

[COMMITTEE PRINT]

94TH CONGRESS }  
1st Session }

SENATE

NURSING HOME CARE IN THE UNITED  
STATES: FAILURE IN PUBLIC POLICY

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Supporting Paper No. 6

WHAT CAN BE DONE IN NURSING HOMES:  
POSITIVE ASPECTS IN LONG-TERM CARE

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PREPARED BY THE  
SUBCOMMITTEE ON LONG-TERM CARE  
OF THE  
SPECIAL COMMITTEE ON AGING  
UNITED STATES SENATE



SEPTEMBER 1975

Printed for the use of the Special Committee on Aging

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## PREFACE

Federal support of long-term care for the elderly has, within a decade, climbed from millions to billion of dollars.

What is the Nation receiving for this money?

This report explores that, and related questions.

It concludes that public policy has failed to produce satisfactory institutional care—or alternatives—for chronically ill older Americans.

Furthermore, this document—and other documents to follow—declare that today's entire population of the elderly, *and their offspring*, suffer severe emotional damage because of dread and despair associated with nursing home care in the United States today.

This policy, or lack thereof, may not be solely responsible for producing such anxiety. Deep-rooted attitudes toward aging and death also play major roles.

But the actions of the Congress and of States, as expressed through the Medicare and Medicaid programs, have in many ways intensified old problems and have created new ones.

Efforts have been made to deal with the most severe of those problems. Laws have been passed; national commitments have been made; declarations of high purpose have been uttered at national conferences and by representatives of the nursing home industry.

*But for all of that, long-term care for older Americans stands today as the most troubled, and troublesome, component of our entire health care system.*

It is costly and growing costlier.

It is increasing in numbers, already providing more beds than there are beds in general hospitals.

And there is every reason to believe that many more beds will be needed because the population of old persons in this Nation continues to grow faster than any other age group.

Nursing home care is associated with scandal and abuse, even though the best of its leaders have helped develop vitally needed new methods of care and concern for the elderly, and even though—day in and day out—underpaid, but compassionate, aides in many homes attempt to provide a touch of humanity and tender care to patients who, though mute or confused and helpless, nevertheless feel and appreciate kindness and skill.

This industry, which has grown very rapidly in just a few decades—and most markedly since 1965, when Medicare and Medicaid were enacted—could now take one of three courses;

It could continue to grow as it has in the past, spurred on by sheer need, but marred by scandal, negativism, and murkiness about its fundamental mission.

It could be mandated to transform itself from a predominantly proprietary industry into a nonprofit system, or into one which takes on the attributes of a quasi-public utility.

Or it could—with the informed help of Government and the general public—move to overcome present difficulties, to improve standards of performance, and to fit itself more successfully into a comprehensive health care system in which institutionalization is kept to essential minimums.

Whatever course is taken, it is certain that the demand for improvement will become more and more insistent.

Within the Congress, that demand has been clearly expressed in recent years. But often congressional enactments have been thwarted by reluctant administration, or simply have been ignored. Now, facing the prospect of early action upon a national health program for all age groups, the Congress must certainly consider long-term care a major part of the total package. Wisely used, the momentum for a total health care package could be used to insure better nursing home care.

Within the administration, there has been drift and unresponsiveness to congressional mandate since 1965. There are signs, however, that rising costs and rising public concern have aroused certain members of the executive branch to see the need for long-term care reform more clearly than before. Their actions and initiatives are welcome, but it is essential that the Department of Health, Education, and Welfare take far more effective, well-paced action than it has thus far.

Everywhere, the demand for reform is intensifying. People know that a nursing home could be in everyone's future.

They ask why placement in such a home should be the occasion for despair and desperation, when it should be simply a sensible accommodation to need.

The Subcommittee on Long-Term Care of the Senate Special Committee on Aging continually has asked the same question.

Care for older persons in need of long-term attention should be one of the most tender and effective services a society can offer to its people. It will be needed more and more as the number of elders increases and as the number of very old among them rises even faster.

What is needed now? As already indicated, the forthcoming debate over a national health program will offer opportunity for building good long-term care into a comprehensive program for all Americans.

But the issues related to the care of the chronically ill are far from simple. Tangled and sometimes obscure, technical questions related to such matters as reimbursement, establishment of standards, enforcement, and recordkeeping, often attract the attention of policymakers, to the exclusion of other questions, such as:

Could nursing homes be avoided for some, if other services were available?

What assurance is there that the right number of nursing homes are being built where they are most needed?

What measures can Government take to encourage providers themselves to take action to improve the quality of nursing home care?

What can be done to encourage citizen action and patient advocacy at the local level?

Such questions intrude even when the best of care is given. In other settings, however, scandal and calamity enter the picture, and dark new questions emerge.

The Subcommittee, in this report and succeeding Supporting Papers, recognizes the importance of the nursing home industry, and it pledges every effort to continue communication with representatives of the industry and with members of the executive branch.

For these reasons, the Subcommittee has devised an unusual format: After publication of the Introductory Report, a series of followup papers on individual issues will follow; then we will publish a compendium of statements invited from outside observers; after this will come our final report. In this way, the Subcommittee can deal with the many parts needed to view long-term care as a whole.

Testimony from many, many days of hearings and other research have been tapped for this report, which is extensive and heartfelt. Concern about people has been at the heart of this effort. The Subcommittee has, therefore, been especially dependent upon responsive staff effort. Mr. Val Halamandaris, associate counsel for the Senate Special Committee on Aging, deserves specific mention for his role in assuring that Subcommittee inquiries remained directed at their real target: to wit, people in need of good care. Mr. Halamandaris has had the primary responsibility for directing the Subcommittee's hearings; he is responsible for the excellent research on data and for writing this report. He is more than a skilled and attentive attorney; his investigatory skills are rooted in concern and, when necessary, outrage. He has made it possible for this Subcommittee to compile and offer more information and insights into the nursing home industry than the Congress has ever had before.

He has been helped considerably by other Committee personnel. Staff Director William Oriol has provided guidance and consultation leading to the design and special points of emphasis in this report. Committee Counsel David Affeldt has given generously of his legislative expertise, as well as painstaking attention to detail.

Particularly fortunate for the Subcommittee was the fact that a professional staff member, John Edie, had special qualifications for making a substantial contribution to this effort. Mr. Edie, an attorney, formerly served as counsel to a program on aging in Minneapolis, Minn. When the Subcommittee went to that city for intensive hearings on scandalous shortcomings in nursing home care there, Mr. Edie testified and then continued his efforts on behalf of reform. In the preparation of this report, he has worked closely and at length with Mr. Halamandaris and his associates.

The Subcommittee also stands in debt to a select group in the nursing home industry and within the executive branch. Usually without much attention or encouragement, these public servants have stubbornly refused to compromise their goal of seeking high, but reasonable, standards of care.

With the publication of the Introductory Report, the Subcommittee began a final exploration of issues. We will publish responsible comments on findings expressed in this document and the Supporting Papers which precede and will follow. And we will, in our final report, make every effort to absorb new ideas or challenges to our findings.

The care of chronically ill older Americans is too serious a topic for stubborn insistence upon fixed positions. Obviously, changes are needed. Obviously, those changes will occur only when public understanding and private conscience are stirred far more than is now the case.

FRANK E. MOSS,  
*Chairman, Subcommittee on Long-Term Care.*

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# NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

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## SUPPORTING PAPER NO. 6

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### WHAT CAN BE DONE IN NURSING HOMES: POSITIVE ASPECTS IN LONG-TERM CARE

#### ABOUT THIS REPORT

To deal with the intricate circumstances and governmental actions associated with nursing home care in this Nation, the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging is issuing several documents under the general title of *Nursing Home Care in the United States: Failure in Public Policy*.

An Introductory Report published in November declared that a coherent, constructive, and progressive policy on long-term care has not yet been shaped by the Congress and by the executive branch of this Nation.

Examining the role of Medicare and Medicaid in meeting the need for such care, the report found that both programs are deficient.

Further, it raised questions about current administration initiatives originally launched personally by President Nixon in 1971.

These shortcomings of public policy, declared the report, are made even more unfortunate by the clear and growing need for good quality care for persons in need of sustained care for chronic illness. It called for good institutions and, where appropriate, equally good alternatives, such as home health services.

(A more detailed summary of major findings from the Introductory Report appears later in this section of this report.)

Supporting Paper No. 6 describes positive and innovative approaches which distinguish America's finest nursing homes. It is unjust to condemn the entire nursing home industry. There are many fine nursing homes in America. A growing number of administrators are insisting upon positive approaches to therapy and rehabilitation, innovations in the structure of the physical plant, and so forth. Examples of new developments are offered in this report as some measure of what is possible with imagination and work.

#### THE FACTUAL UNDERPINNING OF THIS STUDY

Sixteen years of fact-gathering preceded publication of this report. In 1959, the Senate Committee on Labor and Public Welfare estab-

lished a Subcommittee on Problems of the Aged and Aging. Findings from subcommittee reports and hearings have been evaluated. That subcommittee acknowledged in 1960, as this report acknowledges in 1975, that nursing homes providing excellent care with a wide range of supportive services are in the minority.

With the establishment of the U.S. Senate Special Committee on Aging in 1961, additional hearings were conducted. The most recent phase began in 1969 with hearings on "Trends in Long-Term Care." Since 1969, 22 hearings were held and some 3,000 pages of testimony were taken, as of October 1973.

These hearing transcripts have provided valuable information and expert opinions, as have several supplementary studies by the Subcommittee staff, the General Accounting Office, and private groups such as Ralph Nader's Study Group on Nursing Homes in 1971. The Library of Congress and other congressional committees, as well as professional organizations such as the American Nursing Home Association, have also been helpful. Finally, a great portion of the data is from the Department of Health, Education, and Welfare and other administrative or independent agencies, such as the Securities and Exchange Commission. The assistance of State officials proved especially helpful.

## ORGANIZATION OF THIS STUDY

This Supporting Paper will be followed by other Supporting Papers to be published at approximately monthly intervals over the next few months. Each will deal with a fairly specific issue, and each of these issues will be examined in the detail needed for understanding, not only by legislative and health specialists, but by laymen.

**A study of this magnitude would be incomplete without reaction by the nursing home industry and by representatives of the executive branch. Accordingly, national organizations and appropriate governmental units will be invited to submit statements within 2 months after publication of the final Supporting Paper. Finally, the Subcommittee will issue a concluding report intended to update earlier information and to analyze the situation at that time.**

The format is unusual, perhaps unprecedented. But the nursing home industry is too vital a part of our health system and of the national scene for lesser treatment.

## MAJOR POINTS OF THIS SUPPORTING PAPER

- During its 25 hearings between 1969 and 1975, the Subcommittee on Long-Term Care has conducted a careful search for positive and innovative programs which distinguish America's finest nursing homes. The Subcommittee learned that a good nursing home is a complex mix of factors. The first and foremost being a firm belief that the physical and mental problems of the elderly are, to a substantial degree, preventable, and that even when these problems are present they are, more often than not, reversible.

- Good nursing homes are a matter of motivation. Of paramount importance is the administrator's ability to stimulate his staff and to create an intangible kind of harmony and unity of

purpose rooted in competence and compassion. Education for nursing home administrators in these techniques is essential to improved nursing home care.

- Many of the best nursing homes in the United States feature innovative approaches to therapy and rehabilitation. A variety of techniques are used to upgrade the mental and physical functioning of patients. Among these techniques are:

- Reality orientation, the basic aim of which is to put a mentally regressed patient into renewed contact with the world around him.

- Sensory training is a therapeutic program designed to reduce sensory deprivation.

- Remotivation essentially is an effort to find out what activities a patient enjoyed in earlier life (or which he would have enjoyed) and directing him to those same goals.

- Some homes boast improvements in the physical structure which facilitate better patient care and greater patient comfort. Innovations in this area run the gamut from “campuses” for senior citizens, which provide the broad range of health care services in one location, to the use of color and design to make nursing homes more appealing and better suited to the needs of the infirm aged.

- One of the most important series of positive and innovative programs relates to the education and utilization of employees. Nursing homes presently offer a variety of such techniques, including:

- Employee sensitivity training is the practice of requiring prospective employees to assume the role of patients for 24 hours before their employment. By this experience the employees are “sensitized” to the needs of the aged patients.

- Accident prevention programs reduce injury.

- In-service training programs and continuing education programs help employees to perform their jobs. Some schools of nursing have established programs whereby student nurses work in nursing homes as part of their training. Some homes use computers to monitor patient care and for staff education.

- A novel program in St. Paul, Minn., trains able-bodied senior citizens to work in nursing homes.

- Many of the best nursing homes in the Nation feature comprehensive activity programs. Activity programs range from residents’ councils (self-government by patients) to senior citizens’ olympic games. Activity programs generally are inexpensive but they can have a dramatic effect on the patient’s sense of dignity and comfort in the nursing home environment.

- America’s finest nursing homes inevitably find ways to aid the community in which they operate. They may provide outreach services for senior citizens in their surrounding area. Such services may include meals-on-wheels, transportation, recreation, entertainment, social and home health services.

- Still other nursing homes participate in peer review programs established by their State nursing home association. Some

State associations have adopted a code of ethics encouraging good care and disciplining those members found continually in violation of standards.

- Good homes invariably enjoy the support of their local community. Informal "ombudsman" projects have been created in many States to help monitor the quality of nursing home care. Such projects also perform an educational function, assisting administrators who want to improve their overall operations. Formal ombudsman projects under the direction of the Administration on Aging are springing up in almost every State. The National Council of Senior Citizens has established a national ombudsman project.

- Some community groups are printing nursing home directories or issuing ratings to aid consumers in their choice of nursing homes. Some senior citizen groups have established a nursing home referral service. Others have organized volunteers to visit nursing homes and nursing home patients on a regular basis.

- Those who would like to become involved in the effort to bring about a better quality of nursing home care will benefit from the report: *Citizens Action Guide: Nursing Home Reform*,\* prepared by Elma Greisel and Linda Horn for the Gray Panthers of Philadelphia, Pa., April 1975.

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## MAJOR POINTS OF INTRODUCTORY REPORT

(Issued November 19, 1974)

Medicaid now pays about 50 percent of the Nation's more than \$7.5 billion nursing home bill, and Medicare pays another 3 percent. Thus, about \$1 of every \$2 in nursing home revenues is publicly financed.\*\*

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There are now more nursing home beds (1.2 million) in the United States today than general and surgical hospital beds (1 million).

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In 1972, for the first time, Medicaid expenditures for nursing home care exceeded payments for surgical and general hospitals: 34 percent to 31 percent.

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Medicaid is essential for growing numbers of elderly, particularly since Medicare nursing home benefits have dropped sharply

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\*For a copy of this report, send \$1.50 to Long-Term Care Action Project, 3700 Chestnut Street, Philadelphia, Pa., 19104 (telephone: 215-382-3546).

\*\*The Committee's Introductory Report, as released on November 19, 1974, incorporating the latest statistics from HEW, reported that total revenues for the nursing home industry in 1972 were \$3.2 billion and \$3.7 billion for 1973. Subsequent to publication of this report, the Social Security Administration released new estimates for 1974. Total expenditures are estimated at \$7.5 billion. This change reflects spending for the Intermediate Care Program, which, until recently, was a cash grant program to old age assistance recipients. With its change to a vendor payments program such expenses are properly countable as nursing home expenditures. Consequently, changes were made in this report.

since 1969. Average Social Security benefits for a retired couple now amount to \$310 a month compared to the average nursing home cost of \$600. Medicaid (a welfare program) must be called upon to make up the difference.

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The growth of the industry has been impressive. Between 1960 and 1970, nursing home facilities increased by 140 percent, beds by 232 percent, patients by 210 percent, employees by 405 percent, and expenditures for care by 465 percent. Measured from 1960 through 1973, expenditures increased almost 1,400 percent.

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Despite the heavy Federal commitment to long-term care, a coherent policy on goals and methods has yet to be shaped. Thousands of seniors go without the care they need. Others are in facilities inappropriate to their needs. Perhaps most unfortunate, institutionalization could have been postponed or prevented for thousands of current nursing home residents if viable home health care and supportive services existed. Although such alternative forms of care may be more desirable from the standpoint of elderly patients—as well as substantially less expensive—the Department of HEW has given only token support for such programs.

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Despite the sizable commitment in Federal funds, HEW has been reluctant to issue forthright standards to provide patients with minimum protection. Congress in 1972 mandated the merger of Medicare and Medicaid standards, with the retention of the highest standard in every case. However, HEW then watered down the prior standards. Most leading authorities concluded at Subcommittee hearings that the new standards are so vague as to defy enforcement.

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There is no direct Federal enforcement of these and previous Federal standards. Enforcement is left almost entirely to the States. A few do a good job, but most do not. In fact, the enforcement system has been characterized as scandalous, ineffective, and, in some cases, almost nonexistent.

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The President's program for "nursing home reform" has had only minimal effect since it was first announced in 1971 and actions in 1974 fall far short of a serious effort to regulate the industry.

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The victims of Federal policy failures have been Americans who are desperately in need of help. The average age of nursing home patients is 82; 95 percent are over 65 and 70 percent are over 70; only 10 percent are married; almost 50 percent have no direct relationship with a close relative. Most can expect to be in a

nursing home over 2 years. And most will die in the nursing home. These patients generally have four or more chronic or crippling disabilities.

Most national health insurance proposals largely ignore the long-term care needs of older Americans. Immediate action is required by the Congress and executive branch to improve past policies and programs which have been piecemeal, inappropriate, and short lived.

## MAJOR POINTS OF SUPPORTING PAPER NO. 1

(Issued December 17, 1974)

### “THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY”

The Subcommittee's Supporting Paper No. 1 reveals the following were the most important nursing home abuses:

- Negligence leading to death and injury;
- Unsanitary conditions;
- Poor food or poor preparation;
- Hazards to life or limb;
- Lack of dental care, eye care or podiatry;
- Misappropriation and theft;
- Inadequate control of drugs;
- Reprisals against those who complain;
- Assault on human dignity; and
- Profiteering and “cheating the system.”

The inevitable conclusion is that such abuses are far from “isolated instances.” They are widespread. Estimates of the number of substandard homes (that is, those in violation of one or more standards causing a life-threatening situation) vary from 30 to 80 percent. The Subcommittee estimates at least 50 percent are substandard with one or more life-threatening conditions.

These problems have their roots in contemporary attitudes toward the aging and aged. As Senator Frank E. Moss, chairman of the Subcommittee on Long-Term Care, has said:

It is hell to be old in this country. The pressures of living in the age of materialism have produced a youth cult in America. Most of us are afraid of getting old. This is because we have made old age in this country a wasteland. It is T. S. Eliot's rats walking on broken glass. It's the nowhere in between this life and the great beyond. It is being robbed of your eyesight, your mobility, and even your human dignity.

Such problems also have their roots in the attitudes of the elderly toward institutionalization. Nursing home placement often is a bitter confirmation of the fears of a lifetime. Seniors

fear change and uncertainty; they fear poor care and abuses; loss of health and mobility; and loss of liberty and human dignity. They also fear exhausting their savings and "going on welfare." To the average older American, nursing homes have become almost synonymous with death and protracted suffering before death.

However, these arguments cannot be used to excuse nursing home owners or operators or to condone poor care. Those closest to the action rightly must bear the greatest portion of responsibility.

To deal with the litany of abuses, action must be taken immediately by the Congress and the executive to: (1) Develop a national policy with respect to long-term care; (2) provide financial incentives in favor of good care; (3) involve physicians in the care of nursing home patients; (4) provide for the training of nursing home personnel; (5) promulgate effective standards; and (6) enforce such standards.

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## MAJOR POINTS OF SUPPORTING PAPER NO. 2

(Issued January 17, 1975)

### "DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS"

The average nursing home patient takes from four to seven different drugs a day (many taken twice or three times daily). Each patient's drug bill comes to \$300 a year as compared with \$87 a year for senior citizens who are not institutionalized. In 1972, \$300 million was spent for drugs, 10 percent of the Nation's total nursing home bill.

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Almost 40 percent of the drugs in nursing homes are central nervous system drugs, painkillers, sedatives, or tranquilizers.

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Tranquilizers themselves constitute almost 20 percent of total drugs—far and away the largest category of nursing home drugs.

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Drug distribution systems used by most nursing homes are inefficient and ineffective. An average home of 100 beds might have 850 different prescription bottles and 17,000 doses of medication on hand. Doctors are infrequent visitors to nursing homes. Nurses are few and overworked. All too often, the responsibility for administering medications falls to aides and orderlies with little experience or training.

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Not surprisingly, 20 to 40 percent of nursing home drugs are administered in error.



Other serious consequences include: the theft and misuse of nursing home drugs; high incidence of adverse reactions; some disturbing evidence of drug addiction; and lack of adequate controls in the regulation of drug experimentation.

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Perhaps most disturbing is the ample evidence that nursing home patients are tranquilized to keep them quiet and to make them easier to take care of. Tragically, recent research suggests that those most likely to be tranquilized sometimes may have the best chance for effective rehabilitation.

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Kickbacks are widespread. A kickback is the practice whereby pharmacists are forced to pay a certain percentage of the price of nursing home prescription drugs back to the nursing home operator for the privilege of providing those services.

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The atmosphere for abuse is particularly inviting when reimbursement systems under Federal and State programs allow the nursing home to act as the "middle man" between the pharmacy (which supplies the drugs) and the source of payment (private patient, Medicare, or Medicaid).

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Kickbacks can be in the form of cash, long-term credit arrangements, and gifts of trading stamps, color televisions, cars, boats, or prepaid vacations. Additionally, the pharmacist may be required to "rent" space in the nursing home, to furnish other supplies free of charge, or to place nursing home employees on his payroll.

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The average kickback is 25 percent of total prescription charges; over 60 percent of 4,400 pharmacists surveyed in California reported that they had either been approached for a kickback or had a positive belief that kickbacks were widespread; these same pharmacists projected \$10 million in lost accounts for failure to agree to kickback proposals.

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In order to lower costs to meet kickback demands, pharmacists admitted numerous questionable, if not illegal, practices such as: billing welfare for nonexistent prescriptions, supplying outdated drugs or drugs of questionable value, billing for refills not dispensed, supplying generic drugs while billing for brand names, and supplying stolen drugs which they had purchased.

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Congressional action in 1972 to make kickbacks illegal has had little effect. HEW has yet to announce regulations to implement this law.

## MAJOR POINTS OF SUPPORTING PAPER NO. 3

(Issued March 3, 1975)

**“DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY”**

Physicians have shunned their responsibility for nursing home patients. With the exception of a small minority, doctors are infrequent visitors to nursing homes.

Doctors avoid nursing homes for many reasons:

- There is a general shortage of physicians in the United States, estimates vary from 20,000 to 50,000.

- Increasing specialization has left smaller numbers of general practitioners, the physicians most likely to care for nursing home patients.

- Most U.S. medical schools do not emphasize geriatrics to any significant degree in their curricula. This is contrasted with Europe and Scandinavia where geriatrics has developed as a specialty.

- Current regulations for the 16,000 facilities participating in Medicare or Medicaid require comparatively infrequent visits by physicians. The some 7,200 long-term care facilities not participating in these programs have virtually no requirements.

- Medicare and Medicaid regulations constitute a disincentive to physician visits; rules constantly change, pay for nursing home visits is comparatively low, and both programs are bogged down in redtape and endless forms which must be completed.

- Doctors claim that they get too depressed in nursing homes, that nursing homes are unpleasant places to visit, that they are reminded of their own mortality.

- Physicians complain that there are few trained personnel in nursing homes that they can count on to carry out their orders.

- Physicians claim they prefer to spend their limited time tending to the younger members of society; they assert there is little they can do for the infirm elderly. Geriatricians ridicule this premise. Others have described this attitude as the “Marcus Welby Syndrome.”

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The absence of the physician from the nursing home setting leads to poor patient care. It means placing a heavy burden on the nurses who are asked to perform many diagnostic and therapeutic activities for which they have little training. But there are few registered nurses (65,235) in the Nation's 23,000 nursing homes. These nurses are increasingly tied up with administrative duties such as ordering supplies and filling out Medicare and Medicaid forms. The end result is that unlicensed aides and orderlies with little or no training provide 80 to 90 percent of the care in nursing homes.

It is obvious that the physician's absence results in poor medical and to some degree in poor nursing care. Poor care has many dimensions, it means:

- No visits, in frequent, or perfunctory visits.
- The telephone has become a more important medical instrument in nursing homes than the stethoscope.
- No physical examinations, pro forma or infrequent examinations.
- Some patients receive insulin with no diagnosis of diabetes.
- Significant numbers of patients receive digitalis who have no diagnosis of heart disease.
- Large numbers of patients taking heart medication or drugs which might dangerously lower the blood pressure, do not receive blood pressure readings even once a year.
- Some 20 to 50 percent of the medication in U.S. nursing homes are given in error.
- Less than 1 percent of all infectious diseases in the United States are reported—a special problem in nursing homes where patients have advanced age and lessened resistance. This fact was graphically proven in 1970 when 36 patients died in a Salmonella epidemic in a Baltimore, Md., nursing home.
- Physicians do not view the bodies of patients who have died in nursing homes before signing death certificates.

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The need for physicians to exercise greater responsibility for the 1 million patients in U.S. nursing homes is abundantly clear from these and other facts. Until doctors take a greater interest the litany of nursing home abuses will continue, the majority of America's nursing homes will be substandard, and the quality of patient care will be unacceptable.

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#### MAJOR POINTS OF SUPPORTING PAPER NO. 4

(Issued April 24, 1975)

#### “NURSES IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL)”

There are few nurses in the Nation's 23,000 nursing homes. Of the 815,000 employed registered nurses (RN's) in the Nation, only 65,235 can be found in U.S. long-term care facilities.

There are many reasons why this is true:

- There is a general nurse shortage. The U.S. Department of Labor estimates the need for 150,000 more RN's. Others claim it is simply a matter of maldistribution or that the 400,000 RN's presently out of the work force could be induced into service—given better wages and working conditions. Still others assert that

if there is a shortage it is because nurses are required to spend their time with administrative duties and paperwork rather than with patients.

- Few nurses are required by law. At present the Federal standard requires only the 7,300 Skilled Nursing Facilities in the United States to have an RN as their highest nursing officer—and this only applies to the day shift. The 8,200 Intermediate Care Facilities are required to have only a licensed practical nurse in charge—again only during the day shift. The remaining 7,500 facilities need have no “licensed” nursing officer at all. To make matters worse, there are no requirements for ratios between nurses and patients in Federal regulations. By contrast the State of Connecticut requires one RN for every 30 patients on the day shift, one for every 45 on the afternoon and one for every 60 in the evening.

- Poor working conditions. RN’s working in nursing homes do not have the support of physicians and trained personnel that they find in hospitals. Many nursing homes are poorly administered and there is a lack of authority vested in the nursing service department. A very real problem is the fact that nursing homes are isolated from other health care facilities.

- Nursing homes have a poor image. “Hospitals have their pick while nursing homes take what they can get,” is a common statement among nursing home employees. An RN who goes to work in a nursing home will often be asked, “Why are you here? Where did you foul up?”

- Wages and fringe benefits are low. The consensus is that nursing homes do less well in compensating nurses than other health care entities. Many nursing homes also lag behind in fringe benefits, stimulating nursing personnel to seek work elsewhere.

- Nurses have little training in geriatrics and the needs of nursing home patients and are therefore unprepared to work in long-term care facilities. Of the over 1,000 schools of nursing surveyed by the Subcommittee, only 27 responded that they had a program wherein geriatrics was treated as a specialty.

- There are no graduate programs in geriatric or gerontology nursing. Federal Government programs likewise neglect geriatrics. In 1970 there were 144 programs for the training of nurses and health care personnel administered by 13 agencies. None of these programs emphasized geriatrics.

- It goes without saying that the few nurses working in nursing homes are grossly overworked. Because they are overworked or simply not present in significant number, the result is the reliance on aides and orderlies to provide 80 to 90 percent of the care in nursing homes.

- Only one-half of the 280,000 aides and orderlies are high school graduates. Most have no training. Most have no previous experience. They are grossly overworked and paid the minimum wage. It is little wonder that they show a turnover rate of 75 percent a year. Put simply, the absence of RN’s and the reliance on untrained aides and orderlies result in poor care. Poor care

runs the gamut from essential tests not being performed to negligence leading to death and injury.

- In Illinois, an investigator sought employment as a nursing home janitor. Within 20 minutes he was hired, not as a janitor, but as a nurse; he carried the keys to the medication and narcotics cabinet on his belt and distributed drugs to patients. His references were never checked. He never represented that he had any prior experience.

- In Minnesota, aides were instructed how to distribute drugs "in care of an emergency." The "emergency" began the next day; aides continued distributing drugs even though this constituted a violation of Federal regulations and Minnesota law.

- A recent national HEW study notes that some 37 percent of the patients taking cardiovascular drugs had not had a blood pressure reading for more than a year. More than 25 percent of this number who were receiving heart medication had no diagnosis of heart disease on their charts. Some 35 percent of those taking tranquilizers which might lower the blood pressure markedly had not had a pressure reading in more than a year.

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The solution for these problems lies in greater emphasis on geriatrics in schools of nursing and in government programs training health care personnel. Funds should also be provided for the in-service training of nursing home personnel.

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This paper also contains a major report analyzing the role of nurses in long-term care facilities prepared by the Committee on Skilled Nursing of the American Nurses' Association. See highlights, part 2, pages 385-417.

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## MAJOR POINTS OF SUPPORTING PAPER NO. 5

(Issued August 30, 1975)

### "THE CONTINUING CHRONICLE OF NURSING HOME FIRES"

- Older Americans make up 10 percent of the population but 30 percent of the deaths by fire. They are involved in 59 percent of all clothing fires, having a 73 percent mortality rate in such fires as compared to 23 percent for younger persons.

- Nursing home patients present a particular problem because of several factors: (1) Their advanced age (average 82); (2) their failing health (average four disabilities); (3) their mental disabilities (55 percent are mentally impaired); (4) their reduced mobility (less than half can walk); (5) their sensory impairment (loss of hearing, vision, or smell); (6) their reduced tolerance to heat, smoke, and gases; and (7) their greater susceptibility to shock.

● Some patients resist rescue. They are reluctant to leave their room and few possessions. In other cases, those rescued have inexplicably run back into burning buildings.

● Despite much progress in recent years, nursing homes and related facilities still rank number one on the list of unsafe places to be from a fire safety point of view. Six patients die in nursing home fires for every one in a hospital fire.

● In 1973 there were 6,400 nursing home fires (17.5 each day of the year) causing \$3.6 million in damage. An estimated 500 persons lost their lives in single-death fires. Fifty-one persons lost their lives in multiple-death fires (those killing three or more). These figures represent sharp increases from 1971, when there were 4,800 fires and 31 persons killed in multiple-death fires.

● Because nursing home patients often cannot take action to protect themselves in case of fire, they must rely upon the help of others. In most cases such help has not been available. There are few nursing personnel available (particularly at night), and most are untrained in rescue and firefighting techniques. Compounding the problem, many patients are under sedation or bound with restraints.

● Because the elderly cannot protect themselves and nursing home personnel often prove incapable of taking action to save them in case of fire, automatic detection, alarm, and extinguishment are recommended. Sprinkling systems, while far from a panacea, are, by and large, the difference between life and death.

● Over the years, 33 percent of all nursing home fires have been caused by smoking or matches; heating or electrical problems followed next with 18 and 15 percent, respectively. Eight percent were labeled "suspicious"—a suggestion that arson was the fire's cause. Fires most frequently began in patients' rooms (35 percent) and most often took place from midnight to 6 a.m. (42 percent). Some 35 percent of all nursing home fires occur in wood-frame buildings; only 3 percent in fire-resistive buildings.

● Greater emphasis must be placed on the installation of fire-proof furnishings. Too often fire-resistive buildings are constructed only to be filled with flammable carpets, curtains, vinyl upholstery, and the like. The Department of Commerce has yet to promulgate the fire safety standards with respect to carpets (for all age groups) that they promised at hearings on the Marietta fire. There is no emphasis on the hazard of smoke production or on the effect of toxic gases on humans. Recent research demonstrates that deadly gases such as phosgene and cyanide are released when various plastics, acrylics, and nylons are burned. Many such products are found in nursing homes.

● Some 7,200 of the Nation's 23,000 long-term care facilities (personal care and shelter care homes) do not participate in Federal programs, and therefore meet only such standards as are promulgated by the States. All too often, such standards are weak or nonexistent. There are even fewer standards for boarding homes and old hotels which, more and more, are absorbing the thousands of patients discharged yearly from State mental institutions. In some cases the States are placing Medicare and/or Medicaid patients in these facilities; the use of such "bootleg" nursing homes

(so named because they are not certified under Federal requirements) is a violation of law.

- The 15,800 Skilled Nursing Facilities and Intermediate Care Facilities participating in Medicare and Medicaid must comply with the Life Safety Code of the National Fire Protection Association. This requirement was enacted in 1967 but far too many nursing homes fail to comply. In 1971 and again in 1975, U.S. General Accounting Office audits projected 50 and 72 percent (respectively) of the nursing homes in the United States had one or more serious violations of the code. The Department of Health, Education, and Welfare estimated 59 percent had deficiencies in 1974 and notes two-thirds have "several" (four or more) deficiencies in 1975.

- Not only are standards not being enforced, there is a lack of uniformity in the interpretation and application of the code by State surveyors who inspect nursing homes applying the Federal fire safety standards. Only 22 percent of those doing fire inspections had backgrounds qualifying them to do so; 78 percent were nurses, sanitarians, and members of other professions, including State police or detectives. Some HEW regional offices are overzealous while others are complacent. As further evidence that State surveyors are not adequately performing their jobs, fully 87 percent of the deficiencies reported by the GAO earlier this year had not been discovered by State surveyors.

- HEW must take action to insure that Federal fire safety standards are enforced; eight years is too long to wait. HEW must undertake measures to insure uniform enforcement of the code among the 50 States. One such measure might be the mandatory training of State surveyors. If such measures do not prove workable, then HEW should suggest the need for direct Federal inspection to the Congress.

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## **MAJOR POINTS OF FORTHCOMING SUPPORTING PAPERS**

### **Supporting Paper No. 7**

#### **"THE ROLE OF NURSING HOMES IN CARING FOR DISCHARGED MENTAL PATIENTS"**

Thousands of elderly patients have been transferred from State mental institutions to nursing homes. The number of aged in State mental hospitals decreased 40 percent between 1969 and 1972 according to Subcommittee data, dropping from 133,264 to 81,912. This trend is caused partially by progressive thinking intended to reduce patient populations in large impersonal institutions. Another powerful reason, however, may be cost and the desire to substitute Federal for State dollars. It costs the States an average of \$800 per patient per month to care for mental patients in State hospitals while these same individuals can be placed in boarding homes at a substantially reduced cost. Charges of "wholesale dumping" of patients have been made in several States. Acute

problems have been reported, most notably in California, Illinois, and New York.

