HEALTH CARE FOR OLDER AMERICANS: THE "ALTERNATIVES" ISSUE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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WEDNESDAY, OCTOBER 12, 1977

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Holyoke, Mass.

The committee convened at 9:15 a.m., pursuant to notice, in the auditorium of the Holyoke Community College, Hon. Edward W. Brooke presiding.

Present: Senator Brooke.

Also present: Letitia Chambers, minority staff director; Kathleen M. Deignan, professional staff member; Margaret S. Fayé, minority professional staff member; and Alison Case, assistant chief clerk.

WELCOMING REMARKS BY MAYOR ERNEST PROULX

Mayor PROULX. Good morning, ladies and gentlemen. My name is Ernest Proulx. I have the honor and privilege, as mayor of Holyoke, to welcome the U.S. Senate Special Committee on Aging to our city and to welcome Hon. Edward W. Brooke who will preside this morning.

I hope that the testimony offered here today for the committee will aid in its recommendations to the full Senate. We have an opportunity here today to share what we have done in Holyoke, not only our successes, but our failures. Both are equally important if services to the elderly are to be retained and continue to improve.

As we all know, no problem of this magnitude and importance can be solved on the local level alone; we need State and Federal help. We are fortunate in the State to have the interest and the assistance in Washington of Senator Brooke.

Thank you.

OPENING STATEMENT BY SENATOR EDWARD W. BROOKE, PRESIDING

Senator BROOKE. Mr. Mayor, I want to thank you for your words of welcome on behalf of the Senate Committee on Aging.

I also want to express my deep appreciation to President David Bartley of the Holyoke Community College; to Secretary Callahan of the Department of Elder Affairs, Commonwealth of Massachusetts; to Joseph Paul who is the director of the Holyoke Geriatric Authority; and to all of the official members and workers of the Holyoke Community College for their hospitality in having us here with them this morning.

I would first like to introduce the members of the staff of the Senate Committee on Aging and ask them to stand so you will know them when I introduce them.

Dr. Letitia Chambers, who is minority staff director, to my right; Margaret Fayé is a professional staff member; Kathy Deignan, professional staff member; Alison Case, clerk; and Felice Pelosa of my staff in Boston.

Today's hearing is the sixth in a series of hearings being held by the Senate Special Committee on Aging on the subject of health care for older Americans: The "alternatives" issue. It is particularly appropriate that we have come to Holyoke, joining with the U.S. Conference of Mayors' Task Force on Aging, to learn about the Holyoke Geriatric Authority, which is a model for cities all across our Nation. Indeed, it is the only municipal authority of its kind working toward a full range of health and housing services in long-term care for the elderly.

In addition, we are also most interested in hearing about the development of home care corporations in the Commonwealth of Massachusetts. In previous hearings of the committee, witnesses have testified about the ever-increasing need for quality care for our functionally dependent elderly. The care needed by these elderly range from support services in the home for those who can and wish to remain at home, to adult day care centers, to congregate housing with support services, to nursing homes for those who need full-time care.

Critical Needs

These needs of our elderly will become even more critical, for we know that the population of older Americans is increasing at a high rate. In the year 2000, it is estimated that there will be 30 million people over 65 in the United States. As our elderly population increases, the provisions of health and social services and institutional care become a crucial issue.

The city of Holyoke is in a unique position to lead the way in providing such services, as 22 percent of its current population is over 65. To its credit, it has been aware of the problems and potential of its elderly and has taken action. The citizens of Holyoke can be justifiably proud of the opportunities that their city affords its elderly residents.

All too often, older individuals are compelled to give up their usual living arrangements when a municipality fails to provide organized programs of community support to aid such persons to remain in their own homes.

Let me share with you a letter I received just the other day.

> Dear Senator Brooke: I dread going into a nursing home and it would cost the Government more to support me and I would like to live at home as long as possible. My entire living depends on SSI and SSA checks and assistance from my sister. So if it were not for the homemakers' wonderful assistance, we would have to give up everything and be institutionalized which we do not want.
>
> Please let me know if you can possibly keep this program going.

In this anguished appeal for help, this elderly lady sums up what these hearings are all about. The answer to her letter represents not only a dollars-and-cents savings to the Government, it insures the preservation of personal dignity which should be the goal of all of our public policies.

In order that our elderly can live as independently as possible, we must reevaluate our present reimbursement systems which, for the most part, encourage institutionalization by giving only limited coverage for other kinds of care. We can prevent the onset of dependence by providing alternative kinds of living arrangements such as are being planned and executed by the Holyoke Geriatric Authority with the assistance of home care corporations. Much will be accomplished toward maintaining the dignity of older citizens.

It is clear that these hearings are only a start and they will have little significance if we do not follow up with some specific legislative proposals that will encourage other cities to emulate the progressive concerns of Holyoke for its elderly. We in the Congress must do more than listen to your needs—we must meet those needs.

I regret that since the Congress is still in session, the time for our hearing is necessarily shortened, but even this brief time will inform the Congress of the great initiatives and accomplishments of the city of Holyoke and the Commonwealth of Massachusetts in meeting the needs of our elderly.

Senator Edward M. Kennedy, a former member of this committee, wished to be here today, but, due to pressing business in Washington, he cannot attend today's session. He has submitted a statement which I will now enter into the record.

[The statement follows:]

STATEMENT OF SENATOR EDWARD M. KENNEDY

I welcome the opportunity to submit for the record of this hearing, a statement on the public policy issues in long-term care for the elderly. I regret that the Senate schedule prevents my providing this statement in person at the hearing in Holyoke.

Adequate provision and funding of long-term care for the elderly is perhaps one of the most difficult and complex issues we face as a society. It raises economic, social, medical, and humanistic concerns. It is an area that has no single focus of attention or support from government, since it has not been defined as a specific program.

Much of the focus of current public policy in long-term care is directed by the crisis situations which arise with respect to presumed quality deficencies, suspected fraud, escalating costs, etc. The reactions are expressed in terms of Federal and State legislation and regulations that deal with parts of the system, for example, patient advocacy programs, tighter regulation of standards of care, restrictive regulation on what services will be paid by third-party payors, investigations of services. Current policy assumes the continuation of the present "system" of long-term care delivery and financing and attempts to change certain parts of that system hoping for improvement. In the short term this may be beneficial, but the results are uncertain.

Public policy must also be directed at major changes in the "system" of delivering and financing long-term care, assuming the possibility of major restructuring and reorientation, along with incremental change. This is essential if we assume that national health insurance will be a reality within the next few years, and if we assume that some aspects of long-term care must be incorporated into that proposal. At present there is no basis in public policy that would permit inclusion of un-

restricted long-term care coverage, largely because of its presumed high costs.

A reasonable approach to attempting major or even incremental change in the system would be through large-scale experiments and demonstrations that are community and population based, and where the interrelationships between the organization, delivery, financing, and regulation of long-term care could be analyzed and redirected. Public policy should encourage the design and support of such experiments.

The health security bill—S. 3—which is the national health program I sponsored, contains a special section which should provide for demonstration grants in long-term care alternatives. It would include nutritional counseling, meals-on-wheels, home help and homemaker services, transportation and shopping services, and other related personal care services that might be appropriated in particular cases. Community and population-based demonstrations of the provisions of these kinds of services as part of a larger program to provide comprehensive health care services such as are covered in health security, could help to provide us with the necessary information on costs, appropriateness, demand for, and use of the services. In controlled kinds of experiments such as these, where the community would organize all the needed services—and there would be methods to assess individual needs and to screen applicants—we will be able to gain the information we need to design the most effective long-range, long-term care program for the elderly.

Holyoke's Model Geriatric Authority, which you are discussing today, may well be the kind of public organizational foundation for further expansion of demonstrations in alternatives. I am also aware that the home care corporations in Massachusetts, which will also be heard today, are uniquely Massachusetts kinds of attempts to bring together the social, economic, and health care concerns of the elderly. These too are initial experiments along the lines I have been discussing.

I wish it were possible for me to participate directly in these hearings and to learn more about the efforts in Massachusetts to resolve some of these difficult problems. I look forward to reviewing the record and to speaking personally with the witnesses who are on the front line of helping our senior citizens deal with the human problems of long-term care.

Senator BROOKE. As our first witness this morning, we are honored to have Hon. Gabriel Cazares, who is the mayor of Clearwater, Fla., and a member of the U.S. Conference of Mayors' Task Force on Aging.

Mr. Mayor, we are pleased to have you with us and you may proceed with your statement. If it is a lengthy statement, I will ask you to summarize it and your entire statement will be placed in the record. We are delighted to have you with us on this occasion.

STATEMENT OF HON. GABRIEL CAZARES, MAYOR, CLEARWATER, FLA.; MEMBER, U.S. CONFERENCE OF MAYORS' TASK FORCE ON AGING

Mayor CAZARES. Senator Brooke and members of the staff, good morning.

It is indeed a pleasure for me to be in Holyoke on behalf of the U.S. Conference of Mayors' Task Force on Aging and to publicly thank you and the Special Committee on Aging for holding this field hearing in conjunction with our 2-day conference on alternatives to institutionalization.

The task force on aging was created within the Conference of Mayors in response to indications from a number of mayors who felt a need to learn more regarding the needs and concerns of older Americans and to identify resources available to meet those needs.

While cities traditionally have not been substantially involved in the delivery of social services, demographic shifts are taking place, resulting in a concentration of the elderly in cities. In fact, about two out of three persons 65 and older live in metropolitan areas.

In Clearwater, Fla., where I am mayor, persons over the age of 65 represent 34 percent of the city's total population, one out of every three persons, triple the national average. Of these, 37 percent live below the poverty level. In Clearwater, as in most cities, older people, when unsuccessful in their efforts with other levels of government, often turn to city hall to seek solutions to their problems. Therefore, it is critical that mayors and other public officials be able to identify resources and innovative programs which better meet the needs of their older constituents.

