CONDITIONS AND PROBLEMS IN THE NATION'S NURSING HOMES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-NINTH CONGRESS

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MONDAY, FEBRUARY 15, 1965

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
Cleveland, Ohio.

The subcommittee met at 9:30 a.m., pursuant to call, in the Cleveland City Council Chamber, City Hall, Cleveland, Ohio, Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss and Young.

Committee staff members present: Messrs. Frank C. Frantz and Jay B. Constantine, professional staff members, and John Guy Miller, minority staff director.

Senator Moss. The hearing will come to order.

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

We are delighted to be in Cleveland this morning to hold this hearing. We welcome all of you who have come to testify before the committee and others who have come simply to observe and listen.

We are aware of the significance of the subject matter that we are considering this morning. This is a problem not only here in Cleveland and in Ohio; it is a problem throughout the Nation and one to which we are addressing ourselves.

I would like to explain briefly that this is an official hearing of the Senate. Everything that is said here will be taken down by a reporter and will be made part of the permanent record of our committee. Hearings of this kind are an important part of the legislative process. They are among the best ways for the experience and knowledge of people throughout the country to be made available to the legislative committees and the Members of Congress who must develop and act upon legislative proposals.

The problem of having proper facilities and services for all those who need regular and continuing care is a national problem—a problem of pressing concern in every State. The Federal Government already has established programs designed to help relieve the shortage of facilities and to help finance services.

However, it is time now to examine carefully this miscellany of Federal activities which has grown up over the recent years, to study the needs and problems as they currently exist, and to rethink the role of the Federal Government in assisting the long-term care field to develop. This is the task of our subcommittee.

To do this job we plan hearings such as this in cities throughout the country to learn firsthand from State officials, administrators, peo-

ple in the health profession, and other experts about the problems they face in maintaining standards and making progress toward realizing the potential of modern methods of care for the aged.

Some of these problems arise from the limitations of many State budgets. To take one example, we learned in our hearing in Indianapolis last week that the State fire marshal is allotted 12 inspectors for inspections throughout the State.

He testified that last year he received about 40,000 requests for inspections. A little arithmetic will show that to meet this workload, each of his staff would have to make and report an inspection approximately every 40 minutes—including travel time.

Obviously, it is impossible for them to have an effective inspection program. I do not say this to put blame upon the State. I am familiar with and sympathetic to the fiscal problems of State governments.

But we must face up to the fact that effective enforcement of regulations costs more than many States are now putting into it, and we must have effective enforcement.

Another problem is that of adequate payment for care. It is apparent that the quantity and quality of services which our modern society is beginning to demand are far more costly than we are accustomed to paying in most States. We must find a major breakthrough in the financing of long-term care.

As we resume this task today, I am particularly pleased to have with me my colleague—your Senator—Stephen Young. He is a member of this subcommittee, and it is our good fortune to have him, for he has been one of our most diligent and effective members.

Stephen Young and I have served in the Senate now for 6 years, and I count him one of the most effective Senators in the U.S. Senate, and one of my closest friends.

I would like to call on Steve for a comment at this time.

Senator Young.

STATEMENT BY HON. STEPHEN M. YOUNG, A U.S. SENATOR FROM OHIO

Senator YOUNG. Thank you very much, Chairman Ted Moss.

Of course I am happy to be back in my home city, and very happy to be with the distinguished Senator from Utah, who won the greatest victory of all of us last November in the Republican State of Utah.

I am happy to be with him particularly on this occasion because as chairman of this subcommittee throughout the last Congress he did great work in behalf of the elderly people of this Nation.

In addition to that, today's hearing on the nursing home situation in the State of Ohio, Mr. Chairman, and my friends and neighbors, is a great satisfaction to me.

As we all know, the nursing home picture in Ohio—and the Nation—is clouded. Hundreds of thousands of fine older people have been condemned to spend their latter years in firetraps where they receive the most minimal and marginal of care.

There are fine institutions, of course, with high standards and humane concern for their charges. Such homes are, however, in the minority, as our chairman has learned in the many hearings he has

held throughout this Nation. And the costs of proper care in a proper facility are high.

I believe that our task—the task of Government and of leaders in the community and the professions—is to encourage the good and weed out the bad. This objection may call for some ruthless pruning, as well as a greater commitment of public funds.

But we cannot afford another Fitchville fire, where 63 elderly were killed, and we cannot tolerate mediocre or nonexistent care in so-called nursing homes.

In this regard, I should point out that I introduced a resolution in the last Congress which we nearly passed, and which I am reintroducing in this Congress. This would prohibit the use of Federal funds to pay for care in institutions which fail to meet appropriate Federal standards of fire safety and protection. This legislation will be given further consideration in this Congress.

To my thinking, there is no possible way we can justify using public money to keep people in a place where their safety is constantly in danger.

I asked Senator Moss, the chairman of our subcommittee, to include Ohio among those States to be visitied by the Subcommittee on Long-Term Care. Senator Moss agreed with me that Ohio provided an appropriate State for study by the subcommittee.

We are very much concerned over this situation in our country. We want adequate Federal aid appropriated, but we want standards, probably set by the Secretary of Health, Education, and Welfare, so that public money will not be spent unless those standards are adhered to.

Mr. Chairman, as a member of the subcommittee, I am here to learn what progress has been made, what needs to be done, and what assistance may be provided by those of us at the Federal level.

Senator Moss. Thank you very much, Senator Young.

We are happy to be here in Ohio today, and delighted that you are here to participate as a member of the subcommittee. We depend upon your counsel and your assistance.

We have today scheduled a rather lengthy list of witnesses to be heard, many very distinguished witnesses, I may say. We will try to move this hearing along with all deliberate speed so that we can both get the maximum into the record and also finish with the list who have been called.

Unfortunately, we have allotted for this hearing only 1 day, because we must go on where we have scheduled other hearings. I realize to cover this subject we could very well spend many days or even weeks in Ohio getting the viewpoint of many citizens and those who have an opinion on this subject.

As we proceed today, there may be many witnesses who would like to submit their written statement to be printed in full in the record, and then simply comment on it, in order to save time. If any witnesses want to do that, we would appreciate it.

Of course, if you want to proceed in the other way, that will be all right, too, but I am trying to stress the need to keep the hearing moving.

We are particularly pleased and honored this morning that we will have as our first witness to appear before this committee, the mayor of

the great city of Cleveland, who has come here this morning, the Honorable Ralph Locher.

I would ask if we could hear from him now.

Go ahead, sir. We are delighted to have you.

STATEMENT OF HON. RALPH LOCHER, MAYOR, CITY OF CLEVELAND

Mr. LOCHER. Thank you, Senator Moss.

I do not expect special treatment from this committee. I do not get it from anyone else. But I am so pleased that your subcommittee is here, and I also want to welcome, in addition to yourself, our own Senator Young, Congressman Vanik, and President Stanton, of course, and Commissioner Gorman, and other public officials.

I shall be as brief as I can.

At the outset, I want to say that we are extremely gratified that you have come to Cleveland, and that you are concerned with our problems. It indicates to us that the Government in Washington is concerned not only with national matters, but indeed that you are also willing and ready to come right to the grassroots and find what we can contribute and what our needs are.

Briefly, I would like to summarize what I had presented to a U.S. conference of mayors recently on this very subject. I shall not take more than but a few minutes, if I may.

The problem of our senior citizens is one of the most important and most pressing issues of our time, and all indications now are that this problem is going to become more acute, as time goes on. Generally, the prospect facing our senior citizens today is one of poor housing, poor income, poor health, and a life of constant loneliness. Not a very bright picture, to say the least.

But let's look at some statistics: In 1850, 2½ percent of the Nation's population was over 65. In 1900, 4.1 percent of the Nation's population was over 65. By 1975 it is projected that 10 percent of the Nation's population will be over 65.

Let's look at another statistic on the aging: In 1890, 75 percent of the male population over 65 was still working. In 1961 only 29.5 percent of the male population over 65 was working.

Many of us who are at this meeting today can still remember that it was the general custom, when we were young, for grandparents to be living in the home of their married children. Today, this is by far the exception rather than the rule.

One of the reports coming out of the 1961 White House Conference on the Aged reveals that, while the total contribution to the aging from relatives and friends was $3 billion annually, it was only 10 percent of the money income of these elderly people.

My city, Cleveland, has been concerned about this problem and is doing something about it. The increase of the population among the elderly is significant. In our metropolitan area the general population has increased 18 percent, Senator Moss, while the population of 65 and over has increased by 41 percent.

Typical to this population increase is the case history of a man, now age 69, born in southern Ohio of poor parents, who gave up their rural hardships to move to Cleveland on the rumors that industry had great offerings.

This is not a Horatio Alger story. He quit school after the sixth grade. His job provided his family a living, but little else. Now, at 69, living on social security, plus a little left over from the house he had to sell, he has little to live for. He finds it difficult to get around. Occasionally he sees his children. Their income and housing space is already inadequate, so they can be of little help. In his "golden years" he is poor and intensely lonely.

Yet, he is comparatively lucky. His life does not include minority discrimination, medical disability, complete lack of family, nor dishonest slum operators.

The problems that this man has, as do those who are somewhat more or less fortunate, can be attacked as we have done in Cleveland, in three major ways:

1. By stressing public housing for the aged.
2. By encouraging housing for the lower middle-income group with Federal help.
3. By investigating the problem of the "nursing home."

In Cleveland, we had been working on these problems years before the 1956 Housing for the Aged Amendment was passed. Ernie Bohn, patriarch of public housing, and whom most of you know, feels there are four areas of consideration as being particularly important for housing for the aged, and I am sure that he will describe those areas in more detail than can I. But these are, first, site planning.

Two of Cleveland's developments for the elderly have particularly attractive sites—as good as any private housing in the city. One overlooks a park and has within walking distance the Cleveland Art Museum, the symphony hall, and two universities, Western Reserve and Case, and Mount Sinai Hospital. The other is Riverview, which overlooks the Cuyahoga River and Lake Erie. It is near the heart of downtown Cleveland. This unit has a 10-bed clinic.

We have been very fortunate in the location of those facilities.

Second, health maintenance unit. Experience at Cedar Apartments, our first elderly people's development, started in 1953, demonstrated that physical and mental ills of aging often occur without much warning.

Third, leisure time programs.

Fourth, design considerations. Public housing for the elderly in Cleveland stresses the undesirability of segregating persons according to age, rather than creating "age ghettos." In the Cleveland estates, the elderly live in a high-rise building with two-story garden apartments on two sides. The lower buildings are occupied by younger families. This feature we feel is most helpful to all concerned.

Private groups such as the Jaycees, the AFL–CIO, and religious organizations, have been quick to lend a hand, and they must be encouraged.

Presently, there are four lower middle-income projects under construction or in the planning stage. Whereas, the public housing costs approximately 23 percent of the occupants' income, the lower middle-income rates are considerably higher. The extremely successful Westerly housing development, in a Cleveland suburb, charges $72 as a minimum for the lower middle-income group.

These housing arrangements I submit also serve the elderly in the community by offering recreation and entertainment—it is a focal point for the elderly.

Of great importance is the policy of the management. This is true in both public and private housing, and should not be underestimated. It can make the difference in making the building a home, or just a place to sleep.

At Westerly, the manager has given some of the inhabitants small duties, upon request. A man who had once owned his own garden asked if he could care for one of the small trees that had just been planted. This he is now doing. There are numerous other opportunities for similar arrangements.

Urban renewal can also offer opportunities for decent sites for housing for the elderly. Presently, Cleveland is considering making space available for such housing in its famous Erieview urban renewal project, as well as in the St. Vincent charity urban renewal project.

The third area of attack I mentioned, along with public housing and housing for the lower middle incomes, concerned nursing homes. Nursing homes make up what Michael Harrington calls "the storage bin" philosophy. How well we know what he is talking about. I am sure most of us have visited a nursing home at some time or another, and, in most, we have sensed the hopeless atmosphere and gloom.

I should indicate that those who are not of that bleak, gloomy character must be given our constant encouragement and help.

Even though FHA can now insure 90 percent of the value of a private nursing home, who can really afford such service, if the charge for expert care in such a home is $400 to $500 a month? It is just impossible to afford it in most instances.

As it is now, 40 percent of the nursing homes in this country are unacceptable. A recent fire in Ohio, to which the chairman referred and to which Senator Young referred, which killed 63 patients and aroused public alarm, is an example of the Nation's situation.

Attempts to legislate against these poor conditions have been painstakingly slow, nearly impossible, considering the needs and cost for such care.

Recently, in Cleveland, I named a task force of city officials to immediately review all of our existing State and local laws pertaining to nursing homes, to ascertain if these laws are sufficient and where they need strengthening in order to provide full protection to the elderly inhabitants of these establishments.

Law alone, of course, is not enough. Beyond enforcements of these laws, we must undertake to stimulate a new awareness and a more human concern for the senior citizen.

Unless private developers and operators can solve the problem, there seems to be only one solution, and that is for some governmental agency to build nursing homes. This could probably be done under the present law, in the same manner as recreational and craft facilities are built for persons of all ages, as an adjunct to the shelter.

When the facilities are built, perhaps with some assistance from HEW, the operations should be turned over to some local agency which is expert in the field, in the same way that we turn over the recrea-

tional facilities to a settlement house and golden age groups, and the diagnostic unit to a hospital.

These, then, are the three areas, I submit to this honorable committee, that we have considered most important for housing of the aged: First, public housing; second, private housing for the lower middle incomes; and third, public investment with nursing home operations.

I trust, Mr. Chairman and Senator Young, that our experiences here in Cleveland will prove of some help to your committee, and in the deliberations which will follow.

Again, welcome to Cleveland.

Senator Moss. Thank you so much, Mayor Locher, for that very comprehensive outline in a brief time of what has been done in Cleveland and how you have been approaching this problem. You are certainly aware of the problems involved.

I was particularly glad you stressed the fact that it is not only safety we are concerned with, it is in making a more meaningful and independent life for our older people.

I think that in so many instances loneliness and the social neglect that our older people feel is a greater blight on them really than the minimal care that they may receive physically. That should certainly be kept in mind in our deliberations.

We appreciate it very much, and appreciate your coming to be with us this morning.

I do not know whether Senator Young has any questions or comments.

Senator YOUNG. Except this, Mayor Locher, we are grateful for your very fine and helpful statement.

Mr. LOCHER. Thank you, sir.

Senator Moss. If the staff has any questions, they may present them.

Thank you very much, Mr. Mayor. We are glad to have you.

We are pleased to have with us this morning the president of the Cuyahoga County Board of Commissioners.

We will ask President Gorman if he will come forward, please, and occupy the witness chair.

STATEMENT OF HON. FRANK GORMAN, PRESIDENT, CUYAHOGA COUNTY BOARD OF COMMISSIONERS

Mr. GORMAN. Senator, members of the committee, Cuyahoga County does do some of the things that we have been talking about in the nursing home field.

We now operate, thanks in large part to the Hill-Burton money which is available, three nursing homes. We are in the process of converting excess space at a tuberculosis hospital to a nursing home facility.

We are hopeful that the Federal Government will help us once again if eventually Broadview Heights Veterans Hospital is eliminated as a general hospital. We would like to operate, if we could get this facility, Broadview Heights Veterans Hospital as an additional nursing home for some 400 more people.

The nursing homes we operate today I do not feel fall within the hopeless classification mentioned by the mayor. I think it would be worthwhile for anyone who feels that perhaps nothing can be done in the nursing home field to visit any of our nursing homes.

There is one on Franklin Avenue. There are two at Highland View Hospital, which is on the East Side, and one at Sunny Acres, now in the process of being converted. I think that these homes are all examples of what can and should be done in the nursing home field.

We do not at present have any facilities for rest home care, and I feel there is a need for rest home care. Our nursing homes are designed for where there is considerable amount of medical necessity. My understanding of a rest home is that it has less of a medical requirement.

I feel that we are more interested in learning than in telling this committee what might be done, but I do feel that one of the problems we have found over the past few years is that the financial problem seems to limit the good nursing homes which we operate to those people who are on welfare programs.

We have what we consider excellent facilities, and they are substantially unavailable to people of moderate or low means, but not so poor or so badly off financially that they are eligible for public assistance of some form.

I do not know what could be done about this, but it appears to me that the people who are paying the taxes are entitled to some benefits from the public funds which are being financed by Hill-Burton money, by local taxpayers, and with great help from the State.

We have one other problem. We place through our welfare department people in private nursing homes. We find, as I am sure the committee knows, perhaps this is true throughout the country, but I know it is true in Ohio, that the standards set up by the State for nursing home care are impossible of achievement under the amount of money which is allocated by the State for welfare people in these nursing homes.

I do not know what the answer is to that, either. I will defer to your better judgment on this matter, but I do feel that Cleveland and Cuyahoga County have made some start in these directions.

We are still woefully short of space for nursing home care, for rest home care, and of course short of money.

I would like to thank you for asking me here, and welcome you to Cuyahoga County, as you have been welcomed already to the city of Cleveland.

Senator Moss. Thank you indeed, President Gorman.

We are indeed pleased to have you come and give us this brief summary of the activities of the county in this important field.

From your testimony I understand that there are four, or will be four, nursing homes operated by the county here in Cuyahoga County.

Mr. GORMAN. Two of them are two different sections of one of our chronic hospitals, but they are indeed nursing homes.

Senator Moss. These are homes where medical and nursing services are necessary for the patients. Is that right?

Mr. GORMAN. That is correct.

Senator Moss. But the county does not have any boarding houses, or rest homes, as you call them, that it operates?

Mr. GORMAN. No; we pay for services at some of these places, but we do not operate any ourselves.

Senator MOSS. Do you know offhand approximately how many private nursing homes you have in the county and how they compare with these four that are county operated for the public?

Mr. GORMAN. I am pretty sure we do not have any as good as ours, but how many there are I could not tell you. They seem to spring up and disappear overnight. Some literally disappear overnight, taking all of the people with them.

It is a little difficult to tell you how many there are. I am sure there are other people who could give you better statistics on these.

Senator MOSS. These nursing homes are licensed by the State, I understand.

Mr. GORMAN. Yes; they are.

Senator MOSS. So someone from that department ought to be able to give us a better count of them.

Mr. GORMAN. I would hope so.

Senator MOSS. I think you have put your finger on what is bound to be the principal problem; which is how can we finance adequate care within the limits of funds available for public assistance or funds that are available to retired people who have social security or a small pension. You say that is the problem.

Mr. GORMAN. It is certainly one of the big ones.

Senator MOSS. I am sure it is, President Gorman.

Senator Young, do you have any questions of Mr. Gorman?

Senator YOUNG. I have one answer to the question that you threw out.

It seems to me that it is the duty of the General Assembly of Ohio to give thoughtful consideration to this direful situation in Cleveland and Ohio and to try to provide adequately from State funds and not leave everything to our good Uncle.

Do you not agree with that?

Mr. GORMAN. I did not claim we should get the money necessarily from the Federal Government, but I know recently that we had a drastic cut at the State level.

Senator YOUNG. But we do want high standards imposed at the State level, and to have those high standards lived up to. Legislators certainly have a duty to give this thoughtful consideration and to provide legislation for it. Is that not true?

Mr. GORMAN. I agree with that statement.

Senator YOUNG. And of course for our part this is a national problem as well as a State problem, and we do want to provide, and Congress will provide, I am certain, safeguards so that these things that have happened we hope will not happen in the future. Taxpayers should not have their money squandered, and there should not be profiteering at their expense.

You agree with that, of course.

Mr. GORMAN. Absolutely.

Senator MOSS. Any staff questions?

Thank you very much, President Gorman. We appreciate it, indeed.

Our next witness to appear is the president of the City Council of Cleveland, the Honorable James Stanton.

We are pleased to have you, President Stanton, and are glad that you could come to be with us this morning.

STATEMENT OF HON. JAMES STANTON, PRESIDENT, CITY COUNCIL OF CLEVELAND

Mr. STANTON. Thank you, Senator, and Senator Young.

I think it would be presumptuous of me to tell you what the problems are within the great definitive range, because your knowledge is much greater than mine, but I would like to give you my observations as a legislator in a municipality that has a great number of older people who have nursing care problems.

In the annualization of the problem, it seems to me that the individual who is totally indigent and who is on welfare is in a better position when he reaches the age of 65 or over than the individual who has worked all his life, who has supported himself and who finds himself with a chronic illness or some type of illness at the age of 65 and who has the bare minimums of life.

He may have a $14,000 home. He may have small savings of $800 or $900, and he may have his investiture, some small pittance to live on. But if he gets dealt with a sickness that needs chronic care, such as you find in a nursing home, he does not qualify at the welfare.

The truly indigent qualify to meet the needs, so oftentimes he forces himself to go without the care and attention he needs. He lives in circumstances of pain and suffering that other individuals, either because they are totally indigent and go into a public facility such as Commissioner Gorman outlined, provided by the county, or into a State institution.

Therefore, in addressing a problem both the Senate of the United States, the Congress, the State organization under the State body, and the local organization have to meet the problem on the basis that we have to find a program that is reasonable, that does not require one to be totally indigent, to give up every last vestige of property and turn himself upon the public dole before he is eligible for nursing home care or before he is eligible for those benefits which would leave him with some degree of integrity in his old age.

This is the difficulty that I find as a legislator, that the qualification of the legislation to meet the problem today does not truly direct itself to this area.

I understand that certain bills have tried to meet this need, but because of legislative compromises that have occurred in the past at levels of government, we have failed to truly assist the average income earner in this area who needs some type of medical assistance, some type of nursing home care, and gets to the age of 65 and finds that he has one option; he either has to give up all he has, his small home, and turn it over to the State upon his death or demise for the payment of his medical bills that are now incurring, or he has to try and go without the proper care that he might need in his old age.

To me, as a legislator, this is the crucial area. I do not purport to know the answers, or how it is attained. I think maybe wiser heads than mine will have to address themselves to the problem.

I know that Dr. Stocklen and Dr. Wehr, who you will be hearing testimony from, will have certain recommendations, and I think these recommendations should be given strong consideration by this committee.

That is all I have to say, Senator. I appreciate the opportunity to be here, and on behalf of the legislative body of the city of Cleveland, I certainly welcome you and your interest and your efforts.

Senator Moss. Thank you very much, President Stanton.

I understand that Ohio has the so-called lien law, where an elderly person must pledge his real property holdings against any care that is given to him in his declining years, so that the State can recover on his death.

Mr. STANTON. That is my understanding of the law in the State of Ohio. I think it totally lax morality that one should give up every vestige of profit that he has earned or made or developed throughout a lifetime, even if it is small, even if the total value of it is only $8,000 or $9,000, in order to be provided with the type of care that someone who has contributed very little to the society, and who has been an indigent or welfare case all of his life for some circumstance gets much better care than this individual who has contributed to society.

I think we have to address ourselves to this area.

Senator Moss. Thank you.

That is a difficult problem, and one that I am glad to have in the record for us to turn over in our minds as we think about this.

Do you have a question, Senator?

Senator YOUNG. Personally, I am impressed very much, and I like very much the last statement you made, regarding the often inhumane legislation of this State.

I like it that you stated, Mr. President, that we must work together and try to find a program that is reasonable.

I have great confidence in you as a leader in this community, and in Congressman Vanik, and other Ohio leaders who are here.

If it should develop later this year that some VA hospitals in this vicinity or elsewhere in Ohio are given up because of the lack of the necessity for them, and as a matter of economy for our Nation, I do hope, and I have confidence in you that you will be alert to the possible use of these discarded VA hospitals for nursing homes for the elderly.

Mr. STANTON. Senator, I am aware of it, and I know it will assist part of the problem. I hope only that through the State legislature and the Senate and House of the United States that we can address ourselves to the area of people that I referred to, because it is critical. It is one that has not received attention by any great legislative body in our society for many, many years.

Senator Moss. Thank you very much, President Stanton.

We are grateful for your coming this morning.

We will next hear from our colleague, Charles Vanik, Congressman, representing the district here in Cleveland.

We all know Charlie Vanik and have worked with him over the years, and admire him as one of the most able and energetic of our Congressmen, and we are happy to have him here this morning.

STATEMENT OF HON. CHARLES A. VANIK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. VANIK. Mr. Chairman and members of the committee, I first of all want to place in the record our public acknowledgment of the great leadership we have been provided in the Senate by your committee and

its representatives. In particular, I want to pay tribute to the work that our colleague, Senator Stephen M. Young, has done. He has been involved vigorously in the problems of the aged and infirm throughout the United States.

I did not want this chance to go by without a special tribute to his vigilance in the Senate, as you well know.

I want to take this opportunity to thank this committee for coming to Cleveland to conduct hearings on problems of aging and specifically on the problem of nursing home accommodations.

Others can qualify as experts and can cite data on the Ohio inventory of nursing home accommodations—the kinds of homes, the need for additional facilities, and State programs of licensing and enforcement.

As we know, the Federal Government has a tremendous responsibility in this area. The financial contributions of the Federal Government in the aid for the aged programs, social security, and the aid which will come under the King-Anderson bill which we are now currently considering in both bodies of Congress.

These interests will be directed toward the utilization of these resources, but whether we like it or not, the Federal Government is deeply involved, and I am sure we are anxious that the Federal Government's stake is protected, and that our funds are spent judiciously.

In this community we have fine nursing homes—a few are among the best in America—offering full services and therapy in modern, safe circumstances. There are also in this community some of America's worst facilities, which provide little more than questionable food, questionable housing—a place to spin-off the remaining years of life, rather than a place for recovery.

In this community the Federal programs we have enacted for the construction of decent nursing home accommodations have not produces these facilities. During your further interrogations I hope you will endeavor to find out why these Federal construction programs have failed in the face of so much need.

The reasons I believe are related to rather rigid HHFA specifications and construction standards which are not economically sound in this area. Just how many nursing home projects have we been able to develop, and at what costs?

Last week I called at the Valley Springs Nursing Home on Puritas Road. That is very close to the airport, and perhaps on your way out of Cleveland you may have a chance to drop in and see it. It is one of the finest facilities in Cleveland.

It is firesafe, with bright air-conditioned facilities, and more than ample nursing care with therapy available at no extra cost. This building was constructed at one-half the cost of construction which would have been required under the standards of the Nursing Home Act under HHFA. Yet I believe you will find that it satisfactorily meets standards of safety, security, and service.

The use of prefabricated concrete sections on top of brick and block walls provides stability, shelter, and security at lower cost than if we relied on a steel structure.

This type of construction permits a monthly rate of $250 in a four-bed room, $300 in a three-bed accommodation, and $350 in a double-bed room with private bath, and $400 for a private room. All services are with therapy provided free.

This institution happens to require 51 employees to serve the needs of 88 patients. I think they do a mighty fine job, and I think it is worthy of a visit.

Decent accommodations of this type are scarce and hard to come by in this community. A few weeks ago I found myself responsible for the custody of an aged convalescing patient who had to spend $35 per day sitting up beside her hospital bed—which she did not then need—simply because there was no suitable place to send her.

To this patient, a $250-per-month nursing home would be a blessing compared with hospital charges which were running over $1,100 per month.

The reason we are short of decent accommodations—the reason we house in firetrap accommodations—is that Ohio's Division of Aid for the Aged pays only for firetrap accommodations. It is absolutely impossible in this community to provide decent nursing home facilities at $170 per month.

How can nursing homes be rightfully expected to provide extended hospital care—with many of the hospital features and meeting the same requirements under codes that hospitals do at one-sixth of the cost of these same accommodations in a hospital?

Now, I do not know what hotel you are staying at, Mr. Chairman, but I think that a single room at one of our hotels in a building that was built many, many years ago, the wallpaper is probably 30 years old, and the furniture is almost that age, and they probably charge you $16 a day to stay there.

How anybody can be expected to take care of a convalescing nursing patient in a nursing home in the State of Ohio at $6 a day is just beyond my comprehension. I just cannot understand it.

Now, with this ridiculous monthly allocation for nursing home facilities—this State invites and subsidizes firetrap hovels for the sick, the aged, and the infirm. No institution in this State can for very long accommodate a sick patient for $6 per day, and include decent food, housing, supervised nursing and medical care, or therapy.

As long as Ohio pursues these disgracefully inadequate policies, we invite disaster and the hopeless neglect of our aged. Some way must be found to raise State standards of participation in this responsibility.

Generally speaking, adequate facilities are more likely to result if there is adequate financing. And I do not concur in the idea that the Federal Government has to build and operate these facilities. I think they can be built and operated by private operators, if we simply get the State to recognize its share of the obligation and to contribute properly to this cost.

Now, the King-Anderson bill will impose new responsibilities for the development of decent facilities. The Federal contribution will be spiralled to new high levels.

With increased Federal participation under this law, which I hope will pass, and I know that Senator Young and you join me in this hope, the States should be required by contracts with the Federal Government to provide minimum standards of safety, security, and service to go along with the payment of these Federal funds.

Since the Federal Government pays 50 to 80 percent of the cost of nursing home patients, the State should be required to provide adequate supplementary resources to do the job.

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Our task is not easy, but the answers are available in the case histories of our patients, and their tragic lives. We simply have not cared enough, and in Ohio we have hardly cared at all.

Before your committee leaves, I hope that you will endeavor to obtain an inventory of local nursing homes, particularly those which are qualified for extended hospital service, in standards contemplated by the King-Anderson bill.

I also recommend that you determine what convalescent or extended care facilities in this community, if any, are eligible for Blue Cross coverage.

The faults may lie with our hospitals, or our hospital policies, or they may also lie with Blue Cross failure to accredit nursing facilities.

I had a case some short time ago where a lady constituent of my district had her husband at a hospital. After he was there for a week, the social worker of the hospital, and under the guise of social work, came to this woman and said, "Your husband is going to die in 2 weeks, or a month, or 3 weeks, or some uncertain time in the future. We need his bed for someone whose life we can save."

She had purchased a 90-day hospital insurance coverage. She was entitled to 90 days hospital care for her husband. They were asking her to move him. But there was no place that would be accredited and which Blue Cross would recognize. So they were asking her to yield her coverage she had contracted for. There was no place to send him.

Blue Cross coverage in this community means different things to different people. If a doctor has status in the hospital, you can stay there for 90 days and convalesce, but if your doctor does not have status, if he is not head of a division or service, you are out before you get in.

So these people are simply thrown out on the streets. They die in their homes, and on the sidewalks, and they pay the same price for the same coverage, but they do not get it.

I think if you make an inventory you will find what I say has considerable merit, and is supported by considerable cases and experience. You will find that patients of affluent areas with insurance coverage enjoy longer hospital stays than do patients of the central city areas with the same coverage.

I would also recommend that a determination be made on the extent of the deportation of nursing home cases from this community to other remote and removed sections of the State. The Veterans' Administration records will disclose an extensive utilization of nursing home facilities 75 miles from Cleveland, simply because accommodations were not available here. The general community has engaged in substantially the same practice. We have been moving our cases away.

Are the reasons related to costs, or to other considerations such as less supervision, or less expensive standards?

In my judgment, a substantial part of the therapy of a convalescent and a nursing home patient is the privilege of the visitation and interest of family and friends. Under these circumstances, that kind of therapy becomes almost impossible, because the patients are removed from the families that can provide this kind of therapy.

Your work here in Cleveland is a tremendous public service. It will have infinite value, not only for your committee but for our House committee, for the Congress, and the entire Nation, which will be thoroughly reviewing the potentialities under the extended care provision of the King-Anderson bill.

I hope that your staff will endeavor to search out some of these figures and statistics that I have suggested might be available before your committee leaves the city.

I thank you.

Senator Moss. Thank you very much, Congressman Vanik for a very telling statement, and one that does supply us with a good bit of information we wanted to have for this committee.

I understand from your testimony that when the State pays for nursing home care here in Ohio, it is limited to $6 a day. Is that it?

Mr. VANIK. That is my understanding. I have that information from several of the nursing homes that I have visited within the last 10 days. They state that the State of Ohio pays $170 a month, and we cannot possibly provide nursing home accommodations within those limitations.

I think you will find those institutions that are providing it have a subsidy or are supported by religious groups or charitable organizations.

Senator Moss. Does Ohio have the Kerr-Mills medical assistance program?

Mr. VANIK. I believe that Ohio has availed itself under the Kerr-Mills bill, but I think there is a representative here from the State of Ohio who will provide the authoritative position of the State of Ohio.

Senator Moss. The burden of your testimony would be that until we provide adequate financing, we cannot very well demand the standards of care that we need for our nursing homes. Higher payments and higher standards must go together.

Mr. VANIK. That is correct, Mr. Chairman, and I would also like to have some more close search made of the standards that were established by the Housing and Home Finance Agency, because I have seen facilities that were built outside of Government participation and outside of Government loans.

The one home I looked at, they said this home was built—it is an 88-patient home, and they built it for $333,000, and they told me if they had followed the standards under the HHFA, the home would have cost $680,000.

So I think there must be something basically wrong with the standards we have set up under the Housing and Home Finance Agency provisions.

Senator Moss. That is a good point.

Senator Young, do you have a question?

Senator YOUNG. Congressman Vanik, you certainly gave us an informative and a most enlightening statement. I intend to read it very carefully after it is printed in the record of this hearing shortly after I return to Washington.

May I say that the citizens of Ohio are to be congratulated that his colleagues in the House of Representatives elected Congressman Vanik to membership of the only constitutional committee in either

branch of the Congress, the Committee on Ways and Means of the House of Representatives, being the committee that has sole and original jurisdiction over all tax and revenue legislation.

