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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CONDITIONS AND PROBLEMS IN THE NATION'S NURSING HOMES

WEDNESDAY, FEBRUARY 17, 1965

U.S. SENATE,
SPECIAL COMMITTEE ON AGING OF THE
SUBCOMMITTEE ON LONG-TERM CARE
Los Angeles, Calif.

The subcommittee met, pursuant to call at 10 a. m., in the Old State Building, Los Angeles, Calif., Hon. Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senator Frank E. Moss.

Also present: 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 Senate Subcommittee on Long-Term Care.

It is very pleasant to be in Los Angeles again. I am glad that a number of you have been able to come to this hearing, many of you to testify, others as observers.

We are aware that several of the State departments are represented here, and we are very happy that all of you were able to come. It is a particularly beautiful morning in Los Angeles. I never remember the weather being nicer, and this is a good escape for me from the weather we have been having in Washington.

This is an official hearing of the U.S. Senate. The testimony given here today will be taken down by a reporter and will be made a 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 the Congress who must develop and act upon legislative proposals.

Our Nation is confronted with the need for making available appropriate facilities and services for all of those who need regular and continuing care, a need which is very obviously not now being met. Nursing home care is one segment of health care organization, and, unfortunately, it is a segment which often functions in a not so splendid isolation from other aspects of care. In fact, as we have already learned, many of the so-called nursing homes cannot even be regarded as offering health service. Some homes offer nothing more than poor housing.

To assist nursing home development and operation, the Federal Government has established a miscellany of programs intended to relieve the shortage of facilities and to help finance services. It is time, however, to examine carefully the Federal activities, to study current

needs and problems, and to reappraise the role and responsibility of the Federal Government in assisting the long-term care field to develop.

It is becoming clear to us that new approaches are called for. Nursing home care needs to be more closely integrated with a broad range of noninstitutional services. There is also a manifest need to expand the range of services available in the home itself. Hopefully, in time, the nursing home will become a means and not an end.

This is the third hearing this subcommittee has held in the last week's time. We held hearings in Cleveland, Ohio, and in Indianapolis, and we are going on from here to hold additional hearings, so this is not a matter that we are concerned with in California alone, but it is something which we are investigating in all parts of the country.

We have a number of very prominent witnesses who have come today and will testify for us. Unfortunately, we have only 1 day to devote to this hearing and, therefore, must move along with all possible alacrity. It is fortunate indeed that so many of our specialists and people knowledgable in this field have been able to come and be with us.

The people who are called to testify will come and sit at the table right here in front of us and speak into the microphone. Sometimes a person who has been asked to testify may want to bring with him one or two other advisers, and that is fine. They should all sit side by side at the table in that instance.

I have with me here at the table members of the staff of the Subcommittee on Long-Term Care. Their names are before them so they are readily identified. Members of the staff will be asked if they have any questions or comments to make at various times during the hearing this morning.

Our first witness, then, will be Dr. Lester Breslow, representing the California Department of Public Health. I understand that Mr. John Derry will accompany Dr. Breslow.

STATEMENT OF JOHN DERRY, CHIEF, BUREAU OF HOSPITALS, STATE DEPARTMENT OF PUBLIC HEALTH OF CALIFORNIA

Senator Moss. You are Mr. Derry?

Mr. DERRY. John Derry, chief of the bureau of hospitals, State department of public health.

Senator Moss. We are glad to have you.

Mr. DERRY. I bring regrets that Dr. Breslow is not available to attend this meeting due to other previous commitments and activity of his division.

The department has submitted to your committee a written statement and certain exhibits that I would like to refer to during this testimony.

Senator Moss. Very good. We will be very pleased to include the full statement. If you would care to highlight it you may do that, or you may read it in full if you would like to, and the various other documents that you have we will make a part of our file so that we may refer to them as we study this problem in the committee. Thank you very much, Mr. Derry.

Mr. DERRY. Thank you, Senator.

I would prefer to highlight this rather than reading it because I think through this method I can emphasize those points that we believe to be most important.

Senator Moss. That well be fine.

Mr. DERRY. In California the population of persons over 65 years of age is roughly 8.6 percent. This is somewhat lower than the national figures, but there are presently about 1,600,000 in this age group in the State, and there is an increase of approximately 50,000 each year in this age group. In California, and I assume in other States, the distribution of this age group is not uniform. In California with our 53 counties the average number of these older persons ranges from about 6 percent in some counties to nearly 20 percent in other counties. In 22 of the counties of this State with 12 percent of the State's population, more than 10 percent of the population are over 65. So the distribution of population is quite varied.

In planning for long-term care facilities through administration of the Hill-Burton program, which now is known as the Hill-Harris program, we recognize this age differential in trying to estimate needs of long-term care beds. In establishing relative need for additional facilities and the need for modernization of existing facilities, we rely upon the utilization of existing nursing homes and long-care units in hospitals, with an adjustment in those areas which have a population factor that is greater than the State average. We also project need for long-term care beds on a 5-year projection of population increase, with a minimum of 1½ beds per thousand population. This planning technique is primarily for the administration of the Hill-Burton program in the determination of allocations for State and Federal funds to assist in the building of public and nonprofit long-term care facilities.

The details of statewide planning of all types of health facilities under Hill-Burton are included in this document which we have submitted to your committee.[1]

In California there are various types of institutions that provide care and living conditions and environments for this age group. I would like to indicate that in facilities such as tuberculosis hospitals and county hospitals, nursing and convalescent homes licensed by the State department of public health, there are some 45,000 beds. Institutions licensed by the department of socal welfare—and Mr. Cole will comment on this later, I am sure—are 34,000 persons. In the private mental institutions licensed by the department of mental hygiene, the State mental hospitals, and other State and Federal institutions, there are approximately 20,000 beds for the care of elderly persons.

In California we have had a very phenomenal growth of the nursing home, particularly in the last 5 years. We have indicated in our report that in October 31, 1964, 115,000 hospital and nursing home beds were licensed by the department of public health; in these nursing homes of some 40,000 beds; in county hospitals, about 12,000 beds.

The average size of the nursing home in California now is about 40 beds. In 1946 it was an average of 18 beds. This indication of the growth in the average size we believe will continue.

[1] The document referred to above is held in the subcommittee files.

In 1946 two homes in the State had a capacity of more than a hundred beds. In 1964 applications for the review of architectural drawings for proposed construction included 38 facilities with capacities of over a hundred beds.

In 1946, 16 percent of all nursing home beds were in facilities of 10 beds or less. In 1964 less than 3 percent of the nursing homes licensed were for 10 beds or less.

This matter of population growth and particularly the apparent significant impact of the medical assistance to the aged program appears to have further stimulated the development and growth of nursing homes in California.

In 1962 when the medical aid for the aged was initiated, there were approximately 17,000 beneficiaries per month during the first year. By September 1964 it was reported that there were 25,000 and 75 percent, 19,000 of these beneficiaries were cared for in nursing homes in California.

We have included a tabulation of the growth of nursing homes since 1946. I would like to indicate that in 1961 there were 746 homes with 22,000 beds and on September 30, 1964, 985 homes with 39,444 beds. This growth represents 144-percent increase in nursing home facilities since 1960.

In addition, during 1964 architectural drawings for proposed 300 nursing home facilities have been reviewed; 41 of these were for additions to existing homes, and they proposed an addition of 13,000 beds; 47 percent of the plans were facilities in excess of 75 beds.

In September 1964 the department, with the cooperation of the nursing homes of this State and various professional organizations interested in health care, in response to a request by the State legislature, conducted a survey of the nursing homes in California; 735 of these homes replied with very extensive information regarding their facilities, types of patients, services rendered, and other information which would be helpful in terms of evaluating the need for nursing home facilities, classification, and other elements relating to the standards that might be advisable to establishing standards for nursing home care. This report was completed January of this year and submitted to the State legislature, both the senate and the assembly. Copies of this report have been submitted to your committee. I think you will find it very valuable in terms of the quantity of information relating to nursing homes in California.

We are very proud of the cooperation received from the industry, from the medical profession, from the hospital groups, and others that assisted in this work.

This report indicates that of the 750 homes, which represented 76 percent of the licensed homes in California, there was an average occupancy of 86 percent. We believe that if the factor of date of beginning operation, a reasonable period of time permitted, that this occupancy would be higher in the homes in an established period of time, perhaps nearer 90 percent.

In relation to the nursing home programs of California, since 1946 the State has had a Hospital Licensing Act. This has been administered by the department of public health with the advice of an advisory board consisting of hospital administrators, nursing home administrators, public representatives, and consultants in the various

health fields during these years. Continually, the department and other people are studying the standards for nursing homes and hospitals. At least two public hearings are held each year before this advisory board for consideration of the standards that should be complied with in the State, those relating to both the construction and the operation of inpatient care facilities. This licensing program initially was concerned, of course, primarily with the physical plants, sanitation, and other environmental aspects, to assure the safety and welfare of patients in these facilities.

It was also a new venture for the State to be involved in setting standards and conducting a program of surveillance and consultation to assist in improving the standards in these facilities.

Today, with some 1,700 facilities in California licensed under provision of this act, the constant study of the need for better standards and for the development of better measures of quality of care and services for patients is undertaken by various groups. Standards, during these years, have developed criteria for the types of services which are minimum, and cover such things as dietary services, patients' records, nurse staffing, medication control, nurses' services, activity programs, and restorative services.

Physical plants are designed to provide the adequate facilities and space to permit the operation of these services.

In terms of patient care, which is the element that most of us are most deeply concerned with, this has been an area of considerable concern and a very difficult area to grasp and establish specific criteria. However, through this licensing program, through the public hearings, through staff conferences, and group activities of the various health organizations of the State, we are moving ahead in California to consider further improvements in the licensing standards. We are considering additional supervision of nursing services that may be needed. We are considering such things as minimal staffing of nursing personnel or some equivalent, improved procedures for sterilization, activity programs, disaster preparedness programs, and a continuing study of patients' needs and services.

I would like to comment on one other aspect of State public health activities relating to long-term care, and this has to do with statewide and regional and areawide planning.

In 1960 the Governor established a commission on the study of health needs in California. The report of that commission covering the broadest spectrum of services, personnel, manpower, facilities, and the encouragement of the out-institution services, also included the recommendation there should be more specific planning on an areawide and regional basis. Regarding long-term care, this committee made the following statement:

> Nursing homes have generally been isolated from the mainstream of good medical care. They need arrangements with hospitals to bring their patients the benefit of professional nursing, rehabilitation and occupational therapy. Providing this type of care is the only way to prevent some patients from sinking into the tragic and costly state of complete invalidism.

Based on this report many of the activities that have been implemented including the act of the State legislature to establish a program of regional planning for the assistance by State committees to support, assist and guide local communities in developing better planning activities.

In 1962, two committees were established, one in the bay area, one in the Los Angeles region. In 1963 this was continued for 2 years and an additional committee established for the South San Joaquin Valley.

These three committees have completed their study and have submitted a report to the State legislature in December of 1964. A copy of this has been submitted to your committee.

Included in this report is a recommendation that the State should continue to provide assistance and help and guidance to voluntary planning organization in California. This report recommends the establishment of a single statewide committee to continue this study and activities for 4 years. Senate bill 543 introduced by Senator Teale provides the State legislature opportunity to consider whether this activity is appropriate for the State to continue for 4 years.

During this period of time seven organized voluntary planning groups have been established throughout California. These seven are community-oriented. They include representatives of the various health interests and the majority in most cases are public representatives of consumers of health services. These seven organizations are actively engaged in the planning of health facilities and developing a better coordination and relationship of health facilities in terms of acute care, outpatient care, long-term care, and all of the other services needed in providing comprehensive health service.

One of the jobs of this statewide committee, if created, would be the continuation of study and particularly to assist local voluntary groups in effecting a better coordination of facilities.

In closing, I would like only to comment that it appears the trends of the institutional care programs for the aging in California, in the past has resulted in rather wide fragmentation of services and facilities. We believe in the future that the planning activities must be primarily concerned with the medical and health service needs of patients. The department, State agencies, the Federal Government, and those interested in health services should provide leadership to make possible the effective comprehensive health services. In the future attention should be focused on the medical and health needs of the population and the development of standards which will assure the effective care of patients.

I am not saying that financial concern should be secondary, but I think in the past there has not been enough attention paid to the medical and health needs of patients, and this should be in its proper perspective along with the fiscal matters.

I thank you, Senator.

Senator Moss. Thank you, Mr. Derry, for a very excellent statement. We are happy to have that in our records, and you brought these various documents which will be part of our file that we have before us.[1]

Senator Moss. I understand that nursing homes are licensed by the public health department here in California, is that right?

Mr. Derry. That is correct.

Senator Moss. What sort of inspection—do you make a periodic inspection of these homes?

[1] The documents referred to will be found in the files of the subcommittee.

Mr. DERRY. The bureau of hospital staff includes four activities. One is the architectural staff, which is responsible for the review of plans and to verify that the facilities to be built comply with licensing standards. This staff includes architects, engineers, et cetera.

A staff of hospital field representatives with broad experience in hospital and health services make periodic inspection and consultation visits to verify performance in compliance with minimum standards for licensing. Their reports become public documents, and if necessary, disciplinary action is taken for those facilities that do not comply. Basically, this is a service of consultation, education and help to the operators in improving their care.

A third unit in the bureau is the consultation unit. This provides a physician, a nurse, a physical therapist, consultant in administration and a social worker. The unit provides the various disciplines and professional skills that we believe are needed to properly coordinate the services for the aging persons, particularly in such institutions.

We attempt to cover the nursing homes on the average of four visits per year. We were able to accomplish about three visits during the past year. The rapid growth of nursing homes also involves us in a lot of prelicensing inspection.

In addition, we make at least one visit each year to all general hospitals. Many of those we visit an additional time.

Senator MOSS. If these inspections reveal conditions that are not adequate under your standards, do you have a procedure then for suspending the license?

Mr. DERRY. Yes, sir.

Senator MOSS. Or revoking the license?

Mr. DERRY. Under the California law there is the California Administrative Code. This establishes a procedure for the revocation, suspension, or other action for all licenses. This involves the matter of listing those noncompliance items, submitting them through the attorney general to a hearing officer that is appointed by the department of justice. The hearing officer conducts a hearing to determine findings and presents recommendations to the State board of public health. The State board of public health takes final action and may revoke the license or suspend it or take other disciplinary action.

Senator MOSS. Has that action been necessary in the last year? Have you actually had to suspend or revoke licenses here?

Mr. DERRY. Yes, sir.

Senator MOSS. As a result of this inspection and the degree of enforcement, do you have any estimate as to the number of patients that have been transferred from substandard to more adequate homes?

Mr. DERRY. I don't understand your question.

Senator MOSS. Well, I gathered from our talking about the inspections and also the suspension or revocation procedure that some homes have actually been disciplined because they didn't meet the standards. In those instances the patients undoubtedly were transferred to other homes that did more fully meet standards? I wondered if you had any figure as to the amount of shift this entails.

Mr. DERRY. No, I'm sorry; I don't have this information.

Each patient admitted to a hospital or a nursing home in California must be under the care of a physician, and this physician is responsible for the orders of care and the direction of placement or transfer.

In California, also, we have the county hospital system. Many of these patients in nursing homes are under general medical supervision of county hospital and county staff.

Senator Moss. I understood you to say that one of the objectives of the department of health was to establish a relationship and affiliation, as it were, between nursing home and the hospital. To what extent have you been able to accomplish that objective?

Mr. DERRY. This objective is perhaps pretty theoretical in terms of present conditions in California in the sense that nursing homes of California are primarily private enterprise, private investment, operated for profit.

In the administration of the Hill-Burton program any fund granted for long-term care must be to a facility which is part of or closely affiliated with a general hospital. Any funds that are granted through the State or Federal Government in this program affiliation is required.

In terms of other long-term facilities, we are working with the Nursing Home Association, the California Medical Association, and the Joint Council to Improve Health Care of the Aged, that approves the accreditation of nursing homes, in the areas of what type of relationship can be established, and of what effective technique can be utilized for the assurance of continuity of care of patients. These health associations are very actively working on this matter of proper relationship. We think that there is improvement, that we will eventually find the solution in California, but this may take a little time.

Senator Moss. I notice from your statement that there is a trend toward a larger bed capacity in these nursing homes, and this is desirable, I take it, from your point of view?

Mr. DERRY. Yes, sir.

Senator Moss. Do you have an estimate of what the optimum number would be?

Mr. DERRY. We have not studied this to the point of knowing where the optimum is. This would depend, we believe, to a great extent on the types of services to be provided, the types of patients to be admitted, the relationship within the community to other health services, and, probably in the future, would have some relationship to out-of-institution-care programs.

There are many other aspects that may have a bearing on the optimum size, but I think the program that would be proposed would be the determining factor of what would be the most effective size.

Senator Moss. As a general proposition, if you have a larger number, then you could have more specialized services, such as physical therapy, as well as medical services and other rehabilitative services for patients?

Mr. DERRY. This is correct. On the other hand, we hope that in the communities' planning they would avoid the duplication of things that might become unnecessary if there is proper coordination so we don't have this overlap of services which exploits the limited resources of professional personnel.

Senator Moss. Does the department of public health license boarding homes of different types or just nursing homes? There is a shaded line between a boarding home and a nursing home, and I don't know where that line is exactly.

Mr. DERRY. We don't know either. We have been involved in this for these many years with the State department of social welfare, which licenses the institutions for the aged and homes for the aged. These are types of homes that provide supervised personal-care services and persons who are residents in these do not need medical supervision.

The department of public health licenses all facilities providing overnight care for the sick and injured, including nursing homes, except those which have a mental illness or which have some other condition that is under the department of mental hygiene. So we have three departments and three types of facilities, and this gray line is sometimes pretty broad.

Senator MOSS. Do the staff members have any questions? Mr. Frantz?

Mr. FRANTZ. Yes; I have one or two.

I wondered if you would describe your certification-of-need procedure for FHA and small business applicants?

Mr. DERRY. The procedure that the department follows in the certification of need is to provide information to the FHA and Small Business Administration. The service we have provided over several years will assist these agencies, because they have a requirement for such a statement. We utilize the State plan of the current year and provide to the FHA a statement that is in fact in the State plan for that particular area of the State. We have 150 service areas in the State, and we report to the FHA the estimate of need that we have developed for that current year and indicate whether there appears to be need for additional beds and whether there appears to be need for modernization of some existing beds. Over the past 3 years or so we have issued some 1,500 such certificates.

We have now developed a procedure whereby we issue and forward these certificates only to the official agency. Previously we had been providing them to the person asking for it, and they have been utilized sometimes for soliciting and obtaining financial resources from banks and other concerns. We have no objection to this, but it created quite a bit of work for us over and above our normal job.

Mr. FRANTZ. Do you then have a way of following up to determine whether these certificates result in the building of a nursing home?

Mr. DERRY. We have not, sir. We have not inquired of FHA as to what they have approved. We have not followed up to determine what their financial arrangements have been. Just as a matter of trying to follow the thousand sets of drawings that come through the Department a year, some of them became accomplished facts and start construction, some of them are delayed for a couple of years. For many reasons we wouldn't find it necessary to follow through on the actual financial arrangements, whether it is FHA, private or otherwise.

Mr. FRANTZ. Here is the thing I am getting at, and I am sure it is a very simple question really: Applicants request the certificates of you, and there will be delay or possibly abandonment of the plans. It may develop you have six or eight certificates outstanding with respect to a particular area. Now, how can you prevent all six or eight of these from going out and building a nursing home in the area where you have certified need for one in each instance?

Mr. DERRY. We can't, and we do not have any authority to establish priority of FHA procedures. We feel it is our obligation to provide anyone in California, equal information. If the FHA wants to establish a procedure, fine, but any individual or corporation that submits plans in compliance with our licensing program may proceed to construct.

Mr. FRANTZ. Just one thing more on the certificate question: When you make this determination for the certification, do you consider the need for the particular types and levels of services that the applicant proposes to have in his home, or do you consider only the number of beds?

Mr. DERRY. At this time we consider only the number of beds, because in our definition of long-term care facilities it may range from a very minimal type of health and medical care program to rather extensive long-term or chronic disease hospital services. Our licensing program is minimum standards. A facility may staff and provide whatever additional services they wish over and above the minimum.

In terms of need we have only relied upon the number of beds to date and the number of patients to be cared for in the existing beds.

Mr. FRANTZ. You spoke a moment ago about local planning to avoid duplication of services or services that would not be necessary if there were better coordination. When you are dealing with the private entrepreneur sector of health care, do you really have any effective way of doing this?

Mr. DERRY. In the activities of the voluntary regional planning organizations of which there are seven in the State, nursing home operators are members of these committees and are working with the hospital people, the community planning groups, the county supervisors, the zoning people and others. Through their study, through their exposure of what the needs are locally, there has been discouragement of certain of these proposals, not only for nursing homes but for hospitals. It is the hope in California that through this type of partnership of government and voluntary activities there can be developed on a local basis a method for the better planning and to establish only those facilities which are actually needed and fit into the comprehensive program.

Senator MOSS. Is the quality of medical services available in the nursing homes adequate, in your opinion? Do you find a reluctance or lack of interest on the part of the medical profession to service these nursing homes?

Mr. DERRY. Our program of consultation and surveillance includes the matter of the review of medical records, the review of physicians' orders and the review of nursing notes to determine that medication and other treatment has been carried out in accordance with the doctor's orders. If we find that this is not the case, then we have reason to ask the operator to correct it or to work with them toward this.

We have also the ability through the inspection service and consultation unit, to determine professional judgment on any apparent lack of patient care. Through these activities which are within our purview, or if we find a lack of this medical service, we take action for the operator to correct. The responsibility rests with the individual operator or the individual hospital, and in our activities we do not deal or work directly with the medical staffs or medical personnel. Whether there is a reluctance or not I wouldn't know.

Senator Moss. Do you find any widespread quasimedical services by nonqualified personnel, such as giving shots and things of that sort?

Mr. DERRY. No, sir. If we do, then this would involve us with a disciplinary action to bring them to account. We require that the patient be under the care of a physician. We require that the nursing services be supervised by a professional, trained nurse, and therefore we check up in terms of the tangibles that we are able to verify, medical records, medications, et cetera.

Senator Moss. All right. Thank you.

Mr. FRANTZ. I just wanted to ask if you can capsule it in a few seconds: What are your findings in general as a result of your surveillance and examination of the records? Are you content on the whole, with exceptions, of course, with the quality of services available?

Mr. DERRY. We believe that over these years, with the cooperative efforts of the health profession, there has been a very marked improvement in the health care and services in nursing homes. I think all of us believe that there is room for greater improvement.

As I mentioned earlier, we are working hard with these other groups and through accreditation on methods and personnel and standards and types of services that will bring improvement. We would like to urge ambulation and activity programs, including consultation of a physical therapist.

We are not content to rest where we are.

Senator Moss. Thank you.

Do you have a question?

Mr. MILLER. Yes. Mr. Derry, you indicated in your statement that you calculate the need for nursing home beds at the ratio of 1½ beds per 1,000 population, is that correct, or did I misunderstand you?

Mr. DERRY. May I clarify that? In estimating need for nursing home beds and hospital beds, we begin with the number of patients cared for in the latest year for which we have data. We determine how many patient-days of care have been provided. For long-term care we determine the number of beds needed to permit the operation of facilities at 90 percent of occupancy to provide care for the reported patient days. This becomes the base need as of this year.

In projecting for 5-year population growth we add 1½ beds per 1,000 for 5-year growth over and above the present utilization need. We use both factors. At the beginning it is a matter of utilization of present facilities.

Mr. MILLER. Has new construction and licensing of new facilities or expanded facilities kept pace with the population growth in the last 5 or 10 years?

Mr. DERRY. In our analysis, and we aren't claiming a perfect analysis, we find that in certain areas of this State there is an apparent oversupply. More beds are available than needed to operate at 90 percent occupancy. In other areas of the State there still appears to be a need for additional beds.

Very quickly, in terms of last year's State plan, for long-term care facilities we have indicated an estimate of the need for 2,300 more beds and also a need for the modernization of 8,200 existing beds. These are distributed throughout the State in some 150 areas. So in our analysis there is need for new beds in certain parts of the State. There appears to be an oversupply in other areas. Whether this will even-

tually adjust to the population growth of 600,000 a year in California, time will tell.

Mr. MILLER. Are the areas where you feel there is possibly an oversupply of beds, are these the areas where there has been the most static population situation, or is there any relationship between oversupply and population growth?

Mr. DERRY. I don't remember any static population in California right now. I would say in answer that in addition to State planning we must consider that in California there are many municipalities and local governmental organizations which have certain limitations in that particular area. They may have a zoning problem; they may have other problems in a local community that prevent or prohibit the development of additional facilities. In some areas it is very difficult because of the price of land even to build a nursing home where there may be a need.

For some reason, we aren't able to tell yet, most of these nursing homes for the last year are running at about 86 or 90 percent occupancy. Even with this phenomenal expansion of nursing homes in the last 5 years, we need more time and more study to find the factors that are contributing to this utilization. We have to guess right now.

Senator Moss. I think you had a question.

Mr. CONSTANTINE. Just two quick ones: First, you indicate then that the department of public health has no information or knowledge of any widespread practices of the performance of unauthorized quasi-medical services by unauthorized, unqualified personnel?

Mr. DERRY. Not in the facilities which we license and have surveillance over.

Mr. CONSTANTINE. You have no knowledge or information on that?

Mr. DERRY. As I say, if we should find it, we would immediately take disciplinary action to correct it.

Mr. CONSTANTINE. Have you found it?

Mr. DERRY. I think not.

Mr. CONSTANTINE. All right. Do you have any information concerning the monthly rate of employee turnover in nursing homes?

Mr. DERRY. I think there was some information in this report. We know that there is a rather rapid turnover of personnel in certain of the jobs in terms of aids, maintenance, and dietary. But in terms of the professional personnel, the RN's and the LPN's, we don't find turnover so rapid. I think the turnover is slowing down. There is a shortage in these professional people.

Mr. CONSTANTINE. In the nonprofessional people, could that turnover be as high as 25 or 30 or 40 or 50 percent a month?

Mr. DERRY. I don't want to hazard a guess on that. If I may look over a little bit later, I will try to provide that information to you.

(The report states a 42-percent turnover for the 6 months prior to September 1964.)

Mr. CONSTANTINE. Thank you.

Senator Moss. Thank you, Mr. Derry. We do appreciate your coming and testifying for us. You have given us some very excellent material, and we are pleased to have you. Thank you, sir.

Dr. John Affeldt, who is the medical director of the department of charities of the county of Los Angeles, will be our next witness.

STATEMENT OF DR. JOHN E. AFFELDT, MEDICAL DIRECTOR, DEPARTMENT OF CHARITIES, COUNTY OF LOS ANGELES

Senator Moss. We are happy to have you.

Dr. AFFELDT. Thank you, Senator Moss. It is my pleasure and privilege to be able to speak to you on the subject of long-term care. To demonstrate my interest and experience in this, I would simply like to mention a little of my background as relates to long-term care. I did have 2 years of experience in long-term care at Harvard University. I had 15 years' experience at the Rancho Los Amigos Hospital, which is a 2,000-bed chronic disease hospital of the Los Angeles County system, where I was medical director. I am currently medical director of the department of charities for Los Angeles County, which includes a hospital system of approximately 8,000 beds. Of these 8,000 beds, approximately 4,000 are long-term care beds, so that we do have a large area of responsibility and experience in these concepts of care and the use made.

I have prepared a short article here for this committee (which was submitted yesterday), titled "Long-Term Care."

Senator Moss. Thank you, Doctor. The entire text of this will be part of the record, and you may, if you like, go through it in full or you may highlight it to emphasize parts that you think are of particular importance.

Dr. AFFELDT. I would like to go through it, speaking from it, not using it completely.

Senator Moss. You may do so, sir.

(The full text of Dr. Affeldt's prepared statement follows:)

LONG-TERM CARE

(By John E. Affeldt, M.D., medical director, Los Angeles County Department of Charities)

I. DEFINITION FOR PURPOSES OF THIS PRESENTATION

The provision of services to persons with chronic disabling conditions, by various persons of the health professions on a prolonged basis, designed to restore lost function and to prevent or minimize further loss, while maintaining the basic dignity of the individual and his social contacts with others.