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### Supporting Paper No. 8

#### "ACCESS TO NURSING HOMES BY U.S. MINORITIES"

Only 4 percent of the 1 million nursing home patients in the United States are members of minority groups, even though their health needs are proportionately greater. Part of the problem is caused by cost obstacles or lack of information about Medicaid. Discrimination is the greatest obstacle to greater utilization by blacks. But discrimination need not be overt; often relatives are made to feel that their parent or grandparent would not be made comfortable. In the case of Asian-Americans and Spanish-speaking Americans, language barriers often cause insurmountable difficulties. Cultural and other problems, including rural isolation, cause problems to American Indians.

Members of minority groups at Subcommittee hearings have been sharply critical of the Nixon administration's nursing home "reforms." They protested the "arbitrary and punitive" closing of a few minority owned nursing homes that do exist and the absence of assistance to help upgrade standards.

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### Supporting Paper No. 9

#### "PROFITS AND THE NURSING HOME: INCENTIVES IN FAVOR OF POOR CARE"

Profits by nursing homes have occasioned serious and persistent controversy. Nursing home administrators say that Medicaid reimbursement rates are low and that they can hardly become the basis for profiteering. Critics say that the economics of nursing home operation, supported in such large measure by public funds, should be examined more closely and publicly than they now are.

On the basis of available evidence, including a Subcommittee survey made in 1973-74, the Subcommittee has found that the 106 publicly held corporations controlled 18 percent of the industry's beds and accounted for one-third of the industry's \$3.2 billion in revenue (as of 1972). Between 1969 and 1972 these corporations experienced the following growth:

- 122.6 percent in total assets;
- 149.5 percent in gross revenues; and
- 116 percent in average net income.

One recent HEW study, however, shows marginal rates of return in a sample of 228 nursing homes. Thus, the issue is far from settled. But a joint study—conducted by the General Accounting Office and the Subcommittee—suggest significant increases in total assets, revenues, and profits for individual operators as well.



*Two final documents will be issued as part of this study: A compendium of statements by national organizations and administration spokesmen, and a final report by the Subcommittee on Long-Term Care.*

NURSING HOME CARE IN THE UNITED STATES:  
FAILURE IN PUBLIC POLICY

SUPPORTING PAPER NO. 6

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WHAT CAN BE DONE IN NURSING HOMES: POSITIVE  
ASPECTS IN LONG-TERM CARE

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—Ordered to be printed

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Mr. Moss, from the Special Committee on Aging,  
submitted the following

REPORT

“(I) believe there is a growing and unfortunate trend to criticize all nursing homes under a blanket indictment. There are, I want to emphasize, some very fine nursing homes across the country. . . . At the same time there are serious problems. Our study and our preoccupation with these problems, I am afraid, sometimes adds to the impression that there is nothing positive in the nursing home field. I can categorically state that there has been great improvement in the past 10 years.”

—Senator Frank Church.<sup>1</sup>

INTRODUCTION: TWO SCENES

SCENE I

When Frank Forester had his third stroke, it should have killed him; everyone said that—the doctor, his family, his friends—everyone.

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<sup>1</sup> *Congressional Record*, Sept. 6, 1972, S 14143.

In fact, the stroke appeared to leave Frank more dead than alive. As months went by the paralysis slowly left some parts of his body so that he had feeling in his right trunk and extremities. His right arm responded rustily, but his leg refused to answer his commands.

It was simply too much for his 80-year-old wife, with her failing health, to take care of Frank. Their only daughter lived half a Nation away but flew in from time to time to help. Ultimately, they decided to place Frank in a nursing home. The local minister was consulted to recommend a "good one" near Frank's home. The clerk at the local welfare office was obliging, saying Frank's income was low enough to permit him to go in as a Medicaid patient.

One winter day, Frank was told that he was going to a nursing home where "things would be better" for his care. That same day his son-in-law helped move Frank and a few of his things into the institution. Nobody knew what Frank thought because his speech was still unintelligible.

At the nursing home Frank got lots of rest—just what he didn't need. No one came around to help him with his exercises. No one talked to him. He was sometimes helped out of his bed into a wheelchair and sometimes not, depending on whether Jenny came to work that day.

The fact that Frank was incontinent and that he was a welfare patient did not make him one of the home's favorites. He often spent hours lingering in his own waste. Frank was supposed to take four different medications each day. Sometimes he got them and sometimes he didn't. Sometimes he got only two of his medications and occasionally he got the wrong medication—those intended for his roommate. When Frank became noisy (that is, attempting to communicate a complaint or a request for help), his reward was Thorazine or some other kind of tranquilizer, depending on which bottles were full in the medications room.

Nobody hurt Frank intentionally; nobody went out of the way to make life harder for him. Some aides were as kind as they could be, particularly Jenny. Others didn't have the time; they made their job kind of a race to see who could touch all the patients on their floor and return to the nurses station the fastest. For those who cared, there was much too much work to do. Little wonder the home often smelled of urine. Paradoxically, the linen closet and the closet with the toilet paper and supplies were kept locked, but anyone, even the untrained aides, had access to the medications room and the narcotics box. There was a definite shortage of mops and cleansers and maintenance men.

Frank watches a lot of TV, or seems to. No one knows for sure.

**This scene does not date back to another decade or century. It is happening today in many of this Nation's nursing homes.**

## SCENE II

When Frank Forester entered this nursing home, his family was impressed by the continual activity. Standing in the central intersection of the home, they could see persons in white uniforms crossing the halls helping patients to walk, involving them in activities: inspiring them to live and rewarding them for performance.

The day Frank arrived they were having a birthday party for Mrs. Jackson, who had just turned 102. All the residents were there for cake.

Frank's son-in-law thought the beer and wine made a nice addition to the party but commented that it was "pretty far out" for a nursing home.

Frank was given a physical by the home's medical director on Wednesday and saw the doctor again on Friday, the doctor's regular day at the home. The doctor and the registered nurse in charge set up a therapeutic program for Frank, along with his medication regimen designed to restore the movement he lost because of the stroke. Bright and early on Saturday morning, the RN talked to Frank about his program. She talked repetitively and slowly. On Sunday, Frank was wheeled to church services; after lunch the home had scheduled a movie, Douglas Fairbanks, Jr., in tight pants, and everyone enjoyed it.

After a few months of therapy, Frank gained greater use of his arm and began to talk a little. He began to enjoy his roommate's company as they talked about fishing and hunting. One Thursday after therapy, the home held senior citizens olympic games. Mrs. Flores won the bean-bag toss at 75 feet. Frank placed third in men's frisbee at 50 feet. Two days later, all the home's residents, including those who were bedridden, were put into a customized schoolbus with a hydraulic lift and taken on a tour of the city. The patients enjoyed the Christmas lights, decorations, and hustle-bustle of people shopping.

On the way home they encountered a fire engine enroute to a blaze. They followed in the bus and observed from a safe distance.

Later Frank enjoyed the visits from several groups of carolers even though his roommate grumbled each time they sang "Silent Night."

About 6 months later Frank was a much improved man. Although he still had little control of his right leg, his speech was letter perfect; his thoughts were clear. One day that June, Frank enjoyed two memorable events in one day. He celebrated his 81st birthday—his wife and just about everyone was there. There were gifts and champagne at the party. Then, in realization of his fondest wish, Frank got to go fishing. The home piled everyone who wanted to go into a bus and they went to a local pay-as-you-catch fishing hole. Frank caught six rainbow trout. As the fish were frying over the open picnic fire, Frank expressed gratitude to the administrator of the nursing home for making his life worth living.

**This scene is not a look into the future. It, too, is occurring to-day. It is hoped that this scene will become far more common in the Nation's 23,000 nursing homes, soon.<sup>2</sup>**

<sup>2</sup> An example of the individualized nursing home care described in scene II can be found in several homes. Darlington House/the Toledo Jewish Home for the Aged offers a summer camp experience for able residents. In a letter to the Subcommittee from the Greenbrook Manor Nursing Home in Union, N.J., Mr. Herbert Hefflich discusses the importance of each patient's unique needs:

"Key personnel in administration, nursing, social service, recreation, admissions, and dietary science make up the team, which meets in roundtable-discussion style once a week . . . Each in his special area of care relates any information that can contribute to the understanding of each new resident, and the professional expertise of the team is brought to bear on individual problems . . .

"The review covers medical diagnosis and the doctor's orders, and within this framework we set both short-term and long-term goals for each resident. . . .

"Good care—care which is right on target for each individual's needs—does not just happen. Once the nursing care is outlined, we set a program of suitable activities for each resident, and these can serve many purposes. Activities of daily living may help those who are handicapped toward self-help. Physical therapy programs can improve function . . . . Recreational therapy is planned for most, to give a feeling of usefulness and productivity.

"The comfort and well-being of our residents is an important factor in helping to get well. Our team approach solves a variety of problems which bear on keeping the person happy. These may be family problems, personality problems, or there may be a need, as our team sees it, for a referral by the doctor to a specialist or to a community agency."



Two patients fishing. Dan Crescent, on left, is 61, crippled with arthritis. Mrs. Dora Lague, on the right, is 82, and has diabetes and congestive heart failure.



We caught it! Note the fish below her hand.

Photos by Marshal Horseman, Beaumont Convalescent Hospital, Beaumont, Calif.

## PART 1

### WHAT MAKES A GOOD NURSING HOME?

*[This report contains references to a great number of positive and innovative programs in many U.S. nursing homes. The Subcommittee did not (and indeed could not) visit them all. When a visit was not possible the Subcommittee relied on expert testimony detailing particular innovative or positive programs. In some cases the Subcommittee relied upon representations made by the providers themselves or on their behalf by various national organizations concerned with problems of the aged.]*

From the very beginning of the 1969-75 hearings,<sup>3</sup> Subcommittee Chairman Frank E. Moss underscored his intention to discover what makes a good nursing home. The Senator said:

**Before we begin, I would like to make clear that I do not mean to denigrate the nursing home industry. This Subcommittee is aware that there are many homes across the country who are offering the finest care, along with some very innovative rehabilitative and therapeutic programs.<sup>4</sup>**

In the seventh hearing of the series he reiterated his goal:

We seek to emphasize the positive today, to focus on the nursing home of the future. We have questions that we would pose, such as, how can we best care for our increasing number of elderly now and in the future?

Perhaps the question would be better phrased in terms of what future generations will do with us.<sup>5</sup>

Throughout these hearings, the Subcommittee continued its search for the "model" nursing home and for new and significant innovations which could be implemented by other homes for the benefit of resident patients. On October 14, 1971, the Subcommittee devoted a full day to this problem.

Witnesses appearing at the hearing were chosen from hundreds of written presentations submitted by providers of services. Senator Moss had invited members of the American Health Care Association (formerly the American Nursing Home Association), the American Association of Homes for the Aged, and the National Council on Health Care Services to submit written statements concerning their innovative activities. The witnesses, representing diverse positions, presented testimony on such matters as unit-dose systems designed to reduce

<sup>3</sup> "Trends in Long-Term Care" (hereinafter referred to as TLTC), Subcommittee on Long-Term Care, U.S. Senate Special Committee on Aging.

<sup>4</sup> TLTC, part 1, p. 3.

<sup>5</sup> TLTC, part 7, p. 550.

incidences of drugs administered in error and the need for positive public relations and community involvement programs.

Others advocated enactment of the American Health Care Association's Chronicare proposal as part of a scheme of national health insurance. Still others offered unique training, activity, therapy, and education programs. One item of special interest to the Subcommittee was evidence showing that nursing homes more and more are seeking to serve the younger members of the population. Some States have authorized treatment of alcoholics in certain long-term care facilities. Some nursing homes exclusively treat children.<sup>6</sup>

Throughout this hearing, one question was preeminent: what makes a good nursing home?

According to Dr. James Folsom, who developed reality orientation, the first and most important factor is the firm belief that the physical and mental problems of the elderly are, to a substantial degree, preventable, and that even when these problems are present they are, more often than not, reversible.<sup>7</sup>

This is particularly true of those patients handled least well by nursing homes—the unfortunate elderly who are placed under the unscientific and imprecise label of “senility.” Dr. Muriel Oberleir, who works with Dr. Folsom, states:

More often than not, mental breakdown among the elderly is transitory and is associated with some discernible, usually external, stress or with some physical condition other than brain deterioration. And often, if the stress that caused the breakdown is corrected, functioning returns to the elderly.<sup>8</sup>

Most experts agree that the second most important factor is a belief in the basic human dignity of man expressed toward nursing home patients—not in the sense of doing everything for them which has the effect of making them increasingly dependent—rather, it is a sense of helping patients to help themselves.

**As both of these primary factors suggest, good nursing homes are a matter of motivation. Of paramount importance is the administrator's ability to stimulate his staff, to create an intangible kind of harmony, unity of purpose, and spirit, rooted in competence and compassion.**

The American College of Nursing Home Administrators was organized in 1963 on the belief that the ability to motivate can be taught and that the education of administrators is the necessary prerequisite to improving the quality of nursing home care.

Doubtlessly, there are many obstacles in the way of the administrator who tries to coordinate and motivate personnel. But the very fact that some have succeeded so well against strong odds is a persuasive argument that others can follow suit.

An illustration of this principle in action was provided to the Subcommittee by Dr. Karl Menninger. He described his experience with a group of older Americans, all with advanced mental illness—patients generally too difficult for a nursing home to handle:

<sup>6</sup> *New York Times*, Sept. 16, 1970; also, *The Observer Dispatch*, Utica, N.Y., Feb. 20, 1972. The six nursing homes which primarily serve children are located in Baltimore, Md.; Palo Alto, Calif.; Washington, D.C.; Hartford, Conn.; Chicago, Ill.; and Atlantic City, N.J.

<sup>7</sup> Dr. James Folsom, Director, Veterans' Administration Hospital, Tuscaloosa, Ala.; speech to American Association of Homes for the Aging, 1970 convention, Washington, D.C.

<sup>8</sup> Quote, *ibid.* Also, Galton, Lawrence, "Don't Give Up on an Aging Parent," *Parade Magazine*, June 29, 1975.

On the first day of January 1947, there was a total population of 88, and the average age of the patients was 68. These people occupied two wards of a State hospital. They were all considered to have a "senile psychosis," or "senile dementia."

They were not just old people. They were "crazy" old people. They were people whose relatives could not stand them, or did not want to stand them, or keep them.

They were all dreary, dilapidated, hopeless people, waiting to die. Speaking rarely, spoken to rarely.

Fifty-one of them were bedfast; the easiest way to take care of old patients in State hospitals is to keep them in bed. By keeping them in bed, you have less trouble. They do not stumble; they do not fall down.

This is the old theory. Thank God, it is more or less abandoned.

Fifty-nine of these people were bedridden. About a score of them had no control over their excretory functions. They soiled the beds regularly. Forty-one of them were spoon-fed at every meal.

One of them had been on the ward for 58 years. The average stay of these old people on this ward was 10 years!

So, there was this ward full of longtime, bedridden, incontinent, hopeless, vegetating patients. Picture now this young doctor I assigned to it, Dr. Howard Williams, taking over with his therapeutic team of cheerful young nurses, aides, social workers, and psychiatric residents.

Each patient became a focus of attention. The ward was transformed from being a museum of dying human specimens into a hospital home in the best sense.

Music and television was brought in. Cages of canaries, potted plants, aquariums were placed around the dreary halls, new lighting fixtures, drapes were installed, some of them by volunteers.

Birthday parties were held for each individual, and relatives were urged to come to these for weekend visits. A score of social activities were instituted with the combined aid of the patients, staff members, and volunteers.

The patients themselves painted a shuffleboard court on the floor of the previously sacred sitting hall.

A ramp was constructed by the patients, over a short, but difficult flight of steps, which enabled some of the bed patients to be moved into the social center.

Finger painting, furniture sanding, leather-tooling, Bingo games, water-color painting, and all sorts of things were introduced.

A change in the clinical status of the patients was perceptible immediately. Three weeks after the program had begun, one patient was discharged to cooperative and interested relatives who were delighted to have their old father rise, as it were, from the grave and return to them.

By the end of the year, only nine of these nearly 90 patients were still bedfast, and only six of them were still incontinent.



Five had died. Twelve had gone home to live with their families. Six had gone out to live by themselves, and four had found comfortable nursing-home provisions. Four of the original 88 were now gainfully employed and self-supporting. (Abstracted from *Vital Balance*, by Dr. Karl Menninger, Viking Press, 1963.)

As you see, quite a number of the "hopeless," senile, and psychotic patients greatly improved. Why? What made the difference?

It was the same institution. It was the same beds. It was the same two wards.

It wasn't the same atmosphere. It wasn't the same staff. Somebody took an interest in them. Somebody treated them as if they were human beings. That was more important than the structure, it was more important than the equipment.

Everything depends upon the spirit of the place.

There is actually a spirit in that place which says that person is wanted and cared for. That is important. You must give some kind of special attention to each individual, as a person, not as a "senile" or "psychotic."<sup>9</sup>

The importance of the nursing home's "spirit" is amply confirmed in the literature. One interesting reference is Margaret Blenkner's "Control Groups and the Placebo Effect in Evaluating Research". In testing the effectiveness of treatment, the investigator discovered that even untrained workers with the elderly had a "placebo effect" on the recipients of therapy. The writer concludes with a series of inferential questions:

[Isn't it possible that] if a worker has enthusiasm and conviction about his way of helping, most clients will *feel* helped and some will even *be* helped?<sup>10</sup>

Dr. Folsom's reality orientation and attitude therapy incorporates this same sort of "team spirit" (see part 2-A, p. 589). He requires the understanding that "every employee and every volunteer who works in the institution is important to patient treatment."<sup>11</sup>

Nursing homes can meet the physical needs of the residents with or without meeting the emotional needs. Either of these kinds of institutions will turn bedridden patients from side to side every 2 hours to prevent pressure sores.

**Yet, it is the spirit of the staff which makes the difference between "turning the toast" and "taking care of people."**

Yet another example of the positive effects that accrue when the entire staff of a nursing home acquires "spirit" was given to the Subcommittee by Mrs. Ethel Hudson, then director of restorative activities program, Shoshone County Nursing Home, Silverton, Idaho. Activities, of course, are of wider import than entertainment. They involve the patient in his own care; they motivate him to make improvements

<sup>9</sup> TLTC, part 15, pp. 1514-1515.

<sup>10</sup> *Social Work*, January 1962.

<sup>11</sup> The administrator of the Appleton Extended Care Center, Inc., in Appleton, Wis., provided the Subcommittee with a useful example of how he transforms this philosophy into practice. Mr. Charles Barnum makes a point of recognizing and recalling the names of all residents and employees in his facility the day they enter. Mr. Barnum comments: "In my opinion, personal recognition by the administrator of employees, resident patients, and their families creates an atmosphere of mutual respect and interest for everyone."

in himself from his physical appearance to his functioning ability. Mrs. Hudson testified:

The philosophy of patient care at our nursing home is simply this:

The total care of our patients is the only reason for our existence. Every effort of each member of our staff must be aimed toward this end.

Total care of the patient includes all efforts required to provide an environment which contributes to the mental, physical, emotional, and social restoration of the patient to a normal, dignified individual.

Prior to December 1968 there was no activities program. Until the program was initiated, our patients had little to look forward to except eating, sleeping, and dying.<sup>12</sup>

At first, there were only two 1-hour craft classes each week. No one was required to participate. One year later the program had grown beyond all expectations:

By the end of 1969, movies and bingo sessions were scheduled once per week, at separate times. The attendance at each of these sessions increased from the beginning of five patients at each session to the capacity audience of 40 at each session presently.

During 1970, social hours—cocktail parties at which light alcoholic and nonalcoholic beverages were available—picnics, birthday parties, and like events were scheduled. At these occasions free live music, compliments of the local civic groups and the musicians union, playing the older traditional songs, are made available. The patients themselves furnish the singing and dancing to enliven these occasions. These activities added social confidence to our patients, and brought back many of their earlier, pleasant memories. This, in turn, whets their memory recall, thus enhancing their mental alertness.

In 1969, one of our “heavy care” patients, a chronic, severe arthritic, produced a four-act play depicting the birth of Christ. The actors, directors, and stagehands for this play were patients. Actually only one performance was scheduled but due to demand and to limited seating capacity four performances were given with a total of over 600 patients, staff, and public attending.

Other special accomplishments of our patients include:

Fishing, fly-tying, cabinetmaking, and furniture repair and finishing by one of our patients, a paraplegic;

Huckleberry picking, winemaking and to-scale dollhouse making by another of our patients, a double amputee;

Maintenance of a patriotic flower garden which keeps four of our patients busy during this season;

Other activities too numerous to mention.

We have recently installed a chapel for use by all denominations. Aside from worship services, this chapel is used for prayer and meditation, as well as an area for patient-family-

<sup>12</sup> TLTC, part 17, p. 1768.

minister solace and conferences. The finished decoration and the drapes for the chapel will be completed by the patients.

We hope soon to acquire and install a six-leather-pocket pool table for the use of our men patients.

Each week at a scheduled period we have a session of card playing for men only. At these sessions the men patients play poker, pinochle, cribbage, and so forth, for 2 hours. Although money is not involved, chips are used for example in poker. The one who finishes with the most chips, the highest score, or runs the cribbage board most, wins a six pack of beer to take to his room to consume at his leisure, with his physician's permission.<sup>13</sup>

The results of this program were impressive. The percentage of heavy care patients was sharply reduced. Well over two-thirds (67) of the patients admitted to the facility were considered "heavy care" at the time of admission. With the operation of the activities program, the number of patients so classified was reduced to nine.

Mrs. Hudson concluded :

Our patients, who average 81.9 years of age, have taken a new outlook on life. The rather heavy restorative activities schedule, which is geared to patient interests and demands, gives our patients little time for idleness or for worrying about their condition or their problems. Due to a natural fatigue resulting from this active schedule, our patients are, for the most part, sleeping naturally and without the use of sleep-inducing medications.<sup>14</sup>

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<sup>13</sup> *Ibid.*, p. 1769.

<sup>14</sup> *Ibid.*, p. 1770.

## PART 2

### THE FOUR MAJOR AREAS FOR INNOVATION

“Over the past few years I have had occasion to visit many nursing homes—especially in my home State—and I have been impressed by the positive and innovative approaches to rehabilitation and therapy. The best homes I have visited more often than not feature progressive in-service training programs for nursing home employees.”  
—Senator Charles H. Percy.

Federal and State Governments, with all their power, cannot command individuals to love and serve one another, in nursing homes or anywhere else.

And this is as it should be. Public policy cannot dictate attitudes. But public policy can have goals which recognize human aspirations and human needs beyond the merely economic or physical, particularly when public funds pay for so great a share of the cost of long-term care in this Nation.

Tender loving care *can* be provided in our nursing homes, *if* nursing home personnel have the will to provide it, *if* they have the means to provide it with, and *if* public policy does not actually thwart or hinder more humane care.

Previous Supporting Papers in this series have told of such failures or contradictions in policy. Additional Supporting Papers will explore others.

But these papers would be incomplete without an adequate discussion of steps being taken to make long-term care more effective and more patient-oriented.

These positive actions fall essentially into four categories: Positive approaches to therapy and rehabilitation, improvements in the physical features of the home, innovative approaches in the training of employees, and innovative activities or services to nursing home patients. Details follow:

#### A. POSITIVE APPROACHES TO THERAPY AND REHABILITATION

The principles and requirements of a good nursing home are well known to St. Joseph's Manor in Trumbell, Conn., and Golden Acres in Dallas, Tex. At Golden Acres the team spirit concept is expressed as the LIFE program (love, interest, fulfillment, and enrichment). Personnel at Golden Acres and St. Joseph's Manor begin with the premise that the disabled adult can be rehabilitated. It is assumed that much lost function can be restored. Likewise, the Crystal Springs Rehabilitation Center in San Mateo County, Calif., dedicates each and every staff member to the goal of rehabilitation of patients.

In these facilities a variety of techniques are used to upgrade the functional status of mentally impaired elderly patients. The object of these techniques, used singly or in combination, is to modify unacceptable behavior in order to facilitate the patient's reintegration into social groups. Among these techniques are:

### 1. REALITY ORIENTATION

This is a term for a program developed by Dr. James Folsom. The basic aim is to put a regressed patient into renewed contact with the world around him. The program can be conducted in a class or through informal interaction. Orientation is begun at the most basic level. If a patient does not know his own name, he is taught.

If he does not know where he is from, he is told. Then, the patient is taught the day, the week, the month, the year, his age, et cetera. Typically, patients may exhibit confusion for many weeks. Yet, once a patient is able to grasp any bit of information such as his name, the name of his spouse, his birthday, he begins to recall and use ever-increasing amounts of previously known material.<sup>15</sup>

### 2. SENSORY TRAINING

Another program aimed at the consequences of the almost complete dependence created by life in the total protection of the nursing home environment, is sensory training. When nursing home patients sit staring into space, receiving total care and with nothing to do but breathe, swallow, and excrete, dependence develops to the point that they no longer care. Sensory training supplements basic reality orientation by stimulating the patient's sensory sensitivity. As implemented at the White Plains Center for Nursing Care, N.Y., patients are gathered together in small groups and asked to identify objects by smell, taste, hearing, touch, and sight.

Sensory training is useful for patients manifesting psychomotor retardation and poor discrimination between, and response to, environmental stimuli. Dr. Michael B. Miller, director of the facility, claims the program demonstrates that even severely brain-damaged patients can, with social encouragement and warmth and affection of a compassionate leader, respond with increased feeling, increased thought, and even increased coordination.

He echoes the message of Drs. Folsom and Oberleder: "We know that senility need not be a fixed condition. There is much that is reversible about organic brain syndrome and senility."<sup>16</sup> Dr. Miller cautions that rehabilitation is doomed to failure unless it considers the whole person, adding psychological and social therapy to medical techniques.<sup>17</sup>

<sup>15</sup> *Op. cit.*, footnote 6.

<sup>16</sup> *Modern Nursing Homes*, June 1972, p. 40.

<sup>17</sup> California Association of Health Facilities, *Input*, vol. 2, No. 4, April 1974, pp. 2-3. Also *Update on Mental Health and Other Human Services*, vol. 2, No. 7, July 1974, p. 2.

The Guidance Center Sanitarium in Anaheim, Calif., is a facility for the purpose of assisting and caring for the emotional, psychological, and physical needs of the chronic mild mental, and geriatric patient. The facility uses a combined approach of reality orientation, sensory training, and remotivation.

The walls of the facility are decorated with product signs (some new and some old), posters of movie stars, and bursts of color. Corridors are labeled with street signs. Dining facilities have cafe and restaurant facades. In the morning, sounds of dawn are piped into patient rooms, and in the evening, the chirping of crickets. In the penny arcade, gumball and pinball machines serve double therapeutic value—a reward in remotivation therapy, as well as improvement of motor coordination.

### 3. REMOTIVATION

Remotivation is a technique which was developed in mental hospitals some years ago. Essentially, it is an effort to find out what activities the patient enjoyed doing in earlier life or would have liked to have done, and directing him to those same goals.

Remotivation can involve the use of rewards of many different types. Allowing a patient to participate in activities he enjoys is one form of reward. Certain foods can be given as a reward along with the verbal "feedback" and reinforcement given for increased effort and motivation.<sup>18</sup>

Some nursing homes use wine as part of their motivation program (with the physician's permission, of course) as a reward for increased function and independence. Dr. Salvatore P. Lucia, professor emeritus of preventive medicine at the University of California, is the leading advocate of the judicious use of wine in nursing homes as a gentle nontoxic tranquilizing agent. Dr. William Dock of the Veterans' Administration Hospital in New York agrees that wine has much to offer in the context of nursing home therapy. Dr. Robert Kastenbaum, professor of psychology at Wayne State University, also describes wine as beneficial.<sup>19</sup>

Dr. Kastenbaum contends that, in addition to its use as a reward and as a gentle tranquilizer, wine may have important psychosocial effects. Wine supplies needed vitamins and minerals and is a "ready energy" food which requires minimum metabolic effort on the part of the body. Wine stimulates the appetite and increases the flow of digestive juices—functions often slowed down in old age. From Dr. Kastenbaum's study, patients taking a glass of wine at night slept better with more "delta sleep" (deep refreshing sleep) than patients taking sleep inducing sedatives. In addition, there are few contra-indications in the use of wine, particularly in cooking, which enhances the flavor of food. For these reasons, more and more nursing homes are looking to the use of moderate amounts of wine for their patient population.

#### B. IMPROVEMENTS IN PHYSICAL STRUCTURE

The physical structure of a nursing home has far-reaching effects on the quality of care provided to patients and the attitudes of its resident patient population. There appears to be a consensus in the literature that an institutional appearance is best avoided. This premise leads directly to a paradox. Often, converted houses offer patients a "home" atmosphere but are poorly designed to function as nursing homes. On the other hand, facilities specifically designed as nursing homes following the hospital example are well equipped for their function and present few hazards. However, many of these facilities lack warmth.

<sup>18</sup> The Hillhaven Convalescent Center in Ogden, Utah, makes extensive use of remotivation technique. Among their most popular rewards are making homemade ice cream, doughnuts, honey scones, and tacos.

<sup>19</sup> *Nursing Homes*, "Serving Wine in Nursing Homes," March 1971, p. 25.

One witness told the Subcommittee staff that the new nursing homes are so germ free and sterile that a human being can't live there either. Clearly, a retreat to the era when the majority of America's nursing homes were converted mansions is no solution, either. Instead, several newly constructed facilities have found ways to soften their austere appearance. Some of the methods used to achieve this effect follow.

## 1. THE USE OF COLOR

More and more, students of aging and psychology are discovering the effect of color on individuals, especially the elderly. Many seniors have poor eyesight or colorblindness. The best contemporary thinking dictates that drab clinical colors be replaced with a bright color scheme, pleasing to the eye, and recognizing practical considerations.

Colors can individualize each patient's room, allowing the patient some sense of "territory" and a sense of being different from his co-residents. Positive therapeutic effects can result from involving the patient in selecting his own color scheme. This process helps a patient find his own room—often a difficult endeavor in monochromatic facilities. In shared rooms, furnishings can be differentiated by color.

Attention to the color, size, and shape of furniture can keep patients from dangerous stumbles. Furniture should contrast sharply with the walls and floors, in textures or color. Doors in different colors can help the resident distinguish the closet from the hall or bathroom. Light switches can be made more identifiable with color or luminescence.

James W. Ramage of the Northwestern Alabama Mental Health Center, Hamilton, Ala., suggests the use of colors in corridors to help patients get about more easily. A colored stripe on the floor a foot or more from the wall helps in judging distances for wheelchairs and walkers. Handrails are more obvious if painted brightly. Mr. Ramage also suggests painting the nurses' station in warm colors, making it a more pleasant place for individuals to work, and giving patients a sense of security.<sup>20</sup>

In short, the use of color makes it easier for geriatric patients to function: it lessens dependence on nursing personnel and has pleasant psychological effects. If color is used to identify furniture, lockers, and belongings of individual patients, it will also serve to add to their sense of human dignity.

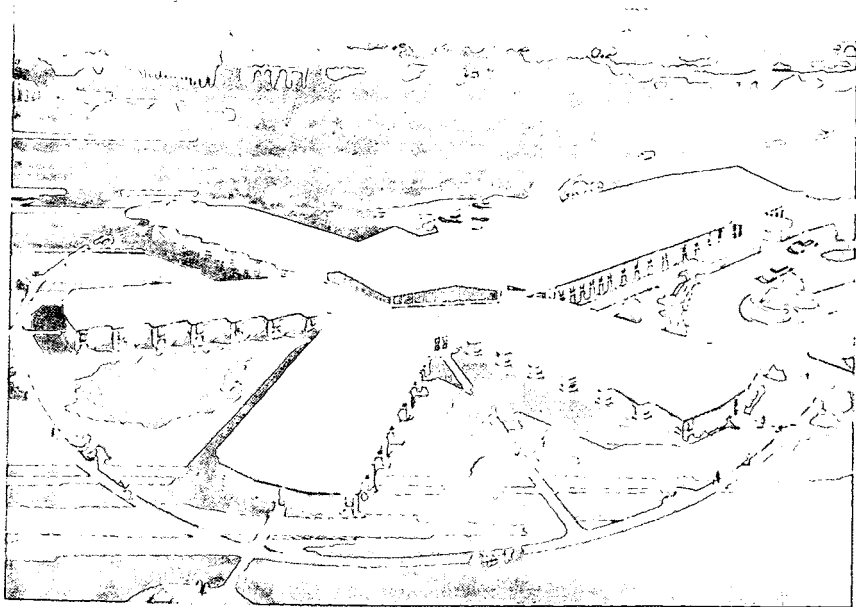
## 2. THE USE OF ARCHITECTURE AND DESIGN

For many years, professionals such as Dr. S. D. Doff, director of the Department of Preventive Medicine and Outpatient Services, Duval Medical Center, Jacksonville, Fla., have been critical of the limited attention the architectural profession has given to the design of long-term care facilities. Dr. Doff and others find the problem understandable since few architects have any knowledge of the needs of nursing home residents.

Nevertheless, in the past few years there have been some significant breakthroughs in nursing home design. Among the most exciting is the star-shaped nursing home with saw-toothed walls, developed by

<sup>20</sup> *Hospital and Community Psychiatry*, September 1971.

Professor Harold Baumgarten, Jr., then assistant professor of administrative medicine at Columbia University. The design has been implemented with success at the Troy Hills House in Morris County, N.J., and in the Cranford Health and Extended Care Center, Cranford, N.J.



The center of the facility is a high domed rotunda which serves as a living room illuminated by a profusion of natural light. From this central core, five wings swing out: four for patient rooms and one administrative wing. Patient wings are in different colors, and the handrails are each differently notched to aid the elderly feel their way back to their rooms, when necessary. In the patients' rooms, the saw-toothed design makes it possible for both patients in each room to have their own window. Each room has an individual thermostat for heat and air-conditioning, a sink, toilet, and shower.

Patient beds are located at right angles, head to foot, so that communication between patients is easier and there is no coughing or sneezing in the other patient's face; a problem when the beds are parallel. This arrangement of beds facilitates patient observation by the nursing staff. Upon opening the door, both patients can be seen at a glance. The nursing stations are located in the rotunda at the head of each wing. This again allows the head nurse to visualize nursing activities throughout the one-story, fire-resistant structure.

The fifth wing of the home, the administration wing, contains the recreation room, the dining room, the chapel, and administrative offices. The premise underlying the innovative design described above is that patient withdrawal can be minimized through personalization and environmental stimulation while enhancing functional efficiency. For this reason there is liberal use of bright colors and a maximum



use of natural light. Dr. Baumgarten contends that the patients soon learn "where the action is" and the design causes them to ambulate to participate in activities in the rotunda or further, to the dining room or bar, located at the back of the administration wing. Under the doctor's prescription, patients can sit in the comfortable lounge and order a drink served in a frosty glass instead of having a paper cup at the bedside.