We in the Senate cannot do anything to provide hospital and nursing home care for the elderly until and unless the House of Representatives first passes the medicare bill.

It is very heartening that the Members of the House of Representatives gave this fine recognition to a dedicated Member like Charlie Vanik. It is a great honor that Ohio has a Representative on the administration's side in that committee, and largely because of your leadership, Charlie, we in the Senate feel hopeful that the administration bill providing hospital and nursing home care for the elderly, erroneously termed medicare, will come over to us from the House of Representative not later than June of this year.

Mr. VANIK. We want to make it an Easter present.

Senator YOUNG. Try to make it an Easter present, and that will be a wonderful step for the Congress and the country. Then we have other duties that follow that.

Thanks very much.

Senator Moss. Very well put, Senator Young.

We do indeed recognize the exceptional work done by Congressman Vanik in the House in his service on the Ways and Means Committee, which is certainly recognition of his outstanding leadership in that body.

As I recall, you once served there yourself, Senator Young, and we do recognize the importance of that great committee.

Thank you, Charlie. We do appreciate your coming here this morning.

Another outstanding Congressman of this area is Congressman Mike Feighan. He unfortunately could not be personally present this morning, because of his commitments in Washington, but Edward F. Kehoe, his assistant, is here.

I would like to recognize Mr. Kehoe for a statement from Congressman Feighan.

STATEMENT OF HON. MICHAEL A. FEIGHAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO, PRESENTED BY EDWARD F. KEHOE

Mr. KEHOE. Mr. Chairman, Senator Moss, and Senator Young, and members of the staff of the subcommittee, I want first of all on behalf of Congressman Feighan to welcome all of you to Congressman Feighan's congressional district.

As you noted, he will not be able to be present this morning, due to a commitment he made several months ago, but he is looking forward to receiving a report of these hearings so that he can be guided in his legislative efforts.

Because he cannot be here this morning, he asked me to read this statement to you.

It is often asked, "What can be done to improve the nursing homes or convalescent homes for the aged citizen?"

Too many of the nursing homes today are in the same predicament as were the mental hospitals of a bygone era, when they were known

as insane asylums. There appears to be plenty of comfortable establishments for those who can afford the high rates involved. There are some fine homes offering excellent care for those who are in a position to pay for the service. But too many citizens are doomed to jaillike conditions, to a slow disintegration of mind and body beyond the sight and conscience of the community.

Nursing homes are designed primarily for people who are disabled, convalescing, or infirm, who cannot remain at home, but do not need hospital care.

Too often Federal fund sources such as those authorized by the Hill-Burton Act are siphoned off by the established complexes of elaborate hospitals and medical centers, as only they have the resources necessary to penetrate the bureaucratic maze necessary to get the grant money from the Federal Government.

The Kerr-Mills Act was directed at providing medical aid to the aged, but this source is all too frequently criticized and ridiculed rather than utilized.

The basic and most important question is: Where do we begin? In my opinion organized training programs are needed to provide personnel required to staff nursing homes.

These training programs should be based on the role of the following disciplines in the nursing home: the sanitarian, the social worker, the physical therapist, the recreational therapist, the nutritionist, the podiatrist or foot doctor, the occupational therapist, the dental hygienist, the public health nurse, and, of course, economical business administration.

Thought must also be given to the desirability and feasibility of accreditation and by what body or authority. Last, but not least, the question of licensing is vitally important, and whether or not it should be concentrated in the local department of health, or whether it should be shared amongst the police, fire, health, and other bureaus of licensure.

How is all this to be accomplished? Community and citizen resources must play a vital and dominant role in addition to the State and city.

In this regard, the Community Health Services Branch of the U.S. Department of Health, Education, and Welfare has recently taken a step forward in this field by a grant of approximately a quarter of a million dollars to the District of Columbia for a nursing home improvement project over the next 3 years.

Under the guidance of Dr. Murray Grant, Director of Public Health for the District of Columbia, this project will serve as a pilot project for the benefit of the rest of the Nation.

While we can look forward with interest to the results this pilot project should produce, what is needed now is action at the Cleveland level.

The form and pace that action should take in Cleveland should be decided by the responsible leaders in Cleveland, based upon a common desire to determine by demonstration what is best to meet the needs of Cleveland.

The urgency of this task is underscored by the fact that passage of a national medicare program is in prospect. That program, when it becomes operative, will require nursing home facilities and techniques

well beyond our present capabilities. What is needed is a new and fresh look at this vital area of service to our senior citizens and others in need of special care.

Thank you.

Senator Moss. Thank you, Mr. Kehoe, for that very fine statement you presented for Congressman Feighan. We appreciate it, and we appreciate his interest.

He is indeed an outstanding Congressman from this district, and we are happy that he presented this information for us.

Senator YOUNG. Thank you.

Senator Moss. Our next witness will be Dr. Joseph B. Stocklen, who is the controller of chronic illnesses for Cuyahoga County.

STATEMENT OF DR. JOSEPH B. STOCKLEN, CONTROLLER OF CHRONIC ILLNESSES, CUYAHOGA COUNTY

Dr. STOCKLEN. Senator Moss and chairman of the committee, my name is Joseph B. Stocklen. I am a doctor of medicine. I live in Cleveland Heights, a suburb of Cleveland, Ohio, and my special fields of interest are administrative medicine and public health.

I hold the title of controller of chronic illness in each of the six health departments in Cuyahoga County, and am administrator of the chronic illness center, a county-operated institution.

The chronic illness center was established in November 1961, following a request by a citizens' group for an agency to assist in the coordination of the complex array of services available for the chronically ill.

One of the chief functions of the chronic illness center is to place the chronically ill patient in the proper environment in order to provide an optimally healthful and happy mode of living.

In order to do this, the center must not only screen patients from medical, social, and economic standpoints, but must also have detailed knowledge of all the facilities available in the community for patients with long-term illness.

Both of these functions are carried out by the chronic illness center staff.

We have in Cuyahoga County at this time 91 nursing homes and 31 general hospitals which also participate in care of the aged sick. With this variety of services, it is very difficult for the general public to know what they need, and indeed where they should go, and how they should find what they need.

The chronic illness center therefore was set up as an information service to bring to the public information as to what facilities are available, and to try to put the patient in the right place at the right time.

This was established by order of the board of county commissioners, and is operated as an outpatient part of one of our hospitals.

In 1963, 1,125 calls for service were rendered. All but 177 of these clients were over 60 years of age. Therefore, although the center has a primary function of caring for the chronically ill, the vast majority of its services is to older persons, since long-term illness is much more prevalent in this age group.

Because of its functions of caring for these older persons and assessing the facilities available for their care, the staff of the chronic illness center has had a unique opportunity to observe the care of the aged in Cuyahoga County.

The committee has had voluminous testimony on the general problems of the aging in the United States, and we will not attempt to review any of these data. Rather, we should like to give to you, on the basis of our experience, the problems encountered by the older person in obtaining adequate care in Cuyahoga County.

They have problems of getting enough to eat, and proper shelter, but I think the outstanding one is getting a place to go when they are sick.

The figure I gave you before on numbers of nursing homes was a recent figure, but following are our official figures. In Cuyahoga County on August 31, 1963, there were 87 nursing homes, with a licensed capacity of 4,672 beds, and with an estimated occupancy of 96.5 percent. These homes vary in size from 3 beds to 240 beds. They range in quality of care from excellent to poor.

The charges vary from $900 a month to $50 per month. Quite obviously, this low cost is in a philanthropic home where the charge is obviously subsidized.

Although sampling studies have been made, comprehensive figures on the cost of care in these homes are not available. The chronic illness center maintains a complete list of nursing homes in Cuyahoga County, together with the stated charges for these homes.

Experience has shown that the present allowance of $170 a month for nursing home care, now the maximum available under the division of aid for the aged of the State welfare department, is totally inadequate.

It is still $170 now, and the Governor has indicated that he will increase it $10 a month. But at the present time it is still $170 a month.

It is not possible to render good nursing home care for this amount of money. Furthermore, the adoption of standards or strict regulations will not improve nursing home care under the present schedule of payments.

We estimate that it would require at least an addition of $80 a month to begin to make improvement in the standards of the nursing homes in Cuyahoga County.

Senator Moss. You mean an increase of $80?

Dr. STOCKLEN. An increase of $80. This is based on experience that we know of.

There are two or three homes that give reasonable care, and I would think at great sacrifice. They are good homes, but it is not plush care, and I think they need more money.

The committee has had extensive information from national sources on the financial status of older persons. These data are supported by the information collected by the chronic illness center. Of the 1,125 patients served in 1963, 429 were able to pay less than $200 a month for care.

If improvement in nursing home standards depends in part on increased payments to nursing homes, and if 40 percent of the population served is able to pay less than $200 a month, it is clear that some type of assistance must be given to a relatively large number of people if they are to obtain adequate care.

There are many fine and modern nursing homes in Cuyahoga County today, but considering the whole problem of nursing home care, this important medical facility is at about the same stage of development as the hospital of 50 years ago.

At that time many hospitals were established in old homes principally because these structures were available. I remember when I was a child in the small town where I lived, the hospital was established in a home. Many hospitals were started this way. Whether the care furnished by these institutions was better than care in the home is highly debatable.

Today, a very substantial portion of nursing home care is given in dwellings which have been converted. Very few of these are structurally suitable from a functional standpoint, and practically all have the serious disadvantage of not being of fire-resistant construction.

I am very happy to see that the Federal Government appears to have adopted the term long-term care. I feel the segregation of these units into rest homes, nursing homes, homes for chronically ill, is unsound. I do not believe you can divide these into categories.

In some respects the term "nursing home" is unfortunate. It gives the connotation of homelike care, and this is sometimes heightened by the fact that the facility is in a converted old dwelling.

I believe the best place for the patient is in his own home. We believe in home care. Sometimes this is impossible. Sometimes the patient is so disturbing to the family that he must be placed in a facility.

We now know enough about the care of the elderly sick to know that the facility for their long-term care needs to be just as carefully designed and well built as the modern hospital of today.

We must stop putting the elderly sick in old buildings simply because they are available. They must be as well built as hospitals. The idea that these people need second class care is erroneous. They may not need laboratory facilities, but other portions must be better or equal to a hospital.

It must be of fire-resistant construction, and must have all the safety features which are so necessary for the handicapped elderly. It must be designed with the idea of wheelchair mobility in mind. It should be large enough to afford the services of a registered dietitian, a physical therapist, an occupational therapist, and a social worker.

Small homes cannot possibly afford these services except by contract on a part-time basis, and this type of arrangement is most difficult.

In exceptional instances gifted administrators are able to perform some or all of these functions, or make arrangements for them in the smaller nursing homes. However, these situations are distinctly unusual.

There is a common misconception that the smaller home is preferable because it affords more privacy and individuality of care. The large institution which can provide many services not found in small homes can offer maximum privacy and personal care, if it is properly designed and operated. And it can offer all of these other facilities.

Incidentally, our State has a rule that a nursing home ought not to be over a hundred beds, which I think is wrong. It is just like saying in an apartment building you cannot have privacy.

In large nursing homes, built and staffed properly, you can have a lot better care and privacy than you can have in smaller ones.

Our nursing home reviews have shown some shocking situations. Inadequacy of professional personnel and particularly nursing personnel is the rule rather than the exception.

On a recent date each of 21 homes in Cuyahoga County had 1 registered nurse, 5 homes had 2 registered nurses, 8 homes had 3 registered nurses, 2 homes had 4 registered nurses, and 1 home had 7 registered nurses.

Thus, of the total 91 nursing homes in the county, only 37 had at least 1 registered nurse, and some of these do not work full time, but are on call. Fifty-four homes have no registered nurses, but have the services of a licensed practical nurse.

One nursing home with 69 patients in residence has only a licensed practical nurse in charge, and she is the only nurse in the home. Another home has 91 patients, and has only 1 nurse, a licensed practical nurse. On the other hand, 1 of the very fine homes has 34 patients, with 3 full-time registered nurses.

Very few homes have the services of a professional dietitian and yet many of the persons in nursing homes need special diets, particularly the diabetics and the cardiacs. In order to save personnel, many homes serve the evening meal at 4 p.m.

In one home that was reviewed, the patients were lying on plastic sheets covering bare mattresses. This last condition has now been corrected under new ownership.

There is a serious need for staff training. Although it is difficult to get data, there is evidence that the prevailing wage among nursing aids in many of the homes is less than $1 per hour. And I suspect it is considerably less than a dollar an hour.

I have two brief reports, staff reports on nursing homes, from our 1963 staff report.

Home No. 1, an evening meal observed in a nursing home consisted of cream of spinach soup, not sufficient to serve everyone, a mixed vegetable salad, one teaspoonful on each tray, beef stew, two large teaspoonfuls on each tray, most containing one piece of meat, one-half slice of buttered bread, one-half cup of custard, one glass of milk or tea. No seconds.

In the same home some months later the noon meal was observed: 16 pork chops were being fried for 32 patients, plus 6 employees.

When this amount of meat was commented on, the operator gave the cook eight more chops to cook.

It was a rainy day. The rooms were dark. The bathroom on the first floor was used for storage, and patients were using the facility without toilet paper or soap.

As another example, a woman called saying her 101-year-old mother fell out of bed during the night and broke her hip. She stayed there till morning.

She moved her to another home. On the day she visited her mother, she found the bed clothing wet. She looked for a nursing aid to help with the patient, and was told the aid was drunk. When the aid appeared, she was drunk and could not stand. Mrs. C was afraid she would fall against her mother and hurt her.

When she complained, the nurse said, "If you don't like it, take her and get her out."

She talked to the social worker, and the worker said she knew the care was not good, but there was no other place to put her.

However, we should like to stress that these conditions are not an indictment of all nursing home administrators. It has been our observation that many operators of nursing homes are dedicated people who are making substantial sacrifices to give adequate care to the elderly sick people under their care.

Rather, it is an indictment of governmental units which proclaim that we cannot afford to care for these people adequately.

No improvement can be made unless the present maximum reimbursement for nursing home care is substantially increased. We believe that as a minimum an increase of $80 per month should be allowed. This would cost the State of Ohio about $24 million in the next biennium. It has been predicted that the budget for the State of Ohio during the next biennium will be about $2½ billion.

We believe that this increase in stipend for nursing homes would be a first step, and that it would be necessary to follow it fairly soon with another increase of approximately $50 per month.

Such compensation would need to be supplemented by an adequate system of licensure and accreditation and a system of inspection of financial records so that patients can be placed in homes of the highest quality at reasonable costs.

At present care is not being given on basis of cost. It is a fixed cost. This penalizes the good nursing home operator. I think governmental units should know what they are getting for their money.

Our recommendations are very broad. I know we do not have time to go into detail.

In summary, to raise the standards of nursing home care, we are recommending—

1. Adequate compensation of nursing home operators.
2. An adequate system of inspection and licensure of nursing homes.
3. A system of accreditation which would enable the public to identify accurately the better nursing homes.

Thank you.

Senator Moss. Thank you very much, Dr. Stocklen. That is a very fine statement.

The two reports that you read indicating some homes have very poor quality, what sort of inspection or supervision is given now in Ohio to nursing homes?

Dr. STOCKLEN. The inspection is given by the State health department. I think this has been increased. It has been reorganized in recent months, we trust for the better.

I saw Dr. Wehr here, of the State health department. He can probably tell you. I personally feel that they do not have enough money, nurses, or sanitarians to inspect these homes properly. That is my own personal feeling. And I think that if we have an adequate system of inspection, that this will require more personnel.

Senator Moss. Now, after a report such as one of these two that you read, would a nursing home normally be served with some kind of notice that, if it did not improve, its license would be suspended?

Dr. STOCKLEN. Up to the present, sir, this nursing home would simply be advised to correct its ways—to improve its standards.

Actually, we have had some nursing home regulations which have been in the courts for about 4 years. They have just been approved by the Supreme Court of Ohio, and I think the staff of the Health Department really has not had time to get their new system working well, so we will have to wait and see what happens in the next year.

But I do feel they need more inspectors, and sanitarians, and a good, tough code. I think we need to make it tougher than it is.

Senator Moss. I guess, growing out of the rather low amount of money available for patients, there really are not enough nursing homes. Is that correct?

I notice you said they had an occupancy of 96.5 percent. That seems very high to me.

Dr. STOCKLEN. It is very high, sir. There are not enough nursing homes. And, in particular, there are not enough low-cost nursing homes.

If anyone in Cleveland has $350 a month, we will find him a bed tomorrow. He can find it himself. There is no problem. But finding lower cost homes is very difficult, really. You shop from one home to another, trying to find a decent one.

Senator Moss. Of course, the vast majority of our older people fall in this low-income group, they are either on public assistance or have a very modest amount of money to use.

Dr. STOCKLEN. That is correct, sir.

Senator Moss. You commented on the optimum size of the nursing home, indicating that you did not agree that the one with a small number of patients was the ideal. Do you have an estimate of what you think would be an optimum number of patients to have in a nursing home?

Dr. STOCKLEN. I think that it might be 150 or 200. This is a guess. I have made no study on this but I hope the Public Health Service will.

I think they agree, in general. I have talked with some of the people in the Public Health Service. It is simply that you cannot have half a dietitian, for example, or half a therapist. You may contract with some of these specialists, and some of the better small homes do. We have some small, very good homes in Cleveland. But in general the small home is a throwback to that day when someone decided they would take a few patients in their home and take care of them. These were frequently motherly old ladies, and they gave care to the best of their ability.

But modern nursing home care has become an entirely different sort of a thing. It requires people who know something about sick people and who will give them good humanitarian care and understanding.

Senator Moss. Because of these specialized services that older people need, you need a sufficient number of them so you can afford to have the specialists there?

Dr. STOCKLEN. That is correct. I think if the nursing homes were built as a series of small individual units, for example, these people could live in a homelike atmosphere. This is essential because many are going to be there a long time.

You go to a general hospital. You are there 8 or 10 days—I think 7 days is the average. You are not there long enough to care whether the food is good or not, or whether you like or dislike your roommate, or whether you have a good view.

Chronically ill people have to have recreational areas and dining rooms. I think if you built a series of small units—six or eight individual rooms, with their own dining room and recreation rooms—I am sure it would provide all the privacy you need and yet all these special services would be available.

Senator Moss. I do appreciate your testimony, Dr. Stocklen.

Senator Young, do you have a question of the doctor?

Senator YOUNG. Doctor, I believe I have two questions only.

We have been told that it often takes as long as 90 to 120 days before approval of an initial application for nursing home care under the aid-for-the-aged program. Now, if this is true, a period of 3 to 4 months, what is the excuse or reason for this lengthly delay in paying for the necessary care?

Dr. STOCKLEN. Your statement is true. It does take from 90 to 120 days to certify an initial applicant for nursing home care. The excuse is that it takes this long to process them.

I do not believe this. If it takes this long, there is gross inefficiency.

I know many of the people who work for the aid for the aged, and they are good people. The fact is that once it has been decided that these people are eligible, there is no retroactive payment, so it simply is a way of saving money, in my opinion. I do not see what other explanation there could be.

Senator YOUNG. We fully agree with you that that should not be permitted.

Now, you also stated that a very substantial portion of nursing home care in Ohio at the present time is provided in non-fire-resistant buildings.

Dr. STOCKLEN. Yes, sir.

Senator YOUNG. That is a deplorable situation and, if that is a fact, does that mean that another tragic nursing home fire such as the Fitchville fire could occur almost at any time?

Dr. STOCKLEN. Yes, sir. I think a statement was made to me by someone in Columbus who said we now have a bunch of poor nursing homes with the best wiring in the world.

Senator YOUNG. Thank you very much for your fine statement.

Senator Moss. There is one question from the staff.

Mr. MILLER. Dr. Stocklen, you indicated that if people had adequate funds, $350 a month, you could without any difficulty place them in a nursing home.

When you are proposing $250 or $300 a month as payment from the public aid, this presumes that these people get adequate, satisfactory care with standards being met in all regards.

If this $250 to $300 a month public aid payment were put into effect, would there be sufficient nursing homes available now to accommodate the people that would require them?

Dr. STOCKLEN. No; there would not be sufficient good nursing homes. This is going to require a gradual rebuilding of the whole nursing home setup.

Senator Moss. Thank you very much, Dr. Stocklen. We appreciate your testimony. You have been very helpful to us.

Dr. STOCKLEN. Thank you for granting me the audience.

Senator Moss. Our next witness will be Mrs. Mildred Barry, who is executive secretary of the Health Council of the Cleveland Welfare Federation.

STATEMENT OF MRS. MILDRED BARRY, EXECUTIVE SECRETARY, HEALTH COUNCIL, CLEVELAND WELFARE FEDERATION; ACCOMPANIED BY VERNON BURT

Mrs. BARRY. Thank you, Senator.

I would like to have Mr. Vernon Burt join me in this testimony.

Senator MOSS. We are glad to have you both.

Mrs. BARRY. Thank you, Senator Moss, and Senator Young.

My name is Mildred Barry, and I am the executive secretary of the Health Council of the Welfare Federation of Cleveland.

The welfare federation brings together more than 200 organizations, both tax-supported and voluntary, for community planning in health, welfare, and recreation. Part of my responsibility over the past 10 years has been in the field of aging and chronic illness.

The nursing problem is of great concern to the welfare federation, and I hope I may have your permission to let Mr. Vernon Burt, chairman of the joint nursing home committee of the welfare federation join me in presenting this testimony. Mr. Burt was formerly chairman of the Governor's Commission on Aging in Ohio.

In my judgment, the nursing home situation is the most deplorable of all the problems of the elderly. It is deplorable because we know how to care for these people, but we just do not do it. It is deplorable because we let unscrupulous segments of our society victimize the lonely and confused, and we let them flout the law. And it is deplorable because we cannot seem to untangle the web of interrelated problems and find a way to insure that people get the care they need.

We have tried—at all levels, local, State, and Federal—and each effort is a step forward, of course. But it is foolish to think that any of these alone solves the problem.

For example, our State nursing home regulations, finally put into effect this past December after 4 years of litigation, are better than the former ones, but they are still subminimal.

Our Governor's request to increase appropriations so that old-age assistance recipients in nursing homes receive $10 more a month is better than nothing, but is most inadequate when this means raising the maximum to only $180 a month.

A Federal program such as medicare will ease the financial load for thousands of older people, and should serve as a lever to improve standards, but it meets a different kind of situation and should not be interpreted as the solution to the nursing home problem.

Let me review some of the nursing home problems as we see them.

At present, old-age assistance clients in Ohio who need intensive nursing home care receive a maximum of $170 per month. In Cuyahoga County there are about 1,850—1,842 in September 1964—old-age assistance clients in nursing and rest homes.

About 70 percent of these are checked as needing maximum nursing home care, and are reimbursed for this maximum care. Maximum nursing home care is described in the Aid for Aged Field Manual as requiring:

> * * * skilled, licensed personnel in attendance for the proper application of the nursing techniques required. A professional degree of evaluative judgment is needed for the seriously ill or completely disoriented patient found in this group. These services are of the type which would approximate hospital care for the chronically ill patient.

Our estimate is that the cost of providing such care in our county, if it were done adequately, would range from $310 to $365 per month for a 50-bed home. This is based on our welfare federation research department nursing home cost study recently released.

If these figures are reliable as an estimate—and they are only an estimate—since we have no uniform accounting system in Ohio, then we can conclude that old-age assistance clients are either receiving some form of subsidy from the homes, or they are not receiving the care they need.

Some do receive subsidy. A proprietary home may take a few aid for aged recipients and make up the differential by higher charges to paying patients. A philanthropic home may make up the difference through its endowments or charitable gifts.

But many homes are filled with old-age assistance clients or others with low incomes. We can conjecture what kind of intensive nursing home care these people receive at $170 per month.

This leads us to the all-important problem of standards. Unfortunately, some think that standards refer primarily to safety. Of course, buildings must be safe, and the personnel must be properly instructed in fire prevention and control. But to think that this is all there is to standards is wrong.

In this day and age, with the knowledge we have about medical care, nursing, therapeutic, and rehabilitative services, and with the understanding we have about feelings of people and their need for living out their days in dignity, what we do to some people in nursing homes is little short of criminal.

What we need can be simply stated: a patient should receive the care which his physical, mental, and social condition warrants. This means a safe and decent facility; it means medical management of the patient; it means properly qualified staff at all levels, but particularly in nursing; it means keeping of medical records and administrative accounts; it means a financing system and payments adequate to insure these things; and it means some system of licensing, inspection, and enforcement to provide the guarantees.

We need to guarantee that the patient receives what he needs, that those providing the service are properly recompensed, and that those paying the bills get what they are paying for.

Incidentally, we have developed a local Manual of Standards to serve as a guide to nursing homes. The standards are based on the State regulations, but are considerably higher. They were prepared with the possibility in mind of establishing a local voluntary accreditation program.

I do not know whether we are going to work on that or not.

Another problem relates to the classification of homes. We tend to overemphasize classification, particularly as a basis for payment. What we need are homes which can provide the gamut of care required by the patient.

Obviously the home needs staff and equipment to provide the most intensive nursing care which a given patient needs at a particular time, and the payment must be based on realistic costs which enable such care to be provided.

But much more emphasis must be placed on proper treatment, based on a physical-social-psychological diagnosis given not only at the time of admission, but repeatedly. It is much easier to let a patient lie in bed, give him medications and a bedpan, and call this maximum care than it is to get the patient up and help him to the bathroom or down the corridor to a dining room.

A patient's condition often varies from week to week, and the care he receives should be based on his condition and the best treatment plan. This seems so obvious, and, of course, is what our good homes provide. But our present system seems to work against this, or at least there is no guarantee that the patient gets what he needs, even if he gets to a facility which is classified as appropriate for him.

For example, if an aid-for-aged client meets the requirements for maximum nursing care and is placed in a home licensed to give such care, he will receive a check from the department of welfare each month, which he promptly endorses over to the management of the home.

He may see the aid-for-the-aged worker occasionally, although with the present caseload, he is lucky if he sees her once a year and, in any case, she is not in a position to judge the quality of his health care.

As far as we can ascertain, there is no assurance that this aid-for-the-aged patient is under good medical management. I have been told by the social service department of one of our general hospitals that patients admitted from some nursing homes are frequently severely undernourished, dehydrated, and with decubiti, or bedsores.

We need better inspection and enforcement by health authorities.

A year ago I presented to a public seminar some figures given me by Dr. Stocklen of the chronic illness center. The center, for referral purposes, rated homes on a five-point scale, from very poor to very good. The figures last year were these: Of a total of 87 homes, with 4,672 beds, excluding the county nursing home:

Very poor: 13 homes with 472 beds—all proprietary.

Poor: 17 proprietary homes with 671 beds; 3 philanthropic homes with 38 beds.

Fair: 18 proprietary homes with 850 beds; 5 philanthropic homes with 568 beds.

Good: 8 proprietary homes with 346 beds; 7 philanthropic homes with 406 beds.

Very good: 6 proprietary homes with 252 beds; 10 philanthropic homes with 1,069 beds.

Rated very poor or poor were 33 homes, out of 87, with 1,181 beds, out of 4,672.

I do not know how many aid for aged or county welfare clients are placed in these 33 substandard homes, nor do I know whether the State and local departments of welfare use the information of the chronic illness center, and would prohibit placement in a home rated very poor or poor, but it seems to me that public money should not go to substandard nursing homes.

I am glad, Senator Young, that you feel the same way.

Either the licensing requirements should be high enough and be enforced or the homes should not be used.

Let me briefly mention a few other problems.

Although I may have emphasized the public assistance client, we should be equally concerned that others in our communities get good care, particularly older people without families living on marginal incomes.

The space requirements in the State nursing home regulations are still inadequate. We all know this. It was a compromise, made to try to appease the Ohio Federation of Nursing Homes, and it did not work.

There are too many separate State authorities in inspection and licensing. Some unified or centralized plan should be worked out.

There should be further review of the personnel requirements in the State regulations, and attention should be given to the minimum wage for aids and maintenance personnel in nursing homes which, I understand, is now 75 cents an hour with a 48-hour week.

There should be uniform cost accounting required of homes receiving public money.

Before calling upon Mr. Burt to complete this testimony, I should like to submit some suggestions for your consideration.

Any medicare program should take responsibility for upgrading standards. There might well be a national uniform code of standards which could be the floor upon which State and local standards are built. Compliance with such national standards should be a requisite for Federal matching funds.

Standards should include: (*a*) safety, building and fire; (*b*) personnel ratio and qualifications; (*c*) medical management; (*d*) patient records; and (*e*) uniform cost accounting.

Affiliation of a nursing home with a hospital is to be highly recommended. Perhaps it should be a requirement for any use of Federal funds. Affiliation in itself, however, is no guarantee of standards.

Any financing plan in which the Federal Government participates should be tied directly to standards of care.

More attention should be directed to the personnel situation. At present there is no uniformly acceptable or adequate guide to qualifications of a nursing home administrator. Attempts to provide education in nursing home administration have not been of much success.

The Federal Government has successful experience in developing educational programs through grants to universities and scholarship awards; as, for example, NIMH program for professional preparation in mental health and, therefore, it might develop a program directed toward professional education of nursing home administrators.

In addition, the Federal Government might wish to direct more attention to the merit system as related to nursing home operations to those employees within the State that do have responsibility for seeing that nursing homes are well cared for.

I have been told that personnel requirements are not always met and certainly we have experience in Ohio with unqualified personnel. Perhaps Federal matching should be contingent on better personnel requirements.

The licensure system must include proper, informed inspection and strict enforcement. While this is the proper responsibility of the State, it might be advisable for the Federal Government to provide model guides or to make some requirements as a condition of receiving matching funds.

A review of the Federal matching program might be in order. Consideration might be given to removing the $70 ceiling on which the Federal Government matches under the OAA program and, as suggested above, to make matching contingent on more stringent State requirements which would insure enforcement of standards and provide some guarantee that care paid for is care received.

As a final point, I suggest that some attention might be given to Federal matching of patients in mental institutions. In Ohio there have been repeated efforts to transfer older patients from mental institutions to nursing homes.

I am not against this, if the patient's condition so warrants. In fact, I have testified against placing the confused older person in a mental institution. But there may be too much of a financial incentive for removal and, therefore, this might receive your attention.

Thank you for the privilege of testifying before you.

May I call now on Mr. Burt to complete this testimony?

Senator Moss. You many, indeed, Mrs. Barry. This is a very fine statement. We may have a few questions for you, but we will hear from Mr. Burt first.

STATEMENT OF VERNON R. BURT, VOLUNTEER CHAIRMAN OF THE JOINT COMMITTEE ON NURSING HOMES OF THE WELFARE FEDERATION OF CLEVELAND

Mr. BURT. Thank you, Mr. Chairman.

I am Vernon R. Burt. I will try to speak extemporaneously this morning, because I know your time is limited.

Senator Moss. We will place this statement in the record in full, Mr. Burt, and ask you if you would like to highlight it, sir.

Mr. BURT. I will try to.

(The prepared statement referred to follows:)

PREPARED STATEMENT OF VERNON R. BURT

I am Vernon R. Burt. I am serving as a volunteer chairman of the Joint Committee on Nursing Homes of the Welfare Federation of Cleveland, the community planning agency for this area. The remarks I shall make, I believe, reflect conclusions of our committee and in some instances, when indicated, the approved position of the federation generally.

The nursing home problem cannot be solved by the requirement of the installation of an S-type fuse instead of a wire fuse.

The nursing home problem cannot be solved by the requirement of the installation of a fire alarm system or a sprinkler system.

The nursing home problem cannot be solved by the requirement of a minumum number of square feet of floor space in each patient bedroom.

No, the nursing home problem cannot be solved by the requirement of a minimum ratio of personnel to patients.

It is true, each of these requirements will help toward making the institution safer, more comfortable, and with some better care. But, the problem requires more than this specific approach to the many apparent deficiencies of nursing home care, license, and financial support. There is required a basic analysis of the health and social problems that are sought to be solved by institutions calling themselves nursing homes, and an equal basic analysis of the kind and character of patients that need the services these homes should be offering.

Basically, there are two types of patients which are treated in what we loosely call nursing homes. In essence, they are—

(1) The patient who on his admission is well or not too sick and where it is intended that the institution shall keep and care for that patient for the balance of his life with a recognition that probably his health will deteriorate and his need for care increase as the days of his stay lengthen.

(2) The patient who on his admission is a sick patient and where it is intended or hoped that his health will improve so that he can enjoy a longer life and possibly eventually return to independent living.

Theoretically, in the first case the patient's health deteriorates and in the second case the patient's health improves. The good-sized, well-run nursing home will have both classes of patients and be able to treat both. Some institutions may accept only one of the two classes of patients. We suggest the core to the approach of the problem is the recognition of this variety of care and the two different basic needs of patients even when the complete variety of patients are within the same home. The issues I wish to discuss, however apply differently to the two major classes of patients I have previously described.

Every institution admitting patients of either classification must be required to comply with the minimum standards established by the regulatory authorities for nursing homes. Such licensure requirements should be adequate to provide a sanitary, safe place with facilities for proper care and sufficiently trained personnel to provide adequate nursing services. We submit that the current regulations, only recently put into effect in Ohio, should be reviewed to determine if they meet these standards. Even more important is the strict enforcement of them under a unified administration. Their enforcement should not be the subject of the activity of several State departments. Consideration should be given, however to the use of local health divisions as deputies of the State department of health.