II. PRESENT AND FUTURE NEED

The tremendous advances in diagnostic and therapeutic programs have decreased the mortality from disease and injury and prolonged life. Both of these factors lead to increasing and accumulating numbers of persons being chronically disabled for a period of years. These persons are dependent upon others for their support and level of activity.

III. PAST STATUS

Long-term care facilities have not enjoyed good reputations in the past. The health professions or administrative bodies have not shown significant interest. This has resulted in facilities located in isolated areas, designed for minimal activity levels with little or no provision for diagnostic, therapeutic, or restorative procedures. The facilities and staff were considered second class by their colleagues and administrative superiors.

This is not surprising when one realizes that the significant prolongation of life is a recent accomplishment and that nearly all health personnel are trained and oriented in the acute teaching hospital environment. They are naturally attracted to the acute medical and health problems as they choose their own career environment. They have not yet had the exposure to the challenge and

opportunities which are present in long-term care. Neither are many of the long-term care facilities yet ready to receive and support the highly trained person who wishes to improve the care of the patient and investigate the problems of chronic disability.

IV. RECOMMENDATIONS FOR IMPROVING LONG-TERM CARE

A. Establish two distinct levels of long-term care

1. *Intensive.*—This should consist of hospital-based diagnostic, therapeutic, and restorative types of care at an intensity level comparable to acute type of hospital care. It is essential to study in depth the original diagnosis and to establish additional diagnoses and complications which have subsequently occurred. This should be followed by the appropriate therapy and restorative procedures to restore or improve functional activity. The hospital facilities for the intensive level of long-term care, although similar to acute facilities, should be administratively separated in order to remove the staff from the acute, crisis-oriented service. This permits the staff to concentrate their attention, planning, and activities to a long-range program of therapeutic and restorative procedures. Staff philosophy and action between acute crisis medicine and long-term medicine is considerably different. Each needs to develop within its own environment. Geographically these two types of units should be as close as possible. The separation is administrative rather than geographic.

The restorative program includes medical and surgical techniques accompanied by physical and occupational therapy services and the provision of assistive and replacement mechanical devices to provide return of function or substitution for it.

2. *Maintenance care.*—This should consist of a program designed to maintain the present level of function and to prevent further loss. It should stress a program of maintenance of human dignity, attempting to retain the individual as an active, stimulating, productive, and pleasant a life as his disability and limitations permit. A pleasant and clean physical environment is essential, with work and social contacts made available and encouraged.

The maintenance units should be affiliated with the intensive unit in order to permit the staff of the intensive unit to follow the patient's course over a prolonged period and to permit ready transfer in either direction as indicated. Geographically the maintenance units should be as close and convenient to the intensive units as the situation permits.

The maintenance units should be graded in activity levels from hospital facilities to nursing homes. There are many patients at the maintenance level who require hospital-type services for medical coverage, for improvement of function, and close surveillance. There are many more who are better handled by high-caliber nursing home programs. It should be noted that both types of facilities, hospital and nursing homes, are needed to cover these gradations of maintenance activity.

B. Teaching and research

Experience over many years has taught us that medical care can best be upgraded by including the functions of teaching and research in the program. This attracts a higher caliber of professional person, challenges old concepts, stimulates new thinking and approaches, all of which result in new knowledge and improved patient care. Addition of these functions requires space, equipment, technical staff and supportive services.

Long-term care programs need the same type of support for teaching and research now provided to centers of medical education and acute care. Although it is logical and desirable to appropriate such support through the channels of medical educational centers, they are as yet preoccupied with acute care and located in the acute environment, making it difficult for them to broaden their horizons and activities to the problems and centers of long-term care. It follows that either the long-term care programs will have to be brought to the centers of medical education, or vice versa, or a compromise somewhere between.

C. Community resources

The basic goal of the intensive-restorative part of long-term care is to restore sufficient function to permit a person to return to this home. Good followup care and periodic supportive services to his home are often necessary to permit a successful discharge of a person with a chronic, severe disability. These services consist of an outpatient clinic at the intensive unit of the long-

term care facility, visits by the health department personnel or local visiting nurse association, and support by a local home care program. All of these services require careful coordination and cooperation between these separate agencies. The long-term intensive hospital unit can best serve in this capacity.

D. Extended care

The concept that a patient who is ready to leave an acute facility, yet cannot return home, is to be placed somewhere out of sight, is no longer acceptable. The patient is actually in need of extended care. This is the essence of long-term care. The problem is to match the patient's needs with the appropriate facility and level of long-term care. An extended care office of the long-term care center can effectively perform this selection and routing function. It can also assist in the discharge function of the long-term care center by acting as the coordinator between the center and the community agencies such as the health department, visiting nurse association, and the home care program. This then permits a smooth continuous integrated service from the termination of the acute hospitalization through a restorative program to discharge home or long-term maintenance with appropriate followup and liaison with supporting community agencies.

E. Program versus patient authorization

As financing of long-term care by Federal through State to local agencies increases, the problem of authorization increases. The system of individual patient authorization requires the creation of large staffs of personnel to receive and process requests for authorization, progress reports, and final disposition. This is an added expense at all levels. The hospital or treatment facility requires personnel for this procedure, the local agency requires a large staff and likewise the State agency. This probably increases the total cost of care by 25 percent. This is a nonproductive expenditure.

An alternate procedure could be program authorization. This would be a blanket authorization of a facility for a defined number of beds. Periodic postaudits would be required to determine whether the program is performing in accord with the original intent and approval. This procedure is routine and historic with hospitals and medical training programs throughout the country. It has been fully tested and proven to be successful.

Dr. AFFELDT. Assuming that your committee is looking at long-term care in a very broad aspect, I have begun with my own definition just to be able to confine my remarks to this particular portion, so they will not be interpreted into other areas which you may be studying but in which my remarks do not refer.

For this purpose I have indicated that I considered that the provision of services to persons with chronic disabling conditions by various persons of the health professions on a prolonged basis, designed to restore lost function and to prevent or minimize further loss, while maintaining the basic dignity of the individual and his social contacts with others.

I think we are well aware of the fact that medical science has been able to reduce the mortality rate and prolong life. But in reducing the mortality rate this does not necessarily imply that they reduced disability, for the person who survives a serious illness may be alive but have the residuals of disability, and so with the prolongation of life and the reduction of mortality we are increasing disability, which requires further care on a long-term basis.

These people are dependent upon others for their support and activity.

We have already indicated the long-term care facilities have not enjoyed a good reputation in the past. The health professions or administrative bodies have not really given adequate attention to this type of program, which has meant that they have been in isolated areas. They have developed at a rather low level and have been con-

sidered second class by the professional, medical colleagues and by the administrative superiors. This is not surprising when you realize this prolongation of life and resulting disability is of recent years and when you also think of the fact that our health personnel for the most part are trained in the acute hospital environment where they are oriented to acute crisis medicine. They are not exposed to the long-term disability problems of patients.

As these health personnel select their own area for career development, and where they will function, it is quite natural that they will turn to the areas of acute medicine and crisis medicine rather than to the areas of long-term care. As such, long-term care facilities have not yet been able to attract top-caliber professional people to serve long-term patients.

With that background of the problem to date, I would like to make recommendations for improving long-term care. The first basic recommendation which I consider important is to establish two distinct levels of long-term care. The first level is an intensive level. This should be a hospital-based program which includes diagnostic, therapeutic, and restorative types of care at a level of intensity which is comparable to that of acute hospital care. It is essential to study and establish additional diagnoses, to study in depth the original diagnosis, and to determine further complications which have occurred over the long period of illness and disability. These facilities would be comparable and similar to acute hospital facilities. But it is important that they be administratively separated in order to remove the staff from the acute crisis-oriented type of service. By removing them administratively, this permits the staff of health personnel to concentrate their attention, their planning, the therapeutic activities on a long-range basis in order to provide restorative types of procedures.

The philosophy of the staff between the acute crisis-oriented service and the long-term type of service is quite different. This administrative separation will permit each to develop their own philosophies and types of care to the best interests of the patient under these circumstances.

When I speak of separation, I do not mean geographic separation. They should be affiliated and as close together as is possible, but the separation should be administrative in order to achieve proper budget support, proper space, facilities, staff, in order to carry out the intensive type of program needed.

The restorative program which I speak of, which is the same as the rehabilitation-type care—you can use whichever term you prefer—this should include medical and surgical techniques, physical and occupational therapy, the provision of assistive and mechanical replacement devices to restore function to these individuals who have lost it due to their chronic disabling condition.

The second level of care which I will propose as a function of long-term care is the maintenance type of care, which should be designed to maintain the present level of function and to prevent further loss. This program should stress the maintenance of human dignity, should attempt to retain the individual as active, as productive, stimulating as is possible, to improve his situation whenever possible, but most important to maintain the level which has been achieved in dignity, and to make his life worth living in the presence of his severe disabilities.

These maintenance units, I believe, should be affiliated with the intensive unit in order to permit the staff of the intensive unit to follow the patients in the maintenance units and to permit ready transfer in either direction as indicated by the patient's condition as it may change.

Geographically, the maintenance units should be as close in proximity to the intensive units as the situation permits, and at most they should be well affiliated with these intensive units. These maintenance units should be graded in activity levels from hospital facilities to nursing homes. For the patient's disability and requirement of medical care and support will grade from hospital requirements to those of nursing homes. This is essential in order to improve the function, to follow the progress of the disease or disability.

There are many, many patients who are best handled in high-caliber nursing homes. But it should be important to point out that the gradation need be recognized from the intensive level of hospital care to the maintenance level, with the maintenance including both hospital-type service and nursing-home-type service.

Another very important factor which must be considered to truly upgrade long-term care is to provide teaching and research activities in these facilities.

The medical profession has long experienced and recognized the fact that the best technique of upgrading medical service is to include teaching and research functions. This attracts high-caliber professional people; it challenges old concepts; it stimulates new thinking and approaches, all of which add to our knowledge and improvement of patient care. But to do this there must be space, facilities, equipment, and staff provided along with supportive services.

Long-term care needs this same type of support, and one of the most important things which I believe I can say here today is that long-term care must be recognized at the same level of supportive care as acute teaching medicine has. As long as we look upon long-term care as secondary, as second class, it will remain second class, and until we are willing to say that it requires the same caliber of professional people, the same type of diagnostic and investigative procedures, therapeutic procedures, until we reach that point long-term care will remain second class and we'll be struggling with the problems which go with that.

The support for the research and teaching should be funneled as much as possible through our medical-educational channels. But I think it is important to note that our medical schools, our other professional schools, for health personnel are for the most part located in the acute hospital environment and have not yet been able to give attention, focus their attention with caliber people to the long-term care problem. It follows that we have by some means, we need to get the medical centers, the educational centers, to the long-term care facilities or the long-term care facilities to the educational-medical center, or find some means of compromising between.

Community resources are very important in terms of these long-term care problems. The basic goal is to restore function wherever possible and to return the individual to his home or to a facility of lesser care. To do this properly and successfully does require the support of the local health departments, visiting nurse associations,

outpatient clinic facilities, and home care programs. These services require coordination and cooperation between themselves in order to properly serve the individual, the long-term care needs, and particularly the one who can go home if given the proper support.

One further point is to use the term "extended care." Extended care really refers to the fact that when the patient is ready to leave the acute hospital but is unable to return to his home for social reasons or disability reasons, he really needs further care. It is not at this point that he is to be set aside out of sight to be forgotten, which has happened so often in long-term care in the past. But, if you set up a concept of extended care, meaning that you select the individuals, you analyze their problems, you then send them to the appropriate level of long-term care, whether it be the intensive or the maintenance level, and the ability to send that patient from one level to the other as indicated, this is the concept of extended care. You get across to the medical profession that the patient needs further care after the acute stage of the disease.

The extended care office can help in the discharge and coordination, the coordination between the health department, between the visiting nurse association, the home care programs and the out-patient clinics. But it is best if this be based in the intensive long-term care hospital facility.

One further point which deals with the financing and support of long-term care: This is a philosophy of how you administer such a program. As we see an increase in the financing from the Federal level through the State to the local community for long-term care patients, we recognize the need for authorization, the need for controls. I would speak of the problem of individual prior patient authorization for each service and activity that is given. This requires the creation of large staffs at the hospital level, the long-term maintenance care level, at the middle-age level, at the State level, at the Federal level. People designed to check the authorizations, to check progress reports, to report back and raise questions, all of which requires clerical personnel, I have no figures to base an estimate as to what this costs, and looking at it roughly I would say it must add at least 25 percent to the cost of medical care for long-term patients.

I would recommend that consideration be given to the procedure of program authorization rather than individual patient authorization. Program authorization has been in effect for years in the hospital services, where hospitals are accredited by the joint commission on accredidation. They cannot receive patients for certain types of care unless they meet the standards. Medical education has long had the system of program authorization for specialty training, nurse training. These are program authorizations. This could be done on a long-term basis rather than individual patient authorization, which creates a large part of the staff for control.

Just to speak briefly of the examples of the system which I have mentioned here and proposals which I have mentioned, within these 4,000 beds of long-term care as a function of Los Angeles County, we have several facilities, each having its own personality and types of program. One of these facilities of 400 beds has developed an intensive program as well as some maintenance types of programs in its facilities.

Over the past 3 years they have found that they can reduce the average length of stay by at least one-third due to the intensive program. They have been able to double their admission rate and triple their discharge rate by virtue of adding the diagnostic, restorative, intensive level of services to the patient. The average age of patients in this facility is 79 years. So they are dealing with the elderly. They are dealing with the severely disabled, and yet they have been able in a 3-year period to double their admission rate and triple their discharge rate. We are reducing the number of beds in the Los Angeles County system by virtue of installing intensive levels of programs for long-term care. Thirty-five percent of these individuals are returning to their homes instead of further health facilities.

Another long-term care facility representing a 2,000-bed institution has extensive programs of research and education. They have been able to develop the artificial muscle, as an example; mechanical devices designed to power function in the upper extremities, the hands, the arms, the lower extremities, all of which make it possible to restore function to these people who have lost function through disability.

These are the types of programs which are needed in long-term care. So I can only repeat: consider two distinct levels, intensive and maintenance. Determine to support these at the same level which now supports acute medical care. I thank you.

Senator Moss. I thank you very much, Dr. Affeldt. That was a most excellent statement, and it heartens me a great deal. I have had a feeling, as you put in words here, that long-term care has been second class, as it were, in the eyes of the medical profession and the emphasis has been on acute care. Some way or another we need to balance them. They are equally important. Long-term care perhaps needs a little extra emphasis at this time until we can bring it up to where it properly serves all elderly citizens who need this care. Your figures on the increase of admissions and discharges was especially heartening, to show what can be accomplished and is being done here in Los Angeles.

Of these 4,000 long-term care beds that you have here, how many of those would be in nursing homes?

Dr. AFFELDT. None of those 4,000 beds are in nursing homes. These are all hospital beds which I refer to.

Senator Moss. Well, now, of those who are discharged from there, you say about 35 percent go home, would the others normally go to a nursing home?

Dr. AFFELDT. They would either go to boarding care homes or to nursing homes or may remain at the maintenance level in one of the chronic disease facilities, again recognizing that some of these patients still require hospital services to maintain them beyond the nursing home type of service.

Senator Moss. Is there any nursing home affiliation with your long-term care hospital functions?

Dr. AFFELDT. Historically, there is considerable nursing home affiliation in which Los Angeles County contracted with nursing homes for the services in nursing homes to these individuals. This has been decreased due to the Federal program of financing patients, State program of financing patients' care in the nursing home, so the county has shifted this from the hospital area to the welfare area. As such,

the contract beds have decreased. The affiliation, therefore, remains a very loose affiliation at the present time and very difficult to define.

Senator Moss. It would be desirable if that could be increased rather than allowed to remain just loose and indefinite; is that right?

Dr. AFFELDT. Yes; I believe so, and as we see the trend, I think it would certainly pay to have these nursing home beds affiliated with these intensive levels of care.

Senator Moss. Do you have questions?

Mr. CONSTANTINE. Just one quick question: Does your department, or do you know personally of any instances where nonqualified persons are performing quasi-medical services?

Dr. AFFELDT. No. We are not aware of any such instances, and I believe that if they were existing sooner or later we would hear of some of them.

Mr. FRANTZ. What, in this pattern that you describe, is the role of the typical general care nursing home? What is the role of the typical general care nursing home of which we have, I think, 48,000 beds in California in this system that you have described here?

Dr. AFFELDT. I would put the nursing home in the maintenance portion of the long-term care, where they do not have hospital facilities to carry out diagnostic or therapeutic procedures or restorative procedures at an intensive level; therefore, I would consider their role to maintain the function of the individual with human dignity. They should go further than that, as much as they can, to attempt mobilization and activity on the part of the patient. But this is still a basic level of maintenance rather than the very intensive rehabilitation or restorative level at the hospital base.

Mr. FRANTZ. In this stratum of the maintenance level, would you wish to have the educational and research activities incorporated, as well as at the other level?

Dr. AFFELDT. Well, I am not sure that you can do research adequately in the maintenance area. Research does require a concentration of laboratories, scientifically trained individuals, and an environment in which they can function with their literature, with their animal studies, with the documentation of results. I believe this would be difficult in the nursing home, at least as we know the private proprietary nursing home.

Education, yes; definitely. This should be carried out there, although you will need to establish centers of education, such as in the intensive part of the hospital base, where the nursing home personnel can go for periodic courses, short-term visits, in order to upgrade their knowledge and attain new knowledge.

Mr. FRANTZ. As you see the balance of the different levels which are required here, would this level represented by the nursing home now have a sufficient number of beds?

Dr. AFFELDT. I cannot adequately guess as to how many beds are needed or whether we have too many now or will need more in the future. I can refer to the experience we have had—namely, that we have been able to reduce the number of beds in the county system by the intensive type of program—however, with our population growth and our improvement in medical knowledge, we can expect more disability rather than less.

Mr. FRANTZ. I was thinking not so much of demographic estimates of need, but your view of the emphasis which is being given to various types now. Are we neglecting one level or a type in preference to another?

Dr. AFFELDT. I do see a danger in terms of upgrading the nursing homes to the point of the hospital level care. If we do this, we will not have nursing homes and we do need nursing homes where they can maintain a good level of maintenance care.

I cannot predict the balance that would be needed in terms of the maintenance beds versus the intensive beds; only experience can bring this to us, and we have only had a few years of experience with this concept thus far.

Senator Moss. Thank you, Dr. Affeldt. We do appreciate your testimony.

Our next witness will be Mr. Clifton Cole, who is representing the California Department of Public Welfare, and I believe Mr. Pyott is here.

Mr. COLE. He was unable to come today, Senator.

Senator Moss. We are very glad to have you, Mr. Cole.

STATEMENT OF CLIFTON COLE, REPRESENTING CALIFORNIA DEPARTMENT OF SOCIAL WELFARE

Mr. COLE. We do have an area staff member from that particular division of the department, who will answer any questions about board and care homes at the end of the testimony.

Senator Moss. Very fine. We will be glad to have him here, if we have questions.

Go ahead, Mr. Cole.

Mr. COLE. Senator Moss, committee members, I am Clifton A. Cole, hospital administration consultant to the department of social welfare. I am representing Mr. Wedemeyer, director of the department of social welfare, who is unable to attend because of commitments made before he knew of this meeting.

In the following statement is a statement prepared by Mr. Pyott for this testimony, and I will read it into the record if you don't mind.

Senator Moss. All right.

Mr. COLE. We have prepared a statement concerning the use of nursing and convalescent homes in California to provide inpatient care under the medical aid to the aged program, which is this State's implementation of the Kerr-Mills Act, 1960.

First, I would like to define what, in this State is identified as a nursing and convalescent home, and to distinguish this from what is called in California, a boarding home or institution for the aged.

By legal definition a nursing and convalescent home in California is a hospital, and is—

* * * any place or institution which makes provisions for bed care, or for chronic or convalescent care for one or more persons exclusive of relatives, who by reason of illness or physical infirmity are unable to properly care for themselves.

Alcoholics, drug addicts, persons with mental diseases, and persons with communicable diseases, including contagious tuberculosis, shall not be admitted or cared for in nursing and convalescent homes * * *.

A nursing home in California is a medical institution caring for persons under observation, treatment, or care for illness, disease, or injury. Well-aged persons are not accepted in nursing homes.

In California there are three licensing agencies. The department of public health licenses hospitals, nursing and convalescent homes, and other types of medical facilities.

The State department of mental hygiene licenses psychiatric treatment facilities which care for the senile aged and in addition they license long-term medical care institution called a type G private institution. A type G institution is primarily for persons who no longer have a mental condition as their primary disability but have a physical condition which requires medical care and supervision. The care for their mental condition becomes secondary.

The main differentiating factor between the type G facility and a nursing and convalescent home is its element of complete supervision for patients that are incompetent, unruly, bellicose, and require constant watching and supervision. In California type G facilities certified as meeting the medical institutions criteria of the Federal regulations may participate in the medical aid to the aged program.

The licensing program administered by the California Department of Social Welfare encompasses residential services and the nonmedical personal care. These facilities are known as homes for the aged, boarding homes for the aged, and instituions for the aged. In many States these facilities are included in this broad category of resthomes or nursing homes.

California was one of the pioneering States in requiring licensing of facilities for the care of the aged. The three classes of licensed facilities, however, do not necessarily lend themselves to the conditions of some patients. We have found that there is a large number of patients that do not clearly fall within the structural pattern of care for which these facilities gear themselves. As an example, persons who are in the well-aged facilities licensed by the department of social welfare, may become ill. The question arises at which point does this patient require nursing home services instead of the personal care services provided in the boarding care home?

HOMES FOR THE AGED; THEIR RELATION TO NURSING HOMES

In order to understand or make any assessment of the program of care, in California, of aged persons outside of their own homes, it is necessary to recognize the special nature and purpose of the personal, or social care, home.

It is important to say, first, what such a home is not. Specifically, it is not a nursing home.

It is intended to be something quite different, to meet, in a positive way, a different need. It meets the need of the aged person who is not able to live independently, who requires some degree of personal attention and assistance with the activities of daily living. In this protected living situation, they remain moderately active, and do not require skilled nursing care.

This distinction in function is recognized widely. It is noted, for example, in the 1961 publication of the U.S. Public Health Service which lists the licensing agencies, in the States, responsible for

hospitals, nursing homes, and homes for the aged. The publication defines each type of facility as distinct from the other two. The nursing home provides care for those—

who require nursing care and related medical services.

The home for the aged cares for—

individuals who are not in need of hospital or nursing home care but who require assistance with essential activities of living, in a protected environment.

In addition to not being a nursing home, the home for the aged in California is quite definitely something else. The standards set for it undertake to provide a living situation which is as near to an independent one as possible, a substitute for the person's own home or that of a relative. These homes range in size from the true foster family home for one, two, or three, to large homes which may have hundreds of guests or residents.

Many of the larger homes also provide specialized nursing home facilities on the same premises. Some of these homes have been authorized, under statutory controls and limitations, to enter into contracts for "life care" which provide all needed care during the life of the resident. Even without the "life care" program, the larger homes tend to associate a nursing care facility with the residential care home. All such nursing care facilities are subject to separate licensure under the State's standards for nursing homes. Current reports show 68 nursing homes are incorporated in homes for the aged. This figure relates to a total of about 300 homes for the aged having a capacity in excess of 15 persons.

The other homes, small to moderate in size, and something over 3,000 in number, do not, for obvious economic reasons, undertake to incorporate a nursing care facility. They are prohibited from admitting to residence, or from continuing in care, an individual who needs skilled nursing care. The larger homes are governed by the same prohibition, with respect to social care space.

There are occasional, but rare, instances where individuals are admitted, or retained, who should be in a nursing home, in order to receive appropriate care. Such instances are transitory and, where found, have usually reflected inability to obtain the required care immediately.

There is no pattern, almost no known instance, of conversion of a social care home to a nursing home. A major reason is the nature of the social care function, as embodied in standards and program objectives. These homes are not mere substandard "nursing homes." The standards they must meet do not lead to conversion to nursing homes.

Nursing homes provide an essential service, available to the individuals living in homes for the aged just as it is to individuals living in their own homes.

The following is a description of the kinds of persons in our medical aid for the aged program cared for in nursing homes. These patients can be divided into three functional groups: minimum, extensive, and a group in between we will call average.

THE MINIMUM CARE GROUP

These persons are able to perform most of the activities of daily living with minimum help and supervision from nursing personnel. They may have recovered from a disabling condition but still require nursing and restorative services to attain a higher level of functioning self-dependency. They still require 24-hour professional observation and supervision to be able to maintain this status. This type of patient may be on dangerous drugs or may require continuous treatment given by skilled nurses or other paramedical personnel. If these persons do not remain in nursing homes they suffer from malnutrition, relapses to acute phases of disease or illness, or regress rapidly to a bedfast condition. For some an early demise may be brought about by the absence of special diets, treatments and/or failure to have supervision and control of medications.

THE EXTENSIVE CARE PATIENT

The extensive care patient is one with chronic multiple medical problems. He requires assistance because of total physical dependency and may be forgetful, confused, and uncooperative in the provisions of his care.

He is generally incontinent and in need of assistance with feeding most of the time. He sometimes has a Levine tube feeding and requires suctioning. He has lost his ability to communicate adequately. He needs assistance to turn in bed, to sit up, or to get out of bed. He may be awkward to handle because of contractures, obesity, or paralysis and would need frequent positioning, special skin care, padding, and other nursing bed services. This patient's condition may be complicated by colostomies, amputations, paralysis, intravenous feedings, or administration of oxygen or positive pressure breathing.

He is usually on the decline and has no potential for restoration to a higher level of self-dependency and in most cases he is terminal though the decline may last for several years.

THE AVERAGE CARE PATIENT

Generally this patient is mentally clear most of the time and is able to cooperate in the provision of his own care. He suffers some impairment which may be improved with restorative nursing. He requires routine nursing care and in addition some physiotherapy, planned program activity, bowel and bladder training, passive or active exercises and mental stimulation. The impairments will most likely be from fractures, cardiovascular accidents, amputations as a result of diabetes or other circulatory impairments, surgery, burns, et cetera. He may be a little disoriented and may have varying degrees of socially acceptable habits. He is able to perform most of the activities of daily living with assistance or supervision. He requires an extensive regimen of medication or chemotherapy, well supervised activities and observation for reactions.

In all of the above described patients nursing and/or convalescent home or hospital care is needed.

HISTORY AND BACKGROUND OF MEDICAL ASSISTANCE TO THE AGED PROGRAM

Medical care was not a part of old age security before 1957. In 1956, amendments to the Social Security Act enabled this State to add outpatient medical services to the old age security assistance program.

A person requiring hospitalization or skilled nursing home care was left to his own resourcefulness. Persons needing these services, whether they were on public assistance rolls or not, who could not pay, had to rely on county hospital facilities, with stringent deterrents to admission, or rely on contributions from relatives to pay for private medical care.

California passed the Rattigan-Burton Act, under the Kerr-Mills enabling legislation, in 1961 and implemented it as medical aid to the aged in 1962, hereafter referred to as MAA.

Seven and a half million dollars of unused appropriated funds were earmarked for the initial operation of the MAA program.

Our objective was to operate the program within the anticipated State revenue and without any increase in local property taxes, and to provide the widest and most comprehensive range of services possible and necessary to meet the needs.

The greatest recognized need for the older citizen was inpatient care, since this was not available under the public assistance medical care program, and particularly longer-term care in hospitals and nursing homes, since these costs were not being met in any organized fashion.

The program, to remain within the fiscal limitations and to provide the heaviest cost service, was geared as a first step, to care of persons requiring prolonged and expensive care—over 30 days and costing more than $3,000.

Before the program for MAA began in January 1962, we estimated an average of 18,000 persons or 2.3 percent of the then State's population over 65, would be receiving care in long-term hospital wards and nursing homes at any one time in the year 1962–63.

The question then to be answered was, in what type of facilities were these persons receiving care? In January 1962, there were 9,545 long-term-care beds in county hospitals, 19,618 beds in nursing homes and 909 long-term-care beds in nonprofit voluntary and proprietary hospitals.

