games" kind of thing. I think that we are the only society in the country—even in the world—that asks the kids how to run the government, and sends grandpa out to play or make paper flowers.

I choose to look at growing old in America as a shame and a disgrace. You just should not get old. You should die at the ripe old age of maybe 39 or something, so that nobody has to put up with you anymore.

Senator DOMENICI. At least 42?

Mrs. WOOD. Yes, Senator, you are lucky to be so young. You know what the alternative is, Senator. If you do not get to be 90, stop at that point and enjoy yourself. But I truly think the "elderly" really are one of the endangered species.

"LOWEST ON TOTEM POLE"

We are the last. We are the lowest people on the totem pole, insofar as Federal public laws are concerned. We are the lowest on the totem pole insofar as what we are getting out of revenue sharing funds. We are just the lowest on the totem pole. I am delighted, of course, that children and youth have to come first, but on the other hand, you cannot just simply say when you get to be 60 or 65, or whatever the "numbers game" is, that you are supposed to cease and desist. You cannot do that.

Because we have thousands of older people in New Mexico, many, many of whom have to depend on public assistance; many, many of whom as you have heard are languishing in boardinghomes or "snakepits" like some people have called them, or "flophouses." I cannot say that I have to look at them in this image. People have to have shelter; people have to have food; people have to have clothing, and so forth. In New Mexico, it turns out that the managers of the boardinghomes or the nursing home administrators perhaps are not the misery merchants that a lot of people think they, or even we are.

Believe it or not, in my book the misery merchants are the legislators, and sometimes even the Congressmen. We let these things happen. We know that we have problems. We do the best we can to try to meet them. Sometimes it is so utterly frustrating, and so hopeless. I think that the people in charge of the hopelessly ill, the sick, the demented, the senile aged, get mean because they do not know what else to do. Sometimes I think it is easier to try to slap down an "old goat" that they cannot manage, rather than try to do something to make a person well and happy.

Sometime today, somebody mentioned that we have to do something to reduce isolation. Isolation and privacy are two very, very interest-

ing and different things. Sometimes I feel the gerontologists, the social workers, and the so-called do-gooders are interfering with peoples' privacy. Older people should be able to live in dignity, and the way they please. They do not need to have some busybody tell them it is this way or it is that way, or whatever else someone else thinks the way should be.

After many, many years of scraping for a living, and succeeding in keeping their homes and their property, older people should not have to be put out to pasture or on the shelf. They should be allowed to continue to work as long as they possibly can. Senator, there is something I know about congressional efforts to correct this. Sometime recently I heard that there were about 2,000 amendments pending to the Social Security Act. Among those 2,000 amendments, one that should enable older people to work as long as they are able to work, should be there. There should not have to be some kind of ceiling or shutoff level at a certain age. Whoever dreamed up the delightful escape clause that if one reaches the venerable age of 72, he can work as hard as he wanted to and earn all of the dough he is able to, but between age 65 and 72, a whole lot of things have to happen and come into the lifestyle picture.

Rather than try to give some kind of philosophical, personal speech about how I feel about growing old, because I am, and about older people with whom we work everyday, I would like to say that the Commission on Aging is charged with promoting the right kind of legislation that would benefit the elderly. The last legislature of this State had a poor record, and I think it was one of the sorriest ones because it was completely antisocial. I will not go into that at this point. But again, to go back to the subject of the hearing, some of the barriers to health care, since I see our barriers to the whole array of medical care and our built-in barriers to social services.

Lack of Federal Coordination

The main one is lack of coordination, and I am sorry to say this exists at the Federal level. It is reflected in the many, many conflicting public laws regarding eligibility for services—social services, welfare, food stamps, medical care—and so forth.

Medicaid is one thing. Medicare is something else. I know it is practically impossible even for a distinguished committee like the U.S. Senate Special Committee on Aging to keep track of the hundreds of Congressmen coming up with bills and to have the bills flow through your office. You would need a staff of about 1,000 people to begin to coordinate and consolidate all the aims of the bills or do all of the things necessary to prevent conflicts of intentions, particularly in laws HEW administers.

Another problem, another barrier, is the malfunctioning in both the health care and the medical care delivery systems. I think people are inclined to confuse health care and medical care, as they are different but similar.

The social aspect underlies and is basically necessary to both types of care. What we are doing with our health and social services resources is really treating people in a very fragmentary manner, and we

need to treat the whole person, the whole family, and even the whole community.

We do have a spotty thing, which is difficult to manage. Again, in the health care and medical care services delivery, the tendency is to practice in the way I just described. I do feel we need a group approach to these things. Insofar as Medicare is concerned, a lot of older people say it is not enough; it is not the answer; there are still too many people caught in the cracks, and there are still thousands of people that cannot get into the system.

I do not know exactly why, but that is what they tell me. One of the biggest barriers, of course, is the failure of the combined financing and delivery system. With that, I would just like to say that the Commission on Aging, at this point, has over a million dollars worth of community services around this State, exclusive of any services in either health care or medical care.

I would like to say that perhaps 15 percent or probably even 20 percent of our total population in the county is age 60 and over, and that many of these people are probably reached through many of the title III or title VII projects that we are attempting to keep funded. The fact is that in New Mexico to date, there is not 1 nickel of State money in these title III and VII programs. We do have these programs in 20 of the State's 32 counties, including senior centers—and this morning you heard both the pros and cons about how people feel about the value of senior centers. We are hoping to have one at least in every county.

We are also at this time working toward a statewide system through what is called the "triple A's" or area agencies on aging. This, of course, is the administration's new strategy: To provide substate offices on aging and to get area agencies down on the ground where the older people are, so that available services can be linked together and delivered in as comprehensive a way as we can possibly deliver them. With that, I will not go on anymore about the "endangered species," but I think the older American population is just that.

Senator DOMENICI. Thank you.

Mr. Whiting?

STATEMENT OF CLIFFORD WHITING, CHAIRMAN, NEW MEXICO COMMISSION ON AGING

Mr. WHITING. Senator, I think that the two hearings that you have held in New Mexico today have done an excellent job in covering the barriers to health care.

We know that you have made an indepth study, but there are several points I would like to mention for emphasis.

One person mentioned that we should do more for the older people. We know that this is true, and that we should get older people clothed properly so that they can leave home and go out and feel comfortable.

The nightmare of all the elderly people, no matter what the circumstances are, is that they do feel that a sudden illness can wipe out their reserves. You heard several examples of that today. That is very true in the health care field. That fear that a sudden major illness can wipe them out, and they will have to go on welfare is very real.

Another thing that you heard about this morning, is that all of them want more money. Now, the commission has the problem of dividing the small amount of money we have in the State among the various projects that need it.

You did not hear a person speak this morning that did not need and did not have a worthy program, but there just is not enough money to go around.

No matter what we do, and we often do the wrong thing, but we try to do the best we can with the money we have, and put it where we feel it will do the most good.

Another thing that every person today has mentioned is transportation. I think that transportation is one of the major problems, if not the major problem in health care in New Mexico. I have not heard anybody even come up with any kind of idea that would solve it.

Just one person mentioned this, and I think this is very important—is prevention—one person mentioned today that she would try to prevent some of the chronic health problems of old age.

I know that the U.S. Senate had this in mind. Congress, when they passed the nutrition program, title VII of the Older Americans Act, because they felt that nutritive increase would help the elderly to stay healthy longer.

Four Percent for Prevention

I understand that only 4 cents out of every health dollar is spent on prevention. There are 19 chronic illnesses that can be relieved by preventive nutrition. I think that is something that we should look into. It is certainly cheaper than putting them in boardinghomes, nursing homes, hospitals, or anywhere else.

Now, I know it would take a major re-education of the American people, but if you worked with the elderly, you see that they keep coming on with the same health problems every year. The only way you can ever do anything to relieve these problems is to start at an early age and make people healthier as they become old.

Again, I would like to thank you and your Senate Committee on Aging, and all of your staff, and all of those who have participated in these hearings today, because I think they have been tremendous.

I think it is going to make health care more visible in New Mexico, and that we just may get something out of it. I am glad you considered New Mexico, and I thank you for it.

Mrs. Wood. Would it be all right if we sent you a written statement about the program of the Commission on Aging, on nutrition, transportation, and so forth? [1]

Senator Domenici. We would love to have it. Let me say to all of you on the panel, we know it is a difficult time. We have set a strange date for all of you. This is a long weekend for most people, and we did impose on it. We understand that, and we greatly appreciate your efforts.

I would like to tell you, however, that it was obvious to us that if we did not have this set of hearings on this day, we would probably not get a formal hearing of the special committee this year.

I think you know that the special committee, which is chaired by Senator Church, has made great contributions when it gets the facts, and when it gets out front on something. I am deeply indebted to Sena-

[1] See appendix 1, item 10, p. 1238.

tor Muskie, the chairman of my subcommittee, for permitting us to come and have the hearings.

He should have chaired the hearing today. It was impossible for him to come. He conducted a seminar in Maine, and I want you to know I am pleased that he let me bring the hearing here. I am more pleased that so many people with families and plans for the weekend took time enough to come and help us.

Mrs. WOOD. We are glad our Senator from New Mexico is on this committee and that you did chair the meeting. I would like to say three other people from the Commission on Aging gave up their long holidays. Our nutritionist, Ms. Marjorie Townsend; our research worker, Ms. Lucinda Ray; and our public information officer, Jim Hahn, stayed all afternoon, and I am delighted that they are here.

CONCLUDING STATEMENT: SENATOR DOMENICI

Senator DOMENICI. Let me thank them also from the committee standpoint.

Let me have about 2 minutes to talk with you and tell you some views that I have.

Felix Rael asked that a statement which he has prepared be made a part of the record.[1] He is an undergraduate student in social work at the New Mexico university. He wanted to be a witness, but we could not work it in, so the statement will be made a part of the record. The committee staff within the time allotted will report with reference to the condition of boardinghomes in Albuquerque and Las Vegas.[2] This was prepared by the staff with the assistance of people in the field, after some visitations, and we want to make that report a part of the record.

If there is anyone in the audience who would like to submit their remarks regarding problems of health barriers, comment on the yellow papers that are in the back. You have 30 days to do it, but you should also make sure you get a formal copy of the transcript of this hearing. There is no other way of sending them to you.

ADMINISTRATION OF PROGRAMS DIFFICULT

I want to talk about two things. First, for the professionals who testified about the very difficult job of administering SSI, Medicare, and Medicaid. And the other aspects, which Mr. Lopez and Mr. Brown spoke to, let me say this: If there is anything that is discouraging after 1 year and 5 months as a U.S. Senator, it is that almost every area where we have serious national problems from social-type legislation, health type legislation, to such an apparent easy thing as transportation, we end up finding ourselves in the position where things are so complicated, have been so compounded by layers and layers of laws, so adopted and pursuant to a completely different objective than the other, that the tendency is that it is too complicated to get involved with, and that somehow someone will work it out. But when you start talking about the technical things done to the delivery of medical services, the strategy of criteria and definition, using one later one for another purpose, and then waiting 5 years to find it did not cover what you wanted, I want you to know, the urge is to let you

[1] See appendix 3, item 1, p. 1244.
[2] See appendix 2, p. 1241.

fellows work it out and sweat with it. I honestly have to say it myself, that everytime I am with people like you, I have some role in this, even if I am not on your local committees. I can tell you, it is a very, very difficult job.

If you had been with me in Atlanta, when we talked about the very mundane thing of building mass transit and roads, and to see the complex situation that we have now gotten ourselves into, the tendency there is to say, forget it. Maybe we will all work, or maybe mass transit will get built in some way, even if we do not know what we are doing. It serves a good purpose for us to get together with you, and to try to understand how frustrating and difficult the problem is.

System of Priorities Needed

Somebody commented that resources were the answer to everything, and that everybody needs money. There is no question about that. There is no question that we need a system of priorities as to what we want to do for the people in this land.

We should figure out what we are not doing for senior citizens, and we can probably add aside from Social Security and Medicaid, $3 or $4 billion in any given budget, and yet not make a dent.

To compare it with other things, we would still have to build mass transit in only 22 of our cities. It would take $3½ billion for the next 5 years, and by that time, we would have rebought another 50 cities that need it, and yet we have no program at all for it.

Specifically, however, to the Commission on Aging, and to you and your people, it seems that you are in a transition period which is going to be very difficult. There are some good programs that have grown up, in an ad hoc, willy-nilly manner, either founded in a model cities kind of concern, with unrestricted funds that built it, or perhaps a progressive city with a little money put in, for which they found some category for grants that they pulled out of the air and got it going.

Now, we all understand that we are moving in a direction of trying to systemitize this, and have the AAA concept, with some focusing in on comprehensive approaches.

I hope those that have good programs, but do not come right now to the purview of the Older Americans Act, will not be cut off while we are doing our planning.

They are fearful in the city of Albuquerque, of where some of their categorical model cities developed programs are going. They are staying, this is a new approach, this transition toward using a more basic and hopefully more continuous and reliable source of funding under the Older Americans Act.

I hope you have status in your funding to inventory programs so we do not lose the expertise and the momentum. These ad hoc programs are doing some work, and they ought to be amalgamated and pulled in.

Mrs. Wood. May I say something? For instance, if the Department of Transportation could be responsible for helping us get some minibuses and that kind of thing, we would have that much more money left over to fund administration for areawide agencies to put more into a program. But when we have to put it in minibuses, there goes the food money. There goes a lot of stuff.