Information Sharing

One of the more successful activities of the task force has been in facilitating a transfer of technology among cities. The experience of the task force on aging concerning the urban elderly is contained in a handbook, "Serving the Urban Elderly: Strategies for Mayors," which is included in the material that has been presented to you. In the area of alternatives to institutionalization, the task force made arrangements for nearly 40 mayors to tour a program in Minneapolis designed to provide a more realistic approach in providing health and support services to senior citizens. This program, the Minneapolis Age and Opportunity Center, is described in our handbook.

It was through the extensive work of the Special Committee on Aging in bringing attention to the need for alternatives to institutionalization that the task force first learned of this program in Minneapolis.

It is fitting that the close working relationship between this Senate committee and the Mayors' Task Force on Aging continues through our combined efforts to develop this conference and field hearing in Holyoke.

It has been 6 years since the White House Conference on Aging recommended as a priority for the elderly the establishment of a community-based spectrum of alternatives in long-term care. Yet, as Dr. Butler, Director of the National Institute on Aging, points out, we are still "warehousing older people in nursing homes."

A recent Congressional Budget Office report estimates that between 20 percent and 40 percent of our Nation's nursing home population could be cared for on less intensive levels if adequate, community-based, in-home care were available. In addition, the National Council for Senior Citizens estimates that one out of six older Americans who

are not in institutions are in need of direct health care and social services if they are to remain in their own homes and communities. Yet, Federal funds tend to be biased toward institutional care—both hospitalization and long-term nursing homes. It is incredible and sad that less than 1 percent of medical expenditures for the elderly provide home health care.

As the chairman of the Special Committee on Aging, Senator Church has commented that:

> Independent residential living is certainly the most preferred type of living by the elderly persons. However, with increasing age, older persons sometimes find that they are unable to keep up with the pace of life to which they were accustomed in earlier years.

We feel it is essential that community-based support services must be available to allow older persons to remain in their own homes for as long as possible. Without these support services, such as home health, homemaking, escort, nutrition, transportation, outreach, and so on, many older persons have no option but to relinquish their independence for physical security in an institutional setting. Adult day care has proven to be exceptionally successful as an alternative to institutionalization in Pinellas County, Fla. Congregate housing would be another important alternative.

"Tragic Waste of Resources"

The lack of reality-based and compassionate, tailormade support services results in a tragic waste of valuable resources. Not only is it a waste of public and private money, but it is a loss of the potential community contributions and very real personal dignity of the individual.

Please do not misinterpret me. I understand that we need nursing homes; therefore, I am not suggesting that we should cut public funding for nursing homes. The Senate Special Committee on Aging has contributed much for which the country can be grateful in focusing attention to some of the fraud and abuse of some nursing homes. What I am saying is that we need a full continuum of service choices available in each community to meet the health and social needs of each elderly individual. Many frail individuals require the skilled nursing and intensive treatment available in nursing homes. Yet, the vast majority—only 5 percent of the elderly population reside in nursing homes—of senior citizens require merely a level of health care and support social services sufficient to maintain their independence in their own homes. I believe that these essential services will be cost effective as well as humane. Adequate health care remains the No. 1 concern and priority of senior citizens.

Few communities can boast of the wide variety of programs being developed in Holyoke for the continuum health needs of their older constituents. The geriatric authority of Holyoke is unique in the country. The city-based geriatric authority combined power and responsibilities of both private and public sector in providing both facilities and services to the elderly. We will have a rare opportunity during this conference to learn from the experiences in Holyoke in developing this innovative approach to meeting the needs of its urban elderly. Perhaps through the dialog which develops from the par-

ticipants, a model can be developed for replication throughout the country.

As vice chairman on aging for the U.S. Conference of Mayors' Committee on Human Resources, I will certainly make recommendations for official policy of the Conference of Mayors based upon the experiences gained from the program being developed in Holyoke.

Senator Brooke, the task force is grateful that the leadership and vast experience of the Senate Special Committee on Aging is a part of this important conference. We are especially grateful to you for taking time out of your very busy schedule to share with us this innovative program being developed in your home State.

Thank you.

Senator Brooke. Thank you, Mayor Cazares, for a very fine statement. I want to also express my appreciation to the U.S. Conference of Mayors for having its task force come to Holyoke today; it certainly will be very helpful as we consider legislation. We look forward to any proposals that you may submit to us.

Could you tell us a little bit more, Mayor Cazares, about the adult day care services or program which you have?

Mayor Cazares. Yes. Very briefly, in Pinellas County we have been able to establish three day care centers in our county and they service a population of 750,000 people, of whom approximately 300,000 are 60 and over. Actually these are just prototypes and these are not really meeting the total needs of our population, but they show what can be done as an alternative to nursing homes. They provide a place where persons who live at home, either in public housing by themselves or with their families, can go during the day to share in learning experiences and to share in the nutritional program.

One of the most gratifying things I have seen in recent years at one of these developed day care centers was a person over 70 years of age that, for the first time in her life, had learned how to write while participating in this activity. It gives them a feeling of dignity and it fights one of the biggest problems that we encounter in the field of aging, that of loneliness. It gives them the companionship during the day that they need and it also permits some families to keep persons at home while they go about their daily work.

Senator Brooke. Well, for example, take an elderly widow who may be depressed, and one problem will lead to another, as you well know. She won't eat properly and, consequently, will need attention and services from the city, such as transportation, meals, and recreational facilities. What do you feel that cities are able to do in regard to this kind of problem?

Cities Can Do More

Mayor Cazares. I think a lot more than they are presently doing. I think many municipalities have in the past felt that the problems of the aged, along with other social health welfare programs, are the responsibility of other governmental entities—the county or the State or the Federal Government—and consequently many of our aged are being penalized by living in cities where inadequate care is being given. Somehow or another, the funding for these programs, whether

it is an adult day care center or a nutritional program under title VII, has got to take recognition of areas where you have disproportionately large numbers of senior citizens as we have in Florida where our rate is triple the national average.

I would like to say, at the present time, that within the method of funding typical title III programs under the Older Americans Act there is a matching requirement on a decreasing basis. For the first year, the Federal Government may fund 90 percent; the next year 75 percent; the next year 50 percent. In some areas this means that the people who need this kind of help the most do not receive it because the local governments do not come up with that additional match.

I might add that in this respect I am very, very sorry to say that Florida comes in dead last when it comes to receiving its per capita share of Federal funds. That means we rank 51st behind the District of Columbia, and that is hard to do. This is only one of the programs that affects our State where, because of the philosophies of government where many governmental leaders, elected officials, feel that people should do more for themselves, those who need the help the most, your senior citizens in Florida, are being penalized because they live under these fund constraints. They receive much better treatment and are recognized to a greater extent in other municipalities and other States.

Senator BROOKE. What can you tell us from your role as a mayor about getting some of these programs started?

Mayor CAZARES. I have been focusing attention on our responsibilities. I have worked with various groups in the community to educate and sway the attitudes of our elected officials. I am one of five elected officials who have to decide whether we are going to participate through the use of revenue sharing funds or through community development grant authorizations or other funds that are available. Up until now it has been very difficult to convince my particular commission that they have a written responsibility in this area, but I think that they are coming around.

I think we will be more successful in the future. I might add, just speaking from the standpoint of the county just to show what the unmet needs are, we have an excellent nutritional program, that is, a dining hall program. We have three of them in my city of Clearwater, but in the past when persons that sponsor these programs would come to our city to ask for space for facilities in which they can conduct these programs, they have been told there was no space; so churches, fortunately, have stepped into the vacuum.

I feel that there is a need for multipurpose senior citizen centers, for example, in municipalities close to where the people are, where you can conduct adult day care centers, congregate dining hall activities, and other social and medical functions.

Our congregate dining hall program, for example, in Pinellas County, where we have 300,000 persons over 60 years of age at the present time, reaches only 2,000 people. I know that there are eligible citizens who are going hungry and who are not participating in this program. We have to reach them; we have to find ways to provide the facilities where they can participate and to make sure that we have transportation to go out there and bring them into this activity.

Senator BROOKE. We have heard that you experience great difficulty in putting together funding for programs for the elderly. Can you give us your perspective on that?

Mayor CAZARES. Yes, sir, I will be very candid, Senator Brooke. I see full Federal funding of programs under title III and title VII as the only way to assure that the people who need this help are reached, because if we rely on matching funds from the local governmental units, we are going to find a lack of uniformity; we are going to find areas where people will suffer because they are in the wrong political or philosophical environment for this type of support. Either that or a direct requirement in revenue sharing programs or other programs that a minimum percentage of funds will be allocated to make sure that these programs are implemented and made to work.

Senator BROOKE. Are you saying that none of this funding should come out of community development block grant money and none of it should come out of revenue sharing?

Mayor CAZARES. No; I think that possibly there should be more explicit requirements and authorization in the guidelines to make sure that municipalities know, for example, that revenue sharing moneys in a certain percentage are appropriate for expenditure, either to fund municipal activities serving the needs of the aged or else to fund social service agencies that are providing these services that a government leader cannot or will not provide.

"IMPACT AREAS"

I would go one step further, Senator. I think that in certain areas, for example, in our particular county, the fact that 40 percent of our citizens are 60 and over—two out of every five—means that our people who are on fixed incomes are not contributing to the tax base what other communities receive from their citizens. It would be appropriate to consider the designation of some of these communities as impact areas so they would be relieved of the necessity of providing the matching portion of Federal funds if the Older Americans Act is readopted as it presently provides.

Senator BROOKE. I just want to be sure that the Conference of Mayors stands behind what you said relative to further guidelines. Most mayors don't want any strings attached to that revenue sharing money or to that community development money. They want to be able to use it as they see fit in their particular community.