As is obvious from these figures, a program had to be geared to the facilities providing the larger number of the beds for the needs the program had been designed to meet.

Eligibility requirements established by the Rattigan-Burton bill, and subsequent amendments, were—

1. The person may have real property holdings, including his home, and/or other real property assessed up to $5,000.
2. The person may have personal property up to $1,200 plus household and personal effects.
3. His income must not exceed the cost of maintenance for the persons and his dependents, plus the cost of his medical care.

Our proposal to the legislature had the support of the California Medical Association, passed without opposition, and became effective January 1, 1962, with subsequent amendments added during the last legislative session.

This department readily realizes the MAA program has not been the answer to all the health problems of our older citizens, nor has it eliminated enough of those problems, nor covered enough people to be considered a comprehensive program.

Each year more than 100,000 low-income older people are admitted to hospitals for periods less than 30 days. The cost of this care still has to be borne out of savings or property holdings and further reduces the aged person's resources.

The legislature extended the program in its last session by allowing hospital care from the first day in county hospitals or county contract hospitals and by reducing the dollar corridor to $2,000 instead of the former $3,000. This was seen as a step toward elimination of waiting periods and dollar corridor.

Further reductions will be possible only as the legislature finds additional funds, since they would put a very substantial burden upon State and county fiscal structure.

Last year we estimated that elimination of the waiting period and dollar corridor would cost an additional $54 million of State and county funds.

To liberalize the personal property holdings requirement to $5,000 as recommended by the American Medical Association would have cost an additional $38 million in State and county funds.

These figures are now obsolete and new estimates are currently being drafted.

In November 1964, in California, there were 26,583 inpatient certificate holders in the MAA program. Of these, 1,156 were outpatients; 25,427 were inpatients.

There were 28,595 beneficiary-months of service given in November 1964. These figures compare with 16,406 beneficiary-months of service given after the first 6 months of the program. The detailed comparison is as follows:

	Beneficiary-months paid	
	June 1962	November 1964
County hospital	6,825	6,506
Proprietary and other hospitals	515	769
Inpatient rehabilitation facilities		125
Nursing homes	9,066	21,195
Total	16,406	28,595

See table M–3, page 12, of attached copy, "Public assistance medical care and medical assistance for the aged, service and expenditure report, November 1964, third quarter 1964."

As of January 1, 1965, there were 42,095 beds in nursing homes in California. More than 55 percent are occupied by MAA patients.

In January 1962, when this State program began, there were approximately 12,000 persons eligible for MAA and our first statistics for that year showed 41 percent of the then-existing nursing home beds (22,264) occuped by these patients. See chart attached "Percent of all nursing home beds occupied by MAA and private patients."

If you will note in that chart, there has been a complete reversal in the occupancy pattern in nursing homes as regards private patients and MAA patients.

SCHEDULE OF MAXIMUM ALLOWANCES, ITS BACKGROUND AND STRUCTURE

When the MAA program began operating January 1, 1962, the rates paid to nursing homes for care of MAA patients were frozen at the maximum amounts allowed for the care of old-age security recipients on October 1, 1961. These amounts had been negotiated by the county welfare departments and the nursing homes and varied within counties as well as among counties. They represented the rates to be paid, if possible, through combination of grants and supplemental aid from relatives, county general assistance, or the person's own outside income.

Early in 1962 the department of finance was given the responsibility for setting rates for payments made by State agencies for medical care including the payments made to nursing homes. To assist in determining the rates to be paid for MAA, the department of social welfare did a cost survey of a 10 percent stratified sample of 80 nursing homes.

The cost data gathered for each home was based on the latest complete accounting period in most cases for the year 1961. The data was analyzed for each home individually within four regions which appeared to have variation in the cost of care. The four regions were later combined into two, northern and southern California.

During this same period the department of social welfare formulated a patient classification system designed to assure that a patient needing a normal level of care received this care and it was paid for accordingly and that a patient needing more extensive services requiring more time and skill of personnel was paid for at a higher rate.

This new payment system based on the median care level and the median cost was placed in effect on Febuary 1, 1963. Full implementation by all counties was completed by May 1, 1963. During this period all MAA patients in nursing homes were classified as needing basic or extensive care and the various rates in counties were replaced by a flat rate in the two regions for each type of care.

Attached to your copy of this statement, you will find the letters describing the range of payments that were authorized in 1963 as well as the department of social welfare's criteria for determining basic and extensive care levels.

In November 1963, cost-of-living increases forced an equalization of the rate at a $7.35 and $9.10 per day throughout the State. In addition to the maximum allowances the department of finance allowed higher rates in facilities having a high investment or high wage cost. This was in recognition of the fact that several areas in the State had high land and construction cost and that some facilities provided more extensive services requiring heavier staffing patterns.

The criteria for use of the higher rates were outlined as a program policy by the department of social welfare. A county welfare department acting on medical advice of the county medical consultant and/or the county medical societies welfare committee could determine that

care was not available at the regular rates (basic and extensive care rates) in sufficient volume to afford patients a reasonable choice of facilities offering care appropriate to their medical needs, or that facilities were needed to avoid placement or retention of patients in more costly medical institutions, when that type of care provided by the institution was not needed by the patient.

To date 36 counties are using the higher rates. Most of these counties are in the northern part of the State where cost of living is accepted as generally being higher. A few of the counties have no nursing home beds and some counties have an inadequate supply of beds to meet their caseload needs.

The use of the higher rates have in some areas stimulated nursing home growth. Unfortunately, some areas that were initially critically short of beds are still short. The industry has not responded with growth in the more isolated areas of need. The increase of beds has been greatest in areas where beds were not needed. Particularly in the Los Angeles metropolitan area. Consequently, the rates for care are lower in this area where competition is keenest.

This condition plus a concern about the quality of care being offered has led this department to begin an on-site analysis and examination of the composition of the industry and the factors that influence its growth and care living pattern. We are currently conducting studies designed to delineate services provided, to determine the cost of providing the services. The results will be used to design a system of payment based on a fair and reasonable cost for services provided and needed by the MAA caseload.

In addition, the department of public health has conducted a questionnaire survey designed to describe the characteristics of the nursing homes in this State. They have submitted this to you in their testimony.

This department working with the department of finance and public health has established a method of payment for care in county hospitals based on the California Hospital Association recommended standards found in the Uniform Cost Accounting Manual Guide, published by that group. This system of payment is based on the cost found to exist in providing care in various service centers normally found in the hospital. A per diem rate is paid for acute medical care, orthopedic care, surgical care, et cetera, and is all-inclusive for the hospital services.

The State departments are currently working with the hospital association to develop systems of payment for other types of hospitals.

When more fundamental information is obtained similar work will occur with the nursing homes.

The nursing homes in California provide a wide range and scope of service within their licensing standards. Most are prepared to provide the total range of services to any patient admitted. This may or may not be the most economical method for the industry to respond to the provision of service but it has been the historical development of the industry in this State. This aspect of nursing homes has not been studied. Since the federally assisted programs have been in effect there has not been enough time or staff budgeted to determine what is the optimum way to meet the need of aged patients for chronic care, or to thoroughly investigate the elements that would have to be incorporated in an adequate and equitable method of payment.

HOW QUALITY IS CONTROLLED

The State department of public health is responsible for licensing nursing homes as previously stated. With licensing, an enforcement of standards is an integral part. These standards are oriented to the physical plant, maintenance, sanitation, fire safety, operation, and to a lesser degree the management and administration of the home. The department of health also prescribes standards for nursing supervision but not for the quality or quantity of other staff members. The quality of the medical care is not regulated except as it pertains to reocrds, emergency service, and orders for care. This element is solely within the dictates of the ethics of the profession and the consciousness of the individual practitioners.

As part of the administration of the MAA program, counties are required to have medical social review teams composed of a physician and medical social worker or trained social worker or nurse social worker. It is the responsibility of these teams to determine continuing medical eligibility, appropriateness of care, changes in level of care and approval of the classification into basic or extensive care levels.

Reviews are made of acute care cases every 30 days and of chronic care cases every 90 days. There is varying degrees of effectiveness with this program. The two major problems are county budgeting for adequate staffing and recruiting qualified personnel. Because of the limited supply of physicians and medical social workers, many counties do not have enough teams to adequately handle their caseloads. Other counties face major fiscal problems which limit their ability to provide staff for welfare administration. In this State there is no State participation in the costs of county administration of the public assistance programs.

It is this department's belief that incentive to good care can be incorporated in the payment system but it is not the case with the present median-based flat rate system. A system of payment related closely to services needed will create incentives to provide good services if the payment is equitable. The cost of administering such a system may be higher but the rewards are greater benefits to patients. We do not propose to pay for "luxury care" or care not related to medical need. We do not propose to recognize retail charges. In our view, systems which merely pay the "going rate" tend to buy unneeded care. An equitable system of payment plus adequate review of patient needs coupled with a form of constructive placement service should meet the demands for better care in nursing homes in the State of California.

In California when the MAA program began, we believed that all persons receiving assistance for their medical need should receive the same treatment and be eligible for the same care whether they were former assistance cases or previously private patients. To believe otherwise would lead to recognition of two care levels.

One for patients who were receiving welfare assistance prior to their medical need; and one for patients who were able to provide for their normal maintenance without assistance but could not provide for their medical need. Prior to MAA we saw in this State most aged and disabled persons' medical needs met only to a limited extent by county hospitals and even then with very restrictive eligibility conditions. These county hospitals were not in the mainstream of the provision of

medical services. In recent years we have seen the emphasis and direction toward making these facilities part of the mainstream of the medical community. Standards of hospital services have improved, many are teaching facilities. To continue to recognize only the county hospital pattern for welfare assistance recipients rather than broad use of facilities by other aged persons would not reverse this trend. We are in favor of and seek an across-the-board medical program for the aged flexible enough to include all patients with a medical need. They should be able to receive services in any facility able to adequately meet their need.

At the present time there is no provision for inpatient medical care for public assistance recipients unless they are eligible for and transfer to the MAA program, except as the respective counties may see fit to provide it through county hospitals. The one exception was recent legislation which made inpatient services available to aid to the blind and aid to the potentially self-supporting blind patients less than 65 years of age.

Our MAA expenditures for 1962–63 were $60 million. We anticipate $142 million for 1965–66. Even with this expenditure short-term hospital care is not provided all older persons in need of care. Those who choose private hospitals must still draw on their savings and jeopardize future self-support.

Our program of utilizing nursing homes in the provision of long-term care service is now entering the second phase. The first phase was implementation. The second phase is program refinement and the third phase will be evaluation and adjustment.

Our primary goal is adequate care for every aged person in need of hospital and nursing home care if he cannot afford to pay for this care from his own funds without depletion of his meager resources or jeopardize his feeling of dignity.

Senator Moss. Thank you, Mr. Cole. That is a very comprehensive statement, an excellent one. We are delighted to have it. The attachments to which you refer will be a part of the subcommittee files. They will make a handy reference for the staff.

This was a rather interesting discussion of the medical assistance program that is being utilized in varying degrees now around the country in different States. I believe you said that 55 percent of all the beds in nursing homes were being financed with MAA?

Mr. COLE. That is correct.

Senator Moss. Therefore, this is a very large part of the load that the State undertakes in this area of caring for the elderly who have medical needs?

Mr. COLE. That's right.

Senator Moss. Now, you pointed out there is a difference of rate somewhere between $7.35 a day to $9.10 a day. Is it either one or the other or does it go all the way in between those two?

Mr. COLE. There are two basic rates. One is $7.35 for basic care. For those patients who it is determined need it, which there are 14 percent in the nursing home caseloads, that is, of the MAA patients. The $9.10 is paid for the extensive care patient or that patient which we determine to need more skill and nursing time, more professional services than what the basic care patient needs. Eighty-six percent of the present MAA caseload in nursing homes is now extensive.

Senator Moss. Do you require some kind of statistical report, breakdown of services actually rendered in determining then which of these two rates to apply?

Mr. COLE. Well, we have a six-point criteria which we use to determine whether a patient is basic or extensive. We will go through that for you briefly. If a patient is receiving any one or more of these particular types of service, then they are classified as extensive and they are paid for at the $9.10 per diem.

(1) The first is complete feeding, in other words, if a patient is being completely fed by one of the nursing staff.

(2) The next is the operation of special equipment required for respiratory insufficiency. This is the operation of a positive-pressure breathing machine or administration of oxygen therapy on a continual basis.

(3) The next is the care of colostomy or incontinence of urine and feces.

(4) The other is time-consuming extra skills required for the maintenance of the patient in bed under physician's orders.

There are some patients who are unable to get out of bed, and they are ordered to remain there, but they require extra nursing bed services, and for this kind of patient we classify this as an extensive-care patient.

(5) A planned program of time-consuming and related services approved by the physician is designed to achieve and maintain maximum independence consistent with the patient's physical and mental capacities. In other words, this is a restorative nursing program which a physician may prescribe for a person who is recovering from an acute illness, for instance, and needs 3 or 4 or 5 months of additional concentrated effort to restore him back to some higher level of self-dependency. This we consider extensive care.

(6) Then there are therapeutic diets ordered by the physician limited to the sodium-restricted or quantitative-diabetic diet. This is where extra materials are needed, extra dietary foods are needed for this patient that are different from that served the regular nursing home patient, and it requires extra expense on the part of the nursing home providing the service.

Senator Moss. Do you have difficulties in getting patients placed at either of these rates, in other words, are the rates too low for the nursing homes to be anxious to take people in at these rates?

Mr. COLE. Our difficulties are varied throughout the State. We have had difficulties in some areas of the State where there are not sufficient beds, where the nursing home operators have refused to take patients at the rates we have or refused to take patients at the basic care rates.

Senator Moss. We have heard in one or two other States that because of the low rate available to recipients of aid, welfare aid or MAA, oftentimes there was a sort of a family payment under the table, as it were, to get patients into nursing homes. Have you had any of those problems here in California?

Mr. COLE. I don't have any factual information to what extent this problem exists; however, we believe that it does exist. It is not permissible, however.

Senator Moss. Is it specifically prohibited?

Mr. COLE. Yes.

Senator Moss. Therefore, it would be illegal to do it if it goes on?

Mr. COLE. That is correct.

Senator Moss. Do you have any questions?

Mr. CONSTANTINE. Just a quick question: On the MAA, how many of the people, since the inception of the program, were transferred from other public programs, that is, State, local and so on, or would have been eligible in the absence of MAA for other public nursing home programs or other public care programs, in effect, in your opinion, is the MAA program in California reaching a new group of indigents, the medically indigent, so-called?

Mr. COLE. Yes, it is. Approximately 45 percent of our MAA caseload that is presently in nursing homes was never known to public assistance rolls before, in other words, these are the private patients who do not have funds to provide for their medical care, but they are able to provide for their own maintenance.

Mr. CONSTANTINE. Fifty-five percent then?

Mr. COLE. Forty-five percent.

Mr. CONSTANTINE. In other words, 55 percent were previously on public rolls?

Mr. COLE. Yes, that is true. This figure is decreasing all the time since the beginning of the MAA program.

Mr. CONSTANTINE. Naturally, it would. But of the balance of that 45 percent, how many of those would have been eligible in the absence of an MAA program, in terms of assets, et cetera, for programs existing prior to MAA?

Mr. COLE. With the present eligibility requirements for MAA, none of those persons would have been eligible. They would have sufficient personal resources so that we would have determined them not to be eligible for public assistance rolls, which programs provided the only assistance prior to MAA.

Mr. CONSTANTINE. Fine. Thank you.

Senator Moss. Do you have one?

Mr. MILLER. Yes. Early in your statement you state that current reports show 68 nursing homes are incorporated in homes for the aged, and then you point out that these are homes which each have total residents in excess of 15. What is the smallest number of residents in one of these homes that has nursing——

Mr. COLE. I should correct that statement a bit, because by definition an aged institution is the term for a facility which is above 15 beds. There are 68 aged institutions with nursing homes incorporated as part of the services. There are 300 aged institutions in the State. There are 3,000 smaller homes less than 15 beds, and the smallest, I would say, would be 1 bed.

Mr. MILLER. Do I understand you correctly, then, that any home for the aged that has in excess of 15 beds must have nursing——

Mr. COLE. No. I said that any home in excess of 15 beds was termed in this State an aged institution, and there is a little different licensing pattern for the ones that are above 15 beds. They are licensed directly by the State. The ones that are below 15 beds are licensed as board and care homes by the local county welfare departments, acting as a State agency.

Mr. MILLER. I am not sure that I understand what you are saying here. Now, these are not nursing homes that by reason of size are called homes for the aged?

Mr. COLE. No. These are specifically different homes. It is just the idea that the smaller facility is more family oriented in that it provides a more personal type of service, and it is desired by many aged persons to live in this kind of environment to replace their own home, and because of this, the delegation of the licensing responsibility has been given to the county welfare departments.

Mr. MILLER. Yes, but getting back to my original question, how small a home for the aged, what is the minimum size of a home for the aged that has nursing home facilities in it?

Mr. COLE. Oh, in the 300 aged institutions, that would be the category which could have a nursing home there are 68. I don't know the smallest size which has a nursing home. The size generally runs, however, between 100 and 200 beds.

Mr. MILLER. What is the average size of these institutions?

Mr. COLE. That I don't know.

Mr. MILLER. Thank you.

Senator Moss. Thank you very much, Mr. Cole. We appreciate the very fine statement, a lot of good information for us.

We are going to continue here with one additional witness before we recess; however, we will take just about a 3- or 4-minute break right now.

(Recess.)

Senator Moss. We will resume our hearing. I appreciate your indulgence for the brief interlude we had.

We have one more witness to hear before the noon recess. This is Mrs. Lillian B. McCall, who is a consultant to the committee on ways and means of the California Assembly. We are very pleased to have you, Mrs. McCall. We appreciate your coming to testify.

STATEMENT OF MRS. LILLIAN B. McCALL, CONSULTANT, COMMITTEE ON WAYS AND MEANS, CALIFORNIA ASSEMBLY

Mrs. MCCALL. Mr. Nicholas C. Petris, the chairman of our subcommittee, had intended to be here today, but legislative business required him to be in Sacramento. He asked me to convey his regrets to the committee.

Senator Moss. Thank you very much. Convey our greetings to him. We are sorry that he was tied up, but we are delighted that you could come to represent him.

Mrs. MCCALL. For the past 2 years, our subcommittee has been conducting a lengthy interim investigation of the MAA program. In the beginning this was mostly in response to pressure from the nursing home industry about MAA rates. Very soon after we began our investigation we realized that rates were only a minor aspect of a much larger problem, not for the operators alone, but in terms of medical care for the aged.

I dislike interjecting reality after listening to the rhetoric that we have been hearing this morning. Our subcommittee has been hearing it for 2 years and it doesn't reflect the real world out there.

We believe that the operators do have a legitimate grievance. But as a medical care program, MAA has been catastrophic as far as the aged are concerned. It has accelerated what we consider to be a system of removal of the aged from society. MAA is paid in the same kind of institutions that existed before passage of the program. We spend a lot more for inferior care. MAA has accelerated the entire process of segregating aged people, and I would say in a rather flat way that it is medical care program in name only. You couldn't conceivably give the kind of care that some of these people need under the system that presently exists in California, nor is there any real planning on the part of the agencies designated to carry out the program.

Some of the problems are due to the complicated licensing procedures in this State; three different agencies license institutions and another sets MAA rates. But which people get into which institutions are not very different medically. For instance, one way of handling some aged is simply to dump them in State mental hospitals. The rate of commitment varies considerably from county to county in California. About 3,000 people a year are committed; about 80 percent of whom will die within that year. There is a great deal of shuffling back and forth among various types of institutions. The report we asked for from the department of public health which Mr. Derry referred to earlier contains some information that would be of interest, but it does not address itself to the questions we asked.

Let me quickly review for you what I think are some of the main problems. First, the rates are set by an agency which has nothing to do with standards or program. The rates were set without any regard for what goes on in these places and without any regard as to whether the particular facility is in conformity with the health and safety code.

Since 1946 we have had a licensing act, and we have a bureau of hospitals, whose major function is to inspect institutions licensed by the department of public health. The inspectors go around and they check off all the violations of the code. We have discovered, partly as a result of this investigation, that there is no effective way of enforcing the code. The result is that we have a great stack of public documents which nobody ever looks at. More than two-thirds of the homes in the State are in violation of the code.

What happens when a home is in violation? Well, there are various sections, and the inspector will check off any of a possible 125 violations. A very frequent violation of the code is that there are no qualified nursing personnel on duty after 3 o'clock. Staff ratios are based on the number of beds rather than on the medical condition of the patient; staffing ratios are based on number of beds rather than how sick the person in the institution may be. Planning for the size of these institutions is tied to arbitrary bed ratios; for example, if you have six people or less, all of whom may be comatose, a registered nurse need not be employed. You may have 250 people in a nursing home and the code only specifies 1 registered nurse on each shift. If you build a 99-bed hospital today you need 1 RN on your staff, but if you have 100 beds you need 3 RN's. This type of planning has been typical for many years now.

We have another problem, which is the problem of the grandfathered institution. According to the Hospital Licensing Act, the

institution doesn't hold a license, but the person does. The legislature intended that when a licensee of an institution operating prior to 1946 surrendered the license, the home would cease to exist. The department of public health, however, will issue a new license. This has had the effect of grandfathering in perpetuity. We hope to do something about that this legislative session.

Another very, very frequent violation of the code is that unauthorized personnel will give medication. In the process of our investigation I saw many nursing homes in the State, and despite all the talk about programs and about care and about standards, when you go and see what is really going on it is pretty hard to maintain a fiction that care is adequate.

Here in Los Angeles County, which has one of the best rehabilitation hospitals in the world, one of those to which Mr. Cole referred, we have about 7 million people. We have other counties which have less than 10,000. Los Angeles County has never granted a supplemental rate for labor and investment. The practice, in fact, has been not to relate the placement in any way to the kind of care which the home is equipped to give, but simply to find the cheapest bed. In Los Angeles, which is considered to have a surplus of beds—again, you see the beds are not compared, they are just enumerated—where there has been a tremendous expansion of building, operators are asked to take care of patients at a rate that really is below what a good motel will charge. Many of these patients do require extensive care.

The terms "chronic" and "acute" are another problem we discovered in our investigation. They are used very ambiguously. Apparently "chronic" simply means that someone is going to be very sick for a very long time. The orientation of doctors really is toward people who are going to get better. What we find is that the aged are a class of people doctors don't really want to treat. Putting them in a nursing home is a way of forgetting about them. We don't provide the operators with sufficient funds for all these great things that they are talking about, restoration and home care and counseling, and so on. Then they are expected to do the job that a general hospital will do with an organized medical staff.

In Los Angeles, for instance, a problem county, the county hospital spends an enormous amount of money for rehabilitation. At the end of this process the patient will be placed in a substandard nursing home which cannot continue the program. You get tremendous and quick regression. I don't believe that the affiliation of nursing homes with general hospitals will solve this. I think that the essential problem here is that the medical profession has really turned its back on the aged. The poor conditions, which exist in many nursing homes, could not exist without the fact that doctors are not interested really in taking care of their patients.

You go through the inspection reports, which we did, on the homes that were used to determine the fee schedule. Almost all of them had very serious violations of the code. Yet in 20 years, the department of public health has not evaluated violations so that there is some legal basis for determining what is a bad violation, what is a minor violation. The point at which it is decided to force the home in compliance is an interesting one, because it has to be entirely subjective. If you

bring a revocation proceeding—a very small number because of the complexity of the code—it will require years of so-called voluntary partnership between the department and the operator, and then the case goes to court and drags on. For 3 or 4 years the inspection reports will list the same violations reported by the same inspector under the same section of the code. If the department obtains a revocation, it will often reissue a license to a relative of the original owner.

In establishing the rate it was assumed that the historical pattern of the industry would contine. But the passage of the Kerr-Mills virtually guaranteed a tremendous expansion construction of nursing homes.

Few loans for construction are made through FHA. We have been told—you need a battery of lawyers to get through the Federal bureaucracy. But you can get a private loan from a bank relatively quickly. For several years nursing homes were considered a better investment than bowling alleys until the problems arose with the rates. There is a great turnover in ownership and personnel in nursing homes. Many operators are very conscientious, but I doubt if any of them could really run a good program under the handicaps that have been placed in their path. Partly it is our fault, and partly it is the Federal law which does not insist on a standard. When we set the rate in the State, we set it without any relationship whatsoever to the quality or scope of the service available in the particular home. The county welfare medical-social review teams serve as a kind of a human computer. Most of the caseworker's time seems to be spent in determining eligibility and persuading people to be placed in the cheapest bed. There is great variation from county to county on the type of resources.

A frequent violation is medication being administered by an untrained person without a physician's signed order. I have been in homes where I have found patients in drug stupors. The medical chart indicates the doctor hasn't been around for 4 or 5 months and hasn't ordered medication or hasn't changed it for a long time. Sometimes dietary orders and diagnosis are not in the charts.

I believe it was the intention of the industry to upgrade itself. Kerr-Mills was a historical point when it would have been possible, but at that point the rates were frozen. What we have now in many instances are very glossy and well-constructed institutions, but nobody pays much attention to the program of care in them; nor is it easily explained why nursing homes should be almost exclusively for the aged. Convalescent homes or nursing homes can provide chronic or convalescent care. Why are not other classes of patients treated in them?

Prepayment plans have been noticeably unenthusiastic about paying benefits in nursing homes. I don't believe that this is entirely the result of the industry's low standards. I think that it also comes out of cultural attitudes and public policy. In California the department of public health is in charge of standards. They are the legal agency. Social welfare administers this program, but the counties actually carry it out. There is no consistency of standards or services from county to county. The department of finance will authorize payments for certain services but not for others. I think I have given you a somewhat different picture than that of earlier witnesses.

One of the problems we feel is a very serious one is that under the present code public health is virtually powerless to enforce. If a case is finally brought to court, which eventually will be required because revoking a license is the only real disciplinary tool the department has, then the attorney general's office gets on it and they go through the whole process again. If you have ever been in some of these places you wonder on what moral ground the Government can be paying out money for this kind of care. Accreditation, which is a voluntary thing, has been essentially ceremonial. It has had little or no effect on upgrading care.

At one of our hearings we asked public health, "What can we do to straighten out the statute, which will enable you to enforce it?" They gave us a report which came out for the status quo.

Our bureaucratic problems almost force people to violate one or another section of the code. By law the doctor prescribes medication; the nursing home operator must follow his order. When she sends in the bill to the county welfare department she may get back a letter saying the particular drug is not in the social welfare formulary and the drug bill will not be paid.

The operator has no choice but to fill the prescription. The doctor is free to write any prescription he wants to. There are 20,000 practitioners in California, many of whom have elderly patients in nursing homes. Doctors are notoriously individualists, and this formulary could work perhaps in a Navy hospital or in an organized group practice, but you can't force individual physicians to follow the formulary. This is one type of problem.

We had a physician-owner testify that she accepted an MAA patient the first week of the month. At the end of the month she submitted a bill to the county welfare department. This happened to be in Los Angeles County. She got back a letter saying that the patient's family had cashed the OAS form that month and they could not pay two bills in the same month. Her position was that she accepted the patient in good faith from the county as an MAA patient; why should she provide almost a month's service without being reimbursed?

So the county welfare had a hearing. There was sworn testimony and her appeal was rejected. She appealed to the State board of welfare which also had a hearing. By now the amount of money that was spent on staff time was six times what the bill was. We asked what the outcome was and she said, "I don't know. That was 8 months ago. We haven't heard yet."

We traced this thing and, 2 months after the hearing, we got a letter from the director of welfare telling us that they were working on it; as soon as they got some information they would let us know.

Just about 3 weeks ago we got another letter saying there was no record of any correspondence whatever but that the county welfare department informed them they scrutinized the bills very closely because of an apparent overutilization of drugs in the facility because the physician owned a pharmacy on the premises. There is no pharmacy on the premises. We have many problems.

Senator Moss. Obviously, you do; and you have related a good many of them. I am very happy to have you come and present some of the findings that you have made to indicate there are some very real areas that need scrutiny and need some corrective action.

You mentioned the great deficiency of not having the care geared to the needs of the patient. The type of care he gets depends pretty much on where he got started in the system.