Senator DOMENICI. I think in transportation, for instance, whether the funding for senior citizen type transportation belongs there or not, the committee on transportation, which has nothing to do with health care, is considering transportation needs for those who are physically handicapped—along with transportation needs for senior citizens.

I would hope you get to the point where it would be part of a national transportation objective, but at the present time we understand it is not.

Mrs. WOOD. And about housing. We understand that there are certain interagency agreements at the Federal level. AoA has an agreement with HUD. AoA has one with DOT. They have it with DOL, but by the time all of the "alphabetical soup" gets strained down to the State, and especially the local level, nobody knows about these things. When we try to tap the stated agreements, we find you cannot match Federal funds with Federal funds and you cannot cooperate. So you just end up blocked everytime you try to turn around to develop a good community program.

Senator DOMENICI. All right. We could go on indefinitely, and nothing would be more interesting, than for us to do it. However, it would be wrong.

I am to give a speech at 7 in Albuquerque. I assume I will be late for that, but I will tell them I have been conducting the business of the people.

Thank you very much. This committee stands adjourned.

[Whereupon, the committee was adjourned at 6:10 p.m.]

APPENDIXES

Appendix 1

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1. LETTER FROM ANTHONY T. ARROYOS, DIRECTOR, SANTA FE COUNTY SENIOR CITIZENS PROGRAM; TO SENATOR PETE V. DOMENICI

DEAR SENATOR DOMENICI: I would like to add to my testimony some comments with respect to the Area Agency on Aging for District II in New Mexico.

I find at this point in time a complete disregard by the AAA of the Advisory Council as outlined in the Older Americans Act.

First of all the staff of the AAA has received from the Santa Fe Senior Citizens Program volumes of Technical Assistance Manuals made up by the Director of the Santa Fe Program. The intent of providing the AAA technical assistance was to help in establishing a plan made of practical experience that would benefit the other counties in the district. Subsequent, the Final Plan of the AAA was a duplicate copy of the Santa Fe Program. Of this the City of Santa Fe has no complaint. However, because of its leadership role, the Advisory Council initiated a letter to the Governor of the State to clarify the decisionmaking process. The letter is attached:[1] The letter sparked controversy at all levels of government. The end result was that the AAA changed the By-Laws of the Council so that the Director of the AAA would be the Chairman of the Advisory Council. The justification of such a move was that the AAA interpreted the Federal Register in order to initiate "change" that would put the Advisory Council "in line with the thinking of the AAA." It is my contention that by having a Director of any Program as Chairman of an Advisory Council or policy council for that matter strongly suggests a conflict of interest.

This concern was expressed to the AAA in Raton, New Mexico. The reply was that "The AAA will establish how the Council will run and what decisions it will make."

I believe Congress' intent was to have an Advisory Council that would establish its "modus operandi" and make suggestions and/or recommendations to the AAA in order for the Elderly to give input to the Plans and Programs for the Elderly. If the present situation exists the Elderly will be overlooked in this District and the AAA will make all decisions regardless of input from the 8 counties regardless of the needs expressed by the Advisory Council. My position in stating this is precarious in that as the Director of the Santa Fe Program undue pressures can be put on the Program by the State and the AAA. However, I cannot compromise my principles when I see a neglect by decisionmakers in administration of funds for the Elderly.

Furthermore, a reply was made to the concerns of the letter to the Governor by the Task Force. It has some astonishing statements one of which was that, since 1969 Funds of the Title III of the Older Americans Act were distributed on "An Individual Merit Basis" to counties and Districts of the State of New Mexico. Absolutely no funding formula was used. The other factor was that the decisions were already made with respect to funding allocations to our District at the state level as early as February 1974. Yet the plan had not been developed or reviewed until June of 1974 (Letter attached).[2]

With all due respect, Mr. Senator, I would like to suggest that an amendment is made in the Federal Register that would insure the Elderly the right of par-

[1] Retained in committee files.
[2] Retained in committee files.

ticipation in an advisory capacity in planning, programming, monitoring and evaluation of projects that will affect their lives. As it exists at present, AAA's will interpret the Federal Register to their means and the Elderly will be handcuffed to the interpretation. However, if a clear definition is given in the Federal Register the Elderly will in fact be a part of the decisionmaking process.

I strongly urge that the Senate Sub-Committee on Aging introduce amendments to the Federal law which would require the approval of Advisory Councils, under AAA's, of the Area Plans and Programs prior to the distribution of funds by the State and Federal Government.

Finally, Mr. Senator, I am attaching for your information documentation that has sparked this reaction fom me.[1] I feel I could not keep it fom you. My actions and comments are shared by the other County representatives but I find myself alone in expressing it to your office.

Mr. Ernie Vigil has been kept abreast of all the events that have taken place and expresses concern with respect to the methods being used.

I hope this testimony will not be held against me or my Program in Santa Fe. If I am wrong in what I express, I would like to be constructively instructed. If I am right, I would like to see someone take the initiative that is not mine to take.

Thank you very much for your attention to my concerns.

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We have organized an AARP and Senior Citizens Boarding Home Legislative Committee to further look into this problem area in Santa Fe and Las Vegas, New Mexico.

ITEM 2. PREPARED STATEMENT OF EPIFANIA R. DURAN, SAN MIGUEL COUNTY DIRECTOR, SOCIAL SERVICES AGENCY

PROBLEMS IN BOARDINGHOME CARE

I am Mrs. Duran, Director of Social Services Agency in Las Vegas, New Mexico, San Miguel County.

For many years I have been concerned about people living in boarding homes. During the 1950's, doctors at the New Mexico State Hospital (now known as the Las Vegas Medical Center) started referring patients to our agency for placement in boarding homes.

We did not have many boarding homes then, but as time went on boarding homes were developed and this became a booming business in our area.

The majority of people placed in boarding homes came from the State Hospital. There were some referred by their families or by local doctors. When all these recommendations started there was no Social Service Division at the hospital, consequently there were no regular referral procedures. As people in the community were opening boarding homes, they would go to the hospital to pick up patients to fill their homes, as they learned of patients ready to be discharged. This practice was discontinued when the Social Service Division at the hospital and Social Services from HSSD became more involved with placement and a more effective referral system was initiated. There has been mutual co-ordination and co-operation between the two agencies.

The majority of the patients referred to our agency for placement were from another part of the state. There have been a number of discussions between State Hospital Personnel and Social Service Personnel about the possibility of referring these patients to the community or county they came from. Many reasons were given for not following this procedure, for example, relatives did not want the patients back in their community, or the local agency had not developed any boarding homes. Many of the clients living in boarding homes in this area are functioning well. We have discussed with them the possibility of moving to their own communities. They appear very happy and eager to move, even if it is to a boarding home.

I believe that if the New Mexico State Hospital Social Services Division does not have the practice of attempting to keep on-going family ties when patients are admitted or committed, this should be initiated if possible. One way of doing it would be by making a referral to the Social Service Agency in the home county of the patient or to the Community Mental Health Co-ordinator. This Social Worker would get in touch with members of the family and suggest and encourage them to keep in touch with the patients at least by writing if visits are not possible. This way when the patient is ready to leave the hospital he can

[1] Retained in committee files.

better adjust back in his own community even if it is in a boarding home close to his relatives and friends.

After the boarding homes were licensed in July 1972 the operators continued not complying with licensing regulations. Many of the old boarding homes who are still in operation were grandfathered in with the stipulation that they were to comply with regulations in 60 to 90 days.

As we work with these homes today we find many operators are not yet complying with the regulations and I often see a very negative attitude towards these poor and old, retarded and sometimes sick people they have in their homes. By negative, I mean that the operators' feeling is that these people are "crazy."

The comment of one boarding home operator was, "They should be satisfied with what we give them and where we keep them". Some boarding home residents have been kept in basements, some in converted chicken coops and some in old torn down trailers.

Through the years that I have worked here I have off and on been involved with boarding homes. During the period from May 1973 to the present, I have had four different caseworkers assigned to work with boarding home clients. The present worker Linda Martinez was assigned in October 1973. Since the beginning of her work here with these clients she has become very interested in helping these residents. She has been co-operative, energetic, tenacious, dynamic and unafraid to get involved in helping these people cope with the many problems within the boarding home.

Because of the number of clients in boarding homes needing services, another one of the caseworkers, Beth Abney has been assigned to the homes classified as "Sheltered Home." She too has been "super" helpful with clients and operators.

A number of meetings have been held with interested people in the community, with State Officials of the Social Service Agency and Licensing Division as well as boarding home operators.

In working with the operators we found that many of them did not really understand what was expected of them. During our recent meeting Mr. Dale Libby, the Inspector from the Licensing Division, explained and discussed with the operators item by item of what was expected of them. The boarding home operators appreciated this review and as a result, *four* homes are being closed. These particular operators feel that they cannot or will not comply with Licensing Regulations. We now have 168 clients living in 31 boarding homes. Linda works with 134 clients and 25 operators for a total of 159.

Anyway you look at this, it is a large case load for one caseworker. We would like to do many other things in the way of services, but it is not possible.

Attachment.

MEMORANDUM

May 23, 1974.

To: Larry Brown, Director of Social Services Agency.
From: Epifania R. Duran, County Director, San Miguel County SSA.
By: Linda Martinez, Caseworker, SSA.
Subject: Boarding Home Information.

In the Las Vegas area there is a total of 168 residents living in 25 Boarding Homes and six Shelter Homes.

A survey study made on these homes by San Miguel SSA Caseworkers, Linda Martinez and Beth Abney, indicates that a large percentage of the residents were formerly from the New Mexico State Hospital.

Being that San Miguel County is the home of the Mental Hospital, and has the largest number of boarding homes per capita in the state, problems existing are somewhat different in comparison to other areas in the state. Las Vegas Boarding Homes could justifiably be called "atypical". The majority of boarding home clients are of Spanish descent. (Survey indicates that of a sample of 42, 28 were Spanish.) The median age is 59.5 while the mean age is 57.95.

Most of the residents in Boarding Homes were from counties other than San Miguel prior to their State Hospital commitment. Efforts were made to return many of the residents to their home communities but were to no avail because there were no boarding homes in the various other counties or families wished to "wash their hands" of their undesirable relatives.

Of the 168 residents in the boarding and shelter homes, 168 have been provided with services. Since the San Miguel Social Services Agency has only one caseworker to provide services for the majority of the residents, it is quite difficult and almost over-bearing to justifiably meet the service needs. Group interviews

in large boarding homes as well as individual interviews have been made to help alleviate the heavy caseload. According to the caseworker, however, many services are still needed but are impossible to be taken care of because of lack of staff.

Services provided are many and of diverse types. They range anywhere from writing a letter to a daughter or son for a boarding home resident, to protecting a mentally retarded man from an intimidating boarding home operator.

Below is a list of the most frequented types of services provided.

1. Periodic visits with boarding homes depending on type of home, attitude of operator, care of resident and individual problems of residents that may arise from time to time.

2. Transportation is provided for medical reasons, recreational activities, to the Social Security Office, pre-placement visits to other boarding homes and to visit with friends and relatives, etc.

3. Protection from exploitation and intimidation by the boarding home operator. These protective services for adults include seeing that the resident is being properly fed, the home is adequately clean, and in some instances, removing a client who has been physically abused by the operator.

Since the separation of agencies in January of 1973, it has been the procedure of the New Mexico State Hospital to call our agency in reference to placing patients as residents in the boarding homes. This is how the majority of our residents are placed. Other referrals have come from families who are seeking a boarding home for a family member, from the Health Department and also from the Public Assistance Agency.

Prior to January 1, 1974, an average of 30 referrals a month were given to our agency by the Public Assistance Agency.

Since the conversion to BSSI, only an average of 3 referrals a month are given to our agency by the New Mexico State Hospital because the patients cannot apply for BSSI while in the institution.

ITEM 3. LETTER FROM MRS. CONNIE SANCHEZ, BOARDINGHOME OPERATOR, LAS VEGAS, N. MEX.; TO SENATOR PETE V. DOMENICI, DATED JUNE 27, 1974

DEAR SENATOR DOMENICI: As of today 13 Boarding Home Operators have joined the R.A.S.H. Organization, and this 13 have always been interested and dedicated.

Our facilities were inspected this past week and aside of some deficiencies the majority of the homes were given an annual license, while other were given 90 days to up-grade or less; but in order for the operators to meet such stringent standards we need You the government to up-grade the rate that is being paid for the services that these homes offer.

The majority of the people that we care for have no one else to care for them or else their families are incapable of caring for them.

Thanking you for your concern.

Sincerely Yours,

CONNIE SANCHEZ.

ITEM 4. LETTER FROM ADELINA ORTIZ DE HILL, ASSISTANT PROFESSOR, DEPARTMENT OF BEHAVIORAL SCIENCES, NEW MEXICO HIGHLANDS UNIVERSITY, LAS VEGAS, N. MEX.; TO MR. WILLIAM E. ORIOL, STAFF DIRECTOR, COMMITTEE ON AGING, DATED JUNE 5, 1974

DEAR MR. ORIOL: I am enclosing excerpts from the 1. AARP testimony that I referred to in my comments. 2. Also I would like to place in the order of sequence the testimony I submitted Saturday, May 25, 1974, the afternoon of the hearing. 3. Finally I would like to comment on health needs the focus of the Committee hearing. I realize that my concerns seemed narrowly confined to the boarding home problem and that while there are health implications involved it is more a concern of mental health.