There are, of course, other examples of architectural design facilitating patient care.<sup>21</sup> The Subcommittee felt the above was illuminating since the cost of construction in 1968 was a modest \$10,000 per bed.<sup>22</sup>

### 3. THE SENIOR CITIZENS VILLAGE OR "CAMPUS" CONCEPT

A recurrent theme in the 1969-73 hearings was the need for a broad spectrum of institutional services in one location. Many witnesses suggested it is unrealistic that nursing homes exist like lonely islands in the middle of suburbia. By the same token, a need to provide housing for the elderly with requisite services is manifest. How does one bring together housing and long-term care under one umbrella instead of treating the two as separate and unrelated entities?

A proposed solution was offered by Mr. Paul dePreaux, then administrator of the Avery Convalescent Center in Hartford, Conn., and former president of the Connecticut Association of Nonprofit Homes for the Aged.<sup>23</sup> Mr. dePreaux outlined the village concept which is being implemented at Avery:

We have five levels of care that we consider necessary for the total care of the patient with total concern. One segment is the apartment. These are for those people who are completely independent, able to live by themselves, cook for themselves, even maintain themselves in the community, working, visiting, driving their own cars, and so forth.

The second level of care that we consider is the congregate living area. This is the area where the person who decides that they no longer wish to cook or clean for themselves can have it done for them. We have a central dining room. In fact, it is hotel-type living.

The third area is the rest home with nursing supervision, which is commonly called the intermediate care facility. This area is for those people who require some nursing surveillance or nursing supervision between visiting nurse care and intensive nursing care.

The fourth area we define is the nursing home or the convalescent home or extended care facility where they receive intensive nursing care covered by RN's over a 24-hour period.

Now, the fifth area which we consider almost as important or even more important than the other four is the area which

<sup>21</sup> The Uthlein Mercy Center in Lake Placid, N.Y., utilizes a similar architectural design. In addition, each room is color coordinated. The easy chairs in the patients' rooms swivel to look out the window or to face incoming visitors. The patients' names appear in large letters on the door, while the room numbers are reduced in size.

<sup>22</sup> *Cranford Chronicle*, Aug. 26, 1968; and *Nursing Homes*, April 1967.

<sup>23</sup> TLTC, part 17, p. 1805.

we call the village center. This is the area which we call the area of community involvement. You see, we believe that unless the other four areas of care are involved in the community, then you find yourself an island of care in the community that doesn't care. If they don't know about you they don't care about you.<sup>24</sup>

By having all of these services within one complex, the resident can draw from a continuum of care, depending on need. The administration and nursing facilities can be centralized. There is a unique opportunity for the community to serve the village and reciprocal involvement of the village in the life of the community. The village can be the central focus for outreach services, meals on wheels, the site of a community clinic, or provide a locus for research in aging. It can serve as a day care center and can provide outreach, physical therapy, and recreation programs.

The benefits to the community and to the patients are many, but perhaps the most significant is that the resident-patient has the security of knowing whatever services he may need are near his doorstep. Moreover, if it is necessary for him to go into the nursing home, he has every expectation of being able to return to the rest home, with its minimum supervision, or perhaps back to independent living. In practice at Avery, this program has allowed numerous husbands and wives to remain together. Even though one might be in a nursing home and the other in the congregate living facility, they can still visit and have meals together.<sup>25</sup>

The appeal of the senior citizens village led to the introduction of S. 1165 by Senator Moss which would authorize the Secretary of Housing and Urban Development to choose the best of three "village or campus designs" to serve as models for wider duplication throughout the Nation.

### C. POSITIVE AND INNOVATIVE APPROACHES TO THE EDUCATION AND UTILIZATION OF EMPLOYEES

The training of employees to provide fine nursing home care is an important and difficult task. Of course, many nurses aides are being paid only the minimum wage, and they show a yearly turnover rate of 75 percent. Thus, there may be little incentive, according to some analyses, to provide such training. Nevertheless, there are many nursing homes which recognize that training not only results in better patient care, but in a more stable cadre of employees.<sup>26</sup> The following examples were provided to the Subcommittee:

<sup>24</sup> *Ibid.*

<sup>25</sup> Other examples of senior citizen villages, campuses, and multiple care facilities include: Grasmere Residential Home, Inc., Chicago, Ill.; the Jewish Home and Hospital for the Aged, New York, N.Y.; Samrkand Retirement Community and Samrkand Hospital (Skilled Nursing Facility), Santa Barbara, Calif.; Lincoln Lutheran Campus, Racine, Wis.; Loretto Center, Syracuse, N.Y.; and Asbury Methodist Village, Gaithersburg, Md.

<sup>26</sup> Colorado Health Care Association: *A Team Approach to Training and Development*, contract No. HSM-110-72-374, Denver Colo., December 1973. The final project report for training of nursing home personnel in Colorado notes that a significant positive correlation was established between the amount a facility participated in the coordinated training programs and the degree of improvement in patient care.

## 1. EMPLOYEE SENSITIVITY TRAINING

The Subcommittee learned of several innovative programs for the training of nursing home personnel. Perhaps the most impressive was "sensitivity training" in effect at the Beaumont Convalescent Hospital in Beaumont, Calif. Marshal Horseman, administrator, told the Subcommittee that he requires each prospective employee in the facility to assume the role of a patient for 24 hours before employment. He feels this experience gives employees valuable perspective.

Employees are groomed by their fellow employees, given baths, fed, and wheeled about in hospital-type gowns that open in the back. They are put to bed at 8 or 9 o'clock like the other nursing home patients and must remain there until morning. They experience trying to sleep while employees, in the hall, converse, work, and socialize. Mr. Horseman contends there is nothing like being at the mercy of the staff, wheeled about in a hospital gown with its attendant problems of maintaining modesty and aplomb, to help a nurses aide learn that nursing home patients are dignified human beings, rather than objects incidental to employment.<sup>27</sup>

## 2. ACCIDENT PREVENTION PROGRAMS

Many nursing homes have established accident prevention programs aimed at minimizing any possibility of injury to patients or to the nursing staff. These programs are taking on new importance in view of the Occupational Health and Safety Act, which requires each employer to provide his employees with a safe place to work. Employers will have to comply with a set of safety standards. Employees in nursing homes are accorded the protections of the act. If a nursing home fails to provide a safe living environment, nurses (and other employees) may notify the Department of Labor and ask for an inspection. If the employer is found in violation, a citation and a penalty will be issued.<sup>28</sup> Under the act, nurses, too, are required to prevent foreseeable accidents.

## 3. IN-SERVICE TRAINING PROGRAMS

There are many excellent examples of in-service training programs in the Nation's nursing homes. One of the largest and most important of these programs is being implemented at the Frederick D. Zeman Center for Instruction in New York City. The center has an enrollment of about 200 volunteers, doctors, and administrators under the direction of Dr. Manuel Rodstein, director and chief of medical serv-

<sup>27</sup> TLTC, part 17, p. 1777.

<sup>28</sup> *Job Safety and Health*, May 1973, p. 23. For the convenience of nurses and employees, toll-free "hotlines" have been established to the Department of Labor. In Washington, D.C., the number is 961-2603. In other areas the numbers are as follows:

Toll-free 24-hour OSHA hotlines are in operation in Atlanta and Chicago regions of the Occupational Safety and Health Administration. Callers can use the hotline to report situations of imminent dangers in the workplace or jobsite accidents any hour of the day or night. During office hours, callers also can receive answers to questions about the Occupational Safety and Health Act.

In the Atlanta dialing area, the hotline number is 892-0259. For the remainder of Georgia, outside the Atlanta dialing area, the number is 800-282-1048. Callers from Alabama, Florida, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee—all covered by the Atlanta region—should dial 800-241-8598.

In Chicago, the local number is 939-5494. For those in Illinois outside area code 312, the number is 800-972-0581. The rest of the Chicago region—Indiana, Ohio, Michigan, Minnesota, and Wisconsin—should dial 800-621-0523.

ices. The cost for the course is only \$35, which covers a variety of topics from death and dying to institutional housekeeping and laundry management.<sup>29</sup>

Another unique approach to provide in-service education is the Mobile In-Service Training to Nursing Homes in Phoenix, Ariz. The project is coordinated through the Phoenix Community College. The mobile unit's prime purpose is to update training for professional and allied health personnel, and to promote better coordination of patient care in nursing homes, extended care facilities, and home health services. Contracts are signed by the institutions using the service, specifying the hours of training and the programs desired. The facility is charged \$15 for each hour the unit is actually in the facility.

The mobile unit provides direct teaching in formal and informal classes, and at the bedside. In addition, it utilizes closed circuit FM radio broadcasts from the college district radio station. The variety of programs offered is remarkable: from 20-hour geriatric nursing assistant classes to much briefer staff in-service training in nursing audit and crisis intervention.<sup>30</sup>

Another recent innovation is the health employees learning program, offered by Hoffman-LaRoche, which encompasses 45 programmed audiovisual segments to help nursing homes provide in-service training for employees, quickly and inexpensively. Films are provided on a variety of topics such as "How to Move a Patient in Bed." The program is aimed at the high turnover of aides which creates a need for continuing training programs.<sup>31</sup>

#### 4. CONTINUING EDUCATION PROGRAMS

Continuing education programs are usually lengthier and more formal than in-facility, in-service education, and are focused on an area of concern rather than a specific problem. Continuing education may be offered by a long-term care facility for their employees and outside individuals. For example, the Jewish Home and Hospital for the Aged in New York City conducts the following courses and workshops relating to care of the geriatric population:

Activities leadership	Occupational therapy
Nursing home administration	Physical therapy
Behavioral sciences	Psychiatry and neurology of the aged
Institutional management	Remotivation
Management and leadership	Residents' councils
Geriatric medicine	Sensory deprivation
Geriatric nursing	Social services
Nutrition for the geriatric patient	

<sup>29</sup> *New York Times*, Feb. 4, 1973.

<sup>30</sup> Harker, Beverly, R.N., M.A., coordinator, Mobile In-Service Training in Nursing Homes, Phoenix Community College, in letter to Subcommittee.

<sup>31</sup> Still another example of innovative in-service training was submitted to the Subcommittee by Cy Weisner and Lou Ann B. Jorgenson of the Graduate School of Social Work, University of Utah, and Sister M. Laurice, OSF, director, Health Services for the Aging, the Catholic Hospital Association.

As part of a nursing home demonstration project, MSW students began a program of social work consultation for St. Joseph Villa Comprehensive Nursing Care Center. As a part of this ongoing program, social work students conduct in-service classes for staff members in communication, death and dying, behavior modification, reality orientation, and other therapeutic skills.

<sup>31</sup> *Nursing Homes*, October 1972, p. 14.

Frequently, however, such courses are more suitable in a college or university. The University of Pittsburgh Graduate School of Public Health, Health Services Administration, has established a long-term care education unit. The unit was created to provide courses for long-term care personnel. The courses vary in length from 1 day to 2 weeks, and the registration fees vary accordingly from \$30 to \$750 per enrollee. The courses are held in various parts of Pennsylvania, and continuing education units (CEU's) are granted.<sup>32</sup>

## 5. TRAINING SENIOR CITIZENS TO WORK IN NURSING HOMES

A program of great interest to the Subcommittee was established in 1971 by a \$40,000 grant from the Office of Economic Opportunity, and was called the senior talent opportunity program (STOP), located in St. Paul, Minn. Under the direction of Dr. Lucille Poor, able-bodied senior citizens complete 3-week training programs and are paid \$1.65 an hour as they train. When the course is completed, the senior joins the staff of a nursing home at regular wages.

The program emphasizes food nutrition in health and illness. Menu planning, food service, the psychological meaning of food and diet, as well as the special feeding of stroke patients, are given attention. The program may present a model for a wider program of employing able-bodied older Americans in nursing homes.<sup>33</sup>

## 6. EDUCATIONAL PROGRAMS WITH LOCAL SCHOOLS OF NURSING

Examples are available depicting the mutual benefit inherent in a liaison between a nursing home and a school of nursing. Such examples are still relatively scarce, but one excellent illustration is provided at the Swope Ridge Nursing Home, Kansas City, Mo. This home is affiliated with Avilla College's nursing home program and cooperates with several other schools of nursing in the Kansas City area. Students spend several days each semester in the facility observing the care of the chronically and mentally ill older adult. The Missouri Division of Employment, which administers the manpower training program for licensed practical nurses, sends LPN's to Swope Ridge for clinical experience.

**No resident is admitted with the idea that he is a terminal patient. The emphasis is on rehabilitation—not vegetation. Residents come to this home to live—not to die.**<sup>34</sup>

<sup>32</sup> University of Pittsburgh Graduate School of Public Health, Health Services Administration: Winter-Spring Bulletin, "Continuing Education Courses for Long-Term Care Personnel, January-June 1975." Courses include: Introduction to Long-Term Care Administration; The Medical Director, Issues and Laws; Labor Relations in the Health Care Field; Environmental Aspects of Infection Control; Environmental Design; Medical Care Organization; Social Restoration Services; Dimensions of Unit Planning and Control; Milieu Therapy; Remotivation Therapy and the Geriatric Patient; A Rehabilitative Approach to Patient care.

<sup>33</sup> *Ibid.*, p. 16.

<sup>34</sup> *Mental Health Care and the Elderly: Shortcomings in Public Policy*, a report by the Special Committee on Aging, November 1971, p. 85-97.

Other examples of nursing homes cooperating with schools include the Hillhaven Convalescent Center in Ogden, Utah, which affiliates with Weber State College. Nursing students affiliate at the convalescent center for geriatric nursing care and for education in

## 7. COMPUTERS FOR PATIENT MONITORING AND STAFF EDUCATION

The Fairview Nursing Home at Forest Hills, N.Y., has devised a system to monitor the attention given to patients by nursing home personnel. This system features a clock installed directly over each patient's bed. When entering and leaving a patient's room, the nursing personnel push a button on the clock, indicating the length of time the patient received care.

A central computer system processes the data, which can be used by the administrator to determine the amount of time various nursing personnel spent with each patient during the night. The usefulness of this system rests in accounting for nursing activity in patient care, and even more in predicting and allocating the amount of nursing time required by each individual patient.<sup>35</sup>

At the Moody Nursing Home and Pavillion in Decatur, Ga., a computerized system for patient care plans has been introduced. The system allows professional personnel to spend less time doing paperwork, while insuring that every patient has an up-to-date plan of care. Introduction of the computerized plan has actually saved money.

The Autopost System incorporates, as a matter of routine, the requirements imposed upon the institution by Federal and State agencies. The plan coordinates the total physician, nursing, and social service care plans: goals, discharge plans, orders, complete medicine profile, and physical therapy. The system also integrates cost accounting data to produce financial/management information. (See appendix 2, p. 627.)

### D. INNOVATIVE ACTIVITIES OR SERVICES

A recent advertisement for color television sets in a leading nursing home journal describes TV as "therapeutic for patients on the mend." Color TV was also touted as therapy for the staff—"Helps stamp out nuisance calls from patients who just want someone to talk to," and therapy for the administrator—"Brings in added income without capital investment."

bowel and bladder training. Social workers and recreation students from Weber also acquire experiences at Hillhaven.

Monroe Community Hospital, a 710-bed facility for care of the aged and chronically ill, is affiliated with the University of Rochester in New York. Monroe is staffed in part by a house staff from the departments of medicine, family practice, and rehabilitation of the university, and will provide a clinical placement for a new program of geriatric nurse practitioners.

The Yale University School of Nursing and the Veterans' Administration Hospital of West Haven, Conn., affiliate for the clinical experience of family nurse practitioners in the nursing home section of the hospital.

<sup>35</sup> Testimony by Elizabeth Connell, TLTC, part 17, p. 1791.

# RCA Color TV... Economy in Nursing Home Therapies

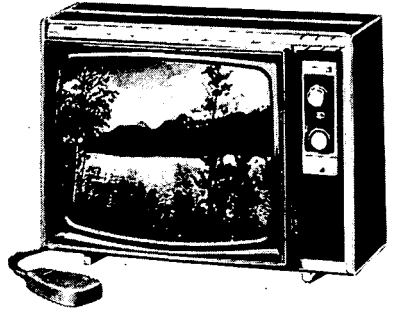
RCA Color TV can be the therapy that brings better results for your nursing home.

Therapy for patients—keeps patient occupied with favorite color TV shows while he's on-the-mend.

Therapy for staff—helps stamp out nuisance calls from patients who just want someone to talk to.

Therapy for administrators—brings in added income without capital investment.

Look into RCA's full line of electronic entertainment and communications equipment, designed expressly for institutions. There's black-and-white TV as well as color—both include versatile remote control with personalized sound—rollabout stands and wall mounts, and sound products. Available through lease or purchase with convenient payment arrangements. Mail coupon for full information.



**RCA** AccuColor®

RCA Service Company  
A Division of RCA  
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Please send full information about RCA Color TV and other RCA products for nursing homes.

Name \_\_\_\_\_

Title \_\_\_\_\_

Nursing Home \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Specifications subject to change without notice.

Simulated TV reception

Unfortunately, the activity programs of all too many nursing homes in the United States reflect precisely this same theme. Television in many nursing homes is the primary form of therapy, as well as diversion. But, there is a growing recognition of the importance of activities programs. One example of the startling and far-reaching effects of a good activity program can have on patients has already been cited. As noted above, Mrs. Ethel Hudson and the staff of the Shoshone County Nursing Home were able to markedly decrease the number of heavy care patients by making them active participants in events.

There is also evidence that activity therapy is receiving increased support and interest in nursing homes. President Nixon's nursing home program allocated \$139,000 to put 10,000 activity directors through a 3-day training program. In collecting the material on activities, the Subcommittee was pleasantly surprised at the vigor with which some nursing homes attempted to involve their residents in programs. The programs enumerated were as common as bingo and as "far-reaching" as nursing home residents' councils.

## 1. SELF-GOVERNMENT BY NURSING HOME PATIENTS

The Subcommittee is aware of a new trend in nursing homes. Several homes are investing patients with the rights and responsibility to make their own decisions. According to one report, residents' councils are becoming quite popular in New York and Wisconsin nursing homes.<sup>36</sup> Consumer participation in the policy of nursing home operation can have decidedly positive effects. At the very least, the program serves as a means of reciprocal communication between the administration and residents of a home.

Dr. Florence Kavalier, acting commissioner of health and insurance programs, New York City Department of Health, has recently written that such council meetings are a hybrid blend of town meetings, sensitivity sessions, peer rally, and forum. She notes that communication is not only between the patients and the administrative and nursing staff; there is communication among the residents. An educational and a recreational function is served as well.<sup>37</sup>

Dr. Kavalier and her cowriter, Dr. Paul Brandt, describe one instance where an aide had begun the practice of giving large numbers of patients their baths on the same morning, in assembly line, "car wash" fashion. At the residents' council meeting, one patient complained about the practice, saying it was undignified. Others agreed, and the astonished nursing home operator corrected the situation immediately.<sup>38</sup>

A similar idea, involving employees, is the institutional council which features representatives from each nursing home shift, including aides, orderlies, LPN's, RN's, and kitchen, maintenance, and administrative workers. These council meetings, generally composed of elected representatives of the home's personnel, set the policy for the nursing home. Since all employees have a voice in the operation of the facility, petty grievances and complaints are quickly resolved resulting in a smoother running operation with less turnover. Such a program is in effect at the Lutheran Home at Mooretown, N.J.<sup>39</sup>

## 2. A NOVEL IDEA AND A LIST OF NURSING HOME ACTIVITIES

A novel idea was implemented at the River Hills Nursing Home in Rewaukee, Wis., in honor of the 1968 Olympic games. At senior citizens Olympic games, residents participated in shot put, discus, basketball throw, darts, javelin, shuffleboard, bowling on the green, skittle bowling, table bowling, and beanbag toss. Winners in individual events in each division, men and women, and in the decathlon received Olympic shields for the first, second, and third place. It was reported that the idea was extremely well received even by those seniors who could only watch. The exercise was beneficial and the competition stimulating.<sup>40</sup>

<sup>36</sup> *Nursing Homes*, "Nursing Home Residents' Councils: A 'New Wrinkle' in Consumer Participation," October 1972, p. 8. Also, *Modern Nursing Home*, February 1970.

<sup>37</sup> *Ibid.* One example of an active resident's council can be found at the Clove Lake Nursing Home in Staten Island, N.Y.

<sup>38</sup> Federation of Protestant Welfare Agencies/Division on Aging: *Establishing Resident Councils*, January 1974, New York, N.Y.

<sup>39</sup> *Modern Nursing Home*, June 1972, p. 46.

<sup>40</sup> *Nursing Homes*, April 1969, p. 11.



No single activity or innovation can do the entire job that must be done in long-term care. A *total* effort is needed on a variety of fronts. One of the most comprehensive efforts to reach the Subcommittee's attention was provided by the Iowa Soldier's Home in Marshalltown, Iowa. There, staff must deal with the needs of domiciliary patients, others requiring skilled nursing, and still others needing more intensive care. In a letter, the administrator gave this list of efforts that might be regarded as "extras" in other facilities:

- Because many of the residents are handicapped and in wheelchairs, the grounds are planned for navigation by them.
- Tables are designed to have wheelchairs fit around them and ramps are provided as an alternative to stairs.
- The grounds feature several birdhouses for birdwatching residents.
- The little league baseball team plays on the grounds in summer.
- The home's grounds is the site of the annual community Easter egg hunt. Residents participate in hiding the eggs.
- Band concerts are held on the grounds through the courtesy of the local musicians union.
- The hills are used for sledding in winter, for parties and picnics in summer.
- Shuffleboard tournaments are held.
- Students working on degrees in nursing work with the residents in both degree and practical nursing programs.
- Reality orientation is practiced with calendars, clocks, and with signs over the patient's beds indicating name, home, and activities for the day.
- A program of government by patients is being tried with suggestion boxes available and meetings arranged between the administrator and the patients.
- There are no restrictions on visits; in fact, children are encouraged—a toy box is provided for their use.
- A rehabilitation kitchen is provided with all appliances adapted for use by the handicapped, including low sinks, radar ovens, and other kitchen aids. The elderly and handicapped can try their hand at preparing their own meals and can even participate in the shopping for these meals—in making lists and going to buy food.
- A library is provided with specially-designed furniture.
- There is a snack kitchen.
- Residents participate in small appliance repairing, wheelchair repair, woodwork, leatherwork, sewing, and quilting.
- A foreign food fair is held with residents dressing in the costumes of the country where their food originated and food is sold by "the taste."
- A fashion show is held with residents participating; likewise, there is a wig show and a hat show.
- Periodically one of the local department stores brings goods and opens a branch in the nursing home for a short while to enable the residents to buy a few needed items.
- Visits are arranged for Miss Iowa and Miss U.S.A.
- Residents prepare Christmas cards to send to families and friends.
- Costume parties are held with prizes.

- Bulletin boards commemorate birthdays with photographs of residents as well as charting the daily activities.
- Adult education is provided in painting, secretarial work, dancing, welding, typing, and biblical history.
- The home runs a toy repair service turning restored toys over to the Salvation Army for distribution.
- The home runs a Santa Claus answering service so that young boys and girls can call or write to the home and hear from Santa.
- A supper club activity is held monthly for residents who have little opportunity to eat in restaurants.
- Church services are provided for all denominations.
- The residents choose an employee of the month who receives a \$25 savings bond.

#### ADDITIONAL ACTIVITIES AT OTHER HOMES

- acting companies formed by residents
- art shows and contests
- barbecues
- basketball from wheelchairs
- bazaars
- birthday parties
- bingo
- bridge
- bar (alcoholic beverages served with consent of physician)
- casino
- cards
- camping
- ceramics
- chinchilla raising
- closed circuit television broadcasting
- creative drama
- croquet
- dance therapy
- dinner parties (each resident may invite two guests)
- dominos
- exercise programs
- fishing
- gift shop for items made by residents
- gardening
- glee club
- guest speakers
- handicrafts, including beads
- knitting
- movies
- music appreciation
- newspaper publishing with extra large print
- picnics
- poker
- parchesi
- pancake breakfasts, with residents cooking
- recitals by musicians, et cetera
- trips by bus to nearby areas of interest
- travelogues
- swimming
- scrabble

In addition to activities, many homes offer unusual therapeutic services. The Hillhouse Convalescent Center in Ogden, Utah, and the Magnolia Health Center, New Orleans, provide oral hygiene and dental services for their residents. By assessing the chewing ability of each patient and taking corrective or remedial measures, patients are made more comfortable, enjoy eating, and maintain better nutritional status. The administrator of Magnolia Health Center states that it costs the home only \$485.73 startup expense to begin dental work. He believes they have saved more than that in "saved" food.

The Good Samaritan Millard Center, Omaha, Nebraska, provides a flexible service—patients serve themselves breakfast. Replacing the old early-morning regimentation of "herding" all residents to the

dining hall, this home now offers "open breakfast." Breakfast is available from 7 to 9 a.m. Residents get up when they wish, dress at their own pace, and linger over breakfast and conversation.

### 3. A HOSPITAL-BASED TELEMEDICINE SYSTEM

A system for providing long-term primary care to nursing home patients has been tested in the Boston area. Boston City Hospital, in conjunction with several area nursing homes, is attempting to cope with the problem of providing high-quality and readily accessible primary care to patients discharged to nursing homes.

A health team for this project consists of a hospital-based medical director, part-time internists, and four nurse practitioners. The nurse practitioners act as the "front end" of the system, visiting each patient at intervals appropriate to the individual's clinical status. On the basis of knowledge and observation, the nurse practitioner decides whether a physician's consultation is needed, and the urgency of such a visit. Consultations are conducted by telephone, at which time the physician may elect to visit the patient or change orders via the nurse practitioner. The health care team provides 24-hour, 7-day-a-week coverage, and one physician is on call at all times. (See appendix 4, p. 635.)<sup>41</sup>

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<sup>41</sup> Mark, Roger. *A Hospital-Based Nursing Home Telemedicine System*, working paper. Boston City Hospital.

## PART 3

### NURSING HOME EFFORTS TO AID THE COMMUNITY

More and more nursing homes are trying to improve their "image" with the general public, which sees comparatively few individuals return from a nursing home. Entering a nursing home is generally thought to be the first step of an inevitable slide to oblivion. In some communities, nursing home administrators themselves are startled or dismayed by harsh attitudes toward a field that should be regarded as a helping profession.

One key to change is the kind of effective rehabilitation program that has been described throughout this paper. But there are other ways to improve the image of nursing homes. One is community involvement.

#### A. OUTREACH SERVICES BY NURSING HOMES

An ever-growing number of nursing homes are offering outreach services for their communities. One example is found at the Lincoln Lutheran Campus in Racine, Wis. Lincoln Lutheran coordinates numerous senior citizen centers, serving the entire Racine community. The centers offer elderly citizens travel, recreation, and entertainment. Lincoln Lutheran sponsors the area meals-on-wheels program, including social work visits to determine if there is a need for other services.

A telephone reassurance program provides daily scheduled calls to the elderly living alone. Lincoln Lutheran even runs a gifte carte in a local department store—a sales outlet for the handicrafts made by elderly tenants.<sup>42</sup>

#### B. PUBLIC RELATIONS GROWING FROM COMMUNITY SERVICE

Nursing homes, more and more, are becoming aware of the importance of public relations. In this respect, they just raise false hopes. Dishonesty or overstatement in public relations is doomed to produce failure and added disenchantment with the industry, reinforcing the negative image extent. PR cannot be a substitute for good care.

However, public relations can and should inform the public of the innovative and concerned involvement by individual nursing homes.

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<sup>42</sup> Other homes which offer outreach services known to the Subcommittee include: Barry Nursing Homes, Inc.; Country View Health Care Center, Gillespie, Ill.; Litchfield Health Care Center in Litchfield, Ill. (meals on wheels, senior citizen nutritional programs, and telephone reassurance); St. John's Home, Rochester, N.Y. (meals on wheels, and day care services as of September 1975); and the Leeward, Cincinnati, Ohio (meals on wheels).

News media tend to report poor conditions and problems, yet, often welcome positive stories as a balance. A striking example is the extensive coverage given to the above-mentioned senior citizen Olympics in a Wisconsin home.

Chastian Nursing Homes, Inc. (a chain of homes based in St. Louis, Mo.), as reported in the February 1972 edition of *Modern Nursing Homes*, apparently has an excellent public relations program. Mr. Ellsworth Cabot, special project consultant for the homes, indicates that an effective PR program can be run on 1 percent of the home's revenue.<sup>43</sup> He claims a program which attempts to involve the home and its personnel in the affairs of the community yields many benefits.

... clergymen become more frequent visitors, doctors come with more regularity, and the local tax assessor is not as likely to overassess a nursing home for which he has high regard.

The Chastian Home donated \$1,000 to help establish a town ambulance service. It sponsors a little league baseball team, awards scholarships, and pays for books and tuition for aides to attend LPN schools. Wherever possible, the home buys from local vendors. The home mans booths at the local county fair and at church bazaars, in addition to the usual brochures, yellow pages, and matchbook advertising. Mr. Cabot actually trains nurses aides in communication with the public. He stresses that each member of the staff represents the facility, whether they are on or off duty. He teaches receptionists the proper way to answer the telephone and respond to visitors. This multi-faceted public relations approach has met with apparent success.

One of the earliest testimonies of the proper use of public relations was received by the Subcommittee in the August 1965 Portland, Maine, hearings. Mr. Berkley Bennett, then a consultant with the Vermont Nursing Home Association, presented a comprehensive list of nursing home community service techniques.<sup>44</sup>

### C. PEER REVIEW—SELF POLICING

As a result of a \$10,000 grant from the Northlands Regional Medical Program, the Minnesota Association of Health Care Facilities, in 1971, established a peer review committee and a written code of ethics. The association indicated that homes found guilty of criminal neglect and poor care would have membership terminated. Unfortunately, the apparent impetus to establish this peer review committee was a reaction to or an attempt to minimize the findings of this Subcommittee's hearings held in Minnesota on November 29, 1971.

If these assumptions are accurate, the reaction by the Minnesota association illustrates a potential hazard of peer review as a mechanism for the review and enforcement of standards by a provider group. Peer review can reform practices and crack down on substandard providers; or, it can serve as a facade for the reentrenchment of vested interest. When implemented as a method of legitimate reform, peer review is of tremendous value.

<sup>43</sup> *Nursing Homes*, April 1969, p. 57.

<sup>44</sup> "Conditions and Problems in the Nation's Nursing Homes," part 7, Portland, Maine.

The Minnesota association, acclaiming its success with new members, recommended that the American Nursing Home Association promote peer review programs. The American Nursing Home Association accepted that recommendation and has encouraged other States to establish methods of peer review.

Not all nursing home associations support peer review. The Metropolitan Chicago Nursing Home Association refused to establish peer review on the grounds that *membership in their association is voluntary. The leadership claimed it had no power over members, and the association was not knowledgeable about the condition and operation of member homes.*<sup>45</sup>

**Ironically, when the *Chicago Tribune* and the Better Government Association investigated Chicago area homes, making front page news, the Metropolitan Chicago Nursing Home Association had no hesitation in speaking about the conditions of member homes. Spokesmen denied the allegations, on behalf of its entire membership, as categorically untrue.**<sup>46</sup>

Nonetheless, the Metropolitan Chicago Nursing Home Association has adopted a potentially useful procedure, the "cool line." Member nursing homes display an emblem bearing a telephone number (in the association office). Relatives, visitors, and patients can call to lodge a complaint about any member home. Association officials promise to do everything possible to ameliorate all such complaints.

<sup>45</sup> TLTC, part 15, p. 1518.

<sup>46</sup> *Ibid.*, p. 1543, press release from Metropolitan Nursing Home Association, Mar. 2, 1971. The *Tribune*/BGA findings were subsequently confirmed at the Subcommittee's April 2 and 3, 1971, Chicago hearings.

## PART 4

### SUPPORT FROM THE COMMUNITY

"I am particularly encouraged by the growing community involvement with respect to nursing homes. I am sure it accounts for much of the improvement in the quality of care that we have seen in the past few years."

—Senator Pete V. Domenici.

#### A. OMBUDSMAN PROGRAMS

Most nursing home patients are infirm and helpless; in need of a stronger voice to defend their cause. Concern about them leads logically to recent experimentation with "ombudsman" programs. Essentially, there are two kinds of ombudsman programs: informal assemblages of consumer and health groups—patient advocates; and formal ombudsman pilot programs funded by the Nixon administration nursing home "reform" of 1971.

##### 1. INFORMAL OMBUDSMAN PROGRAMS

Before President Nixon's announcement of five nursing home ombudsman programs in 1972, there were several informally in operation throughout the country. The Minneapolis Age and Opportunity Center under the direction of Mrs. Daphne Krause received so many complaints from senior citizens about nursing homes that she could not ignore them. Significantly, the same nursing homes kept appearing in complaints she received. In addition to asking complainants to write to the State health department, Mrs. Krause began an investigation of her own. In April 1970, she visited the Subcommittee with some of this evidence in hand. The Subcommittee staff suggested she collect sworn affidavits, supposing a hearing might ultimately be held in Minneapolis.

In January 1971, Mrs. Krause recruited personnel who were nursing home employees in the area. Those who approached her with complaints were advised to perform well and maintain their jobs, while documenting complaints. During the summer of 1971, members of the Better Government Association of Chicago worked in conjunction with Mrs. Krause. Several were employed in Minneapolis-St. Paul nursing homes, while others posed as individuals seeking placement of parents. This Subcommittee's staff visited the area, ultimately holding the hearing. Mrs. Krause maintained her willingness to work with the nursing home associations and the State health department to improve the quality of Minnesota nursing homes.

Similarly, in Detroit, Mich., Citizens for Better Care, founded by Charles Chomet, gives consumers a voice in the quality of care. The

organization began in a climate of distrust, mutual recriminations, and complaints between the Michigan State Health Department and Michigan nursing homes.

Relations deteriorated until 89 out of Michigan's 348 institutions housing Medicaid patients refused to allow State inspectors to visit their homes, while continuing to cash State payments on behalf of the infirm elderly.<sup>47</sup>

Through the years, Citizens for Better Care has grown in stature, presenting a model for duplication in other areas. In Milwaukee, Wis., a group called Citizens for Better Nursing Home Care has been formed. Under the direction of its chairman, Alan Hahn, the group has been effective working with the *Milwaukee Sentinel* to bring about improvements in nursing home care.

The aforementioned Better Government Association of Chicago, Ill., is a watchdog group devoted to monitoring all State and local expenditures. Their investigations have ranged from measuring the number of city employees who "goldbrick" to overseeing the use of absentee ballots in Chicago.