Now, do you now want the Federal Government to write stringent guidelines which will mandate that a percentage of these funds will go for the elderly? Is that what you are saying?

Mayor CAZARES. I would speak very unhesitatingly from my standpoint as the mayor of Clearwater, Fla., and I would back up what I have said. I think it is important that we consider those things, Senator Brooke.

Senator BROOKE. Well, I have run overtime with my questioning, but I do want to ask you this question before I conclude. We are looking at this whole concept of the geriatric authority in Holyoke. It has been stated by some that we are moving in the direction of the cities being left with the very poor, with the elderly, and the disadvantaged, and that the middle class and the more affluent are moving out to the suburbs. Have you seen any indication that this might be nationwide?

Mayor CAZARES. It appears that has been the trend, but it seems that the trend has been reversed now. I think that the energy problems of

the future will probably have a lot to do with reversing that direction. I think there are more of the executive-age population moving back to the central city where they have access to many facilities and services. I think that trend may be reversed, Senator.

Senator BROOKE. Of course, your situation differs. You see, in Clearwater you are in what we up here call the Sun belt. A lot of the elderly are moving south to take advantage of less extreme climatic conditions and living in the Sun. Of course, Clearwater offers that opportunity.

Mayor Proulx, for example, is in the frost belt, and he still has much of his population who are elderly. That is not a phenomenal figure when you think of where you are located—Clearwater, Fla.—but Mayor Proulx has 22 percent in Holyoke, Mass. Now that would argue for the concept that we are moving in the direction of the elderly left behind in the cities. I am wondering if that is going to be true across the Nation. If it is, then we must look at this very seriously. It presents us with all sorts of problems, the tax base problem, as well as many other problems that we will be confronted with if this is going to happen.

I would like the conference of mayors to look at this more closely, if you would, and if you could submit something to us in writing we would be most appreciative.

Mayor CAZARES. Thank you very much, Senator.

Senator BROOKE. Thank you, again, for your very fine statement and response to questions.

Mayor CAZARES. Thank you.

Senator BROOKE. Unfortunately, his excellency, the Governor, could not be present with us today because of other commitments but he sent us a very fine letter. He is certainly very proud of what is being done in Holyoke and he has a representative here with us who will be speaking later in the panel. The Honorable James J. Callahan, Jr., who is Secretary of the Massachusetts' Department of Elder Affairs, is here, and we will ask Secretary Callahan if he will come forward and read a greeting from the Governor.

Mr. Callahan.

Mr. CALLAHAN.[1] Thank you very much, Senator. I want to bring the greetings of the Governor to this hearing, and also the congratulations to the conference of mayors for holding the conference here in Holyoke.

Unfortunately, the Governor could not attend. It seems there are about 95 different things going on in the field of the aging today in Massachusetts, and he is off to some other business.

Massachusetts is very committed to the question of alternatives, and later on during the session I will deliver a formal paper explaining our position. I would like now to bring the greetings of the Governor and to those of you who are from out of State, welcome to Massachusetts. When the fog lifts, you will see the beautiful colors because it is just about that time.

Thank you.

Senator BROOKE. Thank you, Mr. Callahan.

Mr. CALLAHAN. Yes, sir.

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[1] See statement, p. 660.

Senator BROOKE. Now we will have a panel of the Holyoke Geriatric Authority. First will be Joseph Paul, who is executive director of the Holyoke Geriatric Authority.

Mr. Paul, would you come forward?

And Maria B. Dwight, vice president, Gerontological Planning Associates, Santa Monica, Calif., who was the past chairman of the geriatric authority and is given credit by many for being one of the founders and leaders in the geriatric authority concept here in the city of Holyoke. We are glad to welcome her back to Massachusetts.

William Rabbit, the executive director of the Holyoke-Chicopee Home Care Corp., will be accompanied by Mary Forrester, who is a member of the board of directors of the Holyoke-Chicopee Home Care Corp.

We are fortunate to have such a distinguished panel. We will start with Mr. Paul. You may give your statement first.

STATEMENT OF JOSEPH PAUL, EXECUTIVE DIRECTOR, HOLYOKE GERIATRIC AUTHORITY, HOLYOKE, MASS.

Mr. PAUL. Thank you, Senator Brooke.

I do have a prepared statement for the record. I would like to submit that along with some exhibits and documentation on the efforts of the Geriatric Authority of Holyoke. Rather than read this statement, I would like to summarize it orally and then possibly respond to any questions that you may have.

Senator BROOKE. Without objection, your full statement [1] and all the documentation [2] thereto will be included in the record. You may proceed.

Mr. PAUL. Thank you.

Obviously, I want to thank you for the opportunity to be able to talk about what we are trying to do here in Holyoke, Mass. Not having any bias, I know that our efforts may have implications in other communities.

Briefly, the city of Holyoke, back in the late sixties and early seventies, selected a unique vehicle to deliver facilities and services to the aged and infirm in Holyoke. A public authority structure was created because authorities customarily are corporate structures which are usually authorized through legislative action to function outside the typical structure of government in order to finance and construct facilities, and usually to facilitate the process of operation of revenue generating public facilities.

Public authorities usually have a luxury of relative administrative autonomy. Individuals like myself are responsible to an appointed board of directors who, in turn, are responsible to duly elected public officials. The uniqueness of our organization has been tempered somewhat by the fact that we cannot issue our own revenue bonds without the approval of the city fathers, in our case the mayor and the board of aldermen.

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[1] See prepared statement, p. 646.
[2] See appendix 1, item 1, p. 685.

The authority is roughly 5 years old and during that period of time there has been a constant struggle to seek recognition with funding sources in terms of the programs that we are trying to provide and the services that we are trying to provide.

Exhibit D [. 696] of my remarks clearly indicates the sources of financing that we have been able to attract in terms of financing our construction efforts, in developing what we feel is a unique service effort for an older, more frail low-income elderly resident.

The continuum of care that the geriatric authority has is not unique to the industry of health care for the elderly, but rather is an opportunity, an option, or an alternative for older individuals with some health limitations.

"Campus" Setting

In Holyoke, Mass., on Lower Westfield Road, where the municipal nursing home is situated, the geriatric authority is attempting to set up a campus or a village setting of care, and that campus of care would house a 120-bed intermediate care facility and a 120-bed skilled nursing home facility. These two facilities would be the core of providing services for people who would be residing in what we call sheltered apartments.

The whole concept of the deferring institutional care is embodied in the concept of our sheltered housing effort. Sheltered housing provides an opportunity for individuals to maintain their independence in their apartments and yet have access to services that would come from the nursing home. For example, the nursing home could be the site for the nutrition program. We are one of the few long-term care facilities in the State that has an approved certificate of need for an out-patient clinic. The purpose of that clinic would be to provide services not only for the residents in our housing but also provide a geriatric type of clinic services to older Holyoke residents living in our area.

I don't want to overemphasize the nursing home aspect of our efforts when the topic of this hearing is alternatives to institutional care, but the source of many of the programs and services that we would be providing to the residents of our proposed campus would emanate from the nursing home. The outpatient clinic that I talked about, the nutritional program, the emergency medical services and, most recently under the auspices of the home care corporation and the department of elderly affairs, we have been able to secure a van which would be used to transport frail elderly from their homes to the out-patient clinic or other services in the community.

One of the unique things, I think, that we have done in the brief history of our organization is the ability to influence the thinking of those people who have management and control of the community development block grant program. We were able to influence the last administration and the present administration, the mayor, and the city fathers, to set aside some moneys to build a neighborhood facility that would house an adult day care program. We have also been able to secure a subsidy for the operation of that facility. I think the uniqueness in being able to construct a facility and attract the operational subsidy from the community block-grant program has generated interest in other communities.

Most recently, the day care center which is about to be opened, was certified for medicaid payments, so we will be getting third-party reimbursement from medicaid programs.

In summary, one of the most frustrating experiences in terms of developing this whole concept of care and this whole continuum of care has been the inability of the Geriatric Authority of Holyoke to realize the financing for the sheltered housing phase of our program. We all brag about the Geriatric Authority of Holyoke being the only public geriatric authority that has been so constituted to meet the services and facilities for the aged, but our uniqueness has really created some problems for us because dealing with the bureaucracy, especially at the Federal level and HUD particularly—when we identify ourselves as a geriatric authority, some people in chagrin scratch their head and say, "You mean a housing authority or do you mean something else," or, "You are a private and not a profit organization." So our legal structure has, in some instances, eliminated us from eligibility to receive funding for particular kinds of programs.

The architect of the legislation that created the geriatric authority did have some foresight in anticipation of this problem but, unfortunately, the legislation has been in conflict with Federal regulations and those people who have to ultimately make the decision as to whether we are eligible or not have usually ruled us as being ineligible.

The concern that the authority has right now is our ability to be able to provide sheltered housing to that group of individuals who have limited resources. Specifically, I am talking about section 8 subsidies; access to them are highly competitive. In our case, we would need a section 8 subsidy in order to realize the housing phase of our activities.

In terms of long-term financing for our project, I feel that we have resolved long-term financing. There are a number of Federal programs available—section 202, section 8 piggyback, some of the existing FHA programs—but to make this whole program accessible to the people that we are trying to zero in on without section 8 subsidies is just a dream.

I think the mayors and public officials today, especially in older urban communities like Holyoke, Mass., have the problem of taking the minimal resources and getting the maximum mileage out of it. There are those in this community who feel that we have more than our share of subsidized housing. Not being a housing authority and not being in the housing business per se, the authority is trying to provide a service, and sometimes looking to general purpose programs to fulfill a specific purpose throws us in competition with other housing efforts; a community has to come up with priorities.