1. The AARP: State Legislative testimony: I think it is significant to note that Boarding Homes were ranked first in a series of recommendations relating to problems for aging persons in New Mexico, also that it is referred to as prime

importance. I have placed a star alongside the material I submitted for a supplemental comment. I will leave it up to your staff to determine its relevance.

2. In addition to the testimony I submitted Saturday:

a. I provided a demographic profile of New Mexico listing several variables including rural-income-age over sixty-five, etc.

b. Also a copy of the regs in relation to Adult Services which removes from the register money mandated services, always a good excuse for offering none. This hurts rural areas where the Welfare Department and Social Services are the only resource for services. Also Social Services could assist even those not eligible, on sliding scale payments in particular Home Health Aides.

c. The packet of Adult Services which I developed to accompany information on the Medical Evaluation form for Boarding Home residents.

3. In regard to Barriers to Health Care in the State of New Mexico there are several issues I would like to develop. Some will require legislation, others may be administrative.

a. First, I would like to say I concur with Mr. Lopez's testimony about the building of a health care system on a house of cards. There are many areas in the state where doctors will not treat welfare clients, in particular the Eastside and Dona Ana County because of paperwork and red tape.

b. I have always been a proponent of preventive screening. However, I understand that after screening and referral that doctors often do not effectively follow up on referrals. This may be attributed to two things, the shortage of doctors particularly in Northern New Mexico and what Kasterbaum refers to as the "reluctant therapist" less interest in the problems of ill aging people. Despite the fact that this may be the case I still believe that periodic screening for health problems and the possible prompt diagnosis of diabetes, for example, is worthwhile.

c. The language of medicare information, indeed much information, coming from the Social Security Administration is not easily understood. Payments disregard, etc., often the printing is too fine for many elderly whose visual acuity has diminished. A case was reported to me of a woman with a drawer full of uncashed social security checks, because she simply did not understand the instructions about the change of her status. BSSI has now taken on a client with an average of a third grade education. I feel it will have to make a special effort to be intelligible.

d. That while much is said about folk medicine in the Spanish-speaking culture, good medical care can be provided if the care giver understands and can communicate confidence and understanding of some practices. The stoism and fatalism attributed to the Spanish speaking may be the case in minor ailments or illness that to be due to "susto" or a psychosomatic cause. Which may be the case in the greater population as well, certainly the pre-ponderance of drug commercials implies it. Education in the preventive area is quite important and needed.

e. Home health care is also preferred to institutionalization and should be reimbursed by medicare payments.

f. The rural elderly in some communities do not have access to telephones and ancillary health care givers are needed in smaller communities to supplement medical care.

g. Too often nursing homes become terminal placement because families are reluctant to care for the infirm elderly person due to ignorance and lack of training for the minimal up-keep in home. The medical mystique is frightening and the family feels it is unable to give adequate care in the home.

h. In some cases nursing homes could function a day care center for some infirm elderly who require some monitoring such as cardiac problems, etc., so that working family or a housewife can get some relief from the constant care required. This may also be reimbursed by medicare and would minimize use of nursing care homes fulltime or on a cost benefit bases be worthwhile exploring.

i. For the most part I can concur with most of the witnesses who have recommended that prescription drugs, insulin and therapeutic vitamins formulas be covered by medicare.

Thank you again for giving us a forum in which to focus our concerns for our aging population.

Sincerely,

ADELINA ORTIZ DE HILL,
Assistant Professor of Social Work.
Department of Behavioral Sciences.

ITEM 5. LEGISLATIVE PROPOSALS FOR CONSIDERATION BY NEW MEXICO JOINT LEGISLATIVE COMMITTEE ON HEALTH AND AGING, RECOMMENDED BY NATIONAL RETIRED TEACHERS ASSOCIATION/ AMERICAN ASSOCIATION OF RETIRED PERSONS STATE LEGISLATIVE COMMITTEE

SUPPLEMENTARY COMMENTS

1. Establish and enforce sound standards of safety, hygiene and operation of nursing homes, retirement homes and boarding homes housing elderly persons.

A. Increasing, if necessary, payments for indigents who are housed in these facilities so that adequate care is given.

B. Establish as a "minimum standard of need" for indigents the amounts developed in a study by Dr. Gerald J. Boyle and reported to the 1972 Interim Committee on Aging. In brief these are:

	Allowance per month
1 adult in boarding house	$86.50
1 adult living alone	147.00
2 adults living together	195.00

COMMENT

The State of New Mexico now has an agency (Health and Social Services Department) which should be qualified to set up appropriate standards of safety, hygiene and operation of places housing older people, whether these are privately owned or publicly owned establishments. Assuming that this is already accomplished the agency should be responsible for enforcing these standards. We hear that the HSS does not have sufficient manpower to adequately supervise and enforce its present standards let alone any higher level of standards. If the agency is not manned to do this job then it should contract or otherwise have the job done.

We also hear that these establishments housing older people claim State payments for welfare recipients are insufficient to maintain adequate standards. We cannot offer judgment in these instances, we only see upon visitations, dire need. Our investigations have revealed that some older recipients are living in deplorable circumstances. This should not be tolerated.

We maintain that it is the responsibility of the Legislature to insist that its agencies (HSS) establish adequate standards and enforce them. It is the responsibility of the HSS to inform the Legislature of the costs of an adequate realistic program. The Legislature should then arrange for funds so the program can be implemented.

One of the serious problems occur when old persons are elevated out of the State income area restrictions or guide lines by Social Security of other income benefit increases.

We understand that after Jan. 1, 1974 under HR–1, the Federal Government will underwrite some of the expense of the indigent to the extent of

	Allowance per month
1 adult in boarding house	$86.50
1 adult living alone	130.00
2 adults living together	195.00

Whether this will result in a net relief to present State funding we are not sure but it seems to support the minimum need study of Dr. Boyle to which we subscribe.

The 1973 Legislature approved several major legislative items dealing with the Health and Social Services Department and a departmental appropriation of $30.7 million for the fiscal year beginning July 1.

The HSSD Board subsequently approved a total operating budget including Federal funds of $104.4 million for the next fiscal year.

Although the legislators did not okay all programs and expenditure levels sought by the department, relations with the legislative branch were generally "smooth sailing" in contrast to some sessions of the past.

One important bill enacted by the 1973 session extends the Medicaid portion of the Aid to the Aged, Blind and Disabled (AABD) program to those persons who were presently just over the AABD income line but who are facing severe medical difficulties which might lead to death without such assistance.

Passage of the bill, Chapter 311, was given impetus by a State Court of Appeals ruling that the department must provide such aid—even though the Legislature had never specifically mandated such a program nor appropriated funds to operate it. Caught between conflicting pressures, the department sought—and received—the legislative solution represented by Chapter 311.

The bill carried an appropriation of $250,000, which HSSD officials hope to match with Federal funds, but department spokesmen say there is no way of knowing at this point whether the appropriation will be sufficient.

We urge each member of the Health and Aging Committee to secure, read and study a publication entitled "A Guide for Social Services in Nursing Homes and Related Facilities" which is available from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402, at 50 cents per copy. This Guide was prepared by experts in the field. Its 25 pages of comments and conclusions have a wealth of information for the ordinary layman.

Citing just a few items of interest that has come to our attention through this Guide.

WHAT IS A NURSING HOME

I. Characteristics

A nursing home may be "free-standing," a special section of a hospital, of an infirmary in a home for the aged. Increasingly, homes for the aged are adding facilities for medical care for their ill who may have been relatively well on admission but often develop illnesses with advancing years. Older related resources include: "personal care," "rest" or "residential care" homes, "country homes," foster and boarding homes, and chronic disease hospitals or geriatric wards in general hospitals.

Current estimates (1965) indicate that there are approximately 19,000 licensed nursing homes with over 760,000 beds in the United States, 87 percent of which were occupied in any one day. Not represented in these counts is a substantial number of unlicensed facilities (e.g., 3,595 in California representing 34,065 beds, which are considered personal care homes rather than nursing homes).

With about 60 percent of all nursing home residents throughout the country now receiving some form of public assistance, payments by welfare departments have been a major factor in determining adequacy of care. Because of the great range in the amount of payments, often considered inadequate by administrators, some homes have not been willing to accept public assistance recipients.

II. Standards

In the past, attempts have been made by health or welfare departments to classify nursing homes according to services available, and the residents by the needs they present. The basic purpose of this procedure is to match the patient to the home and to compensate the administration for the type of care residents receive, adapting the scale to changes that occur in the resident's condition.

Other standard-setting methods have also been employed. Licensure is the principal method of regulation and standard-setting in nursing homes and related facilities. The agency carrying this responsibility in nearly all States is the State Health Department. In all States and Territories except Guam and the Virgin Islands, nursing homes are licensed. Homes for the aged are also licensed in all but two States and three Territories. There is no established pattern for licensure for other types of group facilities, some of which are blanketed into the nursing home regulations and in other instances are licensed separately or not at all.

A model law was developed in 1966 by the Council of State Governments which incorporates many of the recommended standards in the Conditions for Participation. This document was developed by a multidisciplinary committee collaboratively with members of the Council, including representations from the National Association of Social Workers.

III. Current trends

Funds for modernization and construction of new facilities are available through Hill-Burton, Federal Housing and Small Business Administration sources, each of which provides financial means for improving the physical standards of these facilities. Policies continue to be liberalized with regard to loans, making it easier for nursing home administrators to use these resources.

One of the emerging trends is the use of nursing homes as day centers and for temporary care of persons who can live at home or with relatives but who need supervision at certain periods. Some of the senior centers, which are primarily geared to recreation and socialization, have been extending their services to

residents of nursing homes. This increased involvement contributes to closing one of the principal gaps in services, that of stimulating experiences which assist the residents to remain alert and interested in other people.

Undoubtedly the most important development in relation to nursing homes is the impact of the Medicare legislation. One significant sequel of its passage will probably be in conversion of some nursing homes from their former role of largely custodial institutions to post-hospital convalescent care facilities with high quality medical and nursing (including restorative) services.

There is documented evidence that deterioration often accompanies congregate living and long-term institutionalization even with the best of care. Movement of patients in and out of nursing homes and the use of the facilities for short stays has only in recent years become a growing pattern. The current trend is to provide an attractive and safe environment, medical supervision and high quality nursing care, restorative service and such supports as social services, pastoral counselling and recreation, to enable patients more frequently to return to their normal environmental rather than remain in an institution for the rest of their lives.

People in general are becoming more knowledgeable and are insisting on better care. Somewhat more slowly, the public image of the nursing home is changing. The community is also coming to realize that in these nursing home beds are people with social and emotional as well as physical problems—similar kinds of problems to those of older people who are not in nursing homes, plus others created or aggravated by illness and enforced absence from their normal environment.

PEOPLE WHO RECEIVE CARE IN NURSING HOMES

According to a study made by the National Center for Health Statistics, residents in nursing and personal care homes (from April–June 1963) had the following characteristics:

Age.—Residents of these institutions were primarily an elderly population. The average age of all residents was 77.6 years; 70 per cent of the residents were 75 years and older while only 12 per cent were under 65 and only 2 per cent were under 45.

Sex.—66 per cent of the residents were women, a proportion which varies with age; with increasing age, the proportion of women increases. Men predominate (54%) only among those residents under 65. Among all residents 85 and over, women represent 75 per cent of the nursing home population. The average age for women was 79 years, for men 70 years.

Health Status.—About 57 per cent of the residents in all homes were able to be out of bed except for sleeping; about three-fourths were continent; half were generally mentally alert and four-fifths did not have serious hearings or visual problems. There was an increase in physical disability with advancing age.

Summary and Comments.—Despite variations for age categories, the overall picturization of residents of nursing and personal care homes is predominately one of the aged, with women substantially outnumbering men.

From the cited source and other references, information was provided that, on an average, people stayed in nursing homes approximately one year; some left earlier or later to return to community living or were transferred to other kinds of facilities; however, many lived there the remainder of their lives. For the total nursing home population, hospitals referred between one-fourth and one-third of the residents, other long-term facilities about one-fifth, and the largest and remaining proportions were self-referrals or were referred by others while the patients were living in private dwellings. Available information on the sources of support for care indicates that family members, alone or together with public welfare, carry considerable responsibility for payment to nursing homes.

Some studies have also indicated that between one-third and one-half of the people residing in nursing homes do not need skilled nursing care, but have been referred primarily for social reasons or because other resources are lacking. With the realization that a shortage of nursing homes with acceptable standards still exists, there is growing appreciation that such facilities should be reserved for persons requiring *nursing* care or supervision.

As other supportive services become increasingly available, nursing homes will be more selectively used in the future than they have been in the past. Community programs for special housing for the aged, visiting nurse services, organized home care, homemakers and home-delivered meals will enable aged persons to remain independent within the community for longer periods of time.

NEEDS OF NURSING HOME RESIDENTS

Consideration of social as well as physical needs of nursing home residents should be given by staff of the home whether workers are present or not. As members of society, all people have needs which, in everyday living, are usually met in varying degrees through efforts of themselves, their families, friends and other associates in the community in which they live. These needs encompass food, housing, finances, education, health care, and the gamut of personal, social, and spiritual requirements.

Referral or admission to a nursing home, even if temporary, presents a major variation from the customary pattern of living, a break with past associations and separation from family and friends. This action is frequently disturbing to the prospective resident and to the members of his family.

Before any patient is referred to a nursing home, a medical-social evaluation should be made which will lead to a joint decision as to whether this facility or an alternate plan would be more suitable, and the physician, patient, family and referring agency should participate in this determination. The major considerations in such an assessment are the need for skilled nursing service because a disability is present, and the unavailability of someone to provide the needed care in his own or a relative's home.