Many patients will require more concentrated care that could be furnished by a home that only meets the minimum licensure requirements. The home that accepts such patients must meet a standard higher than that established for all nursing homes under State regulations. This, we suggest is best attained through a well-organized, properly financed voluntary program of accreditation—similar in character generally to the national program for the accreditation of hospitals.

It is suggested that it is the care in institutions of this character that offers the first opportunity for coverage or protection by the voluntary prepayment system and the commercial insurance industry. However, the protection afforded by the voluntary system must, perforce, stop when the patient is no longer in need of active medical management and skilled and intensive nursing care. At the outset we believe that the maximum that can be expected is for the voluntary system to extend its coverage only to the patient who is admitted to the nursing home directly upon his discharge from a hospital. The basic business of these parties has been the protection against costs incurred during a hospital confinement. It is reasonable to believe that these parties are willing to extend their coverage to circumstances where the patient is in a nursing home and his stay is a continuing part of the initial acute hospital confinement. Strong encouragement should be given to these groups to design and promote such protection.

This is the kind of care that is contemplated by the Federal legislation under consideration to provide benefits in nursing homes for people over 65. This system of health protection through the administration of its program has the greatest opportunity to upgrade the nursing home industry, particularly that segment which wished to lay claim as being a health institution. It is mandatory that this system should require as a condition to the payment of benefits that the home meet not only safety, sanitary, and space requirements; personnel ratio of the licensure laws; but that it demonstrate as a condition for recognition—

(1) That its medical policies have been established by the medical profession and that every patient is under the care of a doctor;

(2) That its nursing policies have been established through the joint effort of the medical and nursing profession and that they are maintained through the supervision of registered nurses;

(3) That the patients are under the care of registered nurses or at the very minimum care supervised by registered nurses;

(4) That adequate patient records are kept;

(5) That their meal service is adequately planned by a competent dietician and that there be facilities not only for normal diet but for special diet;

(6) That there be some affiliation with a general hospital which will assure the continuum of good care to the patient; and

(7) That it establish an approved uniform system of cost accounting and financial reporting.

Payment for the utilization of these expensive facilities should continue only so long as the patient's need for them continues and thereafter the patient should be transferred to another part of the home, to another home, or to his own home. However, when such care is needed and received, adequate reimbursement should be made by the third party paying for such care whether it be the Federal Government for the person over 65, the State or local government for its relief recipients, or a voluntary prepayment plan for its subscriber. However, reimbursement by the third party should be geared to the cost as demonstrated from the uniform cost accounting system. It is in these circumstances that our committee has recently recommended to the Department of Public Welfare of the State of Ohio that it recognize as vendors of care to recipients and make payment to them direct rather than increase the subsidy to the relief recipient in order that he may purchase such care.

When the individual needs only the assistance of limited nursing care, perhaps some assistance in his personal needs and a setting that will enable him to continue a reasonably enjoyable life, it still should be mandatory that the nursing home meet all minimum licensure regulations as presently established or approved. However, meeting these requirements does not mean that the voluntary insurance program or the Federal health insurance program should provide benefits when a person is so confined and receiving such care.

However, it is incumbent upon the State and local governments to make a fair and equitable payment to such institutions for the cost of care of relief recipients. This reimbursement should be related to cost and therefore, again uniform cost accounting should be required.

We believe that the State of Ohio has been derelict in its responsibility toward these people by failing to provide adequate funds to pay the cost of such care. Our studies indicate that the cost of such care, excluding any allowance for depreciation or any return on investment, substantially exceeds $200 per month in this community. If more intensive nursing care is needed, costs will exceed $350 per month. The maximum support by the department of public welfare for recipients of aid for aged until recently was only $170 per month regardless of the amount of care needed or furnished. This amount was recently increased to $180 per month. The program of increasing the subsidy by $10 per month only aggravated the basic error in the system. It fails to recognize that some patients need and should receive more care at costs which will be greater than those who need only minimum care. It treats all nursing homes alike regardless of need or service furnished and it still remains inadequate for even the provision of care in those institutions that are nothing but substitutes for a home setting for our aging population.

We believe the State of Ohio must completely reexamine its method of reimbursement to nursing homes. In this connection, our committee has recommended, and the board of trustees of the welfare federation has approved, the following:

"Every effort should be made by State authorities to raise nursing home standards in Ohio and to see that these are enforced.

"The reimbursing authorities, primarily the department of public welfare, should act immediately to establish standards for reimbursement of nursing homes that are realistic, with full recognition of the actual costs necessary to operate a licensed home. Reimbursement should be related to standards and adequate to meet them, but not in excess of services actually provided.

"Reimbursement should be based upon care required by the patient and some system should be developed to do this. This might mean a base rate per patient with additive reimbursement based on extra services required.

"Funds to meet these realistic standards should be increased as a minimum, by an average of $80 per patient per month. The total increase appropriated should be prorated among all the recipients in all classes of services according to need. This would provide the same ratio (of payment to approved standards) to all recipients."

Lastly, we suggest that the Federal Government in its support of the aid for aged program should completely review its rules for assistance to the State. The subsidy under the Federal program to the State has as a maximum $54 per month for each nursing home patient. This is the maximum regardless of the amount of the State payment. We submit that there should be an increase in this subsidy.

So long as it remains as at present, the Federal Government can be properly charged with part of the blame for the failure of the nursing home industry to improve its own standards.

We appreciate the opportunity of presenting our views and welcome your questions.

Mr. BURT. I will speak mostly of the recommendations of our committee, which is a very large, very knowledgeable committee in the field of nursing homes in this community, and we should be proud of their efforts in trying to move this program forward.

Basically, I think we are in accord that the licensure of nursing homes is basically good, to wit, it is handled in the department of public health. The regulations suggested must be approved by the public health council.

This structure, we think, is available for good regulation. We think an attempt to change this structure, which is now being suggested by a bill put into the recent general assembly is not good, in that it would propose regulation instead of by the department of health, by the nursing homes themselves, to establish their own regulations. We do not think that sound.

The regulations themselves should be reviewed. They are 4 years old, and they were passed as a compromise. Many of their provisions, especially on space requirements and personnel ratios, should be upgraded for minimum requirements of nursing homes in our State.

We believe it is incumbent upon the department of public health to immediately take a review of these, and suggest new ones for adoption by the public health council.

In the area of enforcement, we are of the belief that the department of public health needs greater powers, perhaps, and certainly a centralization of powers of enforcement, by bringing into the department that licensure enforcement that is done through the department of buildings and that which is done by the fire marshal, to bring them all into a single area of work.

Furthermore, we believe that the opportunity should be given for the department of health to deputize local departments of health to carry out the enforcement functions, where local departments have adequate capacities, and thereby assist the State in its burden.

On the question of payment, we believe that there are two areas that are of great importance—first the area of the payment for care as a continuum of hospital care, as distinguished from the payment for a moment for the relief client for long-term care.

I am talking now about two areas, the area of the volunteer, self-payment plan and the area proposed under the King-Anderson bill or other Federal social security programs.

We believe here the nursing home that seeks to be eligible for this kind of prepayment services should meet a higher standard than that which is included in our minimum regulations. There must be a provision of greater care, more medical management, more intensive nursing service, because we are assuming this to be a continuum or a substitute, if you please, for hospital care.

We feel in this area there should be developed national volunteer accreditation programs that will accredit the home above the standards that make the minimum requirements of State licensure.

May I say I think here is one of the greatest opportunities of the Federal Government. At this point in their consideration of social security system of payment for medical aid to the aged, it is their chance by proper legislation and regulation to establish standards that will bring about some of the basic things that we seek in this field.

Concomitant with that, however, must be an adequate cost reimbursement for services there.

May I comment on that?

We believe that it is incumbent upon the nursing home industry, if it has a case of less payment than that which is needed for care, to prove this case, and the only way I believe they can prove it is through the establishment of a uniform cost accounting system, and a uniform cost reporting to the public agency that is called upon to pay for it.

I believe that until we know what their demonstrated audits costs are, we have no right to pay them blindly.

In the area of the long-term care, which is the patient that is probably in the home for life, admitted perhaps even as a fairly well patient, we believe standards must be enforced equally rigidly.

We have suggested as our committee that the State abolish its system of paying the relief recipient who will in turn pay the nursing home, that they use the nursing home as an institution and a vendor of health service, and that payment be made directly to it, as it does to hospitals, doctors, nurses, and others in the health fields.

We believe that this will give an opportunity of direct observation of cost, and cost should be the basis of such State payment to nursing homes.

We also believe that payment must be directly related to services furnished and need of the patient. This, therefore, is going to require a whole new scheme or plan for enforcement of what care is available and what care does the patient need, and the payment should be thereby related to those facts.

We believe the proposed increase of $10 beginning, I think the 1st of July, from $170 to $180, basically as a theory is wrong. You are not only making an inadequate payment, but you are compounding the problem by paying a level to all homes, regardless of service, or regardless of need of patients.

We believe that this must come through a knowledge of what the patient gets, and what he needs, and it is with that in mind that our committee, and now approved by the welfare federation generally, has recommended as a minimum step an $80 increase of subsidy.

But I want to make it clear that this recommendation is not a recommendation to pay $250, necessarily. It is a recommendation that there should be added to the budget some $12 million for the benefit of the department of aid for aged, and that that money be spread amongst the recipients in relation to the services they are receiving.

Furthermore, we believe that the department should establish a standard of care, and if they cannot meet it with funds appropriated, let us face the fact that we are not meeting the need, and pay a percentage of need pro rata for the benefit of all patients.

Lastly, we believe that the Federal Government should again review its position in assistance for aid for aged. We believe that the present limit of $54 toward $180 is totally inadequate. We believe that this is part of the problem, and that the Federal subsidy should be increased.

We submit that this, then, is a problem of financing, both from State and Federal Governments.

Thank you for the opportunity. I will be glad to answer questions.

Senator Moss. Thank you, Mr. Burt. That was a very fine summary of your position.

I understand you say that this blanket amount or award, whether it is $170 or whether it goes to $250, has the defect that the proprietary home operator is inclined to give lesser service rather than what the patient needs, because there is no cost accounting breakdown.

Mr. BURT. That is exactly my position. And may I also add where you receive a flat fee, and you are in a profitable business, there is a tendency to increase profits rather than upgrade the service. This is a danger in a proprietary institution.

Senator Moss. I understand you to say also that you would recommend that all the inspection and licensing of homes be concentrated in the department of health.

Mr. BURT. Yes, sir.

Senator Moss. Do you think the department of health inspectors are competent in the fire protection field, for instance?

Mr. BURT. No; I would have to qualify that. In my haste I missed it.

Yes, they are not qualified, but they should be responsible to, and maybe they should be borrowed from. But there should be responsibility of competent inspectors, whether out of the fire marshal's office or with the same capacities, but they should be responsible to the department of health as the centrally licensing authority, rather than having three agencies and depending on cooperation.

I want responsibility. There it is.

Senator Moss. I appreciate your clarifying it. To have it centered in one place, even though your inspectors might have varying qualifications?

Mr. BURT. Exactly, sir.

Senator Moss. I understand your position is that the new regulations which have now finally been approved by the court are already somewhat out of date, and should be upgraded. Is that right?

Mr. BURT. They started too low to begin with, and I think they are out of date. They should be reviewed. The compromises should be stopped, and we should do a job for the benefit of the patient.

Senator Moss. I think that was Mrs. Barry's testimony, also.

Mrs. BARRY. May I make a point on that?

I think Dr. Stocklen's testimony, which indicated the number of homes without registered nurses, is one of the concerns I would have.

I do not see how you can give any kind of nursing care without a registered nurse responsible. This would mean considerable upgrading of our minimum requirements.

Senator Moss. Do you have a question, Senator?

Senator YOUNG. Mrs. Barry, I admired your testimony.

In your testimony you urged that attention be given to providing Federal matching funds for care of the elderly in mental institutions. You will be interested and pleased to learn that the pending administration so-called medicare bill, S. 1, the King-Anderson bill, of which Senator Moss and I are cosponsors in the Senate, would authorize precisely such matching funds as you advocate. Section 3 of the bill does that.

I assure you we have the votes to pass it in the Senate. We passed a similar bill by a vote of 48 to 44 last year, and just as soon as the Ways and Means Committee sends over some tax bill, any bill that we can hook it on, we will pass it.

Mrs. BARRY. Senator Young, I have not been able to get a copy of that bill. I have written and called your office. So that is one reason I am not up to date.

Senator YOUNG. You are up to date, all right, and I will see that you get a copy of that bill.

Let me ask you one other question: We have heard references to a "black market" in nursing homes. I wonder if you are at all familiar with that information, and what does that mean?

Mrs. BARRY. I am familiar with the term, because I have heard this rumor, too. Of course, I do not have any way of knowing whether it is any more than a rumor.

The reference, as I understand it, is to payments under the counter. For example, one example that was given to me was a person who took the older parent into a nursing home—actually took him to a number of nursing homes. The person was on old-age assistance, and they were trying to get him in. They would not take him at $170 a month, but if you forked over a little money under the counter, $45 or $50, then you could get the person in.

I have heard it in other connections. I hate to say this, and I hope it is absolutely untrue, that every now and then a shady person who presumably is a physician gets kickbacks. He does not have to see all of the patients in the home. He can walk in and sign a lot of cards, and collect his money, and give a little kickback to the home.

Now, Senator Young, I do not know whether these things are true, but I have heard them enough so either there are pretty nasty rumors going around, or something is wrong.

Senator YOUNG. Thank you very much, Mrs. Barry.

No further questions.

Senator Moss. I commented that both Mrs. Barry and Mr. Burt spoke about the regulations being inadequate now. What about the enforcement of the regulations that you do have? Are they being enforced?

Mr. BURT. Well, the regulations are so new in their enforcibility that I think it is unfair to comment at this point.

There is an opportunity now. The court action putting them into effect came in late December, I believe, so we are just on the threshold, and it would be unfair to condemn.

I believe there are opportunities for improvement, and I am sure there is a desire. I have high hopes here, but I think they need personnel and cooperation among departments.

Senator Moss. Mr. Frantz has a question.

Mr. FRANTZ. Just one point, Mrs. Barry. One of the examples of the black market you mentioned sounds like supplementation as it is called in most States. Is supplementation not permitted in Ohio?

Mrs. BARRY. Mr. Burt, will you explain the legal part of supplementation?

Mr. BURT. Supplementation is not permitted as long as the standard is $170, and the State seems to be paying that standard. Now, that standard is totally unrealistic. It is an invitation to a violation of the Federal and State regulations.

Mr. FRANTZ. There seems to be a growing body of opinion in favor of allowing supplementation. Would you have any comment on that?

Mrs. BARRY. We have had violent arguments within our own groups, and so I think I would really rather not say, because they are such strong points of view.

I did refer to a kind of subsidy or a kind of supplementation which is all right. It provided for an aid-for-aged client in a home, where the costs may be higher, for the home to absorb the difference. This has been all right so far, has it not?

Mr. BURT. It is perfectly all right for a philanthropic home to charge less than cost.

There are two basic philosophies which wind you up on either side, depending on from where you start. Therefore our committee has not taken a position.

We certainly feel, though, and I cannot emphasize this too much, that one of the major faults is that the standard is $170. This is an unrealistic standard. What we wish to see is an establishment of standard of payment that is realistic. Then you can begin to consider the problem of the supplementation. You cannot, under the present regulations and the inadequate standards.

Senator Moss. Thank you, Mrs. Barry, and Mr. Burt. We do appreciate this very much.

Mrs. BARRY. Thank you.

Mr. BURT. We appreciate the opportunity.

Senator Moss. Mr. Clarence Tittle, chief of the division of aid for the aged.

Will you come forward, please?

STATEMENT OF CLARENCE V. TITTLE, JR., CHIEF, DIVISION OF AID FOR THE AGED, OHIO DEPARTMENT OF WELFARE; ACCOMPANIED BY IRA M. LaMOREAUX, EXECUTIVE SECRETARY, DIVISION OF AID FOR THE AGED

Mr. TITTLE. Sir, is it all right if I have my assistant with me?

Senator Moss. Yes; we are glad to have you both.

Mr. TITTLE. We would like to thank you and the distinguished Senator Young for inviting us to appear before your committee today. I would like to read a statement.

I wish to thank Senator Frank E. Moss, of Utah, for inviting me to appear before this committee, the Subcommittee on Long-Term Care.

I believe that this committee is undertaking a most important and needed study toward determining what can be done to improve the standards of safety and care in nursing homes.

This has also been a concern of mine and, during the past year and a half, the staff and I have been reviewing this problem to learn what we need to do toward improving the quality of care for the aged in long-term facilities.

As you are learning, we find that the problem is most complex and not very well defined. There seem to be no simple solutions available to resolve the problem. The care of the aged in long-term-care facilities requires the active participation of many agencies, professions, and the sponsors of the nursing homes.

Due to the specific concern and interest by these groups, there has been a diversity of opinion and definition upon which to establish a good program for long-term care. However, progress is being made by the various interests working together to formulate better long-term-care programs.

This has been seen in the development of criteria to approve or accredit nursing care homes by the owners or sponsors and the health care professions. Just 2 months ago, the Ohio Department of Health placed into effect new standards for nursing care homes.

It should be noted that a certain group of nursing home operators in this State prevented, through various court actions, these new regulations from being placed into effect for several years. These regulations will do much toward improving the standards of safety and care in nursing homes in this State.

In addition to these other interested groups, the State welfare department has a vital role and responsibility in making it possible for a large number of aged persons to receive long-term care through the aid-for-aged program.

A review of Ohio's aid-for-aged program will reveal a changing pattern of needs of the older population during the years. The program began in 1934, when it was enacted as a result of an initiative petition passed by a popular vote of the people. It was enacted into being one year and a half before the original Federal Social Security Act, which recognized the need and right of the indigent aged to receive public assistance.

The first appropriation for Ohio's aid-for-aged program was exclusively financed by State funds. Since February 1936 it has been financed by State and Federal funds on a matching basis.

The program is administered by the division of aid for aged in the State department of public welfare, and has an office located in each of the 88 county seats in the State. It is the only public assistance program administered by the State. All of the other public assistance programs are administered by city or county governmental units.

The 1963–64 appropriation approved by the State legislators for the aid-for-aged program was $90 million. The appropriation was divided between two major programs; $20 million was budgeted for the health care program, and $70 million for the regular assistance program.

While the aid-for-aged program has since its beginning made provision for meeting the health care needs of the aged, a significant change was made in 1956, when the State legislators enacted several laws to expand the aid-for-aged program to make it possible to recognize health care as an extraordinary need without a ceiling on payments.

This is an expense that many aged persons in this State could not afford without jeopardizing their ability to maintain themselves in their homes or other living circumstances. Assistance is offered to this group of aged persons through the medical only program. There are about 3,500 to 4,000 persons receiving this help each month.

Payment for the health services is made on their behalf through direct payment to the vendor providing the services. Health care services are also provided in this manner to the recipients of regular assistance. About 67,000 to 72,000 recipients receive health care each year.

Prior to 1956, allowances for health care was included in the recipient's budget, and the total for this item could not exceed $200 per year. Since then there has been no dollar limit on the amount required for necessary health care.

There are limitations on the amount that can be charged by the various health care vendors, and these are determined by a fee schedule.

The health care program provides a wide array of services to the recipients. This briefly is an overview of Ohio's aid for aged program, but in order to understand the importance of long-term care for the aged, I would like to point out several trends taking place in this State's aged population as reflected by changes taking place in the nature of the aid for aged caseload.

A review of the caseload since 1934 reveals that several significant trends are taking place. The caseload of those needing public assistance gradually peaked up to 127,106 persons in January 1950 and has descended downward to 78,665 recipients in December 1964. The reduction in the caseload reflects the improvement in economic opportunity to permit a greater number of persons to qualify for and benefit from various retirement programs. The retirement program affecting the greatest number of persons is social security.

These programs enabled the retired aged persons to have financial resources to meet their daily living expenses for food, shelter, clothing, and other things.

While the caseload is declining, the average age for both the recipient and the applicant is increasing upward. The average age of the applicant is 72 years, and that for the recipient is 79 years. It is anticipated that the average age of the recipient will reach 80 years within the near future.

While the caseload is declining, and the program is servicing an older person, there is a rapid increase in the number of aged persons requiring health care assistance and long-term nursing home care.

The total number of aid for aged recipients receiving care in nursing homes prior to 1956 was less than 2,500. Today, there are nearly 12,600 recipients in nursing care homes. There are an additional 2,000 recipients receiving long-term care in other facilities.

Our recent experience indicates there will be an annual increase of 500 to 600 aged persons requiring public assistance to enable them to obtain long-term care.

Presently, the annual expenditure of public assistance funds for nursing home care is $16,800,000. This does not include any of costs for the services provided in the health care program for those recipients staying in the long-term care facilities.

It can be assumed that these recipients, because of their chronic and infirm conditions, require extensive health care services. A study is planned to determine the cost of providing these services for this group, as compared to those living in other circumstances.

The expenditure for long-term care also does not include other financial resources, such as OASI, that is used to pay toward the standard allowances for nursing home care.

The standard allowances for nursing home care vary according to the level of care needed by a recipient. The determination of standard allowances has been a difficult, if not impossible, task, because of

the inability to obtain necessary cost figures from the owners of proprietary nursing care homes.

Prior to 1956, the monthly payments were limited to a legal maximum which ranged in progressive amounts from $25 to $65 monthly, from 1934 to 1956. In 1956 the law was amended to permit payments in excess of the legal maximum of $65 for nursing care.

With the removal of a ceiling, the division of the aid for aged asked the nursing home operators to submit recommended rates for the department to consider in adopting a rate structure. When less than 20 operators submitted recommendations, the managers of the aid for aged offices were asked to respond to a questionnaire, so that a standard of allowances for nursing home care could be established.

The questionnaire dealt with three factors: The amount being paid by private pay patients, the amount being paid by county welfare departments for the care of their recipients, and the amount which would be acceptable for the care of aid for aged recipients.

On the basis of the response to the questionnaire, the first rate schedule was released in December 1956. The rates varied between counties according to the level of care. The following is a listing of that first schedule:

Minimum nursing care range: $75 $80 $85 $90 $100.

Average nursing care range: $90 $95 $100 $105 $110 $115 $120 $125 $130 $135.

Maximum nursing care range: $100 $110 $115 $120 $125 $130 $140 $145–$150.

Special rates were made in 29 nursing homes, regardless of location, because the home had trained nurses on the staff.

The rates were revised again in February 1960 increasing the allowance $10 per month for the two higher levels of care. The special rates allowed in the first schedule to recognize trained nurses on the staff were reduced to the regular county rate.

The third revision placed into effect October 1962 raised the rate for maximum nursing care by an additional $10 per month. This increased the allowance for maximum nursing care to $170. The range is $145 to $170.

A fourth raise will be placed into effect July 1, 1965, and this will increase the rates for average nursing care and maximum nursing care another $10 per month.

The department of public welfare has been reviewing the rate structure to consider further changes.

It is our belief that further changes in the rate structure for long-term care have to be related not only to the various levels of care needed by the recipients but, also, to the quality of services provided by a nursing care home.

Further, we have reason to believe that rates in themselves will not improve the quality of care. While the matter of rates is an important consideration, the ultimate responsibility for improving the standards of safety and care falls upon the nursing home owners themselves. The public agencies have the responsibilities to assist them toward improving their programs, and to utilize their facilities in an appropriate manner.

The role of the nursing home under private ownership is rather new. When the aid-for-aged program began in 1934, there were less

than 300 proprietary nursing care homes, and less than 50 philanthropic homes. Today, there are over 1,000 proprietary homes and 250 to 300 philanthropic homes.

Many of the homes in existence in 1934 were designed for the care of the ambulatory person and operated primarily as rest homes. However, with an increase in the number of the aged requiring long-term care because of chronic health conditions, the facilities are required to provide more specialized services.

We have moved into an era which is placing more demands on the public agencies and the nursing homes to provide improved services to the aged population. The essential problem is the development of a more definitive utilization of public funds, setting of standards, and provision of services.

In conclusion, may I say that our division and the Ohio Department of Public Welfare are giving a great deal of thought and study to the problems connected with nursing home care.

The areas of concern are as follows:

(*a*) Methods of improving procedures which will insure the recipient can secure the care he needs when nursing home care is required.

(*b*) Establishing of payment for nursing home care which will be consistent with the care required by a recipient.

(*c*) Consideration of methods of classifying or accrediting nursing homes according to their ability to give nursing care.

The enforcement of standards of safety and care is closely related to the propriety of the payments made for the care required, and the ability of the nursing home to provide the care needed by the recipient of aid for the aged.

I would like to thank you, gentlemen.

Senator Moss. Thank you, Mr. Tittle, for that very comprehensive statement. It is an excellent one.

I understand that under your Ohio law there is no ceiling placed on the amount that may be given to a public assistance patient for medical services. Is that right?

Mr. TITTLE. That is correct.

Senator Moss. But there is a ceiling on what may be paid simply for care that is not medical care. Is that the $170 ceiling?

Mr. TITTLE. Yes; that is the standard of fees or schedule of allowances, as we call it.

Senator Moss. In other words, it would not exceed $170 unless it could be said that the patient needed some special medication, and then it could go up?

Mr. TITTLE. Yes; if he needed drugs or physical therapy.

As one witness stated, we can provide 10 physical therapy treatments without authorization and, after that, authorization is required.

Senator Moss. Do you have a special form which requires verification for special drugs, or a therapist?

Mr. TITTLE. We verify that by visiting the various homes or therapists or physicians to make sure treatment was given on that date.

Senator Moss. Those are verified by members of your department?

Mr. TITTLE. That is correct.

Senator Moss. Thank you very much.

Do you have a question, Senator Young?

Senator YOUNG. Yes; I have a question.

Mr. Tittle, as I understand our Ohio law, there is a provision for recovery of benefits paid under the aid for aged, a house, or something like that.

Mr. TITTLE. That is correct.

Senator YOUNG. Do you have a breakdown by individual cases of the assets recovered during the last fiscal year, or any recent fiscal year, including the amounts realized from the sale of noncash assets?

Mr. LAMOREAUX. Every recovery is credited back to the recipient's account of payments.

Senator YOUNG. That does not answer my question.

Do you officials have a breakdown by individual cases of the assets recovered during any recent fiscal year, particularly the last fiscal year, including the amounts realized from the sale of noncash assets? In other words, the sale of real estate?

Mr. TITTLE. We do not have those figures as they relate to case to case, because they have to be submitted to the administrator of the estate.

Senator YOUNG. Would you then provide this subcommittee with such an itemized accounting for the last fiscal year?

Mr. TITTLE. For how many cases?

Senator YOUNG. For all the cases.

Mr. TITTLE. Total. I can give you an estimate of the total recovery.

Senator YOUNG. I want the figures, and I will tell you the reason. The reason is that there is a well-defined rumor, whether it is true or not, and I certainly hope it is not true, that there is favoritism shown in the disposition of assets, that favored people may bid in and take over a little property, or some land that has been paid in.

So it is important to this subcommittee that we have this from you within a reasonable period of time. Can you furnish us within 30 days with an itemization for the last fiscal year?

Mr. TITTLE. Yes; we will be happy to. In turn, if there is any favoritism or rumors, I would like to be informed, because I would personally not tolerate it.

Senator YOUNG. I would personally say I hope there is no truth to that rumor, but it would be very important if a complete statement of the sale price of individual cases in the last fiscal year would be furnished to us. You will do that, will you?

Mr. TITTLE. Yes; I will be glad to do that.

Senator YOUNG. I have just one other question: What do you consider would be the effect if the Federal Government were to withdraw its share of the funds now going for the care of aged in unsafe and outrageously substandard nursing homes?

Mr. TITTLE. I would think it would be welcome.

Senator YOUNG. It would be very serious, would it not?

Mr. TITTLE. Yes. We need some administrative instruments in which to enforce standards. It has been indicated that the public assistance agency has very little standards to work with. We, in effect, become a third party.

Senator YOUNG. Yes, your public servants in the Congress have an obligation to all the taxpayers in the country not to hand out matching funds of our taxpayers to unsafe homes in Ohio and other States, and we are preparing to do that. That is one reason we are here, because we want the standards raised, and you want the standards raised.

Mr. TITTLE. Absolutely.

Sentor YOUNG. Would Ohio have substantially greater funds available for nursing home care if the General Assembly of Ohio had adopted the Kerr-Mills program of medical assistance for the aged?

Mr. TITTLE. We have to speculate whether or not they would appropriate additional funds. I think under our present program as it has been enforced since 1956——

Senator YOUNG. You do not want to answer yes or no whether Ohio would have substantially greater funds available had the general assembly taken advantage of the Kerr-Mills program?

Mr. TITTLE. I would say if the necessary appropriations were made, Ohio could have benefited substantially.

Senator YOUNG. It happens that I voted against the Kerr-Mills bill. I thought it was a bad bill then, and I think it is a bad bill now. That is all.

Senator Moss. Thank you, Mr. Tittle, and Mr. LaMoreaux. We appreciate it.

Our next witness is a State senator from Ohio, Mr. Anthony O. Calabrese.

Mr. Calabrese, we are pleased to have you, sir, and we are glad to hear from you now.

STATEMENT OF HON. ANTHONY O. CALABRESE, STATE SENATOR FROM OHIO

Mr. CALABRESE. Senator Moss, Senator Young, and distinguished members of the subcommittee, early this morning the mayor extended you the greetings of the city of Cleveland, with the county commissioner. Now I extend to you the greetings of the State of Ohio, especially where you have in attendance a distinguished Senator, Stephen M. Young, who was a member of the Ohio Senate at one time, and we know his distinguished career.

Senator YOUNG. I was a representative, Senator.

Mr. CALABRESE. In the general assembly.

I have no statement prepared, but I am here merely to go on record in speaking for the tragedy that occurred here in Fitchville, Ohio, and due to the Cleveland Plain Dealer, which spotlighted this terrible ordeal in our great State when we lost 63 lives, the lives of senior citizens who probably gave their lives and blood to this great State of ours and this great country of America.

I can go back many, many years ago, Senator Moss and Senator Young, when I came from Italy at the age of 11 as an immigrant. My dream was that some day when I would get married I would have my father and my mother living with me in our home.

This day has disappeared. The generation of today, the minute they get married, they find a place for the senior citizens and put them in these nursing homes.

Today I am here not to talk about the cost, the care, I am here as a member of the State of Ohio, as a legislator of the senate, as a sponsor of a bill which will regulate, which will put more stringent laws, will license these homes, will supervise the money, good strong supervision.

By the way, I want to commend you, because in the Plain Dealer you

made a recommendation that these laws are inadequate in some of the States, and you hope that the State does look at some of these matters.

So the reason why I am here today, my bill would license these homes, will have the fire marshal inspect these homes, the building division inspect these homes, the department of health inspect these homes, and the welfare department inspect these homes.

This is where they belong. They must have rigid inspection. There must be strict supervision of the State. We will create a seven-member board, and this board is composed not only of people of nursing homes, which I read in the Cleveland Plain Dealer. That is not true. This board will put members of the industry which are familiar with the industry and who are licensed by the State, and put the other members who will have to have the advice and consent of the senate.

I believe that is the salvation of our great State. We must put stronger teeth, otherwise these people are not going to follow the laws.

If these people do not fulfill the obligation, we have penalties, and we have the courts to punish these people.

So I know that your committee is overcrowded with witnesses. I took 4 minutes of your time.

I want to express my appreciation to the entire subcommittee for extending me the courtesy of appearing before this committee today.

If there is any question of the committee, I will be very, very happy to answer it.

Senator Moss. Thank you, Senator Calabrese.

We are indeed pleased and honored that you came here to testify before the committee.

I agree with what you said about the changing times. In your lifetime and mine it has changed from where our parents lived with their children in their older years, their married children, to the point where now, because of, well, just our changing mores, there just does not seem to be room for them any longer in their own children's homes.

Therefore, this problem has grown rather rapidly upon us, and we must address ourselves to it.

I agree with what you say heartily. We must have stringent standards, and make sure they are enforced, so that our older people who cannot fend for themselves are protected by society.

Senator Young, do you have any questions?

Senator YOUNG. Yes.

It happens that I was born and reared 8 miles from Fitchville, where 63 elderly had their lives snuffed out. That was an inexcusable tragedy.

The real tragedy of that conflagration lies in the fact that it could have been prevented, had proper safety standards been enforced.

Senator, the Ohio Federation of Licensed Nursing Homes are the very group of persons that successfully thwarted, through legal actions, enforcement of stricter safety regulations that had been approved by the Ohio Health Council back in 1961. It was this group that caused action to be brought in the courts of our State and delayed the adoption of higher standards. I am not in sympathy with them at all.

I would not want them to be on the board, the seven-member board. I am not narrowminded, but I also would not want a group of nightclub operators to regulate that, or bartenders to regulate the enforcement of sumptuary laws in our State.

I think that if an opposition group of the sort that kept these standards down—in Fitchville they had neither an automatic sprinkler system, nor do I know whether they had any automatic detection system—should not be a party to the maintaining of standards, Senator. Unless the General Assembly of Ohio adopts proper legislation to protect these elderly people, you can count on it that I will oppose Federal matching funds coming into my State, much as I love Ohio, and paid to any nursing home operator who tries to thwart reasonable regulations, as this private group did.