In summarizing my comments, one of the recommendations that I would make to you, Senator, as a member of the Senate Appropriations Committee and as a Member of the U.S. Senate, is the concern that I have regarding the section 8 program nationally. At one time, if you were eligible for the section 202 program, you automatically had the section 8 piggyback. Now I understand that Congress has moved in the direction of making that section 8 allocation a separate process. You are penalized by your overall allocation. If the city of

Holyoke were to receive a section 202 fund reservation, section 8 piggyback, the section 8 subsidy would reduce the section 8 subsidy available to the community. It seems to me that if this administration is really concerned about frail elderly that certain portions of section 8 moneys or subsidies available should be set aside for this specific group of individuals.

What the authority has done locally certainly has application nationally. In recent months, we have been scrutinized by not only the U.S. Conference of Mayors but also by the mayors' counterpart organization, the International City Management Association. We are not preaching that what we have done has application in the format that we have done it, but it certainly could be geared to fit the needs of the communities of people here today which I represent.

Thank you.

Senator BROOKE. Thank you, Mr. Paul. Your prepared statement will be inserted into the record now.

PREPARED STATEMENT OF JOSEPH PAUL

I am Joseph Paul, executive director of the Geriatric Authority of Holyoke. Prior to my appointment to this position, I served as director of development for this organization, a position that I held for approximately 3 years.

It is indeed a privilege for me to be here today and to share with you the experiences of the authority as we attempt to meet the needs of the frail elderly of our community.

I believe our city, Holyoke, Mass., has developed a unique approach to providing facilities and services to the frail elderly. The Geriatric Authority of Holyoke is a city-based authority that combines the powers and responsibilities of both the private and public sectors (exhibit C, p. 694). The Geriatric Authority of Holyoke may be a unique vehicle for meeting the needs of the aged and may have some adaptation in other communities.

In the late 1960's, the mayor of Holyoke (William S. Taupier), the board of aldermen, and a concerned group of citizens led by Maria B. Dwight, initiated a movement which focused on the development of a comprehensive care system for the frail elderly. These individuals selected the structure of a public authority as the vehicle to accomplish the implementation of this care system.

Public authorities are customarily corporate structures, usually authorized through legislative action, to function outside the typical structure of government in order to finance and construct facilities, and usually to facilitate the operation of revenue-generating public purpose activities. Their organizational format and powers are of the nature usually associated with public corporations, and like the latter, they have relative administrative autonomy. In addition to this, public authorities are authorized to issue her revenue bonds (in our case with the permission of the city), which ordinarily do not constitute debt limitations since public authorities are required to meet their resources. Authorities generally lack the power to levy taxes, but are empowered to collect fees or other charges for the use of their facilities, devoting this revenue to payments of operational expenses and to interest and principal on their debts (exhibit B, p. 691.).

In 1971. State legislation created the Geriatric Authority of Holyoke as a public body corporate and politic. In the ensuing years, 1971 through 1974, this newly organized agency assumed the management and control of the municipal nursing home and 18 acres of land adjacent thereto. The authority also employed a gerontological planning firm to assist in assessing the needs of Holyoke's elderly population. This firm conducted a community survey, assessed existing services, prepared a report which identified the needs of Holyoke's elderly, and made recommendations on the direction which future development should take. Encouraged by the results of this assessment, the authority moved forward to initiate a plan that would hopefully plan a continuum of care for the elderly that would delay or deter institutionalization, that is, nursing home care.

Members of the authority felt strongly that there was an overdependence on nursing homes. One of the goals of the geriatric authority was to create a

village or campus where the makings of a community exist, and where the facilities, programs, and personnel can create a sense of identity and proprietorship among the participating elderly. The combining of facilities at one location makes it possible to provide a continuum of care which enables the elderly to live, interact, and receive necessary supports in a secure, familiar location, regardless of their changing needs (exhibit A, p. 685).

In addition to this, the authority is committed to finding solutions which will enable the elderly to reside in their own homes or apartments. A system of providing services to the elderly in their homes was developed as a result of the authority's receiving a planning and development grant from the Massachusetts Department of Elder Affairs. This grant was for the establishment of a home care corporation to serve this region. William Rabbitt is here today and perhaps his remarks to the committee will discuss some of these services to the elderly.

Since 1974, the authority has been able to implement many of its programs which will provide alternatives to institutionalized care. Some of the programs and services include:

(1) Establishment of a home care agency.
(2) Construction and operational subsidy for adult day care services.
(3) An outpatient clinic for a geriatric clientele.
(4) Transportation program for the frail elderly and handicapped.
(5) Construction of a major skilled nursing care facility and renovation of an intermediate care facility whose philosophy will be to provide rehabilitation and restorative services in a manner that might enable many of the residents to return to more independent living arrangements in the community.

All of the planning and development activities that were needed prior to the implementation of the above-mentioned services would have been impossible without the financial assistance from the Administration on Aging. In July 1974, the authority applied for and received assistance from AoA through its model projects program (title III, section 308, Administration on Aging, 1965). This assistance has continued for the last 3 years. Obviously, these AoA moneys supported the development efforts that has resulted in financing for the previously mentioned projects from a variety of sources (exhibit D, p. 696).

However, our success has not been without some frustrations and some failures. The final phase of our proposed geriatric campus—sheltered housing—has not been realized as of this time. Yet, this is our major thrust as an alternative to institutional care.

This phase of the geriatric campus would provide 100 units of apartments for independent living. The options for such supports as meals, housekeeping services, emergency medical services, personal care, and transportation will be available. This housing complex will be located adjacent to the nursing home and outpatient clinic.

The authority has been encouraged by HUD, yet after a number of applications have been submitted to HUD, the authority has yet to be successful in its attempts to secure funding (refer to exhibit A, p. 685, for greater detail). At the crux of our dilemma is our inability to secure some form of subsidy for this project, thus making the housing available to low income frail elderly.

Another issue is the uniqueness of our organization. Being the only geriatric authority in the Nation has been an obstacle in determining our eligibility for funding (section 202/section 8 as an example).

Apparently another issue is the appropriateness of using general purpose housing moneys for a specific purpose.

In spite of these setbacks, the authority will continue in its efforts to realize the development of a care system that will provide the frail elderly with a maximum options so that their freedom and independence will be guaranteed.

In conclusion, Senator Brooke, I would like to offer some observations and concerns from the perspective of an organization that is attempting to provide services to the elderly.

(1) Although there is a great deal of discussion regarding alternatives to institutional care and the alleged costs savings related thereto, in my opinion there is a continued overdependence on nursing home care. A recent survey by the Massachusetts Department of Public Health suggests that 35–40 percent of the present nursing home population could be better served through other supportive living arrangements. Alternatives to low income frail elderly are only available on a limited basis.

(2) There is the obvious need for a greater commitment to the frail elderly at the national level. Query: What is the national policy with regard to the frail elderly? What is the present administration's commitment to the elderly?

(3) There should be a reevaluation of the standards for admission to nursing homes. This evaluation should include the scrutiny of financial incentives which will lead to the elimination of poor care. There should also be the development of new standards of care which would provide for more frequent patient reviews, thus resulting in shorter stays in long-term care facilities.

(4) Programs and services of organizations like home care should be expanded. Incentives should be given to families to help maintain the frail elderly in the home as long as possible.

Thank you for the opportunity to present my views.

STATEMENT OF MARIA B. DWIGHT, VICE PRESIDENT, GERONTOLOGICAL PLANNING ASSOCIATES, SANTA MONICA, CALIF.; PAST CHAIRMAN, GERIATRIC AUTHORITY, HOLYOKE, MASS.

Mrs. DWIGHT. Thank you for inviting me, Senator. It is good to be home. I do have some written comments, which I will hand in, but I have to talk with my hands and I cannot read as fast as I talk, so I will just talk.

Senator BROOKE. Without objection, your prepared statement [1] will be entered in the record and history will record your hand movements. [Laughter.]

Mrs. DWIGHT. Interestingly enough it was October 31, 1971, that chapter 554 was signed into law by then Mayor Taupier, which means that the authority is now 6 years old. If Joe thinks we now have unique problems with the Federals, he should have been around in 1968, because it was a pretty unbelievable experience.

I listened with interest to the other speakers, as well as to Joe, and I think a lot of the comments that I wrote prior to arriving here respond to the concerns that are raised now. I would like to point out that 73 percent of the elderly in the United States live in urban areas and this represents 14.6 million people. There is no question that cities are becoming the home of the aged and the poor, and the poor are often in migrating groups.

Senator BROOKE. Do you see the trend reversing?

Mrs. DWIGHT. I just finished reading the HUD magazine, Challenge. They had a group of different experts responding to that question. Everybody disagreed.

I do think that if there is a reversal it is going to be slow in coming. The housing is not there. I don't see it for 20 years at least.

SERVICE NEEDS OVERSHADOW TAX BASE

I think, as it was pointed out, that this urban population demands programs and services disproportionate to the revenues which it creates for the city. Therein lies the problem and therein lies the genesis of the geriatric authority. I was there at its conception and I certainly was there when it finally went through the long gestation period.

The geriatric authority is a model based on the theory that local government is the appropriate government agency to respond to the needs of its citizens, regardless of their age. It is felt strongly in

[1] See p. 650.

Holyoke that you can influence the local level politicians, technocrats, and appointees better than you can those at the Federal or the State level.

Holyoke has very strong feelings about throwing the rascals out when they don't agree with the policies and politics. I have been convinced of that several times.

The history of the geriatric authority in the last 12 years really has been sort of a Don Quixote situation. Anytime you take a situation where you are trying to have different groups, institutions, and agencies give up some power to organize and coalesce into a new authority or agency, you are going to have friction and turf problems, and we did. I think that any other municipality that goes the same route will have some of the same problems, but they will have seen our track record and perhaps they can see the pitfalls that we didn't see.