The investigation of absentee voting and an investigation of Chicago's proprietary ambulance services led the BGA to nursing homes. BGA investigators worked in nursing homes for several weeks and visited a great many others as part of their initial investigation with the *Chicago Tribune* and later with the Subcommittee staff. The expertise of these former FBI agents and Pulitzer Prize winning investigatory reporters is reflected in the Subcommittee's hearings in Chicago, April 2-3, 1971.

In Davenport, Iowa, a group of concerned citizens and college students solicited support for the establishment of a citizen's monitoring team. Under the auspices of the mayor, this demonstration project attempted to involve the larger community in upgrading the condition in the city's nursing homes. The team supplemented inspections of local and State officials, using State regulations as guidelines, and issued inspection reports to appropriate government agencies, the facilities, and the public. The team acted as a consumer-patient advocate by investigating and referring complaints, and by legislative lobbying and testifying before government boards and committees.

The Gray Panthers (a senior citizens activist group) has focused on more specific tasks. The New York Gray Panther Nursing Home Action Group was organized to address the problem of massive relocation of nursing home patients from facilities closed due to "uncorrectable" fire hazards. To help the more than 1,800 uprooted residents adjust to a new home, the group has recruited neighborhood volunteers. The volunteers will go into nursing homes and welcome transferred patients, orienting them to their new environment.

The Denver Gray Panthers have surveyed and scheduled followup visits to area nursing homes. Fifty-five out of eighty nursing homes responded to the questionnaire. The data obtained will be used to develop a consumer guide of general information about choosing a nursing home, alternatives to nursing homes, and an evaluation of area homes.

<sup>47</sup> Column by Theodor Schuchat, "Retirement and You," Sept. 27, 1970. Also, *The Great*, vol. 35, No. 18. Marycrest College, Davenport, Iowa, Feb. 21, 1974, "Citizens Monitoring Team Developed."



*The Citizens Action Guide: Nursing Home Reform*, prepared for the Gray Panthers by Elma Griesel and Linda Horn, provides a comprehensive list of reform actions taken by consumer groups and others interested in long-term care reform.<sup>48</sup>

Still another informal ombudsman project was begun in May 1973 by the daughter of a nursing home patient and the geriatric social workers of the home. Families United for the Succor of the Elderly (FUSE), had been investigating Long Island, N.Y., nursing homes and health related facilities for 3 years. FUSE acts as a liaison between the family, patient, and nursing home; brings the plight of the elderly to the attention of local and State departments of health; cooperates with appropriate commissions and investigations; and supports a hospital extended-care unit volunteer training program.<sup>49</sup>

## 2. THE FORMAL OMBUDSMAN PROGRAM: THE HALF-MILLION-DOLLAR EXPERIMENT

On August 6, 1971, President Nixon announced an eight-point nursing home reform plan. One, and perhaps the most positive point of the program, was the ombudsman program. The President said:

I have also directed the Department of Health, Education, and Welfare to assist the States in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual patients. The individual who is confined to an institution and dependent upon it is often powerless to make his voice heard. This new program will help him deal with concerns such as accounting for his funds and other personal property, protecting himself against involuntary transfers from one nursing home to another or to a mental hospital, and gaining a fair hearing for reports of physical and psychological abuse.<sup>50</sup>

In implementing the President's plan, the Department of Health, Education, and Welfare funded five ombudsman units in June of 1972 and announced:

Four contracts are with State governments to establish State level offices linked to a local unit. Pending the announcement of these five contracts, the 855 Social Security District Offices were directed to receive complaints from patients or relatives for forwarding to Federal agencies. The White House reported that more than 2,000 complaints had been acted upon by July 1972.

Details of the Ombudsman contracts totaling \$500,000 are as follows:

<sup>48</sup> *Citizens Action Guide: Nursing Home Reform*, Gray Panthers, April 1975. See section II, pp. 11-14. Other monitoring programs mentioned in this publication include: Citizens for the Improvement of Nursing Homes, Seattle, Wash.; Friends and Relatives of Nursing Home Patients, Inc., Portland, Ore.; The Nursing Home Campaign Committee, Inc., Philadelphia, Pa.; Northwest Interfaith Movement, 3700 Chestnut Street, Philadelphia, Pa. 19104; and the Malne Committee on Aging.

<sup>49</sup> Letter from Kay Del Vecchio to William Oriol, Senate Committee on Aging, June 11, 1975. Also, Seymour Marks, "FUSE offers to help new nursing home probers," *Long Island Press*, April 20, 1975.

<sup>50</sup> *Weekly Compilation of Presidential Documents*, Aug. 16, 1971, vol. 7, No. 33, pp. 1148-1150.

*Idaho:* In Idaho the \$49,500 contract calls for an assistant attorney general, located in the State Department of Special Services, to serve as the nursing home ombudsman. His unit, based in Boise, initially concentrates on the seven-county Treasure Valley area of southwestern Idaho.

The Idaho unit has been linked to an advisory committee composed of nursing home consumers, providers, and representatives of State agencies. Volunteers, recruited from local organizations, will participate.

*Pennsylvania:* Pennsylvania, under a \$108,000 contract, has its ombudsman in the Governor's office under the Council of Human Services, with an advisory council of 12 (half to be over 60) representing consumers, professional groups, and the nursing home industry.

A local Philadelphia ombudsman unit, operated by the Nursing Home Campaign Committee, Inc., works through volunteers. A Pittsburgh local unit is staffed and directed by the State ombudsman.

*South Carolina:* The State unit in South Carolina, under a \$82,400 contract, is in the State Commission on Aging, an agency directly responsible to the Governor. A regional unit in Columbia serves the Central Midlands Regional Planning District. Volunteers will be trained to work at both State and regional levels. The medical foundations, a subsidiary of the South Carolina Medical Association, screen medical care complaints and advise on action.

*Wisconsin:* In the State of Wisconsin, the office of the Lieutenant Governor, which received a \$146,000 contract, has been investigating nursing home care for the past 2 years handled about 1,000 complaints; it operates the State nursing ombudsman program, with a local unit in Milwaukee. Senior citizen volunteers surveyed Wisconsin nursing homes.

*The National Ombudsman Program:* The one exception to this pattern of State units, and the most promising, is the program sponsored by the National Council of Senior Citizens which received \$175,900. Its independent program is headquartered in Washington, D.C., with a State unit in Lansing, Mich., and two local units in Detroit and the upper Michigan peninsula.<sup>51</sup>

On June 30, 1973, HEW let 1-year contracts to Oregon and Massachusetts, expanding the number of ombudsman projects to seven. All seven contracts expired in June 1975. However, the Administration on Aging in May 1975 issued a directive to the States, indicating that seed money is available to start up new projects. Moreover, two more States, Hawaii and Illinois, have started projects on their own.

HEW's announced intention with respect to these "ombudsman" units is: (1) to resolve complaints of residents; (2) to document significant problems in the nursing home field; and (3) to test the effectiveness of the use of volunteers in resolving the problems of nursing

<sup>51</sup> "HEW Awards \$500,000 To Test Ombudsman Nursing Home Programs," *Aging*, August 1972, p. 5.

home patients. HEW is testing several approaches to determine what are the most appropriate methods to the ombudsman solution.<sup>52</sup>

The success of this ombudsman program led to the Subcommittee's recommendation that each State establish a nursing home ombudsman program, and to the introduction of a bill to bring this about. In introducing S. 1569, Senator Moss said:

Our report recommends that every State institute an ombudsman program. It spells out that such programs can be very useful if first, they have some degree of independence from the State health department; second, they are permanent and; third, they have power to influence the State in its inspection and licensing procedures.

The State ombudsman programs have been a success. Drawing on this success, I have proposed that every State be required to institute such a program as a precondition of continuing to receive the 100-percent Federal funding of the cost of State inspection. My bill requires that State ombudsman programs be located within the State department of justice, or at least that they not be located in any State agency which has responsibility for health. Such a unit must have the cooperation of all other agencies of State government. Under my bill it would be empowered to, first, hold hearings; second, investigate nursing home complaints; third, enter a nursing home without prior notice; fourth, recommend disciplinary action against a home including license revocation; and, fifth, file an annual report to the Governor and the legislature with recommendations for action.

I am sure it is only a matter of time before this proposal is enacted. I believe that it is worthwhile and will quickly result in the improvement of the quality of nursing home care.<sup>53</sup>

In an August 12, 1975, letter to Dr. Arthur Flemming, Commissioner of the Administration on Aging, Senator Moss had particular praise for the ombudsman project operated by the National Council of Senior Citizens. Urging increased funding for this project, the Senator wrote:

As you know, the NCSC program can be distinguished from the others funded because it has a national unit in addition to its State and local focus. Although this national office is very small—staffed only by one lawyer and a secretary—it has made a solid contribution in protecting the rights of the infirm elderly. The NCSC office is an effective counterbalance to the pressure exerted by vested interests in the nursing home industry.<sup>54</sup>

<sup>52</sup> *Senior Citizen News*, September 1972, p. 3. On June 30, 1973, HEW let 1-year contracts to Oregon and Massachusetts expanding the number of ombudsman projects to seven.

<sup>53</sup> *Congressional Record*, vol. 121, No. 67; Tuesday, April 29, 1975, p. S 6937.

<sup>54</sup> The National Council of Senior Citizens has been a persistent critic of poor conditions in nursing homes and has mounted a major effort for constructive change. For a full description of NCSC goals in this area, see chapter IV, "Long-Term Care for the Elderly," in *A National Policy for Older Americans . . . Response to Their Special Needs*, developed by the National Council of Senior Citizens, Inc., 1511 K Street, NW., Washington, D.C., 20005, April 1975.

## B. NURSING HOME DIRECTORIES AND RATING SYSTEMS

Some State offices on aging or independent groups have prepared and published directories of their State's nursing homes. Such directories aid the consumer to find homes which provide the level of care he needs at the price he can afford. The names of administrators, owners, and other pertinent data are provided. Few directories attempt to provide ratings for the homes listed.

The Nader Task Force recommended that rating systems be established by State health departments, which inspect nursing homes, to advise the public about the quality of care provided by each facility.<sup>55</sup>

On April 29, 1975, Senator Moss introduced bill S. 1568 to require HEW to establish a rating system for nursing homes participating in Federal programs. In introducing the bill, he said:

Our first Supporting Paper makes the point that nursing home care is a "blind item." Essentially this means that you never know from looking at the facility what kind of care you or a loved one will be receiving there. Unfortunately, there is little that consumers can do to aid themselves in selecting a good facility. Day after day my office gets calls asking us to recommend good homes in various parts of the Nation.

In some cases, consumers have been misled, taking a nursing home's certification for participation in Medicare as a sort of "Good Housekeeping Seal of Approval." It is far from that, and it never was intended for that purpose. Despite this fact, many nursing homes use the phrase "approved by Medicare" or a plethora of framed certificates in their foyer as evidence of the quality of care they provide. Some such honors and certificates, are of course legitimate, but many are not.

The consumer needs some guidance in this area. I have felt for a long time that senior citizens clubs in each part of the United States should simply keep files on the various nursing homes. In a short period of time they would have their own referral service. Having encouraged this idea for many years, I regret that it has not taken root the way I hoped it would. I am now convinced that with the increasing role of Government in health in the future, that ratings for nursing homes should originate with the people best in a position to know the conditions of and the care given in various long-term care facilities. These people are, of course, the State surveyors and the employees in HEW's Office of Nursing Home Affairs, Bureau of Standards Enforcement. But my bill does not tie the Secretary's hands. It simply says that he shall establish rating systems for nursing homes participating in Federal programs. I know that former Under Secretary Frank Carlucci and others in HEW have and continue to endorse this proposal.<sup>56</sup>

<sup>55</sup> Nader Task Force Report on Nursing Homes: *Nursing Homes for the Aged: The Agony of One Million Americans*, Center for Study of Responsive Law, Washington, D.C., 1970.

<sup>56</sup> *Op. cit.*, footnote 50.

The National Council of Senior Citizens has announced the opening of a Nursing Home Information Service for the greater Washington, D.C. metropolitan area. The Information Service, which is located at NCSC headquarters in Washington, D.C., will provide to anyone a summary of official inspections of any or all of the Washington, D.C. metropolitan area's 32 major nursing homes that receive Medicare reimbursement for patient services. In addition, this service can provide the names and addresses of all the 80 to 90 nursing or convalescent homes in the area.

Now, as of August 18, anyone wishing to obtain information about the inspection records or charges of the 32 D.C. metropolitan area Medicare-reimbursable nursing homes should come to NCSC headquarters, on the second floor of the Investment Building, 1511 K Street, N.W., any Monday through Friday between 10 a.m. and 3 p.m.

Currently, records of State inspections in Maryland and Virginia or of the D.C. government for Medicaid-certified homes have not yet been obtained. Once they are, these also will be available to the public.

NCSC Executive Director William R. Hutton declared of this new service: "The Nursing Home Information Service should provide a valuable asset to those in this area who are forced to find a nursing home for members of their families or friends. No longer will potential nursing home users be forced to either rely on rumor about individual nursing homes services and conditions or go through the costly and time-consuming process of going from home to home hoping to find one that is both safe and within their price range.

### C. THE USE OF VOLUNTEERS

Hospitals have traditionally made excellent use of volunteers. Nursing homes, however, are having more difficulty in recruiting them.

The public press frequently refers to well known entertainers, professional football players, and politicians who take time to visit nursing home patients. It is remarkable, however, for a newspaper to campaign for citizens to visit nursing homes, as the *Idaho Statesman* did 2 years ago. The newspapers appeal: "Can you spare an hour to visit with an oldster?" was greeted with enthusiastic community response.<sup>57</sup> One result was that a nursing home auxiliary was created through the Boise Soroptimist Club. Responding to the newspaper's plea were teenagers, young mothers, retired men, and older persons. A Boise nursing home administrator was quoted as saying the newspaper's campaign brought about a greater community response to the needs of patients than in all the prior 10 years combined.

The Chicago Division for Senior Citizens of the city's department of human resources urged community clubs to "adopt a nursing home." But perhaps the most significant "adoption" was a program started by a medical student at the University of South Dakota, Vermillion, in conjunction with the town's Dakota Nursing Home. In this program, college students entertain the nursing home patients every Tuesday night with skits, songs, cartoons, and jokes. Almost 100 students were participating either in the entertainment or in more frequent visits, and about half of these have "adopted" a grandparent.

<sup>57</sup> *Idaho Statesman*, March 3, 1972.

One account of the program tells of a patient, sent to the hospital with a coronary, who insisted that she be back at the home the night the "kids" come. The doctors credit this as an incentive for her speedy recovery.<sup>58</sup> The students have also begun to visit local shut-ins.

The students are as enthusiastic about the program as the adults, indicating they have learned much about life from their elders. Some students have learned to crochet. One helped his grandfather build a birdhouse. Another baked a special pie for his diabetic grandmother.

The "adopt a grandparent program" is starting to spread. Reports indicate that similar programs have been started by students at South Dakota Black Hills State College. Students at the Garfield Elementary School at St. Cloud have begun visiting nursing homes. In addition, several dozen schools and organizations have written to Patrick Norman at the Coyote Student Center in Vermillion for further information about the project.<sup>59</sup>

Some debate has been sparked as to whether elementary school children would be well received as visitors to nursing homes, or adversely affected by the experience. Studies by Shirley Harrison, director of social services education for Ypsilanti State Hospital, Ypsilanti, Mich., indicate that both groups benefit from such interaction, even with mental hospital patients.<sup>60</sup> The children usually are free from the inhibitions which stifle open interaction among other groups. Having young people on the ward seemed to uplift the spirits of chronic patients.

Mr. Peter Unintz, assistant professor at the School for Social Work, Wayne State University, Detroit, reported that in two experimental programs, teenagers had a positive therapeutic effect on nursing home patients. Contrary to some predictions, the old people did not mind the high-energy level around them; they seemed to enjoy the presence of teenagers very much.<sup>61</sup>

Both of these studies verify the importance of programs like "adopt a grandparent," addressing the same point Ralph Nader emphasized by having young people work with the elderly on his Task Force To Investigate Nursing Homes. Interaction can do much to reduce the generation gap and provide young people with a sense of continuity with their own future and the history of their Nation. In addition, many contend that the young and the old are natural allies, as both have been relegated to institutions (schools or old age homes), while the middle aged groups occupy the center stage in American society, monopolizing jobs, money, and political control.

Some individuals have suggested that the relationship between the very young and the very old is so similar that the two groups could be brought together in a unique health care and educational environment: a combination nursing home-nursery school. The proponents look to the success of the foster grandparents program as additional evidence that such a program is viable.<sup>62</sup>

<sup>58</sup> *Modern Nursing Home*, February 1972, p. 49.

<sup>59</sup> Column by Theodor Schuchat, Bergen, N.J., *Record*, Aug. 20, 1973.

<sup>60</sup> Symposium suggested for annual meeting of Gerontological Society, Dec. 17-21, 1972: "Resources for the Future: Intergenerational Volunteers for the Institutionalized Elderly."

<sup>61</sup> *Ibid.*

<sup>62</sup> Proposal by Louis Gelwicks, Los Angeles, Calif.

## D. WHAT CAN INDIVIDUALS DO TO HELP NURSING HOME PATIENTS?

1. Cooperate with local and national political leaders to establish participation of the elderly population in political action programs. The Gray Panthers are organized for just such a purpose. Nursing home patients, like all other citizens, have a right to vote and to influence the direction of the country. Many are not using their franchise at present.

2. Drive a nursing home patient to church.

3. Volunteer to set the hair for a patient or two. Pride in appearance does much to restore one's dignity and desire to go on living.

4. Teach a craft.

5. Help repair clothing.

6. Write and mail letters. Many patients have hands crippled with arthritis.

7. Take newspapers and magazines. Even trade papers will be of interest to some patients, reflecting news of a previous occupation.

8. Businessmen can bring their merchandise to the elderly, as few can get to the store to buy needed clothes, tobacco, or other sundries.

9. Read to nursing home patients and establish one-to-one relationships with those having no family.

10. Organize or conduct various field trips for the elderly, in cooperation with the nursing home administrator.

11. Assist in feeding patients at meal time.

12. Correspond when you are away from the site or the facility.

13. Assist in handling personal affairs or run errands.

14. Share your babies with them—the sight of a newborn infant fascinates many oldsters.

15. Organize or participate with local organizations in watchdog “ombudsman programs” to oversee nursing homes. Community interest in nursing home patients is the best protection against substandard nursing homes.

16. Upon finding good care and services, write and spread the news. Write to your Congressman and newspaper to commend the administrator. Likewise, in finding abuses or poor care in your visits, write to your Congressman and your local newspaper.

## PART 5

### SUMMARY: THE NEED FOR PERSPECTIVE

Many heartwarming examples of positive actions have been provided in the preceding parts of this report.

Their significance should not be underestimated: what may at first appear to be "amenities" quite often are triumphs over fixed, negative attitudes toward aging and toward the rehabilitation potential of nursing homes. Each experiment, each successful program, is worthy of the closest possible scrutiny by the nursing home field and by the general public so many will share in the nursing home experience—either directly or through family and friends.

On the other hand, this Subcommittee does not believe that "positive aspects" of nursing home care can exist in a vacuum. Reality orientation will mean little if a home is a firetrap. Good community relationships will turn sour if public funds are being misused or wasted, and scandal occurs.

Always, the fundamental question remains: Is good care being given at reasonable cost?

But the answer to that question is far more likely to be affirmative if the nursing home has the esprit, the philosophy, the staff skills, and the convictions described in this report. Not every nursing home resident can be totally rehabilitated, to be sure. But very few will be if the staff believes that no one can.

In many ways, our nursing homes are engaged in a continuing experiment. There are no rules, except those that are learned as our aging population grows larger, as it grows increasingly older in terms of the number of years lived, and as our healing and helping professions gradually learn more about the medical and psychological capacities and needs of older Americans who need help and treatment.

As Senator Moss has said:

**All in all, the picture is one of great improvement in the attention given to nursing homes by the community and in the efforts nursing homes are exhibiting to make life more worthwhile for their infirm residents. However, despite the new positive and innovative programs, there is still much room for improvement. These innovations must become the rule, rather than the isolated example. Good nursing homes must become better until the day that the negative image of nursing homes has been erased. On that day, children in America will be heard to say: "I want to be a nursing home administrator when I grow up."<sup>63</sup>**

<sup>63</sup> Speech by Senator Frank E. Moss at the American Nursing Home Association convention, Miami Beach, October 1970.



## PART 6

### RECOMMENDATIONS

1. Educational programs for nursing home administrators should be expanded. Nursing home administrators should make an effort to stimulate their employees, rewarding them for dedication and enthusiasm in the care of nursing home residents.

2. Activities and recreation should become a way of life, rather than a treat, in nursing homes.

3. Interpersonal techniques for dealing with the disturbed elderly (such as reality orientation, sensory, training, and re-motivation) should be implemented in nursing homes. Whenever possible, such techniques should be substituted for the excess reliance on tranquilizing drugs.

4. The physical design of homes should accommodate the unique problems of the infirm elderly. Special attention should be given to color schemes, warmth, texture, and to promoting maximum use of common areas.

5. All nursing homes should regularly offer in-service training programs and participate in extramural continuing education.

6. Schools of nursing, medicine, social work, public health, and other health professions should provide education in the specialty of gerontology and geriatrics.

7. Nursing homes and schools of nursing should cooperate to exchange information and expertise.

8. Nursing homes should offer outreach programs to the underserved elderly population in their community through senior citizen centers, meals-on-wheels, telephone reassurance, and other services.

9. Legislation should be enacted to pay able-bodied senior citizens for working in nursing homes. Earnings under this program should be exempt from the Social Security retirement test which presently requires seniors to forfeit some of their Social Security checks if they earn more than \$2,520 a year.

10. All States should establish ombudsman projects to investigate nursing home complaints and monitor the quality of nursing home care. (See S. 1569, introduced by Senator Moss.)

11. Senior citizen groups and community leaders should publish nursing home directories and nursing home ratings. They should establish referral services to aid consumers in shopping for a nursing home.

12. Local civic organizations should make an effort to "adopt" a nursing home, scheduling daily visits and providing other assistance to nursing home residents.

13. Nursing home administrators should actively seek and participate in peer review activity.

14. Nursing homes should consider incorporating telecommunications systems. Such systems used in conjunction with nursing practitioners can be particularly helpful in providing quality health care to every resident 24 hours a day.

15. Resident's councils should be established in nursing homes to provide residents with a real voice in the operation of their environment.

16. A model nursing home should be created within the National Institute on Aging incorporating the broad range of health care services including skilled nursing and intermediate care as well as day care and various kinds of outreach services—especially home health care. The model facility should serve as a focus for further research into the techniques and procedures which will improve the quality of care in U.S. nursing homes. The model facility should implement procedures found to be effective, and serve as an educational and consulting center for providers.

# A P P E N D I X E S

## Appendix 1

### COMMENTS FROM THE IDAHO OMBUDSMAN PROGRAM

Following is a speech given by Arlene D. Warner, State ombudsman for nursing homes, Idaho nursing home ombudsman program, May 14, 1975, at the 102d annual forum of the National Conference on Social Welfare in San Francisco, Calif.

This discussion of the purpose and operation of an ombudsman program is included to assist readers who are not acquainted with the purpose and scope of such programs. See also part 4, p. 608, of this report.

### THE IMPORTANCE OF A COMPLAINT MECHANISM FOR THE INSTITUTIONALIZED AGED

Victor Hugo once said: "Greater than the tread of mighty armies is an idea whose time has come." We feel this is an appropriate analogy to the recent development of nursing home ombudsmanship in the United States.

The nursing home ombudsman concept came into being as the result of the concerns expressed by delegates attending the 1971 White House Conference on Aging. At that time the Department of Health, Education, and Welfare was called upon to search out means to upgrade the quality of care generally available to the consumer of nursing home services.

An interdepartmental work group was formed under the direction of the Health Services and Mental Health Administration to develop models for investigative ombudsman units, and in the Supplemental Appropriations Act of December 1971, Congress made available funds for the establishment of nursing home ombudsman demonstration projects.

As originally conceptualized, the interdepartmental work group described the responsibilities of the ombudsman as one whose role and functions would be most simply to resolve grievances, improve administration, and aid in its oversight. However, the ombudsman would not supply services where none exist or supplement their quantity when in short supply or coordinate the services of others or administer a program of care, which is the responsibility of service agencies—responsibilities for which they are accountable.

The first-year funding established projects in five States. They were Idaho, Michigan, Pennsylvania, South Carolina, and Wisconsin.

The Pennsylvania project was set up in the executive branch of State government with offices in Harrisburg, Philadelphia, and Pitts-

burgh, Idaho and South Carolina were both located within the respective State agencies on aging. Wisconsin: Martin Schreiber, Lieutenant Governor, State ombudsman.

The Michigan program was quite different, in that it was operated by a private organization—the National Council of Senior Citizens, Inc. They established offices at three levels: a national director, in Washington, D.C.; a State office, in Lansing; and local offices in Detroit and Menominee.

In 1973 two additional programs were funded—in Oregon and Massachusetts. A change in administration of the projects also occurred in 1973. Dr. Arthur Flemming requested transfer of the ombudsman projects to the Administration on Aging. This process was completed in February of 1974, and a new “nursing homes interests staff” was created in the Administration on Aging to oversee the project activities.

I would like to talk about the project in Idaho in three different but related, ways: through a complaint mechanism, issue identification, and what I will call program assistance.

The Idaho nursing home ombudsman receives complaints from many different sources. In some parts of the State we maintain a staff of volunteer visitors who call on the residents of a particular facility at least once a week. The volunteers send us complaints that originate with the people in the home. Complaints may also come from family members, facility staff, service or regulatory agency personnel, or just plain interested citizens. We have used prepaid postcards and a statewide toll-free telephone number in our effort to make ourselves as accessible to both the nursing home and nonnursing home population as possible. We have had publicity through radio and television spots, newspaper stories, personal appearances before the media, community or professional groups.

When a complaint is received by our office, it is assigned to one of our professional staff members for investigation. Initially, the investigator determines whether or not the complaint can be verified. Frequently the investigator finds that the complaint cannot be verified. When this happens, an explanation is made to the complainant; and, unless new information is forthcoming, the case is closed.

When verification is made, further investigation is undertaken to determine who is responsible for the problem. If the responsible party can be identified, a referral is made and the situation is monitored to assure that some corrective action has been taken.

All too often we find that the problem may be in an area for which no one has a specified responsibility—this, in spite of our volumes of laws and regulations. The traditional ombudsman at this point would make note of the problem in his report, notify the complainant that nothing could be done, and close the case. We, however, do attempt—on a sort of casework basis—to find some agency, organization, or person who has the resources and will accept the responsibility of meeting the need of the nursing home resident. This is a departure from the original conceptualization of the ombudsman.

Should a responsible party adamantly refuse to correct a situation, there are two possible courses of action we can take:

First, we could take our case to the State’s attorney general or make a referral to the local legal services agency.

Second, we could go public—making the problem known to the representatives of the media.

It is important to understand that we neither have nor seek enforcement powers of our own. We are not a regulatory agency in any sense of the word. We stand outside of the system in the hope that our neutrality and objectivity will remain unimpaired. Trust and confidence, in our judgment, can only be maintained as long as agencies, facilities, and the public know that we have no vested interest in any given case. Our only interest is in seeing, insofar as possible, that the needs of the nursing home population are as fully met as is possible.

Serious or numerous problems for which solutions do not exist may well become subjects of issue papers. Issue papers are reports to various officials and agencies, and perhaps the public, pointing out a gap in our services or regulations that result in a significant predicament for nursing home residents. In the preparation of the report, we attempt to research the applicable laws and regulations, determine the number of persons involved and the extent of their involvement, pose alternative solutions, and project the possible costs of resolution. Where it seems appropriate, recommendations are made. Again, with no enforcement powers, we are dependent upon voluntary cooperation to implement our recommendations. The closest we might come to coercion is through the solicitation of public interest and pressure through the mass media.

Another way in which we differ from the classic ombudsman is through the offering of assistance to those whom we have identified as having responsibility in a particular problem area. This assistance may be offered in a variety of ways. In this capacity, the State nursing home ombudsman is the chairperson of the Idaho Long-Term Care Education Committee. Formed in January 1974, partly through the efforts of the ombudsman, the committee includes representatives from health and welfare, Idaho Hospital Association, Veterans' Administration, Idaho Health Facilities, Inc. (the State nursing home association), Idaho Mental Health Association, State board of nursing, State board of pharmacy and the three area health consortiums in Idaho. The State nursing home association, in recognition of the committee's role, recently passed a resolution naming the committee official educational arm of their association. The committee goal is to raise the level of care being received by nursing home residents through the development of comprehensive and ongoing training and educational opportunities for all levels of nursing home staff. Examples of this committee's activities include ongoing surveys of all Skilled Nursing Facilities in the State to determine their training and educational needs and prioritization of those needs. The committee is in the process of developing a mechanism to become the clearinghouse for all long-term care education moneys and training proposals coming into the State. With the growing concern about the quality of care being provided in nursing homes, we have seen in the past 3 years a number of Government agencies commit moneys to long-term care education. The result in Idaho has been a scattershot effect: the Federal moneys become available, proposals are written, workshops and training programs occur with little coordination or continuity. For example, it was possible to attend workshops on death and dying sponsored by three different agencies during the past year in Idaho.

We recently became aware of a continuing education proposal for "training long-term care personnel" which received funding in which no attempt was made on the part of the continued education people to contact the administrators or nursing home staff for input. It is difficult to understand the rationale for this kind of activity.

Hopefully, the clearinghouse mechanism will give us a vehicle to resolve some of these problems.

Recent activities of the committee include the statewide implementation of reality orientation programs in nursing homes, workshops on the psychosocial aspects of patient care, improving activity programs, and a vocational training program for nurses' aides.

Another area in which we are providing assistance: We are solidly in support of the concept of resident participation in the decision-making process which directly affects them. One practical vehicle for assuring such participation is the resident council. We have, therefore, assisted facility administrators in securing information and materials related to resident councils and use social work student interns to work with administrators to develop model councils. Too long have nursing home residents been totally powerless to affect decisions regulating even the most minor aspects of their daily lives. If we are to be seriously concerned with returning a significant portion of dignity to those residing in long-term care facilities, we must find ways for them to be as self-governing as is physically and mentally possible.

A recent attempt to remedy the powerless position of the nursing home resident has been the legislation to establish a code of patients rights, which was introduced last year by Senator Percy (in Senate bill 2920). After the Percy bill was introduced, the Department of Health, Education, and Welfare, in addition to the Medicare regulations that became final on October 3, 1974, presented its version of the patients bill of rights (20 CFR 405.1121 k). The seven ombudsman demonstration projects participated in the development of the Health, Education, and Welfare regulations. These standards, which became effective in December of 1974, are also applicable to Skilled Nursing Facilities participating in the Medicaid program. The patients' rights generally consist of such simple guarantees as the right to know and make decisions about one's treatment, a regular accounting of a person's personal moneys held in trust accounts by the facility, the right to private communications with one's physician, attorney, and family—rights already conferred by existing law, but difficult to attain in a long-term care setting.

Although the rights are spelled out and it is required that the patients be fully informed about them, the Health, Education, and Welfare regulations and the Percy bill leave up to the individual homes the creation of specific procedures to enforce the patient's rights. This omission is critical since the conferring of rights in a nursing home situation is not workable unless procedures for enforcing them are also provided and that these procedures are also fully understood by the patients.

Additional legislation and regulation are needed. Because many institutionalized people are not covered by Medicare/Medicaid regulations, it will be necessary to work for State legislation to spell out patient rights with meaningful complaint mechanism and enforcement procedures such as a citation system with monetary fines for violations.

In an aside, it is interesting to note that while "patient rights" are aimed at the patient, all of the training we have seen on "patients rights" has been aimed at nursing home staff people. No attempts are being made to go into nursing homes to assure that the patients do understand their rights and have the confidence that they can exercise those rights free of coercion.

Just 2 weeks ago Senator Moss introduced nursing home legislation (Senate bill 1569) which mandates the establishment of a nursing home ombudsman in all of the States. If this legislation is passed, hopefully, we will be assured of one of the components necessary to protect the health and dignity of nursing home residents.

In review, we feel that a viable complaint mechanism for the institutionalized aged would include the following components:

1. Residents' councils with in-house complaint procedures which would be monitored by a State nursing home ombudsman.

2. A State nursing home ombudsman with the authority to investigate violations of patients' rights and with procedures for impartial hearings.

3. A citation system with monetary fines for violations which could be levied against facilities violating patient rights.

Having briefly explained what we do and how we do it, there are some related comments that I feel need to be made.

First, the ombudsman program is not an attempt to weaken or supplant the licensure and survey function. To the contrary, the ombudsman is frequently dependent on licensure people for information and assistance in resolving complaints. The two offices in Idaho work on a cooperative basis. Licensure refers to us complaints over which they have no jurisdiction, and we refer to them problems that require both their expertise and enforcement power. During the past year, our licensure and survey office has conducted surprise investigations in three skilled facilities, resulting in deficiencies which were based on referrals made by our office. The licensure division chief is a member of the Ombudsman Advisory Committee. This facilitates the absolutely necessary communication between the offices.

Aside from making referrals back and forth, we have had cause to work together on such matters as developing improved State regulations, defining levels of care, and the Long-Term Care Education Committee.

Certainly, there are times when we have disagreements about what the regulations should say, how they should be implemented, and what is legally possible.

Those of you who have read what has thus far been released of the Moss report, recently released by the Subcommittee on Long-Term Care of the Special Committee on Aging of the U.S. Senate, must surely recognize that we are a long way from making nursing homes "shining symbols of comfort and concern." I suspect you knew that without the benefit of reading the report. After 3 years' experience, we feel that nursing homes built and operated along acute hospital-model lines will never truly be comfortable and homelike. Short-term, acute-care facilities are organized to perform tasks which give little consideration to the psychosocial and long-term needs of their patients. Since the average stay is only about a week, little harm is, in all likelihood, done. But long-term care is a different game. Life is still the issue, but

it must be defined in qualitative as well as quantitative terms. To allow the spirit of a person to die is at least as much a crime as allowing the body to die. Somewhere along the line we must design a plan of care and a facility that bridges the gap between a person's physical and medical needs and their emotional and human needs. To do so will probably cost a good deal of money. Someone, probably the Government, must be convinced to bear the cost, or admit that the end achieved is not worth the cost. Let us not perpetuate the cruel hoax that today's facility is designed to meet the person's total needs.

At best, such a goal will be a long time in coming. In the meantime, those of us charged with overseeing the care nursing home patients are currently receiving must take seriously our roles and assure all concerned that the best possible care within today's facility is being provided. We need to be working to improve and expand the range of available services. For example, mental health services and dental care should not be allowed to be unknown in the long-term care facility, as they are in our State. Activity programs must be more than arts and crafts. Nursing personnel, including aides, should be well trained and fairly paid.