I am not in favor of them at all.

I have expressed my views here, and I hope you will agree with them.

Mr. CALABRESE. Senator Young, do you mean to tell me if the 106th general assembly adopts a bill with all these regulations and stringent laws to license a nursing home, and when the license is issued to a licensed operator, that this licensee is not qualified to serve on a nursing home board?

Senator YOUNG. I will go on the record, and I am familiar with the facts, and what the investigation showed, and I know in my own mind that the Fitchville fire could have been avoided, had there been decent standards. I am not sympathetic with any persons of the sort of operators of the Fitchville home or of any similar ones. I do not think they should be permitted on a supervising board.

I am not laying down any rules that must be made. I am just one of a hundred U.S. Senators but my vote will go against matching funds unless there are proper standards.

The bill we shall consider in the Senate, identical to the one I introduced in the last Congress, provides that the Secretary of Health, Education, and Welfare of the United States is the proper official, and has authority, to set minimum safety standards.

That is all I have to say on that.

Mr. CALABRESE. OK, Senator.

Senator Moss. Thank you, Senator Calabrese, we appreciate it.

We have one more witness we want to hear before our noon recess, Mr. Dennis McGuire, who is the assistant county prosecutor of Cuyahoga County.

STATEMENT OF DENNIS McGUIRE, ASSISTANT COUNTY PROSECUTOR, CUYAHOGA COUNTY, OHIO

Mr. MCGUIRE. Thank you, Senator Moss, and Senator Young, and members of the staff.

I am going to take about 2 minutes, because I think I am in here on a raincheck.

We in the prosecutor's office are concerned with fraud and penalties. We have a pending case at the present time under indictment—a Eugene Woods. He at one time was connected with the Fitchville operation. Because of the indictment and the canon 20 of the "Code of Legal Ethics," we are precluded from making any mention, and properly so, of the facts in that particular case.

I might say—and I think I am going to take about two and a half minutes, so I can beat the Senator from Ohio on time—I am very

much pleased in a humble way to see this activity here, and the attendance of this subcommittee in Ohio, because of the fact that I happened to spend about 2 months in an intensive investigation of this particular operation.

This man is now wanted by the FBI and, of course, we cannot tell the newspapers not to say anything about anything in particular. I find that in Faith Corrigan's report, she covers the high spots of this particular operation.

As I say, we are concerned only with fraud and the penalty. Our particular statute that we have recourse to in a fraudulent nursing home operation would be the old statute which goes back to the horse-and-buggy days.

I do feel confident that in the final results of this committee's endeavors that you will have properly taken care of the fraud section.

I am mindful of the fact that I hold a position that was formerly held by the distinguished Senator from Ohio, the chief of the criminal division of the county prosecutor's office.

Any information that you would want, or your committee would want, that we could give to you, without violating that canon of legal ethics, you may be sure that the files in our office will always be open to you for whatever information we can give to you.

I thank you for this opportunity, and apologize for taking more time than I should.

Senator Moss. Certainly you have not taken a lot of our time. We are pleased that you came here to appear before the committee, Mr. McGuire.

We understand that you properly could not discuss the case that is in your office, and that has not yet been disposed of, so we are glad to know that it is under consideration, at least, and will be disposed of, I am sure.

Since I was an old county prosecutor before I got to the Senate, I want to particularly welcome you here, and tell you that I appreciate the work that you do for this county here as our county prosecutors do all over this Nation. They are the backbone of law enforcement, of course, and I congratulate you on that.

Senator YOUNG. May I, Mr. Chairman, also manifest my admiration and pay tribute to Dennis McGuire as an outstanding and a truly dedicated public servant.

Mr. MCGUIRE. I am glad to face Senator Young here, rather than across the table in a criminal trial, I can assure you of that.

Senator Moss. I understand your statement, sir.

We will now take our noon recess. We did not complete all of the witnesses we had this morning so we will begin with the two we were not able to reach and then go right on with the afternoon list.

I believe we can shorten up our noon hour a little bit so I am going to say that we will come back in at 1:45 when we will start again and try to complete the rest of our hearing.

We are at recess.

(Whereupon, at 12:20 p.m., the committee recessed, to reconvene at 1:45 p.m., the same day.)

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AFTERNOON SESSION

Senator Moss. The hearing will now resume.

We did not quite make the 1:45 time, but we are getting a little head-start, anyway. I am sorry that we are as crowded for time as we are today.

We have had some very fine testimony this morning and a lot of good information for our record. We look forward to this afternoon's presentation.

Our first witness this afternoon will be Dr. Raymond Wehr, who is chief of the division of medical facilities of the Ohio Department of Health.

We appreciate Dr. Wehr's patience. We had scheduled him this morning and he very graciously agreed to go on this afternoon. He will be our first witness.

Dr. Wehr.

STATEMENT OF DR. RAYMOND WEHR, CHIEF, DIVISION OF MEDICAL FACILITIES, OHIO DEPARTMENT OF HEALTH; ACCOMPANIED BY GEORGE COMPSON

Dr. WEHR. I have with me Mr. George Compson.

Senator Moss. Mr. Compson, we are very happy to have you, too, sir.

Dr. WEHR. Mr. Chairman and members of the Joint Committee on Long-Term Care, my name is Raymond E. Wehr, M.D. I am chief of the division of medical facilities of the Ohio Department of Health. This division includes administration of the Hill-Burton program in Ohio, development of a State plan on hospital and other medical facilities needs, and also the supervision and licensing of nursing homes.

Ohio has an ongoing program for improvement in nursing homes in general, with respect to both care and facilities. This program was partially delayed by lawsuits, but a decision of the Ohio Supreme Court in December 1964 finally has cleared these blocks. We expect that the program will move forward smoothly from this time.

The Ohio Department of Health has been trying to extend a helping hand to the nursing home industry in Ohio. It is our feeling that nursing homes of good quality are critically needed in our State.

We should like to see the standards of nursing homes raised. We even hope that they might approach the professional level that hospitals have reached. As a matter of fact, some of the better nursing homes in Ohio are near this level now, but the average falls far below it.

In our efforts to raise the standards of nursing homes in general, we have tried to establish new minimum regulations for care, service, comfort, and safety. But this is just part of our program. We also have provided expert counseling service for nursing home operators, and we have offered an extensive training program for nursing home employees.

We have been supported in all of these efforts by large segments of the nursing home industry itself. Many operators of nursing homes want to raise standards just as much as we do. Unhappily, some of the other operators have fought against our efforts.

By action of the Ohio General Assembly in 1959, the Ohio Department of Health was given the responsibility of licensing and inspecting nursing homes. This amounted to a transferral of authority from two other departments of the State government.

In order for the department of health to assume immediately its new responsibility, and to avoid misunderstanding and confusion, the Ohio Public Health Council, the regulatory arm of the department, adopted verbatim the regulations which previously had been enforced by the two other departments.

Use of these old regulations was to have been only temporary, but unfortunately had to be continued until the Ohio Supreme Court decision of 2 months ago.

The department of health in late 1959 then bent itself to the task of preparing new regulations. For assistance in this task, a broadly representative advisory committee was created, including representation from the nursing home industry itself, and representatives of the Ohio State Medical Association, Ohio Hospital Association, Ohio Citizens Council for Health & Welfare, Ohio State Nurses Association, Association of Ohio Health Commissioners, Ohio Chapter of the National Association of Social Workers, Ohio Association of Public Health Sanitarians, Ohio Dietetic Association, and the Ohio Association of Business & Professional Women's Clubs.

With the aid of this group and others, the department of health came up with a set of regulations which we believe to be reasonable and purposeful. These regulations were adopted by the Ohio Public Health Council.

Before they could be put into effect, however, legal action was brought against them by a new group of nursing home operators which had been formed during the very period when our department was working so hard to draft the new regulations. This suit and variants of it were kept alive until the supreme court decision of December 1964, despite the fact that the appellants never won a single decision in any of the lower courts.

While the hands of our department were somewhat tied by these legal maneuvers, our department continued to the best of its ability to carry on an inspection and licensing program under the old regulations which had been inherited from the two other departments.

In November of 1963, all of us across the country were shocked by a nursing home fire near Fitchville, Ohio, in which 63 of 84 patients lost their lives.

I might mention that under our new regulations, then tied up in the courts, the home where this fire occurred would have been obliged to install a sprinkler system, or an automatic fire detection and alarm system, or reduce its occupancy to 30 or less. Under the old regulations it was licensed for 85.

The State fire marshal reported that the Fitchville nursing home holocaust resulted from multiple fires starting at one time from arcing in an overloaded and grossly inadequate wiring system.

Under emergency authority granted by Governor Rhodes, the Ohio Public Health Council was able to adopt a special emergency regulation on electrical wiring, without a public hearing and without the threat of court appeal.

This special regulation, subsequently adopted as a permanent regulation, was designed specifically to reduce substantially the possibility of another fire such as that at Fitchville.

In a crash program, all 1,153 of the then licensed nursing homes in Ohio were given an electrical wiring inspection during the month of March 1964. Only 386 were found to meet the safety requirements of the new wiring regulation. All of the other homes were served with notices of intention by the director of health to revoke their licenses unless they took steps immediately to make corrections.

The results of this crash program on wiring indicate what can be accomplished with a firm approach to regulations. Forty-nine homes closed—39 of them voluntarily, 5 by license revocation, and 5 by denial of license renewals.

All the rest of the original 1,153 homes have now met the wiring requirements except 2. Those two are very large homes which have undertaken extensive remodeling along with the wiring improvements, and these are scheduled for completion shortly.

In the meantime, 77 new homes have opened, all of which meet the wiring safety requirements. This means that we now have 1,179 nursing and rest homes in compliance with the new electrical wiring regulation, and 2 others that will meet it shortly.

In addition to this crash program on electrical safety, we continued our general inspections and licensing under the inherited regulations until the time of the supreme court decision in December. Now we are gearing up our program to the new regulations of our own department, which are finally in effect. We realize that it may take many months before these new regulations can be implemented fully by all of the homes in Ohio.

These regulations provide for greater comfort; more space per patient; better service, care, and safety. I shall not go into the details here, but am submitting copies of the new regulations, along with copies of the emergency wiring regulations to which I have made reference.

I should prefer to use my remaining brief time here to mention that we are continuing our educational program for nursing home personnel. For this purpose we have employed in our nursing home unit in the Ohio Department of Health a number of experts in such subjects as nursing care, physical therapy, occupational therapy, and sanitation. These experts call on nursing home operators, offering help on the job as needed.

Furthermore, we have established a program of training courses for nursing home personnel, held in various parts of the State for the convenience of the operators and their staffs. To date, more than 2,000 nursing home staff people have taken advantage of these courses.

We in the Ohio Department of Health want to see nursing homes take a higher place in the total scheme of medical care than they have in the past. The nursing home has evolved as one answer to the need for more institutional resources for the chronically ill and aged.

A population in which the average age is steadily rising creates many problems in chronic diseases. Older persons are sick more often, their illness is of longer duration, and they require more institutional care than any other group in the population.

They do not, however, need this longer period of care in general hospitals which are already crowded. They could obtain this care in special chronic disease hospitals or wings, rehabilitation centers, or in nursing homes having adequate standards of facilities and personnel.

In this connection, I should like to mention that we now have 25 hospitals scattered across Ohio—5, incidentally, are under construction at the present time—which have nursing home units as part of the hospitals. These nursing home units have a total of 1,284 beds. We also have 7 other nursing homes with 587 beds which are owned by hospitals, although not directly attached.

We also are happy to state that according to the last report, 24 nursing home facilities in Ohio are now accredited by the National Council on Accreditation of Nursing Homes. Two of these are approved for intensive care, with 139 intensive care beds.

In all, we have 1,179 precently licensed nursing and rest homes providing care in Ohio. The total number of beds is approximately 33,000.

Thank you.

Senator Moss. Thank you very much, Dr. Wehr. That is an excellent statement, with lots of good information for us.

You indicated in talking about the fire in Fitchville that the home could not pass the wiring examination because it had more than 30 patients. It was licensed for 85, I think. What kind of regulation applied to a home with 30 or fewer? Is it substantially less?

Dr. WEHR. I think perhaps I will ask Mr. Compson to answer that question. He was with the department connected with the program, and I was not.

Senator Moss. Thank you.

Mr. Compson.

Mr. COMPSON. The regulation of our department which would have applied would have required the installation of a conforming sprinkler system or a fire detection service in the home, or any home caring for 30 or more patients.

It would not, and does not today, require the installation of a sprinkler system or a fire detection system in a home of less than 30 patients.

Senator Moss. That dividing line still exists, then?

Mr. COMPSON. Yes; this dividing line—frankly, I cannot tell you where it originally came from. We took it from the Ohio Building Code. The Ohio Building Code was adopted with regard to this occupancy of nursing homes in 1958.

Our regulations in effect adopt the Ohio Building Code for homes constructed after 1958, and temper somewhat the application of the Ohio Building Code to homes constructed or converted to use prior to the adoption of the Ohio Building Code.

Senator Moss. Is the department of health, satisfied with that distinction at 30?

Mr. COMPSON. That is a difficult question to answer, whether the department is satisfied with this or not. I have heard a number of statements by a number of people as to what should and should not be the standard.

The legislative service commission of the State of Ohio has conducted an extensive study with regard to nursing and rest homes. It is critical of this distinction between 30 and above and 30 and below.

Now, I assume in many things there is an arbitrary line which you must draw. It had previously been drawn at 30 in Ohio.

The firefighting association, the State fire marshal, has criticized this in recent months, before this legislative service commission committee.

Senator Moss. The reason I asked the question, I can understand if you are talking about 3 or 4 or 5 that you just consider these pretty much like a one-family home, but 30 is quite a number of patients, or older people to have in a nursing home, and it seemed to me that that was quite a high number to be exempt from the sprinkler requirements and other requirements.

Mr. COMPSON. We in our department, I do not believe we profess to be experts in the area of building codes. When we went to adopt regulations in this area, we went to the Ohio Building Code, which was adopted by the Ohio Board of Building Standards, and we used this as our criteria.

Senator Moss. Thank you, Mr. Compson.

Dr. Wehr, you mentioned that there was an organization formed apparently just to combat these regulations when they were first adopted and brought to litigation that held up for about 4 years the implementation.

Did this organization come into existence for this specific purpose, or do you know?

Mr. COMPSON. I do not know that that is a fair question to ask Dr. Wehr.

The organization did organize during the period the department was developing regulations. I would say this would be unjustified, in saying that it came in existence just to fight this department.

Senator Moss. It still is in existence, the organization, today?

Mr. COMPSON. To the best of my knowledge.

Senator Moss. Thank you very much.

Dr. Wehr, we appreciate having a copy of the regulations that now have been validated, and these will be part of our file for reference in this committee. We are very happy to have it.

They will not be copied verbatim in the record, but will be attached as a file.

Dr. WEHR. If you need more, we will be glad to supply them.

Senator Moss. Senator Young?

Senator YOUNG. I have a question following the question of Chairman Moss.

Obviously, one of the objectives and purposes of the Ohio Federation of Licensed Nursing Homes, so-called, this opposition group, is to oppose the enactment of this recent legislation through court action. Is that not a fair statement?

Mr. COMPSON. They did do this; yes.

Senator YOUNG. These operators who did that, may I ask, how significant are these operators in terms of number?

They were evidently strong enough through court action to litigate for some 4 years. Can they strongly resist the implementation of your new regulations? Can you tell us how significant they are in terms of numbers?

Mr. COMPSON. The size of the organization has varied from time to time, and I could give you no figures at all. I understand you have a person later on associated with the nursing home industry that might be able to give you exact figures with regard to the organization now.

It would not take a large organization. All it takes is one person, and enough money, and you can fight anything.

Senator YOUNG. Have you formed any judgment of why they have objected so vehemently and vigorously to what appear to be reasonable regulations?

Mr. COMPSON. What are reasonable regulations is a matter of opinion, and their opinion differed from that of the department.

The primary basis for objection was our increased requirement with regard to personnel, space, and the increased building code requirements with regard to older buildings.

Senator YOUNG. Dr. Wehr, I go along with the chairman here, that it appears to me that a nursing home with beds for capacity of 30—that is a pretty good sized nursing home.

What percent, if you are able to tell us, of the nursing homes in Ohio have beds of 30 or less capacity?

Dr. WEHR. I would think at the present time it is probably 50 percent, 30 or less.

Senator YOUNG. Of the total nursing homes?

Dr. WEHR. Yes. You are more apt to run from about 50 beds on up. All the newer homes will run from 50 to 100.

Senator YOUNG. What percentage between 50 and 30?

Dr. WEHR. Twenty percent.

I do not have a real figure I can give you, but I can certainly find out and write you and tell you what it is.

Senator YOUNG. I think we would like that in the record, because that would still mean that there are a large number of nursing homes in Ohio that would have a situation constituting fire hazards, even after the implementation of your new regulations. Is that not a fact?

Dr. WEHR. Yes, sir.

Senator YOUNG. I think that is all.

(Dr. Wehr subsequently reported that 69 percent of all nursing homes in the State have 30 beds or less.)

Senator MOSS. A question from Mr. Constantine.

Mr. CONSTANTINE. Dr. Wehr, does your department have any information or evidence indicating that nonqualified nursing home personnel are performing functions such as administering injections and things of that nature?

Dr. WEHR. We run into that from time to time.

Mr. CONSTANTINE. Do you do anything about it?

Dr. WEHR. Yes. The owners are notified that they must stop and they have to get qualified personnel.

We have only had these new regulations in effect for a month and a half today. The thing that is coming out so far, from talking to my field people, is that we apparently do have a shortage of RN's and LPN's who are available or who want to work in nursing homes.

That seems to be the thing that everyone talks to me about, and I have talked to quite a few of them in the last 50 days.

Mr. CONSTANTINE. Does you department, apart from its licensure inspection, have regular medical audits?

Dr. WEHR. What do you mean by medical audits?

Mr. CONSTANTINE. To go in and see what type of care is provided, how regularly the physicians are visiting the patients, to evaluate the quality of care.

Dr. WEHR. The new regulations specifically provide how many times a doctor should call, and it also indicates for private patients that each patient must have a doctor to call in an emergency. And our people are trying to help the operators as frequently as they can get there.

Senator Moss. I think Mr. Frantz has a question.

Mr. FRANTZ. Just one, Dr. Wehr. There is another line here that is drawn in terms of size. In your regulations governing nursing personnel I notice that in homes of 50 beds or less, no registered nurse is required.

Dr. WEHR. That is true.

Mr. FRANTZ. "RN or LPN," is the language.

Dr. WEHR. Above 50? No; that is not true. No; as a matter of fact, you have to have an LPN with 10 or less patients.

Mr. FRANTZ. I am talking about an RN.

Dr. WEHR. When you get to that, you get to your 51 to 100.

Mr. FRANTZ. Fifty-one and above an RN is required on the staff?

Dr. WEHR. That is true.

Mr. FRANTZ. And below that an RN is not required?

Dr. WEHR. That is true.

Mr. FRANTZ. I wonder how you would rationalize this. If you had patients requiring professional supervision, what difference would it make if you had 50 or 51?

Dr. WEHR. I am sure these operators would hire them if they could get them, and some of the fewer patient homes do have them.

Mr. COMPSON. I would direct your attention to where it says, "Comprehensive nursing home patients." This would not pertain there.

Mr. FRANTZ. Comprehensive nursing care patient is defined in a way which means that they would require care that a registered nurse is capable of giving, and that one who was not so classified would not require such care. Is that right?

Mr. COMPSON. I think you are asking how do you rationalize this. I think one of the real problems of the nursing home industry is the ability to attract or even have available trained personnel such as RN's and LPN's.

Now, the industry thought we were extremely severe—the industry generally—in the requirements that we have placed in here right now. Now, you can require anything but getting it might be something else.

We use RN's in hospitals, and LPN's. We have just so many qualified people to go around. And more attention must be directed toward training people that are capable of doing this.

You cannot require someone to have personnel when these personnel just are not available. We thought that these were reasonable requirements at this time.

Mr. FRANTZ. Would it be a fair statement that the distinction is based on what you perceive to be economic realities, rather than on differences in the condition of patients in the small homes and the larger homes?

Mr. COMPSON. I think that is partially true.

Mr. FRANTZ. Thank you very much.

Senator Moss. Thank you very much, Dr. Wehr, and Mr. Compson. We appreciate this. It was very helpful to us.

Our next witness is Mr. L. Bruce Levering, who is the president of the Ohio Nursing Home Association, from Columbus.

Let me say at this point, while Mr. Levering is taking his place, that because of the limitation of time, we obviously cannot hear all of the people we would like to hear today. I do invite anyone who has a comment or some factual information he would like to submit to send his statement to me any time within the next 2 weeks so that it can be included in the record. I will be glad to have you do that.

We do not want to preclude any information that we can get in this record that will be helpful to us. Obviously, we would want you to be contributing some information on the subject at hand, and to give us sound and reasonable statements. But I am willing to accept any such statement that you would like to submit in writing for the record.

Mr. Levering, we are glad to have you here, sir, and you may go right ahead.

STATEMENT OF L. BRUCE LEVERING, PRESIDENT, OHIO NURSING HOME ASSOCIATION, COLUMBUS, OHIO

Mr. LEVERING. Senator Moss, Senator Young, members of the Subcommittee on Long-Term Care of the Aging, nursing home colleagues, and friends, I want to thank you for this opportunity to present the viewpoints of the Ohio Nursing Home Association.

I am Bruce Levering, president of the Ohio Nursing Home Association, which has a membership of 75 nursing homes from all parts of the State. We are affiliated with the American Nursing Home Association, which has membership in 49 States of the Nation. The homes in our organization range in size from 10 beds to 120 beds per home.

Membership in the Ohio Nursing Home Association is contingent upon the applicant's intention to apply for accreditation as to its classification as an intermediate, skilled, or intensive care nursing facility. The accreditation program is sponsored jointly by the American Medical Association and the American Nursing Home Association, with headquarters in Chicago, Ill. It is a nonprofit organization known as the National Council of Accreditation for nursing homes.

This accreditation signifies the type of nursing care one can expect from the accredited home. Today, in Ohio, 29 nursing homes are accredited and, as we understand it, 3 applications are in process.

We are informed from their national office in the United States there are presently 503 accredited homes. This association is convinced that it is in the best interests of all that accreditation becomes a realistic measure of all nursing homes.

Naturally, our efforts in the accreditation area are tied to nursing services' costs. Accordingly, therefore, Ohio Nursing Home Association encourages its members to use the standard chart of accounts as approved by the Department of Health, Education, and Welfare in computing their per-patient-day cost.

A cost survey of participating homes released last summer indicating their cost per patient day is attached to this statement for your information. Results of this survey were distributed to the Ohio Depart-

ment of Welfare and other interested civic groups and organizations so that they might correlate this analysis in their work.

The Ohio Nursing Home Association and its members do not want to shun the responsibility of the great tragedy that occurred in our State some 14 months ago. We in the nursing home business and profession are obligated to prevent such another catastrophe from happening, if possible.

We have all suffered in many ways from this tragedy, and I believe only a nursing home administrator can realize the agony and suffering that would develop from such an incident.

Because of the responsibility that is placed upon the nursing home profession, this association has been willing to undertake the responsibility of improving all nursing and rest homes in Ohio.

Our record is as follows:

Our association began improving the standards in 1959 when we were instrumental in changing the licensing authority from the welfare department to the health department. When the regulations were drawn up, we had representation on the advisory board of the public health council. We then supported these rules and regulations. We urged their adoption at the public hearing before the public health council.

We have continually supported the public health council for the past 5 years in their litigation for better rules and regulations, knowing, however, that it would affect our members as well as other homes throughout the State, both large and small.

The responsible administrator has demonstrated that he wants better rules and regulations, and is willing to provide skilled nursing home service.

Herein, however, lies the problem: In our efforts to provide skilled nursing home care, some 12,000 patients who are aid-to-the-aged recipients cannot afford this care. Questions, therefore, must be asked and solutions attained. Should the aid-for-aged recipient receive private supplementation? Should the local county government make up the difference? Should State and Federal grants be increased so that skilled nursing care on a cost-per-patient-day formula be reached?

As you know, at the present time, not one of today's welfare programs is geared to pay for skilled nursing services.

Seemingly, here, we have a substantial conflict. The Ohio Department of Health, charged with the responsibility to enforce the rules and regulations as set forth by the Ohio Public Health Council, requiring higher standards in the nursing home industry, runs into the nursing home recipient who must receive these services, receiving an average of $125 a month for these services. We recognize, however, the tight budgetary requirements that are placed upon the department of welfare.

One solution, as proposed by the Ohio Nursing Home Association, would be to tie the cost per patient day, using the chart of account as approved by the HEW, with an accreditation program outlining skilled nursing care and facilities.

This approach is similar to that now being conducted with all hospital care. It would, therefore, assure the State that its patient was receiving the type of care that it needed and that it was paying for the type of care that was requested.

We have reviewed, in depth, the present H.R. 1, medicare, and, as you know, this proposed legislation was not intended to provide long-term care for the aged, or 365 days of nursing home service, which most welfare cases now require.

There is a program available by which Ohio's aged could greatly benefit. This is the Kerr-Mills program which is now in effect in 47 of the 54 provinces of the United States.

We are aware that the Ohio Department of Welfare and certain members of the Ohio Legislature have studied our potential participation in Kerr-Mills. However, budgetary restrictions, constant low-paying payments in the total welfare program, have made this potential program economically unfeasible.

There are other reasons why Ohio has not participated in medical assistance for the aging as provided by Kerr-Mills; they are the lien law on property and the residence requirement.

The Ohio Nursing Home Association has been doing an extensive study of the Kerr-Mills program in other States, and finds that it is possible for Ohio to provide care for the long-term-care patient 365 days a year.

In addition, Ohio could receive at least 50-percent-matching funds from the Federal Government. For example, in some cases, the Ohio Department of Welfare is now paying $170 a month to recipients of the nursing program in nursing homes. Of that amount, the Federal Government's share is $47.50. If Ohio was receiving medical assistance for the aged under Kerr-Mills, it would receive $122.50 from the Federal Government, for a total to be paid to the recipient of $245, without any increase in State appropriation.

We recognize that the above formula will require a substantial review of the total welfare program as now conducted by the State. Accordingly, it is our intention to prepare the necessary statistics and work figures to bring Ohio's welfare payments to realistic levels, in light of today's economies.

We of the Ohio Nursing Home Association expect to see legislation introduced in the 106th general assembly that will permit Ohio's participation under the medical assistance program of the Kerr-Mills law.

We fully recognize the implications involved in this step but we also recognize the responsibility that this association has to its members, to the profession, and to the elderly of this State.

We want to thank this subcommittee for their sincere interest in coming to Ohio to inquire into the problems of nursing homes and in attempting to provide the elderly with the necessary services for enjoying the golden years of their lives.

Again I thank you for the opportunity to appear before this committee and will be happy to answer any questions.

Thank you.

Senator Moss. Thank you very much, Mr. Levering. That is a very fine statement, and we are glad to have you here representing the Ohio Nursing Home Association.

One of the things you pointed out in your statement is the need for cost accounting, so that the amount that is needed could be determined to care for each patient for each day. Yet this seems to be one area where there has been considerable resistance from nursing home operators.

What do you think is the reason for that resistance?

Mr. LEVERING. Primarily I think it stems from the longtime nursing home administrator who has never had to produce facts of what his costs were, and is not willing to provide these facts at the present time. They feel that this is a private situation, and they do not want to present the cost figures at the present time.

However, I think this is changing rapidly, now, since many other States are adopting similar positions, where they are paying on a cost per patient day, and I think we are seeing a great turnabout in this philosophy.

Senator Moss. It may be somewhat due to a lack of training, too, in business management methods. Is this a factor?

Mr. LEVERING. This is possible. However, there are some very adequate bookkeeping systems on the market now that make this relatively simple.

Senator Moss. You point out that there are 49 of the 50 States that now belong to the American Nursing Home Association.

Mr. LEVERING. That is correct, yes, sir.

Senator Moss. And the goal of that organization is to establish an accreditation procedure for nursing homes somewhat akin to the accreditation that the hospitals have established in their field.

Mr. LEVERING. That is true.

Of course, we are starting out on a much lower stature, the joint council, but nevertheless it has improved the quality of care, I feel, in the last year the national council has been in existence, and I think it will continue to.

Senator Moss. I think it was Dr. Stocklen this morning who pointed out that 50 years ago or a little longer, hospitals were going through much the same evolution that we find in nursing homes today. Many of them were started in an old home, and they had really no standards, and it has taken them a long time to bring their standards up. So maybe we are following the same pattern here.

Mr. LEVERING. Thank you. I hope we are on the right track.

Senator Moss. I hope so, too.

I congratulate you on a very fine statement, and the work that is done by your association. I know of the efforts of the American Nursing Home Association, and you are doing a fine job.

Senator Young?

Senator YOUNG. Mr. Levering, I certainly am impressed by your fine association, by their work, and by your work as president of this association. You have really done a real and needful service toward raising the standards of nursing home care.

I am proud that you are functioning so well in Ohio under your leadership, but at the same time, frankly, I am somewhat impressed that so few of Ohio's nursing homes seem to share your zeal.

Now, can you explain that? How is it that, as I understand it, you only have about 75 of more than a thousand nursing homes in this State as members?

Mr. LEVERING. This is correct, sir.

Senator YOUNG. I am sorry about that.

Mr. LEVERING. Well, I am, too.

Senator YOUNG. How can you explain that?

Mr. LEVERING. At one time there were over 200 and some homes, and of course there was a split in the association, and the Ohio association took the attitude that we had to have better regulations in Ohio, and we have been striving toward that goal.

As stated in my statement, to be a member of the Ohio association, on the application you have to sign the intent to be accredited within a 2-year period.

Senator YOUNG. You are, however, are you not, keeping up your efforts to increase your membership?

Mr. LEVERING. Oh, yes, sir.

Senator YOUNG. May I ask this: Is it not a fact that about 70 percent, I guess 69 percent, to be exact, of the nursing homes in Ohio have either 30 or fewer beds?

Mr. LEVERING. I would say yes, this is true, because the average, figuring it out real simply, of 32,000 beds in Ohio, by 1,200 nursing homes, we could have about 28 as the average, and so there has to be a much greater number of homes under 30 beds than there is over 30.

Senator YOUNG. Thank you very much.

Senator MOSS. Mr. Miller?

Mr. MILLER. Reference has been made to nursing homes with under 10 beds. Can you give us any indication as to how many of that type there are in the State of Ohio?

Mr. LEVERING. I am sorry, sir, I cannot.

Mr. MILLER. Could you supply that for the record?

Mr. LEVERING. It will have to come through the health department. They can supply it.

Mr. MILLER. Thank you.

Senator MOSS. This split that you referred to, was this the genesis of the Ohio federation?

Mr. LEVERING. Yes, sir; this is true.

Senator MOSS. Thank you very much, Mr. Levering. We appreciate it, and we appreciate the good work you are doing.

Mr. LEVERING. Thank you.

Senator MOSS. The fire marshal of the State of Ohio, Mr. Fred Rice, will be our next witness.

We are glad to have you, Mr. Rice, and look forward to your testimony here.

STATEMENT OF FRED RICE, FIRE MARSHAL, STATE OF OHIO

Mr. RICE. Mr. Chairman, and members of the committee, I have passed out to the committee three separate pieces of paper. The first is evacuation procedure for nursing homes, which is a guide. This particular piece of information has been sent to all nursing homes in the State of Ohio.

The second item is a suggested ordinance which was recommended by the National Automatic Sprinkler & Fire Control Association. This has been sent to every township and city in the State of Ohio.

Senator MOSS. They are both brief, so we will make them a part of the record.

(The documents referred to follow:)

EVACUATION PROCEDURE FOR NURSING HOMES GUIDE

(Fred Rice, State fire marshal, 21 West Broad Street, Columbus, Ohio)

IN CASE OF FIRE

1. Ring the fire alarm bell to alert the personnel and patients, regardless of the size of the fire.
2. Call the fire department: _____. Phone: _____.
3. Designate some persons to pull fire alarm box located at_____.
4. One attendant only use fire extinguisher and attempt to extinguish the fire.
5. All other attendants begin immediately removing patients from the building.
6. Ambulatory patients should be instructed to leave building immediately and where to go after leaving.
7. Bedfast patients in the close vicinity to the fire and upper floors should be removed first.
8. Do not take time to dress, take a blanket and leave.
9. Never prop or wedge fire doors open.
10. Neighbors or passersby should be utilized to assist until arrival of the fire department.
11. After leaving the building patients should go to prearranged destination _____ and stay there until further instructions.
12. After the patients have been removed, the attendants should check for all patients and notify firemen of any absent.
13. Nurses should be the last to leave the building.

FIRE AND FIRE DRILL INSTRUCTIONS

Ring the alarm bell regardless of the size of fire

The reason for a rule such as this is to prevent you from making a mistake that may be fatal to you and your patients. Fire is a treacherous enemy that requires a trained eye to determine the extent of danger involved when it raises its ugly head. What appears to be a minor little flame that a cup of water would extinguish may be concealing a raging furnace within a wall, under a floor, or in an attic. The fire that appears to be extinguished may be "playing possum" only to reappear when you least expect it and finish its dirty work. Why take a chance with your and your patients' lives. You will feel much better having had someone else check it even if the fire is extinguished.