Mrs. McCALL. Where he ends up—whether in a nursing home or mental hopsital—depends on the policies of the particular county.

Senator Moss. The county of origin, and how he gets started in it, and the fact that the agency setting the standard is not the one controlling the rates to be paid.

Mrs. McCALL. Even more than that: Public health sets the construction standard, and they spend a lot of their time rewriting standards. For instance, storage space for patients is one such thing. The operators protest that they have an excessive amount of square footage, which added a lot on construction costs. Later it was decided this was true. But once you have this amount, you see, it builds in a cost factor, and the home must meet these standards in order to get a license. Once they open they find they can't break even because of rates. Public health says, "We don't have anything to do with rates. The department of finance sets all these rates." Between the three agencies, the ball keeps bouncing back and forth. We find it very difficult to pin down responsibility.

Senator Moss. Did you find any of this under-the-table payment business we were talking about earlier?

Mrs. McCALL. Yes. We have testimony from a member of the Los Angeles County Nursing Homes Association. This county has a very serious problem because of the county policy in administration of the MAA program. I do think that the operators have very legitimate and serious grievances. He testified that he thought it was about 25 percent. We have heard private estimates that make it almost universal. The effect of this has been, we think, a very unforunate one. We haven't done very much about publicizing this because we feel that other problems are so serious in the administration of this program that this is a minor one compared to some of the major problems of care. But the effects of this has been a very noticeable system of discrimination in the placement of nursing home patients, particularly in this county. I can get to a nurse's station and I can tell you a great deal about the social and economic background of the patient population in a particular institution. There is discrimination by race, although it is against regulations. There is discrimination by economic class, by education, cultural groups. The older and more decrepit the home is, the more likely you find it caters exclusively to working class people, blue-collar and minority groups. I have had operators tell me very candidly that they will not accept patients except on a set of private criteria, and that they couldn't without losing the rest of their patient population.

We asked, "Why should we have one system for the poor and one for everybody else? You couldn't do it in public education, but we seem to allow it in the treatment of sick people."

Senator Moss. On the other end of the spectrum, is there any sort of inducement to place patients in certain homes, any kind of kickbacks or anything of that sort?

Mrs. McCALL. We have heard testimony to this effect. However, it would be very hard to prove. But there is agitation always on the part of the industry to allow supplementation.

Now, I might see it as a possibility in the States which have very low payments, but our payments are quite high. I don't think that just raising the rates will automatically solve any of the problems unless we tie those rates to a specific set of standards and, unless you do that, you can triple the rate and nothing will change. As a matter of fact, if we go back over the history of the institutions, you find that the cost of care has risen quite a bit over the last 10 years. But I don't think that the standards of care have changed.

We keep going on about how we don't want luxury and only want to pay for medical services. But a chronic unit essentially is a social unit. You are going to have people living there for years and you have to provide them with services you would have in a community, especially recreation.

We also have found to our great astonishment that the construction cost of the most expensive private bed in the State is a third to a half of the most expensive Government bed which is of the dormitory type.

I believe that you asked a question about the labor turnover. It depends greatly on the institution but, in the State mental hospital, about 80 percent of new employees turn over within 6 months. Very few of them finish out the year. High labor turnover is also the case with the kind of unprofessional nursing personnel who provide the bulk of the care in nursing homes.

The department of public health estimates that about half the labor force in nursing homes turns over every 6 months. Most aids are at the minimum wage. Mainly you get people who do not have career choices. They can't work someplace else for more money because they are too unskilled.

You also have the problem of lack of supervision so, if there is any fudging on prescriptions or narcotics or sedatives or tranquilizers, it would be almost impossible to trace this back. I think if I were an addict I would go work in a nursing home.

Senator Moss. Thank you very much.

We have one question here. Mr. Frantz?

Mr. FRANTZ. I just wanted to ask you one thing: The health department has a regular inspection. Apparently, according to the earlier testimony, they do not find on any widespread basis the violations such as the unqualified person administering medication. You appear to have found a different situation. I wonder how you——

Mrs. MCCALL. When we began our investigation there was a lot of protesting from the industry that the homes that were used in the cost survey were not representative of the industry, but they couldn't get any information about the particular ones used in the cost survey.

I asked the department of public health for the hospital inspection report on surveyed homes. Almost all were in violation of the code. Later public health testified before our committee that more than two-thirds of all homes were in violation of some section of the code.

From my own examination of the inspection reports, this is a very, very common situation.

Patients receive all kinds of medication for which there are no doctors' orders. Many of these patients are placed by the county hospital, and while they must have a physician, it is kind of hard to get one. I have sat with operators when they have phoned around a community just trying to get a doctor to come when they thought a patient was exceedingly ill and needed to be seen. It is not easy.

Mr. CONSTANTINE. In Indiana and Ohio the State fire marshals told us the majority of nursing homes in their States posed serious fire hazards. We don't have anyone from the fire marshal's office or the equivalent here today. Do you have any information as to the extent of fire hazard?

Mrs. MCCALL. Yes. Immediately after that last big Ohio fire the fire marshal sent down a notice to all local fire departments pointing out that many of the homes in the State have the same kind of conditions that apparently led to the fires in the other States, and would they please check these out. We have been lucky. We did have a fire recently, but it was not a public health facility; it was a rest home type of facility. But I think it is just a matter of luck. There are many violations. These are locally administered things. It would be hard to pin it down. You have to look at the places if you want to see how these people really are living.

There is one other thing I think we need to remember—the tremendous effort required to adapt to living in a group facility. There is a tremendous shock from the transfer from civilian life to Army life simply because a lot of the freedoms one takes for granted are stripped away. This is true in institutional life generally. You get old people who, up to this point, have lived alone or with their families, and now they are in impersonal surroundings. One of the things I found particularly awful in the Los Angeles County hospital I visited—which has an excellent rehabilitation program—was that I happened to be there around 5 o'clock in the afternoon and they were serving dinner. On every one of the beds was a bedpan, and I asked this nurse "How would you like to eat with this thing staring you in the face?" Apparently it never crossed anybody's mind that this practice is not conducive to maintaining dignity. There are many such practices. Talking about old people as if they weren't in the room or couldn't hear you. I would have nursing personnel tell me this person is senile and then would find the patient could carry on long conversations. They had opinions about the cold war and the elections; they knew what was going on outside. Apparently I was the first one who had spoken to some of them in the many months they had been in the institution.

In practice, we have created a system which makes it impossible to treat aged people as people; we remove them from life. Social workers refer to nursing homes as premortuaries, which reflects the attitude of the so-called professional toward this segment of the population.

Senator Moss. Thank you very much, Mrs. McCall. You have given us a lot to think about and quite a bit for our record.

We will now recess for 1 hour, and then resume our hearing.

(Thereupon, at 1 p.m., the subcommittee recessed to reconvene at 2 p.m. of the same day.)

AFTERNOON SESSION

Senator Moss. The subcommittee will resume the hearing.

We didn't quite finish on the list of witnesses we had this morning, so we are going to finish with them first. We appreciate the very fine record that we are making here. We have had some outstanding testimony, and we look forward to it this afternoon. We are going to

have to move along with some dispatch in order to hear all of the witnesses we have invited and who have come here to help us, and we do want to get all of this in the record.

As the witnesses are called, if you would prefer to do it, we can place your full statement in the record, and then have comments about it; however, that is for the election of the witness. If he would prefer to read it, certainly it is privilege to do so, but I say that simply to help us facilitate getting the record made this afternoon in the time that we have left.

Mr. Grant Cattaneo, the executive director of the Hospital Planning Association of Southern California, will be our next witness.

Mr. Cattaneo, we are very glad to have you.

STATEMENT OF E. GRANT CATTANEO, EXECUTIVE DIRECTOR, HOSPITAL PLANNING ASSOCIATION OF SOUTHERN CALIFORNIA

Mr. CATTANEO. I will elect to comment on the report which we have provided you.

(Prepared statement of E. Grant Cattaneo, executive director, Hospital Planning Association of Southern California:)

The problems of provision of adequate health care for the growing aged population in the United States has been given considerable attention in recent years. The social and economic problems created in part, by a longer average life expectancy, have become an issue of the first magnitude, demanding concern and action at the local, State, and National levels.

The Hospital Planning Association of Southern California, a voluntary nonprofit regional health planning agency, is deeply concerned with the problem of assuring that the elder citizens of its region are provided the appropriate number of facilities and services they need. The planning association's area of concern is the six counties of Santa Barbara, Ventura, Los Angeles, Orange, Riverside, and San Bernardino. This area covers approximately 37,000 square miles, with a present population of about 9.4 million.

Certain general characteristics of the aged should be summarized as a matter of introduction to the problem of providing care for the aged:

1. *The number of persons aged 65 years or older continues to increase.*—At the present time in the United States it is estimated that there are approximately 17.6 million persons 65 years of age or older and it is expected that this population group will increase to 19.6 million by 1970, and 25 million by 1985. This year in California it is estimated that there will be 1.5 million persons 65 years of age or older, and that by 1970 there will be 1.8 million, by 1975 there will be 2.1 million, and by 1980 there will be 2.4 million. (1) Although the future size of the aged population is dependent to some extent upon the future course of death rates, the expected increase is due mainly to past increases in the number of births. It will not be until after 1985 that the decline of the number of births during the 1920's and 1930's will affect the size of this age group. (2)

2. *Major concentration of older persons is in the urban areas.*—It is generally accepted that the metropolitan or urban areas have a higher percent of persons aged 65 years or older. Here in southern California the 1960 census generally supports this factor. It is interesting to note that the migrants to our six-county region are responsible for a higher percentage of population growth in the suburbs or periphery adjacent to the older communities. As an example, Los Angeles County experiences a smaller percentage of migrant population than the other five counties. The importance of recognizing the percentage of migrants to the total population increase becomes evident when we realize that the migrants' or newcomers' median age is less than that of the statewide average. It has been expressed by many that there is a great influx of senior citizens to California, which is not so; as the male migrant's median age is 23, compared to the State's 29, and for the female migrant, a median age of 22, compared to the State's 31. (3)

3. *The incidence of chronic illness increases with age.*—Persons aged 65 years or over are afflicted with twice as many chronic conditions as those under age 65, with approximately 80 percent having one or more chronic conditions. (4) Furthermore, over 45 percent have some limitation of activity, and 15.5 percent are unable to carry on any major activity, referring to their ability to work or to keep house. (5)

4. *The cost of long-term care poses a problem to the aged.*—Proportionately more of the population aged 65 years or more have low income, high medical expenses, and low insurance protection. While needing more home care, or institutional care, the majority of the aged have inflation-prone fixed incomes or less family support. The most recent consumer income data, as compiled by the U.S. Department of Commerce, cövering all persons 14 years of age or over, reveals that 84.3 percent of those persons aged 65 years or more have total incomes from all sources averaging under $2,000 per year. (6)

5. *Estimating long-term care bed needs for the aged.*—One of the difficulties in arriving at acceptable estimates of present, as well as future, needs for long-term care beds and services is the doubtful value of current utilization trends as a reliable indicator. Unquestionably, utilization of long-term care facilities and services is directly related to the ability to pay for the service. The possibility of funds being made available to subsidize the health care of the aged could change the demand for services dramatically. Similarly, the occupancy of acute-care beds in general hospitals by persons with long-term care illness and for convalescence could be changed if sufficient and adequate long-term care facilities were made an adjunct of the general hospital and accompanied by liberalization of insurance and prepayment coverage for the service. Further, the development of organized home care programs and other programs designed to permit the elderly to remain in their homes while receiving adequate care could alter the need for inpatient facilities and services.

Now to some of the specific problems we in planning see as it relates to the provision of health care by long-term care facilities for the aged. The planning association has been in close liaison with the various nursing home, sanitarium, convalescent home, and convalarium associations, so that we may better understand their problems of providing care for the aged. I might also mention that much of the data that we gather and analyze is provided by the Bureau of Hospitals, California State Department of Public Health, the agency responsible for licensing the largest segment of health facilities in California providing health care to the aged. We in planning have a concern that unnecessary, duplicative, poorly planned, and badly situated long-term care facilities will actually increase the cost of medical care and probably decrease the potential of providing the high level of care. This level of care may be defined in terms of the quality of skills pooled to provide given services, as well as the quantity of the services available. It is generally agreed that there is a shortage of skilled medical and paramedical personnel which reduces the potential of providing high quality of care in a community. Planning cannot concern itself with only the development of facilities and services without recognizing its responsibility to help insure that once a facility is created it is properly staffed. I think then all levels of governmental and nongovernmental agencies with health planning must recognize their role as conservationists.

Over the past 6 months we have had an opportunity to analyze the growth of long-term care facilities as it relates to the present use of such facilities. Table I indicates the level of occupancy and the average length of stay of patients in long-term care facilities licensed by the Bureau of Hospitals, California State Department of Public Health, in our six-county region, the past 5 years. The material is still incomplete for the calendar year 1965, but due to the number of beds reporting—69 percent—I think we may make tentative statements regarding what's happening and possibly provide some suggestions in the area of need, services, and pending legislative programs. As you note from table I, we have separated long-term care beds into two categories: private facilities and county facilities.

The following items appear to be the major problem areas which will require further exploration:

1. *Level of occupancy.*—Level of occupancy or utilization in the private facilities for the past 5 years has ranged from approximately 67 to 78 percent. The Bureau of Hospitals, California State Department of Public Health, professionals in the long-term-care field, and our organization, have recommended for the past few years an occupancy figure of 90 percent which appears very prac-

tical. The occupancy which is less than 90 percent simply means an increase in the cost of medical care and/or the reduction in the potential of providing a high level of service. For example, administrators of long-term-care facilities generally agree that an unoccupied bed represents somewhere in the neighborhood of $500 to $700 just to maintain on an annual basis. We can readily see that if this is multiplied by the number of unoccupied beds (estimated to be 6,300) throughout our 6-county region, this represents a large amount of operating costs being passed on to the patient, and to the third-party payer. This, coupled with the construction costs of unneeded beds, represents a luxury which I think the public should not have to support. The county facilities appear to be utilized more efficiently than the private facilities, probably due to the fact that the county facilities have increased very little in size over the past 5 years.

2. *New long-term-care facilities.*—Not shown in table I, I think important, is that in 1964, of the reporting long-term-care facilities, 29 were open less than 1 year, and experienced an average occupancy of 45 percent. The 29 facilities were open on the average of 166 days or just under one-half a year.

If, however, these 29 facilities had not opened, and if the existing facilities were appropriately located to serve the same patients that the new facilities served, the existing facilities would have experienced an annual occupancy of 83 percent. The problem of low occupancy, coupled with an increase in the average length of stay in private facilities (indicated in table I), raises a question in my mind as what, if any, type of services other than custodial care is being rendered these patients.

I would be remiss if I did not express our concern in the anticipated growth of additional long-term-care beds. As of November 1, 1964, an additional 20,000 beds in 1,320 separate construction projects are proposed for the Hospital Planning Association's 6-county region. Much of this proposed construction appears to be stimulated by the pending medicare legislation.

3. *Level of service.*—The quantity and quality of service provided in the long-term-care facilities may have a direct relationship to the economic level and use of these facilities. As I mentioned earlier, provision of health care in an efficient system must pool many elements, particularly skilled personnel and equipment. It would seem logical that fewer but larger facilities could more efficiently use skilled personnel and equipment rather than have these elements dissipated throughout a large number of health facilities. Several surveys have been conducted both by State and voluntary agencies in California which have indicated shortages of skilled personnel, particularly registered nurses and licensed vocational, or practical nurses.

I have gone a long way around to arrive at the point of providing constructive suggestions to some complex problems. I am impressed with much of the present philosophy behind the pending medicare legislation, particularly in regards to posthospital services. I think we are finally going to see a moving sidewalk of medical care; that is, the patient, according to the degree of illness, will move from the general short-term hospital, to an extended care facility, to a home care program, and outpatient clinics. Mr. Arthurs E. Hess, Director, Division of Disability Operations, Social Security Administration, and possible administrator of the medicare program, earlier this month stated, "that the proposed program (medicare) is not intended to cover services provided in conventional nursing homes which are principally oriented to long-term custodial care." (7)

Mr. Hess' statement indicates the emphasis which is going to be placed on the level or quality of service. The point to be made here is that we may not possibly need more long-term-care beds, but a higher level of service and that the Federal and State Government should aline its construction supporting programs to not work in disharmony with this quality of service concept.

The Federal Government, through the Hill-Harris program, Small Business Administration, and the Federal Housing Administration provides support for the development of health facilities. In the case of the Hill-Harris program, the States have developed a priority of need for construction of projects. SBA and FHA, although cognizant of the concept of need, can nevertheless provide financial assistance contrary to the various State plans developed under the Hill-Harris program. These programs should further emphasize an adequate number of services which should be part of the construction projects. Services such as rehabilitation, outpatients' services, and home care programs, need bases of operation to be effective in keeping the aged population out of beds, particularly custodial.

We in voluntary planning, desire to be more closely involved in advising government as to the needs of local communities. There are presently over 40 voluntary regional health facility and service planning programs throughout the United States. The voluntary planning programs have the participation of respected community leaders, and thus these planning groups are probably the most appropriate, nonpartisan sounding boards government could utilize.

TABLE I.—*Utilization of long-term-care facilities in the Hospital Planning Association's region,*[1] *1960–64*

	Percent of beds reporting	Percent of occupancy	Average length of stay (days)
Private facilities:			
1960	94	68	170
1961	100	72	173
1962	100	78	149
1963	78	67	150
1964	69	75	177
County facilities:			
1960	88	95	179
1961	100	90	365
1962	100	82	290
1963	84	92	167
1964	0	0	(2)

[1] 6 counties: Santa Barbara, Ventura, Los Angeles, Orange, Riverside, and San Bernardino.
[2] Unknown.

Source: California State Department of Public Health, and Hospital Planning Association.

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Mr. CATTANEO. There has been so much said, that I think much of what I have to say is a tie-in and, where I think it is repetitious, I will exclude it.

I would wish to comment, first of all, that the Hospital Planning Association of Southern California is one of the seven voluntary planning programs which Mr. John Derry mentioned are active in California.

We are rather new in the area. Some of us are 2 to 2½ years old. We have had some success, and we are gaining more strength as we go ahead in involving ourselves in the programs.

The particular area we are concerned with here in California is what we call the southern California hospital planning region. It consists of Santa Barbara, Los Angeles, Orange, San Bernardino, Riverside, and Ventura Counties. This is an area of about 37,000 square miles and presently about 9.4 million people are living in this same area.

I would just like to briefly go over a few of the key points of my written statement. I would like to mention some of the overall problems of health care for the aged and then speak specifically about a few problems that we see in our six-county region. I want to emphasize the six counties in which we operate do not necessarily reflect the State of California and certainly not the Nation.

Senator Moss. Are you a public body? Just what is this planning association?

Mr. CATTANEO. No, sir; we are a nonprofit voluntary organization. There are some 40 organizations scattered throughout the United States. Most of them have been created in the last 2 to 3 years and have had the support of the U.S. Public Health Service.

Most of the planning programs were originally started with the help of the Public Health Service under grants. Now, most of the planning groups are becoming supported by business and industry within the particular geographical areas that they work.

Most of the organizations, as Mr. Derry commented—and I will have to speak mainly to ours and the other six organizations in California—have a balance of consumers as well as the medical profession and the health facility profession. We have committees which are strictly voluntary, serviced by respected citizens within the various communities in which we operate. This is true throughout California. We have about 175 different private citizens organized into this planning effort. There is a small professional staff to support these private citizens who are working and trying to encourage the proper utilization of health facilities and the proper location and size at the right time.

Senator Moss. That clarifies it and I am glad to have that in the record.

Mr. CATTANEO. Fine. Again, I was just going to go over a couple of elements of what I felt to be some of the general problems in health care for the aged.

The number of persons aged 65 years or older continues to increase here in California, and this is difficult to break down in terms of counties, at this time. I will explain a little bit of the reason.

California is faced with a higher migration problem than probably most of the States in the United States but this year in California it is estimated that there will be 1.5 million persons 65 years of age or older and that, by 1970, 1.8; 1975, 2.1; by 1980, 2.4, so we are talking about a rather large number.

The elder citizen seems to concentrate generally in the urban areas. Just as an example, the percentage of migrants to California differs by counties, and the older, well-established counties seem to take in a smaller percentage of migrants; while it has been expressed by many, that California probably has a large influx of elderly citizens due to the sunshine and the beautiful weather, not to mention the smog, this isn't true.

In several studies, one done by the Department of Motor Vehicles of the State of California, over 100,000 people were interviewed. The male migrant's median age was 23, which compares to the State average of 29. The female migrant median age was 22 as compared to the State's average of 31. So I think the importance here is that if we do experience a great amount of increase in migrant population—this is net migration into California, and it is generally young, and it has generally gone into the younger areas—then we can assume that the urban, the older, well-established communities are the ones that we are going to find the greater percentage of elderly people that are going to need health care.

The incidence of chronic illness increases with age, and there are many references on this in the Department of Health, Education, and Welfare. These are in my statement so I don't believe that it is necessary to go over them unless there are any questions.

The cost of long-term care poses a problem to the aged. This has been well covered this morning, as well as there is some documentation in this area, and I refer to my written statement which has a bibliography on the last page, which will provide the source documents for the statements I have presented in the written testimony.

One point I would like to cover is that the most recent consumer income data is compiled by the U.S. Department of Commerce, covering all persons 14 years of age or over, reveals that 84.3 percent of those persons aged 65 years or more have total incomes from all sources averaging under $2,000 per year. This is just to emphasize the problem of the individual providing his own medical care after the age of 65.

Briefly, to estimate some of the problems in determining how many types of facilities and numbers of beds in the care of the aged, I am not so sure that we can always be completely satisfied with measuring on our present utilization.

With some pending legislation now before Congress, we may not be guessing correctly at that.

Also, with different types of programs being envisioned, you might find the acute hospital picking up some more long-term care beds as opposed to finding them created in separate freestanding entities. This may change in the utilization of freestanding private long-term care facilities.

We also may find a different method of payment which would encourage the flow of patients from acute hospitals even more rapidly than we may see now into other facilities which are designed to meet a certain level of care, depending on the degree of illness of the patient.

We in planning have a concern that unnecessary and duplicative poorly planned, and badly situated long-term care facilities will actually increase the cost of medical care. I think coupled with this is that the cost of medical care probably decreases the potential of providing a high level of care. These are interrelated, and I think it should always be remembered that money speaks, and it does in terms of quality of care. There are two reasons: One. If a facility is not meeting its economic level, it has a difficult time providing services which are costly. But second of all, through the dissipation of facilities where maybe one or two would actually be appropriate and could be large enough to provide a reasonable level of service, there is a

shortage of skilled personnel, and maybe equipment. This is related again to economics.

Planning itself cannot only concern itself with the development of facilities and services without recognizing its responsibility to insure that there is an adequate staff to render the service in particular facilities.

In our planning organization we don't feel ourselves restricted to brick-and-mortar planners. I think we all look upon ourselves more as conservationists. I think health care is somewhat of a personal thing and requires a pooling of various personnel and equipment, those personnel that have a particular skill.

Many studies have been accomplished here in California. We have been involved in several where we have tried to inventory the number of personnel and facilities, and also to inventory the shortage of certain skills in hospitals and related health facilities. We have found that universally the cry is for registered nurses and licensed vocational nurses, or in some States they are referred to as practical nurses.

I think previous testimony this morning referred several times to the shortage of personnel, and although there may be some reports in the bureau of hospitals with a little tick on one side, not having a registered nurse, this isn't always the operator's fault, because there just aren't enough skilled nurses and licensed vocational nurses to go around.

I would like to refer to table I, which is the next to the last page of my written statement. The material that we have developed here has to do with the nursing homes—or should I say long-term care beds. These are the beds licensed by the bureau of hospitals, and I think Mr. Cole pointed out quite well that there is a difference. The bureau of hospitals licenses long-term care beds that provide medical care. The department of social welfare licenses long-term care beds that do not provide medical care.

On table I, then, we presented the private long-term care facilities, and also the county facility long-term care units in our six-county region.

I would like to go over just briefly the level of occupancy. You may note that from 1960 to 1964 in the private category we have gone from 68 in 1960, 72, 78, down to 67, and right now, 1964, with incomplete data—75-percent occupancy. So the level of occupancy is low in terms of bureau of hospitals' recommendations of 90 percent as a reasonable occupancy for these facilities.

Many administrators of nursing homes in our area—and we have done some confirmation about this figure with various local lending institutions in southern California—are in a general agreement, that in a private nursing home category, the cost of maintaining an unoccupied bed on an annual basis represents somewhere between $500 and $700 per year.

Looking at our occupancy figure on the number of licensed beds reporting on our six-county region, which is only 68 percent, but I think a fair representation of what we might expect if the whole 100 percent reported, it is 75-percent occupancy.

We are going to have about 6,300 beds available in our six-county region if this 75 percent holds. If each one of those costs between $500 and $700, just to maintain, just to sit there, just to pay back the 20-

year obligation they have on that bed, plus some of the maintenance and some of the personnel who could probably be spread over that bed, we'll have quite a bit of operating costs passed on to the consumer or the horizontal consumer (the patient) or the third party payer. Somebody is picking up the tab for this unused bed. This, coupled with construction costs of unneeded beds, will again represent a luxury which I don't think the public is going to stand for too much longer and I don't think the agencies, Government, and so forth, will; in fact, everyone is showing concern in this area.

Some mention of new-long-term care facilities I think might be of interest. In table I, we didn't bring this out, but I think you will begin to see why table I is a good reference.

For the year 1964 there were 29 facilities in our six-county region, so far reported, that were not open the full year of 1964. They averaged in length about 166 days of being open, or just under one-half a year, and they ran a 45-percent occupancy.

You can do a little quick juggling here. If those facilities did not open and there were facilities properly located, and assuming the ones that are already existing were properly located and could have served the same group of patients these 29 facilities had, we would have had an 83-percent occupancy, not a 75. I think there are some other questions that may be asked here.

We have seen some pretty pro forma statements put out by proponents about how fast they were going to increase their utilization on a 1-year span. Again, talking to lending institutions, they have begun to realize some of these facilities are going on a long shakedown cruise. There is a long lag before new facilities pick up a sufficient volume of occupancy to meet their payments. So there is going to be a need for an increase in operating capital to carry them over this long, dry spell, so to speak.

The other question which I raise and point to table I, is that because some of the area is experiencing an occupancy less than what many people feel to be a practical level, from 1963 to 1964 in the private category the average length of stay of patients jumped from 150 to 177 or 27 days longer in a long-term care facility.

I am beginning to wonder what, if any, type of services other than custodial may be given in some of the facilities. Now, I am not going to generalize too greatly because this has a lot to do with, if these facilities are also doing a good job, they are actually keeping people alive longer, so there is a paradox here. We just can't say because the average length of stay rose that people are giving less care and just keeping them in the facility. We can say because they are giving them care they are keeping them alive longer, and therefore, certainly, they are going to be around longer in some of these facilities.

One other thing I think which might be important in the new or additional facility paragraph that I am referring to is that as of November 1, 1964, an additional 20,000 beds or about 1,320 separate projects are being proposed in our six-county region. We have roughly 18,000 nursing home beds now in our six-county region. But there is some speculation here evidently of increasing it to more than double or 40,000 beds.

The level of service in long-term care facilities deserves some comment. It seems to me it would be logical, that fewer but larger facili-

ties could more efficiently use the short supply of skilled personnel and equipment. I think Mr. Derry has pointed this out. There seems to be a trend in the size of nursing homes increasing over the past 5 years. I think this is healthy in terms of utilizing personnel more efficiently.

I am given some broad ideas and a few specific problems we see and hear in southern California. I would like to comment about some possible areas of exploration. I am impressed, first of all, with much of the philosophy behind the present medicare legislation being proposed at this time in Congress. I think we are finally going to see a moving sidewalk of medical care, that is, the patient according to the degree of illness is going to be treated in an acute hospital or long-term care facility or be on a home care program or receive diagnosis and treatment on the outside through outpatient clinics, and the medical practitioner's office.