We, as ombudsmen, must approach each complainant's problem with as much objectivity as we can humanly bring to it. However, once we have determined that the problem is real and have defined it, we must then become mediator, advisor, facilitator, coordinator, broker or referral agent, catalyst, patient advocate, publicist, and expert witness—striving with all the resources that can be brought to bear to bring about a resolution resulting in a better life for the infirmed, institutionalized elderly.



## Appendix 2

### COMPUTERIZED CARE PLANS

Sample computerized care plans were submitted to the Subcommittee by the Moody Nursing Home, 4115 Flenwood Road, Decatur, Ga. Two sample plans, one for a patient with multiple fractures and the other for a patient with diabetes mellitus, are presented here in order that the reader may examine the complexity and quality of information recorded in a computerized plan.

In including this information, the Subcommittee on Long-Term Care does not mean to imply that computerized plans are superior to or suitable replacements for planning by health care professionals. See the text of this report, Part 2, section C-7, p. 599, for a discussion of the advantages of computerized plans.

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## CARE PLAN

- |    |          |                     |    |          |                    |
|----|----------|---------------------|----|----------|--------------------|
| 1  | 12/13/74 | FEED SELF           | 2  | 12/13/74 | DENTURES UPPER     |
| 3  | 12/13/74 | DENTURES LOWER      | 4  | 12/13/74 | BATHE PATIENT      |
| 5  | 12/13/74 | EYE GLASSES         | 6  | 12/13/74 | TABLE TOP CHAIR    |
| 7  | 12/13/74 | WASH HAIR PER NURSE | 8  | 12/13/74 | NO KNOWN ALLERGIES |
| 9  | 12/13/74 | PROTESTANT          | 10 | 12/13/74 | COOPERATIVE        |
| 11 | 12/13/74 | HELP WITH DRESSING  | 12 | 01/29/75 | ENC ART            |
| 13 | 01/29/75 | EXERCISE CLASS      | 14 | 01/29/75 | SOCIAL HOUR        |
| 15 | 01/29/75 | BINGO               | 16 | 01/29/75 | BIBLE STUDY        |
| 17 | 01/29/75 | MOVIES              |    |          |                    |

## DOCTOR'S ORDERS

- |    |          |   |    |          |                         |
|----|----------|---|----|----------|-------------------------|
| 18 | 12/13/74 | UP IN CHAIR                             | 20 | 12/13/74 | BATHROOM PRIVILEGES     |
| 19 | 12/13/74 | AMBULATE WITH ASSISTANCE                | 22 | 12/13/74 | VITASIGNS 1ST & 15TH EF |
| 21 | 12/13/74 | SIDE RAILS                              |    |          |                         |
| 23 | 12/13/74 | GENERAL DIET                            | 25 | 12/13/74 | WEIGH 1ST EACH MO       |
| 24 | 12/13/74 | 24 HOUR R. O.                           | 27 | 12/13/74 | BUS OK DR.              |
| 26 | 12/13/74 | OUT WITH FAMILY                         | 29 | 12/13/74 | BLOOD COUNT             |
| 28 | 12/13/74 | URINALYSIS                              | 31 | 12/27/74 | WALK PT TID             |
| 30 | 12/13/74 | TINE                                    |    |          |                         |
| 33 | 01/16/75 | MAY BE TRANSFERRED TO INTERMEDIATE CARE |    |          |                         |
| 34 | 01/26/75 | MAY HAVE BEDTIME SNACK                  |    |          |                         |

## GOALS-DISCHARGE PLANS

- |    |          |   |    |          |                        |
|----|----------|---|----|----------|------------------------|
| 43 | 01/29/75 | DISC. HOME FAMILY & PAT COUNSELING 3 MONTHS |    |          |                        |
| 44 | 01/29/75 | RE-EVALUATION 3 MONTHS                      |    |          |                        |
| 46 | 01/29/75 | PARTICIPATION IN SOCIAL ACTIVITIES 1 MONTH  |    |          |                        |
| 48 | 01/29/75 | IMPROVING PHYSICAL FUNCTIONS 3 MONTHS       |    |          |                        |
| 50 | 01/29/75 | IMPROVING PSYCHO-SOCIAL FUNCTIONS 1 MONTH   |    |          |                        |
| 51 | 01/29/75 | SELF BATHING 3 MONTHS                       | 52 | 01/29/75 | SELF DRESSING 3 MONTHS |

CONTINUE THE ABOVE ORDERS AND CONTINUE SKILLED/INT. CARE DUE TO-----

IT IS/IS NOT MED. CONTRAINDICATED PAT. BE INFORMED OF HIS/HER MED. CONDITION  
IT IS/IS NOT MED. CONTRAINDICATED PAT. MAY SEND & RECEIVE PERS. MAIL UNOPENED.  
IT IS/IS NOT MED. CONTRAIND. PAT. MAY ASSOC. COMMUNICATE & PARTICIP. FREELY

-----  
DR. SIGNATURE

DATE

MC1590 01/30/75  
 MC WILLIAMS OLA C ROOM W139

DR. M MOORE BD 04/27/90 DIAG. FX R RADIUS & ULNA FX PELVIC R

MEDICINE PROFILE

36 12/13/74 \*TYLENOL TABS 325MG ACETAMINOPHEN 2 TABS EV 4 HRS PRN  
 37 12/13/74 \*DALMANE CAP 15MG 1 TAB H. S.  
 39 12/13/74 ISOVEX-100 ETHAVERINE CAP 1 TABTID  
 41 12/13/74 MILK OF MAGNESIA USP 30 CC EA QD PRN

CONTINUE THE ABOVE ORDERS AND CONTINUE SKILLED/INT. CARE DUE TO-----

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 IT IS/IS NOT MED. CONTRAINDICATED PAT. BE INFORMED OF HIS/HER MED. CONDITION  
 IT IS/IS NOT MED. CONTRAINDICATED PAT. MAY SEND & RECEIVE PERS. MAIL UNOPENED  
 IT IS/IS NOT MED. CONTRAIND. PAT. MAY ASSOC. COMMUNICATE & PARTICIP. FREELY

-----  
 DR. SIGNATURE

DATE

TH2434 01/30/75  
 THOMAS MELVIN L. ROOM P102  
 DR. DR. MOORE BD 09/16/17 DIAG. DIABETES MELLITUS

1 09/30/74

CARE PLAN

2 09/30/74 FEED PATIENT	4 09/30/74 DENTURES LOWER
3 09/30/74 DENTURES UPPER	6 09/30/74 TUB BATH
5 09/30/74 BATHE PATIENT	8 09/30/74 INCONTINENT BOWELS
7 09/30/74 INCONTINENT BLADDER	10 09/30/74 ORIENTED
9 09/30/74 WASH HAIR PER NURSE	12 09/30/74 COOPERATIVE
11 09/30/74 PROTESTANT	14 09/30/74 NEEDS SOCIALIZATION
13 09/30/74 ALERT	16 09/30/74 SPEECH PROBLEM
15 09/30/74 SEIZURE PRECAUTIONS	18 01/29/75 SPEECH GROUP
17 09/30/74 NO KNOWN ALLERGIES	
19 01/29/75 SOCIAL EVENTS	

DOCTOR'S ORDERS

20 09/30/74 UP IN CHAIR BID	22 09/30/74 SIDE RAILS
21 09/30/74 RESTRAIN PRN	24 09/30/74 SKIN CARE
23 09/30/74 VITAL SIGNS Q O WEEK	
25 09/30/74 1500 CAL ADA E GM NA PUREED	
26 09/30/74 24 HOUR R. O.	27 09/30/74 CHECK FOR IMPACTION
28 09/30/74 WEIGH MONTHLY	29 10/08/74 C & A BID
30 10/31/74 CONDONE CATH	31 10/31/74 B/P QD
32 01/29/75 ADVANCE R. O.	

GOALS-DISCHARGE PLANS

56 12/20/74 BLADDER TRAINING 6 MONTHS	
57 12/20/74 BOWEL TRAINING 6 MONTHS	
58 12/20/74 RE-EVALUATION 3 MONTHS	
60 12/20/74 IMPROVING PHYSICAL FUNCTIONS 3 MONTHS	
62 12/20/74 IMPROVING INTELLECTUAL FUNCTIONS 5 MONTHS	
64 12/20/74 ORIENTATION TO SURROUNDINGS 2 MONTHS	
66 12/20/74 PARTICIPATION IN SOCIAL ACTIVITIES 2 MONTHS	
67 12/20/74 SELF FEEDING 2 MONTHS	68 12/20/74 SPEECH IMPROVEMENT 4 MONT
70 12/20/74 NO DISCHARGE POSSIBILITIES INDEFINITELY	

CONTINUE THE ABOVE ORDERS AND CONTINUE SKILLED/INT. CARE DUE TO-----

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 IT IS/IS NOT MED. CONTRAINDICATED PAT. BE INFORMED OF HIS/HER MED. CONDITION  
 IT IS/IS NOT MED. CONTRAINDICATED PAT. MAY SEND & RECEIVE PERS. MAIL UNOPENED.  
 IT IS/IS NOT MED. CONTRAIND. PAT. MAY ASSOC. COMMUNICATE & PARTICIP. FREELY

-----  
 DR. SIGNATURE

DATE

TH243-1 01/30/75  
 THOMAS MELVIN L. ROOM P102

DR. DR. MOORE ED 03/16/17 DIAG. DIABETES MELLITUS

### MEDICINE PROFILE

34 10/02/74 \*DILANTIN DIPHENYLHYDANTOIN 100MG PO TID  
 36 10/02/74 MILK OF MAGNESIA USP 30 CC EA QD PRN  
 38 10/02/74 \*ASPIRIN 5GR-ACETYSALICYLIC ACID 2 TABS EV 4 HRS PRN  
 39 10/02/74 MILKINOL OZ. PO QD PRN  
 41 10/21/74 MELLARIL 10MG THIORIDAZINE PO QID  
 43 11/18/74 \*\* BENADRYL 25 MG Q 6 HRS PRN ITCHING  
 45 12/28/74 TOFRANIL 25MG IMIPRAMINE TR 1 TAB TID  
 46 01/05/75 \*DYAZIDE CAPS 1 TAB QD

### PHYSICAL THERAPY

47 11/01/74 R. O. M. EX (P AS A) - F 48 11/01/74 GENERAL STRENGTH EX.  
 49 11/01/74 CONDITIONING EX 50 11/01/74 GAIT TRAINING - QUAD ( ONE  
 51 11/01/74 HOT PACKS RIGHT SHOULDER QD  
 53 12/02/74 RENEW PREVIOUS PT ORDERS FOR 30 DAYS  
 55 01/02/75 RENEW PREVIOUS P. T. ORDERS FOR 30 DAYS

CONTINUE THE ABOVE ORDERS AND CONTINUE SKILLED/INT. CARE DUE TO-----

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 IT IS/IS NOT MED. CONTRAINDICATED PAT. BE INFORMED OF HIS/HER MED. CONDITION  
 IT IS/IS NOT MED. CONTRAINDICATED PAT. MAY SEND & RECEIVE PERS. MAIL UNOPENED.  
 IT IS/IS NOT MED. CONTRAIND. PAT. MAY ASSOC. COMMUNICATE & PARTICIP. FREELY

-----  
 DR. SIGNATURE

DATE

### Appendix 3

## ESTABLISHING A DAY CARE CENTER

The following paper was submitted to the Subcommittee on Long-Term Care by Richard Lamden, administrator, Handmaker Jewish Nursing Home for the Aged, 2221 North Rosemont Boulevard, Tucson, Ariz.

### SENIOR HEALTH IMPROVEMENT PROGRAMS OF THE HANDMAKER JEWISH NURSING HOME FOR THE AGED.—STATEMENT OF PROGRAM

#### EARLY HISTORY

The program initially began in 1967 when two people applying for admission to Handmaker were found to not need or want nursing home care, but rather, to be cared for during the day. Both had spouses who could care for them at night and weekends. Thus day care was founded in Tucson. The initial program was funded under a demonstration grant by the Committee on Economic Opportunity. It operated on a very small basis at Handmaker Jewish Nursing Home for the Aged and at another health care facility across town. The concept of utilizing other health care facilities has continued to this day. As the Committee on Economic Opportunity funding expired, the program was in great jeopardy of dying. Fortunately, Model Cities money became available to the community. A proposal was written to try to get this program picked up under model cities, but a ruling that no existing federally funded program could be picked up by any other source of Federal funds presented a technical problem. A different program was proposed instead to fill a gap in services. This program, under the title "Project Restore," offered day care services for mentally handicapped senior citizens. The programs used the same goals and, although giving similar service, it was run under separate administration. In 1972 with the advent of some additional moneys in the community, the two programs were merged, expanded, and renamed "Senior Health Improvement Programs."

#### PRESENT PROGRAM

The project began with a fairly simple program of crafts, physical therapy, musical therapy, and a hot lunch. It has expanded considerably. Today, a full range of rehabilitative services including physical therapy, speech therapy, inhalation therapy, occupational therapy, recreation therapy, and music therapy, is provided, together with a general crafts and recreation program, a men's group, sheltered workshops, self-care groups including hair care, general grooming, laundry, basic activities of daily living, field trips, picnics, nursing services.

A full social work program includes individual and group counseling, therapeutic groups, spouse and family groups, and psychiatric counseling and evaluation. The program also coordinates medical services with individual physicians. A hot lunch is served and take-home evening and weekend meals are available when necessary. Other activities of the nursing home or hospital are also often shared. Transportation to each center is provided by city special-needs transportation vehicles.

People come from 1 to 5 days a week, depending upon their needs and/or their family's needs. There will be approximately 700 people served by the program this year; 428 persons are presently receiving service.

The entire program is run as the outpatient department of Handmaker Jewish Nursing Home for the Aged, its contracting delegate agency. All administrative offices, program staff, offices, and social work offices are based at Handmaker, as is the largest of the centers. There are five other centers, all located in other health care agencies within the community and geographically placed to provide the maximum amount of service. These are:

- (a) far west side—St. Mary's Hospital and Health Center;
- (b) southwest side—Veterans' Administration Hospital;
- (c) north west side—Tucson General Hospital;
- (d) central—Villa Maria de Guadalupe Nursing Home;
- (e) far east side—St. Joseph's Hospital.

Each of the health agencies donates space for the center.

#### FINANCING

The funds for the program come from three sources: The National Institute of Mental Health, the areawide model project under title III of the Older American's Act, and the Tucson Department of Community Development. Unfortunately, all of these sources are Federal and city moneys. The stability of this money certainly cannot be guaranteed. The program does have a large in-kind budget, which confirms community commitment to the program, but does not provide any hard source of funds. Medicaid in Arizona looks doubtful with respect to coverage of day care services. It is probably one of the major deterrents of program expansion. It is hoped, however, that title XX of the Social Security Act may be a possibility. Funding, of course, is one of the most difficult problems in any area that is considered innovative.

#### POPULATION SERVED

To be eligible, a client must be at least 50 years old. Presently, the project includes persons 50 to 94 years of age. They are residents of Pima County, although most of them are residents of the city of Tucson. All are on the verge of inappropriate institutionalization and need supportive services in order to remain at home. The participants are about 62 percent physically handicapped: most have some types of mental deterioration and/or residual mental effect from their physical handicap. Some are nonambulatory or may ambulate on a limited basis with the aid of a walker, cane, or crutches. Some require assistance to the bathroom while some need actual transfer assistance. Several persons are incontinent. Approximately 38 percent of the

participants are mentally handicapped. They may exhibit signs of depression (both mild and severe), paranoia, schizophrenia, or some stages of senility. Severely disoriented persons in each center are limited to two, owing to the staffing patterns and building limitations.

All participants are admitted under a physician. Individualized treatment plans are developed and regularly reviewed. The program is health oriented.

It is not a babysitting service and does not allow participants to "drop in".

#### GENERAL

The average stay in the program is 23 consecutive weeks with 78 percent of the people leaving the program to lesser supportive service, such as a socialization/nutrition program or families. Of those who go on to more supportive services, many are really ready for institutionalization and can be helped to plan for placement.

More than 92 percent of the population served live on less than \$2,000 per year.



## Appendix 4

### NURSING HOME TELEMEDICINE PROJECT

The telemedicine project presented in the text of this report (part 2, section D-3, p. 604) combines a variety of resources to provide accessible medical care for nursing home patients. Information concerning the establishment of this project, clinical decisionmaking, financial arrangements, and evaluation may be of interest to readers attempting to undertake similar projects.

The first item in part A of this appendix is the interim status report of the project which summarizes the productivity, attitude evaluation, and continuation of the project. Following the interim report is the decision matrix designed by the project to illustrate how nurse practitioners determine resources needed for the management of an individual patient.

Part B of this appendix contains a copy of the contract between the telemedicine project and the Department of Public Welfare in Massachusetts. The contract provides the framework of legal responsibilities of telemedicine and the chargeable rates for services rendered.

Part C is a survey conducted by Rogers and Pendleton of the Levinson Policy Institute of the Florence Heller Graduate School for Advanced Studies in Social Welfare, of Brandeis University. The text of the survey is entered in its entirety as a comprehensive analysis of the telemedicine project. This survey discusses administrative aspects of the project and various operational issues.

#### PART A

##### INTERIM STATUS REPORT, JUNE 15, 1975

###### 1. INTRODUCTION

The nursing home telemedicine (NHTM) project at Boston City Hospital is nearing the end of its grant-supported activities, and is beginning the transition to a wholly self-sufficient health care program. It is the purpose of this brief report to present, in a preliminary manner, certain available evaluation data, to summarize recent developments relating to ongoing financing, and to indicate future directions for the program. It assumes that the reader is familiar with the organization and objectives of the project, and the data presented in the first annual report to the National Science Foundation for the period April 15, 1973-July 31, 1974. The project's organization and objectives are also summarized in a brochure prepared for the Miami Telemedicine Conference in November 1974.

During the approximately 2 years of NSF/RANN funding, the NHTM program has provided primary medical care to approximately 519 patients discharged from Boston City Hospital to local nursing homes. At the present time there are about 340 active patients enrolled in the program, living in 13 nursing homes. During the grant period, a matched group of about 508 control patients have been followed. The comparability of the two groups of patients was presented in the annual report. Data are being collected relating to patient outcome (mortality, changes in activities of daily living, transfers out of nursing homes, hospitalization, et cetera), certain measures of medical care process (visit frequency, management of antibiotics and cardiac glycosides, et cetera), and costs of care (hospital days, transportation, lab tests, clinic visits, et cetera). These data are not yet fully collected and processed. It is expected that the data base will be complete sometime in July. The appropriate computer programing for data base management has been completed. Final statistical data will be available in the final report of the project which will be available by the end of the grant period in September 1975. Some preliminary data were hand-processed on a subset of 400 patients (200 control and 200 study) from four nursing homes. This analysis showed that significantly fewer hospitalizations and a lower mortality occurred in the study group (see table I). In addition, medical followup was more frequent among study patients.

TABLE I.—*Results of Pilot Study of 400 Patients*

- NP's see an average of 9 patients per day (range is 6 to 13).
- Fifty-seven percent of the average NP day is spent on patient visits and associated paperwork.
- Overall average length of patient visit is 36 minutes.
- Initial patient workup lasts 83 minutes.
- Followup patient visits last 27 minutes.
- Eighty percent of NP visits do not require MD consultation.
- Average number of days between NP/MD visits to patients is 16 days compared with 30 days interval for NH patients receiving traditional care.
- Hospitalization rate per 100 patient-months is three, compared to four for NH patients receiving traditional care.
- Mortality rate per 1,000 patient-months is 9, compared to 14 for NH patients receiving traditional care.
- Estimated cost per patient visit is about \$19.

## 2. ATTITUDE SURVEY

An important part of the evaluation of any health care program is its assessment by other interlocking elements of the health care network. We were particularly concerned with the subjective evaluation of the NHTM program by nursing home administrators, nursing directors, and staff nurses. Consequently, we requested that the Levinson Policy Institute of the Florence Heller Graduate School of Brandeis University conduct an independent in-depth survey of nursing home administrators and staff members, as well as various professionals at Boston City Hospital and some community physicians, to determine

their opinions about the NHTM program. The Heller school group, under the direction of Professor Robert Morris, was particularly well suited for this task. They are a well known and highly respected group in the area of gerontology and are independent of the Boston City Hospital.

A summary of their findings is included here, a full report of all aspects of the survey will be a part of the final project report.

### *Summary of Findings*

The study was intended to determine how the telemedicine program was accepted by the nursing homes and what the impact of the program was on the administration, operation, and care of patients in the homes.

Of the 50 administrative and floor staff interviewed, 40 said they would prefer to have the program in their homes, five preferred not to have it, and five were undecided.

According to administrative staff, the most important objectives of the program were improved quality of patient care and reduced costs to the health care system through reduction in transfers to the hospital.

Twelve of the fourteen administrators answering felt quality of care had been improved, while two felt it had not. Ten felt the objective of economy had been achieved, while four disagreed.

The majority of the administrative staff said there had been no problems or difficulties in introducing the program, and that it was operating with no conflicts or difficulties at present. The two problems mentioned most frequently by the others were: (1) personality conflicts between the telemedicine nurse practitioners and the nursing home staff, due primarily to misunderstanding or resentment of this new health professional's role, and (2) lack of compliance with State regulations on tasks which must be performed by a physician, especially prompt signing of patient orders.

Administrators said the major benefits of the program were thorough physical exams of the patients and reliable emergency back up by the NP's. The program had negligible effect on the home's costs, staff turnover, and staff recruitment.

Nursing home staff in seven of the nine homes felt relations with the city hospital had improved in that access to specialists was easier and continuity of care between the nursing home and the hospital was better. The majority of the staff said that information available on patients was better with the program, and that the nurse practitioners were helpful in explaining things. Twenty-five of the 46 respondents said their work was made easier by the program, and 10 said it was harder. But, of these 10, 6 felt that the increased workload was good because it improved staff morale and patient care. Thirty of the 45 respondents said that medical monitoring of patients was improved by the program. While eight said it was no different and two said it was worse, the majority (27) of the respondents said that patients were more satisfied with their care under the program, because of the increased attention and concern showed them.

### 3. CONTINUITY OF NHTM PROGRAM AFTER THE GRANT PERIOD

During the period of NSF support, the NHTM program has been supported almost entirely by NSF funds. During this period Medicare's policy precluded the reimbursement of nurse practitioner services as rendered in the NHTM program. As a result, the only services which have been reimbursed by Medicare have been certain physician visits, and some EKG interpretations. The total reimbursement from Medicare during the period April 1973–May 1, 1975, was \$13,960. This is obviously a tiny fraction of the estimated medical care budget of approximately \$226,000 for the same period. Hence, RANN funds have supported essentially 94 percent of the clinical services of the program in addition to the research component.

Fortunately, during the period of grant support, the NHTM program was viewed with enthusiasm by Massachusetts Medicaid officials. As a result, the Department of Public Welfare has established a 1-year, renewable contractual agreement with the trustees of Health and Hospitals of the City of Boston, Inc., to purchase continuing services from the program for Medicaid patients in nursing homes. Since virtually 100 percent of the study patients are on Medicaid, the NHTM program will be self-supporting on a fee-for-service basis. A regulation has been established by the Massachusetts Rate Setting Commission to set reimbursement at a flat rate of \$20 per visit,\* regardless of the type of visit (NP, MD, emergency, routine, et cetera). It is expected that a smooth transition will be possible, with no disruption in clinical services. With reasonable estimates of productivity (patient visits per NP per day), this reimbursement schedule should cover program expenses. The effective date of the contract and regulation is May 1, 1975. Thus, on or about that date, clinical personnel will begin transfer from RANN support to fee-for-service support. A copy of the contract and regulations are included as part B of this appendix.

### 4. DIFFUSION OF THE INNOVATION

Project-related personnel, nursing home administrators, staff members, and Massachusetts Medicaid officials are convinced that the NHTM program has resulted in improved patient care. Mechanisms have been established to permit the financing of the program on a continuing basis. Thus, many of the requirements for transfer of the program to other sites have been met. There are two problems which we see as significant, however. First, the program demands rather highly skilled front-end professionals—either nurse practitioners or physician assistants. In general, we have found that several months of on-the-job training is required before NP's or PA's are able to function in a cost-effective manner. Thus, recruitment of adequately trained front-end professionals may represent a problem to new sites. On the other hand, job satisfaction seems to be quite high. Our NP's have found their positions to be highly challenging as well as rewarding,

\*One dollar allowed to pay for special data processing requirements for Medicaid evaluation.

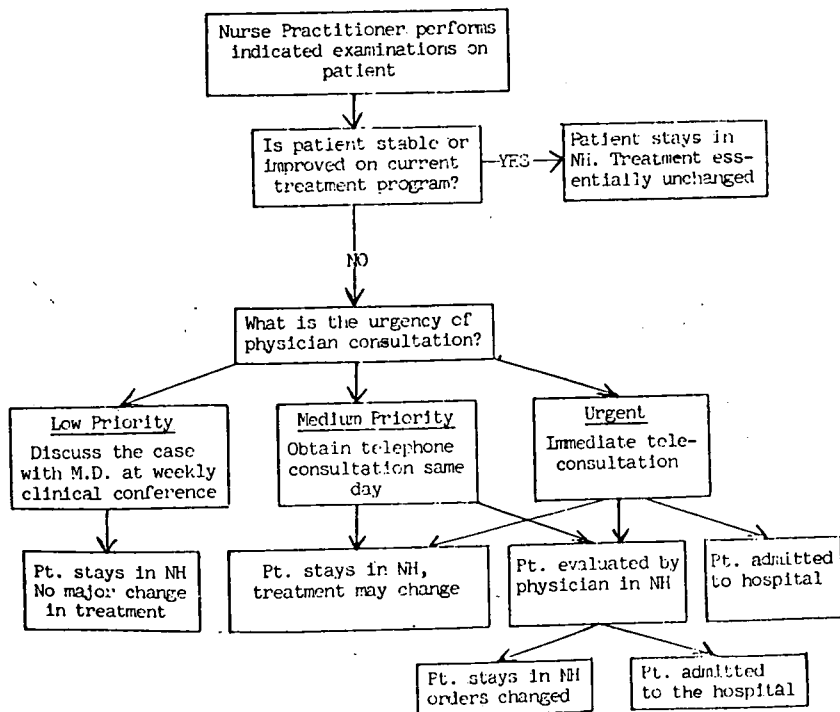
and turnover has been low. It has been our experience that recruiting physicians has also been difficult. Geriatrics, particularly the area of nursing home patient care, is not a highly sought after professional activity. The aversion of physicians toward these patients has been documented elsewhere (Solon, J. A., "Medical Care: Its Social and Organizational Aspects," *Nursing Homes and Medical Care*. N. Eng. J. 269: 106, 1963.). On the other hand, we have found that once involved in the NHTM program, the physician finds much more challenge and reward than initially anticipated. It would appear that several part-time physicians rather than one full-time physician would be preferable.

A second problem area which continues to remain unresolved in Massachusetts is the delay in formal approval of the role of our NP's by the Massachusetts Department of Public Health and HEW. The MDPH has approved the program on an experimental basis, but has yet to firmly establish policy relating to such issues as signing of orders and progress notes by NP's. As a result, certain nursing homes are sometimes written up as being delinquent, and (as the opinion survey showed) this is a source of considerable anxiety. It is apparent that this issue must be clarified if dissemination is to proceed efficiently.

#### 5. CONCLUSIONS

The NHTM program appears to have achieved many of its objectives during the grant period. Most observers seem to feel that patient care and continuity has been improved. Hard data on costs, outcome, and care process will be available by September. Arrangements have been made by Massachusetts Medicaid to continue clinical services on a fee-for-service basis, and transition from grant support is now underway. Despite the problems of personnel recruitment and Department of Public Health regulatory policy, we feel that the techniques developed in the NHTM program are potentially generalizable, and that an effort to understand and implement a dissemination program should be undertaken.

## NURSING HOME TELEMEDICINE PROJECT: DECISION MATRIX FOR NURSE PRACTITIONER



### PART B

#### CONTRACT BETWEEN THE TRUSTEES OF HEALTH AND HOSPITALS OF THE CITY OF BOSTON, INC., AND THE DEPARTMENT OF PUBLIC WELFARE, COMMONWEALTH OF MASSACHUSETTS

*Whereas*, the Trustees of Health and Hospitals of the City of Boston, Inc., operates the Outreach Care Program (formerly known as the Nursing Home Telemedicine Program and hereinafter referred to as the Provider) from the Department of Health and Hospitals (hereinafter referred to as the Hospital); said program being a primary medical care provider to a geriatric and disabled population and having the following objectives:

(a) To provide comprehensive primary medical care on a twenty-four (24) hour a day, seven (7) day a week basis to nursing home patients, as well as to certain former or potential nursing home patients who require a similar level of medical involvement in order to be maintained in a community setting;

(b) To extend the resources of the hospital into nursing home settings to meet existing needs; and

(c) To provide continuity of care when hospitalization is required.

*Whereas*, the Department of Public Welfare, Commonwealth of Massachusetts (hereinafter referred to as MDPW), administers a

broad medical care program which recognizes the need for primary care in any comprehensive medical care program, and desires to purchase such a program of primary care from the Provider on an experimental, trial basis,

Now, therefore, the Provider and MDPW, in consideration of the mutual promises and covenants contained herein, enter into the following agreement.

1. The Provider agrees that it shall provide its services to Medicaid recipients who fall within the following listing: Initially participation shall be limited to categories (a), (b), and (c). At a later date, category (d) shall be added upon the mutual agreement of both parties.

(a) Patients who have been discharged from the hospital to participating nursing homes;

(b) Other appropriate nursing home patients, upon request, i.e., individuals who are entering a participating nursing home from their homes;

(c) Patients who have been previously enrolled in the program who have been discharged from nursing homes into a community setting but who do not have alternative forms of followup care available to them; and

(d) Homebound persons who are residents in public housing projects.

2. The Provider agrees that all health care team members will be employed and salaried either through the Department of Health and Hospitals or the Trustees of Health and Hospitals of the City of Boston, Inc., and will relate to the hospital's medical and nursing staffs. The program's professional staff shall have access to hospital based patient data and the use of both in-patient and out-patient facilities of the hospital.

3. The Provider agrees to assure close coordination between the program staff and related hospital professionals including, but not limited to: social workers, house staff, emergency room staff, and the out-patient department.

4. The Provider and MDPW agree that all patients entering the program, for whom reimbursement is being sought through MDPW, must be in possession of a currently valid Medicaid card, or eligible for such a card.

5. The Provider agrees that prior to enrollment the program shall be outlined to every patient and/or his/her family who is being placed in a participating nursing home from the hospital by the hospital social worker who is arranging said placement. The Provider agrees that all Department of Health and Hospital patients who are being transferred to a participating nursing home shall be accepted into the program if they or their family so requests.

6. The Provider agrees to accept referrals from directors of participating nursing homes, particularly for patients entering the nursing home from their homes or other health care institutions. The Provider agrees to accept such individuals into the program when appropriate. It is understood that non-DHH patients will compose a very small fraction of the total patient population served by the program.

7. At which time both parties agree to add category (d) as stated under Section 1, the Provider further agrees to accept referrals for homebound elderly public housing tenants from other medical providers or community resources and shall accept such individuals into the program when appropriate.

8. The Provider agrees to establish the following medical care procedures:

(a) Following the patient's transfer to the nursing home a complete medical evaluation shall be performed by the responsible nurse practitioner (NP) or physician assistant (PA) making full use of hospital data:

(b) A team physician shall review the initial workup and personally examine each new patient;

(c) A medical record shall be established and maintained at the hospital and the nursing home (for nursing home patients) and a plan of care shall be established by the health care team;

(d) The MD, NP, or PA shall visit each patient at intervals which shall be determined by the individual's clinical status and treatment plan;

(e) Followup examinations which consist of obtaining pertinent medical data by means of an interval history, a physical examination, and relevant laboratory tests, shall be performed;

(f) Protocols for the NP, or PA to follow, shall be developed by the medical director for many of the more common medical problems (i.e. congestive heart failure, diabetes, chronic lung disease, strokes, etc.). These protocols shall serve as guidelines for the NP/PA in areas where independent judgment is required;

(g) All data shall be recorded in a problem oriented format which shall include the appropriate use of flow charts; and

(h) If the NP or PA feels that a problem warrants a physician's involvement, (s)he shall engage in a telephone conversation with the program staff physician; on the basis of the information transmitted, the physician shall institute the appropriate treatment via telephone or elect to personally evaluate the patient in the nursing home; if appropriate, the physician may arrange for the immediate admission of the patient to the hospital.

9. The Provider further agrees that the program shall follow similar procedures for homebound tenants of public housing when these individuals are participating in the program as stated under section 1.

10. The Provider agrees that when a patient is admitted to the hospital, the program staff will assure transfer of all relevant clinical data to the in-patient medical service; and will maintain close liaison with the ward staff during the patient's hospital stay.

11. The Provider agrees that all nursing homes where patients in the program reside will be informed of the principles of the program and must agree to have nursing home staff cooperate with the program when possible.

12. The Provider agrees that it shall have at least one full-time equivalent physician for every 500 patients; all M.D.'s shall have been trained in internal medicine, with a minimum requirement of one year of medical internship plus one year of residency in internal medicine; all program M.D.'s shall be members of the hospital's medical staff;



one physician will function as the medical director of the program; the medical director shall have experience in primary care; at least one-half of the medical director's work week shall be devoted to the program. The medical director and all other physicians shall be appointed in consultation with the Chief of the Medical Service. Incremental staff increases required by a patient population in excess of 500 will be dependent on the additional revenues derived from the increased demand.

13. The Provider agrees that the medical director shall be responsible for all aspects of medical care in the program and shall be responsible for the activities and actions of the NP's or PA's that relate to medical care.

14. The Provider agrees that, since the NP or PA is the spearhead of the system and prime agent of care, all NP's and PA's shall have had an extensive background in independent clinical care and shall have successfully completed an adult NP or PA training course. The Provider further agrees to endeavor to insure that the NP's or PA's shall be capable of providing primary medical care to geriatric patients (primary medical care includes comprehensive medical, nursing, rehabilitative and other resource requirement evaluation, and the provision of patient monitoring and followup). The Provider further agrees that there shall be at least one NP or PA for each 125 patients.

15. The Provider agrees that it shall designate an administrative director who shall insure that all aspects of care are coordinated and that the nonclinical work of the NP's or PA's and physicians are facilitated. The Provider further agrees that the administrative director shall have clerical assistants, as needed, who shall deal primarily with correspondence, record maintenance, billing, and data collection.

16. The Provider agrees that all nonphysician professional staff shall have letters of recognition from the directors of the appropriate clinical departments at the hospital. Such letters shall indicate that the individuals are, in the opinion of the clinical departments, qualified for their role in the program. In the case of nurse practitioners, letters shall be required from the Departments of Nursing and Medicine. In the case of physician assistants a certificate of graduation from a recognized training program and a letter of approval from the Department of Medicine shall be required.