Call the fire department

In case after case it is determined that a contributing factor in major fires is the delay of sending an alarm. In 1 rest home fire, 72 lives were lost and 1 of the patients had previously reported that he smelled smoke. Even 5 minutes is too long, for a fire can engulf the whole building in that time. Fire departments never complain when the fire is out upon their arrival. But if it is not, you are going to be mighty happy that they are there.

One attendant only use fire extinguisher and attempt to extinguish the fire

Of course, someone should attempt to put the fire out, and this rule may, at first, appear strange. After the alarm bell has been rung and fire department called (or during the time these things are being done by someone else) one attendant should try to put the fire out using extinguishers or taking the necessary action. The reason we say one attendant is, if the fire is of such nature that extinguishers are going to put it out, one person will probably be able to do it. If the fire is of such nature that more than one person is required to extinguish it, then it is of sufficent size to endanger life. Your first obligation is protecting and saving the lives entrusted in your care. This will also avoid everyone standing around watching one or two attendants fight a fire while precious minutes are being lost, if the building has to be evacuated.

Ambulatory patients should be instructed to leave building immediately and told where to go after leaving

By having regular fire drills, and instructing all new incoming patients, the ambulatory patients should know to leave the building when they hear the alarm bell or when told to do so. They should not be permitted to just stand around outside or wander off. A regular place to assemble or meet is a must. There the patients can be accounted for, kept warm and dry, receive medical or other attention, and be fed and clothed if necessary. Large heated garages, churches, business or lodge rooms, etc., are recommended. Strict obedience should be required of all ambulatory patients, many of whom are similar to little children, during all drills so they will require as little supervision as possible during any actual emergency. Instruct any capable ambulatory patients to assist in emergencies.

Bedfast patients in the close vicinity and upper floors should be removed first

Bedfast patients, of course, are in great peril and your interest is to get them all out of the building safely. The patients in the same room as a fire or directly over the fire in the case of basement fires are in the greatest immediate danger and should be removed first. However, remember that heat and dangerous smoke and gases travel upward and patients on the upper floors should be removed before patients in other rooms on the same floor level as the fire is occurring. Fire will seldom travel laterally as fast it will travel in an upward path. Of course, these are general rules and it is the responsibility of the attendant to use this as a guide to intelligent action.

Do not take time to dress, take a blanket and leave

We are not interested in either modesty or belongings. The first thought you must have is to the protection or saving of life. If the fire is of minor nature you and the patients will be back in the building in a short time and will have lost no clothing or valuables. If the fire is serious you do not have time to worry about modesty or clothing.

Never prop or wedge fire doors open

The fire door is required in rest homes to keep fire, heat, smoke, and gases from traveling from one part of the building to another. If you prop it open you may be condemning someone to death. While you are evacuating patients, that fire door may keep another patient alive until you can return for him or until firemen can reach him. After all the patients have been removed from a given room, the door should be left completely closed.

Neighbors or passers-by should be utilized to assist until arrival of the fire department

Plans and requests for assistance from nearby people are necessary before the emergency occurs. In this way the people are willing and expect your request. This is especially true of the emergency temporary housing of the patients. When the emergency occurs, they will come to your aid without being called.

After leaving the building patients should go to some designated place and stay there until further instructions

These arrangements must be made before the fire and the ambulatory patients should practice going there and waiting even when you have drills. The attendants should carry out their part of the drill by checking the patients to avoid everyone wandering off.

After the patients have been removed, the attendants should check for all patients and notify firemen of any absent. An actual head count should be conducted

The reasons for this rule are obvious. If a patient is found to be missing, it should be decided whether the patient was removed from the building, if he were in the habit of returning to the building without instructions during fire drills, and if he is still in the building, where would he most likely be. This information should be brought to the attention of firemen at once. The attendant in charge at the time of the fire, or someone designated by her, should keep herself available to the fire department officers during the entire operation.

Never, for any reason, return to the building after the evacuation is completed until ordered to do so by one of the fire department officers.

Each employee must read these instructions and sign his name.

SUGGESTED ORDINANCE

AN ORDINANCE PROVIDING FOR SAFETY TO LIFE IN NURSING HOMES AND BOARDING CARE HOMES (NOVEMBER 1955)

(Recommended by the National Automatic Sprinkler & Fire Control Association (a nonprofit organization founded in 1914 for the preservation of life and property from fire) Building Code Committee, New York, N.Y.)

Fire Protection shall be provided in accordance with the requirements of the State Fire Marshal's Department. Approval by the State Fire Marshal of the fire protection for a nursing or boarding care home shall be a prerequisite for licensing.

SECTION 1. DEFINITION

1.1 *Ambulatory.* The term "ambulatory" when used in these standards shall mean a person who, without the aid of another, is physically and mentally capable of walking a normal path to safety including the ascent and descent of stairs.

1.2 *Approved.* The term "approved" when used in these standards shall mean acceptable to the State Fire Marshal.

a. "*Approved Standards*" shall mean any standard or code prepared and adopted by any nationally recognized association.

b. "*Approved Equipment and Material*" shall mean any equipment or material tested and listed by a nationally recognized testing laboratory.

1.3 *Approved Organized Fire Department.* The term "approved organized fire department" shall mean any municipal corporation, town or village or political subdivision that has adequate fire fighting equipment and manpower subject to their control and approval of the State Fire Marshal.

1.4 *Area of Refuge.* The term "area of refuge" shall mean a ground area, reasonably accessible from a building, of sufficient size and in safe condition for refuge by all building occupants at a safe distance from such building. When used in relation to areas within buildings this term shall mean an area beyond a fire wall or smoke barrier of sufficient size to offer refuge to all occupants on the same floor of the building.

1.5 *Attic.* The term "attic" when used in these standards shall mean the space between the ceiling beams of the top habitable story and the roof rafters.

1.6 *Automatic Sprinkler System.* The term "automatic sprinkler ssytem" shall mean an arrangement of piping and sprinklers designed to operate automatically by the heat of fire and to discharge water upon the fire.

1.7 *Basement.* The term "basement" when use in these standards shall mean that portion of the building partly underground, but having less than half its clear height below the average grade of the adjoining ground.

1.8 *Bed Patient.* The term "bed patient" shall mean a person who is not ambulatory as defined in these standards.

1.9 *Boarding Care Home.* The term "boarding care home" shall mean a home licensed to provide care for aged or infirm persons requiring or receiving personal care of custodial care as defined by the Department of Health.

1.10 *Cellar.* The term "cellar" shall mean that portion of the building partly underground, having half or more than half of its clear height below the average grade of the adjoining ground.

1.11 *Combustible.* The term "combustible" shall means that which is not within the category of "noncombustible," as defined in these standards.

1.12 *Exit.* The term "exist" shall mean the exit doorway or doorways, or such doorways together with connecting hallways or stairways, either interior or exterior, or fire escapes, designed to provide means by which individuals may proceed safely from a room or space to a street or to an open space which provides safe access to a street.

1.13 *Fire Wall.* The term "fire wall" shall mean a wall of brick or reinforced concrete having adequate fire-resistance and structural stability under fire conditions to accomplish the purpose of completely subdividing a building or of completely separating adjoining buildings to resist the spread of fire. A fire wall shall extend continuously through all stories from foundation to or above the roof.

1.14 *Incombustible.* The term "incombustible' 'shall mean the same as "noncombustible" as defined in these standards.

1.15 *Means of Egress.* The term "means of egress" shall have the same meaning as "exit" as defined in these standards.

1.16 *New homes.* The term "new homes" shall include new construction, additions to existing licensed homes, existing buildings converted to nursing or boarding care homes, and transfers of ownership for which a new license is required.

1.17 *Noncombustible.* The term "noncombustible," when used in relation to any material thing, shall mean that which will not readily ignite and burn when subject to fire.

1.18 *Nursing Home.* The term "nursing home" shall mean a home licensed to provide care for aged or infirm persons requiring or receiving nursing care.

1.19 *Patient.* The term "patient" shall mean any individual cared for in a nursing home, even though such person does not require nursing care.

1.20 *Resident.* The term "resident" shall mean any individual cared for in a boarding care home.

1.21 *Smoke Barrier.* The term "smoke barrier" shall mean a partition with a fire-resistance rating of not less than one-half hour, equipped with a door and jamb of the same rating and hung so as to be reasonably smoke and gas tight when closed. The door shall be not less than 44 inches wide and shall not be fastened in an open position by a device which will require more than one movement of normal strength to swing such door to a closed position. Such barrier shall be located to provide ample area of refuge on each side of such partition or barrier for all occupants served by the barrier. The barrier may have wired-glass panels, each not to exceed six (6) square feet. The wire-glass shall be standard clear wire-glass.

1.22 *Sprinklered.* The term "sprinklered" shall mean to be completely protected by an approved system of automatic sprinklers installed and maintained in accordance with approved standards.

1.23 *Story.* The term "story" shall mean that part of a building comprised between a floor and the floor or roof next above and shall apply to the basement and other floor areas below. The first floor shall be that story which is of such height above grade that it does not come within the definition of a basement or shall be that story located immediately above a basement.

SECTION 2. SUBMISSION OF PLANS

2.1 Plans and specifications covering the construction of new buildings, additions to existing buildings, or alterations to existing buildings shall be submitted to the State Fire Marshal for review and approval with respect to compliance with the fire protection standards.

SECTION 3. CONSTRUCTION

3.1 Every nursing home or boarding care home hereafter constructed and every addition hereafter made to a nursing home or boarding care home shall comply with State Health regulations.

SECTION 4. USE OF THIRD FLOOR

4.1 The third floor may be used for ambulatory patients and residents if such use of the third floor is approved by the State Fire Marshal after an inspection of the home has been made.

SECTION 5. USE OF ATTICS, BASEMENTS, AND CELLARS

5.1 No patient or resident shall be permitted to sleep in any attic, basement, or cellar as defined in these standards.

SECTION 6. OTHER OCCUPANCY

6.1 No nursing home or boarding care home shall contain an occupancy which is not within the immediate control of the management or which is not incident to the operation of the home.

SECTION 7. LOCATION

7.1 New nursing or boarding care homes shall be located in an area which is serviced by an approved organized fire department.

SECTION 8. EGRESS FACILITIES REQUIRED

8.1 Exists shall be located remote from each other, providing the best practicable means of egress for all patients and residents in the event fire renders one exit impassable.

8.2 Each story of every building used as a nursing home or boarding care home shall have at least two means of egress to the outside. Each patient- or resident-occupied room shall have at least one doorway opening directly to the outside or to a corridor leading directly, or by stairway, to the outside, or an opening without a door into one adjacent room which leads to the outside in the same manner.

8.3 Means of egress in addition to the minimum of two required from each story under Section 8.2, shall be required when the maximum possible occupancy exceeds 60 patients or residents. There shall be at least one additional means of egress for each 30 additional patients or residents, located to give adequate passage from all areas, each by separate stairways and/or passages to the outside. Exits shall be of such number and so arranged that it will not be necessary to travel more than 100 feet from the door of a patient-occupied room, and from every point in wards, day rooms, dormitories, and dining rooms to reach the nearest approved means of egress from that story.

8.4 Exits shall be so arranged with regard to floors that there are no pockets or dead ends over 10 feet in length in which occupants may be trapped.

SECTION 9. EGRESS PASSAGEWAYS

9.1 Corridors and passageways from patient- or resident-occupied rooms leading to egress stairways and thence to the outside from the first story and to areas of refuge shall be not less than 72 inches in width in new buildings or additions to existing buildings, and not less than 36 inches in existing buildings, and shall be of such greater width as is necessary for free passage of beds with patients to the outside or to an approved area of refuge.

9.2 Corridors and passageways considered as approved means of egress shall be at least 84 inches in height.

9.3 Access to all interior and outside stairways, to fire escapes and other exits considered as approved means of egress, shall be unobstructed, and shall not be through a bathroom or kitchen or a room used for any other purpose that may obstruct free passage, nor shall access be veiled from open view by ornamentation, curtains, or other appurtenances.

9.4 Passageways from inside stairways to the outside shall have the same fire-resistance quality as required of the connecting stairways.

9.5 All egress passageways shall at all times provide unobstructed and safe passage to a public street, alley, or to a suitable area of refuge.

SECTION 10. EXIT SIGNS

10.1 Exit signs or lights are required only when more than 12 persons are housed.

10.2 Signs bearing the word "exit" shall be placed at each egress doorway, except at doors of patient- or resident-occupied rooms entering upon common-use corridors or passageways, and shall be so installed as to be legible from the direction of travel thereto. Where such doorways and signs are not readily discernible from patient- or resident-occupied room doorways, an adequate number of additional signs shall be provided bearing the term "exit," with an arrow pointing in the direction of such exit.

10.3 Exit signs shall bear letters at least 4½ inches in height with strokes not less than ¾ inches in width.

10.4 All exit and directional signs shall be maintained clearly legible by electric illumination or other adequate means when natural light fails.

SECTION 11. ILLUMINATION OF EXIT PASSAGES

11.1 Adequate facilities shall be provided for the lighting of all corridors, stairways, and egress passages at all times.

SECTION 12. STORAGE OF GASES

12.1 Storage rooms for combustible anesthetics shall be constructed of an assembly of building materials with a minimum fire-resistant rating of one hour, and shall not communicate directly with an operating, delivery, anesthesia, or furnace room, or any room containing an open flame or spark-producing device.

12.2 Oxygen and nitrous oxide shall not be stored in the same room with any combustible anesthetic agent; such as, cyclopropane, divinyl ether, ethyl chloride, ethyl ether, ethylene, vinethylene, or vinyl ether.

12.3 Provision shall be made for racks or fastening to protect cylinders from accidental damage or dislocation.

12.4 No open flame, smoking or spark-producing device shall be permitted within a room in which combustible anesthetics or compressed oxygen is used or stored.

12.5 All rooms in which combustible anesthetics are stored shall be individually ventalated to the exterior.

12.6 Oxygen and nitrous oxide of a total capacity in excess of 1,500 cubic feet, when located within the building shall be enclosed in a separate room or enclosure within a room with a minimum fire-resistant rating of at least one hour. The manifold enclosure shall be individually vented to the outside.

12.7 Oxygen and nitrous oxide of a total capacity of less than 1,500 cubic feet shall be stored in rooms or enclosure within a room. The rooms or enclosures do not have to be vented to the outside but the doors to such rooms or enclosures shall be provided with louvres at top and bottom.

12.8 Rooms or enclosures for combustible or nonflammable gases shall not be used for storage purposes other than for the cylinders containing the gases. Storage of empty cylinders pending their removal is permissible.

12.9 Electrical wall fixtures in oxygen and nitrous oxide storage rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage.

12.10 In storage locations for combustible anesthetics the electrical wiring and equipment shall comply with the explosion-proof requirements of the National Electrical Code.

SECTION 13. FLAMMABLE LIQUIDS STORAGE AND USE

13.1 Flammable liquids shall be stored in suitable buildings, rooms or compartments used for no other purpose and shall be constructed of building materials having a minimum fire-resistance rating of one hour.

13.2 Flammable liquids shall be stored in and used from approved metal safety cans or containers.

13.3 Benzine, benzol, gasoline, naphtha and their compounds shall not be stored in any basement, cellar or pit.

SECTION 14. EXTINGUISHING EQUIPMENT REQUIRED

14.1 All nursing or boarding care homes shall be provided with approved fire extinguishers for each 2,500 square feet of floor area or fractional part thereof, adequate for the conditions involved and suitably located.

SECTION 15. FIRE HOSE AND STANDPIPE

15.1 Fire hose and standpipe shall be required on all new construction over two stories high. All fire hose couplings shall conform to the size, thread and pattern adapted to the standpipe installed.

15.2 The number of standpipes shall be such that all parts of every floor area can be reached within 30 feet by a nozzle attached to 100 feet of hose connected to a standpipe.

15.3 Standpipes shall be so located that they are protected against mechanical and fire damage, with outlets within stairway enclosures, as near the stairway as possible, or outside or immediately inside of the exterior walls, within one foot of a fire tower or exterior stairway or fire escape.

15.4 Standpipes shall be installed in accordance with approved standards and maintained in readiness for use at all times.

SECTION 16. SPRINKLERS REQUIRED

16.1 Nursing homes or boarding care homes which are occupied by bed patients or by ambulatory patients and residents shall be protected throughout including stairways, closets, basements, cellars, attics, storage rooms and chutes by a system of automatic sprinklers installed and maintained in accordance with approved standards.

16.2 Waterflow alarms shall be provided on all sprinkler installations. Central station waterflow alarm service is desirable but central station waterflow alarm service does not necessarily waive the local alarm requirement.

16.3 When a sprinkler system is installed plans shall be submitted to the State Fire Marshal for approval before installation is made.

SECTION 17. HAZARDOUS OCCUPANCIES

17.1 No motor vehicle, or other device which may cause or communicate fire, not necessary for patient or resident treatment or care, shall be stored within a nursing home or boarding care home. All such devices and materials necessary for use within the building shall be used with reasonable care for safety from fire and by trained personnel.

SECTION 18. LOCATION

18.1 No nursing home or boarding care home shall be located within 85 feet of underground or 300 feet of above ground storage tanks containing flamable liquids used in connection with a service station, garage, bulk plant or marine terminal or bottling plant of a liquified petroleum gas installation.

SECTION 19. ATTENDANTS

19.1 There shall be an attendant or attendants on duty or on call at all times.

19.2 The number of attendants required shall be sufficient to perform the duties required under the evacuation plan.

19.3 Attendants as required herein shall be at least 18 years of age and capable of performing the required duties of evacuation. No person other than the management or an employee of the management shall be considered as an attendant.

SECTION 20. EVACUATION PLAN

20.1 Each nursing or boarding care home shall formulate and post a plan for the protection of all patients and residents in the event of fire and their evacuation to areas of refuge or from the building when necessary. All employees shall be instructed and kept informed regarding their duties under the evacuation plan.

20.2 On request the State Fire Marshal will arrange for instruction in fire equipment and evacuation of patients and residents.

SECTION 21. SMOKING

21.1 Smoking in bed shall be prohibited, except in case of bedfast patients who may be allowed to smoke while under personal supervision of a member of the staff.

21.2 Smoking in nursing or boarding care homes may be permitted where ash trays of noncombustible material are provided.

21.3 Metal containers with self-closing devices shall be provided for the disposal of the contents of the ash trays.

SECTION 22. HOUSEKEEPING

22.1 The entire premises shall be kept clean and in a tidy condition, free from accumulation of combustible debris or other waste material.

SECTION 23. FIRE EXTINGUISHING EQUIPMENT REQUIRED

23.1 All rooms and enclosures containing heating and cooking appliances shall be provided with approved fire extinguishing equipment. Such fire extinguishers shall not be placed in close proximity to fire units, or in any other position affecting their availability in the event of a fire.

SECTION 24. ELECTRICAL WIRING

24.1 All electrical wiring, appliances, fixtures and equipment shall be installed to comply with the State Electrical Code and the National Electrical Code.

JAMES A. RHODES, *Governor.*
J. GORDON PELTIER, *Director of Commerce.*
FRED RICE, *State Fire Marshal.*

(Distributed through the courtesy of Division of State Fire Marshal, Wyandotte Building, Columbus, Ohio, 43215.)

Mr. RICE. My statement primarily deals with fire safety.

In my opinion, the finest place for an aged person to spend his last years on this earth is by being cared for and living with relatives and/or friends. Apparently, in this modern world, this is not always possible, and, to meet the need, nursing homes have come into existence.

They have come a long way in Ohio since their inception. Naturally in nursing homes, as in any other business or institution, there will always be needs and problems, but I believe that the nursing home operators in the State of Ohio are putting forth an outstanding effort and are responsive to these needs.

Nursing and convalescent homes pose fire safety problems unequaled in any other occupancy today in Ohio. Structures housing such homes are of any type from converted frame dwellings to modern fire resistive constructed hospital buildings.

Convalescent homes are often located in rural areas some distance from the fire department, and there isn't sufficient water available for adequate fire protection.

The very nature of the patients, aged, sick, infirm, and mentally retarded, are factors which contribute to the seriousness of a fire occurring in a nursing home. Aged occupants, too, often cannot escape. Their senses are dulled. Their intellects are too slow to be cognizant of danger. Their bodies are lethargic in response to emergencies that demand quickness and agility to stay alive. Often they are nonambulatory and must lie in confusion and wait until someone can carry them from the burning building.

In locations some distance from the fire department, the on-duty personnel of the home at the time of a fire will have to evacuate the building by themselves. They cannot await the arrival of the fire department which is located 10 to 15 minutes away because within 5 to 7 minutes a fire may be raging out of control.

What chance would 3 or 4 untrained personnel of a nursing home of 75 to 100 patients have of removing the patients at the time of a fire?

These are some of the facts that account for the tremendous loss of life in nursing home fires. Seventeen died in Madam Henri's Nursing Home in Montreal, Canada. Seventy-one lives were lost in Warrenton, Mo. Fifteen deaths in Council Bluffs, Iowa, and 5 of 8 patients died in fire in Bardstown, Ky. Fifteen other nursing home fires have been responsible for taking 283 lives, and now in Ohio 63 lives snuffed out in a terrible holocaust.

While automatic sprinklers afford excellent protection, they alone are not a cureall. Many other factors enter into the picture that must be considered.

Sprinkler systems have proven their worth many times. Some fires that you have not heard of because they were quickly extinguished with automatic sprinkler systems are: Soldiers and Sailors Home, Minneapolis, Minn.—short in wiring at 2 a.m.—no injuries—small loss; Harriet Ingersoll Jones Nursing Home—basement fire—no injuries—negligible loss; St. Louis, Mo.—elderly patient set fire in bed—no injury to patient—loss only to mattress and bedclothing.

My point is this—sprinkler systems alone are not enough. Buildings must be of a type that lend themselves to fire safety. Construction must be of material of slow flame spread, exits and halls must be of a type that will permit quick evacuation of the building at the time of a disaster. Electric installed in accordance with the national electric code.

Homes must be located close enough to approved fire protection that the fire department can function properly. Auxiliary fire protection provided for the extinguishment of small fires when they start. Direct communication line to the fire department to insure prompt reporting of fire.

Sufficient trained personnel on duty at all times to insure prompt detection of fire, evacuation of building, and, if possible, extinguishment of fire with first aid equipment before the arrival of the fire department.

Semiannual inspection of the premises for fire hazards by the division of State fire marshal, and monthly inspections by the fire department.

Sprinkler systems in addition to the above would be the ultimate. Without all of the above, the sprinkler system would be only a fair substitute.

As previously stated, a sprinkler system is subjected to human error and mechanical failure. A valve can be shut off, a break in a waterline at the time of an explosion can render the system ineffective.

We need to pay close attention to all of the above. There is no one cureall. When planning for fire safety, we need to consider all aspects of the situation, and then put into operation the programs that will be most effective in guaranteeing the most fire safety.

Some buildings could only be safe for occupancy by a nursing home by the installation of a sprinkler system. Others could be safe with adequate trained personnel on the job 24 hours a day and close adherence to the above requirements.

In closing, I wish to emphasize the importance of training personnel and patients concerning preparedness for operations at the time of a fire. Each employee should have assignments that he will carry out at the time of a fire.

The following things must be accomplished: The fire department must be notified—patients must be notified of the fire—bedfast patients must be removed to safety—ambulatory patients must quickly leave the building—first aid firefighting equipment must be put into operation—in inclement weather, patients must be removed to temporary shelter.

I would like to point out since it came up in previous testimony about the Fitchville fire, when the electrical wiring was installed originally, 220 in this particular nursing home, in my opinion it was done according to the national electrical code.

Many times after this happened, I would say, a farmhand or an inexperienced person was asked to put in receptacles or to do wiring in the building. More than seven persons had done this. Therefore the covers in the attic were off the wiring.

They had had many warnings such as fuses blowing out. They would put in heavy duty fuses.

In one instance the switches would burn out, so they put on a heavy duty switch.

But these are things if you build today a properly built-to-specifications nursing home, the people have to be educated to bring in a man who knows how to wire according to the National Electrical Code.

One instance which was never reported until after this fire, when they cut in they blew out all the fuses and the lights. There were many instances where the 220 circuit had been cut into to put in 110 wall plugs.

To me this is something that the people have to be trained to call on trained personnel, or it would have no effect. In other words, after you build it today, you have to have proper maintenance with the proper type people.

The fire prevention bureau of the division of State fire marshal has trained personnel that will set up an evacuation program for your nursing home, and will provide instructions.

We try to go to nursing homes and set up a particular evacuation plan for that particular nursing home.

I have a copy of the staff research report of the Ohio Legislative Service Commission on Nursing Homes that I will give you, and also a copy of the Fitchville report on the fire.

If you need more of those, I will be glad to furnish them.

Senator Moss. We are pleased to have them, and they will be made a part of the file in this case for our reference.

We appreciate this very much, Marshal Rice.

What part do you play in the licensing of nursing homes? Is your inspection required before a nursing home can get a license?

Mr. RICE. This is correct. At any time the health department receives a request for license, before they grant that license, they notify this department, and we inspect it before the license is granted.

Senator Moss. Do you have a regular scheduled followup when you reexamine these homes?

Mr. RICE. Yes; we do. Not monthly. They do not know when we are coming. I would say during the last 2 to 3 years we have been in every nursing home in the State two to three times a year.

In addition to this, there are 1,356 fire departments in the State of Ohio, and many of these do have good inspection bureaus. So in addition to our inspection, the local fire deparments, where they do have an inspection bureau, many of the 1,356 are making monthly inspections.

Senator Moss. That is fine. What size staff of inspectors do you have?

Mr. RICE. Of inspectors alone, out of the State fire marshal's office, we have 22.

Senator Moss. You also indicated that you are doing some of this training work in the homes, trying to establish good practices there so that you would not have the repetition of what happened in Fitchville.

Mr. RICE. That is correct.

I think the important thing is fire prevention and fire safety. I think No. 1 in a nursing home is not to have the fire. No. 2, if you do have one, you have to get it put out before it does any damage, with trained personnel.

Senator Moss. Is there a regulation about how many patients can be on the second floor, for instance, in a nursing home, and so on?

Mr. RICE. Yes, sir; there is, but I cannot give you that number. I think the health department could.

Senator Moss. Thank you, Marshal Rice.

Senator Young?

Senator YOUNG. In addition to your 22 inspectors, you have other personnel?

Mr. RICE. Yes, sir. We have a fire prevention bureau. Normally the fire prevention bureau is the department which goes into each home and tries to sit down and work out with them an evacuation program.

We even have lots of requests where we have not gotten to them fast enough, and they will write us and ask us to do that.

Senator YOUNG. Apparently, you do have an adequate staff of inspectors.

Mr. RICE. In my opinion, we do.

Senator YOUNG. May I ask you, of the 1,200 nursing homes in Ohio, about how many at this time have established satisfactorily written evacuation plans, and hold frequent fire drills? Are you able to tell us that?

Mr. RICE. Senator, purely a guess, I would say that probably 60 percent or more of them have evacuation plans. Probably over 90 percent at least say they have them, have them on a piece of paper.

Recently in Franklin County there was a fire where all 67 people were evacuated before the fire department arrived. This was on an evacuation program we had worked out with these people shortly before.

Senator YOUNG. You are trying to get all of them to have these plans and fire drills?

Mr. RICE. Yes, sir.

Senator YOUNG. Do you bear down on them pretty hard?

Mr. RICE. Yes, sir; we work hard.

Senator YOUNG. That is fine.

No other questions.

Senator Moss. Thank you very much, Mr. Rice. We appreciate it.

Miss Faith Corrigan, who is with the Cleveland Plain Dealer, will be our next witness.

Miss Corrigan, we are very happy to have you.

STATEMENT OF MISS FAITH CORRIGAN, REPORTER, CLEVELAND PLAIN DEALER

Miss CORRIGAN. A President lay dead in Washington when the Golden Age Nursing Home burned to the ground in the early hours of November 23, 1963. The tragedy of 63 helpless victims could have been overshadowed by the news of the assassination that week that America mourned. But the editors and staff of the Plain Dealer knew that this was no ordinary fire.

It had been predicted, not the particular location, but the certainty that such a fire would occur in an Ohio nursing home. Welfare reporters, such as myself, had long known of the legal blocks to the new nursing home regulations drawn up by the State health department in 1960.

A staff of six reporters, Anthony Thomson, Allen Ashbolt, David Kent, Sam Marshall, and Mr. and Mrs. Andrew Ruckman, were rushed to the scene by the Plain Dealer, which gave the most comprehensive and complete coverage to the event than any other newspaper in Ohio.

These skillful reporters revealed in their fire stories for the first time—

what had happened to many mental patients over 65 who had been moved out of State hospitals in 1960. Most went to mediocre nursing homes that would accept the low payment for their care offered by aid for aged.

the absence of records on many of these people, whose identity had been lost during long years in State institutions.

failure to inform near relatives of the places their relatives were sent to. Many children learned for the first time where their father was when they read his name in the casualty list.

By early January, it appeared that Fitchville and the conditions it revealed would fade from the news columns. All the hard news had been written, the investigations covered, and the reports written in full.

But a column written by Philip Porter, executive editor of the Plain Dealer, caused Rabbi Rudolph Rosenthal to ask the Plain Dealer to sponsor a meeting on the subject of nursing homes. This unprecedented all day seminar was held on January 15, 1964, at the Hotel Statler-Hilton.

Russell Reeves, day managing editor of the Plain Dealer, presided before a blownup photograph of the smoking ruins of Fitchville.

A copy of Mr. Porter's columns and the reprinted testimony of that seminar are offered in evidence.[1]

As a result of that seminar, a citizens' action committee on nursing homes was formed, with Mr. Reeves as chairman. One of its purposes was to keep the issue alive, and to try to shake loose the nursing home regulations, which, if in effect, would have cut the number of victims at Fitchville.

I was assigned by the Plain Dealer to cover the subject of nursing homes on a full-time basis, and began to make a study of the problems for a series which eventually ran in September 1964. A set of these stories are also included in the exhibit.

But while I was still preparing my materials, early in May, a Eugene H. Woods was arrested in Akron for operating a nursing home without a license. Woods had built the Fitchville home, and obtained a license for it from the State. He had sold it before the fire, for a reported $105,000.

I was sent by my editor to the Hotel Regent he ran at East 105th and Euclid, to see what was happening there.

[1] The material referred to is held in the files of the subcommittee.

I found the Hotel Regent, which Woods had operated under a corporative name of Senior Citizens of America, abandoned by its proprietor. No one was in charge, and about 27 aged weeping people were left behind, seeking information about his whereabouts.

Woods, I learned, had left for Akron under the threat of an investigation by Mrs. Marion Jackson, chief caseworker for the Cleveland aid for aged office. He took 34 aid for aged clients along with him, hoping to start again in another place. Left behind were those pensioners whose checks would not be forwarded, county welfare clients, people on social security, and private means.

Woods had been moving old people around the State for many years from one home to another, whenever things got hot in one place. Many of the Fitchville victims had been moved three or four times.

This time he did not get away with it. A visiting nurse in Akron reported him to the police.

The people he left behind at the Regent were in various stages of senility and sickness.

Gentlemen, can I describe to you the atmosphere of that hotel, the tears of the aged, confused by the absence of Woods, who had completely won their confidence.

Many had paid their rent in advance and had no other funds to pay rent in a new place. Many did not want to move. Some did not even realize anything was wrong. Among these was a 98-year-old schoolteacher discovered in her sixth floor room gazing placidly out the window.

Those on public assistance were lucky. Social workers from the county welfare department and aid for aged moved them out to other rooms. By 4 p.m. in the afternoon, after being on the premises all day, it was obvious to me that there were still many people in the hotel, incapable of taking care of themselves, for whom no agency, city, county, or State, had legal responsibility.

Where were their relatives? Many had none.

The landlord of the hotel, unpaid for several months, wanted to padlock the hotel that night. The staff, unpaid for a week, were about to quit. The illuminating company wanted to turn off the lights. That bill was also long overdue.

I found the local social security office could only stop checks, but could not help otherwise.

In desperation, I called Ralph Findley, the Cleveland director of welfare, who personally promised to pay some of the staff to assure that the abandoned old people would have the use of the elevator and get breakfast the next day.

Mr. Findley called the disaster unit of the Cleveland chapter of the American Red Cross, which usually keeps busy with fires. This group of volunteer citizens, businessmen, bankers, housewives, and teachers, devoted a weekend to running the hotel and personally moving the bandoned ones to other homes.

Each one needed separate attention and help. The Red Cross, in its most unusual operation, found it necessary to make a room-by-room check of the hotel to see just who was there.

For the moral crime, the abandonment of the aged who trusted him, Eugene H. Woods will face no penalty, except in the tribunal

of his own conscience and that of his fellow men. He is today under indictment for larceny by trick, evidence of which was discovered by this reporter, in the tangle of personal papers he left behind at the Regent.

John Huggins was 71 years old. His only claim to fame was that he served his country for several months in World War I. He never married. He lived in a room by himself and saved his money. In his old age, he fell into the hands of Eugene Woods. Today he is dead. He died in November of 1964 at a nursing home he was moved to after the closing of the Woods' home in Norwalk.

But even if he were alive, he would never be able to face Woods across a courtroom. He had been senile for many years, and his competency as a witness could be challenged by any fledgling attorney.

Woods knew the nature of the people he dealt with.