I think the philosophy that is beginning to be expressed in this medicare legislation is healthy in terms of developing this movement. I think there should be some movement, but according to the degree of illness. Mr. Arthur E. Hess, Social Security Administration, and the possible administrator of the medicare, earlier this month stated, and I quote—

that the proposed program—

and this is medicare—

is not intended to cover services provided in conventional nursing homes, which are principally oriented to long-term custodial care.

So there is quite a bit of recognition in your level already of some of the problems.

Mr. Hess' statement indicates, I think, an emphasis in beginning to describe the level of care, the quality of care, in terms of insuring that there are adequate services available and that we somehow divorce ourselves from just counting numbers of beds or back to the brick and mortar.

The Federal Government through the Hill-Harris program, Small Business Administration, and the Federal Housing Administration, provides support for the development of health facilities. In the case of the Hill-Harris program, any support comes through the States and their local Hill-Burton health facility construction programs that are operated normally by the State departments of public health.

They develop pretty much an objective method of distributing these funds, and have set it out on a priority basis with estimated bed needs. I think this is a very good way of doing it.

The Small Business Administration and the Federal Housing Autority, although cognizant of this concept of need—and someone asked the question, the certificate of need—both organizations do contact the Bureau of Hospitals on this certificate of need, but it isn't spelled out that they have to follow it, and in some cases they have contradicted what the State plan said in awarding support for particular health facilities.

I think then there has to be better coordination so that all governmental agencies that are disbursing moneys get together. I realize the Federal Housing Administration doesn't give money, but it helps to insure that that money will be available if things go bad. I think

it would be nice if we could get some coordination in these areas where they would all be in harmony rather than disharmony in terms of the development of health facilities. We in voluntary planning—and I think I can speak for probably the 40 planning groups in the United States—desire to be more closely involved in advising government at any level from the local community. We have something, I think, that very few other organizations have to offer. We have the cooperation and participation of individuals within the local community.

It would seem to me that we could serve many agencies as a good sounding board for finding out what does the community feel it needs in its local area.

That is all I have, unless there are some questions.

Senator Moss. Well, thank you, Mr. Cattaneo. This is a very good presentation. Your statement as it is typewritten will appear in full with the commentary that you have given us on it.

Does your association simply push planning and make it available on a take it or leave it basis to those getting into the field?

Mr. CATTANEO. I thought you would never ask. This is a question that is universally asked, and I think every planning group probably has a little different answer. When we first started we thought the ivory tower approach was all that was needed. You just publish a lot of data and people will believe you. We found out you can publish a lot of data, and a good example here in Los Angeles County happened in 1947, when the county board of supervisors raised $82,500, had a group of hospital consultants do a master plan—it was accomplished and quickly filed on the shelf. Well, we tried that method, too, developing a lot of data, and it didn't sell. We have about 175 citizens that are intimately involved in local committees scattered throughout our six-county region. They represent lawyers, doctors, and consumers. Based on the data we have generated, they began to talk to the lending institution. People are asking us for recommendations. We have no control whatsoever. We are strictly advisory. But city councils, city planning commissions, boards of supervisors are beginning to pick up the ball and show some interest in terms of understanding that health problems must be looked at in terms of community planning. The city councils and planning commissions have been historically involved with land use—if the curbing is there and the lightpost is there, that's fine. Now they are beginning to ask the question, Is there a need for the type of health facility, and is it in the best interests of the community?

The lending institutions are beginning to ask the question of need. A few of them have gotten burned on health facility projects, not necessarily projects for the aged—we have some acute hospitals that have represented some real financial problems to banks and lending institutions. Health facilities are pretty much single-purpose entities. Banks aren't too happy about trying to operate a hospital.

When these various interests begin to listen to the recommendations of a community planning group, then things begin to happen and we do get the job done. Our planning group had no idea that we had an ally in local government, nor did we realize we also had an ally in the financial interests.

Senator Moss. Thank you. That does answer it, and I am glad to have you take us through those steps.

In your planning have you come to any conclusion about the ideal size, the optimum size of a nursing home?

Mr. CATTANEO. No, we haven't, We are in the same predicament that the bureau of hospitals is. I might add that I never see an arbitrary minimum and maximum for a State. We are going to have to talk about the areas because certain areas cannot support a certain size hospital or nursing home, and in other areas it would be injurious to the community in terms of economics and level of care if we gave them something less than a recommended minimum size for a nursing home or even an acute hospital.

Also, you must measure sometimes the characteristics of the area. We are fortunate or maybe unfortunate in talking about our six-county region. We have got some counties that are entirely different in terms of characteristics. I refer to Riverside and San Bernardino Counties, which are rather small in population, and they haven't really developed into this megalopolis that we have in Los Angeles County and Orange County. They have small, isolated communities.

We found it of interest that each community, with the exception of one in Riverside County, having a nursing home, serves the people within their community.

I would say that generally there should probably be some guidelines for developing the minimum.

The bureau of hospitals has indicated 26 beds is a minimum size for long-term care facilities, with some qualification that if a particular area has a problem and can't meet that there might be something less than that.

If it is a little community out in Riverside, isolated from the area, yet in need of it, maybe it should be 20 beds or 15. It hasn't even happened in the acute hospital—people begin talking about the maximum. Everybody always likes to use maximums. When do you lose efficiency? I think there are some dramatic changes being looked at in terms of methodology and administrative efficiency, using computers and new machinery and business office equipment, which will help increase the maximum size of facilities which can efficiently operate. This maximum will have to be dependent upon its services and the type of people and the geography which it is going to serve. I look for no panacea of minimums or maximums at all.

Senator Moss. Thank you very much. I recognize what your answer is directed to, and obviously it is right. I was thinking more of how many patients you need in a nursing home to be able to provide the necessary specialized services such as a physical therapist, an RN on duty the clock around, occupational therapy, and so on. Obviously, you can't do that with 6 or 12 or maybe even 20. Maybe you need 75. Maybe you need 150. I don't know. I just wondered if you had any conclusions in that area.

Mr. CATTANEO. No, sir. I thought you were speaking of staffing ratios to occupied or unoccupied beds.

Senator Moss. Yes.

Mr. CATTANEO. I seem not to be answering your questions. I have no answer specifically to your question. I don't know what the proper ratio is.

We are dealing quite closely with many of the nursing associations here in southern California and the statewide organizations in discussing some of these problems, and there is some concern and general agreement that ratios by themselves don't measure quality or don't even measure the hoped-for services you are going to get, because a lot depends on the quality of personnel that you have. Sometimes it is dangerous to develop these types of ratios and then assume that they are right, because we tend sometimes if we think we have built a perfect system, we leave it alone and go over and tangle with another problem, and we might really have created one.

Senator Moss. We do appreciate your testimony. It was very fine.

I think we will move along now and have the next witness. Thank you.

Mr. CATTANEO. Thank you.

Senator Moss. Mr. Walker Gabbert, assistant chief underwriter, Los Angeles insuring office, Federal Housing Administration.

Will you come forward, Mr. Gabbert. We are pleased to have you, sir.

STATEMENT OF WALKER GABBERT, ASSISTANT CHIEF UNDERWRITER, LOS ANGELES INSURANCE OFFICE, FEDERAL HOUSING ADMINISTRATION

Mr. GABBERT. Senator Moss and members of the committee, I have not prepared any written statement to present, and my general statement will be very brief because I am sure you will have questions that will bring out what you are interested in knowing from us. But, first, the area that we serve with respect to processing loans under section 232 of the Housing Act, which is the nursing home facility should be defined. This is the southern California area, with the exception of San Diego and Imperial Counties.

Also, our facilities apparently fall somewhere in between—much that has been mentioned here. They are not per se housing for the elderly. They are not necessarily long-term care institutions. Based on the literature that is put out at our Washington headquarters, and presumably follows the intent of the Housing Act, they are to provide a service that is inbetween what can be done in the private home and the intense care that is needed in the hospital. Theoretically they are to serve the short-term convalescent type of case.

While we recognize the fact that in practically all of the institutions that we have financed, we have had some MAA patients, and that practically every nursing home apparently has a few, it is also obvious that it is simply not possible to conform to the standards that are set up for us to follow with respect to type of building, equipment, and so forth, and also, to the State of California standards, and provide services at the fees that are available from the typical MAA patient.

We attempt to administer an act, and we have not made any big splash in the field. We have five going nursing homes that have been in operation from just a few months to a little over a year. We have an additional three under construction, and we are processing applications for approximately five more. The total in all of them is just over a thousand beds.

Senator Moss. You say there are three under construction now?

Mr. GABBERT. Yes, sir.

Mr. FRANTZ. I was distracted for just a moment while you were speaking. You may have covered some of this; if so, I apologize. But for each of these applications that are presented to you, do you make a survey of the market for the facility that is proposed?

Mr. GABBERT. Yes.

Mr. FRANTZ. And within the immediate area where it is proposed?

Mr. GABBERT. Yes.

Mr. FRANTZ. Could you tell us what goes into that market survey, what factors you consider and how you ascertain them?

Mr. GABBERT. OK. To start with, the initial thing that comes to us is a certificate of need issued to the applicant by the State of California. That is a prerequisite before we even get into the picture. Then they submit to us a site on which they propose to erect a nursing home for x number of beds. We go into that community, survey what is there, attempt to ascertain to the best degree we can the approximate income level of the folks who live there. We check the site with relation to its convenience to existing hospitals and doctors' offices. We operate under the assumption that every patient in one of these nursing homes is going to be under the care of a physician and it will be at a competitive disadvantage if it is not conveniently located with respect to his office.

We attempt to analyze them from the standpoint of the type of institution they are developing with relation to the income of the community; for example, if you are in a low-income neighborhood—and many of these are and have to be—private rooms are not economically feasible, and things of that sort.

We consult with operating nursing homes in the area. We try and talk with doctors in the community and ascertain their feeling as to the need, whether or not this location appears to them to be a good one, and another check that we make is to try and find out how many other people may have already started on their way toward getting ready to build or actually have under construction a nursing home, because there is no limit on the certificates of need that are issued. Until such time as a new institution is actually licensed, a given community still needs beds, and, for instance, we have at the present time certificates of need issued to four or five people in the city of Santa Maria. Each one of those is a potential for the 82 beds that are certified as needed in Santa Maria at the present time. So we want to make sure before we approve and indicate that we are willing to insure a loan for this party that somebody else isn't already on the way to provide those beds.

Mr. FRANTZ. As a practical matter, can you determine that with assurance? Obviously, with respect to other applicants for FHA you could, but are you able to determine whether others with purely private sources of financing may be coming into it?

Mr. GABBERT. Not always, but usually you will run across it somewhere in talking with lending institutions or doctors or officials at the local hospital, things of that sort. Somebody will make the comment, "Such and such a firm was in here inquiring. They have got a site," and so forth. But once in a while we find that somebody else has started. We frequently have people who are unhappy with us when

we refuse to honor a certificate that has been issued to them because somebody else has already an institution underway.

Mr. FRANTZ. I believe Mr. Cattaneo said that certain of the nursing homes in his survey which were 6 months old had occupancy of around 45 percent. Is this a normal expectation, do you think? Have FHA homes had that same experience?

Mr. GABBERT. We base our calculations and our financial requirements on probably a year of deficit operation. But typically, with one exception, ours have achieved a sustaining occupancy in a shorter period of time. We have one in Ventura that had difficulty and is still having it, but we think primarily because on an adjacent site a high-rise building was being constructed, and the noise and dirt and everything else made it pretty unpleasant to be in the nursing home, but they are past the break-even point now.

Senator MOSS. Thank you very much, Mr. Gabbert. We appreciate that. We are glad to have you come and testify.

Miss Marie Zaremba, who is the director of the Central Registry of Adult Care Facilities, Department of Charities of Los Angeles County is with us.

It is nice of you to come.

STATEMENT OF MISS MARIE ZAREMBA, DIRECTOR, CENTRAL REGISTRY OF ADULT CARE FACILITIES, DEPARTMENT OF CHARITIES OF LOS ANGELES COUNTY; ACCOMPANIED BY LEON ROSENFIELD, STAFF ADVISER

Miss ZAREMBA. Thank you, Senator. Gentlemen, it is a pleasure to appear before you.

I presented to Mr. Constantine a fact sheet pertaining to the services of central registry.

Just to give you a little background about central registry, I established central registry in 1958 at the request of the Los Angeles County grand jury. We have in our files all of the licensed facilities that have been mentioned by previous persons. Whenever we are notified that a facility is licensed, we send out a questionnaire, asking certain questions as to the type of patient they will accept, men, women, and so forth. We have in our files some 1,700 facilities in the four categories that you will see in the fact sheet here.

In making referrals we take into consideration the type of facility that is needed for the person, the area in Los Angeles County where they wish to locate, and we give no less than three names, the names of three facilities. We try to rotate to the best of our ability. If there are certain requests made, such as a request for a strictly kosher home, we give just that type of facility.

In the nursing convalescent field, as you heard previously, the inspection reports are open to the public. The copy that is available to the county welfare department eventually gets to me, and I read these reports very carefully. When I find that there is any serious violation of the licensing requirements I, on my own, put a "Don't refer" on that facility. It means that central registry does not give out the name of that facility. We do not notify the operator because the operator has the original of the copy that I receive. They know that they should take care of these violations. And if the violations con-

tinue, the "Do not refer" continues. If the violations are corrected, I remove the "Do not refer."

My position is not to be punitive anywhere along the line. Our focus is the service to the general public, they being the persons who need the facility. We feel that we are in a position of public trust and if we knowingly referred a facility that was not meeting the minimum standards we would be violating our public trust. We don't just give the names of three facilities indiscriminately. If there are any special needs, as I mentioned, a kosher home, or if there is a language handicap, we try to fill the bill to the best of our ability, and we do quite a bit of counseling. This is, in many cases, a traumatic experience for these people to make a transition from one sort of type of living to another. So we have really tried to do a good service, give a service to the public, and I think our service is unique in the United States.

Senator Moss. I believe maybe it is. I haven't heard of it in other areas where we have been so far on these hearings. This is strictly a public service.

How is your organization supported financially?

Miss ZAREMBA. We are part of the Department of Charities of the County of Los Angeles.

Senator Moss. So it is a public body in that respect?

Miss ZAREMBA. That is right. About 50 percent of our requests for facilities come from the department of charities, that is, the medical-social workers of the general hospital and the social workers at the bureau of public assistance. The other 50 percent is from the general public.

You might also be interested in knowing that approximately 90 percent of the persons who need facilities are recipients of some public assistance. The other 10 percent are persons with other sources of income.

Senator Moss. Are there other private referral agencies who refer people to homes?

Miss ZAREMBA. Yes. I think Los Angeles County is unique in that area, also. I haven't had too much contact with these agencies; however, they are listed in the yellow pages of the telephone book, and it might be interesting for you to look in the yellow pages to see what kind of service they offer, free public service.

Senator Moss. Is it free?

Miss ZAREMBA. That's what they say.

Senator Moss. Oh, yes. [Reading:]

Call for free information; helps you find the right place with the right care, the right price; licenses are screened; luxury or budget accommodations. Ask us about MAA, medical assistance to the aged. Licensed counselors.

Do you know who would license these counselors?

Miss ZAREMBA. I would like to call Mr. Rosenfield. Mr. Rosenfield is the consultant in the Welfare Planning Council of Los Angeles, and he had occasion to check into that. I think it would be interesting to have him tell us a little bit about that.

Senator Moss. We will welcome that.

Would you do that right now, Mr. Rosenfield? Give your full name to the reporter, please.

Mr. ROSENFIELD. I am Leon Rosenfield, staff adviser. We are a private agency financed largely by United Way funds, and do social welfare planning throughout the county of Los Angeles, for both public and private agencies. We have had a very deep concern with the whole matter of out-of-home placement, and this is why I believe Miss Zaremba has asked me to be involved here.

To get the one thing out of the way, when Miss Zaremba indicated to me there was some concern about the matter of so-called licensed counselors as depicted in the telephone book, I took the occasion to call the two agencies that are so advertised, and after some rather frantic backing away from the question on the telephone, I finally elicited the information that the licenses are business licenses, which in the county and city of Los Angeles are $5 a year with no qualifications other than the opportunity to operate a business, and this makes them licensed counselors. They are counselors because they give people counsel and they are licensed because they have a business license, and this is the sum and substance of it.

There are a number of other questions, though, that are involved.

Senator MOSS. I was wondering where their remuneration would come from.

Mr. ROSENFIELD. Should I go ahead?

Miss ZAREMBA. Yes.

Mr. ROSENFIELD. We were brought this problem almost 3 years ago now by two social workers in the community who were very much concerned about a number of things that were happening. We opened, as it happened, a regular Pandora's box of problems. The problems lie in a number of different areas. One area, which in this particular instance is somewhat minor but nevertheless very annoying, is the matter of zoning, because zoning for out-of-home placement is undergoing in this community, as it is in many communities in California—and I dare say throughout the country—some real problems in the fact that zoning boards are concerned about complaints that they get from communities about the kinds of people who go into these homes, whether they are the well aged, what we are calling now mentally restored, or the mentally retarded. Placements of all kinds are under fire, and they are using the specious argument that these are commercial placements, despite the fact that in the city of Los Angeles we have a city attorney's ruling that money coming primarily from a State agency or a city agency does not invalidate the idea of having a family installation. (These are primarily the small homes, for five or fewer people.)

The second problem is the concern of the community about the fact that we have not been able through persuasion or otherwise to get the county board of supervisors to give the central registry enough money to do the job that needs to be done. We are concerned about this lack of budget to secure proper investigation of homes, the fact that they cannot offer clients transportation in this very widespread community to see what they are going to get into, and the lack of skilled social work help to be sure that the patient or client is getting exactly what he needs in an out-of-home placement.

We come to the matter of the proprietary placement agency, to which we referred when we talked about the licensed counselor group. Now, in the telephone book I think you will find about seven agencies

listed. Of the seven, about three or four of these are giving us a number of problems in the community by staying just within the law (as is quite evidenced by the phrase "licensed counselor,") and a number of other things that are going on, but they are doing things that we might consider not ethical if there were any standard of ethics in the particular service that they offer. They are obviously performing a service; otherwise, they wouldn't still be in business. So far as we know—and we have conducted what we think is a fairly broad survey—I had the opportunity to go to a national conference on protective services for the aging just about 2 years ago now, and we surveyed everyone who came there from communities all over the country about whether this proprietary placement agency problem exists anyplace else. So far as we know, it exists in exactly two places, southern California and New York City. However, there is only one agency in New York City, as far as we were able to find out, and it is operated by two social workers and has had no problems, apparently.

The ones that we have here seem to be operating for two or three reasons: One of them is, of course, in this tremendously widespread community, and with a lack of communication about the job that central registry does, there is no opportunity for the average person to know about central registry. It is not listed in the telephone book under sanitarium registries or where the other agencies are listed; it is buried among the agencies of the Los Angeles County, which is probably the largest county operation in the country, and people just can't find it. So this is one service, in that they take people around to see the places they are going to place them in.

Now, we know also that they get a fee for every placement that they make. They are doing a number of things that enable them to collect fees more than once for the same client, and not on account of problems that the clients necessarily are giving to the operators, but for a lot of reasons. They are moving clients without any valid reason. One of the cases we have on file shows that a person had bought a nursing home and had gone downtown to the county office to make sure that the license was valid and to make all the arrangements about the transfer of the license. When she came back seven or eight of her patients were lined up in the hall with their baggage, being prepared to be moved out to another home. She was astonished at this, and she tried to find out what had happened.

The agency that had placed these people said:

> Well, now that you are a new person you will want new clients, so we are going to move these to someplace else that we know.

Well, the fact that the agency collected a fee for each one of these people that was placed and, of course, collected again from this woman for replacing the people whom they had removed.

They are placed without regard to any real need or the ability of the home to care for the patient. The operators are being victimized and the poor unfortunate, in most cases bewildered, older person is also being victimized by this frequent replacement.

I think probably the classic example is one that was so shocking that people don't really believe it and it is pretty hard to believe. There is a tale in the literature, which is fairly well substantiated, that this

particular woman was placed in a home, and the operator called the place about 3 or 4 days later and indicated that—

> I can't keep this person here. She is fighting with me, with the other people in the home, and she is a very disturbing influence. You must remove her.

The placement agency said, "If she has got to be removed, we will." They placed her in another home and 3 or 4 days later the same call came from the second operator, and at this point the placement agency realized what they had on their hands, and they replaced her 13 more times, collecting a fee each time. So they collected 15 fees for this 1 client and, in the end, she had to be hospitalized, anyway. This is probably the most horrible example that we have anywhere.

Senator Moss. Are these fees collected from the home?

Mr. ROSENFIELD. From the home, and they range from 50 percent of a month's fee in several different directions, depending upon the arrangement that the placement agency has with the home operator. The families many times are required to replace a person who has been placed in one of these homes, because the person obviously does not fit in with the clientele the home already has, or is presenting problems; for example, the licensing agency of Los Angeles County did a short survey for us a while back, probably 4 or 5 months ago, and they surveyed homes which at that time had about 187 clients in them. Among the clients we found a number of people who had been placed as being one kind of client, and found out that they were something quite different. They had been placed as ambulatory, and they weren't; they had been placed as just ill people, and were found to be psychotic or severely neurotic. In a number of instances, the operators have forced families to remove these people, and when the families have indicated, "I have already paid a fee. Can I get a refund?" the answer was that they could not, in spite of the fact there is supposed to be a ruling that refunds are written into the contracts. But somehow the contracts get lost; they are not available. People don't get refunds. The main reason is the oprator has already paid the placement agency a fee and cannot get it back from the placement agency. They are doing other choice little bits, like hospital chasing. They are waiting on people in hospitals, waiting by the bed for a person to be ready to leave the hospital, and forcing cards on them and so forth, saying, "You won't get service from anyone else. I will be glad to take you around and show you what is available in the community when you get out of the hospital."

The nursing homes, fortunately, in Los Angeles County, at least the associations, are beginning to police themselves and resist this type of thing. But the small operator may depend on the proprietary placement agencies for their clientele.

I believe several people have indicated the town is really overbuilt in terms of nursing homes and board-and-care homes. The result is that people are struggling for business, and this is one way that they get it.

We see a very strong need for protective services in this area and in many others. One of them, a study was made by the State department of public health recently, which studied some 149 cases out of about 1,800 that came to the attention of the county health department and, of these, practically all of them were subjects for protective services—

services which can be described very conveniently as services for which people cannot or will not ask, as opposed to supportive services.

We have a committee on the aging in the Hollywood-Wilshire area that conducted a voluntary survey, gave information, and so forth. They found out there were a great many proctective services needed in that area.

The city health department did a housing survey in the Hollywood area and found out the same thing.

There are only two comprehensive programs—I should say semi-comprehensive programs—of protective services in the United States today. One of them is in Cleveland, where the Benjamin Rose Institute, a heavily endowed private agency, takes care of about 50 people annually on a protective service basis, and 1 county in California, Santa Clara County, has a protective service arm of their public health department, which takes care not only of those people who are on public welfare but people who do not so qualify. The city of Pasadena, which has a city-operated welfare department, does some protective work also.

I would like to give you a copy of our proposed protective services grant which we hope to institute in Los Angeles very shortly, hopefully to be financed through the Social Security Administration.

Senator Moss. Very good. We are happy to have that. Also, we would like to include in the record at this point this fact sheet that Miss Zaremba has given us.

(The document referred to follows:)

CENTRAL REGISTRY OF ADULT CARE FACILITIES

LOS ANGELES, CALIF.

Central Registry is a Public Service provided by the County of Los Angeles which gives counseling, information, and referral services relative to licensed out-of-home care facilities for adults in Los Angeles County. *There is no charge for this service.*

The staff of Central Registry is available to furnish current information on community resources. They will discuss your individual and special needs. They will give you the names of several facilities in the area of your choice which you may visit to determine which is most satisfactory to you.

The services of Central Registry are available to individuals, their families or friends, social workers, doctors, and other interested persons.

TYPES OF FACILITIES AVAILABLE

Board and care homes for the aged are for persons 65 years or older. They accept only those who are up and about and able to care for their own personal needs. These facilities are licensed under the jurisdiction of the State Department of Social Welfare.

Nursing homes and sanitariums are privately operated facilities, established for the care of persons suffering from chronic illnesses or physical infirmities who can no longer be cared for in their own homes but who do not require hospital care. These facilities provide 24-hour nursing service under the medical direction of the person's own physician. They are for both small and large numbers of persons and are licensed by the State Department of Public Health, Bureau of Hospitals.

Sanitariums for the emotionally or mentally disturbed are operated by private individuals and accept small and large numbers of persons who require care due to mental or nervous strains. Nursing care, under the medical direction of the person's own physician, is provided. These facilities are licensed by the State Department of Mental Hygiene.

For adults under the age of 65, Central Registry files contain information regarding approved Room and Board facilities.

PRELIMINARY ARRANGEMENTS

Finances.—When you decide on a facility, it is important that you have a clear understanding of the rates and exactly what these include. Is there an extra charge for such items as laundry, hair cuts, and other services? If it is a nursing home, discuss the charge for medicines, for the services of a physician or nurse. Make sure you understand the arrangements for refunds or credits in the event you should be away for several weeks or leave before the end of a pay period. You may be asked to sign an admission agreement form; *be sure you understand it completely before you sign.*

Physical examination.—Before entering the home, a complete physical examination is required as a protection for you and for the other residents. At the time you enter the home, arrangements should be made for continued medical supervision.

Personal belongings.—All personal belongings taken into the home should be marked for identification and listed. The list should be signed by you. This will prevent later misunderstanding.

Miss ZAREMBA. I would like to say one more thing: Just last week I received this little letter. Prior to receiving this notification, the man whose name is signed here called my office. I was out of the office. He conducts a free placement service and professional counseling, consulting service. He called my office and wanted to know if it would be illegal for him to charge a fee for placing MAA patients.

Well, he was told, of course, that we were not in a position to give him any legal advice.

You might be interested in hearing from Mr. Highley, who operates the Highlander Nursing Convalescent Home in San Fernando. He came to my office a couple weeks ago with a list of MAA patients whom he had accepted as patients and for whom he was charged a fee by one of these agencies in the San Fernando Valley.

I cleared all of these—I think there was a list of about 20, and one of those central registry had referred, and here this operator, one of these agencies, had collected a fee.

Senator MOSS. This is very interesting to have this information, and I have not run into it before. I was interested in Mr. Rosenfield's statement that he only knew it existing here and in New York.

Miss ZAREMBA. That's right.

Senator MOSS. I, of course, know nothing about its legality under your California law, except that it obviously is subject to abuse.

I wonder, if these proprietary placement agencies or counselors were not available, do you have the facilities to take care of all of the people that would need referral?

Miss ZAREMBA. Well, we could increase our staff. As you will notice in the fact sheet, we are an information, counseling, and referral service; we are not a placement service. I think a placement service, from the standpoint of the county of Los Angeles, would be almost an impossibility. There are social workers in the bureau of public assistance district offices who are in a position to assist if there is need to assist in the placement of the patients. We could increase our staff if the need was there.

Senator MOSS. Thank you very much. We do appreciate the information you gave us.

We go to the next witness, Mr. George McLain, chairman of the California League of Senior Citizens.

We are glad to have you. You may either place the statement in the record and comment on it, or you may go ahead and read from the statement.

STATEMENT OF GEORGE McLAIN, CHAIRMAN, CALIFORNIA LEAGUE OF SENIOR CITIZENS

Mr. McLAIN. Thank you.

My name is George McLain. I am chairman of the California League of Senior Citizens, with headquarters at 1031 South Grand Avenue, Los Angeles, Calif.

Along with our activities to improve the economic, health, and housing problems of the elderly, we conduct welfare counseling service, and therefore are well aware of their requirements for nursing and convalescent care.

Through the years, nursing and convalescent homes developed without any supervision. It naturally follows the quality and character of these homes vary widely. Individuals requiring this specialized type of care and attention cover the entire economic range—those with no income to pay for such services and accommodations, to the affluent members of the elderly who can afford expensive care and attention.

The great advances made in medicine and medicinal and therapeutic skills have greatly extended the lifespan of our citizens, with the resulting vast increase in the number of the elderly who require the special facilities, care and attention afforded by nursing and convalescent homes. It is a fact there has been considerable building of new, modern, and desirable facilities to care for this segment of our people.