17. The Provider agrees to implement the following policies and procedures regarding records:

(a) All records shall be kept in a problem oriented format, including fact sheets of problems and flow sheets on individual visits; and

(b) Duplicate patient records will be maintained in the nursing home and at the hospital as a reference for team members and for the in-patient staff in cases of hospital visits and special clinic visits. An automated record system permitting access from a variety of geographic points is an acceptable alternative.

18. MDPW agrees to reimburse the Provider on a fee-for-service basis for all medical visits provided by an MD, NP, or PA (as per paragraph 3) in accordance with a rate determined by the Massachusetts Rate Setting Commission, and the Provider agrees to accept said payment by MDPW as payment in full for its services.

It is agreed by the Provider that during the initial year of the program, reimbursement for visits to patients in group (c) will be at the

same rate as for visits to patients in groups (a) and (b). Furthermore, the Provider will accumulate data regarding costs of its services to group (c) patients. This data will be used to determine the feasibility of continuing service to group (c) patients in the future years, and for establishing an appropriate reimbursement.

19. The Provider agrees that it shall collect and compile program information for MDPW as specified below:

- (a) Number of visits by type of provider;
- (b) Average visits per patient;
- (c) Visit interval data;
- (d) Type and number of hospital referrals; and
- (e) Other relevant data collected by the project.

20. The Provider agrees to give access to representatives of MDPW to its facilities and records for the purpose of MDPW's evaluation of the program.

21. The Provider agrees that it shall not approach nor authorize any individual to approach patients for participation in any project, activity, or practice which is not designed primarily to meet the medical, psychological or social needs of Medicaid recipients through established and accepted nonexperimental methods, if such project, activity, or practice would place any patient at increased risk by exposing him to the possibility of physical, psychological, or social injury as a consequence thereof. MDPW must grant prior written approval to any exception to this provision.

22. The Provider and MDPW agree that this agreement may be terminated upon 90 days written notice by either party.

23. The Provider and MDPW agree that this agreement shall run for a period of one year beginning on May 1, 1975, and ending April 30, 1976, and shall be subject to review not later than 90 days prior to each subsequent renewal.

24. The Provider and MDPW agree that if any provision of this agreement is found to be illegal or invalid such invalidity or illegality shall not affect any other provision of this agreement or the agreement as a whole.

*In witness thereof*, the parties have executed and delivered this agreement as of the date and year stated below:

Effective date of agreement: May 1, 1975.

COMMONWEALTH OF MASSACHUSETTS,  
DEPARTMENT OF PUBLIC WELFARE.  
THE TRUSTEES OF HEALTH AND HOSPITALS  
OF THE CITY OF BOSTON, INC.

**TITLE 14:—RATE SETTING COMMISSION.—CHAPTER IV: BUREAU OF  
NON-INSTITUTIONAL MEDICAL PROVIDERS.—PART 409: TELEMEDICINE  
SERVICES**

**SUBPART A: GENERAL PROVISIONS**

**SEC. 409.01 *Scope, Purpose, and Effective Date.***

This part shall govern the determination of rates of payment and rates of payment to be used by all governmental units and purchasers under the Workmen's Compensation Act for Nursing Home Telemedicine services provided publicly-aided and industrial accident patients.

This part shall be effective from the date of its publication by the Secretary of the Commonwealth.

**SEC. 409.02** *Coverage.*

This part and the rates of payment contained herein shall apply to telemedicine services rendered by an eligible provider to publicly-aided and industrial accident patients in a private nursing home.

The rates of payment under this part are full compensation for telemedical services rendered as well as for any related administrative or supervisory duties in connection with the provisions of telemedical services without regard to where this service is rendered.

**SEC. 409.03** *Authority.*

This part is adopted pursuant to G.L., C. 6A, ss 31-36. This citation of authority conforms to 1 CHSR 26.45.

**SUBPART B : GENERAL DEFINITIONS**

**SEC. 409.04** *Telemedicine.*

Shall mean an on-going, full-time hospital based program of outreach medical care to long-term care facility patients by a telemedical group. The program shall include, but shall not be limited to, initial and annual complete examinations by a physician and nurse practitioner; ongoing medical examinations, compilation of medical history, treatment, ordering of necessary lab work, and consultation with a physician when required.

**SEC. 409.05** *Telemedical Group.*

Shall mean a registered nurse who has successfully completed a training program for adult nurse practitioners, licensed physician, and necessary clerical staff participating in a telemedicine program.

**SEC. 409.06** *Eligible providers.*

Shall mean a hospital based telemedical group who meet such conditions of participation as adopted from time to time by a governmental unit or purchaser under the Workmen's Compensation Act.

**SUBPART C : GENERAL PROVISIONS AND MAXIMUM RATES**

**SEC. 409.07** *Records—Maintenance of Medical Records.*

All medical records shall be reviewed and signed by the responsible physician of the telemedical group.

**SEC. 409.08** *Maximum Allowable Rates.*

Procedure description: patient visit by any member of the telemedical group.

Provider: Boston City Hospital Telemedical Group.

Fee: \$20.

**PART C**

**INTEGRATION OF THE BOSTON CITY HOSPITAL NURSING HOME TELE-MEDICINE PROJECT AND ASSOCIATED HEALTH SYSTEMS.—PRELIMINARY REPORT**

(Survey: "Nursing Home Staff and Administration Opinions on the Impact of the Boston City Hospital Nursing Home Telemedicine

Program" by Beatrice Rogers and Sylvia Pendleton, Levinson Policy Institute, the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Mass., June 1975)

#### INTRODUCTION: STUDY AIMS AND METHODOLOGY

The three interlocking components of the Boston City Hospital Nursing Home Telemedicine Project—hospital-based physician, nurse practitioners, and communication devices linking nursing home and hospital—together form an innovative subsystem for providing primary medical care to nursing home patients discharged from the city hospital.

The feasibility of incorporating such a program into the existing health care system depends to an important extent on acceptance by those established institutions in the system that must work intimately with it: the nursing homes and the relevant units and departments of the backup hospital.

To help determine how well the telemedicine program meshes with the day-to-day procedures and organization of these institutions, the Levinson Policy Institute of the Florence Heller Graduate School, Brandeis University, was requested by Project Director Dr. Roger Mark to conduct an independent opinion survey of the administrators and staff of the participating nursing homes and hospital departments that have interacted with the program. The survey questions were primarily open-ended, serving as guides to get at subjective assessments by the respondents concerning the impact of the telemedicine program on all aspects of the functioning of the institution. The subject matter included routine operation, regular staff performance, morale, and turnover; operating costs; and relations with outside agencies such as the Department of Public Health, and interaction between hospital and nursing home. While the principal focus of this study was on the integration of telemedicine into existing organizations, we also asked for perceptions of the role of the nurse practitioner and for judgments as to the quality of care provided and differences in patient satisfaction since the introduction of telemedicine. An objective of the study was to identify points of friction as well as areas where the telemedicine program has made no difference or a positive contribution to the functioning of the institution and the system as a whole.

This preliminary report will be limited to a discussion of the responses of nursing home personnel to certain of these questions dealing with the assimilation of telemedicine into the nursing home structure and procedures. It also addresses the fundamental question of whether, as nursing home staff see it, the telemedicine program is a valuable and desirable addition to the system.

The questionnaires for nursing home personnel were in two formats: a basic version for RN's, LPN's, aides, therapists, social workers and other staff, and an expanded form for owners, administrators, and directors of nursing. Questions in the two formats were similar regarding the impact of telemedicine on the working of the home and on quality of patient care, with additional questions pertaining to administrative matters directed to the upper level staff.

All but 1 of the 11 nursing homes participating in the telemedicine demonstration project were included in this study; the exception was excluded because it had only one telemedicine patient. Three of the homes provided both level II and level III care, the remainder only level III. Two of the level II homes were physically adjacent and had the same owner, administrator, and director of nursing, so these two were treated as one. The size of the nursing homes ranged from 44 beds to 175 beds, with the number of telemedicine patients varying from 9 to 119. Three of the homes participated in the pilot project beginning June 1972; the remaining homes joined the program during late summer and early fall of 1973. Descriptive data on each home are listed below:

- Nursing Home A: 110 level II and level III beds; 44 telemedicine patients (40 percent); joined program June 1972 (pilot).
- Nursing Home B: 112 levels II and III beds; 28 telemedicine patients (25 percent); joined program September 1973.
- Nursing Home C: 120 level II and level III beds; 18 telemedicine patients (15 percent); joined program September 1973.
- Nursing Home D-E: 170 level III beds; 119 telemedicine patients (67 percent); joined program June 1972 (pilot).
- Nursing Home F: 67 level III beds; 38 telemedicine patients (55 percent); joined program October 1973.
- Nursing Home G: 76 level III beds; 17 telemedicine patients (22 percent); joined program September 1973.
- Nursing Home H: 150 level III beds; 31 telemedicine patients (20 percent); joined program August 1973.
- Nursing Home I: 44 level III beds; 9 telemedicine patients (20 percent); joined program September 1973.
- Nursing Home J: 94 level III beds; 17 telemedicine patients (18 percent); joined program October 1973.

Dr. Roger Mark, director of the nursing home telemedicine project, sent an introductory letter to the administrator of each home explaining the purpose of the survey and requesting cooperation. The Levinson Policy Institute interviewer then telephoned the administrator to arrange to conduct in-person interviews in the nursing home with appropriate staff. The interviewer attempted to see one staff member from each category of personnel retained by the home.

In each nursing home, interviews were conducted with the administrator, the director of nursing, one RN, one LPN, and one aide, if available. If additional staff, such as occupational or physical therapists or social workers were employed by the home, they were interviewed as well. It was hoped that night staff might be included, but this turned out to be impossible.

Interviews with the floor staff (RN's, LPN's, and aides) were arranged by the administrator or the director of nursing. The selection of staff to be interviewed seemed to be based on who was available at the moment, and it is not likely that any bias in response resulted from this selection of respondents. The initial reaction of administrators to the interviewer ranged from complete cooperation to a rather guarded caution. However, once face-to-face contact was made, no one refused to be interviewed and, with one exception (an administrator denied access to an aide), no one refused to have any staff member inter-

viewed. In general, interviews were conducted in private, but in a few instances no separate room was available and others were present. No one appeared uncomfortable about responding under these circumstances. The anonymity of the individuals and of the nursing homes was assured.

The interviews were conducted from the latter part of March through the first week of May 1975. Individual sessions with administrators and directors of nursing lasted from 25 to 45 minutes each; interviews with other staff, about 20 minutes each. A total of 50 nursing home personnel were interviewed, with the breakdown as follows: 9 administrators, 9 directors of nursing, 1 director of health services for a chain, including 3 nursing homes in this study, 5 RN's, 9 LPN's, 7 aides, 3 physical therapists, 1 occupational therapist, 4 social workers, 1 activities director, and 1 recreation director.

In some instances, the same person filled more than one slot; i.e., the director of nursing was also the administrator or the home RN or LPN; in one the administrator was also the owner. In the former case, the individual was classified only as the director of nursing; in the latter as the administrator.

(The interviewer also contacted 10 private physicians affiliated with the participating nursing homes to ask their assessment of the telemedicine program in two respects: its impact on their own practice and on the quality of care provided to patients. These interviews were conducted by telephone without use of a questionnaire and lasted approximately 5 minutes each. Names of physicians interviewed were provided by the nursing home administrators. Summaries of these interviews will be presented in the final report of the study.)

## PRELIMINARY ANALYSIS OF RESULTS

### PERCEPTIONS OF THE PURPOSES AND ACHIEVEMENTS OF THE NURSING HOME TELEMEDICINE PROJECT

The first questions asked of the administrative staffs of the nursing homes were: "As you understand them, what are the purposes of the telemedicine program?" and "Some of the purposes the program hoped to achieve were . . . (list read). Do you feel these were achieved?" No prompting was given for the first question, but for the second, the interviewer listed all the original objectives of the program, and respondents judged whether these had been achieved or not. There were 18 respondents to these questions: 17 administrators of the 9 nursing homes, and one administrator of a chain to which some of the homes belonged. Not all respondents answered every part of every question, so the number of responses to each question is not consistent.

Table 1 shows the number of times each objective was mentioned as a purpose of the telemedicine program.

TABLE I

Question: As you understand them, what are the purposes of the telemedicine program?

Purpose	Times mentioned
To improve quality of care.....	12
To economize, primarily on patient transportation to hospital.....	7
To improve continuity of care.....	5
To relieve burden on physicians.....	5
To reduce hospital visits.....	5
To facilitate return of patient to community.....	2
To individualize program of care.....	1

Telemedicine's own objectives had included the reduction of hospital visits under the heading of economy, but it was mentioned as a separate objective by several administrators. In their comments, they indicated that the reduction in hospital visits was an aspect of better patient care in that it avoided a disruptive and frightening experience for the patient. It also represented a reduced burden on the nursing home staff who would normally have to arrange the hospital visits. The objective of improved quality of care signified different specific things to different respondents. For many, such items as continuity and individualized care appeared to be understood as part of quality, and so were not mentioned as a separate objective.

The responses made it clear that the telemedicine program was seen as an effort to affect patient care and, less importantly, the work load of the physician. Objectives relating to the administration of the nursing home, such as in-service education and improved relations between the home and Boston City Hospital, were not mentioned at all.

When asked to judge whether the program had achieved its objectives, respondents did not evaluate all objectives in spite of prompting from the interviewer. A "no answer" seemed to be an indication that the respondent felt the objective was irrelevant to his particular nursing home, or that its relevance was not understood. For example, many respondents felt that their patients had no potential for returning to the community, so the objective had no meaning for them. In the case of the relationship with the hospital, respondents who did not answer indicated that the collaboration was independent of the telemedicine program and not subject to any impact from it.

Table 2 shows the number of respondents who felt each objective had or had not been achieved.

TABLE 2

Question. Some of the purposes the program hoped to achieve were (list recited); how well do you feel these were achieved?

Objective	Very well/well	Not so well/poorly	No answer
Quality of care.....	12	2	4
Continuity of care.....	12	1	5
Individualized care.....	12	1	5
In-service education.....	11	5	2
Economy.....	10	4	4
Improved relations with BCH.....	7	3	8
Return to community.....	6	1	11

In every case, the majority of respondents felt that the objectives had been achieved; for patient care objectives, the favorable estimation was almost unanimous. The objectives which were most frequently judged not to have been achieved were in-service education and economy. Other accomplishments of the program which were spontaneously mentioned were: (1) The expanded scope of patient problems which were handled, including psychological and emotional issues; (2) the improvement in information received from the hospital about the patient; and (3) improvement of the performance of private physicians in the home due to the presence of the telemedicine program, which "kept them on their toes."

Specific objectives of the program are discussed in greater depth and detail below. However, a few comments will help to clarify the responses presented in table 2. Regarding quality of care, one negative evaluation was based on a feeling that nurse practitioners (NP's) waited too long to admit sick patients to the hospital and that they took too much medical responsibility. Respondents from two homes specified that the improvement in continuity of care was provided by the NP's, not by the physician. The other negative evaluation of the program's impact on patient quality of care was confined to "healthy" patients; the respondent indicated that care of the more seriously ill had improved.

In the discussion of in-service education, administrators in three homes mentioned that such programs were offered at Boston City Hospital. In two homes this was seen as a problem; the third home found it helpful. Several respondents explained that telemedicine did not offer formal in-service programs, but discussed issues informally and held conferences on individual patients.

On the subject of economy, respondents from two homes explained that the program did not affect the nursing home, but that it saved welfare and medical expense. Several respondents said that telemedicine helped to avoid unnecessary hospitalization. One explained that private physicians are not reimbursed for visits to the home in excess of the minimum, but they are reimbursed for hospital visits, so there is an incentive to hospitalize which is not present in the TM program. In one home, the reduction in hospitalizations was seen as a disadvantage, because NP's were providing the care rather than physicians.

Facilitation of the patient's return to the community was seen by several respondents as a major advantage of the program. In one home, telemedicine was responsible for the first patients ever to return to the community. In another home, increased return to the community was considered "the best thing about the program." Administrators in five homes mentioned approvingly that the program follows patients into their own homes and will arrange for a visiting nurse or homemaker or for the smooth integration of the patient into the family setting.

#### INTEGRATION OF THE PROGRAM INTO NURSING HOME ORGANIZATIONS

Nursing home administrators and nursing directors were asked several questions designed to explore administrative difficulties which might have arisen as a result of incorporating the telemedicine program. These questions were as follows: (a) Were there conflicts at the beginning?; (b) The telemedicine program has its own procedures, personnel, lines of authority, and allocation of responsibility. How have



these fit in with your own?; and (c) Are there any problems or difficulties at present?

While the specific questions are distinct, the comments in response to each applied to the whole area of administrative conflict and cooperation throughout the program. Table 3 shows the responses to the question about the nursing home. There were 19 respondents: nine administrators, one chain administrator, and nine nursing directors. In this table the number of responses is consistent because if no problems were mentioned for a particular area, a response of "none" was coded. The same five respondents answered "don't know" in all categories, because they were not present at the start of the program. There were four homes which reported no initial conflicts in any of the categories. The homes which reported "many" conflicts were not the same for each problem area. The majority of respondents felt that there had been no difficulties in initiating the program. The area in which the most problems arose was that of personality conflict, although the comments made it appear that most of these conflicts were due to poorly understood definition of job responsibilities.

TABLE 3

*Question.* Were there conflicts at the beginning?

	Many	Some	None	Don't know
Procedures.....	2	1	11	5
Line of authority.....	2	0	12	5
Job responsibility.....	2	0	12	5
Personality.....	2	3	8	5

One administrator described the floor staff as feeling threatened at first by the presence of the NP's. In another home, staff had felt themselves "under surveillance" because of the program. Both homes reported that this problem had been resolved. Other personality problems reportedly stemmed from floor staff resentment that NP's gave orders to the nursing home staff, made medical decisions about patients (particularly about hospitalization) which the staff had been accustomed to making, and that they "acted too much like doctors." Administrators averred that these problems had been resolved by means of discussion and confrontation, although floor staff responses to other questions (discussed below) showed that in a few cases, resentment lingered. In only one case a personnel conflict was identified specifically as the product of the NP's personality: She was described as aggressive, condescending, and unwilling to cooperate with or listen to advice or information offered by nursing home staff.

Procedural problems were primarily concerned with paperwork: use of different forms for recording and reporting information. In two homes, the NP's met with the administrators at the start of the program and reached an agreement on procedures before problems had a chance to develop. Two other homes reported that the paperwork was done differently by TM, but that this did not create any difficulties. Two homes specifically cited the problem of having NP's sign

records where physicians would normally sign. As will be clear from subsequent results, this issue was a continuing problem.

One other procedural problem mentioned was that of assigning patients to the program. Initially, nursing homes had been requested by BCH to transfer a bloc of patients from their present physicians to the TM program. In one home which did this, there were problems of resistance and resentment from community physicians, and clearly the administrators themselves resented being placed in this position. Two other homes refused to transfer patients en masse, but assigned new patients to the program as they were admitted. In these homes there was better acceptance by private physicians and one home reported that physicians occasionally requested transfer to TM for patients requiring close supervision.

The response to the general question of how telemedicine fit in with the administration of the nursing home are presented in table 4.

TABLE 4

*Question.* The telemedicine program has its own procedures, personnel, lines of authority and allocation of responsibility. How have these fit in with your own?

	Very well	Well	Not so well	Poorly
Procedures.....	8	6	2	3
Authority.....	7	6	5	1
Job responsibility.....	7	7	3	2
Personnel.....	7	7	5	0

When a respondent did not explicitly select one of the classifications listed, the interviewer decided on the appropriate category based on the content of the respondent's comments. There were 19 respondents. The majority of respondents felt that the program had fit in well or very well in every area. The problems which were identified were approximately evenly distributed among the categories.

Once again, the procedural problems identified had to do with paperwork requirements. Three homes adjusted their own recording format to conform to that of the NP's, and in one case the NP's were given an entirely separate set of records for their patients in order to avoid problems of inconsistency. In three other homes, administrators reported that NP's know the State recording regulations and abide by them.

However, two homes mentioned the specific problem of having NP's sign orders and other records which are required to be signed by a physician. Another procedural problem which arose was that nursing home staff is accustomed to calling the patient's physician in case of an emergency, while in the TM program, it is the NP who must be called. One home reported some staff resentment at being cut off from the doctor, but added that there is no problem reaching the NP's in such situations. In another home, some resentment was reported about the requirement of notifying the TM physician before a patient is admitted to the hospital, which created an additional task for nursing home staff.

The personality and job role problems mentioned in answer to this question were similar to those discussed above: negative feelings about the unorthodox role of the NP, and resentment of one particular NP who "came on too strong."

The question "Are there any problems or difficulties at present?" was asked in order to determine which issues had been resolved and which had continued. Table 5 shows how many people felt each area was or was not still causing problems in the nursing home. There are 18 respondents, since one of the administrators interviewed was retired and could not speak about the present situation.

TABLE 5

*Question.* Are there any problems or difficulties at present?

Problem area	Yes	No
Procedures.....	5	13
Authority.....	2	16
Job responsibility.....	2	16
Personality.....	5	13

The majority of respondents felt that the program was operating without difficulties in their homes. The personality and job role problems which were mentioned were the same as those discussed above. One administrator who said the conflict was ongoing added that the conflict was healthy, the result of a two-way relationship in which both sides were able to compromise. Another administrator felt that the telemedicine personnel may demand a higher level of care than the nursing home is able to give, because of financial and staff constraints. However, one respondent from a third home said she resented the NP's attitude "that they were out to save our patients from the terrible care they were getting." This situation created an ongoing individual personality conflict between one NP and the respondent.

One ongoing procedural problem was the failure of the telemedicine physician to sign patient records. In five homes it was considered a problem, and others mentioned it as a potential problem, if the State should become more rigid. Respondents from two homes mentioned the TM physician's failure to make routine visits, and in one home the failure of the NP's to append laboratory reports to patient records was cited as a difficulty.

The administrative staff were asked, "Have there been any points of contact where the telemedicine program has been helpful to the regular operation of the nursing home?" The question was intended to focus on administrative areas, but answers covered a wide range of issues, many of which related to patient care. Only two respondents felt there had been no helpful contact with the program, and one of these was not directly involved in the operation of a nursing home.

Among the others interviewed, the improvements mentioned most frequently were the thoroughness of the patient's evaluation (physical examination), and the reliability of emergency coverage by the NP's (six respondents). Four respondents cited the increased frequency of

visits to the home under the TM program with consequent closer monitoring of the patients. Three people mentioned the higher level of concern for patients shown by the NP's as compared with private physicians, and the fact that they deal with the patient's social and emotional as well as physical difficulties. One administrator said that the high level of psychological support for patients and their families was a problem, since families then demand too much from the nursing home.

In terms of benefits to the nursing home itself, three respondents mentioned education and two others mentioned help to the staff by the NP's. One respondent said that the NP's "upgrade the whole staff, down to the aides," and another mentioned that the good example of the NP's had raised the level of performance of the private physicians associated with the home.

Staff of two homes felt that the program had improved the reputation and image of the home and had "helped get over the stigma of being a nursing home." Responses to this question indicated that even some of those who did not favor the program recognized some of the advantages which it offered.

The survey questions just discussed prompted a variety of comments ranging over the entire area of interaction between nursing home and the telemedicine program. However, certain questions in the survey focused on specific administrative and operational points of concern. These will be dealt with in the following sections.

#### ADMINISTRATIVE ISSUES

It was anticipated that certain administrative issues would have a significant bearing on whether or not the TM program was accepted by the nursing homes. These were the cost of the program to the home, the effect on staff turnover and recruitment, and the official reaction of the Department of Public Health, which licenses the homes. Specific questions were asked covering these three items.

#### COST

The cost issue appeared to have very little effect on the administrators' attitude toward the program. Table 6 shows the breakdown of answers among the 19 administrators to the question addressing the impact of cost.

TABLE 6

<i>Question.</i> Has the telemedicine program affected your own operating costs?	
<i>Costs:</i>	<i>Respondents</i>
Higher -----	3
Same -----	11
Lower -----	5
Don't know -----	0

Most respondents saw no change in their operating costs as a result of telemedicine. Of the three who said costs were raised, one indicated that the change was slight, resulting from the purchase of IV solution and tube feedings. No one said costs to the nursing home were lowered by the program.

## STAFF TURNOVER AND RECRUITMENT

Staff turnover and recruitment also did not appear to be affected by the program. Table 7 shows that most of the 19 administrators saw no difference in staff turnover or ease of recruitment.

TABLE 7

*Question.* Has the telemedicine program had any effect on turnover of your staff?

Has the telemedicine program had any effect on recruitment?

Turnover :	<i>Respondents</i>
Higher -----	1
Same -----	17
Lower -----	0
Recruitment :	
Harder -----	0
Same -----	15
Easier -----	2

In the one home which had a higher turnover of staff, a situation had developed which precipitated a series of resignations as a result of a misunderstanding of the legal implications of the program. No administrator said that turnover of staff had been reduced by the program, but two staff members in one home stated in response to another question that they would not have continued to work there if the telemedicine program were not there. In response to the question about staff recruitment, two people said it might be a little easier, but there was no strongly identifiable effect.

## MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

The role of the Department of Public Health was mentioned frequently by all the administrative staff members. When asked whether they had had any problems with the department, the administrators of five homes and the administrator of the chain mentioned that they had been cited for deficiencies because of the telemedicine physician's failure to sign orders and records, or because the signature of the nurse practitioner appeared in place of the doctor's signature. In the other four homes, administrators stated that they had had no problems yet, but they expected them, since they knew that regulations were being violated. Some reported that the DPH inspector had apologized verbally for citing the home, in view of the nature of the new program, but the written deficiencies were still sent. Several administrators gave as their reason for not approving the program, the problems in conforming to the DPH regulations.

Most respondents recognized the need to redefine the regulations in order that a program such as telemedicine could work. In two homes, the administrative staff accepted the regulations as they are at present and felt that the TM program must conform to them. The problem was taken very seriously by some respondents and was treated more lightly by others, but everyone emphasized it as a problem which would have to be solved for TM to be accepted on more than an experimental scale.

## OPERATIONAL ISSUES

The telemedicine program was expected to have some impact on the operation of the nursing home which would affect the program's final

acceptance or rejection by the home. The areas in which significant changes were expected to take place were: (1) Acceptance of the role of the nurse practitioner as a new kind of health professional; (2) collaboration with and access to resources from Boston City Hospital; (3) education and the flow of information among the staff; and (4) staff's perception of the program's impact on their work.

#### ROLE OF THE NURSE PRACTITIONER

As is evident from the results discussed under "Integration of the Program" above, a poor understanding of the NP's role contributed to conflicts and problems in initiating the telemedicine program. In order to determine how the NP's are viewed in the homes, the staffs were asked, "What do you see as the role of the nurse practitioner in the home: does she function more as a nurse, a physician's assistant, a substitute for the physician, or something else?"

Of 46 people responding to the question, 20 said she was a physician's assistant, 19 said she was a substitute, five said she was a nurse, and two said she was in a separate category. Of those who said the NP was an assistant, all felt this was an appropriate role. Three respondents specifically stated that the NP does not and should not do the job of a physician, and one person mentioned that there had been no difficulty in reaching the doctor when necessary. Of the 19 who answered "substitute," 15 felt this role was appropriate, and four felt that it was wrong. Among the 15, several mentioned that the NP did call the doctor when he was needed and "knew when to ask for help." The four who disapproved objected to "nurses making medical judgments," and to the fact that patients saw the NP instead of a doctor. Of those who saw the NP as a nurse, one expressed disappointment that the NP was not a physician's assistant, but did not explain the basis for this judgment.

There was no consistent trend either by staff level or by nursing home to view the NP in a particular way. Each person had an individual perception of the nurse practitioner's role. A higher percentage of the floor staff expressed positive feelings about the NP in whatever role was assigned than that of the administrative staff. The trend among the responses was strongly positive, however, with respondents mentioning that NP's visit more often, spend more time, come more quickly in emergencies, and show more concern for patients than a private doctor. One aide stated, "I don't know what to call them, but they do more than their share."

#### COMMUNICATION WITH BOSTON CITY HOSPITAL

A number of questions dealt with the relationship between the nursing home and Boston City Hospital. Respondents were asked whether the TM program had affected their feelings of collaboration or cooperation with the hospital, their access to the hospital as a source of help, or the transfer of patients to and from the hospital. Of the nine homes, staff in seven reported improvement in one or more of these areas as a result of the program. Six people reported improved relations between the nursing home and the hospital. Two attributed this to having a liaison or knowing the individual to call, and two referred to the fact that the hospital knows the home better and has greater

respect for its capabilities. In terms of access to resources, eight people said that access to specialists and consultants was improved because of the contacts of the TM staff, and one person mentioned improved access to information at the hospital about patients.

Regarding transfer of patients, seven respondents said that transfers were easier and went more smoothly under telemedicine. Six responses referred to the fact that NP's make the arrangements for hospital transfer, reducing the burden on nursing home staff. Six more cited the advantages of continued care from nursing home to hospital and back, including the fact that patients can return sooner to the home because of the level of care available. Four respondents referred to the fact that if a patient is sent to the hospital under telemedicine, he can be certain of admission. In one home there was a negative impact on relations with the hospital. Two staff members in one home stated that when TM patients were admitted to the hospital, it was hard to get them sent back to the home, because of the attitude of the NP.

#### INFORMATION AVAILABILITY AND EXCHANGE

Improved information exchange appeared to be one of the major benefits of the TM program. The staff was asked whether the information available on patients through TM was better, the same, or worse than that on other patients (a) prior to nursing home admission; (b) from the initial workup; and (c) throughout the patient's stay in the home. Another question was whether telemedicine increased the exchange of information on patients in informal conversation and in formal conferences.

The responses to the first question are tallied in table 8. Those who answered were evenly divided about whether there was an improvement or no change in information available from the hospital. On the initial workup, however, the overwhelming majority of respondents (32 out of 35) said that the information obtained was superior. Nineteen respondents stated that the workup was more thorough; five others specified that it dealt with psychological as well as physical problems; two reported that medical problems were identified in the workup which had been missed at the hospital; and two stated that the workup was clear, specific, and understandable. One respondent objected that the workup was performed by a nurse rather than a doctor.

TABLE 8

Source of information	Better	Same	Worse
Hospital.....	10	8	0
Initial workup.....	32	2	1
Patient stay.....	23	1	0

The information from followup visits during the patient's stay in the nursing home was also felt to be superior by the majority of respondents. Thirteen people mentioned the frequency of visits as the reason for this; two cited the longer time spent with the patient; four referred to the broader scope of problems dealt with; and two commented on the clarity of the reports.

There was less agreement on the extent to which information exchange had been affected by the program. Nine respondents felt that more information was available on telemedicine patients, and no respondent said that there was less. But eight said that there was more informal exchange as a result of the program, while five said there was no difference. Seven reported more formal meetings, while six reported no change.

There was general agreement that the NP's were willing to explain specific patient problems and answer questions. Eighteen people spontaneously mentioned this as an advantage of the program, while one person said that the NP's would not discuss things with her. This aide said that the NP's talked to the nurses but not to staff at her level. In six other homes the aides specifically mentioned that they felt freer to ask questions of the NP's than of private physicians. In eight of the nine homes, the LPN's also stated that the NP's were always willing to explain things, while in one home the LPN complained that orders on TM patients were not fully explained. All the social workers interviewed felt that more information was available on telemedicine patients and that this was helpful in planning for the patient. Seven respondents said they had found the increased information helpful in their jobs, and seven said they had learned from the NP's.

#### IMPACT ON NURSING HOME STAFF WORKLOAD

Finally, the question was asked whether the telemedicine program made any difference in the tasks performed by the regular nursing home staff or made their work easier or harder overall.

In terms of tasks performed, the majority of respondents said the program made no difference in the variety, frequency, or difficulty of their tasks. Of course many of the floor staff operate independently of the NP's: Social workers and various kinds of therapists are usually autonomous within the home. Table 9 shows the tally of responses to this question. Among those who found greater variety in the orders, one cited the use of IV's as an example. One explained that the NP will order treatment which the floor staff requests, and more than one said they had learned new tasks from the NP. Of the nine who said that frequency of tasks had increased, only two felt this was a disadvantage. The others indicated that it was no problem and improved the care of the patient. Of the three who felt their tasks had been reduced in frequency, two explained that the NP's keep their own records and write their own orders, in contrast to private physicians, and one said that the NP's do their own medical tasks and do not interrupt other staff while they are working.

TABLE 9

*Question.* Has the telemedicine program made a difference in your work with regard to the kinds of tasks you perform in terms of variety, frequency, difficulty?

Tasks	Increased	Decreased	No change
Variety-----	5	0	17
Frequency-----	9	3	12
Difficulty-----	3	0	18



Table 10 shows the breakdown of answers to the question of whether the work of the regular nursing home staff was made easier or harder by the presence of the telemedicine program.

TABLE 10

(Adm.) "Do you feel the TM program has had an effect on the work to be done by the regular nursing home staff—that is, did the TM program help or hinder the work of the staff?"

(Floor) "Overall, is your job easier or harder with the TM program in the home?"

(Staff) :

Respondents :

Help/easier -----	25
Same -----	11
Hinder/harder -----	10

The comments of the staff showed that they did not use the term "easier" to mean having less to do, but rather to mean that it was easier to perform their jobs well. Of the 25 who answered this way, eleven stated that having more information enabled them to do their jobs better; ten cited the security of knowing that medical assistance was readily available. Others mentioned that, in contrast to the home's private physicians, the NP's did their own paperwork and their own medical care tasks, freeing the floor staff for their nursing tasks, and that their orders were clear and complete.

Perhaps even more interesting is the fact that of the ten respondents who felt that telemedicine had increased their workload, six felt that this was a good thing, because standards of care were raised and more real nursing care was provided. One respondent stated, "It (the program) makes you feel more like you are nursing," and another said, "There is more work, but this is what the job ought to consist of." Four respondents did object to what they saw as an increased workload due to the telemedicine program.

#### OPINIONS ON QUALITY OF PATIENT CARE

Nursing home staff were asked for their perception of whether the program had influenced the care of the patients and their satisfaction with it. It was felt that impact on patient care would be a significant factor in whether or not the program was accepted, and this expectation was confirmed in the following question about the reasons for wanting or not wanting the program to continue in the nursing home. The question was asked whether there was any difference in the kind of care the TM patient receives, in terms of appropriate medication, monitoring of medications, and of patient progress, and access to primary care. Other aspects of care mentioned in the question (access to laboratory facilities and other equipment, for example) did not appear to be relevant and received little response. Regarding the appropriateness of medications, most respondents said there was no difference with TM patients; only three said medications were more appropriate, while 11 said they were the same. The question on monitoring received the strongest response. Thirty respondents of the 45 who answered the question said that monitoring of the patient and his medications was improved under telemedicine. In contrast, eight respondents said there was no difference in monitoring, and two stated

that it was worse. Those who said it was better cited frequency of visits as the major reason. Of the two who said monitoring was not as good, one felt closer monitoring was needed because NP's changed their medication orders more frequently than private doctors, and the other explained that NP's gave less attention to disoriented patients than to those who were aware.