Once we became an entity we realized that we could not possibly generate the revenues within the city that we needed to respond to the needs of our elderly. That is when the geriatric authority really took on the role of a catalyst, if you will, undertaking the herculean job of coordinating HEW, HUD, the Department of Elderly Affairs, the ratesetting commission, programs, and so forth, into an implementation phase.

I could go on and on. Getting all these people to work in concert in answering the needs of one specific group of persons was difficult.

I would like to point out that the elderly's needs are consistent and the response to those needs is very fragmented. And older person cannot enter a system and get feedback that helps and supporters him or her to find what is needed. What happens is that they get bounced around like a pinball machine kind of thing. This is what we are trying to reverse.

It certainly is an exciting concept and I do believe it works, even after all we went through. I came here to be very positive today, but there were some very rough days in the past. Since 1971, I think, we have seen an incredible change, not only in what the authority is actually delivering, but it certainly has raised the consciousness of this entire community to the plight of some of our elderly who are not only frail, but who are poor, and some who are poor but not frail but still need services that do not exist.

I am here looking back, but I am also looking forward, and I am looking forward to much of what Joe discussed. We were out there banging the drum in 1969, I believe it was, for what we called sheltered living. Now, it is called congregate housing. We were and are looking for community outreach. We were anticipating the trend toward ambulatory care and rehabilitation, which is on the increase for the elderly.

I just returned from England where I was studying a movement called hospice, which is the care for the terminally ill. I have seen the incredible job of humane, excellent nursing care that is given. It is a realistic team approach to the care of the terminally ill. To me, it is as appropriate for long-term care. It is possible for chronic home care. I would certainly like to see that concept introduced into the long-term care field.

In England, I also saw child care centers in the hospices. This was one of our original concepts when we put the geriatric plans together.

We didn't have 2 pennies to rub together, much less 3, and the third penny was the child care center, and it got lost. I would love to see it come back. There is nothing greater that anyone, no matter how skilled, or with how many degrees, or how much empathy, can bring to a campus of elderly people than the joy of children. I think it would be a fantastic thing. I have seen it and I know it works.

Thank you very much for asking me.

Senator BROOKE. Thank you. Your prepared statement will be entered into the record now.

[The prepared statement of Maria B. Dwight follows:]

PREPARED STATEMENT OF MARIA B. DWIGHT

The Geriatric Authority of Holyoke is a model based on the hypothesis that local government is an appropriate agency to assume the responsibility of responding to the needs and demands of its residents, regardless of their age. The premise is based on a variety of assumptions, some based in theory, others in historic evidence, and still others in cold, hard reality.

Political theorists reside in at least two camps (local or federalized) when the issue concerns which level of government is most qualified to make policy decisions. Theorists are further splintered when forced to pinpoint who will be the decisionmakers at any level. The GAH embraced the theory that the local citizens—elected, appointed, and employed (the technocrats)—are most aware of community problems and are best able to make appropriate decisions and implement programs that respond to specific needs. They are also the most accessible of the citizenery, should those policies and plans go awry.

The management of urban centers, with their inherent problems, has grown increasingly more complex. As technology increases, as government commitments spread, as social mobility continues to drain leadership and financial resources, cities are faced with disturbing problems which demand sophisticated solutions. Long-range implications must be evaluated in the immediate response. Unfortunately, quick and easy answers are often more expeditious and appealing than they are wise.

The history of the development of the authority is a quixotic saga, involving any and all of the conflicts that are inherent in the formation of a new and innovative department within a government. It was played out in a time of national turbulence, during the late 1960's and early 1970's, when the focus of national attention was on rebellious youth and cities were primarily concerned with survival. The implementation phase was launched in a period of severe economic recession in the city, the Commonwealth, and the Nation. The experience of the geriatric authority seems to have empirically proven the "Peter Principal" that, "if anything can go wrong, it will." But as we can see here today, the authority model works, and as the vaudeville saying of years ago proclaims (and not without basis): "If you can make it in Holyoke, you can make it anywhere."

It had become evident in the early 1970's that political rhetoric on the national level was having little effect on the quality of life for elders at the local level. The GAH was conceived in a vacuum of pubic response. But the authority was not too naive to recognize that the Federal and State governments had financial resources that were unavailable to the local community. So the authority assumed the role of catalyst for a consortium of interests: the Administration on Aging, Hill-Burton, the Commonwealth's Department of Elder Affairs and Public Health, rate-setting commission, the regional comprehensive health planning council, the Holyoke board of aldermen, office of the mayor, and public and private agencies were some of the participants in this complex undertaking.

Individuals in all levels of government and on both sides of the political aisle were outstanding in their support of the concept of an easily accessible system which would provide a continuum of care and support for the frail elderly of Holyoke. It is a herculean task to coordinate diverse interests to focus on a single problem. It is difficult to convince groups, institutions and agencies to divest themselves of some power in order to create a new autonomous authority. But the needs of our urban elderly were real, and demanded to be addressed. Selective intervention through supportive services, quality health care, and preventive medicine, good housing, adequate transportation, physical and emotional security are some of the goals for which the authority was and still is reaching.

Seventy-three percent (14.6 million) of the old people in this country live in urban areas. The majority of them live in the oldest neighborhoods and have dwelt there most of their lives. Cities are changing. Old neighborhoods have been targets for "improvement," which has taken the form of highway construction, urban renewal, and relocation. With the flight of the younger middle class to the suburbs and the exodus of the merchant to the shopping mall and the industrialist to the industrial park, the city has increasingly become the home of the poor; the newly arrived migrant population and the left-behind elderly. This population consumes a disproprotionate amount of city services for the revenue it generates to the city. Agencies, both public and private, have tried to respond to the myriad social and economic problems which the evolution of urban life presents, but their efforts have been fragmented, inefficient and most often "band-aid" solutions for global concerns.

Holyoke, Mass., can be considered a representative community in urbanized America. Its history of growth from its industrial revolution roots to its present day decline are symptomatic of most manufacturing centers. Holyoke's present population is over 22 percent elderly and around 15 percent minortiy. The total population of the city has decreased over the decade while the population of the SMSA has increased.

The elderly in Holyoke are also representative of the national elderly population. They are a conservative, proud population managing on severely limited incomes. Their needs, as articulated in the community survey for the 1973 "Community Plan for the Elderly" typify the needs of older city dwellers nationally and are consistent with recent surveys in other parts of the country. The formation of the Geriatric Authority of Holyoke is illustrative of an answer to one of the human problems of the current urban evolution. It shows how a city struggled with a global urban problem and found an innovative solution.

We are here today not only to look back but also to look forward. Now we can see a modern new health center, offering rehabilitative and ambulatory care as well as outstanding quality long-term care for the elderly. We see a functioning home care unit and a new day health center. Hopefully, we soon will see other components of the continuum of care in place, particularly the sheltered living complex which was a primary focus and integral part of our original planning.

I would also like to see more innovation in the future. Having recently returned from England, where I studied the hospice movement's excellent efforts in caring for the terminally ill, I was profoundly impressed with the holistic approach to health care. The team approach of medical, nursing, religious, and social work professions working in concert with patients and their families is as appropriate to those in long-term care facilities as it is to those in hospice care. There, too, I saw child care centers as an integral part of the nursing facility and the program. This concept was included in our original 1973 plans for the geriatric center. Though I was among the skeptics and put the inclusion of a nursery school low on the priority list, now I have seen the impact that children have on the environment. They bring a joy and celebration of life to a facility that no program director or occupational therapist, no matter how skilled, can duplicate.

I am pleased to be invited here today to participate in the sharing of the accomplishment of the first geriatric authority in the United States. It has come a long way in a few short years. The model is well worth emulation.

Senator BROOKE. Mr. Rabbitt.

STATEMENT OF WILLIAM RABBITT, EXECUTIVE DIRECTOR, HOLYOKE-CHICOPEE REGIONAL HOME CARE CORP., INC.

Mr. RABBITT. Thank you, Senator, for the invitation.

I do have some case studies of various individuals that we have been involved with that I would like to leave with the committee staff.

If I may, I would like to read a brief statement.

Senator BROOKE. Without objection, those case studies will be included in the record.[1]

[1] See appendix 1, item 3, p. 697.

Mr. RABBITT. The question of alternatives to institutionalization in long-term health care is at last getting the attention it deserves and the attention called for at the 1971 White House Conference on Aging. I know that this hearing is only one of a series conducted on this issue over the past year. In the course of previous hearings before this and other congressional committees, the testimony of a wide range of professionals and elderly consumers has repeatedly stressed the need to make available a wide variety of community centered social and health care alternatives to institutionalization.

In fact, the testimony has been so overwhelmingly in favor of expanding the availability of such services that I am afraid we are all here today, in a sense, to preach to the converted in that the committee and its individual members have already begun to press for new or amended legislation, bringing the availability of community centered social and health care alternatives more clearly into the mainstream of services to older persons.

It should be made clear, though, that we are talking about a package of alternatives which must be as widely divergent as are the needs of the elderly population.

The work of the Geriatric Authority of Holyoke, which this conference is meeting to examine, is a clear example of the kind of thoughtful approach to alternate services that is so badly needed, but in and of itself the programs of adult day care and sheltered housing being developed by the authority cannot be seen as the only alternatives to institutionalization; rather they must be viewed in the context of a wide range of possible alternative services available in Holyoke out of which can arise a specific service plan for each individual in need.

With each new service available, we come closer to the ideal in which the service plan is written based upon the individual's actual needs rather than the unfortunate situations which have existed in the past in which we found ourselves trying to make the needs of the individuals fit the available services.

ELEMENTS EXIST—COORDINATION NEEDED

With the development of the adult day care facility and the proposed sheltered housing in Holyoke, and in the surrounding service area, we feel we have the various elements already in place which would now constitute a package of viable community centered and/or home care services for elders. At this time, all of the elements exist, but what we are still working toward is a banding together of the various elements into a well coordinated system.