PRESENT RATES TOO LOW

In the present medical assistance for the aged under California's State welfare budget dealing with nursing home care, the minimum rate allowed is $7.35 per day, and the maximum rate for extensive care is $9.10 per day. These rates are of vital importance to a vast number of the elderly unable to care for themselves and with no income except old age assistance checks or social security, yet these rates are not realistic and are, in fact, inadequate to assure proper care in desirable facilities. We do not have to be concerned with the senior citizens who have means and income that permit services of the quality of their choice. Our concern relates to the low income group whose income is not elastic and is inadequate to provide the good care required in the years when our senior citizens are unable to care for themselves.

In today's family life the care of helpless parents and close relatives is to a greater and greater degree being channeled into nursing and convalescent homes. It is a fact of life supported by statistics. I will not dwell on this developing aspect of the social problems of today.

The important matter for immediate consideration is to revise the yardstick presently applied by the State of California Department of Public Health in determining the need for additional nursing and convalescent facilities. The present yardstick is a "bed count." This bed count is related to the population of an area. It takes in consideration all of the licensed nursing and convalescent facilities, including the number of beds in each licensed premise.

BED COUNT

The Department of Health of the State of California takes the position that the "bed count" is the final answer, and determines whether or not they will issue a certificate of need letter for additional nursing and convalescent facilities in a community. Little consideration is given to the type of maintenance, or the quality of the facilities. It is a tragedy that many of the nursing and convalescent homes do not deserve a license. Any change from the present easily applied yardstick of measurement involves hard decisions and will lead to controversy. That is admitted. We might as well face the fact that progress in any field involves controversy and our social progress has been achieved in slow fashion and has faced bitter opposition.

We take the position a "certificate of need" from the California State Department of Health must be revised to reflect the physical quality as well as the management shown in the operation of these homes. A substantial percentage of the total nursing and convalescent beds available in California are in old Victorian mansions, remodeled homes and buildings, with the management usually reflecting the inadequacy of the physical surroundings.

I have visited some of these places and have been almost overcome by the stench because of the lack of proper ventilation. I have viewed cots crammed side by side into room after room, with just enough space to walk in-between. I can understand why visits are so short as visitors cannot leave these places quickly enough. Yet these facilities are licensed by the Department of Health of the State of California and are then included in the bed count of the local community.

CERTIFICATE OF NEED

The State department of public health exercises almost total control over the construction of new facilities in its present use of a bed count yardstick. The importance of the "certificate of need" issued by the Department of Health of the State of California is its relation to financing new properly designed, fireproof convalescent homes through recognized lending institutions or through FHA insured loans. Without such certificate of need, FHA will refuse to insure and lending institutions become ultraconservative. Yet the increasing demand for convalescent homes grows greater and greater. This condition has attracted the usual promoters and builders to encourage unexperienced individual property owners to use their land and funds to finance and operate inadequate and economically unsound nursing home facilities where no "certificate of need" from the State is required—only a State license easily secured locally after completion.

The solid financing is in the Federal Housing Administration insured commitment for this type of facility. The FHA experience in the construction field is an important safeguard in the adequacy of such facilities. In addition, ample funds are available under their insured mortgage program, particularly to nonprofit organizations. The key point is that the FHA will not entertain an application for a nursing and convalescent home unless the report of the Department of Health of the State of California indicates a need, and we have explained why a community may have an adequate bed count in rela-

tion to the present yardstick used by the department of health, but the quality and the physical condition of the homes leaves a great deal to be desired. The only improvement will be in the construction of more new adequately designed nursing and convalescent homes. In far too many of our daily papers we read of disastrous fires trapping and burning to death elderly inmates in these reconverted old places used as convalescent homes.

In summary, I wish to make two recommendations:

It was found that many millions of dollars were being used to perpetuate slum and deteriorated housing by public assistance recipients living in them. About 2 years ago, President Kennedy issued an Excutive order to the States to discourage this by helping recipients to live in higher quality housing under safe and more healthful conditions. I recommend (1) this committee ask the Department of Health, Education, and Welfare to interpret President Kennedy's order as also applying to nursing and convalescent homes for the elderly, as funds for the maintenance of public assistance recipients in such homes come from Federal funds under the Kerr-Mills Act, et cetera, and to so inform all State departments of health, as well as State departments of social welfare.

In my appearances before the House and Senate Subcommittees on Housing, I have advocated that in order (2) to encourage nonprofit groups to become interested in providing nursing homes and convalescent facilities for the elderly on a nonprofit basis, they should be given 100 percent financing under FHA. This financing to include furnishings, fixtures, and equipment needed to operate such homes. Most nonprofit corporations, because of the nature of being nonprofit, should not be compelled to assume unreasonable obligations along with the responsibilities they are required to meet by Government agencies.

I wish to take this opportunity in behalf of the elderly of California to thank Senator Moss and the members of his committee for taking an interest in this important phase of the problems of the elderly and for honoring us here in California by their presence. I am sure that nothing but good will come from this hearing today. Thank you, and God bless you.

Senator Moss. Thank you, Mr. McLain. That is a very fine statement.

I was interested in your recommendation about 100-percent financing for nonprofit nursing homes. I recommended that last year to Senator Sparkman who is chairman of the Housing Subcommittee.

Mr. McLain. Wonderful.

Senator Moss. I am sure it would be a move in the right direction.

As you point out, unless we can upgrade these homes, we are going to continue to have people living in deplorable conditions. We tend now to measure needs simply by the number of beds in the area; therefore, if the State licensing procedure were really enforced, we would tend to get away from this condition, wouldn't we?

Mr. McLain. That is correct.

Senator Moss. So your recommendation would go to that very strongly, I understand.

Well, I appreciate your fine statement, the work you have been doing.

Does the staff have any questions?

Mr. Constantine. No.

Mr. FRANTZ. No.

Senator Moss. Thank you very much.

Mr. Clinton Jones, I understand, is going to appear for Mr. Harberson, executive director, California Association of Nursing Homes, and I believe Mr. Stephen Morris. We are glad to have both of you gentlemen here today. We are sorry Mr. Harberson could not be with us.

Mr. JONES. He is another victim of the executive flu.

Senator Moss. That is a status symbol.

STATEMENT OF F. CLINTON JONES; ACCOMPANIED BY STEPHEN MORRIS, BOTH REPRESENTING CALIFORNIA ASSOCIATION OF NURSING HOMES, SANITARIUMS, REST HOMES, & HOMES FOR THE AGED, INC.

Mr. JONES. I am F. Clinton Jones, representing the California Association of Nursing Homes, Sanitariums, Rest Homes, & Homes for the Aged, Inc.

I might preface my remarks, Senator, that within the course of our written testimony we have filed with you, quite a number of facts and statistics have already been referred to this morning and early this afternoon, so when I come to those I may glide over them or place them into relationship to the voluntary profession which we represent. Each time I will point this out to you so you will recognize it as something that one of the previous agency representatives has mentioned.

The rather lengthy name of our association reflects a broad scope of resources for the long-term care of the aged, disabled, convalescent, and chronically ill in California. Our membership constitutes the only statewide organization of voluntary—that is, nongovernmental—facilities, both proprietary and nonprofit. California's growing long-term-care profession—as distinguished from short term or acute hospital services—is in partnership with government—Federal, State, and county—to provide both medical and residential care for welfare recipients of age 65 or older, as well as patients and residents of all adult ages with private resources.

Let me focus briefly on the scope of these voluntary, nongovernmental resources in meeting the needs of our aging who are indigent. Some 55 percent of all occupied beds in California's nursing and convalescent homes hold welfare recipients at any given moment. About two-thirds of all residents in licensed boarding homes and aged institutions, which Mr. Cole mentioned, are welfare recipients, mostly on OAS grants, with most of them in small proprietary boarding homes. There are approximately 40,000 licensed nursing and convalescent home beds in the State, plus about 36,000 beds in boarding homes and aged institutions. In addition, there are over 6,000 beds in mental hygiene facilities, also described this morning. Thus, the grant total of some 82,000 beds is the capacity of the voluntary, long-term-care profession in California today. By comparison, the comparable number of long-term-care beds in governmental facilities, such as county hospitals, is quite small. Mr. Derry mentioned about a 12,000-bed figure.

I have listed these figures to indicate the extent and vital importance of the profession to California is providing appropriate facilities for long-term care. And there is another significant factor in this picture.

Our own State association membership alone represents a voluntary investment of over $85 million in facilities. Approximately 800 members currently pay over $30 million annually to hired personnel. They are spending over $35 million annually for goods and services in California's local communities. In short, they create jobs, they help the economy of their communities—and they pay taxes—over $25 million annually.

If I may refer again to the long name of our State association, it reflects another important reality with which this subcommittee should be familiar. The voluntary long-term care profession in California is licensed and regulated by several State agencies. Nursing homes and convalescent hospitals are one and the same thing, administratively. They are licensed as nursing and convalescent homes by the bureau of hospitals of the State department of public health. Boarding homes for the aged and aged institutions are licensed by the State department of social welfare with counties acting as its agent in the case of the small boarding homes. Mental hygiene facilities are licensed by the bureau of private institutions of the State department of mental hygiene.

Thus far I have spoken only of licensing, in order to make clear that three separate State agencies perform this function as well as inspection for their particular class of facility. However, the complete picture is far more complicated. Public health, through licensing and inspection, in effect, sets standards of care for nursing or convalescent homes. However, since the inception of Kerr-Mills legislation, MAA, called the medical assistance for the aged program or MAA in California—the department of social welfare, through its agents, the counties, effectively regulates these facilities and sets rates through its administration of MAA—which is the public financial resource for the 55 percent of the nursing and convalescent homes' patients. Thus, public health controls the standards, which in turn control costs of care, but social welfare controls rates. The State department of public finance acts legally as an adviser to the social welfare department on the setting of rates; however, the final responsibility legally on rates rests with the State department of social welfare.

The picture is further complicated at the mental hygiene level by the recent extension of MAA payments to mental hygiene patients plus the transfer of some State mental hospital patients into boarding and nursing homes, thus multiplying the overlap of agencies concerned with long-term care. However, despite administrative fragmentation, it is generally conceded that California stands in the forefront of all the States in sincere and comprehensive efforts to provide appropriate long-term care for its citizens.

Let me digress here to note that California nursing homes and related facilities, heavily regulated as they are, are the unwitting victims of recent waves of criticism in the press and other national publications. With the general public becoming conscious of programs to improve the health care of the aging, it is tempting for writers to seek the sensational and the exposé as the veil of privacy is being lifted from facilities housing the aged. But with minimum standards of care below California in many States, national generalizations are made in print that—when read in the "Golden State"—carry the implication that neglect of the needy, bedridden aged is commonplace.

With the spread of the MAA program in California in the last 3 years, recent press articles have implied that care in nursing homes and related facilities here follow the generalized image. Yet actual in-the-field studies by inspectors of the bureau of hospitals show that noncompliances with the Hospital Licensing Act are few. This was referred to by Mrs. McCall in her earlier testimony, and I think it might be apropos at this time for me to enter into the record the exact totals of the noncompliances which were referred to this morning in this report relative to noncompliances with the Hospital Licensing Act. There are some 125 possible noncompliances on the inspectors' lists, of which only half are considered major items. During the first 9 months of 1963, the bureau's representatives made a total of 2,100 visits to nursing or convalescent homes, in three waves during the first three quarters of the year. This is where they found that two-thirds of all nursing homes were in violation; putting it the other way, one-third were not. This is the basic beginning of this survey. In each quarter, respectively, they found one-third of over 600 homes inspected without a single noncompliance. At the opposite extreme—homes with 12 or more noncompliances out of a possible 125, in the first quarter they found exactly 13 homes so guilty; in the second quarter, 22; in the third quarter, 15. At the time of the studies there were nearly 900 nursing homes licensed and operating in California. Thus it is easy to see how the overzealous can pounce upon a relatively few exceptions and attempt to discredit the entire profession.

The California Association of Nursing Homes, et al., is not a policing organization. It was organized in 1945, incorporated in 1950, and has from inception been devoted to furthering the long-term care profession and working toward higher standards of care. It has consistently fostered education and training programs for personnel—too numerous to detail here—continuing programs in this regard are carried on with both the University of California at Los Angeles and the University of Southern California. I won't detail others. Its stature has been recognized by the Governor in appointing two of our members to the hospital advisory board. Also * * * our president sits as consultant on both the board and the hospital advisory council. Recently the State legislature in providing for statutory hospital regional planning committees specified a nursing home administrator sit as a member on each of these important committees, which has been done. In addition, we have representatives on every voluntary hospital regional planning group in the State.

In 1961, our association joined with the California Medical Association, the California Hospital Association, and the two State dental associations to establish the California Commission for the Accreditation of Nursing Homes and Related Facilities. Accreditation recognizes superior standards of care, beyond State minimum requirements. In little over 3 years, the commission has accredited 175 institutions. I checked today and I think the figure is now 178. The program is proceeding apace into its fourth year.

An earlier statement represented only about 11 percent of the nursing and convalescent homes. I think this figure is wrong, but I think the accreditation people will probably give you more detail on that, which they have and I do not have.

Here in Los Angeles, a few weeks ago, the quarterly board meeting of our State association reaffirmed its financial and moral support of the California accreditation program; commended the commission for its achievements and our two recent past presidents who sit on the commission; and urged our membership to seek accreditation. We call your attention to the California program because it turns the focus squarely upon the basic problem as faced by our profession throughout the Nation. Care costs money, and it is impossible to separate standards of care from the costs of that care. For example: our association's recent 9-month study of the cost of care in California nursing and convalescent homes showed that food and labor expenses alone and together account for two-thirds of all cost per patient day. And these keep rising, unaccompanied by MAA rate payments.

The same study found that 78.2 percent of the broad sample of 133 homes are receiving less or no more than their actual costs to care for California's welfare aging, disabled and chronically ill. Here—as in other States—the dwindling supply of patients and guests with private resources is being forced to subsidize public assistance programs, as a result of unrealistic rates, accompanied at the same time by demands for higher standards of care. Our association is spending much of its effort in seeking more equitable rate formulas, commensurate with patient needs.

In conclusion, we are well aware of the dramatic growth of nursing and convalescent care facilities in California, particularly since the advent of MAA some 3 years ago. Our prime concern is that this and future expansion be planned—that better trained administrators and personnel become available—and that this growth of the voluntary profession shall not reduce levels of long-term care.

If standards can be held and improved, through such programs as accreditation, and realistic rates are provided to assure such standards for all who need long-term care, then the basic economics of supply and demand can again apply to our growing profession. We believe California is properly in partnership with voluntary enterprise to accomplish these goals.

Senator Moss. Thank you, Mr. Jones and Mr. Morris, a very fine statement.

Do you have anything to add to the statement?

Mr. Morris. Nothing to add. I would be very happy to answer questions that I may be qualified to do.

Senator Moss. Thank you. How many of the California nursing homes belong to your association?

Mr. Morris. We have at present approximately 700, slightly less than 750 of the licensed facilities out of this 900-odd.

Senator Moss. So you would have a substantial majority?

Mr. Morris. I might put it another way: We represent at present a little over 25,000 beds in the State.

Mr. Jones. May I enlarge upon that?

Senator Moss. Yes.

Mr. Jones. My job is keeping track of the figures. In order that it may clarify the percentages for you, you recall that our membership represents facilities licensed by three different agencies. When you speak of 82,000 beds, total long-term care, voluntary beds in California, and you refer to 25,000 beds as being our members, you are cutting

across different types of licenses, so that the percentages of membership in relation to the total in each license varies in each of the 3 categories. I won't bore you with breaking it down further, but I will bring it down a little closer to your question.

Approximately 42 percent of the nursing and convalescent homes having the same kind of license in California, are members of our association.

Senator Moss. Is this by number of homes or by number of beds?

Mr. JONES. It works out almost the same in percentage. The difference between the number of facilities and percentage of beds is not too great at this particular moment. It is in the 40-percent range.

Senator Moss. I assume all licensed homes are eligible to join?

Mr. JONES. Yes, they are.

Senator Moss. I commend you particularly for your joining with these other organizations in sponsoring the accreditation program. We are going to hear from the director of the council on accreditation.

Has the number of members in your association been increasing steadily or has it remained fairly static?

Mr. JONES. At a very rapid rate we have been increasing; if you put the curve of the number of facilities as they have grown as against the curve of membership, the curve of membership is increasing at a much higher rate.

Senator Moss. That is very interesting.

Do you have any questions, Frank?

Mr. FRANTZ. I wondered if you impose any requirement upon the homes to be eligible for membership other than that they be licensed?

Mr. JONES. I think Mr. Morris might better answer that than I.

Mr. MORRIS. The requirements for acceptance go to the local chapter of our organization. We are at present reorganizing our State association radically, which would put the power of appeal as to admission primarily in the board of directors as an ultimate board of appeal. We are setting up a very effective committee on ethics, which would be used as a mechanism for ascertaining the acceptability of memberships, and this is part of our immediate program this year.

You must remember that our association, by and large, has a relatively short lifespan. Actually, its growth has been rather cyclopean, I would say, in the last 3 or 4 years. We are very proud of the ongoing development of the association, but it is a very recent one. Such organizations as the accreditation commission, and the very direct support of the State agencies has enabled us not only to improve our own policies and programs within the association, but to invite and secure the interests of membership potentials that didn't exist in the past.

We will, of course, as any good professional organization, immediately set our house in order as to the acceptance of membership. This is a very touchy subject, as you can well appreciate. It goes primarily to the ascertaining of standards of ethics by which a given operator proposes or has operated his institution. This takes quite an effective—I won't call it policing mechanism, but reviewing mechanism. I can only assure you we are hard at work upon it.

Senator Moss. Thank you, Mr. Morris.

Mr. CONSTANTINE. You seem to write off the fact that two-thirds of the homes inspected had noncompliances by explaining that seem-

ingly to indicate that most of the homes were guilty of only minor noncompliances. Do you have any data as to how many of those two-thirds were cited for noncompliances for major items?

Mr. JONES. I don't have them right here. The entire chart is a very lengthy thing, which is in the hands of the bureau of hospitals.

In the summary I gave you we went from the extreme of no noncompliances to those of 12 or more and gave you those figures for each quarter. If the percentage of what they consider major and minor is concerned, applied equally in each of those samples, why, then 12 or more noncompliances would mean on the average 6 major and 6 minor, for example.

Mr. CONSTANTINE. Do you have any information in the material you presented us as to the duration of noncompliances?

Mr. JONES. No. I do not recall that that was spelled out; in other words, this was sort of a specialized survey put on top of the normal inspection procedures of the department. I do not recall in the survey seeing any delineation or any footnote relative to that. I could not answer that.

Mr. CONSTANTINE. One final question: Have you done any income surveys of your membership; that is, do you have any idea of the range of aftertax profits of your member homes? No one seems to have any hard cost data. Is is very difficult, apparently, to get good cost accounting out of the nursing homes. Have you done any income studies?

Mr. JONES. Well, I think Mr. Morris might give us something on that, in addition to the study which we did.

Mr. MORRIS. Up to the present all of the data has been directed to the element of costs and I think there is a very good rationale for that. After all, you and I might both be engaged in comparable businesses, but you might be a far more able and prudent administrator than I. Necessarily, then, on the very same revenue, you would run a better profit, and this has been the tradition of American enterprise, and I would assume it would always be a fundamental economic fact of life.

When you speak about what kind of net operators return, you are then engaging yourself upon an inquiry into relative merits and skills, and I don't know how really you would set any basic pattern to that.

Mr. CONSTANTINE. I was just referring to a range.

Mr. MORRIS. Range?

Mr. CONSTANTINE. Yes.

Mr. MORRIS. I have been in business a long time. I am afraid my views might be a little bit postdated at this time. There was a time when there was a very, very broad range, running all the way from a minor and practically marginal profit up to what we would all, I think today, agree would be an excessive profit.

Due to the overwhelming and almost massive impact of the MAA program and similar welfare programs which, as you were advised, take 55 percent of the patronage in our occupancy today, there has been a leveling of income and a leveling in all areas of the economic picture, and I can only say that, from personal acquaintance with many people in our organization, that as yet the profit margin does vary, and I would think we would have to admit that it was a substantial variance but by comparison with any such profit 5 years ago, even it has been drastically reduced.

Don't misunderstand my personal position on this. I do not think that any welfare program should open the doors to conscienceless profiteering. I have great concern about the establishment of an appropriate rate structure. But my approach to it is simple, in substance. Rates should be keyed to the standard of care, however that standard of care is set. In this State we have several departments, each functioning rather independently. One says, "We want a certain standard"; another one says, "We won't pay for it"; another says, "We are not really concerned about that subject; we are concerned about a sociologic concept." Back of them the taxpayers say, "Welfare costs are outrageous. We have got to do something about it."

I am sure you, Senator, find the funding of these programs a great headache. Nevertheless, it is quite irrational to ask of any provider of service, be he nonprofit, so-called, or profitmaking, to demand of that person a level of care which is not funded. So we have a very serious problems of searching out, which means studying, just what do services cost, and then in the American tradition attempting to determine to what extent a reward should be allowed.

I am not speaking specifically on the concept of utility programs, for instance I don't think we are utilities; I think we are providing a far more precious and intimate public service. But the concept broadly is there, and we, as private entrepreneurs, must recognize it, and I believe I can go so far as to say we are recognizing it.

Senator Moss. Thank you very much, Mr. Morris. We do appreciate your testimony, and yours, Mr. Jones. You have been very helpful to this committee.

We will next hear from Dr. Pierre Salmon, who is the chairman, and Dr. Arthur H. Dearing, who is the executive director, of the California Council for the Accreditation of Nursing Homes.

STATEMENTS OF DR. PIERRE SALMON, CHAIRMAN, AND DR. ARTHUR H. DEARING, EXECUTIVE DIRECTOR, OF THE CALIFORNIA COUNCIL FOR THE ACCREDITATION OF NURSING HOMES

Dr. SALMON. You have before you a short statement and the bylaws, the standards for accreditation, and the directory of accredited facilities as of April 1, 1964.

Senator Moss. We are grateful. The bylaws and standards and directory will be a part of the files of this committee and will be referred to, and you may proceed with your presentation, sir.[1]

Dr. SALMON. I shall merely highlight a number of items in the four-page statement, and I think this can be incorporated.

Senator Moss. It will be printed in full in the record, and you highlight it, sir, if you will.

(The prepared statement of Dr. Salmon referred to follows:)

This is a brief résumé of the history, purposes, and program of the California Commission for the Accreditation of Nursing Homes and Related Facilities.

The commission was organized in March 1961, as a voluntary, nonprofit association. Its inception was prompted by the fact that the medical profession, hospital administrators, and nursing home administrators felt the need for high standards of care to which nursing homes could subscribe. It is an effort to

[1] The documents referred to will be found in the files of the subcommittee.

improve the care of the patient in the convalescent hospital and nursing home.

The major purpose of the commission as stated in the constitution is as follows:

"To conduct a survey and accreditation program which will encourage the establishment and improvement of nursing homes and related facilities; and to establish and apply certain basic principles of organization and administration for efficient and kindly care of patients or guests of nursing homes and related facilities."

The membership of the commission consists of two representatives each from the California Medical Association, California Hospital Association, the California Association of Nursing Homes and one representative each from the California Dental Association and the Southern California State Dental Association. The commission is supported financially by contributions from the member organizations plus fees received from nursing homes and other related facilities requesting survey and accreditation.

As of January 31, 1965, a total of 252 requests for initial survey and accreditation had been received. Twenty-five nursing homes have been denied accreditation as not meeting the standards of the commission. Twenty-two have allowed their accreditation to lapse. In addition there are applications from other facilities awaiting initial survey.

To qualify for survey by the commission a facility must have been in operation under the same ownership for a period of at least 6 months. It is the feeling of the commission that this is the minimum period of operation which will permit a true evaluation of the quality of care in a facility.

Nursing homes and convalescent hospitals are furnished with full preliminary information of the standards of the commission and the requirements for accreditation. Inasmuch as the major objective is to improve the care of the patient and quality of care, the commission feels that its function is educational as well as accreditation. Facilities are furnished with self-evaluation questionnaires which permit them to find their weak spots and correct them before applying for accreditation.

Accreditation is purely voluntary on the part of the nursing home. Application accompanied by a fee of $60 plus $2.50 for each licensed bed must be made to the commission. A careful survey of the institution is then made. The report of survey is examined by all members of the commission and if approved a certificate of accreditation is issued to the facility. The licensing agency is then notified of the accreditation as is also Hospital Service of California, Hospital Service of Southern California, California Physicians' Service and interested commercial insurance companies which may write health insurance for care in convalescent hospitals.

Accreditation is for a period of 2 years from the date of survey and is not automatically renewed. For continuation of accreditation during the next 2-year period request must be made to the commission. A full survey is made and the report passed upon by all members of the commission as in the initial survey.

Provision is made in the bylaws whereby interim surveys may be conducted if there is reasonable report or belief that the facility is not continuing to meet commission standards of accreditation. If this interim survey reveals major deficiencies or serious substandard operation, accreditation is withdrawn. The facility is then ineligible for accreditation for a period of 6 months and must file formal application for survey if they wish to become accredited.

In establishing criteria for nursing homes or convalescent hospitals which may be reimbursed for the care of individuals covered under health insurance, Hospital Service of California and Hospital Service of Southern California (Blue Cross) have indicated in their policies that facilities which have been accredited by the California Commission for the Accreditation of Nursing Homes shall be deemed to have met their criteria. Western-65, includes accreditation by this commission as a minimum requirement for a convalescent hospital or nursing home to be qualified to receive payment under their policies. Other commercial companies, writing insurance for nursing home care accept accreditation as an indication that a facility meets their requirements for payments.

The nursing homes that are accredited or applying for accreditation are about equally divided between northern and southern California. They extend from Alturas on the north to Indio on the south. The great majority are in the areas adjacent to Los Angeles and San Francisco.

The first survey was conducted in September 1961. As of January 31, 1965, there were 178 nursing homes on the accredited list, representing 10,864 beds. This is 17.5 percent of the 1,014 licensed homes in the State and 27 percent of the 40,094 beds.

The program of accreditation by the commission has been publicized widely to all nursing homes in the State. As the program becomes better known, more and more nursing homes and convalescent hospitals are seeking accreditation. It is noted that physicians seeking a facility for convalescent care for a patient or nursing home care for the aged are giving preference to those homes which have met the standards of this commission. The standards of accreditation are rigid but it is the feeling that such a necessary in order to promote a high quality of care in all of its aspects to the patients in nursing homes and convalescent hospitals that they may obtain the greatest benefits offered by medical and nursing science.

Attached herewith is a copy of the constitution and bylaws and the standards of the commission.

Dr. SALMON. I would like to emphasize that this is a voluntary, nonprofit association, and that the major purpose of the commission, as stated in the constitution, is as follows:

To conduct a survey and accreditation program which will encourage the establishment and improvement of nursing homes and related facilities; and to establish and apply certain basic principles of organization and administration for efficient and kindly care of patients or guests of nursing homes and related facilities.

You have heard the membership of the agencies that support this commission. In addition fees are charged for the services provided to the facilities requesting survey and accreditation. It is a totally voluntary type of organization, and our figures as of January 31 are contained at the top of page 2 of the report. The number of nursing homes accredited on that day was 178, representing 17.5 percent of the facilities, and 10,864 beds, representing 27 percent of the beds of the nursing homes. This is in those homes licensed by the State department of public health.

Our program has not been very successful in the other areas. We have only two facilities licensed by the State department of social welfare. Our major effort has been in the nursing home field.

The accreditation actually is for a period of 2 years. It consists of a survey by Dr. Dearing or a surveyor under him who inspects the facility on the basis of the standard which you have in front of you and who makes a judgment at that time which is reported to the members of the commission, stating that the facility in question has the capability of meeting the standards at the moment of the survey and is actually in practice meeting those standards at that moment. It is not a policing organization, although there is a mechanism for appeal by some outsider who feels that the facility may not be living up to the standards of accreditation.

The mechanism has been utilized by a number of the insuring third-party payors as a means of recognizing the homes in which they will make payment under certain circumstances.