Administrative and floor staff were asked whether there was any difference in the treatment plans of TM patients in terms of the actual orders given and nursing tasks performed. Among the administrators, seven felt there was a difference, eight felt there was no difference, and three did not know. Most of those who saw a difference cited greater thoroughness, accuracy, and frequency of checking. One said the difference was only among sicker patients who needed more intensive treatment. One respondent felt the change had been detrimental to patients because frequent alteration in orders was disruptive.

Among the floor staff, 22 felt there was a difference in the orders given on TM patients, while seven felt there had been no change. Of those who saw a difference, two felt orders were less complete and harder to follow because the NP's wrote their own orders, whereas private physicians allowed the nursing staff to fill in what they thought was needed. Twenty felt that the change in orders was an improvement, citing the fact that they were up to date (eight respondents), and more complete and detailed (five respondents), and that the NP's were available to discuss them and to answer questions (six respondents).

Another question explored in the study was whether the program had altered the patients' level of satisfaction with their own care. Table 11 shows the breakdown of the staff's answers to this question.

TABLE 11

*Question.* Has the telemedicine program made any difference in the patient's satisfaction with his health care and with the nursing home in general, compared to non-TM patients?

Respondents :	
Increased -----	27
Decreased -----	5
No difference -----	14

The majority of respondents said that patients felt more satisfied with telemedicine care. The reason cited most frequently (16 respondents) was the greater degree of personal attention and concern which the TM staff evinced toward the patient. Other reasons given were (1) patients' confidence that their problems would be attended to; (2) frequency of visits; and (3) attention to psychological and emotional aspects of the patient. Of those who said the patients were less happy with telemedicine, two respondents said they were not sure but felt that patients might want to see a physician rather than a nurse. The other three also cited this reason, one adding that patients are accustomed to being examined by a male. Those five respondents came from two nursing homes.

The respondents who said there was no difference in patient satisfaction gave as their reasons that the patients were too senile or disoriented to be aware of any differences, or that the patients had no basis of comparison because they had only experienced TM care.

ACCEPTANCE OF THE TELEMEDICINE PROGRAM BY NURSING HOME  
PERSONNEL

As a measure of overall approval or disapproval of the telemedicine program, the final question of every interview asked whether or not the respondent preferred to have the program in the nursing home. Administrative personnel were asked, "Taking an overall view, would you prefer a mix of telemedicine patients with regular patients, an all-telemedicine patient population, or no telemedicine program at all in your home?" The comparable question to floor staff was, "Overall, would you rather have the telemedicine program in the home or not?"

There were 50 respondents to the question: the 19 administrators, and 31 floor staff including RN's, LPN's, aides, social workers, and recreational, occupational, and physical therapists. Table 12 shows the responses to the question.

TABLE 12

Response :	<i>Number of Respondents</i>
Have TM program in home-----	40
Not have program-----	5
Undecided-----	5

The overwhelming majority of respondents stated they would prefer to have the telemedicine program operating in their homes. The reasons mentioned most frequently for wanting the program were (1) improved medical care of patients (6 homes); (2) frequency and length of visits by the NP's (5 homes); and (3) accessibility of TM staff when needed to deal with specific problems or patients (5 homes). Other benefits of the program mentioned by more than one home were the thoroughness of medical coverage, the fact that TM handles the whole patient, not just his physical problems, and that it deals with families. Respondents from three homes cited improvements in staff morale because of increase of information and the security of having reliable medical backup. In two homes respondents specifically mentioned the willingness of the TM staff to listen to the advice and opinions of the floor nurses and aides. Several people specifically praised the personal qualities of dedication, competence, and cooperativeness of the NP's and the TM physical examination. In one home, a personality conflict arose involving one NP, but the personnel of the home still favored the program.

Respondents from four homes who favored the program cited as a problem the need for clarification of DPH regulations regarding the role of the nurse practitioner. In two of the five homes where administrators said they "didn't know" whether they would want the program, the resolution of problems in conforming with State regulations was cited as the critical factor in their decision, and of the five respondents who did favor the program, two mentioned these problems as the major reason.

Of the five respondents who did not favor the program, three were from a single home, one from another, and the fifth was an administrator in a nursing home chain. In one home, the three upper level staff did not like the program (administrator, nursing director, and RN), citing problems with State regulations and with acceptance by the staff and the patient. They stated that the program did not respond to emergencies and did not allow floor staff to exercise their own judg-

ment. In the same home, the aide and the LPN gave as their reasons for favoring telemedicine the better quality of medical care, frequency of visits by the NP's, their accessibility by phone when needed, and the fact that they take time to deal with the patient as a person and to listen to the opinions of the nursing home staff. In another home, the reason for not wanting the program was that it did not deliver continuity of care because patients were not seen by the TM physician when they were readmitted to Boston City Hospital.

Five respondents who favored the program said they would prefer a mix of telemedicine and private patients rather than a 100 percent telemedicine population. Two respondents explained that patients must be allowed free choice of physician and could not be obligated to accept TM. Two others said they would choose all telemedicine except that it would jeopardize their relationship with community physicians, and one administrator felt that if all his patients were on TM, it would give the program too much leverage over the nursing home.

### SUMMARY OF FINDINGS

The study was intended to determine how the telemedicine program was accepted by the nursing homes and what the impact of the program was on the administration, operation, and care of patients in the homes.

Of the 50 administrative and floor staff interviewed, 40 said they would prefer to have the program in their homes, five preferred not to have it, and five were undecided.

According to administrative staff, the most important objectives of the program were improved quality of patient care and reduced costs to the health care system through reduction in transfers to the hospital.

Twelve of the 14 administrators answering felt quality of care had been improved, while two felt it had not. Ten felt the objective of economy had been achieved, while four disagreed.

The majority of the administrative staff said there had been no problems or difficulties in introducing the program, and that it was operating with no conflicts or difficulties at present. The two problems mentioned most frequently by the others were: (1) Personality conflicts between the telemedicine nurse practitioners and the nursing home staff, due primarily to misunderstanding or resentment of this new health professional's role, and (2) lack of compliance with State regulations on tasks which must be performed by a physician, especially prompt signing of patient orders.

Administrators said the major benefits of the program were thorough physical exams of the patients and reliable emergency backup by the NP's. The program had negligible effect on the home's costs, staff turnover, and staff recruitment.

Nursing home staff in seven of the nine homes felt relations with the city hospital had improved in that access to specialists was easier and continuity of care between the nursing home and the hospital was better. The majority of the staff said that information available on patients was better with the program, and that the nurse practitioners were helpful in explaining things. Twenty-five of the 46 respondents said their work was made easier by the program, and ten said it was harder. But, of these ten, six felt that the increased workload was good

because it improved staff morale and patient care. Thirty of the 45 respondents said that medical monitoring of patients was improved by the program. While eight said it was no different and two said it was worse, the majority (27) of the respondents said that patients were more satisfied with their care under the program, because of the increased attention and concern showed them.

## Appendix 5

### EXCERPTS FROM "THE SOCIAL COMPONENTS OF CARE," AMERICAN ASSOCIATION OF HOMES FOR THE AGING, MAY 1966

## Introduction

WE ARE TO EXPLORE TOGETHER the social components of Homes, not only as a technical subject—for techniques can become mere instruments for the gross manipulation of people—but at their deeper levels as forms of our own self-definition, to try to engage our own emotions in this process, and to stir up, if this is necessary, a new awareness of our own personal meanings. Only at such a level does a subject like this have genuine significance both for us and the people with whom we work.

Let me illustrate, not from case histories, but from the poetic sensibility of our times, since it expresses in far more dramatic and moving form the problems we face when we talk about Homes and their social components.

You have probably experienced on the stage or in book form the dread, the almost unbelievable horror, the pathetic resignation and final peace of Synge's brief, *Riders to the Sea*. With poetic magic, this play symbolizes a reality many of our older people have experienced. An old woman, waiting for evidence that one of her sons has drowned, later receives it, and with dread watches another leave for the sea. When his dripping body is placed on the kitchen table, the last of the eight men in her family, she sprinkles holy water over it and says:

"It isn't that I haven't said prayers in the dark night till you wouldn't know what I'd be saying; but it's a great rest I'll have now, and it's time surely.

It's a great rest I'll have now and great sleeping in the long nights . . ."

Were that old woman to enter our Home with her burden tomorrow—what would we offer her with our social components program? Movies? Transportation to stores? A sheltered workshop? Jollyng? Yet she lives in our Homes, thousands upon thousands of

her, and whatever our Homes mean at their deepest levels—this is what we do offer her as our best. It may be a Catholic faith, a Protestant, a Jewish, a humanistic, but without that meaning our techniques are as tawdry as the tinsel in our dustbin after Christmas.

Ultimately a whole battery of mere techniques will rightly be despised by those who must endure the indignities of the body which insult the aged. Ultimately, something must mean something, or life, lacking the Catholic faith portrayed in *Riders to the Sea*, or some other faith, is a macabre joke.

When we accept responsibility for the management of a Home, what do we mean with our Home and its social components? What inner reality are we trying to communicate with our pleasant lawns, our brick buildings and our programs? How deeply are we engaged with our older people? I think these the most troubling of all questions—and they forcefully assert themselves far more in this than in other functions of our Homes.

We are conferring these days on continuity of care for older people. What we call the social components of Homes is an inescapable part of every institution in the whole spectrum we deal with—from the residential Home to the mental hospital. Whatever our degree of consciousness about it, each of us already has defined these social components for himself. None of us altogether disregards them. It would be most commendable if all of us, based on a conscious and mature outlook, carried on a full and vital program for our older people. We probably fall somewhere between the extremes of totally rejecting these components and of having an ideal program.

As members of the Committee on Approval of Extended Care Facilities<sup>1</sup> we had to identify—and this was the hardest part of our job—those characteristics of residential Homes which make them Homes as distinguished from mere boarding facilities or apartment houses. Perhaps more time was spent on the social components phase of our programs than on any other. We did not come up with the high standards the idealists wanted to write. On the other hand, we do not apologize for the standards which we finally wrote; we had to keep in mind 18,000 for-profit facilities as well as 5,000 voluntary Homes. We could not avoid realities in

<sup>1</sup> A multidisciplinary committee which developed criteria for the now discontinued approved program for extended care facilities of the American Hospital Association.

the field. We sought values; we strove for high fashion in social components; we also knew that too many owners and administrators lacked the cloth and the skills and even the chance to staff Homes with the skilled people necessary to achieve high fashion. Some of our standards, therefore, rest on what is politely known as the ground floor level.

Definitions of social components are hard to come by. The physical Home itself communicates or does not express social components. The cleaning lady mopping a resident's room or a hallway expands on the social components of the Home or shrivels them. The nurse taking a temperature, the maid racking dishes in the kitchen, all vitally help create the meaning of the Home or do not help, and may even destroy it. These remarks touch here only in this passing way on the social component factor in the whole gamut of medical and nursing services as well as the general services of the Home. We will concentrate on those aspects of the Home's program in which social components obviously surface as primary. At best also we can only hope to define, to identify, to describe; and, except in a most general way, we cannot discuss the implementation of what we have defined.

Broadly defined, the social components of Homes for the Aged are their arrangements—either their physical or their program arrangements—which allow and encourage their older people fully to realize themselves both as individuals with personal dignity and as members of the Home's community and of the larger community in which the Home is located.

And may I muster into service, first of all, that most threadbare of clichés in our field: a Home should have a homelike quality. This can be the limpest and greyest of all truisms; it can also be filled with an indescribable warmth of meaning. It all depends on each of us. It depends on our self-definition; it depends on our family-definition. And underneath it lies one of the saddest and most bitter ironies of our times: we are asked by a depersonalized and fragmented society, a society painfully suffering a notorious divorce rate, to make a Home for its older people, a genuine home. Or perhaps we are not asked; we simply claim this as our ideal. But can we be brutally frank about this business? No communal living arrangement can ever really be a home in the true sense. No matter how brightly we wrap the package, it remains a communal living arrangement. Our staffs, if they have and warmly



act on deep insights about old people, may come close to being adequate substitutes for families, but they will never be the same as real family. The communal arrangement may be necessary and hold great values, but it is not a family. Nor should we try to make it one or apologize because it falls short of family realities. If we understand and are honest about that, we have made some real progress.

Sometimes its owners locate a Home as if it were shrugging its shoulders and turning its back to the whole community. Of course, there are enormous real estate difficulties in our urbanized society and a competitive and indifferent community may force Homes out to the urban fringes; yet location, accessibility, adequate parking, and room for outdoor recreation are significant features of Homes, even in our highly mobile society. Long ago John Donne wrote that "No man is an island, entire of itself," and even in this country we need to let down all the drawbridges to the community which we can.

Space itself, moreover, communicates the degree of our social feeling and the respect for personal dignity and privacy for which our Homes stand. If you have had a rural experience, you have probably seen, as I have, a hermit in a hovel so small he could almost wrap it around himself like a blanket. The walls of such a shack speak with their own anti-social accent. Homes need generous space for many personal and social reasons. Space which says: be yourself in privacy of your room, find there or elsewhere nooks for you and your family to experience the golds and blacks of family life; space which invites a sharing a meal with them; space which suggests loafing or games or songs for a few together or for many; space which is lighted by the special sacredness of the holy candle of worship. Space, at twenty dollars a square foot or whatever, is the *sine qua non* of social components.

And there is one other cliché generalization which we need carefully to finger: that our Homes have a minimum of rules and discipline and open their windows to let the wonderful free air of the hills sweep through their halls, their staffs, their family of older people. I know we try, and perhaps all our regulations can be printed on a small sheet of paper. Yet a power structure exists and must exist in our Homes, and for this reason a thoughtless frown can sometimes be as damaging as a regulation. And a deviation from routines may create an anxiety crisis in us.

In our own Home we have often talked about Job, sitting in sackcloth and ashes, children and property gone in a major calamity, his body an ugly mess. Could we stand keeping our hands off him in the 20th century? In suffering he was experiencing his identity, his freedom, his total dignity as a man, and an enormous growth crisis. If he sat in one of our corridors, we would nervously cluck and flutter over him and distractedly try to decide which of our battery of services we should first rush to his help. Of course, our values are different than his, or those of his culture. Of course, it would be the worst kind of negligence not to antibiotic him, soothe him, perhaps even psychologize him. Rules and regulations? We may have five down on paper, but they are supported by 500 and more and by the enormous power structure of our society. But would we understand that the flame of suffering which seared him was really also the flame of the freedom which has been movingly identified by geniuses like Sartre and Dostoievsky as the very core of man? I am asking only this: let us rigorously examine and reexamine ourselves and our Homes to determine what degree of freedom and individuation they really reflect and what meaning we and our Homes really have.

We can identify another cluster of values as those centering around the person of our resident as a person. Does he have available to him all the ordinary decencies of life accessible outside the Home's walls? Is his room a stripped cell or does it, through his personal possessions, reflect at least the essentials of his meaning, at least a few symbols of what he once was and what his closest people still mean to him? The furniture of life is such a strange business at best: the picture which leaves us cold but which he can invest with a special glow, the worthless ribbons which symbolize some passion. What do we do about that property of his which has objective values—will we put his monies, his jewelry or whatever, in safekeeping? What will we do about his appearance? May he launder? May he tailor, should he want to? Where can he get a haircut? Does she have a beauty shop available? What about his clothing? How far do we go in keeping him dressed according to today's norms? If he is financially pinched, have we clothing for him? Will we shop with him, on his behalf? What about his small personal needs? What about his communications with the world outside? His mail? His telephone? All these questions he once answered for himself, when he walked our streets as a competent

man. Now he may lack some measure of competency, and we believe that every Home should offer satisfactory answers to these questions.

You have probably seen modern sculptures in which the body of a man is not solid but suffers gaping holes. Man today is, as Adamov indicates, an invaded man—invaded either by the bloody forces of war or by the relentless pressures of our social system boring into him. This the applicant to a Home feels, in most instances, quite strongly. The transition at admission, from private to communal living, may be highly traumatic. Mutual responsibilities must be clearly defined, preferably in writing, and a whole emotional complex, ranging from the anxieties of the older person to the guilt feelings of his family, may have to be worked through. At this crisis far more than meets the eye may be at stake—with the Home defining itself, its humanistic or religious stance, its understanding of the nature of man, its role as more than a social institution. Is encouragement to enter a Home a form of parricide for some children, as the poetic sensibility of the age has more than broadly hinted? Does the Home see itself merely a business proposition providing the externals of life? In what posture of social feeling does the Home find itself at the admission crisis? Perhaps some issues at this point reach such emotional depths that at times we prefer to avert our faces. At any rate, our standards try to measure the measurable, the records kept, the person assigned to admissions. What these mean, beyond superficial mechanics, depends finally on us.

Are you familiar with Singer's story, both grim and delightful, of the aged Jew who was, I think, a hundred years old and who endured for a while the terrible Warsaw ghetto under the Nazis, successfully fled to his childhood village, where he married and found his people showering him with warmth and a security of wealth out of respect for his old age? This touching story embodies a far-reaching insight into the dignity and humanity of an older person. His community believed that it should bestow upon such an old man even more than the ordinary securities of life. While the standards stay coolly aloof from this insight, AAHA's committee on social components embraced it and stated that—recognizing the varying stances of particular Homes—need, and not ability to pay, should block out the kinds of care he receives. We published our concerns about an older person's monies as a tangible form of

his inner meaning. We would grant him the dignity of a clear contract with a Home, preferably in writing. We would move most cautiously into trustee or guardianship commitments, and then only with an unbreachable respect for his person and integrity. While many conflicting feelings may play and dance around a sheltered workshop, we would recognize its great values for those who strongly define their identity by their power to command even a small paycheck. Our culture, its pockets so fat with its gross national product, can afford economic respect for older people.

King Lear's mad gesture led to the wild and stormy night on the heath and ended with five of the most appalling words ever wrenched from history's tear-stained face. As this old man holds the dead body of his daughter, he knows that life will come no more to her: "Never, never, never, never, never," He has dredged and scraped the ragged bottom of all the blackness in the world. His heart breaks; he dies. At the very beginning, at his blindness to real affection and his arrogant insistence on affection's mere words, could therapy have unmasked him to himself? Perhaps the levelling forces we live under save us from his special arrogance. But we have our own Lears today in our Homes and our new, painful scalpels, applied as gently as possible, to peel away the layers of self-deception which lead to massive rage and despair. Used within the framework of the older person's values and identity beliefs, therapy—whether that of psychiatry or social work—is a tool we would claim and use for our older people. We need social services' skills also for other reasons; we must screen those who think they want to enter our Homes, help them find their way into the great and bewildering room of communal life and understand what special help lodges in what corners of that room.

Only our century could have produced the convincing distortions of Yamakawa's recent short story about a man so submerged in the conformist way of Japanese life, that he clung to the dynamite he always carried around as a means of identifying himself. I think this dynamite a most dramatic and fitting symbol. No one who has read Wilma Donahue's impersonal and precise (and, I imagine, pioneering) account of how an activities program, like a fairy wand, transformed a county Home, can fail to be profoundly moved by it. Listless old people, vacantly staring into a space which was empty of yesterday's laughter, of past exultation of sweating muscles, of songs sung on beaches or of party shouts,

dully struggled, perhaps, to understand why the community condemned them, at the last, to their dreary county Home. Locked away from life, they were locked into themselves.

Sophisticated and manipulative, we may underestimate the simple human rituals, which reach back to tribal days, of games and firelight songs and the flair for carving a crude design on a crude knife. But these instincts are rooted deep in us and only as we let also older people experience the ceaseless rhythms of life will they flesh out the skeletons of meaning they carry within themselves. A pantomime staged in a Home is not a symbol of second childhood; it may even contain the missed delights of first childhood, release some of the greatest human forces. For one man it may be a secret celebration of the Holy Trinity, for another the Hassidic joy Buber so glowing writes about, and for a third a humanistic delight in life itself. Whatever it means to the particular person, it may deeply stir man as man in his immense dignity and help to satisfy his communal urge. So we wrote an activities program into our social components, noting the basic principles of acceptance, self-determination, starting at group levels, and all the rest.

Unless we come at last to the sterile madness of Huxley's *Brave New World*, the family will remain. The century hacks bloody wounds onto its body, yet it survives as an abiding value. We not only deal with families, we often become a part of the family fabric. We may become a symbol of the guilt of torn families and thus, scapegoats; we may sit as a trusted and accepted member at the family table, sharing its intimate laughter and tears. Unless we reject the family as part of life's meaning, we will help build all the bridges we can to families and help repair the broken and unused bridges within families. In creative love, staffs and volunteers will find a hundred ways to do this. God knows, it needs doing; our culture shipwrecks too many older people on lonely islands.

In the preface to their symposium, *Man Alone*,<sup>2</sup> Eric and Mary Josephson mourn the breakup of community and describe today's older people as outcasts who live in a twilight world. Certainly we sluice them from the American mainstream. Some still may interpret the very walls of our Homes as the suffocating sides of a coffin and dread a symbolic burial while they yet breathe. I know

<sup>2</sup> Published by Dell Publishing Co. Inc., 1962.

we do not mean this with our Homes. But whatever the traffic through our front door, I suspect many of us could take steps fruitfully to intensify it. A lot of community walls still stand through which we as staffs need to punch holes. It will mean meetings, and however gorged we may be with them, we must swallow our weariness. In Wisconsin we put together a mechanism of state professional societies to manage an accreditation program. With the new national program giving a healthy birthwail, we have abandoned our own, but we could not pry apart our group and no longer want to, for it serves as the only platform for professionals to talk to each other about Homes. Your own imagination will sketch in the whole picture: the church groups, the civic-minded people, and all the rest whom you really haven't reached as yet. We all know PR styles and practices and their urgency. But I have sometimes wondered if some of the glowing literature we create about our Homes isn't at bottom simple defensiveness over against a community that hardly finds time to give us a hurried and casual glance.

On another level we must invite the community into our Homes for face-to-face meetings with our older people. We need not fear that at first or perhaps ever they will sweep through our doors in flood proportions. We may encourage visitors by doing away with visiting hour rules, should we have them. We may recruit volunteers. We may invite group entertainers and lecturers and clergymen. We may encourage intimate parties designed for the friends of our older people. We may try also to reverse this traffic, sending our own people into the homes and churches and shops and galleries and parks and theaters of our community world. All this in a good deal more detail our committee saw as part of the social components of our Homes. With all their limitations, our older people are not the social pariahs about whom our society should be standoffish. Does our culture turn its face away, because it dreads the deep lines on the faces of our aging? Does our community use the social complexities of our time as escapist rationalizations?

New Testament Anna stayed in the temple day and night, serving God. Here finally is the brilliance of life, the brilliance beyond all other brilliances, beyond a boy's laughter as he feels the goodness of life, making stones skip and dance on a lake, beyond the moonlight caress of a loved one's hair, beyond the delight of

one's children opening the red and green of Christmas packages, beyond the satisfactions of maturity and strength and carving a place in life, beyond the reds and browns of the woods in the crisp fall wind. Here is the brilliance of order and meaning against the wild chaos of sensations, against passions that tear man apart, against the grim tragedies of our private lives and of the social order we live in. And as the twilight descends on our older people—and it does descend no matter with what giant hands and programs we try in our Homes to push it back—here is the last holy candle burning against the darkness. Perhaps it was also the very first in a man's life. With his faith he sorts out his own meanings and the world's. Here he comes to grips with the brooding mysteries of the cosmos, with life and death itself, with good and evil, with final terms. Many, perhaps most of our older people master the cosmos through religious faith. The AAHA Committee on Accreditation recognized this also and wrote the meeting of religious needs into our standards. I think our requests are simple and obvious: space and personnel for religious services, opportunities for the clergy to visit their parishioners in privacy at reasonable hours, and the calling of the clergy in extremities. Here is the quintessence of the order and meaning of our Homes.

We return a few of our people to the community. Most of them die in our Homes. I would deeply sorrow for, but I could understand with a shudder, the man who died experiencing Dylan Thomas' celebrated lines at the death of his father,

“Do not go gentle into that good night,  
 Old age should burn and rave at close of day;  
 Rage, rage, against the dying of the light.  
 “And you my father, there on that sad height  
 Curse, bless, me now with your fierce tears, I pray.  
 Do not go gentle into that good night.  
 Rage, rage, against the dying of the light.”

Life is indeed precious. But if we have done our work well, if with our social components we have helped our older people experience the fullness and richness of life also in their last years, if in our Homes we have helped them find their meaning and identity, we may hear from them, in one form or another, the immortal line in Webster's *The Duchess of Malfi*. A young widow, about to be secretly murdered by her powerful brother, the Duchess hears her executioner suggest escape: “Come, be of comfort; I

will save your life." Confident of her deathless identity, she disdains him: "Indeed, I have not leisure to tend so small a business." A good many of our Homes have certain style about them, even a high style. A Home whose older people ended life in that spirit can well be said to live with verve and richness and high style.

Despite its simply magnificent achievements, our science, through one of its key premises, throws a pall over life. As it has proven with mountains of evidence, knowledge is power. And yet—to know is not enough. Even if we all knew and accepted these or similar remarks and their premises, it would not be enough. It is no good merely to learn matters like these once and for all time. What finally counts is each concrete moment we live through and the way we translate our facts and insights into the living reality of experience and dialog. Dialog with our community, dialog with our staffs and boards, dialog, above all, with our older people and their families.

Here, finally, is a tender fairy tale that comes from a much simpler and seemingly remote world—and yet a world just around the last corners we turned. Only about a century old, Hans Christian Andersen summarizes for me so many of the values I have talked about. It is the story of the old Street Lamp, "the very honest old lamp that had done its work for many, many years, but which was now to be pensioned off." It worried about being useless and melted down and talked to the wind and the moon who merely told it to be sensible. An old watchman finally saved it, and in the end the old lamp was used to light his home festively and knew, "They love me for myself; they have cleaned me and bought my oil. I am . . . well off now. . . . And from that time on I enjoyed more inward peace; and the honest old Street Lamp had well deserved to enjoy it." Amid the terrible frustrations of aging, it had found meaning and love in small service in a humble home. And perhaps it would not be too much to read into Andersen's story that it had found identity even beyond the stony horizons of this world. And so the great myths of our world still summarize some of our deepest truths, including those about the social components of our twentieth century Homes.

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# I. THE SOCIAL COMPONENTS IN ACCREDITATION

## Preface

THE COMMITTEE ON ACCREDITATION of the American Association of Homes for the Aging prepared, as part of its contribution to the first formal meeting of the American Hospital Association's Committee on Approval of Extended Care Facilities, a working document on "the social components" of Homes' services.

The document was intended to set out guidelines for the integration of social components of care into standards developed for the multilateral approval program, then to be conducted under AHA auspices. These guidelines, or principles were included among the criteria for approval of extended care facilities finally adopted by that program and are now being integrally woven into criteria for accreditation of extended care facilities in the new unified national program of the Joint Commission on Accreditation of Hospitals.

Since, by the very definition drafted by the AAHA Committee on Accreditation, ". . . all phases of the Home's operation, broadly speaking, directly or indirectly form a part of the 'social components' . . ." some of AAHA's officers, members and staff and other knowledgeable persons from related professional disciplines in the field, envisioned in the working document potentials of usefulness which its authors had neither intended nor anticipated.

The suggestion that it be given wider distribution in the field prompted further editing by the Committee on Accreditation, including revision and augmentation based upon the critical evaluation of a number of professionally skilled persons whose advice and assistance was sought.

Even as revised and supplemented, the document consists of

working guidelines, the wet clay which permits further molding, additional dimension, not the final cast. At the same time, AAHA, through its Committee on Accreditation, would hope that it be considered more than simply "a checklist for accreditation" and that its content will help our understanding of concepts of the social components in our Homes.

The American Association of Homes for the Aging is deeply grateful to its Committee on Accreditation—Rev. William T. Eggers, Chairman; Rev. Roland Bosse, Jerome Hammerman and John James—for the service it has rendered to our membership and to the field. We also acknowledge with appreciation the editorial comments of our President, Herbert Shore, our Vice President and President Elect, Thomas M. Jenkins and Mrs. Ruth B. Taylor, Medical Social Consultant, Nursing Homes and Related Facilities Branch, Division of Medical Care Administration, U. S. Department of Health, Education, and Welfare.

## Introduction

While the Committee on Accreditation focused primarily on the social components of Homes, another part of its primary task was to identify these characteristics of residential Homes which distinguished them from independent living facilities housing for the aged, and similar living arrangements.

The Committee, moreover, was at that time working with a basic document prepared under the auspices of the Joint Commission on the Accreditation of Hospitals called "Explanatory Supplement to the Standards for Accreditation of Nursing Facilities." This document contained a heavy and, for the most part, a satisfactory treatment of the medical and nursing aspects of nursing care facilities.

For these reasons the social components material which follows makes little or no reference to health care in nursing facilities, but does deal at some length with the health facilities of a residential Home. It also has some emphasis on ancillary services as well as the residential Home's food services.

The Committee fully understands that some of the general principles which it enunciated have an overall application to all types of facilities—those offering purely residential or purely nursing services, as well as those which offer the entire spectrum of care for the aging. The reader will be able, the Committee feels, readily to apply the various principles to the appropriate facilities.

## Definition

The social components of Homes for the Aged are their arrangements—either their physical or their program arrangements—which allow and encourage their older people fully to realize themselves both as individuals with personal dignity and as members of the Home's community and of the larger community in which the Home is located.

All phases of the Home's operation, broadly speaking, directly or indirectly form a part of the "social components" of a Home. All Home personnel and programming may help to build or destroy the ideals and the positive atmosphere of a Home. The paragraphs which follow concentrate primarily on those aspects of the Home which seem most directly to help create the kind of an ideal Home which was the Committee's concern.

## General Principles

1. Homes are unique facilities, in that they are staffed and equipped, in some instances, to render services provided by a hospital specializing in short-term care of the acutely ill together with their more traditional provision of long-term care, so that many of the principles of an accreditation program for them must take into account services covering both residential and health care of patients and residents.

2. It is the objectives of the accreditation program to evaluate the professional quality of service in two basic types of facilities, though both may be available in one facility and, if so, each will be judged independently: 1) the Home offering residential care, which is to be understood as also providing personal care services; 2) the Home rendering skilled nursing service.

3. Homes should not continue to care for individuals whose needs have so changed that they require other kinds of services. Unless a Home is prepared to care for people with such changed needs, it must transfer them to other facilities.

4. Homes should be concerned with the best possible care they can render older people.

5. Because Homes care for individuals over long periods of time, sufficient consideration must be given to the homelike quality of the facility. Individuals in Homes need, in addition to good nursing care, the amenities of normal community life, including opportunities for social relationships both within and outside the institution, opportunities to mark personal and social events, as well as the holidays common to all men, religious observances important to their way of life, recreational outlets which may interest them. These should be provided in a setting which minimizes adherence to strict discipline or regulations and maximizes opportunities for self-expression and independent action.

6. One of the major goals of Homes is to provide nursing care facilities for sanitary, efficient nursing services of the highest professional level; and the patient's room in a chronic illness nursing unit of a Home should offer, in terms of a social setting, a great deal more than an acute hospital room.

7. The surveyor should be primarily concerned with the functions, services and environment of the Home, rather than with the organizational structure of the staff. This means that in the

smaller Homes there may be some overlapping of staff functions within appropriate professional limits.

### Administration

8. The members of the Board of the non-profit Home should be selected in a manner that will achieve rotation of its members and/or broad community representation. The Board should have an executive, finance, building and maintenance, medical staff conference committee, personnel and social service committee. It is advisable that the Board meet at least 4 to 6 times a year. An average attendance of two-thirds of the Board should be expected.

9. A properly constituted Advisory Committee, with clergyman, nurse, doctor representation from the community's public health program, together with a representative of the public, should be part of the structure of a Home and should meet periodically with the Home's administrator.

10. If the minimum requirements to qualify an administrator are too stringent, initially, great hardship might be worked in the field. Nevertheless, even current *minimum* qualifications for an administrator should include: good mental, physical and emotional health and good moral character; age over 21; a high school diploma and two years experience in a supervisory or assistant administrative capacity in a nursing facility or patient care institution; or, as an alternative, a college degree in a field related to health facilities management.

11. When a Home or nursing facility changes ownership or engages a new administrator, or when a new facility is created, the minimum requirement for the executive, in order to upgrade the field, shall be formal academic training in professions associated with today's social and health institutions—social work, the ministry, medicine, business administration, registered nurse, etc., as well as a number of years of experience in the field. The executive shall supplement his education either in formal courses or by recurrent and regular attendance at recognized institutes.

12. In connection with the qualification of the executive, significant preparation would include formal academic training, experience in the field and special orientation through continuing academic and professional education.

13. The proper function of the Board is that of establishing policies that will determine the kind of service the facility will

render. The administrator alone should be responsible for the implementation of these policies.

14. The relationship of a Board and its administrator in carrying out the expressed aims of the facility are crucial to good patient care. In this respect, good administrative practice requires that the administrator be present as an advisory and resource person at all meetings of the Board and its committees, in order to insure that full and proper information is available to the Board.

15. Residential facilities as well as nursing care facilities shall maintain adequate community-professional relationships.

16. The Home, residential and nursing, shall maintain an adequate in-service program for all personnel.

17. The Home shall maintain an accounting system which will permit it to accurately analyze costs and shall make available to the surveyor its books to determine if such a system is in use.

18. There shall be a full disclosure of the actual owners and members of the lay advisory Board.

19. Formal evidence of compliance with all applicable state, county and city regulations shall be made available to the surveyor.

20. The long-term facility, which has indicated its readiness and ability to serve the chronically ill patient, must provide sufficient personnel to render the necessary services its patients require.

21. The availability of professionally trained personnel may sometimes be a problem, and the willingness and ability of the institution to secure necessary personnel in the light of these shortages should be considered in the evaluative process.

22. While some material on ideal patient-personnel ratios exists and while additional studies are being made in this field, no authoritative conclusions have been reached. The accreditation program should take into consideration what can reasonably be attained and should be used as a means of upgrading standards of care in all facilities and also to encourage educational centers to help to meet the need for professionally-trained workers in all categories of geriatric care.

23. The requirement for professional people on staffs and the performance of their functions should be mandatory in the accreditation program and whatever flexibility is provided should be allowed in connection with other items and will of necessity be rather minor.

24. The codes of ethics of the various professions associated with the Home shall form a part of the administrative policy; copies shall be part of the administrative record and there shall be evidence that these codes are in use.