But preserved in the files of the Cuyahoga County prosecuting attorney is a series of documents, all gleaned from Woods own papers, which will speak for Huggins. They consist of a power of attorney signed by Huggins which gave Woods the right to withdraw $15,000 from a Canton savings and loan company. The check for $15,000 is there, showing it was put into a Lorain bank by Woods, to the credit of a corporation he organized. This transaction took place February 28, 1962.

During the month of March 1962, Woods used all of the money to pay creditors who were pressing him, personal bills to bars, restaurants, and dress shops. All of the canceled checks on this account where Huggins' $15,000 was entered were found. Not one could have possibly been for the care of Huggins.

The old man's bill at the Woods' home was paid for by his social security and his veteran's pension.

I had noticed the papers while on the premises of the Regent, and was refused access to them by the landlord, who feared a lawsuit from Woods.

Woods disappeared early in May. Only through the intervention of the brilliant chief assistant county prosecuting attorney, Mr. Dennis McGuire, was I able to have an opportunity to search these abandoned records, which were about to be destroyed. The landlord wanted to clear the building in an effort to find a new tenant.

I went to Mr. McGuire about the third week of May 1964 and asked him to get the papers for me. They were brought to his office, and I spent three dusty and exhausting days gleaning out the important documents which formed the basis for the indictment against Woods.

Woods, in his rush to leave, did not have time to destroy them, but he had mixed them with apparent discards to mask their importance.

Here I must add a personal note: I am the daughter of a man whose name I proudly bear, the late William J. Corrigan, who was known as "The Great Defender." I was brought up on conversations about the right to a fair trial and the rights of the accused.

Pa was opposed to trial by newspaper.

All the time I was going through these papers, I was not comfortable in the role of the pursuer. The prosecuting attorney's office had always been the camp of the enemy.

At that time Woods looked just like a businessman who had gone under. And I really did not know what I was looking for. My initial motivation for looking at the papers had been curiosity.

But as document after document piled up, I began to think of John Huggins and his rights. I began to feel I had been chosen for this task of exposing Woods by a power greater than myself. Everything I had done before—my reporting of interior design for the New York Times, which made me conscious of detail; my legal studies at New York University; my days as a housewife straightening out attics—all seemed to be building to this point in time when I was to be the agent, to sift and sort, to compare and link together papers that proved the evil truth about a man I did not know and his dealings with another stranger.

By the time I completed my research and turned over the findings to Mr. McGuire, I was convinced that Woods had bilked Huggins and that he had done this to many others.

I wondered when legal charges would be brought against the still-missing Woods. And I learned an important lesson: Bad morals do not a criminal make. And a newspaper story and a criminal case are two separate affairs.

"Isn't this enough?" I asked Mr. McGuire, spreading the papers out on his desk.

"What we have here is strong suspicion," he commented. His staff and Detective John Rogers of the Cleveland Police Department spent several months of further investigation before bringing the case to the grand jury.

The prosecuting attorney, I learned, is also aware of the importance of the rights of the accused. At one point Mr. McGuire read to me canon 20 of the "Canons of Legal Ethics" of the American Bar Association pertaining to pretrial publicity.

Adept at evading the law, Woods hid out for 6 months in Washington, D.C., waiting for the "heat to cool off" in Ohio. He was about to start a boarding house for retired civil servants when news of the indictment reached him October 10, 1964. He fled from Washington, and his whereabouts today are unknown. He is on the "Wanted" list of the Federal Bureau of Investigation.

Left behind in a Washington hospital was a tiny 7-week-old baby, born to Angela Mahl, a registered nurse who was a partner with Woods in the Huggins affair. She is accompanying him on his flight. The deserted baby became a charge of the District of Columbia Child Welfare Department and has since been adopted.

How unique is Eugene H. Woods, a man who discovered the profit in senility? The Greater Cleveland Accredited Nursing Home Association called him "as representative of the nursing home industry as an embezzler is of banking." I think that is true.

The Veterans' Administration, alerted by the Plain Dealer stories about Huggins, ran a check on all World War I veterans in Ohio nursing homes. The investigators found no similar cases. Nevertheless, one Eugene H. Woods is enough.

The vast majority of nursing home operators are good people, but the problem in Ohio is that the medical profession has turned over to the free enterprise system the care of the aged chronically ill patient.

The homes must make a profit to stay in business, so little concern is shown for the welfare patient whose maximum payment in this county, the highest in the State, is $170 a month.

Recent studies by the Welfare Federation here show that a minimum of $190 a month is needed for minimum care. The aged poor of Ohio who are chronically ill go into substandard homes. They have to be, to operate on the amount given for care. The cut is made on diet, the type of personnel hired, and the type of building.

Many will think that because someone is poor in her old age, she should be content with poor care, since it is what she has always known.

In my research for the nursing home series, I had an opportunity to talk to these forgotten people, and my greatest shock was to discover how many had a history of a productive life.

Franklin Delano Roosevelt once said that to some generations much is given and to some much is required. The generation past 65 today is the generation of which much was asked and little given.

Many spent their most productive years before social security, pensions, and unionization of industry. They were housewives before the days of automatic washing machines and dryers. They bore babies without painkillers and without doctors. They shoveled coal instead of adjusting thermostats. They are working people who are all worn out.

They were frugal, but inflation, funeral expenses for members of their families, and hospitals bills for an illness in their old age wiped them out.

They are the most deserving of any group on public assistance in America today. The question we must ask is: Is this a good country to grow old in?

These are the people that aid for aged must put in substandard homes. When the Cleveland office gets a phone call from a hospital, they must place the patient. The social workers call the list of licensed homes and plead with them to take the welfare client.

The owner is always reluctant. This is going to cost money. I have had reports of nursing home operators here asking families of aid for aged clients for a payment "under the table" to supplement the amount allowed by the State. This is illegal, but there is a shortage, and it always creates a black market.

The social workers may know that the home is not offering good care, but if it is licensed by the State, that is all that is legally required.

A tube-fed patient on welfare who is placed in a nursing home will certainly not be cared for properly. The homes do not have the skilled personnel to handle this task. Only about four in Cleveland are accredited by the national council on accreditation.

We have had cases here in Cleveland of old, sick people dying in ambulances while being moved from hospitals to nursing homes. You might ask why does not the hospital allow them to die in peace. Aid for aged covers hospital bills only up to a certain point, and the philosophy of the hospitals is that their function is to offer service where there is a reversable situation, a chance for life. A stroke or a cancer case may linger for months. And who's going to pay for it?

If the hospitals ran the nursing homes, or had wards for care of the chronically ill, the question of payments would still be unanswered.

Nursing home care is not covered by hospitalization, but if it were, I am sure the hospitals would show more interest in chronic illness. Then we would have assurance that the nursing homes of Ohio would be truly professional medical institutions.

The hospitals do not need frequent inspections and many regulations. They regulate themselves through the ideals and standards of the professional staffs. Blue Cross will not get into nursing homes until assured that their payments go for good care.

If we had Federal standards for nursing homes, which covered not only fire and safety, but care, this would be a guide to hospitalization insurance programs. Welfare payments could also be raised with the assurance that the extra money was being spent in the care of aged Americans, rather than enriching substandard operators.

In closing, I want to call attention to the most pitiful group of aid for aged patients in nursing homes, the Negroes. Nursing homes in Cleveland are segregated, usually because the operator wants it that way. Without a doubt, these Negro nursing homes are below standard, and there are very few of them, to boot.

I also wish to state that while few prosperous nursing homes have welfare patients, the philanthropic homes of Ohio, because of their religious orientation, care for many welfare patients, making up the difference by donations and payments of those who can afford it.

Thank you very much.

Are there any questions?

Senator Moss. Thank you, Miss Corrigan.

I am sure we will have maybe a question or two.

Let me tell you that we do appreciate this very striking and rather gripping report which you have made, based on your investigation into the situation as it exists in Ohio. I am sure this general situation exists in many, many of our States, maybe all of them, and it does indeed give point to what we are now trying to do: trying to find the answer to the neglect that we have been inflicting on many of our older people.

I was interested in the latter part of your statement, where you indicated that the nursing homes seem to be completely segregated in Ohio. Is this true? Are there no integrated homes that you know of?

Miss CORRIGAN. Very few.

There are two factors here. If you have a Negro operator, he prefers to have members of his own race, and also there are cases where some white operators will accept Negro patients, but this is pretty generally true, if you have a Negro patient on welfare, and I have heard the people at aid for aged say what a time they have placing them. They have no places that are available.

When you heard about the 101-year-old women who fell out of bed, this was run by a Negro. This was a Negro home. They are pretty bad.

Senator Moss. I suppose the Negro, too, being economically not too well off tends to have the poorer facilities. Is that also your finding?

Miss CORRIGAN. Yes. They are in the poorer sections of the city, for example, in the inner city area. Of course, they all have the trouble of getting RN's. You know you are never going to have better nursing homes unless you have a crash program for educating nurses, like we

had in the war, the Cadet Nursing Corps. All the girls who went to high school when I did went into nursing because they received free training and a good many of them are still working part time in nursing, working 2 or 3 days a week.

Senator Moss. That is a good point you made. You cannot have a requirement if you do not have the people to meet it.

Miss CORRIGAN. No; you can pass all the laws you want, but if you do not have the nurses, you are never going to get it done.

Senator Moss. I think your testimony and your findings are certainly something that will galvanize action. I am sure they have had a great effect in Ohio, and this will now affect the committee a good bit, I think, in our thinking, and in our efforts to do something that we can from the Federal level in this field.

I do appreciate your testimony very much.

Senator Young?

Senator YOUNG. May I say—and I say it as one who over the years was a personal friend of your father and of your mother—that you gave a beautiful statement here, a statement of fact. It should be published and should be read by millions of Americans.

It is depressing reading, of course, but it it is a great factual document, and I compliment you on it.

Regarding the latter part of your statement, the facts are that title 6 of the Civil Rights Act, which we enacted into law, prohibits the payment of Federal funds to any nursing home where segregation is practiced. I hope that if nursing homes have been segregated in Ohio, that the operators cease that practice immediately.

I want to compliment you very much on your fine statement.

May I say this: I knew your father, and in our younger days when we were both aggressive county prosecutors. Your father later was a great defender, nationally known in the defense of criminal cases, but in those early days he and I were aggressive prosecutors, and he believed and I did, and as I now do, that certain punishment like a shadow should follow the commission of crime.

Like you, we all hope very much that this man Woods will be apprehended, and will be brought to the bar of justice. You have done your part toward accomplishing that, so I congratulate you.

Miss CORRIGAN. Thank you.

Senator Moss. Thank you very much, Miss Corrigan, for your very fine testimony.

Judge Herbert E. Arfman is the general counsel of the Ohio Federation of Licensed Nursing Homes. He will be our next witness.

Judge Arfman, we are very glad to have you.

STATEMENT OF JUDGE HERBERT E. ARFMAN, GENERAL COUNSEL, OHIO FEDERATION OF LICENSED NURSING HOMES

Judge ARFMAN. Senator Moss, Senator Young, it is a pleasure to have the opportunity to come before your subcommittee and perhaps give you just a little bit different approach to this problem which we have been discussing all day.

I sincerely hope that this committee does not take the proposition that all nursing homes in the State of Ohio are guilty until they are proved innocent.

I come before you in many different capacities. I am an attorney at law, I am a little county judge, and I am general counsel for the Ohio State Federation of Licensed Nursing Homes. I do own and operate three nursing homes, one 12-bed nursing home, one 26-bed nursing home, and one new and modern 118-bed nursing home.

And I say to you and Senator Young that of all the capacities that I operate in I am most proud to come before you as a nursing home operator in the State of Ohio. I do not hold my head down. I do not take offense at what took place here today. I say to you I am proud to be a nursing home operator, and the vast majority of nursing home operators who are in this room will echo that position.

It was my understanding that this committee was coming into Ohio to investigate how we can provide adequate care for our aged in nursing homes. I would like to give you a few suggestions from an experienced nursing home operator.

Mrs. Arfman and myself have operated nursing homes for 15 years.

I would also, if time permits be very happy to discuss with this committee the aspects of the public disdain of nursing homes, good or bad, here in the State of Ohio which result from Fitchville, which result from the fight over rules and regulations, and which result from false and malicious statements of certain public officials.

However, I feel the most important aspect of my testimony should have to do with how can we provide adequate care for these aged people.

One of the previous witnesses before you said that the State of Ohio pays for firetrap accommodations. Never was there a truer word stated.

Let's analyze what is paid in the State of Ohio for the wards of the State of Ohio, the aid for aged patient.

There are four different categories of payment here in the State. In the one category, which is the large municipal areas, an average care patient can be paid $145 a month. He can receive a maximum care payment of $170 a month.

In a neighboring county, that same patient, with the same amount of care, can be paid $135 only for average care, and a maximum of $160 a month for maximum care. In the next neighboring county the average care patient, the very same patient, depending on where he was born or where he was residing, can only receive between $110 and $125 a month for average nursing home care, and a maximum of $150 for maximum care.

And once again, in another county, our more rural counties, the average care paid for by the State of Ohio is between $100 and $105. This could be the same patient. And the maximum amount that the State of Ohio will pay is $145.

Do not be misled. These are paper figures in many respects. Only those homes in these various four categorized areas receive this maximum care amount if they are approved by the Health Department of Ohio, in which the health department certifies to the welfare department or the aid for aged office that that recipient home complies with all rules and regulations of the State health department.

In other words, there is already and has been for years a differentiation in the amount of payment to those homes which attempt to provide better care. It is the difference in many counties of $10 or $20 per month per patient.

In other words, take the area of Columbiana County, in which my three homes are located. We are in the third category. An average care patient receives $110 to $125 a month. The maximum payment is $150. That is $5 a day.

But there are only one or two homes in Columbiana County that are eligible to receive this maximum payment of $145. The vast majority, and I think there are 13 homes in Columbiana County, and I will hazard a guess that there are not 3 homes in Columbiana County which are on the so-called preferred list which are eligible to receive the maximum care payment of $150 per month.

That same patient in Columbiana County, if sent to one home, the maximum amount that he can receive is either $110 or $125 a month, or at this three or four, I am not sure which ones are preferred now, they can go to $150. So in our county being on the preferred list is equal to $25 per patient. And yet there are only three or four in our county which are on that preferred list.

Now let me discuss with you just a moment, and I will not hold this committee up, on what I think is a new approach to the idea of taking care perhaps of the aid for aged patient.

The Federal Government has poured into Ohio millions and millions of dollars to aid philanthropic, nonprofit type homes. These same philanthropic homes pay no taxes. They pay no real estate taxes, no personal property tax, and no Federal corporation tax.

The Federal Government I feel has adequately provided for the philanthropic nonprofit type of home in the State of Ohio.

What has the Federal Government done for the proprietary type nursing home in the State of Ohio? One, they are now eligible perhaps to get a small business loan, but in attempting to comply and receive such a loan, the cost of building a building under their specifications, would be so exorbitant that I am just going to hazard a guess there probably are not half a dozen proprietary homes in the State receiving small business aid.

Another thing, one of the big things that we have to contend with here in the State of Ohio, is that nursing home investment money, that is money available to proprietary type nursing homes, is considered a high risk type of money. We pay a high rent interest rate, if we want to borrow money to build a proprietary nursing home. We give points to secure money to build nursing homes.

I am going to point out one thing that I feel is important, and that is why I have differentiated between the philanthropic nonprofit home and the proprietary home. Here in Ohio as of March 1964, who has met the challenge of caring for the aid for aged patient? Who has met the challenge? Has it been the philanthropic nonprofit institutions? Or has it been the proprietary types homes which we are all too willing to criticize?

Let me give you the figures. It has been estimated in March of 1964 that 8,820 AFA patients were put or were in nursing homes of the proprietary type, that 1,246 aid for aged patients were in nonprofit philanthropic type nursing homes. That is about 19 percent.

So with all the help the Federal Government has given to one class of nursing homes, it has resulted in the care of the indigent aid for aged patients of 1,246. With almost complete lack of any help at all to

the proprietary-type nursing homes, we in the State of Ohio are caring for 8,820.

What can we do?

Let me use a home just as an illustration. In Salem, Ohio, I built a 118-bed nursing home, new and modern, and I think it is the best one in the State of Ohio. Last year on the 350-foot lot that this nursing home was built on, the real estate tax amounted to $60. This year, since I have built this nursing home at an expense and cost of about $450,000, I estimate that my real estate tax will amount to roughly $4,500. I estimate that my personal property tax will be somewhere between $1,000 and $2,000.

And probably, based upon total income of my practice, my judgeship, a little profit out of nursing homes, I will probably pay an income tax of $4,000 or $5,000.

Now, in Columbiana County, the State of Ohio will pay me to take care of an aid for aged patient the total maximum amount of $150 a month, $5 a day. In this new nursing home that I have equipped and which does meet every regulation, does meet every personnel requirement, does have four RN's on the staff, I provide skilled nursing care for $7 a day, and a semiprivate two-bed room, not four beds, for $7 a day, $210 a month.

I provide skilled nursing care in a private room for $10 a day, or $300 a month.

But let's take the AFA patient. The State of Ohio will pay me only $5 to take care of that patient. I say that I must have $7 to be able to take that aid-for-aged patient, probably would have to have in the long run $8, because we only get maximum-care-type patient.

But here is my suggestion: Give us, the proprietary homes in the State of Ohio, and in this country, just a little bit of help, also. Give me, who has invested $450,000 to do something about this problem, a $2 a day tax credit for every AFA patient that I take into my nursing home, which would in effect bring it up to $7. Give me a $2 a day tax credit against my real estate tax, against the personal property tax, and if my thinking is correct, that it probably would have to go to $8 before this is over, give me $1 tax credit on my Federal income tax.

And I will tell you this, gentlemen: That one simple proposition would induce me to build another nursing home, perhaps, in which I could take care of these aid-for-aged patients, and it would induce other proprietary nursing homes across the State of Ohio to do the same thing.

And if you want to put these firetraps out of business, if you want to put them out of business, give us a sufficient amount of money that it becomes competitive.

Do you think for 1 minute that an aid-for-aged patient who can afford to come into my nursing home is going to go into a mansion-type firetrap? He is in that mansion home firetrap out of necessity.

There is another proposition along this same line, Senator. You had before you today a witness who is, I am not sure of his position, but it is with Blue Cross here in the State of Ohio. Make Blue Cross insurance available to nursing homes, not at $28 a day, but at somewhere around $7 or $8 or $9 a day.

I could give you example after example of patients who remain in the general hospital, which is directly across the street from my new

nursing home, who stay in that hospital day after day after day because they have Blue Cross insurance, and they are across the street at $28 a day, and they could come over into my nursing home at $7 a day.

And I can tell you the same thing, that in our county the aid-for-aged office has a contract with the city hospital for care of the aid-for-aged patients, and it is at a cost of $28 a day.

And before they would pay to me $7 a day for the care of that AFA patient, they will leave that patient in the hospital across the street at $28 a day.

There have been cases where a doctor in that hospital has said, "We will release this patient from this general hospital if they can go to the skilled nursing facility across the street," but there is no provision, evidently, for the aid-for-aged patient who will be paid, where the State and county will pay $28 a day in the general hospital but cannot pay $7 a day in a skilled nursing facility.

That is something again that should be remedied.

One other thing that will help induce nursing home operators to expand facilities here in the State of Ohio, and that is that we would get a set of standards, a set of rules and regulations, that would have some permanency.

I will just illustrate quickly what I mean by that.

Ten years ago a nursing home in Portsmouth, Ohio, built a 100-and-some-bed nursing home. Ten years ago he built it to 120 square feet in the rooms, all rooms—in other words, 60 square feet for two beds.

This was a concrete block, every partition was a loadbearing wall.

Now, before his mortgage is paid off, June 1 of this year, he will have to go to 70 square feet per bed. In other words, instead of a potential occupancy of, say 110, his capacity is reduced to 55. Seventy percent of his patients are aid-for-aged patients, and in the very lowest category of pay that I mentioned to you.

Now you say, "How does that affect us today in bringing costs down?"

It affects us in this way: this year I have built a nursing home; it is a concrete and steel building, poured concrete, and every room in it is 160 square feet—80 square feet per bed.

If I make a private room out of it, I just move a bed out, so a private room bed is 160 square feet, a semiprivate room is 80 square feet.

You have heard testimony here today stating, "Let's raise the standards again." And the one item that they mentioned of "Let's raise standards" is square footage.

I have a 15-year mortgage. What hope do I have if here before the present regulations are even a year old, or 2 years old, that they are already talking, "Let's have higher square footage"?

Basically, gentlemen, that is the big issue here in the State. That is, giving some kind of permanency to risk capital who are willing to go out and invest a lifetime of savings and borrow on a 15-year mortgage on a lifetime of money to help us solve what to do for the aged.

Give us a tax credit and set our standards. We have no objection to standards, none at all. Set good nursing home standards and say, "Fine, Mr. Arfman, if you want a $2 tax credit, you will provide a RN here and there, you will provide this and that, and you will provide that." And if I want the credit, I will provide it.

We can solve this problem. We can solve it.

Now there was some mention about a Mr. Woods. Let me tell you something, gentlemen. I have before me a Thermo-Fax copy of an affidavit that was filed back on the 19th day of December 1958, charging this man with operating an unlicensed nursing home.

We of the nursing home industry tried to do something about this man back in 1958. It said, this was the Fitchville Home that he managed, a nursing home or convalescing home, without having obtained a license in any of the years 1955, 1956, 1957, and 1958, contrary to the statutes in the case made.

So back in 1958 we, the nursing home operators, said, "Let us do something."

You know what the result was? He was suddenly issued a license so that on February 8 of that next year, the prosecuting attorney went in and nolled that case.

Nursing homes in the State of Ohio have been vilified because of the Fitchville fire, and I will say this to you, humbly, that we accept a certain amount of the responsibility, but many of the public officials who appeared here before you today also share in that tremendous responsibility.

The State fire marshal gave you a copy of his report, of his investigation of this fire. You will find nowhere in that report that in March of that same year the Fitchville home was inspected by the Factories and Building Division of the State of Ohio, that a Mr. Carr was the inspector, and that on that inspection there was the question, "Does this home comply with the National Fire Code?" and in Mr. Carr's handwriting it was apparently so.

And this same home was inspected the year before that by the State fire marshal's office, and the factories and building division and the State health department, and it was inspected the year before that by the same three.

Let me say this in all sincerity, gentlemen: There has been talk that if it had not been for the Ohio State Federation of Licensed Nursing Homes, that this Fitchville fire may not have occurred, if they had not held up regulations, that there would have been a sprinkler system, or a detection system, or even firewalls.

Let me say this to you, gentlemen: That was in the law years before the Fitchville fire. That home was permitted to operate in complete violation with the building code of the State of Ohio.

It had more than 30 beds. It should have been supplied and built with a sprinkler system. It should have had partitions in which not over 30 patients were between each of the firewalls.

They made a true statement, but it is a two-sided statement. Let me read what Mr. Rice wrote. He said:

> Compliance with these particular regulations would have required the home to have had either a sprinkler system or an automatic fire detection system as of the date of the fire.

The regulations that were held up in court by the organization also required it, and you say, "Mr. Arfman, you are talking through your hat." And I will show you that I am not, because under date of

February 13, 1964, here is a statement made to the newspapers by the acting chief of the industrial relations unit. He said:

> Inspectors are checking particularly for adequate sprinkler systems required in homes with more than 30 patients. They also are making sure that fireproofing material is applied over the exposed wood members and the joints and determining that the number of exits meet requirements.

Actually, he is referring to 1234–07, Revised Code, probably. It that is so, realize the fire marshal says this in his report on page 26 that he just gave to you, here is what he says:

> On October 1, 1963, the department of industrial relations issued procedures to be followed by the division of factories and buildings inspection in inspecting nursing homes. Since that date, such procedures have been followed in the issuance of renewal license in present building code nursing homes.
>
> These procedures have already proved their effectiveness and would have resulted in reduction of patient load or installation of a sprinkler system in the Golden Age Nursing Homes, Inc., when inspected for renewal of its license April 1, 1964.

In other words, this procedure that the fire marshal tells you about was instituted prior to the fire, but they were not going to inspect the nursing home until April 1, 1964.

Nothing had changed. If this procedure about sprinkler systems could have been instituted on April 1, 1964, it could have been instituted on October 1, 1963, October 1, 1962, or October 1, 1961, because nothing had changed.

The same rules and regulations were in effect then. The same laws were on the books then. So you, gentlemen, come to your own conclusion.

Did this lawsuit of the Ohio State Federation of Licensed Nursing Homes prevent the putting of this sprinkler system in this building? And I say to you it does not. There is no question in my mind but what the State fire marshall and the State factories and buildings division has had authority to inspect nursing homes before this fire, and they have it today.

The code sections involved here are plain and explicit.

Now, one other reason. This has been used as an illustration of some of our problems, and I am going to answer the question so there will be no misunderstanding why did the Ohio State Federation of Licensed Nursing Homes take this set of rules and regulations to court.

No. 1 was this 60 square feet, because the very problem that I indicated to you is a problem today. And you know thinking in terms of the hospital across the street from me, it is an intensive care hospital, it is a hospital that takes care of acute care patients, it has an operating room, it is the largest hospital in our area, and you would think that this acute care institution should perhaps have a set of regulations which would be just a little more stringent than that which would be required of me across the street building a nursing home.

In fact, the situation developed that if we were for low standards, if the members of the federation were for low standards, it would not have been difficult to have called my nursing home an operating room, because under the definition of hospitals here in the State of Ohio, it would be rather simple to qualify under the proposition of a hospital instead of a nursing home.

What advantage would that be to me? The advantage would be this: That across the street in this acute care institution, 60 square feet is all that is required in their patient rooms, yet to build as a nursing home, which we have to recognize does not take the acute type patient, I must provide 80 square feet.

Not only must I provide 80 square feet in the bedroom, I must provide 25 square feet of sitting room and lounge area for 75 percent of my patients, and if we figure that up, gentlemen, at about 20-some dollars a square foot, it probably would have saved me a great deal of money to have built my institution as a hospital rather than as a nursing home.

The same identical organization which imposed upon the nursing homes of this State this square footage rule is the same health council that makes the rules and regulations for hospitals. The very same one.

And for the record, of the Ohio Sanitary Code, it is regulation 402 which says that a hospital must only provide 60 square feet.

Now I will say this to you, gentlemen, you heard a little different story today than I heard 2 years ago when we had a public hearing on rules and regulations in the State of Ohio.

Irrespective of statement after statement by nursing home operators of how they had advertised for nurses, RN's and licensed practitioners, and that they were not available, the testimony put before this health council by the health department was there was and is no shortage of nurses in the State of Ohio.

Yet here today, after the regulations are now effected, you hear the statement that, yes, there is a shortage.

Why is that important? I am sure you gentlemen know that nursing home regulations, or any kind of administrative regulations, when once adopted, have the force and effect of law, so what we have been faced with here in the State now is that by law nursing homes must provide x number of nurses.

That was perhaps the second problem and reason that we went to court.

Gentlemen, for the last 4 or 5 years, nursing home operators in the State of Ohio, the good nursing home operators, have said that there is a difference of inspection between nursing homes, that if a person were to go in one nursing home and then go into another, it would be hard to believe that the two institutions were inspected and licensed by the same regulatory agency. We have put up with inspections which favor certain nursing home operators and are detrimental to other ones.

Let me say this, gentlemen. You heard the testimony on electrical inspections when only 300 and some homes passed. All three of my homes passed. I am inspected to the hilt. And I do not object to it. But I would sure like my competitors to be so inspected.

And that is the biggest problem in the whole State of Ohio on rules and regulations, that at the last minute, after the public hearings had ended, a variance clause was put into these rules and regulations which would permit the health department, the director of health, to grant a hearing, and the word is "may," which is permissive.

He may grant a hearing to any nursing home operator who said that he is affected, but it does not say "shall." And if he is satisfied, he could grant a variance of a year, which could be renewed.

So that we are going right down the old lane again, still going down the lane of I must comply 100 percent to the regulations, but my competitor could be granted a variance, and I have no recourse to the courts, based upon the proposition that the director may grant a variance.

Those in sum and substance were the reasons for this Ohio Federation of Licensed Nursing Homes going into court.

But let me say this, just in closing, that under the old regulations which everybody criticizes, under those regulations it was required that before an application for a nursing home was either accepted or renewed, that that home must be inspected by the State fire marshal's office, and be passed, that same nursing home would have to be inspected by the factories and buildings division, and have to be passed, or they would not receive a license or a renewal.

That section has been deleted from these new regulations.

Gentlemen, this is the subject that I have spent a great number of hours and a great amount of heartache and a great amount of pleasure in.

I appreciate the opportunity to come before you and perhaps give you, as I say, a picture of the other side of the coin.

You will find that nursing home operators as a whole have a heart bigger than their pocketbook, and that is illustrated in more ways than one, when over 80 percent of all of these indigent patients are being taken care of in proprietary nursing homes.

I thank you.

Senator Moss. Thank you, Judge Arfman. I do appreciate your coming and giving us this position and point of view.

Obviously we want to have before the committee both sides of every controversial matter, and I think you have eloquently stated your side.

As you say, you have spent a lot of time, and it is obvious that you know the subject very well. I am glad to hear about the nursing homes you are running. They sound as though they are very fine ones, particularly the third one that you were talking about, with 118 beds. It sounds as though it is a very fine home, and this is what we need.

I think we will all agree that there is no surplus of nursing homes, there is a shortage, and the more we can get of good ones, the better off we are, and I think you made a very good, concrete suggestion as to something we might look at for finding ways to better care for our older people who are on welfare and must have contributions from the State.

All the witnesses have agreed that the amounts available in Ohio, and I think is true in the other States of the Union, are too low, and they just preclude the proprietary nursing homes giving the standard of care that we all agree ought to be given elderly people.

And this suggestion of the tax credit, at least it is something to work with. This might be a possibility. So I think you have made a good contribution there.

There are one or two questions I wanted to ask you.

You said that one of the principal objections to the regulations which were litigated was this requirement of 80 square feet for a patient, whereas a hospital only had to have 60, but do you not recognize that there is quite a difference between long-term care, a person living

for a long period of time in an area, whereas a hospital stay is an average of 7 days, I think it is, where a person is really confined to his bed and is there a very limited time? Is there not quite a difference there?

Judge ARFMAN. Senator, if I may, I would like to qualify my statement in just one respect. This 60 square feet that we have been discussing would apply only to those homes which were licensed prior to 1958.

In other words, that was the rule of the game, back prior to 1958. Under the present regulations, up until they become effective, they could have 70 square feet, and then those afterwards would have 80.

Now, I do not object to 80. The only thing I am saying is let me protect my 80 square feet.

In answer further to your question, Senator, we have to provide, by regulation, as I said, 25 square feet of lounge area for 75 percent of our patients. We must provide a certain amount of hall or corridor space, which is 7 feet wide at the present time. We also provide kitchen area and bathing area.

So in the overall picture we provide a great deal more than an average of say 60 square feet, even in the old homes, and it is livable.

I hope I have answered your question.

Senator MOSS. Yes, I understand your position.

One of the witnesses earlier indicated all of the various organizations in Ohio that participated on the council in working up these regulations and recommending them, as they were promulgated by the department of health.

I wondered, since this seemed to me to be a very inclusive list, if you felt that large a group, with the points of view of all of those organizations, could have been so unfair as to require this litigation over a long period of time on those regulations.

Judge ARFMAN. I can answer that, sir, with an emphatic yes. I will tell you why. Of this whole group that made up these regulations, there was only one nursing home operator on that.

Each of those professional groups—I will use the word loosely—has an ax to grind, perhaps looking after their own particular organization which is represented.

They came up with a set of rules and regulations, sir, that, believe me, in my humble opinion, were ridiculous.

We asked to have representation on this committee, and we should have had. If they had had two or three nursing home operators on there, I think they could have come up with a set of regulations we could live by.

We are not opposed to standards. These three or four items that I mentioned, Senator, could have been removed from the regulations, and then the set of regulations passed, and we could have debated those in the courts, if necessary, but it was decided you will take the whole package in a group or none.

This was an administrative decision by the health department that we would accept these rules and regulations word by word, sentence by sentence, with not so much as a comma changed, as a result of 3 or 4 days of public hearings, in which doctors, and lawyers, and nursing home operators, came in and testified at great length.

Not a sentence, not a word, not a comma was changed, except two things: They had first offered us, before the public hearing and it was in the record, 60 square feet in the 1958 homes for 10 years. There was no mention of this variance clause.

After the public hearing was closed, they reduced the 60 square feet for 10 years and reduced it down to 3.

They added this variance clause which they knew was punishment to the very best nursing homes in this State. This was a vindictive act to punish nursing homes, private enterprise, who had the courage to stand up for 3 days and try to do something about the nursing homes in the State of Ohio.

Senator Moss. Do you honestly think it was punitive from a group like that?

Judge ARFMAN. Yes, sir.

Excuse me, sir—not by this advisory committee—I am talking about the Health Council of the State of Ohio, and I sincerely say "Yes."

Senator Moss. You are entitled to your point of view.

You indicated if you could get Blue Cross reimbursement perhaps in the nursing home field, such as hospitals, that this might be another possible solution. What is the position of your organization on cost-accounting procedures for care?

Judge ARFMAN. We do not oppose it. However, I would say this to you: From a personal standpoint, this cost-accounting proposition I feel is being used as a whipping boy to forestall the payment of an adequate amount to nursing homes.