After this decision has been made, factors to be considered in making a choice of home are: the services and surroundings which best meet the individual patient's requirements and preferences in terms of medical and nursing needs; dietary and paramedical services, opportunities for fulfillment of social, cultural, religious, and recreational interests; a location convenient to family and friends; and a cost suitable for the prospective resident and his family. Influencing the final decision will be the financial resources available to the patient and family for purchasing needed care; however, great expense does not necessarily guarantee good standards or quality services.

Our New Mexico HSSD and staff is mindful of its overall responsibility to aged. This is demonstrated by a recent paper developed by a staff member, Mrs. Adelina de Hill for consideration by the management of HSSD.

In brief Mrs. Hill's proposals encompass the following: Toward development of a systematic approach to offering services to aged, blind and disabled persons in the State of New Mexico

Goal.—To systematically reappraise the program for assistance and services current in the State of New Mexico in order to enhance services to client population.

Objectives

1. Define needs through a realistic appraisal of information gathered on the social, economic and cultural characteristics of the client population.
2. Review current ideologies and inconsistencies as they relate to needs.
3. Restructure methodology and task related concepts that are obsolete and are not consistent with task enviornment needs.

A. Broader Scope of Activities

In order to provide services to those persons in need of them, particularly in counties where resources are limited, a system of sliding scale payment for services should be made available in order to cover a broader spectrum of those who need services.

1. Justification—Though there is no statistical backup for this assumption, it seems more than likely that a significant amount of time is spent daily giving information and determining eligibility. With the institution of a broader scope of activities, social services could expand and assist those persons in need but not now eligible.
2. By being more directly involved with problems of low and low middle income persons the stigma of welfare would lose its sting and gain respectability.
3. A greater ir volvement in community needs would mean a gain in the number of people that could assist in advocating services where gaps exist; and enhance the development of more viable volunteers and credibility from the community.

B. Services Development—(Designated Priority Areas)

Communities should be assisted in the development of services that will fill the needs of that community. A study of the uneven development of services and programs illustrates that counties with over a 10% ratio of welfare recipients, also have higher unemployment rates, more poverty, less economic development

and fewer resources. At least 14 counties should be designated as target communities in need of development. Given a high priority these counties would receive consideration in the development of services contracts by the state to qualify for social services purchase.

C. Special Programs or Funding—(Shelter and/or Income Needs)

It is becoming increasingly apparent that some policy should be developed in regard to group homes which offer more than room and board. These establishments tend to offer social treatment and education in a specialized area of endeavor. A case in point would be a group home for adult retardates which would include home management education and treatment, two activities that require more skills and involvement than ordinary boarding home operations. At present we do not compensate for treatment for adults in any other area but health, with designations of sheltered care, ICF and nursing in which case fees for payment are made accordingly. Under supplementary income (SS) persons requiring treatment are required to get this service prior to receiving this income. If this service is refused, the individual will be denied this income. It is incumbent on us to develop this service more evenly.

Boarding homes are not being used for the purpose originally intended and all too often contain individuals who need services that cannot be provided because this setting should be for healthy independent persons. The need for the development of substitute specialized care is great and can be documented by many sources in the field. The principal deterrent to this development is the inadequate payment schedule. Presently more than half of the residents in boarding homes receive OAA and APTD. The counties that have the largest numbers of this type of placement are Santa Fe, San Miguel and Bernalillo. For the most part, residents in boarding homes have problems that go unattended.

There is the special problem of the alcoholic who is periodically institutionalized and returns to the community and rebounds to the State hospital, the recidivism rate is high. Adult retardates, institutionalized elderly (often times inappropriately) the young adult and other special problem groups that could benefit from group home experience, education and training. An estimate of the needs in the current State Hospital population in specialized areas that could benefit from this type of treatment are:

(1) Alcoholics—100; 20%.
(2) Paisano-Ward 65 & over—35, 55; 75%.
(3) Young adults (17 to 21)—60; 30%.

Even the advent of supplementary income under social for supplementary income will not create an incentive for development of this type of home. The base income level of $134 per month is only $25 more than the present boarding home payment and has only a $20 disregard for income. For earned income, the first $65 and ⅓ over. Supplemental Social Services assistance could be developed that would match shelter payment for vendors who develop specialized treatment.

If the state should offer additional supplementary payments, administrative costs are paid by the federal government and protect the state against any increase over 1972 expenditures for welfare payments to AABPTD. The "state supplement" will go to all who are eligible. The state can set own residence requirements, additional income disregards, and eligibility for additional supplementary assistance.

"Medicaid now provides vendor payments for indigent residents in long-care facilities under OAA. In keeping with family ties and the culture ethnic prevalent among the Spanish-speaking families, it is recommended that an elderly person's immediate family be eligible for a subsidy or allowance payment to make possible for family care for the person probably at a much reduced rate than vendor payments to nursing homes. The precedent for such are already exists in foster home care programs." (Homer Martinez—Senate Hearing)

There are certain imperatives that have been documented in countless Senate Hearings with ample statistical information in research and policy statements such as the Brandeis Policy Statement on Personal Home Care, all pointing to the direction of lack of adequate home care or shelter for the ABPTDB category.

In many cases costly nursing care or institutionalization can be prevented if alternative types of care are permitted to develop. Along with the encouragement of group homes, and more incentives for familial responsibility, the promotion of family (foster) home care should be developed.

D. Special Needs (Protective Services)

Legislative activities to develop more meaningful protective legal rights for the developmentally disabled adults and the elderly should be encouraged and acted on. Conservatorship offices could be designated as an activity in county court houses across the state. This activity should have the leadership and encouragement of the State Social Services Department.

E. Telephone Service

The findings of the 1970 OAA and APTD studies suggest that persons in these highly vulnerable populations for the most part do not have access to a phone. Sixty per cent APTD recipients do not have access to phones. Sixty-two (62.8%) per cent of the OAA recipients do not have access to phones.

The implications of this information can be that a significant number of persons that could most effectively use this service for emergency medical needs, assistance and are isolated due to lack of mobility, could be more independent.

The cost benefit effects of underwriting telephone service would balance in favor of savings. The time and transportation costs of service workers maintaining contacts can be costly if contacts are maintained at desirable level to provide services. The social costs and the waste of manpower energies on the road are not factors totaled into budgets but none the less exist. Earnest consideration of providing this service should be given to assist in the proper maintenance of independent living.

F. Personnel

No emphasis has been placed on the imperative need for bilingual staff in a state that has a significantly higher percentage of Spanish-speaking recipients:

61.3%—APTD category.

60%—OAA recipients.

Greater efforts should be made to recruit and utilize staff with native expertise that cannot be equated with a B.A. in Library Science, etc. If we do not recognize this need, we demonstrate a lack of concern for the needs of our citizens.

Countless demonstrations and testimony before Senate Committees reiterate the need for persons aware and able to communicate with the client group. Realistic job specs and task-related concepts are more in keeping with needs and would demonstrate that to align the staff with client needs, we need bilingual staff.

As an example that HSSD is making a valiant and professional effort to meet its responsibilities toward welfare recipients the following is offered:

EVALUATION AND REVIEW OF BOARD AND ROOM ARRANGEMENT RESIDENTS

To find persons not receiving social services but receiving public assistance, request a list of all clients in a board and room arrangement situation. Identifying information and pertinent, recent (not over two years old) medical and social information can be shared. Offer services explaining the purpose of the interview which is to identify problems, effectively offer services, and develop a plan to improve living conditions, if needed. Some individuals will be content with present conditions but may need diagnostic evaluation for medical problems that could prevent chronic and disabling illness. In some cases, individuals in boarding homes might have special medical needs (diet, etc.) that cannot or are not attended to in this setting. The Form ERSS.01 (Evaluation and Review SS–01) is to be used as a *lay* medical and social evaluation of the situation. This form was designed as a diagnostic checklist to organize information for planning and referral for medical evaluation of the client's present state of health.

A copy should be forwarded to MAD for approval (Medical Assistance) so that a physician can examine and prescribe the best type of living situation for the individual under the circumstances. In some cases, this may require placement in more intensive care type facilities. In some cases prescribed remedial or prophylactic treatment that will be required to maintain and improve health and functioning.

If the situation is related purely to social functioning because placement is not in keeping with the preferences of the client, efforts should be made to alleviate this problem.

In many instances persons are too far removed from family or their natural environment. In such cases, contacts should be made with home counties so that effective placements can be made. Efforts are being made on a state level to develop other means of substitute care so that persons can find shelter near families, friends and in the area they most prefer.

As laymen we are considerably impressed with the thought and completeness of the forms developed by the HSSD. We feel that this helps to confirm our contention that the Health and Aging Committee must rely upon the HSSD for its basic information for aid to older citizens who need welfare assistance.

2. Establish a permanent Joint Committee in the Legislature to collect and examine information relating to aging and to recommend legislation or changes found necessary to better the condition of the aged.

COMMENT

The problems of the aged will always be with us. This segment of our population is increasing at a rapid rate. It is an area that each of us, including Legislators, will join as years pass. It is an age bracket that has long been ignored. The problems are complex, not easily solved and can involve not only years of study and consideration but also substantial money involvement.

To cope with these many and diverse problems the Legislature should have a permanent committee to collect and examine information. This is not a one or two session problem—it is a continuous and growing problem.

The question of whether the Legislature should address itself to the problem should not be a yearly exercise of political maneuvering. It should be an established fact and part of the legislative structure the same as the corporations, conservation, education, finance and judiciary committees.

The following are some policy questions we believe the Committee, together with HSSD, should explore as issues that could have some impact on services for aging persons in the State.

I. Issues

a. Problems of adequate health care in the preventive area—the difficulties encountered by the chronically ill, not needing hospitalization or nursing home.

b. The need for good home care and maintenance for the majority of elderly who prefer to stay in their own home.

c. Inadequate alternatives in housing for the elderly homeless and isolated.

1. Boarding homes (improved).
2. Group homes.
3. Special problem groups not requiring institutionalization but having special needs.
4. Family Foster Care.
5. Day Activity Centers.
6. Nutrition programs.
7. Home Health aides.
8. Protective legal services.

All of these alternatives need development on an evener scale to cover a broader part of the population.

d. More information and referral to get through the bureaucratic maze.

e. The rural elderly who do not have programs of assistance except those on welfare.

f. The duplication over-lap and gaps in service delivery, because it is so uneven.

g. Nonexistent services in many areas.

II. In the event that these services are developed by Health and Social Services the only persons eligible under the Federal regulations would be Public Assistance Recipients.

The state could opt to offer services in County offices and expand the scope of these services on a sliding scale. Much the same way that Day Care is handled, with liberal allowances and payment based on ability to pay. Services should be offered on need and not means.

a. There is a sizeable segment of the working poor (more current now due to inflation) or elderly living on limited incomes.

b. Services should be based on vulnerability due to age handicap, income or limited other community resources.

c. The average income of State Social Security Insurance recipients is $87 per month. This coupled with the fact that there are a significant number of low wage earners that will retire at the lowest income level means a growth in the numbers who need services.

d. Land poor persons who do not qualify for OAA due to holdings are paying taxes just the same.

e. Rural elderly who could afford services but find them generally unavailable.

III. Funding and Legislative Action

a. Federal Revenue sharing moneys either from Special or General funds. Communities could opt to purchase services. Or a commitment made at a statewide level.

b. State surplus funds used as a match with Federal.

c. Moneys not yet appropriated from the Older Americans Amendments.

d. Economics of scale and improved efficiency would generate and assist in financing.

e. Huge social costs due to neglect of our most deserving citizens, who should not spend their later years enduring hardships, pain, loneliness and suffering from anxiety.

IV. The Implications

a. We would be better prepared to service the growing numbers of elderly.

b. We could build in quality and concern into our present day system of neglect and buck passing.

c. The stigma of welfare is supposedly gone with the separation of public assistance from Welfare. Services should be everybody's right.

d. The cost factors are minimal compared to attempting to duplicate services, both of which will be less adequate. We promote a double standard which is undignified and unworthy of our citizens who have carried their own freight and are worthy of our concern.

ITEM 6. PREPARED STATEMENT OF ADELINA ORTIZ DE HILL, ASSISTANT PROFESSOR, DEPARTMENT OF BEHAVIORAL SCIENCES, NEW MEXICO HIGHLANDS UNIVERSITY, LAS VEGAS, N. MEX.

My name is Adelina Ortiz de Hill. I am a specialist in Aging, a native of this State and a national coordinator of Pro Personas Mayores, an advocacy association for Spanish-speaking aging persons.

I wish to reinforce and express some of the concerns expressed in testimony this morning. There are many front line workers, providers, and citizens attempting at various levels to resolve problems relating to isolated elderly living in boarding homes.

I have been involved with the traditional steps taken at the community level and have made efforts to implement programs at the state level. I also assisted members of AARP in preparing testimony before the State Legislative Committee on Health and Aging, all to little avail. The solution seems to be beyond the grasp of this State because of limited resources, sensitivities, commitment, and a bureaucratic snarl of monumental proportions.

There is no accurate count of boarding home residents that are 65 and over. In a 1970 HEW Report on OAA recipients of the 2,033,025—2.3 or 47,724 lived in boarding homes in the U.S. The same report suggests that of the 8,999—OAA recipients in New Mexico 2.5 or 225 lived in a boarding and room arrangement. I do not know for certain if this includes both licensed and unlicensed homes. In an official and unofficial capacity I have visited over fifty boarding homes in this State, California, Kansas and Michigan. I have also talked to many persons concerned with this problem in these States. There seem to be many commonalities.