I would like to describe for you the home care/AAA function we are performing. This description will, I hope, briefly outline what we feel are the essential elements for a complete package of viable home care alternatives and at the same time serve to illustrate those areas and artificial barriers to services which exist under current legislation and regulations. Included as part of this testimony will be several actual cases which illustrate most clearly the difficulties of providing adequate home care services when faced with these barriers.

The Holyoke-Chicopee Regional Home Care Corp. was established in September 1974 using title III funds of the Older Americans Act of

1965, as amended, provided by the Massachusetts Department of Elder Affairs. The original application for funds was made by the Geriatric Authority of Holyoke. The application for funding came at an ideal time as the Massachusetts Department of Elder Affairs was expanding its home care concept and programs across the Commonwealth. I know that the secretary of elder affairs, Dr. Callahan, is appearing later today to report on the progress of the home care program across the Commonwealth, so I will limit my comments to this particular service area.

The Holyoke-Chicopee Regional Home Care Corp. is a private, nonprofit corporation organized under chapter 180 of the Massachusetts general laws. The corporation is administered by a 15-member board of directors made up of local, mainly elderly, area residents. The corporation also has a 22-member advisory board, again made up of elderly citizens. Major funding for the programs of the corporation is title III of the Older Americans Act, as amended, and title XX of the Social Security Act, as well as local municipal, county, and community funding.

Case Management Essential

We feel that the most needed function in a coordinated approach to services is the case management function. The corporation right now is one of 27 home care corporations in Massachusetts using funds available under title XX of the Social Security Act. We are able to see to it that a wide range of the support of social services are made available to needy elderly.

Major services available to older persons under the State's comprehensive social service plan are case management, homemaker, and transportation services. Using these title XX funds, the corporation has served more than 1,200 individuals. The current active caseload of individuals receiving one or more of the various services is 906 individuals.

The second major role of the organization is that of an area agency on aging or a triple A agency. In this function the corporation makes use of title III funds under the Older Americans Act of 1965, as amended, to identify needs, gaps, and available service in the service area, then using the title III money to fund local programs or projects to meet those needs.

Recently, in Holyoke, for example, the corporation has provided funds for a minibus, a grant for legal services, and a grant to expand the existing available home health services. While the corporation is not the grantee for the title VII program, the title VII nutritional program in this area provides a close working relationship. The title III and title VII agencies have enabled us to provide a continuity in developing service plans for individuals.

There is a wide range of possible elements that we feel are necessary in developing a comprehensive service plan for the individual's needs. The city of Holyoke has come a long way in making a number of these services available.

One of the major programs in the city supported by the mayor is the council on aging program which provides drop-in centers, home-delivered meals, unlimited health screening clinics, employment services, and friendly visiting and outreach programs. These are just some

of what we feel are the essential elements in a total package that would be called alternatives of care.

In our judgment, the central element, as we have said earlier, is the case management function for those elderly in need of limited assistance in maintaining their own homes. The adult day care and sheltered housing programs give the city of Holyoke an added dimension and available services, making possible the development of individualized service plans.

If I may be so bold as to urge some committee and individual action on your part, I would urge that the committee work to centralize and strengthen the role of the Administration on Aging in all aging programs of the Federal Government. For example, one of the most valuable resources available to programs is elder workers themselves. We find a variety of programs such as Foster Grandparents, and so on, available under ACTION programs and some elderly employment programs administered by different branches of HEW.

I think it is essential and it would be far more effective if the various elderly service programs were coordinated and administered by a strengthened Administration on Aging.

I would also like to urge the committee to continue to press for a broadening of the definitions of available services under the various titles of the Social Security Act. This action would go a long way, we feel, toward the realization of a goal of a true alternative institutionalization and dialog.

If I may, I know that the committee often hears from staff and professionals, but I think it is far more important that the committee hear from the elderly themselves. I have asked Mary Forrester, who is on my board of directors and also is very active in elderly programs in this service area, to come here this morning.

Senator BROOKE. Mrs. Forrester, we are pleased to have you here. You may proceed.

STATEMENT OF MARY FORRESTER, MEMBER, BOARD OF DIRECTORS, HOLYOKE-CHICOPEE HOME CARE CORP.

Mrs. FORRESTER. Since you all know my name, I will skip that.

I have the privilege to be a member of the board of directors of the Holyoke-Chicopee Regional Home Care Corp. I am also very proud to be on the project council of the community and reginal opportunity program, and also connected with the RSVP.

I am over 60, and as I look around, probably I am the only one over 60 here. However, here goes.

On our board we have members from many walks of life with much experience in living and caring who are not happy unless sharing with others who are in need. After all, won't it be our turn in the future if we are left alone without family or friends or good neighbors who care?

How can home care help? I think of it as a good triangle. Suppose you have been in the hospital for more than several days: you need to go to a nursing home but then you return home with the assistance of a visiting nurse.

Or it could be this: You are in the hospital: you return to your apartment with a homemaker, followed by meals-on-wheels.

Another triangle would be: You were at the emergency room at a hospital; allowed to go home with full instructions with meals-on-wheels or a homemaker, depending on the case; and when able, go back to a congregate meal at one of the many nutrition sites.

Our aim is to keep the older Americans in his or her apartment or home as long as possible. Yes, we are aiming to avoid entrance to institutions.

Then, too, the older American with limited fixed income may need legal advice. He cannot afford the usual lawyers' fees, so we at home care refer him to available legal services—even setting up the appointment.

Maybe the older American needs help in taking care of the apartment or home. Why not ask for chore services, but the individual must be interviewed.

"Sense of Security"

What does home care provide for an older American? I believe not only services are rendered, but a sense of security and knowing someone cares. Homemaker services and/or visiting nurse services at home means a client can sidestep the hospital or nursing home, and it costs less, too.

At senior citizen projects, namely, Bury, or Kida in Chicopee—many of our senior citizens cannot manage the washing of the big front windows; it is more than any of them can handle. This is when home care comes to the rescue and this chore is handled quickly and well. Often all that is needed is to furnish an elderly person in need with the Holyoke-Chicopee Regional Home Care Corp. telephone number.

Some time in the future, Chicopee Visiting Nursing Association plans to purchase a Readocrit machine service to test for anemia, and also the Ames eyetone colorimeter for diabetes screening, which is most needed and is a newer way to identify either anemia or diabetes.

Daily our home care caseworkers do valuable outreach work besides answering questions and referral. Everyone of us can be an outreach worker when we recommend.

In Chicopee we have an elder care center. Some clients are handicapped while others need to get away from the family home or small apartment from 10 to 4. This gives the member or members at home an opportunity to work part or full time or have a little freedom from the family responsibility. A nurse is in attendance; a pleasant atmosphere abounds; arts, crafts, and recreation are available; a good nutritious meal provided; and rest, if needed. I am much impressed by this setup.

Home care gives me and others a sense of security. I can get help when and if I need it. Once upon a time family, friends, and neighbors took care of the elderly, willing and lovingly. Today some still do it that way. Most of the time the older American is on his own and needs help when his family is far away from his community.

Transportation is another of the great needs for the older American. This is partly solved by the minibus services to shop, to get to and from the doctor's and dentist's offices, to recreational programs, to congregate meals, et cetera.

Yes, we sorely need better and improved public relation methods to keep potential clients informed by newspaper and radio announcements. TV is too expensive to consider; however, occasionally we get on TV as a news item.

In Chicopee we have more than 9,000 elderly; in Holyoke over 10,000. In just these two cities it means much needed work ahead and increased appropriations to accomplish our aims. It is a challenge. Let us help those elderly who are in need. Home care is working on it with all we have to give.

"Living With Grace" Important

Survival is one of the key words; but living with grace is important, too, especially for us older Americans who lived through World War I, the Depression of the thirties, World War II, the Korean war, several assassinations, the Vietnam war, and Watergate. Let us do what needs to be done now.

Senator Brooke. Thank you, Mrs. Forrester, for that very articulate statement on the problems facing the elderly.

I thank all of the members of the panel.

Let me start with you, Mr. Rabbitt, on some questions.

You say in your testimony that all the elements of a viable community based system of long-term care now exist here, but that they need to be coordinated.

What is needed to accomplish this coordination?

Mr. Rabbitt. As I said, I think first what is needed is a revision in some of the various titles of the Social Security Act—a bringing together of title XVIII, title XIX and title XX services, and the broadening of some of the definitions of services that can be provided, for instance, under medicare. We would not face the situation which we have faced in the past in Holyoke—where a Holyoke visiting nurse is able to provide a limited amount of care. The needs of the client go beyond that to some social service needs. We have to call in, then, the title XX funding source, the duplication of paperwork, the duplication of time expended in most kinds of efforts, trying to insure that the clients are actually getting the service that they need, as one of our areas.

Another element in coordination, I think, is strengthening; as I mention again, the role of the Administration on Aging. There is a lack of continuity, for instances, in the volunteer program. What happens is, in a city the size of Holyoke, for instance, we have the council on aging, which is receiving municipal funding, providing certain services; the title III agency, which is the Home Care Corp., providing certain services; the title XX agency, also in this case the Home Care Corp., providing services; the various medicare and medicaid funding sources making available services; and the geriatric authority with different services.

There are, I think, all the elements available. We have management—it is kind of a harsh term, the management of the client. Once the client becomes known to us, we have to insure that there are individuals capable of managing the client through the system, and that is a function, in Massachusetts, now being filled by title XX funding. It is still a situation where we are bending too much, I think, and trying

to make the needs of the client fit what is available, rather than making available what the client actually needs.

Senator BROOKE. Do you believe that increasing expenditures for home care will actually save money in the long run, due to decreased need for institutionalization?