I will explain to you why, sir. In Salem this last year we put a bridge over the railroad and it cost a billion and a half dollars and, in the building of that bridge, the very best of materials went into it; the very best of labor which, of course, would be union labor, in the area. But when the State of Ohio with matching funds said, "Let's build this bridge," they did not say to the contractor, "Show me your books." They said, "Let's put it out for bids. Who can build this bridge, based upon the standards that we set?" They did not ask private enterprise to open their books.

Basically, we do not oppose it, but I think it is being used as a crutch—as an excuse for the low payments.

Senator Moss. Your analogy is not very good, between building a bridge for which specifications are set, and it is a constant thing, rather than the care of an individual whose condition may change from week to week and month to month.

Judge ARFMAN. Yes; we are under that already, Senator.

If I take a maximum care patient in my home, and we hand-feed or intravenously feed him, and we get him up in a wheelchair, the amount is reduced, and we do not object to it.

Here is the thing really I am saying to you. When it comes to building roads, when it comes to buying a notebook, when it comes to renting a hall, when it comes to any one of the things the Government buys, they say we want the very best, and we want to pay a fair price for it, everything except when it comes to taking care of their own wards, the 13,000 or 10,000 or 15,000 aid-for-aged patients in the State of Ohio.

They go and shop for nursing homes the same as you and I would go out and shop for a pork chop.

And I made the statement at one time that there were more aid-for-aged patients in unlicensed nursing homes, uninspected nursing homes, than there were in licensed nursing homes. That may still be the condition. I do not know.

But I will say this: To a person who dies, whether he dies singly by fire in a nursing home, or whether he has company of the number that was in the Fitchville fire, to that person the ultimate sacrifice is still death.

We had a fire in an unlicensed farmhouse down in Steubenville, Ohio, back when we were fighting these regulations. Nobody seemed to care. Three patients were in that nursing home, two of them dead by fire, burning in an old farmhouse that had never had any kind of inspections.

Yet I found out at a later date this home was operating with the full knowledge of the health department. Yet the person who died was taken out of the home of a nursing home operator, operated by a person in this room, and was taken to that farm home, and that person died.

The death of one poor old lady was not news, evidently, but it is in the news of the public hearing.

I am sorry to make a speech.

Senator Moss. I would agree, one death is as bad as another. They are all tragic. We would like to avoid them all.

I respect your point of view. I do not know that I agree with it entirely. We are glad to have this in the record, and I think you have presented it very well.

We have spent quite a little time getting your statement in here, and I appreciate the way you have done it, and the manner in which you have done it.

Are there any questions?

Senator YOUNG. I would like to ask a few questions.

How long have you been general counsel of the Ohio Federation of Licensed Nursing Homes?

Judge ARFMAN. Close to 4 years.

Senator YOUNG. When was this federation organized?

Judge ARFMAN. It was organized, I would say, probably immediately after the first draft of the proposed rules and regulations were issued, where we nursing home operators had a chance to take a look at them.

Senator YOUNG. Are you also president of the association?

Judge ARFMAN. No, sir.

Senator YOUNG. How many nursing homes are members of this federation?

Judge ARFMAN. I have no knowledge of the exact number. I am general counsel of the federation.

Senator YOUNG. You have no knowledge of that?

Judge ARFMAN. I have not finished, sir.

I would give you my best estimate. It is probably around 80 or 90 homes.

Senator YOUNG. Of those homes, you operate three of those; is that right?

Judge ARFMAN. Yes, sir.

Senator YOUNG. Your organization is supporting the bill introduced by Senator Calabrese?

Judge ARFMAN. No, sir; I have never even seen that bill. I will say this: All I know about that bill is what I have read in the newspapers.

Senator YOUNG. You have not read the bill?

Judge ARFMAN. I have not seen or read the bill.

Senator YOUNG. You have testified about the financial difficulties of your members. Are you able to tell us, as general counsel, approximately what percentage of them are losing money?

Judge ARFMAN. Losing money, sir?

Senator YOUNG. Yes. Are any of them?

Judge ARFMAN. I would say this, sir, that the director of health preceding me——

Senator YOUNG. I would just like your answer.

Judge ARFMAN. I have no exact knowledge of how many there are. Yes; I think there was a statement made to me yesterday that some nursing homes have a mortgage on a mortgage on a mortgage.

Senator YOUNG. Instead of resorting to hearsay, I will ask you this: What is the range of aftertax profit on the three homes that you personally operate? Are you losing money, or are you making money?

Judge ARFMAN. No, sir. I am making money. I make no qualms about that.

Senator YOUNG. Is it your policy as general counsel of this organization—I want to hurry along—to continue to oppose implementation of the new nursing home regulations?

Judge ARFMAN. Just the opposite, Senator. One of the things I have been insisting on among our members is we want these regulations now enforced to the hilt.

Senator YOUNG. You are not opposing them?

Judge ARFMAN. No, sir. I want them enforced to the hilt.

Senator YOUNG. Is it a fact that the ownership of the corporation in Fitchville was a member of your association at the time of the fire?

Judge ARFMAN. Yes, sir. And I make no apology.

Senator YOUNG. He was a member of your association?

Judge ARFMAN. Yes.

Senator YOUNG. Would it be factual to state that your federation has opposed the fire sprinkler and detection regulations?

Judge ARFMAN. No, sir; it would not. I think it was as a result of the neogtiation by the federation that the detection system was added into the regulation.

Senator YOUNG. Do you personally—as the owner and operator of three nursing homes, one of them a large one and one a modern one, as you say, with 118 beds—do you personally believe that there should be fire detection and sprinkler regulations?

Judge ARFMAN. As applied to the 118-bed nursing home?

Senator YOUNG. Yes.

Judge ARFMAN. That home is of concrete.

Senator YOUNG. Do you believe in that?

Judge ARFMAN. I do not believe that a sprinkler system is necessary in a fireproof building.

Senator YOUNG. If you oppose the installation of fire detection and sprinkler regulations, is it because you believe them unnecessary, or because you object to the expense involved?

Judge ARFMAN. Senator Young, I do not oppose the putting of these into nursing homes. Under no statement at all could you interpret that I would oppose either a sprinkler system or a detection system. It has never been the position of the federation to oppose those two regulations.

Senator YOUNG. Do you support those regulations?

Judge ARFMAN. Yes, sir. And we telegraphed the Governor telling him that a long time ago.

Senator YOUNG. Are you supporting any legislation now pending in the State assembly?

Judge ARFMAN. Senator Young, let me say this in all sincerity, with the views expressed by yourself, which are probably shared by many, we know when we are licked.

Senator YOUNG. Are you opposing any regulation at the present time?

Judge ARFMAN. No, sir.

Senator YOUNG. That is all.

Senator MOSS. Did you give the average size of home of your members? Do you have that figure in mind?

Judge ARFMAN. I do not. I can give you my best judgment, which would be this: That the average nursing home that belongs to the federation is probably between 20 and 30 beds.

Senator MOSS. I see.

Judge ARFMAN. And that the average all over the State is roughly 30 beds to a nursing home.

Senator MOSS. Thank you, Judge Arfman. We appreciate it very much.

Judge ARFMAN. I thank you for the opportunity, sir.

Senator MOSS. Our next witness is Mr. J. Edwin Farmer, of the Central District Nursing Home Association.

We are pleased to have you, Mr. Farmer.

STATEMENT OF J. EDWIN FARMER, CENTRAL DISTRICT NURSING HOME ASSOCIATION

Mr. FARMER. Senator Moss, Senator Young, and members of the committee, the hour is growing late, and I am not going to burden you with reiteration of those things which have gone before.

Suddenly there is a public conscience. One of the children of a large family has been caught with his hand in the cookie jar. The parents of this child have been aware for a long, long time that the child might have had his hand in the cookie jar, and have not paid much attention to it.

We have a had a steady stream of witnesses today. With the exception of two, all of them are public officials, all of them responsible for rules and regulations, all of them responsible for making recommendations to various public bodies, all of them serving on public bodies that could make recommendations or make rules and regulations.

There are only two representing the industry itself.

The people that I represent are not members of the federation, and they are not members of the Ohio association. They are loosely organized. They attend meetings when there are problems involved. They do not pay any dues.

When there are problems, they try to band together to meet those problems.

The nursing homes in my organization were among the original committee that helped write the rules and regulations that were held up in court for over 4 years.

They met in an extra, or rump session that really solved the argument over the space problems with the various officials, while the meeting of the health council, was held in abeyance.

A group of nursing home operators decided what the regulations on space per patient was to be, and the recommendation was finally taken back to the chief of the division.

My group very strenuously objected to legislation introduced in 1963 to set the square footage per patient at 60 square feet. It was our photographs, submitted to the Ohio Senate, which showed what a room of 60 square feet with bed and table and the other accouterments that are required would really look like.

The bill had passed the house, and it had almost passed the senate. The photographs convinced the senate, I believe, that 60 square feet was not enough space.

So, my people are, and were, definitely opposed to freezing room space at 60 square feet.

They also were adamantly opposed to the Celebrezze bill of 1963 to create a nursing home board of nursing home administrators. The bill was killed in the committee with our help.

What I am trying to say here is that I do not want you to believe that out of a thousand nursing homes there are 75 who are interested in the rules and regulations because they were banded together under one organization, or there was a group of another 75 adamantly opposed to it, and the others did not care.

The people I represent are not interested, for a number of reasons, in belonging to either one of the organizations, so they try to operate in the best way they can to improve the general scope and field of nursing home business.

I have been in public health service most of my life, and have dealt with the Public Health Council on many occasions. I think they were eminently fair in trying to arrive at some intelligent conclusion. The rules and regulations as we know them now could very well have been adopted in the normal course of procedures within 10 days after their approval by the Public Health Council. Then individual sections, which were at issue, and on which there were legitimate differences of opinion could have been attacked in court, because the Administrative Code of the State of Ohio provides for this.

This could have been done. It has been done in other things, and it could have been done here.

The new rules and regulations have not been in effect long enough for us to really know if they are going to work or not. What we need is time to find out whether these rules and regulations will work.

One thing we need is a single license not several as we have now. Now you have a State license. In a charter city you also have a license from a city. Then you have to have a State food handler's license. Then you have inspectors from those licensing agencies and fire and building inspectors, and department of welfare, and aid for aged per-

sonnel all coming in and putting their own interpretations on the regulations causing great confusion and inequity.

Everyone forgets there are old people involved who do not understand all this coming and going, and all the things that are being discussed and people are arguing and fighting over. They do not understand how they got where they are, or who is really responsible for them, and I do not think anyone else does.

We need to very seriously examine ways to create a single responsible agency for the one license. It is all very well to say the State shall be responsible but then the State farms out the responsibility to a local health department. If the local health department is capable of carrying out the duties, all is well, but unfortunately we have many rural counties with poor health departments in Ohio, and we have many nursing homes in rural counties.

We were trying to ascertain the division of homes in large cities, urban areas, and small areas. It looks as if there are about as many in rural areas as in urban, and those in rural areas are not very well serviced by health departments.

We need a single set of regulations operating over the entire State, and we need a single licensing agent or agency, someone specifically responsible where you can put your finger and say, this man or this agency is responsible.

I am of the opinion that the support money should follow the inspection, although there are those who disagree with me. It is difficult to get nurses, and it is difficult to get licensed practical nurses.

I recommend that if a licensing program is developed, that you tie some refresher courses or education into the regulations, so that the licensing agency will be responsible for providing refresher and teaching programs, see that the money is provided for it, and the requirement that nursing home staffs must attend if they are to be licensed.

It is very well for fire prevention experts to say bring your people in and we will teach you something about how to handle fires. But people are not going voluntarily. They are running nursing homes, and they do not have enough people to operate the home while they are there. So I think staff orientation and staff education is highly important.

One thing that has only been touched upon lightly is the number of old people who are now living in old hotels—people who should be under better supervision.

Most of the aged people are getting aid for aged assistance, and they want to live where they want to live, but advantage is being taken of this type of individual. If the State or the Government is going to be involved in paying the individual, aid for aged assistance, then the State should assume some responsibility for deciding whether that patient is competent to handle the money and live in inadequate and dangerous quarters. Many times we see patients in early senility being enticed into old hotels that are definitely substandard and competing with the standard nursing home.

Nursing homes are willing, most of them, to cooperate and to help develop standards, and I believe you are aware that all of them do not have their hand in the cookie jar.

Senator Moss. Thank you, Mr. Farmer.

I am sure you are right. I think some of the things you reiterated here about the need for training programs for nurses and fire prevention certainly underline what has been said by other witnesses.

I am glad to have you explain. When I looked at this list, I did not know how you fitted in with either the federation or the nursing home association. There are really three groups of nursing homes here, although your organization is very informal, as I take it.

Mr. FARMER. That is correct.

Senator Moss. I am going to have to excuse myself at this point. I have to leave to catch an airplane. Senator Young will take over the chair.

We still have some witnesses after you are through.

I want you to know how much I appreciate your appearance, and I want to say in advance to the others who will be called I apologize that I must leave early. I will read carefully in the record what you say, and of course, knowing under the guidance of my friend, Senator Young, we will have a complete and full record made.

This has been a very fine hearing. I have learned a great deal in listening, and I hope to learn still more when I read this record carefully, but I must ask to be excused.

Mr. FARMER. I would not want this committee to go away with the thought left by both Mayor Locher and Dr. Stocklen that there is agreement that the only way to solve the problem is to put all the aged patients in old VA hospitals or in huge institutions, because I think this is not so, and certainly we do not agree with them.

Senator Moss. Thank you.

Mr. CONSTANTINE. Mr. Farmer, how many members are there in your organization?

Mr. FARMER. There are no members, as such, as I said to the committee. The original central district nursing home group was the central Ohio division, of one of the original nursing home associations. It was a district division, and when the severance occurred in the State organization, this group of people continued to hold meetings. I will be glad to furnish you with a list of them.

Mr. CONSTANTINE. You yourself operate a public relations firm. Is that correct?

Mr. FARMER. That is correct.

Mr. CONSTANTINE. Do you have a financial interest in any nursing home?

Mr. FARMER. I own two pieces of real estate that are nursing homes. I do not operate the nursing homes.

Mr. CONSTANTINE. Are these nursing homes handling aid to aged cases?

Mr. FARMER. Yes; they are.

Mr. CONSTANTINE. What other homes are involved apart from those? Do you have other homes in the central district association?

Mr. FARMER. Yes; and I will be glad to give you a list of them and their addresses.

Mr. CONSTANTINE. Where do you differ, basically, from the Ohio Nursing Home Association and the Federation?

Mr. FARMER. With the Federation, both in terms of goals and approach, and with the Ohio assocaition I have personally no particular difference.

I think the schism occurred because of personal differences between the organizing officers of the Ohio organization. This is why there is more than one organization now.

The one comment I might have about the Ohio association in this particular program is the accreditation program, and I was associated with it for a while. I think it is a fine thing, but I do not think it is the answer to the problem of aid for aged patients.

You cannot compare the accreditation of hospitals with the accreditation of nursing homes, because the problems and people and controls are different. The accreditation of hospitals is tied directly to the medical profession, and you cannot do that with nursing homes.

There are too many nursing homes, and they range in size from 10 or 12 beds up to the maximum sizes that have been spoken of here. There must be nursing homes of various sizes, because if there are not, and you concentrate everybody in big institutions, then you are negating the entire philosophy that has been expressed by so many people, that you want to leave the old person in his own environment, where his friends can see him and make him feel happy.

But if you bring them all to Cleveland or Columbus, and so on, out of Athens and Marietta, you are not going to accomplish this.

That is one reason we opposed the golden age bill in the State of Ohio, because they were proposing and are still proposing building institutions on mental hospital grounds, and facing mental grounds, and putting in the old people collected from all over the State. You cannot keep old people happy in huge groups away from their homes, and all old people do not need intensive care.

Senator YOUNG (presiding). Thank you very much.

Mr. FARMER. Thank you, Senator.

Senator YOUNG. Now the subcommittee will be pleased to have the Right Reverend Monsignor Michael Ivanko, Dr. Weil, and Rev. Roland Bosse.

Will you step forward, please. We will hear the testimony of each one of you.

May I say that the prepared statements will be received and will be printed in full in the record of the hearings here, and whatever you care to add to the prepared statements, we shall be glad to consider.

You may proceed.

STATEMENTS OF REV. ROLAND C. BOSSE, HONORARY PRESIDENT, AOPHA, EXECUTIVE DIRECTOR, LUTHERAN HOMES FOR AGED, WESTLAKE; RT. REV. MSGR. MICHAEL B. IVANKO, HONORARY PRESIDENT, AOPHA, DIOCESAN DIRECTOR OF CATHOLIC CHARITIES, CLEVELAND; AND DR. JULIUS WEIL, HONORARY PRESIDENT, AOPHA, EXECUTIVE DIRECTOR, MONTEFIORE HOME, CLEVELAND

Reverend IVANKO. Thank you.

I hope you can hear me, because I have a bad cold.

As one of the representatives of the Association of Ohio Philanthropic Homes for Aged, and personally as director of Catholic charities for the diocese of Cleveland, I wish to express appreciation to the Senate subcommittee for coming here to learn about the needs of long-term care.

We join our hopes to yours for good results. My two colleagues are covering very important points. I shall touch on two—standards of safety and financing.

SAFETY STANDARDS

It is definitely the practice of all our homes to provide for our residents. Even before regulations became effective—good housekeeping such as the prevention of floor hazards and avoidance of rubbish accumulation, so easily the cause of fires—we have had self-imposed rules. For these items we have been complimented repeatedly by the inspectors.

And I refer to this down through the ages, because we have been in this business for 130 years.

With the passing of regulations we have done our best in matters of sanitation, electrical safety, plumbing, and all items called for by the law. At times we have had to delay, not because we did not want to comply but rather because financing was not available at the time. In one instance, my own organization spent over $5,000 to correct an electrical system.

Cooperation is important—everyone admits. Sometimes cooperation is not too easy when there is some misunderstanding. This arises from the fact of multiple inspections with the resulting multiple reports.

EXAMPLE OF A PROBLEM

It is possible in some areas for two different departments of government to inspect the same item and submit conflicting reports. As an illustration, in one instance exit signs in a corridor were pointing in one direction, as had been requested by one department. But a day after installation, another inspection by another department demanded that these signs be pointed in the opposite direction.

Departing for a moment from my representative of our organization, I personally wish to recommend that all inspection reports be compiled into one, before forwarding to the home asking for compliance.

Now may I call to your attention one further item. Our Association of Ohio Philanthropic Homes did not oppose in any way the State regulations, which would have been of great help to our State.

I have indicated above the fact that, sometimes in making changes for safety, money was not always available. This brings up the topic of our financing.

FINANCING

Our homes are sponsored by the various faiths. Our groups feel a responsibility in this field. We would like to carry a big load. This is not possible. We try to do at least part of the job.

First, we build our homes at our own expense. Usually capital costs are not included in the cost of care. Our people take on the responsibility of paying for the building. Our homes operate on a deficit basis (about 20 percent).

Second, operating costs are subsidized. Our homes operate on a deficit basis. Good care is expensive. Our patients as a whole cannot pay the total operating cost. Consequently, we run a deficit.

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In preparing for this presentation, my colleagues and I compared our subsidies which the people of our faiths have to supply. We were surprised to discover that the six homes represented by us annually have a deficit of about 20 percent.

A businessman would go into bankruptcy with an annual 20-percent deficit. We are forunate in having this deficit covered by donations of our peoples.

REASON FOR THE DEFICIT

But why the 20-percent deficit? Permit me to explain: Fortunately, we do have some patients who can pay the total cost of care. Others can pay only part of the cost. Among these are those who are receiving old-age assistance—in Ohio called aid for the aged.

About 45 percent of the residents of our homes are aid-for-aged recipients, this despite the fact that only about 12 percent of the elderly citizens are on aid-for-aged rolls. The care of each of these individuals is subsidized because the State grant is not sufficient for a good standard of care.

Finally, in spite of all pensions and forms of assistance, there are still some persons who can pay nothing. These we also admit into our homes, although totally dependent.

NEED FOR FURTHER FINANCIAL SUPPORT

My own purpose right now is to stress the need for further financial support. If our bills are paid, and our mortgages are up to date, you may ask, "Just why are you asking for financial help?" For two reasons: (1) the cost of care will go up; (2) we want to do more than we can now do, both in type of service and in the number of people we serve.

COMMENTS ON THE OHIO LEGISLATIVE SERVICE REPORT

For a moment we want to take full advantage of this opportunity. We have just explained our policy of operating on a deficit basis because we provide care also for those who cannot pay all or part of their bill. May I call to your attention that a legislative service commission of our State legislature has made a survey and prepared a report on nursing care. In it is a statement that in general it seems to be the policy of philanthropic homes to admit only those who can pay. My statement above shows this to be an utter misrepresentation of facts.

CONCLUSION

In conclusion, may I repeat in the name of the Association of Ohio Philanthropic Homes for Aged: We have provided, and will always provide, good care for our patients. We will not compromise in this stand. Safety will always be one of our objectives. Further, we do request you for financial help so that we can do more.

A SHINING EXAMPLE OF SELFLESS LOVE AND TIRELESS SERVICE

The Holy Family Home of Cleveland provides a very high standard of care to patients suffering from incurable cancer. It admits only those who cannot afford to pay total cost of care anywhere else. The

staff consists of Dominican sisters of St. Rose of Lima, established by Rose Hawthorn Lathrop, daughter of Nathaniel Hawthorn.

In the past year this home has supplied 25,550 days' care to its patients. All this care was free—entirely free. Not one patient nor his family was given a bill. Fortunately, due to the appeal of this wonderful program, voluntary donations have supplied the money.

In respect to this home, we do not need any money; in fact, if you offered it, we would have to decline it. But for the sake of the programs of our many other philanthropic homes, we say: "Give us a break—help us a little bit—and we will give increasing service in a field growing by leaps and bounds due to the ever-growing number of our elderly citizens."

Thank you.

Senator YOUNG. Thank you very much, sir. We are going to try to help. We are much impressed by your testimony.

We will proceed. Reverend Bosse.

Reverend BOSSE. I will brief my testimony in the interest of time, but I would like to highlight a few things.

(The prepared statement of Reverend Bosse follows:)

TESTIMONY PRESENTED BY THE ASSOCIATION OF OHIO PHILANTHROPIC HOMES FOR AGED, INC., LAKEWOOD, OHIO[1]

PART ONE

High standards of care in homes for aged made possible because of community interest and concern

One reason why the average charitable nonprofit home for aged can have and maintain high standards of care is because of community interest and community concern.

Generally the influential leaders in the community are serving on the board, including business executives, professional men, priests, rabbis, ministers, lawyers, and doctors. But more than that, the very people who elect the board of trustees or advisory board, often are the people who have, or have had, mother, father, sister, brother, aunt, or uncle in the home. They have a definite interest in the standards of care that are maintained because it involves a service to members of their own family or to their friends. These are the people who control the purse strings of the donations which make the operation of a home for aged possible.

Importance of preserving the dignity of the individual

It is of paramount importance that any changes in legislation or regulations affecting the home for aged take into consideration the need for protecting the dignity of the individual. Caution should be exercised that in striving to do something for the welfare of the older person we do not deprive him of one of his most precious possessions—his independence.

The average geriatric patient has experienced many losses. It may have been the loss a spouse, children, sisters, brothers, friends. He has a reduced income or may even be dependent upon public assistance. Often he can no longer take care of his personal needs and must depend upon some one else. Even institutionalization is usually accompanied by a strong sense of loss. As one writer remarked, "loss of physical prowess, family, associates, familiar routines, and not infrequently loss of hope."

Let's "put on the shoes" of the "insider"

Many residents of the home for aged realize that they will have to spend the rest of their lives in an institution. Having experienced so many losses, the few things which remain to the older geriatric patient are very precious to him. They may seem insignificant to us who are still active in the everyday affairs

[1] Prepared and presented by Rev. Roland C. Bosse, honorary president, AOPHA, executive director, Lutheran Home for Aged, Westlake, Ohio.

of life and are able to lead an independent existence. If fate should suddenly force us to step into his shoes we would better understand how acutely they can pinch.

Major loss or minor loss—Depends upon the viewpoint of the individual who experiences it

Recently it has been proposed in our State that the monthly old-age assistance check be paid directly to the nursing home operator in which the recipient has been placed, rather than to the individual himself. Just having the right to receive his own check and hand it over to the nursing home for his care helps the recipient to retain a feeling of self-respect. Taking away this right may represent a major loss to the individual affected, although a minor loss to those of us who are still fortunate enough to be living independently. However, his old-age assistance check is generally a substitute for the paycheck of days gone by. Moreover, if the recipient's check should pass over his head into the hands of the nursing home operator, he is apt to fear that his right to be placed in a nursing home of his own choice might be curtailed.

Importance of considering difference of hospital care and residency in a nursing home or home for aged

Many persons in favor of making old-age assistance payments directly to the operator of the nursing home, argue that this is the practice followed in making payments to hospitals, and that it has proven very satisfactory. However, there is great difference between hospital care and residency in a nursing home or home for aged. Most hospital care is short termed. But care in a home for aged can stretch on for years and years, and so little things become of greater and greater importance. We have a lady in our Lutheran Home for Aged for whom we have provided nursing care for over 11 years.

Pertaining to supplementation of old-age assistance grants

In order to provide higher standards of care for our aging people who are in need of nursing care, supplementation of old-age assistance grants by friends and individuals should be permitted without a corresponding reduction of the amount paid by the State. At the present time, supplementation is possible only if all the income and resources of the needy individual, together with the old-age assistance payment, do not exceed the State's defined standard of assistance. As it now stands, each State must define the "need" to be met under its federally aided program and establish standards used in determining the amount of payment. Standards set in the State of Ohio at the present time are from $75 a month to $170 a month, depending upon the amount of care needed. The maximum of $170 is to be raised to $180 on July 1.

We believe that many of our aging people who need nursing care would be helped in their needs by relatives and friends who would be willing to supplement the State grant, if their donation would not be negated by a corresponding reduction in the State grant to the individual.

Information about the Association of Ohio Philanthropic Homes for Aged

Our association, the AOPHA, represents homes caring for the aged in our State, including the physically chronically ill and the mentally impaired or senile. These homes operate not for profit, but solely for the purpose of furthering the health, welfare, and happiness of those placed in their care. They are sponsored and given financial support by churches, fraternal organizations, and charitable agencies and individuals. Our homes not only operate with no thought of financial gain, but most of them accept many persons who can pay only partially or not at all for their care. Following is a summarized statistical report of the Philanthropic Homes of Ohio, recently completed:

A. Number of philanthropic homes in Ohio	135
Total bed capacity	10,519
B. Number of homes included in questionnaire report	104
Total bed capacity	8,284
1. Total bed capacity of homes reporting (104)	8,284
2. Number of these beds which are nursing beds	2,767
3. Number additional beds readily convertible to nursing care	1,073
4. Number of residents who are AFA recipients	1,667
5. Number of residents in these homes unable to pay cost of care but for whom AFA assistance has not been requested	1,466
6. Number of residents who are not AFA recipients for whom the home receives only the amount AFA would pay, or less	952

Reverend Bosse. The philanthropic homes in general have been homes that have operated at high standards. One reason why the average charitable nonprofit home for the aged can maintain high standards of care is community accountability.

Generally the influential leaders of the community are serving on the boards, including business executives, professional men, priests, rabbis, ministers, lawyers, and doctors. But more than that, the people who elect the board of trustees or advisory boards often are the people who have had mothers, fathers, sisters, brothers, aunts, or uncles, in the home.

They have a definite interest in the standards of care that are maintained because it involves a service to members of their own family or friends. These are the people who control the purse strings, who make the donations which make the operation of a home of the aged possible.

I am referring here to the statement of Monsignor Ivanko that we are operating at approximately a 20-percent deficit.

We did say something in our testimony regarding the dignity of the individual. We are concerned that any regulations be really with the older people and not just for the older people, and that no additional losses be imposed on them by regulations.

They have so little left in life, so many losses they have incurred, that even the things that sometimes seem minor to us that may be taken away from them can be very traumatic.

We did want to say something about the matter of supplementation. In order to provide higher standards of care for our aged people in need of nursing care, supplementation of the old-age assistance grants should be permitted by friends and individuals without a corresponding reduction of the amount paid by the State.

At the present time supplementation is possible only after all the income and resources of the individuals, together with the old-age assistance do not exceed the State's standard of assistance.

Standards set in the State of Ohio at the present time are from $75 a month to $170 a month, depending on the amount of care needed. The maximum of $170, by the way, is to be raised to $180 on July 1 in some counties.

We believe many of our aging people who need nursing care would be helped by relatives and friends who would be willing to supplement the State grant, if their donation would not be negated by a corresponding reduction in the State grant to the individual.

We would like to say a word regarding the association of AOPHA which we represent.

Our association, the AOPHA, represents homes caring for the aged in our State, nonprofit homes, including the physically chronically ill and mentally impaired or senile. These homes operate not for profit but solely to further the health, welfare, and happiness of those placed in their care.

They are sponsored and given financial support by churches, fraternal organizations, and charitable agencies and individuals.

Our homes not only operate with no thought of financial gain, but most of them accept many persons who can pay only partially or not at all for their care.

I would like to correct a statement or testimony of a previous person who testified here. He stated that the philanthropic homes only have a certain number of indigent people, and he based it on the fact that he took the AFA records.

Our record, however, shows that in 104 homes for aged reporting there were 1,667 of these AFA recipients in our philanthropic homes of Ohio. This, however, is not the entire story. We had a questionnaire a few months ago in which we solicited the information from the homes of the types of people they had in the homes, and we were able to gain this information.

By the way, we have 135 philanthropic homes in Ohio, with a total bed capacity of 10,519. About 77 of these homes are members of our organization.

In the questionnaire referred to above, 104 of the 135 homes for aged answered. These 104 homes had a total bed capacity of 8,284. We asked them about the number of residents who are AFA recipients. This is the figure of 1,667.

We also asked them how many people do you have in your home who are not able to pay the cost of their care who would be eligible to apply for old age assistance if they wished, but had not applied for old age assistance. We come up with the figure of 1,456.

In other words, many of our philanthropic homes are taking care of people for whom they are not even bothering to apply for the assistance.

We additionally asked that whether these homes have people in their homes who were paid what AFA pays or even less, and we have 952 of such people.

Thus, of the 8,284 beds represented, we had 4,085, virtually 50 percent, who were either not paying for their care or only partially paying for their care. Therefore the record of the testimony previously given is not exact, because it does not include many of these other factors of charity and care.

I think we should also mention that whatever comes to the philanthropic home never goes into any profit in any way, but is only used for the good of the individual and for raising standards of care. In other words, all funds are used for the aging individual.

I would like to say a word in closing on the matter of accreditation. I do not know as I was not here this morning, whether the other accreditation program—the national accreditation program—was mentioned or not. I did hear the national council mentioned, which is an accreditation program sponsored by the American Nursing Home Association, and the American Medical Association.

However, there is another national accreditation program that is in operation at the present time. The American Association of Homes for the Aging (of which our association is a member), is the national association of philanthropic homes, government homes, and nonprofit homes, which was very active in the organization of this other accreditation program.

It is a multilateral accreditation program under the sponsorship of the American Hospital Association, the American Association of Homes for the Aging, the American Nurses Association, the American Dental Association, and the American Association of Social Workers.

This program is in operation. We do not appreciate this dual effort.

We are not in favor of it. We would much prefer one national accreditation program. The aim and goal of philanthropic homes, and also of this accreditation program, is that there be one accreditation program, and that it be taken back under the joint commission, where it was originally proposed, and where the plans for accreditation for nursing homes and homes for the aged were originally started.

Senator YOUNG. Thank you very much, Reverend Bosse and Monsignor Ivanko. You have certainly given the subcommittee some important factual information that we in turn later on will pass on to the whole committee.

Now, before we proceed to hear Dr. Weil's statement, I would like to ask Monsignor if there is anything further he wanted to say, because certainly this acting chairman wants to say you are giving very important testimony, and I want to hear it all.

I have a question to ask of either of you. It is this: In philanthropic homes, are you assured of professional personnel, or do you have as much difficulty in securing competent professional personnel as proprietary homes seem to be having, according to the testimony?

Reverend IVANKO. Yes, it is a constant battle with us, and we do not give up.

One of the things I wanted to bring here, Senator, and I think it goes along with one of the recommendations made by Senator Moss with regard to training individuals within the field, is 10 to 12 years ago the Association of Philanthropic Homes sponsored workshops in Bowling Green that wound up in establishing an annual workshop at Western Reserve University of 3 to 4 days, to which it has attracted anywhere from 50 to a hundred people from the nursing home and philanthropic home people.

We have provided people well trained in order to try to bring up the level of staffs, so even if we cannot get the full complement of nursing staff, at least they will have some equally or partially trained in handling the patient properly. This is one effort we have made.

Senator YOUNG. And the salaries that you are offering, are they in fact competitive with hospitals and other employers along the same lines?

Reverend BOSSE. Yes, Senator, unless it would be the sisters or some of the church organizations working as a sacrifice, we might say, in rendering this service.

However, I would qualify with the statement if you took many of the salaries of many of the administrators, many of the top people, they would probably be much less than what would comparatively be paid in the field.

Senator YOUNG. I can believe that. I would believe that, sir.

Mr. FRANTZ. I just want to follow up with one point on the recruiting of nurses and paramedical personnel.