1. Isolation and a deprived environment, desolate and destitute surroundings.

2. Overcrowding—beds are placed in dining and living areas with little or no life space; no private space for personal belongings.

3. Diets are inadequate.

4. Drugs are administered and there is a mix of functional and disoriented people.

5. Residents are exploited by a string of petty charges that range from having to purchase toilet paper, to no lights after dark, no heat, no diversion—all for the convenience of the operator.

6. Often there is physical intimidation or mental cruelty, threats such as being sent to the State Hospital or being thrown out are used as coercion.

7. Social contacts outside the home are not encouraged.

8. Boarding home residents have little or no attention given their needs, while operators are referred to as humanitarian.

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9. Many residents may need another level of care either more skilled or more independent.

10. Often problems revolve around a lack of licensing standards enforcement, excuses are there are no alternatives, not sufficient staff and payment insufficient.

I would like to comment on payment. Many of these homes are run down and old. As an example, an ordinary three-bedroom house, that may rent for $120 a month including utilities will have from 8 to 10 residents paying $120 a month each, living on a diet of oatmeal and beans, over crowded, dark and cold.

Using my own home as an example and applying current practices, I could house 18 persons in a three-bedroom house using the dining area, and living room including rent and utilities pro rated it would cost me $175 a month, this excludes my full basement. Using boarding home resident labor and the nutritional standards in practice I estimate my overhead including depreciation to be $600 a month (a generous estimate), gross income would be $2,160, my income would be $1,560 per month.

In the seven months that I functioned as Adult Specialist, in the Program Development Division of HSSD, I developed a comprehensive packet suggesting alternative proposals to alleviate some of these problems. This packet was approved by the HSSD board. I met in executive sessions with the Social Services Division regarding budget matters and recommended an increased staff of six, though I was told these were unnecessary. There was a budget surplus at this time, which was later cut. With the exception of a preliminary review by the Field Operations staff it is my understanding that this packet has not been released to County Offices. (See item 2)

Among some of the alternatives I developed were:

1. Medical and Evaluation Review of Boarding Home residents.
2. Group homes for independent living.
3. Day Center activities in cooperation with Senior Centers.
4. Family Foster Care.
5. Supportive services to keep people in their own homes, rather than institutionalization.
6. A broad application of homemaker health services.

I have also recommended a sliding scale for homemaker health services and social services to rural areas. There is no even development in regards to these needs in the state. I also recommended supplementary payments—all of these were submitted by the AARP legislative committee—Most of the concerns related to the problems of boarding homes have been treated by scapegoating and buck passing by various divisions in HSSD, DHI and the Commission on Aging.

Since much is said about the mental competency of these people, I would like to comment on the mental competency of many of the formerly institutionalized elderly. I recognize that organic and functional disorders may be more likely to occur in old age, but this is not always the case.

1. These may be episodes due to a collection of problems, depression and result temporary disfunctional behavior.
2. That institutionalization may cause regression and dependency.
3. That persons relatively functional in many respects but isolated are institutionalized because of concerns that they may harm themselves. Example, A blind isolate placed in the hospital because of concerns about his care.
4. Idiosyncratic behavior and a repertoire of complex "deviant behaviors."
5. Aged but harmless patients who could be released such as burned out schizophrenics.
6. Malnutrition and/or under-nourishment can cause delusional states.
7. Lack of trained professionals to make proper diagnosis or to process treatment; a commitment and treatment process that leaves much to be desired.
8. Other causes too numerous to mention, all a part of the reactional biography of individuals which is more complex in old age.

I recognize that your concerns are related to the Federal role of intervention and concerns relating to nutrition, Health and B.S.S.I. In this context these are my concerns.

1. The need for conservatorship or guardianship to end the exploitation of these people and what small amounts of spending monies, are available to them. It is a practice in nursing homes and boarding homes, to put monies in a trust and draw interest on this money. The client often unable to spend the money risks losing B.S.S.I. by over saving the amount to be eligible. The status of these savings is not defined.
2. Housing needs for isolated individuals.

3. A look at Federal regulations that do not mandate the scope of activities of S.R.S. services to the elderly. Often in rural counties there are no developed services for the elderly and they are excluded from services which could be offered on a sliding scale.

4. Better linkages must be developed between Social Services and the Social Security Administration sharing information, at present this link seems to function only between Public Assistance and SSA.

5. Regular and periodic physical screening for health problems should be built into the system. If this was cost benefited the savings would be greater and social costs lessened.

ITEM 7. LETTER AND ENCLOSURE FROM ADELINA ORTIZ DE HILL, NEW MEXICO HIGHLANDS UNIVERSITY, LAS VEGAS, N. MEX.: TO SENATOR PETE V. DOMENICI, COMMITTEE ON AGING, DATED JUNE 24, 1974

DEAR SENATOR DOMENICI: Thank you, I very much appreciate your concern in boarding homes. Your involvement has changed the lives of the resident for the better. Many more persons have expressed concern and certainly more activities have resulted because of it. The State Pharmaceutical Board has stepped into monitoring the distribution and use of drugs and licensing procedures are being better enforced.

I appreciate the opportunity to express my concerns and make recommendations. In response to your request I have enclosed some thoughts on standard settings for boarding homes. I had submitted a packet I developed to the Committee earlier, this was an attempt to seek alternatives rather than depend on one resource for the care of isolated elderly. Family Foster Care and Group Homes are possibilities in this area.

Once again I am assisting the A.A.R.P. in this state in the preparation of testimony before the State Legislative Committee. We are better organized this year and with a longer session may be able to achieve something in this area. The hearing is scheduled for July 24. I will testify and present information at that time.

Perhaps if we persist at all levels of concern we can effectively alleviate the problems that revolve around boarding homes. I certainly hope so, thank you again and God bless you.

Sincerely,

ADELINA ORTIZ DE HILL.

[Enclosure]

Perhaps some safeguards that could be recommended are:

Charges should be assessed on a sliding scale according to need rather than in a flat fee. Aging is relative and various individuals function and demonstrate various capacities. I mentioned the Hawaiian plan of graduated payments.

Another possibility along this line might be to have boarding homes licensed for varying levels of care. There is a wild mix in boarding homes of young, mentally disturbed, disabled and isolated aged. Perhaps more homogenous populations would provide for more individualized programs and payments be made according to need. Perhaps compensation could be given for at least two levels of care.

Level I (*Any of these three circumstances could apply*)

a. Special diet (low sodium or diabetic), etc.
b. Assistance with dressing, grooming and laundry.
c. Low activity level or not ambulatory.
d. Incontinent.
e. Disoriented, not alert mentally, assistance in purchase of needs.
f. Not needing skilled nursing, but observation, in which case not all of these services would apply.

Since these individuals will be more homebound, the milieu should be supportive and meeting all the needs, of constant supervision and monitoring the resident. Compensation should be at least $220.00 per month with no more than four persons placed in an ordinary home meeting space requirements.

Level II

a. Balanced nutritious three meals with tea or coffee, snack at mid-morning and mid-afternoon.
b. Laundry facilities and space for grooming.

c. Space for activities and yard space.
d. Bathing facilities and sanitary facilities, one for every seven boarders.
e. Outside activities, contact and independence encouraged.

No more than eight persons should reside in an ordinary four bedroom home. Payment should range according to the ability of client to be involved in upkeep and own participation in care.

In cases of mental incompetency due to physical or emotional decline such persons should have guardians appointed to monitor needs, expenses and purchase necessities. I pointed out that there are questionable practices in regard to this in nursing homes and is often the case as well in boarding homes. I strongly recommend that a social worker employed outside the boarding home be responsible.

I understand that B.S.S.I. does require accounting when institutions are made payee. I believe it is a common practice to make the boarding home resident payee. Often the check is cashed by the operator and how much given to the resident is not known and various amounts reported. There should be strong legal sanctions against exploiting payees in these circumstances.

Standards under which payments are made should provide for adequate life space so vital to mental health with privacy, activity areas and sanitary facilities. We should discourage large homes of over eight persons. Records should be kept and outside activities encouraged.

Dining space should be adequate enough so that all residents can sit down at a meal at the same time. I have observed homes that have a table and four chairs and meals are served in staggered shifts. Meals should be nutritious and balanced.

Some of the implications of these recommendations will be that:

1. Enforcement will be a headache unless some cooperative effort is developed between states and the Federal Government. At present I still believe that social services (though historically more concerned with protective services for children) could be mandated to act in this area.

2. That many operators that are currently unmonitored and use to their own kind of management in this area will close down. This will create some chaos until such time as better homes are found and encouraged with more payment and better standards.

3. The uneven development of this type of housing has resulted in impacted areas, with people far removed from their home communities. More even development and more homes should be encouraged to avoid these pitfalls and because we can expect this type of population to grow for two reasons in particular More people are living to an old age and upward mobility in our society has been disruptive of nuclear family ties and helped create this type of isolated individual.

ITEM 8. LETTER AND ENCLOSURE FROM LAWRENCE C. BROWN, DIRECTOR, NEW MEXICO HEALTH AND SOCIAL SERVICES DEPARTMENT; TO SENATOR PETE V. DOMENICI, COMMITTEE ON AGING, DATED JUNE 24, 1974

DEAR SENATOR DOMENICI: Here is the New Mexico Board and Room Evaluation Study referred to in my testimony before the Special Committee on Aging:

1. The study was directed towards determining the needs of a board and room client in regards to a higher level of care, as in a shelter care facility or a nursing home. The client was found to be in need of a higher level of care, if (a) he could not care for himself adequately and (b) being unable to provide adequate self-care, the client did not receive adequate care in the boarding home. Because of the emphasis of this study on determining the need for a higher level of care, the study may have had a built-in bias. The actual living conditions of the client were examined indirectly, although the necessary information was readily extracted.

2. Although some homes do not meet the minimum licensing standards for boarding homes in New Mexico, the State Health Agency is now in the process of reevaluating and upgrading those homes not meeting the current standards.

3. In Las Vegas (San Miguel County) a somewhat unusual boarding home situation exists, in that many boarding home clients are former patients of New Mexico State Hospital in Las Vegas (some of whom are still outpatients). Of these clients, most of them formerly resided in other counties but upon release from the State Hospital did not return to their homes, because a) the relatives did not want to associate with the client any longer, or b) there were no board-

ing homes in their former community. Because many ex-patients never return to their community, Las Vegas has the highest number of boarding homes per capita in the state. In other counties, it appeared that most boarding home clients lived with their relatives; however, in San Miguel County this was not usually the case as the clients lived in commercial boarding homes run by non-relatives. Because of the atypical situation in San Miguel County, the condition of the boarding homes here may not reflect those in the rest of the state.

4. Where the boarding home client was living with relatives, the living situation usually seemed to be quite positive; this attitude was impled by occasonal case-worker comments on the study forms. However, where the clients boarded with non-relatives, the living situations appeared to be mostly neutral, but occasional positive or negative comments were made about the living situation. No exact figures could be found on the number of clients living with relatives or with non-relatives because this information was not required on the form, but it was either given by the worker or found indirectly. However, clients living in unlicensed boarding homes were more likely to be with relatives than if they were in licensed homes.

The results of the study are summarized as follows, with first a summary from San Miguel County and then the nine-county summary. The nine counties studied were: San Miguel, Santa Fe, Rio Arriba, Bernalillo, East Valencia, West Valencia (East and West Valencia are separate SSA administrative areas), Torrance, Dona Ana and Luna Counties.

In San Miguel County, *106* clients in Board and Room arrangements were studied; of these, *23* were aged and *83* were disabled. *Ninety-three* (87.7%) clients were able to provide adequate self care, with no change in living arrangements indicated, nor were protective services indicated. All but two of the clients were contented. Of the *93* clients, one was not provided with adequate care from the boarding home. *Ten* (9.4%) clients were unable to adequately care for themselves; however, no indication was given that living arrangements should change, nor was there any indication given that protective services were needed. These *10* clients were not living with relatives. *One* (0.9%) client, who was not living with relatives, was unable to provide adequate self care, with no change in living arrangements indicated; however, protective services were indicated. *Two* (1.9%) clients who were disabled and not living with relatives; however, recommendations were given that the living conditions be changed to shelter care. Protective services were not recommended for these clients.

In the nine counties, *683* clients living in Board and Room arrangements were studied, *200* (29.3%) of whom were aged, *6* (0.9%) were blind, and *477* (69.8%) were disabled. *Five hundred and seventy-four* (84.1%) clients were able to provide adequate self care, with no change in living arrangements or protective services indicated. Nearly all were contented. *Three* of these clients did not receive adequate care from their boarding homes. *Five* (0.7%) clients were able to provide adequate self care, with no change in living conditions indicated; however, protective services were indicated. *Ninety-five* (13.9%) clients were unable to provide adequate self care; however, neither changes in living conditions nor protective services were recommended. *Three* of these clients did not receive adequate care from the boarding homes. *Four* (0.6%) clients were not able to provide adequate care for themselves; although protective services were indicated, a change in living arrangements were not. *Five* (0.7%) clients were recommended for a higher level of care; of these clients, two were able to provide adequate self-care, three were not; *2* clients did not receive adequate care from the boarding home.