### **The Physical Plant**

25. Room size: although many factors influence an ideal room size, e.g., type of structure, climate, location (urban, suburban, rural), the suggested minimum in future construction should be 100 square feet for private rooms, 80 square feet per person for multi-resident rooms.

26. Many people will seek out and utilize communal living facilities to meet their needs for social and recreational activities. However, it is equally important that opportunities for privacy be afforded to the residents in these facilities. Opportunities for individual residents to entertain guests and family members should be provided. It is desirable, wherever possible, to give relatives and guests an opportunity to share a meal with the resident.

27. In all facilities there should be at least two general purpose areas, aside from bedrooms, of adequate size, one used for communal dining purposes, the other used as a lounge or recreational center. It is desirable, wherever possible, that additional recreational areas, of adequate size, be provided for small group activities, club groups, religious purposes, relative visiting.

28. The resident or patient should be encouraged to bring in many of the personal items of importance to him, such as pictures, radio or television set. The policy concerning larger items of furniture must be decided by the individual institution. However, a homelike atmosphere should be maintained and the furnishings of the general areas should reflect a real effort on the part of management to make the facility genuinely homelike.

29. A residential Home should also have adequate office space for administrative purposes as well as an adequate conference room.

30. Adequate and easily accessible outside recreational areas for residents, parking facilities for guests and for residents should be provided. While it would be difficult, and in some instances impossible because of the location of Homes now in existence, to provide these facilities, nevertheless, wherever possible Homes should be encouraged to provide them; and it should be mandatory

for all facilities now being planned or erected in the future.

31. It would be desirable to provide facilities for residents to sit down while waiting for elevators, or in long corridors, and other suitable places.

32. All residential Homes must meet all appropriate governmental standards with regard to space and safety.

33. Requirements to insure the safety and well-being of the resident and the understanding and support of these requirements by the staff and residents of the Home are important. Even though a residential facility serves ambulatory and capable people, it too should incorporate all reasonable and available safety devices, including an emergency lighting system, hand rails, grab bars.

### **Personal Services**

34. Opportunities for residents to take care of the personal amenities of daily living, as able, such as laundry or tailoring, should be provided.

35. Space shall be provided for a barber shop and beauty parlor and an adequate program utilizing proper personnel shall exist. If space for these services is not available in the agency then adequate provision must be made to care for these needs of the residents outside of the Home. However, in any facility not devoted exclusively to the care of the ambulatory well, provision for barber-beauty shop services must exist on the premises.

36. There must be evidence that adequate transportation to the community exists for residents able to utilize it. If the Home is conveniently located to public transportation, this will be considered sufficient. If the Home is not so located, it must furnish reasonable opportunities either to reach public transportation or to reach shopping and other significant community areas.

37. In addition to the provision made for the safekeeping of residents' monies and valuables, provision should be made for an adequate and convenient mail distribution as well as for the mailing of letters and packages. In addition, there should be a reasonable system of telephone communication, providing the resident with an opportunity to receive incoming calls as well as to make personal calls, free from censorship.

38. The housekeeper or some other appropriate person shall be in charge of handling the clothing and other personal needs of the resident or patient. As much as possible she shall observe these



needs, suggest to residents their purchase, provide for these needs out of the Home's donated stocks, or if it is the policy of the Home, she shall assist the residents in their purchase or make purchases for the residents, if that is necessary. For the convenience of the residents the Home may provide a shopping service on its premises.

39. The individual resident's permanent record shall include information concerning the person to contact at the time of death. Wherever possible, the name of the funeral director to be called should be a part of this basic information. Ideally, on admission the Home will, as the resident and family desire, make the necessary arrangements, at least tentatively, to meet the problems that immediately follow death, such as the financial arrangements, the options open to the individuals.

40. In general, the Home shall make whatever provision is necessary and capable of accomplishment to meet any of the personal needs of the residents that may arise, whether these needs have been specifically referred to or not. One qualification should be that such provisions do not affect the rights, activities or morale of other residents.

### **Admission Policies**

41. Admission policies should be written, clearly understood by the management of the facility and the prospective resident and/or his family.

42. The admission policy should state clearly the types of service the Home intends to provide, the way in which it intends to provide them, and the points at which it will not continue to provide services.

43. The admission policy should clearly state the financial and legal obligations of the institution as well as that of the individual resident.

44. In general, the Home's administrator or staff members should not accept, without legal sanction, assignment as guardian of property or person. However, in such instances, where this action becomes necessary for the well-being of the resident, provision should be made that the procedure is ethical and above reproach.

45. The practices of accepting patients from, or transferring them to communities at a considerable distance from the community in which they have lived is to be discouraged and considered as evidence of poor social planning on the part of the

institutional facilities involved. Homes should give serious consideration to the advisability of area and regional planning.

### **Finances**

46. A program of care should be based on the principle that the capacity to pay for treatment and the right to receive it should not be confused.

47. Accreditation should be granted only where evidence shows that ethical financial practices are observed in dealing with residents or their families.

### **Health Services**

48. The Home which does not provide nursing care to its residents as part of its total program nevertheless has some responsibility for the health of its residents including a program of preventive medicine. The following paragraphs define this responsibility and the standards which it must meet with respect to health care.

49. No resident shall be admitted to a Home without a thorough physical examination. A copy of the report of this examination shall become a part of the resident's permanent record. This shall not only be conducted according to the requirements of the Joint Commission standards, but shall also conform to the provisions of the various state codes and in general be a full and satisfactory physical examination of the resident.

50. The Home shall require that its residents have a complete physical examination (including lab tests and x-ray) at least annually, and that the findings of this examination become a part of the resident's permanent record.

51. The same provisions for health records, made by the Joint Commission standards for nursing homes, shall apply to Homes serving only ambulatory residents, either in conformity with state regulations or as a supplement to state regulations.

52. There shall be in every residential Home separate and adequate space for a doctor to carry out a program of physical examinations and other necessary routines as well as adequate and well-equipped space, to provide emergency nursing care for at least 24 hours, to residents needing temporary care at the Home before being transferred to a facility which can adequately meet their needs.

53. There shall be a registered nurse or licensed practical nurse on duty 7 days a week during the day shift. If patients are being temporarily cared for in the infirmary, adequate personnel shall be on duty at all times. At all other times at least one staff person, e.g., nightwatchman, or matron, shall be dressed and on duty to take care of emergencies and be able to call in an appropriate responsible person.

54. The Home shall maintain adequate control of medications. If these medications are prescribed by doctors other than those on the Home's medical staff, this provision shall be interpreted to mean that the nursing personnel administers or supervises the utilization of the drugs by the resident and maintains a record to indicate the staff person's activity in this matter.

55. The Home shall develop a program of preventive medicine. This shall be interpreted to mean disseminating information concerning health problems through such means as lectures or private counseling. It shall also include proper dietetic provisions, annual physical examinations, and any other program which will help to maintain the highest level of health among residents.

56. The Home shall have a medical director. Even though he may not be called upon to attend to the physical problems of the individual resident, he should be available for emergency purposes, and he should serve to advise the management of the Home on all matters of medical policy and to cooperate with the nursing department and the pharmacy (if one exists in the Home) in an advisory capacity, as necessary. The medical director shall check medical records from time to time to determine if they are adequate and up-to-date.

57. Although a residential Home may not normally have restorative services of any major kind, should a resident be returned to the Home needing such restorative service, it shall be the obligation of the Home to make certain that the resident does receive it or avail himself of it.

58. The Home shall have a panel of specialists as consultants on policy matters in their fields—podiatrist, dentist and eye-ear-nose and throat specialists. It shall make information concerning these specialists known to its residents and shall encourage them to avail themselves of this kind of service as the need arises.

59. From time to time, as a part of a health education program of the Home, members of the medical panel might be utilized

to acquaint the residents of the Home with health information and an understanding of the symptoms associated with their specialties.

60. The Home should make provision for obtaining clinical, laboratory, radiological and other such diagnostic services as are required for the adequate care of patients.

61. Each Home should make proper arrangements with at least one acute general hospital, where patients whose condition requires it will be admitted with a minimum of delay.

62. Every Home which purports to render adequate residential care, even if its policy does not provide for skilled nursing home care, must be prepared to render non-professional personal services where necessary. These include such things as assisting with bathing, assisting with dressing, the care of the hair and similar care items.

### **Ancillary Services**

63. The Homes offering nursing services should have the services of a social worker, podiatrist and the rehabilitation service as indicated in this section. The emphasis is on the fact that these services should be mandatory in such Homes. In smaller Homes, which do not need the full-time services of these specialists or which find it difficult to maintain the rehabilitation departments, social services may be obtained on a part-time basis and the Home should contract for the physical and occupational therapy services in valid physical and occupational therapy departments outside the Home. Whatever the arrangements, whether these services are rendered by full-time staff persons or part-time staff persons or, in the case of physical and occupational therapy, by contract with an adequate outside facility, they are necessary to do full justice to the needs of the patients.

64. Realistically, there is a shortage of these professional people, especially in remote and rural areas. Because of this, for at least several years, professional accreditation should be granted institutions which may lack one or the other of these services but is giving evidence of making a serious effort to obtain them. The needs of the patients as expressed in the accreditation standards should be used to encourage the appropriate national professional organizations to intensify their recruitment efforts and expand the number of professional people available.

65. A psychiatrist must be a part of the medical staff of a nursing care facility and shall also, if possible, be a part of the staff structure of a residential Home, at least on a consulting basis. In both instances the psychiatrist serves two vital functions: (a) to advise the administrator and staff on patient needs and institutional policy, and (b) to make diagnostic studies of individual residents, as these become necessary, and to suggest appropriate treatment.

### **Food Service**

66. The Home shall have the services of a dietician or a nutritionist with dietetic background, at least for menu planning including the planning of special diets. The shortage of these professional people is recognized and a determination must be made concerning the amount of professional time that the Home will realistically be able to engage in this area. For this reason, a ratio of full-time professionals to the number of residents in the Home should be established. Smaller Homes must give evidence of the part-time service of a dietician on their staff, or the regular utilization of a dietary consultant in the community.

67. The tables in dining areas shall accommodate no more than six persons to a table.

68. A record of food purchases shall be maintained for the preceding year and be available to the surveyor.

69. Persons in charge of the dietary service should work closely with the nursing department on all dietary problems and together they shall be responsible for the carrying out of all special orders.

70. If patients cannot be moved to dining areas, every effort should be made to have them out of bed and in chairs for meals.

71. The Home serving only well residents shall incorporate as part of its dietary program all the provisions of this section except those which specifically deal with special dietary needs of patients. Meals should be served at reasonable hours, and it is suggested that choice of menu items and between-meal snacks be made available.

### **Housekeeping**

72. For the residential Home, the housekeeping provisions of the Joint Commission will generally apply.

## Social Service

73. Since the emotional, social and physical problems of the person entering the residential Home generally are not as acute as those of the person entering the nursing care facility, a social service department should not be made mandatory for the residential Home. However, provision should be made for social services in residential Homes.

74. It should be pointed out that one of the major and highly significant community functions of the social service department of a Home is to screen prospective residents, at times to make clear the facility's functions, and to refer, when necessary, to other community services and facilities which more adequately meet their needs, and/or are presently available. It is expected that the non-profit Home as well as the for-profit would render this service.

75. With regard to Social Service, it might be appropriate to define it as "that process which is used to help individuals cope more effectively with their problems in social functioning." It is a process which contains within its means the end being sought; that is, to so influence the client that he develops effectiveness in coping with his problems, or to so influence the problem as to resolve it or vitiate its effect. In the institutional setting social service has several facets:

- 1) It helps the applicant and the family determine if institutional care is appropriate.
- 2) When this has been established, it helps the resident adjust to the demands of his environment.
- 3) It helps the resident utilize whatever services are needed and available both within and outside the institution.
- 4) It helps the resident find new purpose within the group-living experience.

## Activities Program

76. All residents, regardless of their physical and mental condition, can and should be involved in a variety of recreational activities, depending on their capabilities and interests. To a large extent the interest of the individual should be the primary factor in determining the components of an activities program. An appropriately trained and qualified individual or individuals should be responsible for maintaining and sustaining an activities program. The activities program, moreover, is part of the basic

service being offered by the facility and no additional charges should be made for general involvement in this program; this in no way should impinge, however, on the need for the resident to pay his own way for outside activities.

77. In evaluating the activities program, the following factors should be kept in mind:

1. the degree of self-involvement by the Home's residents;
2. the degree to which they determine the kinds and amounts of activities;
3. the degree to which the staff person motivates, counsels, and assists;
4. the balance between individual, small group and large, and recreational and educational activities;
5. the entire scope of the program.

78. In order to insure that a varied program is possible, appropriate rooms for both large and small group activities should be available for the use of residents.

79. Certain professional disciplines are particularly equipped to render effective leadership for this program; social group workers, educators, recreational therapists, activities directors, and occupational therapists. In many facilities, the occupational therapy and recreational departments may, and in all likelihood will, share a good many of the activities of the resident activity program. A sufficient number of staff or volunteer assistants can be used to enable all residents to participate in the program.

80. Information about the scheduled activities program should be publicized among the residents.

81. It is the Home's responsibility to provide whatever equipment is necessary in such a program, such as projectors, phonographs, cards, games, craft and other supplies.

82. To whatever extent possible, the activities program of the Home should be correlated with ongoing community activities.

83. Group activities might include such projects as movies, entertainment by community groups, publication of a weekly newspaper by the residents, organized resident club groups, choirs, musical groups, book reviews. Other activities might include handicraft, art projects, ceramics, library service, adult education programs, either through the institution's library or through community facilities.

84. Group Work Programs. In developing group work programs in a Home for the Aged, a number of principles must be made:

*First:* That recreational services are of fundamental importance; that a program is offered not as the frills, the luxuries, the show aspects, but because of the basically essential value of these services to a good adjustment and a satisfying life for residents, not instead of or in place of a medical or any other program, but because of its own right it is valuable;

*Second:* That programs in which the residents themselves take part are far more valuable to the participant and the observer than programs put on for the "dear little old people"; that the generic principles of doing *with* and not *for* people applies as well in a Home for the Aged as in any situation;

*Third:* That *nothing of interest* to an adult human being is *alien to the program* in a Home for the Aged;

*Fourth:* That activity is only a part and parcel of group work service. That program changes as needs change, and needs change as program changes. That program is not offered as a means of escape;

*Fifth:* That the vital fluid of all services is *relationship*. That nothing will happen without it and that through it things will happen;

*Sixth:* That the knowledge we have of what has happened to groups in other situations is transferable; the information we have on the problems of older people must be used for effective programming;

*Lastly:* That basic social work principles apply; "recognizing the rights of individuals" and "accepting group members for what they are," and "beginning at the level of the group," cannot be by-passed or violated.

## **Relation To Families and Community**

85. The Home shall make a reasonable effort to maintain and strengthen the relationship between the resident and his immediate family. This may include a regular check on family contacts, staff encouragement of the family to visit the resident, and writing of letters or making telephone calls on behalf of the resident. If a volunteer organization exists within the Home, some of the activi-



ties may be carried out by volunteers. Ideally, a social service worker can be utilized to carry out this function.

86. Visiting hours should normally be unrestricted and any necessary exceptions may be handled on an individual basis.

## **Religion**

87. Every residential or nursing facility should endeavor to meet the religious needs of its residents. The clergy of the community should be consulted in this regard. The administrator and staff should refrain from imposing their religious beliefs on their residents. Residents should be free to attend or not to attend religious services inside or outside the Home or nursing facility. Larger Homes may wish to have a chaplain on their staffs.

88. The non-profit Home under religious auspices should provide religious services in keeping with the denominational framework in which it operates. We recommend that the non-denominational non-profit Homes arrange for the conduct of religious services in such manner as to be acceptable to the majority of the residents. In all facilities space should be made available for this purpose and, if at all possible, elementary equipment such as a lectern, a simple portable altar, be provided. In all instances, where this is necessary, arrangements for these matters should be made through the local Ministerial Alliance, Catholic Chancery office or Council of Rabbis, or through local churches and synagogues.

89. Members of the clergy should be permitted to see residents at all reasonable hours and an area should be provided where residents may consult with clergymen in privacy.

90. The Home should cooperate with the resident, as necessary, in obtaining the services of the clergyman he desires and should automatically call the appropriate clergyman in times of critical illness; information about religious beliefs and the appropriate clergyman should be a part of the permanent record of the individual resident.

91. If the resident wishes to attend a religious service and is able to do so, the Home or nursing facility should make every effort to make attendance possible. Transportation arrangements may be made with local churches and synagogues.

## II. OBSERVATIONS FROM PRACTICE

### Edited Selections

# Social Components In Long-Term Care of Patients

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The following observations relating to the social components in programming for patients in long-term care facilities are excerpted from addresses presented at the Institute of Provision of Social Services for Nursing Home Patients, sponsored by the Division of Chronic Disease, Massachusetts Department of Health and Health Research Institute, Inc., in 1964 and the Institute on Nursing Service Administration for Long-Term Care Facilities, sponsored by the American Hospital Association, in 1965.

. . . THE GOAL OF CARE in all long-term facilities, including extended care facilities (nursing homes), is to improve or restore, if possible, but certainly to maintain the patient's physical, psychological and social functioning. The goal can be stated simply. Its achievement is a highly complicated process, requiring constant attention to those three intricately interwoven aspects of the patient's life . . .

. . . The social component is not an entity by itself which can be neatly identified and examined, nor unfortunately, does it lend itself easily to quantification and ready measurement. Rather, it is a concept which is all-pervasive and includes the purpose and function of the particular institution, the physical location, the design of structure, furnishings and equipment, policies, services, and the manner in which the program is carried out. The social component is always present whether it is destructive or constructive for the patients and responsibility for it rests with everyone connected with the institution. . . .

. . . The goal for all residents and patients in extended care facilities should be conceived in the context of motivation and development theory which imply dynamic and positive horizons of personality development throughout the life continuum and which "view the individual as constantly giving birth to himself and expanding the dimensions of his personality" in response to growth needs toward a master tendency of "self-actualization",<sup>1</sup> the end point in the continuum being that of "finding an inner fulfillment, an inner meaning and integrity as one moves inevitably toward approaching death. . . ."<sup>2</sup>

. . . Within these general concepts of the goals of extended care certain crucial elements seem to have particular relevance: a) the degree to which a sense of continuity and development is possible for the patient between his previous way of life and that in the nursing home, b) the extent to which he feels he has some essential mastery of himself, his environment, and his own destiny despite what may be his physical or mental limitations. Various factors contribute to these elements: the process of his admission; the physical and social environment of the extended care facility the services and care he receives, both the kind and the manner in which they are given . . .

. . . Group living for most people is a radical departure from their usual way of life, yet it is a central feature in any kind of institution, and in long-term facilities, group formation is at the essence for the individuals concerned. Application of some aspects of small group theory may well be helpful in guiding the groupings of patients to promote the most useful social interaction for them, and in developing a pattern of personnel and services, particularly in large institutions, in order to minimize some of the difficult aspects and maximize the advantages of group living.

Each of us can remember some lonely and fearsome moment when we were the only new student in a class or a school, the only outsider in a closely knit group in which everyone knew everyone else, students and teachers alike. Everyone else knew all the rules, written and unwritten, what to expect and what was expected, who was boss, and why. Soon some "kind" soul took you aside and filled you in on all the terrible things you could expect. From feeling

uneasy and strange you then progressed to real fear, which was enhanced by the knowledge that you were caught and held with no escape possible. There is a real analogy between that kind of vicissitude of youth and the experience of a newly admitted patient in a long term facility. The social system which develops within a patient group is often fearful and wonderful to behold and the stress to which it can subject newcomers deserves careful attention by the staff. Experimentation in some long-term facilities<sup>3</sup> suggests that the formation of orientation groups for newly admitted patients or residents is a useful method in enabling them to become acquainted with their new environment, in encouraging them to question and discuss all aspects and their feelings about them, and especially to enable them to gain strength and perspective from one another in coping successfully with this new mode of living.

The factor of group living plus the philosophy, the policies, the program of care and services, and especially the personnel who provide the care are at the heart of the matter for the patient. Policies must provide order, support and safety for the patients as a group, but at the same time should reflect the importance of individuality for all. This is a very neat balance to achieve, especially in a long-term care facility, for although many technical aspects of medical and nursing service are similar to those in hospital care, nonetheless, particularly for patients of long stay, emphasis must be placed on the word "home". "Home" carries many significant connotations. Among them are: receiving and entertaining visitors; coming and going as one wishes and is able to do so; having meals at accustomed hours, and, within reason, having food which follows old familiar patterns; choosing when to engage in solitary pursuits and when in activities with others; having and using familiar possessions; selecting one's clothing and dressing for a day of living, in contradistinction to a day of hospitalization; following previous interests and using old skills and developing new ones. All of these, and many other factors are important to the patient's sense of identity and self-fulfillment, and aspects of all of them can be attained through policy and program which express this philosophy. It is the melding of high standards of technical medical and nursing care with this kind of concept of "home" which is perhaps the distinguishing feature of long-term care of excellence . . .

. . . *By implication it is clear that if the patient (in a long-term care facility) is to be permitted and encouraged to sustain himself in the mainstream of life a variety of services and activities must be available to him for his selection and use. The importance of such matters as religious services and spiritual counselling, opportunity to pursue cultural interests and creative and entertaining activities are obvious; what may require emphasis, however, is the value for the patient to leave the facility from time to time if possible, in order that he may keep in touch with the activities and look of the community and to renew familiarity with non-institutional living. Arranging for outings of various kinds for patients who are feeble and tottery, who use walkers or wheel chairs is sometimes complicated as to planning and logistics, but one has only to accompany individuals or a group of patients on a drive, to a picnic, to luncheon, tea or a barbecue at the home of a volunteer to realize the enormous value of such undertakings in the pleasure, stimulation and increased well-being for the patients.*

*It is equally important to recognize that although "spectator" events and activities are important as one factor in life, the most vital and self-fulfilling activities for the patient are those in which he is himself an active participant. As part of this he should have opportunity, encouragement and assistance to continue to be a part of the general community, insofar as he is able, contributing to the life of the neighborhood or general community, as do other adults . . .*

## REFERENCES

- <sup>1</sup> Fink, Fautz and Zinker, *The Growth Beyond Adjustment: Another Look at Motivation*, Highland View Hospital, Cleveland, Mimeo, undated (Reviews and Synthesizes theory as developed by Goldstein, Angyal, Fromm, Maslow).
- <sup>2</sup> M. Blenkner, "Developmental Considerations and the Older Client" in *Relations of Development and Aging*, J. E. Birren, ed., Charles C. Thomas, Springfield, Ill. 1964 (Reviews and discusses theory as developed by Erickson, Peck, Bublér and others.)
- <sup>3</sup> S. Saul, A. Segal, S. R. Saul, "The Use of the Small Group in Orienting New Resident To a Home for the Aged: The Admissions Group", Mimeo., Group Work Dept., The Jewish Guild for the Blind, 1880 Broadway, N.Y.C. (updated)

## Appendix 6

### ADDITIONAL ACTIVITY IN THE TUCSON AREA

In appendix 3, Mr. Richard Lamden described a comprehensive senior health improvement program which uses a home for the aged as its primary base in Tucson, Ariz.

Additional developments have occurred in the Tucson area within recent months, and they promise to broaden the base of community support considerably for a comprehensive program of long-term care services serving an entire county.

One indication of public awareness of the need for comprehensive action was voter approval of a \$7.2 million bond issue last November for improvement of facilities and programs for the elderly in Pima County. Another welcome development was the decision by the county board of commissioners to contract with the Pima Council on Aging to assess the needs and bring forth recommendations for a comprehensive delivery system implementing a continuum-of-care concept.

As the following statement by the Pima council indicates, the plan has been published and it was—in October 1975—to become the subject of public hearings and discussions.

For additional information on outcome: write either to the Pima Council on Aging, Suite 406, Alameda Plaza Building, 100 East Alameda Street, Tucson, Ariz. 85701, or Jim Murphy, Deputy County Manager, Pima County Board of Supervisors Governmental Center, Tucson, Ariz. 85701.

#### A PLAN OF LONG-TERM CARE SERVICES FOR PIMA COUNTY

Tucson, Pima County, Ariz., is the metropolitan center of a large area of the southwestern desert where both the problems of the elderly and potential solutions of those problems are receiving constructive attention in the fall of 1975.

In October, a series of discussions of a proposed Pima County long-term care system will be held at the invitation of the county board of supervisors. The plan was devised after a 6-month study conducted by the Pima Council on Aging under contract with the county. The plan outlines a comprehensive service delivery system providing assistance ranging from part-time aid in performing household tasks to full-time residential care in a skilled nursing home.

Such a plan departs radically from the role the county has traditionally assumed as service provider to the aged. That role has been, in effect, one of custodian of those whose medical and financial needs required that they be admitted to a nursing home with part or full county support. Only those persons eligible for such full-time nursing care received any help at all.

Recognizing inadequacies at both the county-owned 190-bed nursing home and several proprietary homes where an additional 400 patients are currently provided nursing care at county expense, the supervisors in 1974 sought citizen approval for a \$7.2 million bond issue to finance additional gerontological services. The bond issue was passed by the voters.

Before undertaking to spend these designated funds, the supervisors sought expert assistance in determining how the money might best be used. Rather than employing an agency from outside the community to assess the situation, county officials turned to Pima Council on Aging as its prime consultant. The council has an 8-year history of activity in the Tucson area as aid and advocate to the elderly, coordinator of Federal grants on behalf of the aging, and information center. Specialized knowledge and affiliation with national gerontology organizations give the council access to the highest quality of expertise; and established position in the community give it credibility and a sense of responsibility toward the project itself and its impact on the county as a whole.

#### THE SURVEY

Three techniques were used by the staff assembled by P.C.O.A. to conduct the survey making possible a description of present and projected needs for services to the elderly of Pima County.

1. The best national and local data available were collected and correlated in order to obtain estimates for the present and for 1980 of both numbers of aged and disabled persons in Pima County and the nature of their limitations.

2. Proven instruments used for evaluating services were studied, a selection was made, and after certain adaptations, the resulting questionnaire was used to survey a sample of services to county-supported nursing home patients. Responses were collated, recorded, and displayed on a series of tables presenting a profile of the kind of care patients are now receiving. (See part 3 of the preliminary report presented in draft form to the Pima County supervisors in July 1975.)

3. Nursing home directors, nursing supervisors, and other professional personnel were interviewed. Patient records were reviewed. Nationally recognized consultants conducted visits and prepared reports on both the county nursing home, Posada del Sol, and a sample of contract homes. Guaranteed that information obtained in these interviews and reviews would be given complete confidentiality, nursing home staff members provided a high level of cooperation.

#### THE PLAN

Based on the information systematically collected over a period of 4 months, the team of consultants prepared a recommendation for establishment of a comprehensive health care services system to include:

1. Acceptance of a philosophy of a continuum of care; placement of the responsibility for such care in a health maintenance agency, the county health department; appointment of a director of long-term care, a coordinator of grants and funding, designation of an ombudsman to investigate reports of service problems and promote necessary

adjustments; and establishment of the role of the facilitator as permanent representative of each client admitted to the system.

2. Extensive renovation of Posada del Sol (the county-owned nursing home) facilities.

3. Development of a full range of services: information and referral, home health care, transportation, day care, mobile meals, rural health care centers, expanded mental health facilities, congregate living centers.

4. Establishment of quality control and data recording systems.

5. Institution of a family incentive payment mechanism.

#### IMPLEMENTATION

In response to a favorable county staff report on the draft of the P.C.O.A. long-term care services plan for Pima County, the county has printed an additional 250 copies of the preliminary document and announced that public meetings will be held in October to discuss its recommendations. To be distributed to interested officials and agency representatives, and other persons involved in providing services to the elderly and disabled, the report will be used as a working paper to elicit comments and suggestions from concerned persons and agencies. On the basis of these responses, modifications to the plan will be made and it is anticipated that the first phase of implementation could begin as early as the winter of 1976, probably with remodeling Posada del Sol.

While disagreement about certain aspects of the overall plan and some legal constraints create situations that stand in the way of full implementation of the plan as presented, there is every indication of wide acceptance of its major concepts. The foresight and willingness to innovate that have been shown by the county supervisors, the quality and cooperativeness of many local agencies, the availability of highly skilled professionals within the local community, and demonstrated support from citizens are some of the major factors that make Pima County the kind of place where a need for change can be recognized, a plan of action devised, and implementation undertaken in an orderly fashion. If these things can happen in one community, they can happen in others.



## Appendix 7

### EXCERPTS FROM GRAY PANTHERS CITIZENS ACTION GUIDE

In April 1975, the Gray Panthers—a social action organization concerned primarily about older Americans—published a *Citizens Action Guide: Nursing Home Reform*. As the title indicates, the publication provides detailed information on actions that can be taken by consumer groups and others interested in long-term care reform.

The preface to that report and its listing of nursing home action groups follow. For additional information, write to Long-Term Care Action Project, 6342 Greene Street, Philadelphia, Pa. 19144; or telephone (215) 848-2314.

#### PREFACE

The Gray Panthers have been funded by the women's program of the United Presbyterian Church to prepare a *Citizen's Action Manual* on nursing home reform. This guide to citizen action is a preliminary to the comprehensive manual scheduled for publication in the summer of 1976. It also represents an update and expansion of a "Nursing Home Action Proposal" prepared by Elma Griesel and Nancy Wilson while work for Ralph Nader's Retired Professional Action Group in 1972.

Most concerned citizens have no idea where or how to start action to help solve the many complex problems related to nursing homes. There is so much work to be done from so many different angles—ranging from organizing personal help and companionship for individual residents to reforming the State and Federal inspection, certification, licensure, and reimbursement systems. Many people shy away from action because of the complexity of the issues and because of the emotional aspects of confronting institutionalized older people—people who have, in too many instances, been placed in institutions because there was no alternative community service available for them.

Although day-to-day skilled nursing and/or medical services are necessary for some people, and many nursing homes offer excellent services, we have made a tragic mistake in our society by failing to develop every possible program to keep people in their own homes or, at least, in homes where they could share communal living with a small group of compatible people.

As a society, we have generally shunned our elderly aside. Many have become the victims of a low-quality delivery system which was developed primarily by businessmen seeking to make the highest possible return on their investments.

We believe that the problems faced by the elderly in institutions are primarily the result of our neglect and of our guilt-laden trust that the business world could, or would, develop—as a first priority—a system of high-quality health and personal services. Even those owners and administrators who have taken this public trust seriously and have managed to provide such services have done so without the general support and direct involvement of the community.

On the other hand, we do get hundreds of letters from individual citizens or groups who contend that they would like to do something about poor nursing home conditions or, at least, help the many lonely older people isolated in institutions. Most people ask for directions on how to find solutions to the problems and how to get action started.

Our basic belief is that we must act aggressively to promote the development of alternatives to institutional living. However, we believe that this effort must be coupled with extensive citizen campaigns to reform nursing home conditions so that the people presently institutionalized may receive the care and support they need to live out their lives with dignity. It is also extremely important to identify those people living in institutions who can be returned to the community as options become available.

We have become aware of many citizens, either through groups or as individuals, who have taken action that resulted in nursing home reform. Our primary purpose in presenting this guide is to introduce the readers to those committed groups and to indicate what can be done by concerned people who educate themselves to the issues and ways of solving them and proceed to act decisively for positive changes.

In this guide, we have presented (1) an overview of the major problems, (2) a brief sketch of what actions citizen groups have taken to help solve the problems, (3) recommendations to begin education and to promote public support, (4) recommendations for specific types of actions necessary for nursing home reform, and (5) a special resource directory. This directory tells you where to contact groups and agencies that should be able to provide you with additional information, support, and direction.

The resource directory also contains a reprint of the major findings and initial recommendations for change from a report released in November 1974 by the Senate Special Committee on Aging titled, *Nursing Home Care in the United States: Failure in Public Policy*. This report was compiled under the direction of Senator Frank Moss, chairman of the Subcommittee on Long-Term Care.

Through the preparation of this extensive report, Mr. Val Halamandaris, counsel for that subcommittee, has provided U.S. citizens with an invaluable tool for supporting and initiating nursing home reform. We urge all groups working on this issue to order the Introductory Report and Supporting Papers available as listed in this guide.

The proposed outline of our *Citizens Action Manual* is included in the appendixes, page 61. As it indicates, our final manual will have detailed models for citizens to follow. Existing citizen groups are providing us information about their successes, their failures, and recommendations for action. We will also recognize and describe institutions which offer innovative programs which should be adopted by other facilities.

We hope that this guide will offer you the motivation and basic information needed to get started on nursing home reform. As you conduct your work, you will turn up new sources of information, new strategies, new allies, and a new understanding of public interest work. We hope that you will send us information about your activities and offer us further ideas to strengthen our own insight and knowledge of nursing home reform activities.

It is possible that the action you take in your local community can serve as a model for other community groups to follow. We will contact you in the future regarding the availability of our *Citizens Action Manual*. In the meantime, please do not hesitate to call on us for further information and support.

ELMA GRIESEL  
LINDA HORN.

### DIRECTORY OF NURSING HOME ACTION GROUPS

- Gray Panthers Long-Term Care Action Projects, 3700 Chestnut, Philadelphia, Pa. 19104; Elma Griesel, Linda Horn, (215) 382-3546.
- Citizens for Better Care, 960 Jefferson Avenue E., Detroit, Mich. 58207; Mr. Chuck Chomit, executive director, (313) 963-0513.
- Citizens for the Improvement of Nursing Homes, 9103 32nd Avenue NE., Seattle, Wash. 98115; Mrs. Dorothy Kallgren, president, (206) 523-1211.
- Citizens Monitoring Team (of Davenport, Iowa), 577 North First West, Logan, Utah 84321; Ms. Patricia Powers, former coordinator.
- Denver Gray Panthers, 2619 Clermont, Denver, Colo. 80207; Mr. Duane Gall (contact will change in May) (303) 355-8470.
- Friends and Relatives of Nursing Home Patients, 1765 East 26th, Eugene, Oreg. 97403; Mrs. Ruth Shepherd, (503) 343-7888.
- Minneapolis Age & Opportunity Center, Inc., 1801 Nicollet Ave. South, Minneapolis, Minn. 55403; Ms. Daphne H. Krause, executive director, (612) 874-5525.
- National Consumers League, 1785 Massachusetts Ave. NW., Washington, D.C. 20036; Mrs. Alice Shabecoff, executive director, (202) 797-7600.
- New York Gray Panther Nursing Home Action Group, 149 West 4th Street, New York, N.Y. 10012; Ms. Ann Wyatt, Ms. Pat LaMariana, (212) 674-4886.
- Northwest Interfaith Movement, Greene St. at Westview, Philadelphia, Pa. 19119; Mr. Bruce Tischler, (215) 843-5600.
- Nursing Home Campaign Committee, Inc., 1547 Pratt Street, Philadelphia, Pa. 19124; Mrs. Elizabeth Maier, president, (215) 744-0882.