In Indianapolis the opinion was expressed by one of the witnesses, a physician who was very familiar with nursing homes in his area, that one of the reasons for the difficulty in recruiting this type of personnel was that the nursing home was a low status employer, and was not attractive to persons who were nurses, physical therapists, and so on.

I am wondering if you have any comment on that. I am repeating his comment.

Reverend BOSSE. What do you mean by low status as an employer?

Mr. FRANTZ. Well, given the same salary, a nurse will elect to work for a hospital rather than a nursing home because it has more prestige attached to it.

Reverend BOSSE. I believe some of this may be true. This is my personal opinion. Generally there is a feeling, of course, of "aversion," shall we say—put that in quotation marks—against working with older people.

There seems to be an attraction to working with children, with the middle aged. They are much more alert, they are more interesting to converse with in general.

I think if the people had the experience of working with older people, they would change their mind.

I might suggest in our training programs of nurses and LPN's there would be a requirement that the nurses would spend 1 month of affiliation in a good home for the aged. I think their attitude would change immensely, because we find when our nurses do come to our homes, after they have had an opportunity of working with the older people, they tell us very frankly we thought we would not like it, but when we experienced the depth of appreciation of some of these older people we began to love our work.

Dr. WEIL. I might add something. I think the homes for aged in our category, we endeavor to pay more than the hospitals pay because of what Reverend Bosse just brought out now. The glamour is missing in our institutions. Satisfaction comes afterward, when the nurses and OT's and PT's have worked for our institutions.

I am assigned to what is a good program for a home for the aging. Even though I am now an administrator, I have been a psychologist and social worker for some time. We are guided by professional thinking and therefore on this basis we select our staff and carry out our program.

I have roughly outlined a framework of such a program. The requisites are:

1. A good physical fireproof plant.
2. Good medical and nursing program.
3. Good equipment in all departments.
4. Good beds and sanitary facilities.
5. Trained staff—nurses (RN's), LPN's, nurses' aids, orderlies, et cetera.
6. Psychiatrist.
7. Care of the senile.
8. Physical therapy.
9. Occupational therapy.
10. Sheltered workshop.
11. Good food.
12. Good housekeeping.
13. Social program that serves the needs of the group and the individual.
14. Individual social work help to each patient or resident.
15. Caseworkers.
16. A well-balanced program.
17. An adequate staff—trained and devoted to the service to old people.

18. Dental care.
19. Podiatry.

I am pleased to learn of the efforts of the proprietary homes which we have been trying to go along with.

CONCLUSION OF EXPERT CONSULTANT IN FIELD OF AGING

A recent study by an expert consultant in the field of the aging arrives at the following conclusion:

The question is frequently asked us as to whether commercial facilities can be properly utilized in place of the voluntary agency. The commercial home can and does serve some segment of the population, but commercial facilities have the following basic deficiencies:

1. Many of the present commercial nursing homes are substandard in operation.
2. Only the rich and the upper middle class can afford the decent and professional type of care in commercial facilities which even nearly approaches the quality of care provided by the voluntary agency. The indigent or those in public welfare could not receive the kind of care in commercial homes that the community desires for the aged and chronically ill.
3. Integrated services available through community voluntary agencies can provide the full range of medical and social services necessary for the best possible care for those requiring this quality of service during the declining years of their lives.

In order to know the type of physical setup a nursing home shall consist of, we have to know what type of patients we serve. We therefore have to classify our population:

1. The physically chronically ill.
2. The mentally confused, or what we commonly call the senile.

The nursing home of today, in general, has few ambulatory patients whose illness permits them to be independent and self-sustaining. This leads us immediately to the question of what do we need for the physically chronically ill and what do we need for the senile.

WHAT WE NEED FOR THE CARE OF THE PHYSICALLY CHRONICALLY ILL

A nursing station with medical examination facilities fully equipped to meet the needs of these patients. A nursing station that is so centrally located that the nurse on duty can oversee adequately the floor for which she is responsible.

The number of these patients should not exceed 40, and ideally, 26.

Equipment such as EKG, oxygen, aspirator, resuscitator, are just some of the necessities of any good nursing station, besides other paraphernalia needed for daily service in nursing care. Air mattresses and hi-lo beds are essential for good nursing service. Preferably, X-ray equipment and a minor laboratory should be available.

Naturally, adequate examination offices for the doctors, with possible conference room for consultation with specialists such as ophthalmologist, urologist, and cardiologist, and so forth.

The physician in charge of the hospital program is held responsible for the total medical care of the aged population.

Hospital-type recording is desirable, and especially so if the staff consists of an adequate complement of registered nurses.

It goes without saying that a high-type nursing staff is paramount for good service to the patients of the home. This should consist of

registered nurses, licensed practical nurses, and aids and orderlies whose character and temperament are suited for service to our sick and old people, and who are devoted enough to forgo glamorous results, such as general hospitals offer.

The number of nursing personnel should be in direct relationship to the severity of the illnesses of those whom we serve.

WHAT WE NEED FOR THE CARE OF THE SENILE

An ideal physical setup for a nursing station is one which is so centrally located that the patients' rooms are within the view of the nurses, and the patients under supervision at all times.

Physical therapy, occupational therapy, and a sheltered workshop are rehabilitative services which are indispensable in any home caring for the aging. The physical therapy, as an adjunct to the nursing care, is to a certain extent restorative of the various functions which have become impaired by illness, even to people as old as 80 and 90.

Occupational therapy offers great encouragement to both types—the physically sick and the mentally confused. The sheltered workshop, through its earning possibilities, offers great incentive to the older person who is still intellectually intact and aware of his needs, and likes to earn money.

Food, housekeeping, and shelter were the three essentials under which the original poorhouse or the old folks' home were conceived. It is a matter of course that good food is prepared in a palatable fashion, geared to the needs of the geriatric patient.

We have to take into account the multiple deficiencies, illnesses, and idiosyncrasies of the aged patient. It therefore is practically a condition that every home have a dietitian, even if it is only on a part-time or consultative basis.

The saying goes that "Cleanliness is next to godliness," and this holds true for any institution, and especially with a nursing home, where the patient with so many deficiencies—such as incontinence, enuresis, as well as encopresis—call for more painstaking housekeeping than any other institution. The sanitary facilities naturally have to be kept in the same fashion.

"Man does not live by bread alone." The many remaining hours outside of mealtime would wear heavily on the minds of the people in an institution if they would not be filled out with some purposeful and meaningful activity.

Workshop, with earning possibilities, is one of the most essential. Occupational therapy also fills out the time in a constructive way. But just as the workingman in younger years needs some recreational activities, so does the person in an institution need an outlet for his intellectual and emotional life.

A good, well-rounded activity program, led by a well-trained and resourceful group worker, helps to ease the minds of our patients and lets them forget for a while that they are dependent upon strangers and do not have the opportunity to live by themselves or with their children.

This is one of the greatest sources of sadness of older people, and therefore they need somebody who gives them personal attention, who shows interest in their emotional needs. Therefore, a social worker is another important factor in institutional life.

Be it in illness, where the patient is worried as to what is going to happen to him, or his spouse, or his children, be it in conflicts with other residents, or with any staff member or administration, the social worker is the inalienable friend who takes all the worries, all the woes, and all the abuse, without becoming impatient, angry, or indifferent.

The caseworker—and of course we mean the good caseworker—so to speak leads the patient by the hand through all the turbulence and hostilities which daily life entails. Casework thinking and casework concept should permeate the whole institution, the administration and all the staff members.

Everybody—by which we mean the porter, the housekeeper, the dietitian, the cook, the waitress, the maintenance men, or the administrator—has to form the wheel, with each one a link in the total.

Senator YOUNG. May I say that what you and your associates are advocating and what you are presenting to this subcommittee is a good program for a home for the aging. That is certainly the understatement of the year.

On behalf of the subcommittee, I think we can offer our thanks to you. You have manifested that you are great humanitarians, and I only hope that this can be put into practice, with the aid of the Federal Government and the State government and with your supervision, because this is certainly a needful program, and it is a wonderful program you have outlined to us.

Reverend BOSSE. Senator, I just wanted to say that we are concerned that not only health or medical care be considered as a standard, but that also social life be included as a standard. Unless we give them something to live for, the health and medical care, which needs to be the best, is not going to provide the things that he needs for worthwhile living. We also need, as we would like to put it, the social component.

I would like to say that the accreditation program of the American Hospital Association, a multilateral program, has included this social component as well as the spiritual program in their accreditation standards.

Senator YOUNG. You have manifested a thorough understanding of a very complex problem that affects all of us. We are very thankful to you for appearing here and testifying.

Dr. WEIL. We thank you, sir.

(The following supplementary statement was subsequently received:)

SUPPLEMENTARY TESTIMONY BY THE ASSOCIATION OF OHIO PHILANTHROPIC HOMES FOR AGED, INC.

PROPOSED TRAINING PROGRAM FOR PERSONNEL IN HOMES FOR THE AGED AND NURSING HOMES

(By Helen K. Weil, ACSW, director of social service, the Montefiore Home, director of personnel training, Association of Ohio Philanthropic Homes for Aged, Inc.)

In view of the nature of the present-day population in homes for the aged and nursing homes and the need to insure sound standards of care, procurement of well qualified staff is of major importance. Staff members in such homes fall into three categories: professional, semiprofessional, and maintenance. For the persons in all three categories specialized theoretical and practical prepara-

tion are necessary. A personnel training program is therefore an essential element in the field of care for the aging and aged chronically ill.

The proposed program is as follows:

I. PROFESSIONAL PERSONNEL

A. Physicians, in addition to basic medical education should have courses in geriatic medicine and clinical experience with older patients. Doctors on the staff of homes for the aged and nursing homes should be given the opportunity for—

1. Participation in training courses given by the National Geriatric Society, the Gerontological Society and various universities.
2. Easy access to current literature on the understanding of the aging process and the treatment of the older patient.

B. Professional staff members in the field of rehabilitation, registered nurses, physical therapists, occupational therapists, and sheltered workshop supervisors should be given the opportunity to participate in institutes, seminars and workshops dealing with understanding the aged and his care in their respective fields of training. The schools of nursing should be encouraged to include in their curriculums specific material on the subject of the aged and thus provide the nurses with sufficient information for their work with the elderly patient. The same should be provided in the curriculums of schools for physical therapy, occupational therapy and vocational guidance. For students preparing for these professions, field placements should include experience in homes for the aged, nursing homes and hospitals for the chronically ill. This experience should be in institutions of high standards.

C. Graduate social workers should have had—

1. Content on the physical, mental, and emotional aspects of aging;
2. Opportunity to study case material from welfare agencies, both public and private, with reference to housing, counseling, and recreation;
3. Content on institutional care for the elderly.

Schools of social work should be approached to include in their curriculum pertinent information on institutional care for the elderly. A large percentage of older people in need of casework service have to seek institutional placement. Analogous to the teaching on the children's institution, the graduate student interested in the field of the aged should be well informed on all facets of institutional care for the older person.

II. SEMIPROFESSIONAL STAFF

The semiprofessional staff member is usually a high school graduate with some special training in such vocations as that of—

(*a*) The practical nurse.
(*b*) Nurse's aid.
(*c*) The food supervisor.
(*d*) The housekeeping supervisor and/or housekeeping assistant.

Members of the semiprofessional staff need specialized information on the understanding and care of the aged. The provision of such information while the person is on the job is not enough. The employee needs some theoretical background of gerontology to function effectively.

The training of this group of personnel should be effected through the inclusion of specific material in the post-high-school courses which the personnel attend. Thus these semiprofessional staff applicants will have at least some educational preparation for their work in the field of the aged. An inservice training program for these staff members, the provision of adequate reading material, and other media of staff development should supplement the theoretical training.

III. MAINTENANCE PERSONNEL

The training of maintenance personnel is done on the job for the most part since the maintenance employee has usually had only elementary schooling or little more. Since this group of personnel, however, comprises the majority of the institutional staff and since these employees have the most frequent contact with the patients, adequate training for their respective jobs is extremely important.

This type of training belongs in the area of inservice training and should include—

(*a*) A well-defined job description;
(*b*) A job schedule;
(*c*) Job supervision on a person-to-person basis;
(*d*) Department meetings and use of specific literature and visual aid material;
(*e*) Participation in general staff meetings.

IV. STAFF AS A WHOLE

The attendance at workshops, institutes, and seminars in gerontology and geriatrics should be considered part of the staff development program of every agency in the field of the aged.

Since the quality of care of the aged in the community setting as well as in the institution can only be as good as the quality of the staff that renders the service, the education, preparation, and training of staff is the most dynamic force in the welfare of our senior citizens in homes for the aged, nursing homes, and hospitals.

Senator YOUNG. William McCrone, Cleveland AFL–CIO.

You have been waiting a long time, and the subcommittee is happy to hear your testimony.

STATEMENT OF WILLIAM McCRONE, CLEVELAND AFL–CIO

Mr. MCCRONE. Mr. Chairman and gentlemen of the Subcommittee on Long-Term Care, I am William G. McCrone, director of the Community Services Department of the Cleveland AFL–CIO.

We thank the committee for the opportunity of appearing here today, and adding our voices with those of others who are interested in better long-term care for our either sick and/or aged citizens.

I would like to read into the record the following resolution which was unanimously adopted by the Cleveland AFL–CIO Federation of Labor Council last Wednesday, February 10, 1965.

One of the major aims of organized labor is to assure the American people of comfort and security in their old age.

Thousands of elderly men and women who have long been useful members of society are now living out their terminal years in nursing homes.

While many of these nursing homes are operated by sincere and well-intentioned persons, conditions in others are a deplorable disgrace.

When the public becomes aware of the shabby manner in which many senior citizens are treated in their twilight years, there will be widespread demand for reform and improvements.

The Cleveland AFL–CIO Federation of Labor, speaking for 250,000 union members and their families, herewith urges the U.S. Senate Subcommittee on Long-Term Care to make a most thorough investigation of nursing home conditions in the Cleveland area and throughout the country.

We welcome the subcommittee's decision to hold an all-day hearing at Cleveland City Hall on Monday, February 15.

We hope that this and other hearings and reports will focus public attention on the nursing home problem, and will arouse the conscience of America to compel major improvements in the care and treatment of our elderly invalids.

We go on record as asserting that this is a major problem which merits the concern and action of the entire community and country—not just of the individuals and families directly affected.

That, gentlemen, was the resolution.

Further, gentlemen, we feel that every man and woman on the labor council who voted for this resolution did so from the heart.

This problem of nursing homes is one with which virtually every family is familiar, either through their own experience or through the experience of friends and neighbors.

It is a heart-rending, difficult decision for a family to determine that it has become necessary to place a father, mother, or grandparent in a nursing home.

Very often, such action must be taken for the welfare of young children and others in the family.

Besides being an agonizing, emotional exerience, placing an elderly person in a nursing home can also be an economic disaster.

At this very moment, hundreds of Greater Cleveland families are searching for facilities they can afford—facilities in whch they would not be ashamed to deposit an elderly father or mother.

Many are learning that proper care is beyond their pocketbooks. It is a rare family that can afford an additional burden of $300, $400, or $500 a month.

These figures make the pittance allowed by the State for care of the indigent aged in nursing homes a disgraceful mockery.

Every day, this tragic nursing home situation causes indescribable misery and despair. It makes a crude fiasco out of our status as the richest nation on earth, with what is supposed to be the highest standard of living in the world.

This is a problem that involves flesh and blood—men and women—human beings—people who deserve something better from the society they have served than to be shoved into what amounts to a grim state of suspended animation, waiting for death to release them from cheerless despair.

What are we going to do about this great human problem?

I respectfully suggest that this committee could perform a major public service by helping develop a national program to provide better nursing home care for the elderly, and by compiling a report pointing out what resources are now available to help American communities cope with this situation.

For example, the Federal Housing Administration should make greater use of the lending power of the Government to help finance nursing homes—both commercial and nonprofit.

Government agencies should establish a massive program to train the competent, dedicated people needed to operate satisfactory nursing homes.

Official studies should be made to determine the actual cost of operating a decent nursing home.

Standards of decent care should be established, and should be vigorously enforced. If a subsidy is required, we should be courageous enough to face the facts.

This is a problem that will not go away if we ignore it. It will be with us, and will constantly affect more and more families as medical progress continues to expand and extend the normal span of life. We cannot in clear conscience attempt to sweep either the problem or the human beings affected under the rug of continued neglect.

Organized labor sincerely hopes that this investigation of nursing homes by a subcommittee of the U.S. Senate will result in creation of a courageous national program of progressive action.

The need for more retirement and nursing home facilities is with us here and now, and cries out for national and community action.

This, gentlemen, concludes the official statement that I have prepared and submitted to the committee.

I might ad lib for the record. Even before the question might be asked, what is organized labor's interest in nursing homes, well, as I introduced myself, I am the director of the Community Services Department of the AFL–CIO.

We try to lend ourselves to problems of our members, their families, and their neighbors, whether they carry a union card or not in the community with the problems that deal outside of their employment.

We try to guide them to the intelligent and distinguishable use of the public and private agencies, and although we recognize that many of the members of our union are affluent by way of retirement programs that they have had negotiated with employers, we feel as though our neighbors and friends that live in the community with us are equally important.

We feel as though that lending ourselves along with the other good people of society toward these worthy aims is part of good citizenship.

All our members and its leadership dedicate themselves to these principles, because we feel in good citizenship we automatically will be good members of our union as well.

And again I want to on behalf of the Cleveland AFL–CIO Federation of Labor, its president, Patrick J. O'Malley, executive secretary, Sebastian Lupica, my community services committee, thank this committee for the opportunity to appear here and to lend our voice to this most worthy exploration.

Thank you, and if there are any questions, I will be happy to answer.

Senator YOUNG. The acting chairman of this committee really has no questions to ask, but my observation is that you made a most effective and factually correct statement. The acting chairman concurs wholeheartedly with every expression of hope for what we may be able to accomplish for the welfare of the aged who need nursing home care.

Your statement will of course be printed in the record. It will be referred to when the subcommittee staff helps us in the preparation of our report to the whole committee. I express the hope for the members of the subcommitee and for the aids who are with us, that you in turn report to your associates that we were very glad to hear you, and that we consider a helpful service was rendered to us and in the end to the Nation by the fact that you testified here.

Are there any questions?

Go ahead.

Mr. CONSTANTINE. Mr. McCrone, we have heard a great deal today about the costs of care in nursing homes. Has the Ohio AFL–CIO, the Cleveland AFL–CIO, any information or policy position on wage levels prevailing in nursing homes?

Mr. MCCRONE. Are you referring to the cost of construction?

Mr. CONSTANTINE. No; the operation, wage levels of the employees of the homes.

Mr. MCCRONE. I do not think it is any secret to this committee or anybody else that organized labor will always continue to be in pursuit of higher wage levels for the members of its union. I have seen no indictaion that organized labor is prepared to relax their policies along those lines. If so, the heads of those international unions could best speak for themselves.

But if this is what you are referring to, if I read into your question, there, that is organized labor prepared to have some kind of a separate arrangement for people that work in these kinds of institutions—

Is that what you meant?

Mr. CONSTANTINE. No; I would not dare suggest that.

Senator YOUNG. I did not think that was implied in the question.

Mr. CONSTANTINE. What I meant was there are currently unskilled or some employees of nursing homes are underpaid, and we wondered if you would be helping there, such as has developed in hospital fields, where there is a drive to develop the salary of those personnel.

Mr. MCCRONE. Certainly, Mr. Constantine, where we have these people as members of our union, we are in constant pursuit of bettering their wages and working conditions, and everything else, the same as we would every other member in any other union.

Mr. CONSTANTINE. Thank you.

Senator YOUNG. Thank you very much, Mr. McCrone.

Mr. McCrone has been here since first thing this morning, and the subcommittee was glad to hear his testimony.

We really want to hear anyone who cares to testify, and the acting chairman wishes to state the same as the chairman stated, that anyone who cares to file a statement with the subcommittee, that will be printed in the record and referred to the main committee.

The chairman has already taken the plane to leave for Los Angeles, and the acting chairman and all the attachés here of this subcommittee are leaving for the airport very shortly to go either to Los Angeles for a hearing starting at 9:30 tomorrow morning, Los Angeles time, or return to Washington.

STATEMENT OF ERNEST J. BOHN, DIRECTOR, CLEVELAND METROPOLITAN HOUSING AUTHORITY, AND CHAIRMAN, CLEVELAND PLANNING COMMISSION

Mr. BOHN. Chairman Steve, I appreciate the opportunity to again meet with your committee. I have no words of wisdom for the committee. I do want, however, to discuss a few problems.

Before doing that, I want to discuss training about which a good deal has been said today. We have done something here in this area, and there is a person, Hannah Protzman, in the back of the room who has been working very hard to train people to operate nursing homes.

More than verbal encouragement, however, she needs some money.

I think that your committee, over a period of years that I have had the privilege of meeting with you, has addressed itself to the subject as have various advisory committees of HHFA and HEW.

I think you ought to do something specific to make this job as attractive as Dr. Weil and Reverend Bosse paint it to be. Perhaps scholarships—I mean something real—something more than just encouragement to train for this job.

Perhaps if you asked Miss Protzman to come to Washington or to prepare a paper, she might tell you some of the difficulties in getting people or recruiting people and training people for this job.

There are many training programs under Federal assistance where people can actually get on a payroll while they are being trained.

This is not possible in the nursing home field. There is need for it, and we ought to do something about it.

There are two specific problems I want to present to you. As you know, I worked for legislation which makes it possible for people who are not ready to go to nursing homes but able to fend for themselves—can live in public housing although they are single. People of low income, are now able to live in public housing if they are single persons 62 years of age or older.

All over the country there are now high concentrations of elderly people of low income living in public housing. There is a great concern about the use of their leisure time. We have been doing something about this for 10 years. We believe, and there is ample medical testimony to prove, that the day when they become so they cannot fend for themselves any more is thus delayed. They may go to a nursing home, but that day is delayed for some years because they are able to be occupied in their leisure time.

Here in Cleveland we also go a step further. We have a clinic in two of our housing estates which are operated by the nearby hospital. We have a well-elderly clinic at Riverview which is operated by Lutheran Hospital, and a treatment clinic at Springbrook operated by the Mount Sinai Hospital, both of those with assistance of funds from the U.S. Department of Health, Education, and Welfare. The very earliest estate with special design features for the well-being of the elderly does not have a clinic, but is near Charity Hospital which helps through its outpatient department.

So you see we do not draw religious lines, we use Catholic, Protestant, and Jewish hospitals.

All of our housing estates which have special design features for the convenience and safety of the elderly are located near hospitals. We mix up elderly and young. We are thus helping to alleviate somewhat this problem of need for more decent nursing homes for people of low income, because we put off the day when they are needed by them.

Something was said here a while ago about the fact that, years ago, people had their mothers and grandparents living in the home. I think that people love their parents and grandparents just as much today as they ever did. The situation has, however, changed. The United States has been urbanized. No longer do we have these large houses in small towns. Urban means smaller houses, fewer square feet, and there is no room for extra persons.

Furthermore, the electrical industry has also changed our lives. There are a lot of laborsaving devices. The mother or grandmother is no longer needed to help do the laundry. We have electric washers and dryers and vacuum cleaners, so the parent or grandparent who in a sense was like a maid is no longer needed to the same degree.

With this high concentration of elderly people in public housing around the country, we get to a point where we find that many of them all of a sudden can no longer fend for themselves. They become senile, or sick, so that even in those places with a clinic we can no longer take care of them. They have to go to a nursing home.

What happens? Since most of them are on aid for aged or social security they cannot get into our fine nursing homes. There are no better ones in the country than several we have. They are unable to

take care of them—not because they do not want to, but it is because low-income patients cannot afford to pay the freight.

Where do they go? We are able to persuade some of our religious homes to take some of them but there comes a time where they have no room. And why should the individual charities subsidize all of this large population?

So this is the problem. I am not going to put them in the filthy firetraps which you have been discussing earlier in the day.

A few years ago I read a piece in one of the national magazines which told the story. I think the title was "I Had To Put My Mother in a Nursing Home." Here was a bookkeeper, with two children, who was supporting his wife and his mother. The mother and daughter-in-law got along nicely because she helped with the housework and the care of the children and everything was lovely.

Then grandma had a stroke, and was flat on her back. So overnight, instead of giving the daughter-in-law assistance in taking care of the children, the wife had to take care of the children herself and also the mother-in-law. After a while there was the inevitable crisis in the home, so this poor chap started looking for a nursing home for his aged invalid mother.

The locale evidently was Chicago, because I recognized certain streets. On three or four Saturdays when his office did not work he looked at various places. He looked at places where the fee was $400 or $450 a month. He could not afford that. He finally did find a place he could afford. His friend asked "Why did you choose this particular place?" "Because the smell of stale urine was less pronounced in this place than in the other places," was his answer.

Now, this is one hell of a way to choose a nursing home for a beloved parent. And this is a problem throughout the country today.

We put a person in a fine public housing estate with reactional facilities, a clinic in a fireproof building, and when they get to where they really need help, we put them in a place where "the smell of stale urine is less pronounced." We are not going to do it.

Unless we make it possible for private enterprise to do the job there is only one way out—the public must do it.

I am a Republican, so don't call me a Socialist. There is only one solution. As Abraham Lincoln said "When private enterprise is unable to do a job which needs to be done, then the public must do it."

It is quite appropriate to refer to Lincoln today since it is only a few days after his birthday.

Another program is one that Ohio is in the forefront of. We are attempting to solve the problem of getting out of mental institutions young and old who have now been either cured or should not have been there to begin with and who are nonpsychotic. We want to get them back into the community.

This is a big problem, and it is receiving a great deal of concern. I certainly know some members of your staff and members of your committee who are concerned about it.

These people have no business being in these institutions. How can we do it? There are two laws passed by the Ohio Legislature. One to have the State issue bonds to build normal housing for them and it did not seem to work. In the last session of the legislature the housing authority law was amended so that the authority can provide

not only housing for low-income families and persons but can now enter into agreements to feed people who have come out of mental institutions who are nonpsychotic.

We have pilot projects in Toledo and Columbus now underway. These facilities will be occupied by nonpsychotic persons who are certified by the institution that they are now cured, or that they are able to go back into the community.

Fortunately many are able to go back to their own homes, but there are many who have nobody to whom they can turn. They go to skid row or to some nursing homes like those that burned down. That is where some of them go.

We are not going to do any such thing. We are experimenting with solutions to the problem with the assistance of Federal subsidy. We are going to bring them back into a normal community, not into another separate institution. If they are ready to go back into the community, let's do it, and do a decent job.

These are the two problems I wanted to present to the committee to consider in whatever legislation that you will ultimately write.

You have had a hard day, and I am not going to talk to you any longer. Thank you.

Senator YOUNG. We thank you for your very informative testimony. Thank you very much.

FROM THE FLOOR. Mr. Chairman, in view of the fact that the time of the committee was monopolized, you might say, by the interests——

Senator YOUNG. It was not monopolized by anyone. We were here on a factfinding mission, and we have had a very productive day. It has not been monopolized by anyone.

Do you care to testify?

FROM THE FLOOR. All I want is 10 minutes.

Senator YOUNG. You will not be given 10 minutes.

FROM THE FLOOR. I just want to make a two-page statement. We have public nursing homes——

Senator YOUNG. Your statement will be received. You may submit it to the chairman, Senator Frank Moss, or you may mail it to me.

Your statement will be printed in the record of the hearings just as if you gave it.

FROM THE FLOOR. But it is too one sided, sir.

Senator YOUNG. The meeting is adjourned.

No one is going to dictate to me. What you said was an affront to this committee, and I do not appreciate it.

(Whereupon, at 5:30 p.m., the committee was adjourned.)

(The following statement was received for the record:)

STATEMENT OF WITNESS WILLIAM J. KENNICK

Now comes William J. Kennick, who upon his oath deposes and says that his mother suffered a broken hip, in October 1964, and that during November and December 1964 he tried to get a bed for his mother at one of the following nursing homes: (West Side, Cleveland):

No. 1. At this home two colored practical nurses showed affiant two vacant beds, and was told to contact the registered nurse the next day before 6 p.m. Affiant went there the next day—but nurse left at 5 p.m. instead of 6 p.m. Affiant called the practical nurse by phone same evening; nurse told him that the two beds were taken the day before.

No. 2 East Side, Cleveland. Practical nurse showed affiant an empty bed—in my presence the practical nurse talked to the owner about my mother being a State case * * * the owner stated she could not accept State case.

No. 3. East Side, Cleveland.

No. 4. I was told that I could get a room if I would pay the difference between the amount paid by the State ($175) and the price of a private patient (about $300).

No. 5. East Cleveland. They said the State does not pay enough.

No. 6. Golden Age, East 152d Street. Owner would accept State case * * * but the home is too congested.

No. 7. Evergreen Manor. Said they put my mother's case on the waiting list. I did not see the list to see how many were ahead of my mother.

No. 8. A modern nursing home—manager stated they were a private home and did not have to take State cases.

No. 9. I was told by the Chronic Illness Center to visit several homes—the implication being that there were some vacancies there—but on arrival I was told there are no vacancies * * * (after I mentioned that the patient was a State-supported case).

CONCLUSIONS

(1) Nearly all of the homes seem to evade or do evade taking State-supported cases.

(2) Some of the homes are willing to accept State cases—these are the homes which have some six or eight patients to a room * * * the homes are congested like a concentration camp.

(3) Private nursing homes are making large profits, or would make large profits on the basis of $170 per month.

(4) Many nursing homes will claim that they are not making any profits at $170 per month—as a justification, or an excuse for overcrowded conditions.

(5) In many nursing homes rents are low, labor is cheap, food is small in quantity—and the owners will not submit expense statements to the State to show how large their profits are.

(6) Nursing homes will not accept State cases as long as they can get private cases at $300.

(7) Nursing homes can get private cases at $300 because the supply of homes is inadequate to meet the demand. The supply of additional nursing homes is met by putting up (in part) additional homes resembling slum conditions, by getting large 20-room houses.

(8) Private nursing homes are inadequate to meet the demand. Inasmuch as there is a shortage of nursing homes, the State or the city, or the Federal Government should provide public nursing homes, the same as they provide public hospitals, and public housing.

(9) The profiteering should be taken out of human misery. The protection of health is a governmental function.

(10) Inasmuch as the Government is paying for the expenses of nursing care—these governmental expenditures should not go into the pockets of private nursing homes, but they should go toward the construction and maintenance of new public nursing homes.

Very respectfully submitted.

PROF. WM. J. KENNICK.

STATE OF OHIO,
County of Cuyahoga, SS:

Personally appeared before me, who is a notary public, Wm. J. Kennick, who under oath states, after being duly sworn, that the statements and allegations of fact made in the foregoing statement are true, as he verily believes.

Sworn to before me and subscribed in my presence this February 15, 1965.

[SEAL] WM. A. KEANE, *Notary Public.*

My Commission expires November 13, 1968.

PUBLIC NURSING HOMES IS THE SOLUTION—PRESENTED BY PROF. WM. J. KENNICK

At the hearing Monday, February 15, 1965, at the Cleveland City Council chambers, of the U.S. Senate Subcommittee on Long-Term Care. I submitted a statement of my personal experiences with private nursing homes, and of

some of my conclusions. I wish to supplement the foregoing statement by the following more elaborate and analytical remarks:

(1) It does not necessarily take an expert to determine that nursing homes can make a substantial profit even if they would confine their business to welfare clients, wherein the State pays the maximum of $170 per month. If it costs $300 per month rent for a 15-room house in the East 82d-Euclid Avenue area, or elsewhere, into which can be concentrated 50 patients, the gross income would be $8,500 per month. If the food bill is $750 per month, heat and light $250, registered nurse $40 per day, and cook $30 per day, and eight other persons are hired at $12 per day, there still remains over $2,000 per month profit. If the homes get $300 per month from half the patients, the profit would soar to $5,250 per month.

(2) But in spite of these profits, most of the nursing homes evade or outrightly refuse to accept welfare clients, claiming they are private enterprises, and that they have the right to refuse aid for aged patients.

(3) Why do most nursing homes refuse welfare clients? This is simply the economic law of demand and supply in action. The poor welfare client must compete with the rich for the limited number of nursing homes available. Inasmuch as the number of elderly people is now some 17 million or more, there is such intense competition for this limited space in nursing homes, that only the highest bidder gets the space. This constitutes an emergency situation, the same as in wartime which logically calls for price control, or the establishment of public nursing homes. To allow the situation to drift, means that the excessive demand for space will be met by private operators renting more $300 rooming houses and more packing of patients from six to eight to a room.

(4) It is obvious that private nursing homes will be inadequate both from the standpoint of quantity and quality to meet the excessively growing demand for space by our elderly citizens. In this emergency situation, the U.S. Subcommittee on Long-Term Care, should give greater consideration to, and hear more testimony on, the only adequate remedy, that of public nursing homes to be constructed by the proper governmental agencies.

(5) Other reasons for public nursing homes are that the preservation of the public health is a governmental function, the same as the preservation of the public safety. It is logical that a governmental function should be performed by the Government itself without distributing profits to private operators. If the Federal and State Governments are obligated to pay for the elderly citizens' long-term care, the principle of least cost to the taxpayer requires the elimination of private profits.

(6) However, as in the case of public education, private nursing homes may exist side by side with the public, for those who want and can afford them.

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