From the San Miguel County summary and from the nine-county summary, the following information can be gleaned:

1. Most clients were able to care for themselves adequately and were generally content living in boarding homes.

2. Of those clients unable to care for themselves adequately, the care they received was adequate.

Also enclosed for your information is the document which describes our study, along with the instructions and form used to carry it out.[1]

Sincerely yours,

LAWRENCE C. BROWN,
Director.

[Enclosure]

[1] Forms retained in committee files.

STATE OF NEW MEXICO, HEALTH AND SOCIAL SERVICES DEPARTMENT,
PUBLIC ASSISTANCE AGENCY

INTERDEPARTMENTAL MEMORANDUM

[PAA-Gi 73-148]

To: All Public Assistance and Social Services Staffs.
From: Charles Lopez, Director, Public Assistance Agency; Lawrence C. Brown, Director, Social Services Agency.
Subject: Project study to determine appropriate level of care for adult clients presently living in board and room arrangements.

Effective October 1, 1973 the Department will initiate a statewide review of current public assistance recipient cases in which adult clients are living under a board and room arrangement. The purpose of this study is to determine the adequacy of present living arrangement for each client's needs and desires and to offer opportunities for change to a more appropriate type of service and care.

The study will be carried out through the coordinated efforts of the Public Assistance Staff, the Social Services Agency Staff, the client's physician, and the New Mexico Foundation for Medical Care. Essentially the various functions will be:

1. Case identification	PAA staff (local)
2. Referral of client for study	PAA staff (local
3. Interview with client for services and screening	SSA staff (local)
4. Approval of medical examinations when needed	PAA—MAD
5. Arrangement for needed medical examinations	SSA staff (local)
6. Recommendation of a higher level of care	Client's Physician
7. Evaluation, approval/disapproval of the recommended higher level of care	N.M.F.M.C.
8. Services to client for the recommended level of care	SAA staff (local)
9. Eligibility determinations for recommended living arrangement, authorization of appropriate payments	PAA staff (local)
10. Service follow-up with client subsequent to evaluation	SSA staff (local)

PROCEDURES FOR THE STUDY

A. Public assistance county staff

1. *Case Identification.*—Each PA worker carrying active AABD cases is to review the caseload to determine those AABD cases in which the client lives in a board and room arrangement. This includes clients in (1) licensed boarding homes, (2) unlicensed boarding homes, (3) shelter homes, and (4) clients living with relatives or friends in which a board and room arrangement is recognized and budgeted. The county's FA payroll for the month indicates those cases *reported* as receiving board and room and are coded "1" or "2" under the "Special Care" column. It is recognized that counties may not have reported, through form 198, all cases involving board and room or shelter home care as Special Care, (e.g., the client receiving board and room from a close relative). Therefore, counties will need to identify those cases by means other than the payroll.

2. *Referral to Social Services Agency.*—Each individual client identified as living in a board and room arrangement is to be referred to the local Social Services Agency by means of the Evaluation and Review Form. (See attached copy of ER Form and Instructions for the form). The worker will also include the referral whatever medical and social information is available that is considered pertinent to the evaluation. This might include copies of medical reports which will be attached to the ER form. Generally, reports that are over two years old would be of questionable value. In the case of an AD or ANB client whose disability has been established, judgment will need to be exercised in each case, as to what medical reports and information that may have been gathered earlier for disability determination will be useful in studying the client's current circumstances and need for care, to avoid copying of extraneous material.

Before referral forms are transmitted to the Social Services Agency, it will be necessary for each county to establish a control point in the office to process and list each referral. The forms should be batched and sent daily with a dated cover tabulation listing each referral by category, case number and client's name. The listing will be made in triplicate, the original kept in the county office, one copy

sent to the SSA County Director, together with the referrals, and a copy sent to Central Office, Public Assistance Statistical Unit.

Referral of all the active cases is to be accomplished before November 1, 1973. Thereafter, new cases of clients living in a room and board arrangement will be referred to Social Services at the time of approval and whenever a recipient decides to live in a room and board arrangement. Referral of new clients will be made on the "Evaluation and Review Form" until December 31, 1973 only. Thereafter, they will be made on regular referral Form REF 008.

3. *Eligibility determination and payment adjustment in cases recommended for a higher level of care.*—As soon as the Social Services Agency has completed the screening process in a case, the Social Services worker will return a completed copy of the screening Form "Evaluation and Review" to the PA worker to make known the findings.

When the SSA worker determines that the client should remain in a board and room arrangement, this will be indicated under Item 31 of the Evaluation and Review Form. No further action will need to be taken on the part of the PA worker if the client is to remain in his present arrangement. If a client is found in need of higher level of care as recommended by a physician, the PA worker will determine the client's eligibility for such care and advise the SSA worker of the determination. The SSA worker will advise the PA worker of the client's decision and, if the client decides to follow the recommendation for care, both workers will work closely in coordinating their functions to arrange for the client to receive the recommended care. The PA worker will discuss with the client the effect such change in living arrangements will have on the assistance payment and to explain to the client any possible medical care credit from client's income which he may be expected to turn over to the facility toward his care.

B. Social services county staff

1. Upon receipt of a referral (Form ER) and medical-social information from PAA identifying the client, the SSA worker assigned to the case will schedule an appointment with the client to complete the Evaluation and Review Form. Items in Section II of Form ER will be discussed with the client and his need for care assessed following this review. If the client's current condition warrants a medical evaluation to help determine the level of care needed, the Social Services worker will request prior approval for an examination from the Supervisor of Medical Care. Medical Assistance Division-PAA address:

Supervisor of Medical Care
Medical Assistance Division, Albuquerque Office
P.O. Box 25146
Albuquerque, New Mexico 87125

See Part C, 1 for the procedures to be followed in requesting a medical examination. If the examination is approved, the SSA worker will then assist the client in obtaining the medical work as authorized.

After receiving the report from the client's director, the SSA worker will review the medical report. If the client's doctor has recommended skilled nursing facility care or ICF, the doctor will then be requested to complete Form FMC 401 "Patient Transfer" which will be submitted to the Supervisor of Medical Care for review by the Foundation for Medical Care for their evaluation of level of care needed. See Part D for procedures to request evaluation and approval by the Foundation for Medical Care. If a higher level of care is approved by FMC and the client wishes such care, the SSA worker will refer the matter to the PAA worker to determine eligibility, make appropriate budgetary adjustment and to plan jointly to move the client to another level of care. The yellow copy of the completed ER Form will be sent to the PAA worker to be made a part of the client's PAA record.

2. If the SSA worker and the client complete the ER Form and agree that the board and care arrangement is satisfactory, or if the client refuses a medical evaluation, or refuses to change his living arrangements, or if the Supervisor of Medical Care disapproves a request for a medical evaluation, the review will be considered completed, facts noted on the form and the yellow copy of the ER Form will be sent to the local PAA for its records. The original form will become a part of the SSA record. In all cases, the original ER Form will be retained by SSA and the yellow copy will be sent to PAA. In those cases where authorization

for a medical evaluation is requested, the pink copy of the ER Form will be sent to the Supervisor of Medical Care.

Social Services Agency county offices will provide a monthly report to the Social Services Agency, Statistical Unit in Central Office, indicating the following information:

a. The number of public assistance clients screened by listing each individual case;

b. The clients determined not in need of a higher level of care, i.e., hospital, skilled nursing home or intermediate care facility;

c. The clients in need of a higher level of care but client elected to remain in present living arrangement; and

d. The clients in need of a higher level of care and either transferred or awaiting transfer to (1) a skilled nursing home or (2) an intermediate care facility.

The report containing the above information will be submitted no later than the fifth working day of each month.

A control and reporting system will be established by each county SSA office in order to tabulate the above information on the reviews processed.

C. Review and Approval to obtain Current Medical Information—Medical Assistance Division—PAA

1. *Prior Approval for Medical Evaluations during the Screening.*—If during the screening process the SSA worker determines that a medical evaluation of a client is needed to determine the extent of care and services the client may require, approval for a medical examination will be requested from the Supervisor of Medical Care. The SSA worker will forward to the Supervisor of Medical Care the pink copy of the Evaluation and Review Form (parts 1 and 2 completed) and a Form 309 "Authorization/Approval Medical Services" and attach whatever other medical information may be available. Only the client identification items and the name and address of the client's physician will be entered on Form 309 and signed by the SSA workers. The request for a medical examination should also be indicated under Item 31 of the Evaluation and Review Form.

a. *Request Approved.*—If the Supervisor of Medical Care approves a medical examination, the Form 309 authorizing the examination will be returned to the SSA worker. The Supervisor of Medical Care will include on the Form information to the client's physician describing the specific type of examination required. The SSA worker will send the white copy of Form 309 to the examining physician and forward the yellow copy to the PA county office for filing as per the regular instructions for the form. The goldenrod copy may be retained in the client's Social Services case folder. (The Supervisor of Medical Care will retain the pink copy.)

b. *Request disapproved.*—If a request is denied by the Supervisor of Medical Care, he will return Form 309 and the Evaluation and Review Form to the SSA worker indicating disapproval on Form 309 and the reason for denial of the request.

2. *Report of Medical Examination.*—The SSA worker will request the client's physician to submit his medical report to the SSA county office. After review of the report, the SSA worker will indicate on the Evaluation and Review Form under item 35 whether or not the examining physician recommends a higher level of care for the client. The SSA worker will attach the original medical report to the yellow copy of the Evaluation and Review Form and forward them to the PA worker.

D. Review and Approval of Doctor's Recommendation for care in a skilled nursing facility or ICF—New Mexico foundation for medical care

1. *Prior authorization for client entering a skilled nursing home or intermediate care facility.*—If the client's attending physician recommends that the client be transferred to a skilled nursing facility or intermediate care facility and the client agrees to such a transfer, the SSA worker will request the client's physician to complete a Patent Transfer FMC Form (Foundation for Medical Care Form No 401), instructing him to leave Item 6 blank. Once the FMC Form is completed, the SSA worker will submit it to the Supervisor of Medical Care, with a cover memo requesting review and approval by the NMFMC prior to planning transfer of the client. The Supervisor of Medical Care will forward the request to the appropriate personnel at the Foundation for evaluation and decision. The Foundation will return the form to Supervisor of Medical Care with its recommendation, and he will forward it to the SSA worker.

2. *Recommendation Approved.*—If the Foundation approves the recommended level of care for the client, the SSA worker will, at the time client enters a facility, insert on the FMC Form (4 copies) under Item 6 the name of the facility to which the client is being admitted and forward the copies as follows:

White—to nursing facility or ICF
Yellow—to Foundation for Medical Care
Pink—to attending physician
Goldenrod—to PAA county office

3. *Recommendation not Approved.*—If the recommendation that the client be transferred to a skilled nursing facility or an ICF is disapproved by the Foundation, the SSA worker, upon receiving the disapproval notice from the Foundation, will inform the client and his doctor of the decision and offer him any alternative services that the Agency is able to provide. The SSA worker also will notify the PAA worker of the disapproval decision. The white copy of the FMC Form 401 may be filed in the clients Social Services record, the pink copy forwarded to the client's physician and the goldenrod copy forwarded to the PAA worker to be filed in the client's case record. (The Foundation will retain the yellow copy.)

FORMS REQUIRED

ER Form.—*"Evaluation and Review."*—(Used by PAA and SSA) an initial supply of Evaluation and Review Forms are being sent to each PAA county Office. The Form will be used by (1) the PAA worker to initiate referral of clients living in a board and room arrangement to the Social Services Agency and (2) the SSA worker to record findings of the study of a client and the recommendations regarding a client's care. This form is not available from the stockroom. PAA county offices needing an additional supply of this form will request it by memorandum, from the Financial Assistance Division, PAA, Room 526, Central Office.

FMC Form 401.—*"PT Evaluation."*—(Used by attending physician) an initial supply of Patient Transfer (PT) Forms are being sent to each SSA county office. This form will be given by the SSA worker to the client's physician for completing in those cases in which the physician recommends either skilled nursing care or intermediate care for the client. The information will be used by the Foundation for Medical Care to approve or disapprove the recommendation of the client's physician that the client be placed in a facility which provides a higher level of care. This form is not available from the stockroom. SSA county offices needing an additional supply of this form will request it by memorandum, from the Program Development Division, SSA, Central Office.

ITEM 9. PREPARED STATEMENT OF THOMAS J. SHINAS, DEPUTY DIRECTOR, STATE HEALTH AGENCY, HEALTH AND SOCIAL SERVICES DEPARTMENT, SANTA FE, N. MEX.