Mr. RABBITT. Although we don't have extensive figures, some of the staff studies that we have done indicate that you can provide home health services and the support of social services at a much less expensive rate than the full cost of institutionalization.

I would like to say, and I am sure that the Senator would agree, that, in our effort, it should not be so much focused around the cost of the service, but what is the more humane way of providing service to our elderly citizens.

Senator BROOKE. Mrs. Forrester, as a senior citizen in this community, do you see unmet needs among the elderly?

Mrs. FORRESTER. I certainly do.

Senator BROOKE. What are they?

Mrs. FORRESTER. Well, first of all, a long waiting list for nutrition. Next is transportation. Now some of them have cars at the present time, but the cost of running a car is so great.

The next is the ability to drive a car; in the evening they won't drive. Many activities are at night, so they are deprived of that activity.

Then, when one is not sick enough to go to the hospital, and there is a period of convalescence, it would be shortened if they had care in the home rather than trying to do both.

At the present time in many of these instances they will have homebound meals or meals-on-wheels, depending upon being approved, but in some instances it would be much better if the homemaker were available at different stages. Have a homemaker when they are unable to get out of bed. If there is some change in improvement, then it would be the delivered meal. The next step would be to be able to go back to the congregate meal if they go to a congregate meal, and so many of them are on a waiting list.

TRANSPORTATION

Now as far as transportation is concerned, the minibus gets them there. Many of them on October 26 will have a flu clinic here in Chicopee—I suppose it will be in other cities some time—which means that we have to provide transportation for them. It means some of them are not coming to congregate meals, so the council on aging will probably have to handle that area.

All right. Now supposing there is a clinic for diabetes on a different date. Supposing another for anemia? There are all these different areas. Supposing all of a sudden Mercy Hospital says on such-and-such a date there would be a free examination, and they all come out in the thousands, it seems, from everywhere. It appears in the paper; it might be announced on the radio and TV, and transportation becomes a big deal there. Transportation is very much a big problem or need.

Senator BROOKE. Thank you.

Mrs. Dwight, as a founder of the geriatric authority and now working with other communities in other States, do you feel that the Holyoke experience, as an example, is exportable or appropriate for other areas of the country?

Mrs. DWIGHT. Very. Holyoke, I think, is a microcosm of the urban situation in this country. We have a decline in the city of population and an increase in the SMSA. We have a large minority population. We have the big shopping malls and industrial parks which have taken people out of the inner city. I see that nationally. I see it everywhere I go. California is booming, but its inner city is not; it has the same suburban flight that every place does.

The elderly in Holyoke are very typical of the national surveys and the demographics that I have read; they are very proud and should be. They are tough. They have worked hard all their lives. They don't want to beg and they should not have to. And if it can work here, it can work anywhere. I mean, if you can pull it off in Holyoke, you can pull it off anyplace. [Laughter.]

Senator BROOKE. Would you agree, Mayor?

Mayor PROULX. Yes, I would agree.

Senator BROOKE. You pulled it off here, didn't you?

Mayor PROULX. Yes.

Mrs. FORRESTER. Senator, if I may interrupt here.

Senator BROOKE. Yes.

Mrs. FORRESTER. I was born and raised here until I went away to school. I know what happened in Boston, but I had property in Chicopee, so when I retired early because of illness I went to Chicopee to the house that I had. I have been aware of what is happening to these two cities. Once upon a time Holyoke was far superior to Chicopee. I hate to say that Chicopee is far more outstanding, but there are so many things that have happened to Holyoke.

Senator BROOKE. That is not within the scope of our hearing. [Laughter.]

Mrs. FORRESTER. But I want to bring this out. The fact is the project council to which I belong goes from one site to another for our project council meetings. I visited site C, Liberty Quoit Club, site G, the Elks in Holyoke, of the nutrition program. So I have a chance to meet people who are at my age level, and I know their needs from the Holyoke point of view. My heart goes out to them because I know what Holyoke was when I was growing up—I loved it. I am not too keen about Holyoke as is. I am sorry to say that.

Mayor PROULX. You will be after next year's Chicopee tax increase. [Laughter.]

Senator BROOKE. See, I tried to stop you. [Laughter.]

Why don't we go on then to Mr. Paul, because I don't want equal time claimed on this committee for Chicopee or Holyoke.

Mr. Paul, is there a difference between the type of residents in the facility when it was a municipal nursing home and now that it is an authority and, if so, what happened to these people before the creation of the authority?

Mr. PAUL. I think in general we are serving basically the same type of individual in our present facility that the municipal nursing home has served in the past. If you look at the history of the municipal nursing home from its growth from a city poor farm to a nursing home

hospital to a skilled nursing home facility, and at the commitment the city of Holyoke has to its aged and infirm, our focus has been purely with a low-income or limited-income individual.

Unfortunately, our facility in the past would take individuals that other nursing homes would not take because of their limited resources. Under the reorganization of the geriatric authority, the focus is now changed from a maintenance type of nursing home to one that will provide restorative and rehabilitative services. So at least an individual who comes to our facility will have every opportunity to move to a less skilled nursing care facility, back into the community, or back into the service network of home care or home health care services that are available.

If you look at the financial records of the geriatric authority you will see that, while 96 percent of the revenues that we generate for services come through the medicaid program——

Senator BROOKE. Looking at that financial record, what is the savings to the residents of the city of Holyoke because of the existence of the authority?

SAVINGS TO CITY

Mr. PAUL. The creation of the authority resulted in taking the operation of the facility off the city tax rolls. The geriatric facility, being public in nature, provides revenue through the services that it generates, so the actual operation of the home is not reflected at all in the tax rate in the city of Holyoke.

Second, we are able to return to the city of Holyoke, through a predetermined fee for service or per diem, a tax payment to the city of Holyoke and, for the first time in 1974, I believe, we made that in lieu of tax payments in Holyoke, which had an impact of about $1 per thousand on the tax rate. So it is a self-sustaining organization which provides, in my opinion, quality free care and is now beginning to move away from the institutional type of approach to a more broad-based community approach. We are working with organizations like home care, the Visiting Nurse Association, and organizations like that to come up with systems that will deter the institutionalization process. Our attitude is, there will always be a need for a nursing home, and in that context we will try to provide the maximum care within the ability of our organization.

Senator BROOKE. I have many more questions to ask each of you. Some I will be able to submit to you and ask you to respond in writing to the committee. Unfortunately, there are votes on the Senate floor and I will have to catch a plane at 11 or 15 minutes after, so I will be leaving very shortly. We have a very distinguished panel to follow, the Honorable James Callahan, who is secretary of the Department of Elder Affairs, and an old friend, Frank Manning, who is the president of the Massachusetts Association of Older Americans.

I am going to ask this panel, however, if they will indulge me. If they will let this other panel commence, I would like to hear their statements and then staff will continue on and ask additional questions for the record.

For those who don't know how this works, every question and every response will be included in the record. That will be given to the committee so we will have the benefit of that information, whether they are asked by me or asked by members of the staff.

So if you will let Mr. Callahan and Mr. Manning give their statements and then come back, I would appreciate it.

Before Secretary Callahan and Mr. Manning begin, I would like to say that we welcome both of you. Obviously, I am going to have to leave in 10 minutes. I don't want to interrupt you so, without objection, I am going to make a closing statement which will appear in the record at the conclusion of all of the testimony and questions and answers.

I regret that I must leave at this time but, as I said, Congress is still in session and I must return to vote. However, I am going to ask the staff to continue to take testimony in order that those of you who wish to testify may do so. In fact, Dr. Letitia Chambers, to my right, will continue the hearings with other members of the majority and minority staff, and also a member of my own staff.

I would like to remind you that if you have a statement you wish to make for the record [1] or any questions that you wish to ask, there are forms available you may fill out and send to my office. These are the blue forms that you may have already seen which say:

If there had been time for everyone to speak at the hearing on Health Care for Older Americans: The "Alternatives" Issue in Holyoke, Mass., on October 12, 1977, I would have said:"

We only give you one sheet, but if you need two, three, four, or five, feel free to get them because we very sincerely want all of the input that you may choose to give to us, or any questions, as I said, that you might ask.

So without further comment. again I welcome Secretary Callahan and Mr. Frank Manning.

Mr. Callahan, you may proceed, and then Mr. Manning will follow. At the time I leave, why don't we declare a 5-minute recess because the dear lady to my left has been working that machine since 9 o'clock and she will need a break.

If you could complete your statement, Mr. Callahan, within the next 7 minutes, I would be most grateful to you.

Mr. CALLAHAN. All right, Senator. Thank you.

Senator BROOKE. Bearing in mind that your whole statement will be in the record.[2] If you could summarize, then we will have some questions.

STATEMENT OF JAMES J. CALLAHAN, JR., PH. D., SECRETARY, MASSACHUSETTS DEPARTMENT OF ELDER AFFAIRS

Mr. CALLAHAN. All right. My name is James J. Callahan, Jr., secretary of the Department of Elder Affairs for the Commonwealth of Massachusetts. I am very pleased to be here today to testify before you. I would like to congratulate you and the Senate Committee on Aging for holding this hearing in Holyoke and for the fine work that the Senate committee has done over the past years. I look forward to each new report coming from the committee as it is always full of good information and thoughtful conclusions. I would like also to congratulate the conference of mayors for holding the conference

[1] See appendix 3, p. 709.
[2] See p. 663.

in Holyoke on the subject of the aging, and I would like to congratulate the Geriatric Authority for its leadership, not only here in Massachusetts, but on the national level as well.

The subject before us is the alternatives issue. I am going to assume that that means that we are looking at the alternatives to nursing home care. This is a subject that has received a good deal of discussion and analysis in recent years, and all seem to agree that, because of the cost of institutional care, community alternatives are required. Recently, however, there has been a tendency to look again at the question, and some commentators feel that community care may indeed not be less costly or more efficient than institutional care.