I think these are the highlights of the report, Senator Moss.

Senator MOSS. Very fine. I am pleased to know of the functions of this council of accreditation.

Are the number of nursing homes and other institutions seeking accreditation growing? Is it becoming more accepted all the time?

Dr. SALMON. Yes. Our pattern of growth has been spotty, because there have been several outside influences come to bear on it, but at the moment we are in the fairly rapid growth portion of the curve. The toe of the curve has been somewhat longer than usual, but I think we are now ascending at a rather rapid rate.

Dr. Dearing perhaps can give us some more in the way of figures, but I believe some of the activities at the Federal level with respect to proposed legislation are influencing the seeking of accreditation as well as activities in the State level.

Senator Moss. What are your charges, Dr. Dearing?

Dr. DEARING. $60, the basic charge, plus $2.50 for each licensed bed. A 100-bed facility bears $250 plus $60 for the charge for survey, which is not refundable if they are not accredited by survey; that is kept. But at the end of 2 years, if they wish to continue accreditation, they must again request survey, pay the fee, and be resurveyed, just as if they started over again.

Senator Moss. It would be a full fee again after 2 years when they were reexamined?

Dr. DEARING. Yes, sir.

Dr. SALMON. I might call attention to the fact on the top of page 2, roughly 50 out of the 250, approximately, requests have been turned down as not meeting our standards.

Senator Moss. That is a very interesting figure. Approximately 50 failed to qualify.

Dr. SALMON. These figures are at the top of page 2 in the report, sir.

Mr. MILLER. May I direct a question with reference to that?

Senator Moss. Certainly.

Mr. MILLER. Have you been in operation long enough for any of those people who were turned down initially to have reapplied and by reason of improvements to have become acceptable?

Dr. SALMON. Yes. Our program is, as has been mentioned by several others previously, educational as well as a service program, and as a result of our turning down a number of facilities, they have made specific changes in their methods of operation and so forth and have reapplied and have been successful in becoming accredited.

We believe this is a very potent force in controlling the quality of medical care and/or care generally in this type of installation.

Dr. DEARING. May I expand in reply to your question directly: The first surveys in accreditation became effective in September of 1961 so that the 2-year periods began to end along in September of 1963, and we have had approximately, I think, of the group at that time, beginning at that time, there were about 120 accredited facilities, and that was the total, and they have come back into the fold, if I may use that expression. We have had a very small number who have failed to be reaccredited or who have failed to apply.

Our regulations also require that a facility which is sold loses its status of accreditation, or it did at that time. For that reason there have been facilities that lost our accreditation.

Senator Moss. How does you accreditation program compare with the national programs, one of which is sponsored by the American Hospital Association, the American Nurses Association and several other groups, and the other sponsored by the nursing home association and the AMA?

Dr. SALMON. Well, our program is unique in that in California the hospital association and the medical association are cooperative. At the national level this is something less than true. I believe, as a consequence, California—and this is my personal opinion, of

course—is being reserved as the preserve, if I might use that word, for a unification of the national program hopefully sometime in the future. I think it is agreed by anyone who thinks about it that rival accrediting programs are not very productive of good, and I personally hope that some type of adjudication can be carried out at a national level within a relatively short time.

Senator Moss. How large a staff is required for your program?

Dr. SALMON. Dr. Dearing has with him one surveyor, and he himself does surveying. We have an office staff of one girl. Actually, Dr. Dearing has been kept on the hop pretty much.

Senator Moss. I would think so, with that many applications to process.

Thank you very much, gentlemen. This is very interesting, and very heartening. It sounds as though you have done a really fine job in moving forward in this field of upgrading the quality of services rendered by nursing homes.

Dr. SALMON. Thank you.

Dr. DEARING. Thank you.

Senator Moss. Mr. Maurice Ostomel, who is executive director of the Jewish Home for the Aged, and representing the Association of Southern California Homes for the Aged, is next. We are happy to have you.

STATEMENT OF MAURICE OSTOMEL, EXECUTIVE DIRECTOR, JEWISH HOME FOR THE AGED, AND REPRESENTING THE ASSOCIATION OF SOUTHERN CALIFORNIA HOMES FOR THE AGED

Mr. OSTOMEL. Senator and gentlemen, I will make some informal remarks, because I see the time is getting short. I will give some description of the way the nonprofit homes for the aged are developing in southern California and throughout our State.

The homes for the aged in this area have been taking two major directions. Both kinds of homes are represented in our association. We work together, but they do have somewhat different emphasis.

One group, like the home with which I am identified, has a therapeutic approach to the very, very old people who are infirm, who need protective shelter care. Homes of the kind that I supervise generally have both kinds of licenses in California, that is (1) personal care from the social welfare department license for those who are old but who can manage to be about and with services to assist them, manage to the best of their ability, (2) along with nursing and convalescent care for them in units licensed by the public health department.

The other kind of home is a "retirement" one. It generally takes in a younger type of person, persons who are identified by religious background, fraternal or other interests; they come together and have a way of life that is productive and important to them. We feel that this is very important, and it is retirement oriented for this group.

Many of their residents, however, do seek the security and protection of knowing that they will be cared for for their whole life, and these homes have arrangements for this kind of protection, and must have the resources to guarantee this.

In this connection and I think this is very pertinent for long-term care, these homes increasingly are seeking to have under their own

auspices nursing care facilities; for example, the Lutheran home now has in architectural drawings a 100-bed nursing home unit which they will build a short distance from their life care retirement facility.

There is a divergence of opinion administratively about how these should be organized. Some homes, like the Pacific Homes, which has several of these retirement homes in southern California, have some units with nursing facilities at the same location as the "retirement" home as well as separate nursing and convalescent units for their people when they get to the stage where they need that type of care if the "retirement" home itself does not have this resource. These latter are still under the same nonprofit auspices, but they are located away from the retirement home itself.

Others are in favor of having perhaps a separate nursing care building but reasonably close so it can be associated with the home for aged itself.

Perhaps it is of some interest that our concepts about the requirements for nursing convalescent care for the elderly have been changing.

Several years ago I was a member of the staff of the Welfare Planning Council of the Los Angeles Region. I was secretary on their committee on aging. We were doing some study about protective care requirements and found at that time that it was desirable for a nonprofit home for the aged to have approximately 20 percent of their beds dedicated for nursing care for their own residents. That proportion is slowly going up, and I will venture, if a study were made now, many of the homes would say that 30 or 35 percent of their beds are required for this.

Our own organization is developing a site which we have in the San Fernando Valley where we will have more than 50 percent of the beds earmarked for nursing and convalescent care, because we found that this is important.

These are some general observations about the directions of homes for the aged. There are under a hundred of us in the Association of Southern California Homes for the Aged, and a larger number in a State association, with an overlapping membership.

If I might, I would like to speak for a moment about Federal legislation and its potential impact. I don't believe that has been mentioned to any appreciable extent.

Senator Moss. I would be glad to have you comment.

Mr. Ostomel. And make some observations in that respect.

I noticed with pleasure that two bills that have been introduced in the Congress, H.R. 1 and Senate bill 1, have reference to, among other things, an amendment in which Federal matching would be allowed for both assistance through OAA and medical assistance through MAA, paid in the first and last month of care in the medical institution.

Many of us in California appreciate the importance of that type of an arrangement, because it is not unusual for a person who is an old-age assistance to have paid for his care or paid toward his cost of care, as they do in our place, for the first month; he gets his OAA check in advance of the month, then perhaps the 15th or 20th he needs to get hospital care or nursing care and doesn't have the funds for this more expensive care. It seems important that Federal legislation should help correct this gap.

Some of the homes for the aged have been concerned in other States, not in California, that there be a flexible understanding about nursing care in homes for the aged.

I think in California we are very fortunate in that we do have a licensing system that would clearly indicate where there is professionaly skilled nursing. In some States that distinction is not carefully made, and, after all, we are concerned about flexible care of the patient. We would hope any Federal legislation would take that into account, so that a nonprofit home for the aged in a State where these distinctions are not as carefully made would have an opportunity to participate in this program, if it is genuinely giving professional nursing services.

These various nonprofit homes that I have been talking about have an increasing interest in developing nursing units. One of the problems that all of us face is that of finding the capital for them. We are very happy to note the amendments that have been made to make possible FHA underwriting and financing for this for nonprofit organizations but some of us believe that perhaps a lower interest type of arrangement, such as that available for low-cost housing, might be an added stimulation for homes to the aged to be able to take care of their own in nursing units. This would be helpful to us all in caring for these older people.

The "retirement homes" that have started out with people in their midseventies are finding as time goes on these people are getting older, they are requiring more and more medical care. Providing nursing care is going to be a pressing problem, especially in the future.

Homes also are broadening their concept about the care of elderly people who are variously described as senile, brain-damaged, in mental institutions, and so on.

I know in our own facility we are quite flexible in that regard. We have been able to give care to many individuals who otherwise might be in State hospitals. In fact, we have taken some from these hospitals and carefully worked out a program between their psychiatrist and ours. So any Federal legislation that will assist the States in helping encourage programs for these individuals who would be cared for more flexibly in their own communities and in these protective-care facilities certainly would be very useful.

If I may make a personal observation about the proposal on amending the social security benefits: We know that the particular legislative proposals that I referred to, would allow an increase of cash benefits of 7 percent. Those of us who are in this work are very familiar with the fact that the social security benefits themselves are in many cases of a minimal amount. Especially is that true for the widow, who does not secure the full amount, the primary benefit that her late husband had received, and any upward revisions would be extremely helpful. Personally, I was hoping that it might be much more than 7 percent.

In reference to assistance for the widow, I note that the financing for certain individuals for hospital care, who are not covered by social security, would include some funding through general funds of the Federal Government. Perhaps some similar approach should be taken to help provide the funding for individuals who are insufficiently covered through the social security program. We know that for the assistance program these general funds are going to the States. Fre-

quently a recipient is getting funds from two sources. I believe that in California approximately 50 percent of the old-age assistance or old age security recipients are also on old age and survivors' insurance.

It seems to some of us that perhaps there might be some economies and certainly added dignity if those funds are directed directly to the person in the form of increased social security benefits.

I thank you for the opportunity to present these ideas.

Senator Moss. Well, thank you for your very fine presentation. I particularly appreciate your comments on these various areas of Federal legislation.

You were discussing the fact that many of these homes for the aged also included nursing care facilities, and this brings to mind the fact that one is licensed by one department of the State and the other section, as it were by another department.

Have you found that to be cumbersome or difficult?

Mr. OSTOMEL. We have been very fortunate. We have been able to work very nicely with various departments. We haven't found any unusual problem about it. It may be necessary to comply with somewhat differing requirements, because there are many different jurisdictions, not only in reference to State licensing, but in respect to local codes as well. We have been fortunate to have been given a Hill-Burton grant for the nursing unit for our expansion program in the San Fernando Valley, and we found we have had to work with quite a number of different State and local bodies. That is just the way it is, but these requirements are met and they grow out of the complexity of our many different specialties as well as levels of government.

There are differences of approach and different codes. The U.S. Public Health has one set of standards that is a little different from that of the California Public Health Department, and the city of Los Angeles has some standards which are somewhat different than both, and we have had to work with all these different authorities.

Senator Moss. This hasn't been insurmountable, though?

Mr. OSTOMEL. No. It takes a little more extra time.

Senator Moss. Do the homes for the aged participate in this accreditation program we were hearing about earlier?

Mr. OSTOMEL. Not very materially. I think that one of the reasons is that the accreditation program is not only beneficial in raising the standards, which all of us agree are very desirable goals—we commend all of those who are working that way—but most of the homes for the aged have waiting lists. Our problem is we don't have enough space for the people who are applying, and we draw from special groups who have a special interest in being with people of like mind or like background and so on.

I think it is good that in our society we have a pluralistic approach to services and that there are proprietary facilities and nonprofit facilities and governmental facilities, and people have a choice. In my philosophy that is important.

It is also important that aged persons have the means to make these choices, so that they can go in whatever direction they want to go. If they want to go to a facility near where they live, fine. If they want to go with people from the same fraternal organization or religious identification that would be good, too.

Senator Moss. Does your association support the national accreditation efforts being made by the American Hospital Association and the groups associated with them?

Mr. OSTOMEL. Many of the members of our organization are members of the American Association of Homes for the Aging, and we look with favor upon the program that has recently been developed with the American Hospital Association. In fact, the particular home with which I am identified was listed before this recently developed arrangement was started with the American Hospital Association. We were listed as a long-term care facility, and in that connection we have a working hospital affiliation with the West Valley Baptist Hospital in the valley for our nursing unit there.

Senator Moss. Very good.

Any questions?

Mr. FRANTZ. I noticed you said your nursing care facility was a Hill-Burton facility. You may not have any comment on this, therefore, but I wondered if you would know whether the 10 percent equity requirement under the new FHA mortgage insurance program for nonprofit nursing homes is a serious handicap to using this financing to develop new nursing care facilities?

Mr. OSTOMEL. I am not qualified to speak on that, other than this one observation: The interest requirements for FHA are not so far different from those available through private financing; it's the long-term funding through FHA that seems to be the major advantage. I know that in our organization at one time we were thinking about seeking funds at about 3½ percent but we found that this Federal program was basically available for low-cost housing rather than for the more extensive type of care that we provide.

I feel confident that if there was a possibility of the nonprofit facilities going through this lower interest rate route and providing long-term care that many more then would take this course.

Senator Moss. Thank you, Mr. Ostomel. It was very good of you to come, and excellent testimony that you gave us.

Mr. Theodore Rosen, executive director, San Diego Home for the Jewish Aged.

Mr. Rosen, we are glad to have you, sir. We have kept you waiting a long time today, and we are glad you are up to bat.

STATEMENT OF THEODORE ROSEN, EXECUTIVE DIRECTOR, SAN DIEGO HEBREW HOME FOR THE AGED

Mr. ROSEN. Thank you, Senator Moss. I would like to discuss an aspect of long-term care that hasn't been mentioned today. I refer to the role of the small home for the aged. Because of the lateness of the hour, I will limit my remarks to a few highlights of a paper I have prepared on this subject. May I request that a copy of this paper be made a part of the official record of today's hearing?

The term "home for the aged" is used here to include boarding homes, nursing homes, and mental hygiene homes.

Applicants seeking admission to homes for the aged can be generally characterized as those men and women who are not acutely ill enough to stay in a hospital, yet too ill, physically disabled, or mentally impaired to be cared for properly in their own homes or with family.

In addition to decent living quarters and adequate physical facilities, the home must provide for them a therapeutic milieu that offers a full range of medical, paramedical, nursing, social work, and allied services in the areas of diagnosis, treatment, and rehabilitation.

In attempting to perform this multiservice function effectively, the small home for the aged is faced with a serious predicament. The needs of its residents are similar to those living in the large homes, and yet, notwithstanding its own characteristic virtues, how can the small home possibly provide the variety of services, facilities, specialized programs, and skilled professional staff offered by its larger counterparts?

On the one hand, the small home's overhead expenses are inherently high, while, conversely, its income is derived for the most part from the limited old-age assistance and medical assistance to the aged grants of an innately circumscribed resident population.

The fiscal burden would be intolerable.

It would appear from the realities of economics that the long-range solution to this problem lies in:

1. Upgraded levels and substantial increases in old-age assistance and medical assistance to the aged grants.

In the State of California, the maximum payment to institutions for the aged for the care of OAA recipients is frozen at $150 a month. But as a matter of fact, the actual per capita cost of care for the so-called well, ambulatory residents of our San Diego Hebrew Home for the Aged, a nonprofit community agency, is $300 a month. This is what it costs us to give the kind of care and services these residents need.

2. Extended professional services for OAA and MAA recipients, paid for by governmental funds.

In the State of California we are fortunate that our residents on MAA may receive as needed, medical treatment, physical therapy, occupational therapy, and drugs. However, the MAA program does not provide for speech therapy nor for psychiatric consultation, services which may be of vital importance in meeting these residents' needs.

3. Third-party governmental and private insurance payments for full cost of care and medical, nursing, and rehabilitative services.

These possibilities of broadened financial assistance should be certainly taken into account by the small home in its long-view planning program.

However, if it is to raise its standards of care and services here and now, the small home cannot mark time waiting for these possibilities to materialize. It must of necessity make an immediate and ongoing determined effort to explore, mobilize and utilize appropriately all possible community service resources in accordance with the particular requirements of its applicants and residents and with what is actually and potentially available in a community. This applies to the nonprofit as well as the proprietory home for the aged.

I would now like to discuss another problem—the serious shortage of trained staff in long-term care facilities for the aged.

One of the ways of alleviating this problem is by utilizing small-, medium- and large-size homes for the aged as community training resources.

In San Diego County, a joint planning committee, in cooperation with educational institutions and the California State Department of Education, has organized educational training courses for the development of vitally needed professional and vocational personnel. Funds for trainee stipends and instructors' salaries have been obtained through the Manpower Development and Training Act program.

The San Diego Hebrew Home has been utilized as a clinical and field training facility. Fieldwork at our home is an integral part of geriatric training courses given by Mesa College and San Diego State College. During the past 12 months, the following have received clinical field practice at our home:

1. Two classes of nurses' aids (40 people), 240 hours of field training.
2. Two classes of registered nurses (28), 240 hours. These are registered nurses who desire a training experience in geriatric nursing.
3. Two classes of home health aids (40), 240 hours, who will be working with the aged in their own homes under the supervision of a Homemaker Service Agency and the Visiting Nurse Association.
4. A speech therapist taking a master's in speech therapy at San Diego State College (100 hours).
5. A graduate social work student taking a master of social work degree at San Diego State College (90 hours).
6. Fifteen undergraduate social work students of San Diego State College and California Western University.
7. Ten high school students involved in a job exploration program sponsored by the San Diego Department of Education for students interested in nursing and social work.

One final point which has major conceptual implications—I feel that chronically ill, disabled, and socially dislocated aged people who are receiving long-term care should not be referred to as "patients." They are residents. They dread the thought of having to live for a long-term period in a hospital or hospital-oriented atmosphere. Whatever their chronic illness or disability, they require and desire as homelike a living arrangement as possible, where of course, diagnostic, treatment, and rehabilitative services are available as needed—that is to say, where the doctor, the nurse, the therapist, etc., is on tap, not on top. We must recognize that what is most meaningful and satisfying to residents in long-term care facilities is their opportunity to continue and maintain, as much as is realistically possible, their previous patterns and style of living and their contacts with family and the community.

Senator Moss. Thank you very much, Mr. Rosen. That is a very interesting presentation, and it did give us a lot of additional information.

What is the capacity of your Hebrew home?

Mr. ROSEN. We have 56 beds; 27 of these beds are in our nursing care wing, which was built last year at a cost of $400,000; 28 residents live in our "well ambulatory wing," which is licensed by the State Department of Social Welfare. I think that if a statewide survey were made, it would be found that elderly people who are in facilities licensed for the well ambulatory aged are not so well.

We have found it necessary to have licensed vocational nurses and skilled nurses' aids on duty around the clock, 7 days a week, in our well ambulatory wing.

Our nursing staff in the nursing wing consists of a director of nursing, 4.5 registered nurses, 4 licensed vocational nurses, 10 nurses' aids, and 1 male attendant. In addition, we have a psychiatric consultant and an intensive inservice training program of 4 hours a week, for all staff members.

Senator Moss. That is very good. I particularly liked your suggestion about the extra effort being made to train personnel. That is what we hear everywhere, that there is a great shortage of trained personnel.

What you are doing there obviously is a good way to attack the problem.

Senator Moss. Are there any questions?

Thank you very much, Mr. Rosen.

(The statement of Mr. Rosen follows:)

PREPARED STATEMENT OF MR. THEODORE ROSEN, EXECUTIVE DIRECTOR, SAN DIEGO HEBREW HOME FOR THE AGED

The swift and steady advances made by Jewish homes for the aged in their care and service programs during the past 10 to 15 years have been propelled by two interrelated forces:

1. The persuasive influence of advisory standard-setting organizations and the requirements of licensing and accreditation agencies.
2. The basic inner drive of Jewish homes for the aged to fulfill their share of responsibility in meeting the changing and developing needs of our aging population.

Applicants seeking admission to Jewish homes for the aged today can be generally characterized as those men and women who are not acutely ill enough to stay in a hospital, yet too ill, physically disabled, or mentally impaired to be cared for properly in their own homes or with family. In addition to decent living quarters and adequate physical facilities, the home must provide for them a therapeutic milieu that offers a full range of medical, paramdical, nursing, social work, and allied services in the areas of diagnosis, treatment, and rehabilitation.

In attempting to perform this multiservice function effectively, the small home for Jewish aged is faced with a serious predicament. The needs of its residents are similar to those of the residents living in the large Jewish homes. And yet, notwithstanding its own characteristic virtues, how can the small home possibly provide the variety of services, facilities, specialized programs, and skilled professional staff offered by its larger counterparts?

On the one hand, its overhead expenses are inherently high, while, conversely, its income is derived, for the most part, from the limited old-age assistance and medical assistance to the aged grants of an innately circumscribed resident population. The fiscal burden would be intolerable.

It would appear from the realities of economics that the long-range solution to this problem lies in—

1. Upgraded levels and substantial increases in OAA and MAA grants.
2. Extended professional services for OAA and MAA recipients, paid for by governmental funds.
3. Third party governmental and private insurance payments for full cost of care and medical, nursing, and rehabilitative services.
4. Increased local Jewish federation and community chest fund allocations to the home.

These possibilities of broadened financial assistance should crtainly be taken into account by the small home for Jewish aged in its long-view planning program. However, if it is to raise its standards of care and service here and now, the small home cannot mark time waiting for these possibilities to materialize. It must, of necessity, make an immediate and ongoing determined effort to explore, mobilize, and utilize appropriately all possible community service

resources in accordance with the particular requirements of its applicants and residents and with what is actually and potentially available in the community.

To approach such a major undertaking systematically it is incumbent upon the small home to—

1. Survey and assess the total needs of its residents and of the residents as a whole.
2. Review and analyze the existing programs and services of the home in relation to how and to what degree they are now meeting the needs of the residents.
3. Identify the gaps of service.
4. Take appropriate steps to obtain the specific community service resources needed to fill these gaps.

In the growing complexity of modern social organizations, the small home cannot be expected to have full knowledge of the many social, health, education, and welfare agencies, and of the various volunteer service organizations in the community. It is necessary that contact be made with local, State, and National agencies under Jewish and general community auspices which serve as information and referral centers in the field of services for the aging. These agencies can help the small home pinpoint and gain access to functional agencies and organizations whose specific services are needed and are available for use. The local Jewish federation agency and community welfare council, functioning as they do in the area of overall planning, can do much to forge an initial communicative link between the small home and community service agencies, and can lend encouragement to their ongoing working relationship.

There are many ways of classifying community service resources. In this paper I would like to discuss them under two main headings: (1) Those brought into the home, and (2) those used at their source outside of the home.

While these services and facilities are listed separately, it must be emphasized that their relationship within each other and with the home's existing intramural care and service program make it possible for the resident who is not accessible to any particular one of these approaches to be helped by their totality.

THE FLOW OF SERVICE RESOURCES TO THE HOME

Professional services

Of major importance in the configuration of helping forces are professional services supplied directly to the resident, as well as those used by the home for purposes of supervision, consultation, and staff training. Sources in the community from which professional services may be obtained include professional societies and organizations, hospitals, rehabilitation centers, State and local departments of health, colleges and universities, departments of education, State department of social welfare, county department of public welfare, social agencies, volunteer health agencies, and private practitioners interested in the home and its program.

Medical

Efforts should be made by the home to secure a physician interested in geriatrics and group care for the following purposes: To examine each person applying for residency; as house physician, to examine each resident on a regular periodic basis and to write orders for the staff; to be on call for emergencies; to take a leading role in the development of the home's general medical policies and daily medical program. His presence in the home as principal physician and chief medical consultant insures continuity of contact between all residents and a physician. This gives the resident a feeling of security and enables the home to carry out a program of preventive and restorative medicine. As an additional step in guaranteeing adequate health care, a panel of qualified medical consultants can be invited by the principal physician to advise in diagnosing specific complicated cases and, in some instances, to give direct treatment.

Psychiatric

Psychiatric service is an invaluable adjunct to the program of the small home. In addition to making psychiatric evaluations of applicants to the home, the psychiatrist can be called upon for direct brief therapy, for planning and directing therapeutic programs for certain residents, and for the orientation and training of staff with respect to the psychiatric aspects of care of the aged, the dynamics of human behavior, and staff self-awareness. Psychiatric serv-

ice makes an important contribution to the small home by helping the disturbed become less disturbing to others, and by remotivating and restoring residents to the greatest possible degree of their adaptational capacities.

Dental

Teeth and their supporting structures may exert considerable influence on the everyday life of the residents by affecting their health, appearance, and emotional well-being. A dentist who is interested and qualified to provide dental service to aged persons, in their beds if necessary, is an essential resource for the small home. All new residents entering the home should have a dental examination, and a dental evaluation should be included in the resident's health record. The dentist can also give direct treatment for the relief of pain and elimination of dental infection. The county dental society is a good resource of supply of portable dental equipment to be used by the dentist for nonambulatory and homebound residents. Through these services, numerous chronic diseases and impairments can be detected and controlled. Furthermore, experience has shown that with dental ailments corrected, many of the dietary problems of the residents disappear.

Podiatric

The small home should not underestimate the foot problems of its residents. Diabetes and circulatory deficiencies can create serious difficulties for the resident who has ingrown nails, corns, and callouses which might become ulcerated and gangrenous. In other instances, a resident may seem to be cranky and obstreperous and require extra care and staff attention, when the trouble is simply that his feet hurt. It is therefore important that the home interest a podiatrist in the community to visit the home on a regular basis for the purpose of examining and treating the residents' feet, as a necessary part of the home's preventive program.

Dietary-nutritional

Well-balanced meals with full nutritional value and which are protected against destruction of vitamins or other essential elements, are directly related to the health and happiness of the residents. To realize this objective, the home should seek guidance and direction in menu planning, food preparation, and diet therapy from professional dietitian consultants whose services are available from the State health department, community hospitals, colleges, universities, etc.

Nursing

A major problem in operating a good nursing program in the small home is that of obtaining qualified and well-motivated personnel. The small home often finds itself in the position of having to employ persons who have little or no training in nursing. To offset this problem, the home should secure from the Visiting Nurse Association, Public Health Nurse Bureau, or local chapter of the Red Cross the services of instructors for an ongoing in-service-training program in the areas of bedside care, rehabilitative techniques, incontinence and odor control, etc. These agencies can also provide consultants to help the home delineate the specific functions of the various levels of its nursing personnel and to help determine how the staff members in each category can be used most effectively. In addition, staff members of the Visiting Nurse Association and professional nurses interested in doing volunteer work can give supervisory and direct service in the home's nursing program.

Physical therapy

The way to take care of residents in any home for the aged is not just to take care of them. They need assistance in becoming as independent as possible. Self-help, ambulation, and rehabilitation are specific methods of accelerating convalescence and recovery. Physical therapy is a basic ingredient in rehabilitation. It is important that the small home seek the services of a doctor of physical medicine. At the point of a resident's admission, the physiatrist can provide a prescription of therapy and set up the framework of prospective goals for the resident. This procedure is valuable because the new resident is brought under active treatment with a minimum timelag from the date of admission. The direct service of a registered physical therapist, obtained from the Visiting Nurse Association, Crippled Children's Hospital, rehabilitation center, State health or educational agency, can be used to follow out the doctor's prescription, when complicated procedures are involved. The physical therapist can also play an

important part in the development of a physical therapy program in the home by teaching daily followup rehabilitation techniques to the staff and volunteers, as well as to the residents. It should be noted that the activity required of the resident in a physical therapy program may in numerous cases alleviate anxiety, and assist in overcoming many of the psychological concomitants of progessive chronic illness and disability. The small home can have a practical physical therapy program without expensive- or impressive-looking equipment. With a set of the physical therapist consultant's plans at hand, a good maintenance man can build physical therapy equipment, on an as-needed basis.