Mr. Chairman, prior to licensure law July 1, 1972, some 150 plus boarding homes were identified statewide. By November 1972, applications were received from 86 facilities—72 of them were licensed. A number of homes had correctable deficiencies and were, therefore, given temporary licenses. Upon receipt of a plan of correction and a follow-up visit to inspect completion of these deficiencies, an annual license was issued. Since November 1972 to date, 15 homes have had their licenses suspended or not renewed. Since January 1974, licensure personnel made 60 inspections on a state-wide basis. By June 30, 1974 we will have contacted at least 30 more. Some calls were on a routine basis; others on follow-up activities and yet others after receiving a complaint. We also use local government personnel such as sanitarians; fire prevention specialists; as well as Social Service caseworkers and Public Assistance caseworkers to assist us in local monitoring of facilities. There are four licensure representatives on the staff at the state level plus the chief of the unit. At our request, in the fall of 1973, we were granted a budget increase commencing July 1, 1974 to secure two additional representatives. We are also planning on adding a nutritionist to the staff for dietary consultation to facilities. The boarding home industry, though it may be a loose term at this point in time, was for years a family's way of using the extra room in the house. Widows or couples would use extra rooms to take in boarders. No licensure was required. Then came the massive unloading of institutional clientele, backward people in mental hospitals and institutions for

the mentally retarded plus the fact that people are living longer and, I'm sorry to say, old people are sometimes not wanted. The independent and homeless individual tried to find a home with his welfare check. Those who were merely old but had no serious handicap did much better for the most part in finding a place to live; but those who were handicapped with strokes, diabetes, arthritis, and mental or emotional problems or any debilitating disease had a harder time of it because boarding homes were not equipped or staffed to care for this type of need. Interestingly enough though, many boarding homes took these people in anyway, and today I venture to say that a great number of boarding home clients need something more than room and board. I might say in defense of many good boarding homes that they have accepted many responsibilities of care for a very minimal amount of money because we must remember that the boarding home law requires only board and room in an otherwise living independent situation with no other services mandated. If, however, a large number of boarding home clients do need additional services, it seems obvious that we must identify that level of need to accommodate the needs of clients. HEW is now in the process of broadening the intermediate care facility category downward in recognition of this need. This means the gap between the original intent of ICF's and boarding homes will be narrowed. Essentially the program will pick up more people who need long-term custodial care, intermittent nursing on a consultative basis and medications. This new program should help considerably. As for the boarding homes who cannot meet a reasonable standard of service, we will have to work hard to help them improve or revoke their license. With additional staff in July and the assistance of a nutritionist, we fully intend to launch an all out effort. We are also planning on locating inspectors on a district level to allow for easier follow-up visits rather than maintain a central location with long distances of travel. This will assure regular assessibility to boarding homes as well as other licensable facilities in the immediate area.

Finally, to offer some suggestions toward improvement above and beyond what I have already said, since boarding homes are a business they should, like any business, bill for their services in a manner consistent with other HEW programs like nursing homes or ICF's. Payments should be based on the cost of service plus the right of audit of those costs. This could eliminate, to a great degree, a system that merely provides for a payment on the basis of whatever the traffic will bear. Unfortunately, federal regulations prohibit this possibility at this time. Though I recognize that room and board means exactly that, BSSI clients who choose a boarding home to live in cannot receive any food assistance through the Food Stamp Program. It may be that some system or formula could be developed to assist in the area of food and nutrition. In a sense, the boarding home client is discriminated against. However, since nutrition appears regularly among our complaints, it would seem that some supplemental food, through the Stamp Program, would help that problem.

In summary, I wish to reiterate that the State Health Agency of Health and Social Services Department will continue to do everything in its power to maintain a strong surveillance of boarding homes and continue to welcome the comments of community groups who have a great concern for the elderly so that this young industry known as boarding home care to not only grow in stature but provide a safe home environment for those who are homeless.

ITEM 10. SUPPLEMENTAL STATEMENT OF K. ROSE WOOD, DIRECTOR, STATE COMMISSION ON AGING, SANTA FE, N. MEX.

In May, 1974, New Mexico has more than 116,000 persons aged 60 and over, with about 30% with incomes below the poverty level. Priority needs identified by some 4,500 senior citizens in 86 forums conducted around the state in 1971–72 were as follows and in this order: (1) Health Care, (2) Income Maintenance, (3) transportation, (4) Low and Middle Income Housing, (5) Better Living in Retirement, (6) Nutrition, (7) Education, and (8) Employment.

In the spring of 1974, results of a survey of needs of senior citizens in eight northern counties of Colfax, Los Alamos, Mora, Rio Arriba, Sandoval, San Miguel, Santa Fe, and Taos, the chief barriers to health care for the elderly were listed as isolation, lack of transportation, poor roads, insufficient income, high costs of medicine and medical services, education, and sanitation. Resources listed which could help break down the barriers included: home health services, nutrition, telephone reassurance, homemakers, improved nursing and boarding homes, tax relief, and better housing.

The Commission, as the State Advocate for the elderly, attempts to meet these needs through programs it is able to fund, or has funded since 1966, in 22 of the state's 32 counties with titled program allotments under the Older Americans Act of 1965 as amended (PL 93–29). Individuals are not served directly by the Agency as our clients are communities with such organizations as councils of governments, community action agencies, city councils and county commissions as clients, which in turn provide direct services through approved, planned activities. Major responsibilities, therefore, are in the field of Gerontology and not in Geriatrics, and so the Agency cannot be said to be in the fields of health or medical care for the elderly.

However, we are very much aware of the problems of attacking the barriers to health care which are well-known to be serious in New Mexico and many . . . Division of the state by Executive Order and statutes into 7 Planning and Service Areas (PSA's) facilitated the Commission's mandate to work within these areas to develop comprehensive plans for designation of sub-state or Area Agencies on Aging (AAA's) responsible for insuring delivery of needed services to elderly within their jurisdictions. As of July 1, the Commission will have in operation, six Area Agencies under earmarked funds provided by Title III of the Older Americans Act; 20 multi-purpose community services projects under another source of Title III, and six Nutrition Programs for the Elderly in seven counties under Title VII of the Act. Complementing these services are ten Retired Volunteer Service Programs with hundreds of volunteers serving young and old in ten cities or counties. RSVP stations include hospitals, nursing homes, and other health care facilities, clinics, churches, schools, welfare offices, and also the private homes of elderly shut-ins who might need institutionalization if planned home visiting were not available.

In other efforts to break some of the barriers to health care through senior center programs, mini-bus transportation facilities, social and recreation activities, counseling, and information and referral services, two major thrusts are being made. The primary one is in nutrition education and provision of hot, nutritious meals five days per week to approximately 2,057 older people in low income and minority ethnic groups. It is recognized, with both shame and embarrassment, that thousands more should be included to break down the barriers to poverty as well as health care, but a small but good beginning has been made and both state and local governments are becoming increasingly aware of the value and need for nutrition programs and their battery of supportive services. Local officials are beginning to concede that a "fair share" of their Revenue Sharing funds might be used to expand the meals service, or even to start a meals-on-wheels or home delivery service on a small scale to confront their awareness to the plight of older residents who insist upon remaining in, and should remain in, their own homes so long as possible rather than move into poor boarding homes or expensive health care facilities.

The second thrust at the barriers was made almost accidentally one day when a staff member of the Commission on Aging was in a podiatrist's office for treatment of a sprained ankle. She remarked to the foot doctor that when she met with groups of older people she couldn't help but notice their feet and their shoes. They seem to "walk funny", as if their feet hurt or their shoes didn't fit. She wondered if the young podiatrist wouldn't like to help set up a clinic for older people, and possibly develop some special training for personnel in health care facilities so that patients could be "kept walking" and moving instead of sitting around all times in their places of residence. . .

The podiatrist, Ronald Wilner, D.P.M., of Santa Fe, an active member in the State podiatry society, liked the idea and began reading material on podogeriatrics and the need to advance pedal health among the aged and chronically ill. The national society became interested, and eventually Dr. Wilner filed an application for a training grant under title III for a project to be conducted by the State society in cooperation with the School of Medicine, University of New Mexico, Albuquerque, and the state association of administrators of health care facilities (formerly nursing homes).

A three-day seminar was held in Albuquerque May 10–12, 1973, in which 60 personnel from health care facilities participated with great enthusiasm. Over 16 applications were received and strong demands were made for a series of workshops as no one had previously experienced the novelty and practical application of podogeriatric training which proved to be beneficial not only to their many patients and clients, but to the participants themselves. The

materials, techniques, and ideas presented in the seminar were termed successful in the diagnosis and treatment of the following five major needs: arthritic deformities, diabetic manifestations, care of excrescences, skin and nail care, and proper foot gear. Guidelines for foot care in extended care facilities were developed and trainees returned to their jobs enabled to give more attention to individual patients' problems and to integrate foot care with required and expected general health care routines.

The Commission on Aging has applied for additional funds to enable Dr. Wilner and the State Podiatry Society to conduct at least two more workshops in two other areas in New Mexico to enable more practitioners and professionals to improve the general well-being of the elderly and to keep them walking and moving with more freedom, comfort, and dignity.

Appendix 2

REPORT ON THE NEW MEXICO BOARDINGHOME ASSOCIATION

PRESENTED TO: HONORABLE PETE V. DOMENICI—FROM: VAL J. HALAMANDARIS, ASSOCIATE COUNSEL, U.S. SENATE SPECIAL COMMITTEE ON AGING

I. BACKGROUND

In recent months, the New Mexico press has carried stories sharply critical of the boarding home situation in New Mexico. At the request of Senator Domenici, I talked with state and local officials, critics and boarding home operators in an attempt to assess the current situation and to suggest possible solutions.

II. THE CHARGES

The charges levied at boarding home operators by critics and some state officials include: poor food; negligence leading to death or injury; deliberate physical punishment inflicted by operators on their residents; poor care, i.e. allowing patients to sit in their own urine, binding them to the toilet with sheets and not cutting toenails to the point they curl up under the feet making walking impossible. A recurrent charge is profiteering, that is, cutting back on food, light, water and heat to save money. One state official told of a home's policy to make all patients use the toilet before it could be flushed in the morning ostensibly to save water. Other state people pointed out several make-shift houses including a former chicken coop which kept patients until it was closed last week.

CONCLUSIONS OF THE INVESTIGATOR

After visiting several boarding homes and talking with many state and local officials as well as critics, senior citizen representatives and boarding home operators themselves, I am convinced that the above charges are valid in the majority of New Mexico's boarding homes. Some facilities were nothing less than reprehensible. Immediate action is necessary on the part of state, local and federal officials to ameliorate the problem and to remove many patients from direct physical jeopardy.

After my visit to New Mexico, I am even more convinced that the conditions here are symbolic of problems which exist in each of our 50 states. The boarding homes in New Mexico, as bad as they are, are no worse than those I visited in downtown Washington, D.C. or Chicago, Illinois.

III. THE CAUSES OF THE PROBLEM

The primary cause of the current problem include:

(a) The Pressure on States to Empty State Mental Hospitals.

(b) The lack of suitable alternative housing and/or supportive services to maintain individuals in their own homes.

(c) The Impact of the new Federal Supplemental Security Income (SSI) program and the lack of accountability of SSI funds.

(d) The Lax enforcement of State regulations with respect to boarding homes.

These causes are discussed in more detail as follows:

A. *The Pressure to Empty State Mental Hospitals.*—All 50 states have underway programs to discharge the aged from state hospitals into smaller community based facilities including boarding homes. In the U.S. in general, there were 131,000 aged in state mental hospitals in 1969 and about 80,000 at the end of

1973 or a *40* percent drop in just 4 years. The number of mental patients of all ages in U.S. mental institutions decreased 29 percent during this same period.

In New Mexico, there were 700 patients in 1969 dropping to 400 at the end of 1973. *There were 168 over age, 65 in 1969 and only 61 left at the end of 1973.* These facts show the national and local trend to dump patients out of state hospitals. The reasons for the trend are: *humanitarianism*, the idea that state hospitals are "snake pits" and that human beings are better off virtually anyplace else; recent *court decisions* which require that patients committed to state hospitals have right to treatment and that if they fail to receive such treatment, they must be released—states have decided to release patients instead of going to the trouble of treating them; *cost*, the average patient in a state mental hospital costs $800 a month to take care of and such payments to state hospitals are invariably *state* money. Given the tortured condition of state budgets, many states are discharging patients on to their welfare roles because Congress 2 years ago Federalized the welfare program for indigents. Accordingly, the patient placed on the welfare roles would be eligible for $140 in Federal Supplementary Security Income payments and could be housed in a boarding home for this amount. The saving to the state in replacing state with federal dollars is astronomical.

It is significant that almost all the residents in Las Vegas boarding homes were former patients in the State hospital who were placed in facilities by personnel for the State Social Services Agency. The majority of patients in Bernalillo County likewise were former patients or had a history of mental disabilities.

B. *The Lack of Suitable Alternatives and/or Supportive Services.*—Experts unanimously agree that most of the residents in boarding homes are there because they could not live alone. They need some help getting dressed or with baths or some supervision in taking medications. They are not physically ill; rather, they are dependent and in need of support.

Suitable alternative housing is not available in New Mexico nor is there the adequate supportive services to maintain these individuals assuming that they had homes or relatives (which most do not). Nevertheless, some could live almost independently if they had minimum supervision and the services of homemakers to help prepare meals, to help with baths, supervise medications, etc.

C. *The Impact of the new Supplementary Security Income program and the lack of accountability of SSI funds.*—Most rates for boarding home care in New Mexico are geared to the SSI rate which pays $140 per month. In a few cases, the residents have small social security or other pension checks which pay their own way. In still fewer cases, the relatives subsidize the resident's stay. Rates increase with ability to pay. Some residents pay as high as $385 a month.

A significant problem exists with respect to SSI checks and other government annuity checks. Such checks are delivered to the boarding home with the resident named as payee. The resident endorses such checks over to the operator who then cashes them. There is presently no firm policy which limits how much of such checks a boarding home operator can keep. Some operators keep the entire $140. Others return $20 a month spending money to the resident for his personal use to buy cigarettes or have their hair done or whatever. In some cases, residents receive $200 in Social Security and never see it again after endorsing these checks. In some cases, they never see the checks at all—the endorsement is an "X" on the back of the check signed by the operator himself.

Accordingly, there is a crying need for some definite policy with respect to the treatment of personal expense money.

Yet another problem is the general lack of accountability with respect to SSI funds. Assuming an operator has 8 residents, all on SSI at $140 each, he will have a monthly income of about $1120. From this amount, one state official estimates utilities in one typical home would cost the operator about $20 and food no more than $200 monthly. The remainder, about $900 a month, is profit to the operator. All of the boarding homes presently operate at a profit in New Mexico and they fully understand that the more they spend, the less profit they will have; there is therefore a financial incentive in favor of poor care.

D. *The Law Enforcement of State Regulations.*—In 1972, the State of New Mexico enacted legislation requiring the licensure of all boarding homes. These standards include many of the requirements of the Residential Occupancy Provisions of the Life Safety Code of the National Fire Protection Association. Most states need to follow New Mexico's example and enact such legislation. Only

about 8 have such boarding home licensure laws now. In New Mexico, it is a matter of getting the law enforced. The law is not enforced because of:

1. Fragmentation of responsibility between Agencies in the State Department of Health and Social Services Department (HSSD). One agency is responsible for licensure and inspection; another is responsible for payment (Public Assistance) and a third is responsible for placing patients in homes (Social Services). To make matters worse, there is fragmentation of authority between other state and local agencies. State and County Fire Marshals are responsible, the City Housing and Development Departments and the City Environmental Health Departments and the City Environmental Health Departments all have some jurisdiction in addition to state people. The Department of Hospitals and Institutions also has its share of the blame. Everyone and no one is responsible.

2. A shortage of Inspection personnel in HSSD is another reason for the problem. There are only 3 inspectors in the state to inspect over 100 boarding homes, nursing homes, shelter care homes, hospitals, child day care centers and foster care homes. More than 2,000 facilities and 3 inspectors!

3. "There is no place to put them if we close boarding homes" is the common cry of state officials. This is like feeding a starving man arsenic on the rationale that it is better than no food at all. Some facilities must be closed and some state people are confident that the state could find places for them. It would be troublesome and costly but it must be done or the quality of care will remain at its preposterously low present level.

E. *The Attitudes of the Operators.*—What makes a good home more than anything else is the attitude of the operator. Good care is a function of will; not of dollars. More money would not improve the care. However, the state might seek to reward good homes with certificates and publicity to encourage good care. Many operators have heavy control on their residents by telling them "If you are not good, I will send you back to the State hospital." Some State action should intervene and prohibit the unilateral discharge of residents on the street or back to the State hospital.

IV. SUGGESTED SOLUTIONS

1. Senator Domenici introduces a bill in the Senate to require every boarding home with 3 or more SSI patients to conform to standards such as New Mexico has in effect.

2. Senator Domenici offers to cooperate with State officials in the enforcement of present standards. Specifically to support their request for more inspection personnel and plans for the consolidation of authority for inspection and licensure of boarding homes in one agency.

3. Encourage the State to require boarding homes with 3 or more patients to file their financial statements with the state and to adopt policies to vouchsafe part of SSI of Social Security checks as personal spending money for residents.

4. Senator Domenici sends a copy of the hearing record to HEW Secretary, Caspar Weinberger, who has authority under Public Law 90–248 to insure that no federal funds are going to facilities which do not fully meet state licensure requirements. Under such authority, the Secretary can promulgate a wide series of regulations to improve the boarding home situations in the 50 states.

5. Senator Domenici cosponsors S. 2960 introduced by Senator Muskie to broaden the scope of Medicare to provide expanded in-home services such as day care, home health, homemaker services, etc., to support individuals in their own homes and in independence as long as possible.

Appendix 3

STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. STATEMENT OF FELIX G. RAEL, STUDENT, NEW MEXICO HIGHLANDS UNIVERSITY, LAS VEGAS, N. MEX.

I am writing this statement as an active citizen who is concerned about the social problems that affect the boarding home residents in Las Vegas, N. Mex. I am an undergraduate student at New Mexico Highlands University, majoring in social work. My first experience in working with boarding home residents began when I was assigned field placement at the Social Service Agency to work with Linda Martinez, the boarding home caseworker.

Judging from my observations of the boarding homes I worked with, I find the main problems are focused around the operators not complying to the licensing regulations. A great deal of exploitation and intimidation by the boarding home operators was quite obvious during my internship.

Listed below are some of the examples of exploitation I witnessed that threatened the safety and mental health of the residents.

(1) Some operators did not even provide their residents with the nutritional meals. Residents in one particular home complained that their meals consisted of only beans and macaronis. The operator did not keep written records of menus nor did not serve the three meals required. Many of the residents informed me that they were hungry for meat or a variety of foods instead of the same servings.

(2) In all the boarding homes I have observed residents are not urged to keep their own personal lockers for their belongings. This creates friction between the residents. I have observed several incidents where clients accuse each other of stealing personal items.

(3) Many of the residents are not capable of being self-sufficient which is expected to a degree. There was an incident I observed where a resident was overdosed with medication. She was unable to change her bedding which was dirty. There was no effort by the operator to put clean sheets on the resident's bed. I think the management of linen and storage has to be improved by most operators.

(4) There is one boarding home I observed that has a hallway and a room, which lack sufficient light to make all parts of the area clearly visible. There is a telephone in the house, but it is not available to the residents. If the residents were to need help in case of a fire, they could not use the phone because it is locked. The operator lives apart from the boarding home and one of the residents has to call her in case of an emergency. I think this is neglecting the residents' safety.

In attempting to solve environmental and social problems in the boarding homes, there has been some impact made by community groups and agencies. I think there is need for even more community awareness which could have a positive effect on the development of programs for boarding home residents. For example, recreational programs are badly needed. Socializing with other people can improve the mental health of the residents. I also think boarding home residents are in poor physical health and there is need for programs that stress health education.

My recommendations to solve these problems would be to do something about boarding home operators who are not complying with licensing regulations and standards of the State's licensing division. I think that operators have to be made aware that these residents are human beings and they require adequate health standards and nutritional food. It is obvious to me that most operators see their residents as a source of income on a one-sided basis. The residents' needs are neglected and the operators are still making money.

ITEM 2. A PROPOSAL TO MINIMIZE THE HARDSHIPS ENCOUNTERED BY THE AGED

1. Establishment of a minimum living cost base yearly, fluctuating with the Consumer Price Index to take care of inflation.

2. Identification of all those above 65 years of age subsisting below this base. This can be done by the Internal Revenue Service on receipt of Income Tax Reports.

3. That the I. R. S. provide such persons with an Identification Card to identify them as earning less than the prescribed minimum base.

4. That this card enable card holders to obtain a graduated discount on all living costs including taxes in any form, such discounts to increase with age, for example:

Age:	Discount (Percent)
65	25
70	40
75	50
80	55

5. That discounts may also increase to the degree to which the card holder's income is below the established base.

6. That the Federal and State governments share in paying for such discounts as they do for transportation, education etc.

Sincerely,

SAMUEL ROSENBERG,
Editor, "Newsletter."

Appendix 4

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

If there had been time for everyone to speak at the hearing on "Barriers to Health Care for Older Americans," in Santa Fe, New Mexico, on May 25, 1974, I would have said:

The following replies were received:

LINDA V. MARTINEZ, LAS VEGAS, N. MEX.

Mr. Larry Brown, director of Social Service Agency, mentioned the survey which he said was done or rather filled out by caseworkers throughout the State. Well, I am a caseworker with a case load of 168 boarding home residents. I was given the surveys in October. First of all I would like to say that I feel this survey would have been very beneficial, however, our local agency wasn't even given the correct procedure or directions on how to properly fill out the survey form. Secondly, most of my boarding home residents were not even capable of giving me the information needed. And even if they would have mentioned their unhappiness with the home and their need for more care, their intimidating boarding home operator would have "reprimanded" them for it later.

One more point—if caseworkers are to adequately conduct a survey such as this, I feel they should be trained or at least versed on "problems of the aging," including isolation, health problems, et cetera. Thanks for listening to us.

I am the only caseworker for 168 boarding home residents who live in 32 boarding homes. Despite what many testified today about how there are really not too many problems in or with the boarding homes—I would like to say "bunk." I provide services for these people in the boarding homes and even though I am at the "bottom of the totem pole." I can truly say from working with these people that they are unjustly treated. I could give you many examples. Please feel free to call upon me if you should desire any examples.

ALBERT VALLEGOS, LAS VEGAS, N. MEX.

I am director of the Las Vegas-San Miguel Senior Citizens title III program. We provide a senior center with recreational activities for the elderly in the Las Vegas area. We provide limited transportation in and around Las Vegas to program activities, to medical facilities, and to other agencies dealing with elderly needs. We also provide in Las Vegas, a 50-meal-per-day meal program for the elderly. Our transportation program consists of one van and one five-passenger sedan. Our problems as I see them include the need for more facilities for the elderly, like senior centers and services for the elderly especially those living in rural areas. We have a large geographical area in San Miguel County and in order to begin to provide some of the essential services needed by the elderly, we need more transportation. Some of our participants come from boarding homes and many complaints about the treatment they get there, including lack of proper nutrition meals, and recreational activities. I feel part of the boarding home problems could be taken care of by State government, mainly licensing division. Many boarding home clients are not getting the essential everyday needs that most of us take for granted. I am a member of the Task

Force on Aging for district II which will later become the advisory committee for the new triple A. As you know NCNMEDD received a grant from the New Mexico Commission for planning. Once the plan is approved NCNMEDD will become the triple A for the district. My concern is that the funding level for the next fiscal year for district II is being reduced by $86,000. The number of elderly in the area has increased considerably and yet the funds are being reduced. Even though the Commission on Aging and NCNMEDD were aware that we were going to be cut since last January or February they have had us doing extensive planning to increase services in areas where expansion is needed and providing services in areas where they currently are nonexistent. There is nothing wrong with long-range planning, however, many elderly and other people have been involved in this plan and were led to believe that completion of this plan would mean additional services for the elderly as well as new programs in areas where they are now urgently needed, but do not exist. The reduction of $86,000 in fund for the district means that not only there will not be an expansion of services provided, but that there will be a reduction. For example our program in Las Vegas will be cut down about 37 percent of the Federal funds we're now receiving. Concerning the new triple A, I feel that it is not, at least at the present time, too concerned about receiving the funds for the district and becoming the triple A, even though the amount they will receive is considerably less than the district now has under the Commission on Aging. I also feel that the Federal law, concerning advisory councils or committees need to be strengthened to state that the action and recommendations of the advisory council on aging to the triple A must be taken into account before a policy decision is made by the triple A. The triple A (NCNMEDD) board now can override any input or recommendation made by the advisory council without consulting the advisory council and without any justification. The Triple A was not even concerned enough to be at this hearing.

I would also like to remind the Senator that there is a title V in the Older Americans Act that need funding.

MEL ORTIZ, SANTA FE, N. MEX.

Our society St. Vincent De Paul are very much involved with all people in need including our Senior Citizens. The matter of transportation and drugs has been pretty well covered and I favor a program paying for all drugs in total—also transportation especially in northern New Mexico where no public city or county transportation is available to get from one little town to a health clinic or doctor many miles away is a must in priority for all the poor and in particular for the aged.

Many of our older citizens that live in there own homes are always needy of help to do minor repairs to the home, yard, plumbing etc. For a person on Social Security to call a plumber or other professional to do a repair job at their home would mean half of their monthly income would be gone, at least. We in our society of St. Vincent De Paul try and help in this area plus all other needs. Our working income is derived from donation at church one Sunday each month.

On the matter of the son or daughter to take over the duty of caring for a parent. I favor this very much. It has been my experience however, that, a son or daughter willing to take the responsibility are penalized. My mother-in-law as an example was widowed and ill so we brought her to live with us free of any expense. We my wife and I had five children and at that time my income was not too great. We tried to get the Department of Welfare in our state to help her with medication, doctor and hospital bills if any were incurred, because her Social Security income was about $32.00 per month. The only way they would help was if she went out and rented her own place, live alone, etc. This is finally what she did thus costing the tax payer an additional out lay of cash for rent and utilities.

The State of New Mexico allows $38.00 towards rent and $18.00 for utilities under their welfare program—How ridiculous! Give the son or doughter a decent tax break and pick up the tab for *all* medical help needed and I feel you will find the parent being cared for by the immediate family rather than a nursing home. Make the Senior Citizen eligible for food stamps as an individual even though being cared for by their children who most likely is already overspending their household budget on food for the family without considering a father or mother on permanent basis.

I hope and pray to our Lord something good will come out of this hearing and feel free to call on me for help in this direction.

TROY A. NEWCOME, WHITE ROCK, N. MEX.

Having served 3½ years as a member of the New Mexico Commission on Aging, I had the opportunity to visit several boarding homes and two nursing homes and I found the service and sanitary conditions deplorable.

In 1972, through the combined efforts of the State Commission on Aging and other senior citizen groups, there was a law passed to set up standards of inspection and licensing of boarding homes which to date have been found inadequate and should be enforced more fully. There are not enough qualified inspectors to enforce this law as it now stands.

I believe with more funding and more qualified people directing this program it could be one of the finest in the country.

With the backing of the fine senior citizen groups and Commission on Aging this can be accomplished.

JO ROYBAL HOGUE (MRS. EUGENE), SANTA FE, N. MEX.

Enclosed are some clippings which concern the boarding homes in New Mexico.[1] They are self-explanatory. I have exhausted every avenue for help. After my exposé, the people who ran the boarding houses forbade me to enter the premises. And since I had no official title, they were within their rights.

My friend Miguel Archibeque is now dead. On his deathbed, his last request was that I continue to seek help for the senior citizens. Gentlemen, how can I help you help these poor forgotten souls?

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[1] Retained in committee files.

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