Occupational therapy

If a genuine treatment and rehabilitation program is to be instituted in the small home, the services of a registered occupational therapist should be sought from a community rehabilitation center, specialized hospital, or educational institution. A professional program of occupational therapy is medically oriented. It is based on medical, psychiatric, or orthopedic diagnosis, prognosis, and prescription. The registered occupational therapist uses his skills in direct treatment and in supervision of staff and volunteers to stimulate the resident's desire to participate in activities which are specifically designed to improve psychological attitude or to restore impaired physical function, or a combination of both. Occupational therapy contributes along with medical, nursing, social work, and other rehabilitation services toward helping the resident move closer to normal patterns and more independence in daily living.

Speech and hearing

Problems in communication tend to appear in multiples and present severe complications in treatment and management. Speech and hearing specialists have an important role to play in the rehabilitation of residents who have problems in hearing and articulation. An arrangments should be made with a hospital, rehabilitation center, or speech department of a college or university whereby a speech therapist is assigned to the home on a loan basis. Through a variety of techniques, the speech therapist helps the resident with voice and articulation problems to approach inteligibility. The aphasic resident is assisted in returning to former language patterns.

Through the cooperation of speech and hearing centers associated with colleges, universities, and specialized hospitals, the home can enlist the aid of a clinical audiologist and hearing therapist. Under the medical direction of an otolaryngologist, they engage those residents asking for assistance and those referred by staff in testing, evaluation, hearing aid orientation and counseling, and in auditory rehabilitative procedures. The acquisition of better speech and hearing helps the resident to overcome frustration in the communication process, and to make a more positive adjustment to daily living in the home.

Sight

A large number of the residents in homes for the aged have eye difficulties. Professional service is needed for their comfort, for conservation of eyesight and for their protection against blindness.

In line with its preventive program, the small home should participate with the local department of public health in a sight survey and glaucoma-testing program for the residents. In addition, the local guild for the blind can be approached to provide consultative and supervisory service for the care of the home's blind residents.

Laboratory and X-ray

Laboratory and X-ray services are essential to the home's program since availability of diagnostic service is basic to good medical care of the residents. The provision of these services by technical staff obtained from hospitals and clinics and through X-ray services made available regularly by the Chestmobile service of the department of public health or County Tuberculosis Association assures the residents of continuity of care.

Casework

The applicant to a home for the aged requires casework help so that he may identify the essential problem at hand and determine, on the basis of his needs and the services offered by the home, whether residence can provide the solution to his problem. An admission study by a professional caseworker, as part of the home's operating procedure, serves to benefit the client in arriving at a decision about entering the home. The small home should make every possible

effort to work out an arrangement with the local Jewish family service or nonsectarian agency for this necessary service. If possible, casework service by the family agency worker should continue on during the undercare period of residency. Here, the focus is on helping the resident adjust to his new environment and changed role, and on assisting him in dealing with his feelings and reactions to illness, disability, dependency, and other personal and family problems which stand in the way of his making constructive use of the care and services of the home.

Groupwork

Most elderly persons in a home for the aged cannot maintain a status quo. They either progress or regress. The social, behavioral, and physiological concomitant of inactivity in detioration. It is therefore advisable that a plan be worked out with the local Jewish community center or nonsectarian center, whereby one of the center's group workers is assigned to the home for a specified time each week to help organize small groups and to develop a variety of programs related to the residents' interests, desires, and problems. Through the group worker's direct service and supervision of staff and volunteers, the residents are helped to use formal and informal activities creatively and meaningfully. A professionally supervised group work program offers an excellent opportunity for the residents to express grievances and suggestions, to participate in planning and decisionmaking, and to gain recognition, acceptance, status, a sense of belonging and an improved self-concept.

Education

A consultant from the State office for the aging or State department of education can give guidance and assistance in the development of an adult education program at the home. Under the auspicies of the adult education division of the board of education, extension courses, taught by instructors who are trained to work with the aged, can be established at the home. The value of this kind of program lies in the fact that when the residents learn new modern things, they are inspired to look ahead for satisfactions in living.

Librarian

A professional consultant furnished by the public library or university library can stimulate the interest of the residents in the world of books. He is also their resource person for books of special significance, books with large print for residents with poor vision, etc.

Rabbinical

The rabbis of the local community should be invited to visit the home, to officiate at religion services, and to offer spiritual counseling to individual residents. These services are a vital source of sustenance, comfort, and solace to the residents. They give emotional release and broaden narrowed horizons. The spiritual stimulation recreates a desire for living and often creates new goals for residents whose lives have lost much of their meaning.

Interior decorator

A professional interior decorator should be enlisted to work with administration, appropriate board committees, staff, and resident council on the choice of materials and coordinated color selection for the various parts of the home. And by helping the individual resident decide on the decor, furniture arrangement, etc., of his own room, the interior decorator contributes toward the home's efforts to foster and maintain, as much as it can, the resident's distinctness and uniqueness as a person in his own right, within the group living residential community of the home.

B. VOLUNTEER SERVICES IN THE HOME

It is most important that the small home develop a structured lay volunteer program, in which the volunteer's potentialities and abilities are matched with and are channeled toward the particular needs and interests of the individual resident and the residents as a group. The choice and diversity of tasks assigned in the volunteer program will depend upon many variables, including the nature of the specific service, the type of residents in the home, community interest in the home, and availability of volunteers.

The following are some of the sources in the community from which volunteer workers may be obtained: Individuals who are interested in the home, the res-

idents' relatives, women's auxiliary of the home, National Council of Jewish Women, and other Jewish service organizations, synagogue and temple groups, senior citizens groups, B'nai Brith Youth Organization and other youth groups, children's groups, service clubs, Red Cross, central volunteer bureau of the local community welfare council, unions, special interest groups (art, music, drama, gardening, chess, etc.), department of recreation, nursing and rest home association volunteer projects, et cetera.

Friendly visitors

Though he doesn't live alone, the resident of the small home may feel lonely. One of the best ways of combating this loneliness is through a friendly visitor program. The intervention of human contact from the outside community sustains and nourishes the resident's sense of personal worth. The friendly visitor program offers someone new, someone different, and someone very special personally. The smiling face of the friendly visitor may often be more valuable to the resident's morale than any other aspect of treatment. In planning a friendly visitor program, the small home should recognize the importance of the vibrancy which only children and adolescents can bring to the situation. Selective visiting which matches residents and children has much merit. A program in which members of the local B'nai B'rith youth organization, Jewish community center youth club, or temple youth league, adopt residents as "grandparents" not only allows these residents to expand their contacts but also gives them an opportunity to do something for their adopted "grandchildren."

Social activity and recreational volunteers

Social and recreational activity programs including games, music, drama, entertainment, hobbies, gardening, arts and crafts, resident newspaper, lectures and discussions, readings and book reviews, Torah classes, birthday parties and holiday celebrations, are an essential part of living in the home. They give the residents an opportunity to have fun and companionship and to develop new interests and creative achievements. They allay anxiety and offset deleterious stagnation and regression. The recruitment of volunteers with specialized skills and talents from the local central volunteer bureau and from service clubs and organizations is a basic necessity, if these programs are to be successfully developed by the small home. Through selective utilization of activities and the volunteer workers' purposeful efforts, a warm intimate association between the residents and the volunteers is evolved. This gives real meaning to the aims of the home's social and recreation activities program.

Beautician and barber volunteers

The services of a licensed beautician is needed by the home to give its disabled women residents the complete hair care they would receive if they were to visit a beauty salon in the community. The local cosmetologist association can be approached for such a volunteer. The space set aside in a beauty salon can also be used as a barber shop, staffed by local barbers who are willing to give freely of their time and tonsorial skill. A beauty salon-barber shop service in the home does much to raise the morale of incapacitated residents. They can now take pride in their appearance and this is a big step toward better self-concept and recovery.

Sheltered workshop volunteers

For many residents, the best kind of therapy is paycheck therapy. If an activity is to be purposeful and meaningful for them, their work has to bring some financial return. A sheltered workshop program provides a good way of filling the bill. It serves as a stimulus in directing the resident through his own motivation, interest and activity, back to normal patterns of life and expression. The local chamber of commerce and business people can help find local manufacturers who might be interested in having some of their work done for them on a contractual basis by residents at the home. A local vocational service agency can be approached to recommend volunteers who are qualified to organize and supervise this project.

Gray Lady and Candy-Striper volunteers

A Gray Lady and Candy-Striper program can be developed into a most helpful service, bringing into the home a warmth and enthusiasm which noticeably affects the spirits of everyone. By assisting infirm residents in walking, bringing wheelchair residents to activities, feeding disabled residents, serving refresh-

ments, writing letters, reading to residents, etc., the Gray Ladies and Candy-Stripers make it possible for the staff to concentrate more fully on ministering professional, technical, and specialized services vitally needed by the residents.

C. COMMUNITY SERVICE RESOURCES USED BY RESIDENTS OUTSIDE THE HOME

Going out into the community has special significance for the resident. It gives him an opportunity to procure needed services and programs which cannot be brought into the home. Furthermore, a change of atmosphere away from the home dispels some of his underlying fear of being depersonalized and homogenized by constant group togetherness and orderly routine. It makes him feel that he is indeed a part of a wider community. It makes possible the continuance of earlier patterns of living and the enjoyment of new experiences.

The residents must have transportation if they are to be able to make effective use of extramural services available for them in the community. To insure adequate transportation on a consistent basis, the home should develop a well-organized motor corps service. Volunteers for this service may be obtained from the residents' families, the women's auxiliary of the home, Red Cross, service clubs, central volunteer bureau, colleges and universities, synagogue and temple groups, fraternal organizations, etc.

Health services

Since the medical needs of its residents are numerous and varied, the small home should develop a close liaison with a general hospital and a cooperative relationship with outpatient clinics of the department of health and rehabilitation centers. This will enable the residents to have easy access to intensive medical and surgical treatment and to elaborate diagnostic and rehabilitation services.

Family and social activities

In addition to the pleasure gained from visiting family members and attending such family gatherings as weddings and bar mitzvahs, the residents derive great satisfaction out of being invited to the homes of their friends and to social functions and meetings of the women's auxiliary, Jewish fraternal groups, synagogue and temple organizations, and so forth.

Civic Affairs

The residents' experiences in going out to register and vote, in participating at election rallies, and in attending civic forums make him feel equal in status to all other citizens in the community.

Recreational and cultural activities

Essential for the welfare and happiness of the residents is the opportunity to attend and partake in the recreational and cultural activities of the Jewish Community Center and senior citizens centers. The diversified and well-rounded program of the local community indoor sports club can develop the potentialities of the handicapped and disabled residents. Trips, tours, picnics, outings, boat-rides, shopping, etc., are popular activities. They give the residents mental exhilaration, improve their psychological and emotional outlook, and thereby make living in the home more pleasant for them.

Educational activities

Attending adult education classes in local community center and library extensions gives the resident of the small home an opportunity to select courses which are geared to his educational background and interests. His experience in these outside classes add zest to the day, and the school certificate he receives upon completion of a course buttresses his sense of mastery and feeling of accomplishment and adequacy.

Synagogue and temple services

Participating in religious services and religious study at the synagogue or temple in the community where they were members, has special meaning for some residents. It represents an ideal combination—the renewal of deep religious emotions combined with seeing old friends.

Resident volunteer projects

The need to make a contribution to the community through their own resources, energies and productivity, motivates many residents to engage in a variety of volunteer work projects, related to mass mailing and the packaging of

bandages and nursing supplies at the work headquarters of community health and welfare agencies. Other jobs may involve the making of articles at the home which are then delivered by the residents to child care agencies, hospitals, Red Cross, Cancer Society, and so forth. By participating in these volunteer projects, the residents develop feelings of self-worth, independence, and responsibility to themselves and to the community as a whole.

SMALL HOME AS A COMMUNITY RESOURCE

While this presentation is concerned with how the small home and its residents are the recipients and beneficiaries of outside community services and facilities, it should be noted that the home is itself part of the mainstream of community service resources. Serving the field beyond the scope of its immediate sector of care and services for its residents, the small home can participate cooperatively in general community planning by providing facility for the following programs:

Field training of undergraduates and of graduate school of social work students.

Clinical field training in geriatric nursing on all levels, cosponsored by schools of nursing, colleges, adult education division of the board of education, and the State department of employment.

Research in the dynamics of small groups and medical, psychological, and psychiatric research.

Day care for older persons who wish to continue to reside in the community.

Senior citizen clubs.

Kosher meals on wheels.

SMALL HOME-RESOURCE AGENCY RELATIONSHIP

A good working relationship between the small home and the assisting community resource agency can be effectively developed when—

1. The respective responsibilities they assume for professional personnel and volunteers being supplied to the home are delineated.
2. Systemized referral procedures are set up and put into operation.
3. Upon referral, the resource person is oriented to the function, purposes, policies, practices, and limitations of the home.
4. The resource person's specific duties, his role-position in the home's structure, and his relationship to administration, supervisor, staff, other community resource personnel, residents, and residents' families are clearly defined.

ROLE OF THE ADMINISTRATOR

Teamwork is hard to come by even among staff members employed in the same home, let alone among separate outside community resource persons who come to the home at different times and under varied auspices, and who are guided by different philosophies.

The administrator of the small home has a basic responsibility to coordinate and interweave the functional skills and talents of the staff and the numerous outside professional and volunteer workers, so that all services and care rendered to the residents are rehabilitatively and therapeutically focused. The key to the cooperative efforts of community resource personnel and staff lies in the tone set by the administrator. In promoting a positive enthusiastic climate, he enables the staff to respect and accept outside professional and volunteer workers as part of the home team, which is most conducive to consistency and stability of needed services.

EVALUATING COMMUNITY SERVICE RESOURCES

As a final step in the process of planning, procuring, and utilizing community service resources, an evaluation should be made of these services in the light of the small home's goals and perspectives. For this purpose, periodic reviews are conducted by the administrator and appropriate professional staff, with board committee members, members of the local Jewish federation planning committee, and representatives of community resource agencies participating.

Discussion at these evaluation sessions are centered on two main points:

1. Gaging the degree of effectiveness of the resource services being reviewed, within the context of the total program of the home.
2. Determining whether these outside services should be: continued as is, modified, expanded, terminated, or absorbed as an organic part of the home's own service program.

CONCLUSION

The small home for Jewish aged has an ongoing responsibility to take account of the particular unmet needs of its residents and to give them a high priority as immediate objectives in its long-range prevention, treatment, and rehabilitation program.

In line with this, the plan of action organized by the administrator should involve the mobilization of accessible services and resources other than those which the small home for the Jewish aged can extend.

Prompt, adequate, and skillfully rendered forms of these professional and volunteer service resources serve to—

1. Raise the standards of professional care and services of the small home.
2. Heighten the home's effective functioning as a Jewish community service agency.
3. Demonstrate how community planning and coordination can be brought into play to avoid unnecessary duplication of already existing services in the community.
4. Point up to the home's board of directors and sponsors, and to the local Jewish federation agency that certain selected services rendered by outside community resources as demonstration projects, warrant inclusion in the home's own intramural program of services, for which provision should be made in the home's annual budget.
5. Involve the community in varying levels of participation and enhance the home's community relations.

Senator Moss. We have come to the end of our list of witnesses. We appreciate all of the witnesses who came today. I do want to say that if there are any of you here who would like to submit a statement in writing, if there is something that hasn't been covered, or if some of the material that has been covered you would like to amplify or explain or contradict, we will be glad to have your statement, and we will include it in the record. You can mail it to me in the U.S. Senate, and it will be made part of this record, which will be held open for about 3 weeks' time to take any additional statements or publications that we should include here in this study.

I have received one letter asking for permission to do that, and I extend that offer to any of you who would like to do it.

Let me thank you one and all, those who participated, and those who stayed and listened today, and took an active interest in this most important problem. We are going to continue our study. Denver is our next hearing, and we will have other hearings in various other places throughout the United States.

I think the evidence here today is that California has indeed made some great strides forward, and I am quite heartened with what I have been able to hear.

I think we have a long way to go. We have some things that are not yet up to standard, or up to what we want them to be, but at least we are aware of the problem and it is being attacked from many areas.

Thank you. The hearing is now adjourned.

(Whereupon, at 4:30 p.m., Wednesday, February 17, 1965, the committee adjourned.)

(The following was subsequently supplied for the record:)

LOS ANGELES COUNTY NURSING HOME ASSOCIATION,
Los Angeles, Calif., March 1, 1965.

Re U.S. Senate Special Committee on Aging, Subcommittee on Long-Term Care, meeting at Los Angeles, Calif., on February 17, 1965.

Senator FRANK E. MOSS,
U.S. Senate,
Washington, D.C.

DEAR SENATOR MOSS: In connection with the above reference matter, the undersigned, as president of the subject association desires to acquaint you and your committee with certain factors that have existed and which presently exist in the long-term-care field.

I would first like to express my deep concern and regret that our association had no knowledge of the committee meeting here sufficiently in advance to enable us to be on the agenda for said meeting or to prepare a detailed, written statement for the committee at said hearing.

It is fitting, I believe, that you know that our association is a nonprofit organization duly authorized in 1946 and existing under the laws of the State of California, with a membership of approximately 135 member facilities with a bed capacity of over 6,000.

Since the association was organized and formed, we have constantly stressed the necessity of improving standards and long-term care for the aged and we have developed programs to assist in this regard. The association has regular board meetings monthly and membership meetings at least once in every 3 months and, at said meetings, educators and speakers, well versed in long-term care, are in attendance. Also, the association is active in conferences, seminars, and meetings with all of the facilities that are interested in said care and we have sponsored, together with the UCLA School of Public Health conferences at its center at Lake Arrowhead, Calif., and presently we are working on two conferences to be held with them at said center this year. In other words, we are constantly improving ourselves from within.

The State of California does possess good nursing facilities for long-term care and it is my firm belief that they are better than those that may be found throughout the rest of the United States but that there must be a realistic approach and proper legislation in this field to enable good facilities to operate in California and elsewhere. For example, the FHA standards for the construction of nursing facilities are as they should be, high; but the rates that have existed and which are proposed for long-term care are low. This, of necessity, creates problems which affects care and makes the long-term care operator a slave of his environment. If the proper facility is built according to the requirements to enable the operator to exist, there has to be an adjustment in care which, in many instances, might well be below proper standards which destroys the proper care factors.

The cost index presents a further problem in that, wage increases by law, insurance premium increases, and the rise in maintenance expense have raised the basic cost in the approximate sum of $11.28 per employee, per month, but there has not been to date any programing to adjust the low rates paid for care. It appears that MAA is basically charity but it is so easy for one to be placed on this program that there are many families that are deriving benefits when they, themselves, could well afford to pay for any care. This results in draining the budget to a point where there is not enough money remaining for the care of those that are really in need and this is a factor that should be cured by proper legislation.

In many counties in the State of California, and in many States, higher allowances are allowed and supplementation by the family or interested persons is permitted but this is not true in the county of Los Angeles, State of California, and there exists a situation which makes it almost impossible for the individual long-term-care operator to adjust or to compete. At present, the same patient that might be placed in a long-term-care home or in the Los Angeles County Hospital establishes a different rate for said care. If, in a private nursing home, the allowance is $9.10 a day but if in the county hospital, the allowance is $18.87 a day and I do not know of any way to reconcile this difference, other than the fact that this rate is the one that has been established by the proper authority concerned with establishing the rates for care.

I am sure that you and the committee have been advised of the many surveys that are being conducted on different levels and concerning different factors that are involved in long-term care but it is my considered opinion that the results of said surveys are not accurate and that they do not reflect the true existing situations. I feel that this is true because in the majority of instances the surveys are being conducted and information is sought from other than the operator of long-term-care facilities themselves with the result that there is not a proper or true basis presented to substantiate the findings of said surveys.

There exists other factors and situations which are pertinent and material on the problems that exist and some of these, but not all, are detailed in a documented report made by John A. Williams, Robert A. Thornblad, and Dolores Towe, all members of our association and all on its board of directors on October 5, 1964. This report was made to Assemblyman Nicholas Petris, chairman, and his committee, which is the assembly committee on institutions for the State of California.

I enclose herewith, a copy of this report for your study and consideration.

In closing, I wish to express the appreciation of the association for the interest shown by you and your committee and the opportunity to present this letter and its enclosure for assistance in aiding your determinations on long-term care.

Our association stands ready and willing to assist you and your committee at all times.

Respectfully,

ARNOLD FREED, *President.*

REPORT PRESENTED BY JOHN A. WILLIAMS, ROBERT A. THORNBLAD, AND DOLORES TOWE

LOS ANGELES COUNTY NURSING HOME ASSOCIATION,
Los Angeles, Calif., October 5, 1964.

Assemblyman NICHOLAS PETRIS,
Chairman, Assembly Committee on Institutions,
San Francisco, Calif.:

The Los Angeles County Nursing Home Association represents approximately 125 facilities providing a total of 5,500 beds in the southern California area. The association has as one of its chief aims, the promotion of higher standards for all institutions caring for the ill and the aged, and seeks to assist responsible governmental agencies in developing the finest professional nursing and convalescent care industry in the country.

Much of the voluntary effort to upgrade patient care and raise standards of operation was undermined by the advent of the MAA program when unrealistic rates not truly commensurate with quality (not luxurious) patient care were forced upon the industry. The current MAA rate structure has fostered marginal substandard care in the old as well as the newer facilities.

A very typical example of the problem facing the nursing home operator today is briefly this. A private patient is in the facility. This patient usually requires extensive nursing care. The patient applies for MAA and is granted this assistance. Up to this point the patient has been paying for nursing care under the free-enterprise system at a truly competitive rate. Now, however, the administrator must decide whether to keep the patient at the MAA rate (which provides less than the cost of care), or discharge the patient, or accept illegal supplementation to bridge the gap between the inadequate MAA rate and the fair competitive rate previously acceptable. The families, obviously, are well pleased to be able to obtain care in a first-class care facility at very small cost to themselves. There is really no justification for keeping the patient since the cost of care has not changed.

With the virtual elimination of family responsibility, the AMA program has been readily available to families of means, and private patients are difficult to find. It should be mentioned that nursing operators counted on their private patients to pay for and carry their MAA guests; however, this margin of safety has virtually disappeared. This association has been violently opposed to the State's program of having the private citizen and the independent businessman subsidize the welfare program in this manner.

If the MAA patient is accepted and is classified under extensive care, the rate is $9.10 per day. If the facility, through skilled, professional effort, improves the patient's condition to where the patient exhibits a lesser degree of dependence, the facility is rewarded with a stiff penalty since the patient is reclassified

to basic care and the rate reduced to $7.35 per day. The rates in most nursing homes are based on the number and type of beds in that facility—not on the relative needs of the patients (which often vary daily). Recommended staffing patterns by licensing agencies are also based on the number of patients, not their condition. It should be apparent, therefore, that a patient in a skilled, professional nursing facility will cost that facility the same whether he is bedfast, partially bedfast, or ambulatory. The primary difference is with those patients who are feeders or incontinents. The private patient pays for the extra expense in proper proportion—the MAA allows nothing for this additional and very costly care.

This association supports most heartily the public agencies. It feels that violation of regulations should receive prompt and energetic attention, and that all licensed facilities, whether private, nonprofit, or governmental, should be required to be in full compliance at all times. The regulations applying to the industry are only as effective as the enforcement agencies make them.

As to the rampant, uncontrolled building of nursing and convalescent facilities, we believe the vast majority are being constructed purely for speculation. Many are built with the idea of immediate sale or lease. Many leases today are selling for $75 plus per bed. We know that these facilities cannot long remain in business with the rates that exist today, and it is assumed that within the next few years a number of business failures will be observed—providing, of course, that these operations are not permitted to accept and survive on illegal supplementation.

Along with said uncontrolled building, we have a further vital concern as to the effect this has had and will have on professional manpower. There has existed for a long time in the past and there presently exists an acute shortage of qualified professional personnel. In order to comply with the regulations that exist, it is most difficult to obtain the required qualified nursing staff for existing facilities without considering the new ones being presently built and those proposed for construction. The association knows from its experience that this building program will increase such shortage to a most critical point and it believes that this will affect and cause serious problems in acute hospitals and the nursing field.

This association has long been a strong supporter of the reimbursable cost method. It was recommended that this be based on a uniform accounting system (which was also presented) so that all costs were basically equal, or accounted for on a fair and equal basis. Those facilities willing to work and operate with required efficiency would be fairly repaid for their efforts under this program. The reimbursement level should have a ceiling in order that inefficiency may not be rewarded. It is the feeling of the association that under this system a facility or marginal operator would not be rewarded for keeping a patient in bed, since he would receive the same rate and would know what to expect. The luxury facility would care for the private patients, and the private and MAA patients would receive comparable care at rates that covered the cost of this care.

While we favor the reimbursable cost formulas as being fairest to the nursing facility, patient, and the taxpayer, we would comment on supplementation by patients' families by pointing out that seven States permit supplementation of MAA rates. Testimony in a previous hearing, when it was stated that when State welfare agencies set what they considered to be a full and complete rate for nursing service, supplementation was not permitted; however, in States where the rate was not considered adequate to cover the cost of care, the family could then in fact make up the difference. It was emphasized by staff members at that time that California has established "a reasonable standard of care," and that the State had set up a program predicated on reasonable rates, which then, in their opinion, prevented the vendor (nursing homes) from seeking supplemental payments. While the State department of welfare may be technically correct relative to the letter of the law, we suggest that there is a strong moral issue to be raised, if not truly a legal one. Since only the State staff members feel the rates to be "reasonable," it seems appropriate for us to feel that we are justified in seeking to obtain legal supplementation of the current MAA rates.

In Los Angeles County, the bureau of public assistance is not able to certify that MAA beds are not available because many nursing facilities accept supplementation. This has been truly disastrous since the two supplemental factors of payroll and investment have not been applied to Los Angeles County nursing facilities as they have in most counties in the State. To indicate the impact that allowance of these factors makes, it is interetsing to note that of 138

facilities in northern California approved for this increase, the average supplement proved to be $1.49 per patient per day. We obviously do not have a fair and equitable statewide policy or uniform MAA program that is even remotely administered in a uniform manner.

Illegal supplementation in Los Angeles County cost the county no more, and the patient is receiving care. However, the facilities accepting supplementation face the possibility of being caught and penalized for charging what in reality is a fair, competitive, and entirely normal and proper rate. The nursing home operator is forced to accept supplementation more as time goes on since he has fewer and fewer private patients, because of the unrealistic welfare regulations, and because in many cases he is not able to provide the care necessary for the patient under the rates allowed by MAA. In an attempt to remain in business he is forced into an illegal position. The present hard and fast rate forces the operator to cut corners. The reimbursable cost method has been very successful in the hospital field with Blue Cross payments involved, and few would say that this procedure has made the service less satisfactory.

Another method of payment supported by many in the industry is legalized supplementation to a maximum limit. This would insure that all welfare patients would receive care, but those who wished could select better accommodations providing more extensive care. This essentially is no different than what has been happening through the years, since no patient went to a county facility through choice—only necessity. This approach would foster free and open competition, provide the families and patient really free choice and restore private enterprise in this field to a level of dignity and pride.

A typical facility giving reasonably acceptable care shows these costs for 1963:

Central service	$0.16
Dietary	1.78
Nursing	4.26
Housekeeping	.42
Laundry and linen	.24
Utilities	.22
Repairs and maintenance	.36
Insurance	.09
Taxes and license	.29
Administration	1.93
Employee benefits	.53
Subtotal	10.28
Return on investment	.92
Depreciation	.68
Total	11.88

No advertising or interest costs were included in the above. No profit, other than a return on the investment, was included. Salaries for the operation were included.

With the increase of the minimum wage on September 1, 1964, and the increase in workmen's compensation insurance on October 1, 1964, facilities can experience an increase in cost averaging $11.28 per employee per month.

The average nursing facility could not exist on MAA allowances. A reimbursable cost program would, however, permit these facilities to exist and render proper care. Legalized supplementation would tend to upgrade service and facilities as the currently lacking incentive to improve would be present.

In conclusion, the Los Angeles County Nursing Home Association is strongly in favor of legal supplementation since this would not increase the cost of the MAA program. The alternate possibility is adoption of the reimbursable cost method with a uniform accounting system and a ceiling established for tight control. We are most hopeful that one of these possibilities will be accepted to correct the numerous problems now being faced by the industry.

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