Community Care Should Be Expectation.

I have seen analyses that show that when one looks at costs of income maintenance, community based health care, food stamps, and other public programs in the community, the cost in an institution may be less. If one follows this line of reasoning to its conclusion, we may decide that the institution is indeed the way of solving many of the problems of the elders. I think it is very important at the very beginning of my remarks to meet this line of reasoning head-on. The community is not an alternative to the institution. Rather, the institution is an alternative, and a very specialized alternative, to community living.

Most people are born, grow up, and die in the setting of the community. This is both a fact and an expectation. Since the abandonment of the poorhouse in the 1800's, social legislation has been designed to provide assistance and support to individuals and families residing in the community. From "outdoor relief" in the 1800's, the workmen's compensation law of 1908, the Vocational Rehabilitation Act of 1920, the Social Security Act of 1935, and the various amendments including medicare and medicaid, we see a succession of programs designed to provide economic security and personal independence. They have become an essential part of both our economy and our culture. What I want to emphasize is the community should be the expectation, and I really think we have to maintain that as our basic philosophy; otherwise, we are going to run into some problems.

Mr. Rabbitt mentioned some of the developments in home care. Massachusetts has taken significant steps in developing a community base which will enhance the life of its elders. Approximately 5 years ago, the first home care corporation was established. At the present time, the entire State is covered by home care agencies. Although the home care corporation is only one of the many agencies in the aging network, it is, in many ways, the key for all the others.

Massachusetts has been divided into 27 planning and service areas. In each one of these areas, a home care corporation exists. The home care corporation is a nonprofit agency with a board of directors representative of the elderly. The boards are composed 51 percent of members appointed or selected from councils on aging. Massachusetts now has 305 councils on aging out of 351 cities and towns. The heavy involvement of elders in the policymaking organ of the home care corporation is critical. The problems of the elders will best be solved by input, leadership, and direction from elders themselves.

Services of Home Care Corporations

The home care program is funded primarily under title XX of the Social Security Act. Income limits for eligibility are $4,800 for an individual and $7,200 for a couple. If you are within those limits, you can get the service. If you are above the limits, you don't get any service. One of the things we want to do now is develop a program to increase this for the people above the limits.

The home care corporations provide homemaker service, chore service, transportation, information and referral, and case management. Case management, which involves the skillful mixing of a variety of local community resources in behalf of the elder, is perhaps the key component at the service delivery level. Sixty-five percent of expenditures are for homemaker services. Administrative costs run between 15 and 17 percent. The current caseload is characterized by 65 percent of the participants being SSI recipients and 35 percent being non-SSI individuals. The reason for this is that as of July of this year we assume the homemaker caseload of the department of public welfare, so now all elders in Massachusetts receive service through the department of elderly affairs and not through the other.

The average cost per case is approximately $1,100. Home care is a growth program and, in fiscal 1975, the State spent $9 million on it; in 1976 this increased to $14 million; in 1977 it increased to approximately $18.5 million. For 1978 we have been appropriated $21.3 million, and in 1979 we will be looking at $30 million.

The demand for home care is quite high. In some instances home care corporations have waiting lists; this is another problem that we are going to have to work on.

Another thing that the department is interested in is pulling together the various agencies of the aging network—the councils on aging, the senior centers, and the nutrition programs. We feel that in some ways we are quite far ahead on this in that many of the home care corporations have been designated as area agencies on aging.

We are concerned about the relationship of home care to the health system which also has been discussed previously. Should home care corporations add nurses to their staff? Should contracts be written between the home care corporation and the community nursing agencies or hospitals? This is another area of concern to us.

The department is getting very involved in monitoring and assessing the programs to determine if they perform as they should. I do not have too many recommendations today. We are studying the impact of welfare reform and renewal of the Older Americans Act and will have recommendations about these particular programs. My one recommendation in respect to home care would be that Congress take action to remove the cap on title XX funds where those additional funds are spent on services to the elderly.

Massachusetts will spend a large amount of title XX funds on the $21.2 million. Our cap is about $72 million. I feel that if the cap is removed specifically for services to the elderly, it will help Massachusetts and it will serve as an incentive to other States to develop services for the elderly.

I would like to thank you for holding this hearing and if the department of elder affairs can be of assistance to your committee in any way, please be assured that we are available.

Senator BROOKE. Thank you, Dr. Callahan. You are right on target. You even gave us back 2 minutes. Your prepared statement will be inserted into the record now.

[The prepared statement of Dr. Callahan follows:]

PREPARED STATEMENT OF DR. JAMES J. CALLAHAN, JR.

Senator Brooke and members of the panel, my name is James J. Callahan, Jr., secretary of the Department of Elder Affairs for the Commonwealth of Massachusetts. I am very pleased to be here today to testify before you. I would like to congratulate you and the Senate Committee on Aging for holding this hearing in Holyoke and for the fine work that the Senate committee has done over the past years. I look forward to each new report coming from the committee as it is always full of good information and thoughtful conclusions. I would like also to congratulate the conference of mayors for holding the conference in Holyoke on the subject of the aging, and I would like to congratulate the geriatric authority for its leadership, not only here in Massachusetts, but on the national level as well.

The subject before us is the alternatives issue. I am going to assume that that means that we are looking at the alternatives to nursing home care. This is a subject that has received a good deal of discussion and analysis in recent years, and all seem to agree that because of the cost of institutional care, community alternatives are required. Recently, however, there has been a tendency to look again at the question, and some commentators feel that community care may indeed not be less costly or more efficient than institutional care. I have seen analyses that show that when one looks at costs of income maintenance, community based health care, food stamps, and other public programs in the community, the cost in an institution may be less. If one follows this line of reasoning to its conclusion, we may decide that the institution is indeed the way of solving many of the problems of the elders. I think it is very important at the very beginning of my remarks to meet this line of reasoning head-on. The community is not an alternative to the institution. Rather, the institution is an alternative, and a very specialized alternative, to community living.

Most people are born, grow up, and die in the setting of the community. This is both a fact and an expectation. Since the abandonment of the poorhouse in the 1800's, the workmen's compensation law of 1908, the Vocational Rehabilitation individuals and families residing in the community. From "outdoor relief" in the 1800's, the workmen's compensation law of 1908, the Vocational Rehabilitation Act of 1920, the Social Security Act of 1935, and the various amendments, including medicare and medicaid, we see a succession of programs designed to provide economic security and personal independence. They have become an essential part of both our economy and our culture.

A particular target of these programs are older persons who from choice or need no longer work. Although about 16 percent of the elderly have incomes below the poverty line, the large majority are able to live decent lives in the community. The incapacities that come with age are compensated for by a caring person, friend, relative, or social service. This will continue to be the case in the future.

Income protection, health services and housing are basic programs available to citizens across the board. The need for institutional care must be based on the individual's need for personal and professional services that can be provided best in a collective setting. A small proportion of elderly persons (3 to 6 percent) have significant needs for personal care, nursing, and medical services. For these, the community is an unsatisfactory setting, and an alternative to community living is required. That alternative is the long-term care institution. Those elderly who reside in such an institution must be assured of the quality of the care they are receiving. We know how extended institutional care encourages isolation and dependency resulting in the so-called institutional neurosis that may be apparent in a person's very physical appearance. In fact, that dependency may be prematurely created if the cost of obtaining institutional care forces the recipient to give up previous independent or quasi-independent living arrangements. The

need, therefore, is great that we develop and maintain a strong set of community-based programs, so that the institutional alternative will only be used when it is absolutely necessary and not as a substitute for community living.

Massachusetts Home Care System

Massachusetts has taken significant steps in developing a community base which will enhance the life of its elders. Approximately 5 years ago, the first home care corporation was established. At the present time, the entire State is covered by home care agencies. Although the home care corporation is only one of the many agencies in the aging network, it is in many ways the key for all the others. Massachusetts has been divided into 27 planning and service areas. In each one of these areas, a home care corporation exists. The home care corporation is a nonprofit agency with a board of directors representative of the elderly. The boards are composed 51 percent of members appointed or selected from councils on aging. For those of you not familiar with councils on aging, these are municipal bodies appointed by the mayor or board of selectmen to serve as advocates and, in some cases, as service providers for the elders. Massachusetts now has 305 councils on aging out of 351 cities and towns. The heavy involvement of elders in the policymaking organ of the home care corporation is critical. The problems of the elders will best be solved by input, leadership and direction from elders themselves.

The home care program is funded primarily under title XX of the Social Security Act. Income limits for eligibility are $4,800 for an individual and $7,200 for a couple. Persons within those limits are entitled to full home care services without charge. Persons above that level, even by a slight amount, are not eligible at all. This is a gap in the program, and one which we hope will be rectified with the development of a sliding fee scale. The home care corporations provide homemaker service, chore service, transportation, information and referral, and case management. Case management, which involves the skillful mixing of a variety of local community resources in behalf of the elder, is perhaps the key component at the service delivery level. Sixty-five percent of expenditures are for homemaker services. Administrative costs run between 15 to 17 percent. The current caseload is characterized by 65 percent of the participants being SSI recipients and 35 percent being non-SSI individuals. This compares to a year ago when just the reverse was true.

The reason for the change was that up until July 1, 1977, homemaker services to the elders were provided both by the home care corporations and the department of public welfare. The department of public welfare was limited to SSI recipients and the home care corporations could take SSI recipients plus others to the income limits. Welfare is no longer a resource, and hence the home care corporations must meet the complete need of SSI recipients. The implications of this have not been thoroughly considered. One implication of this, however, is that the average cost per case for home care corporations will increase this year. We figure that the average cost per case for 1978 is approximately $1,100. The actual average cost appears to be somewhat higher than that at this point due to the heavy influx of SSI cases. In 1978, approximately 28,000 elders will be served by home care corporations.

Home care is a growth program. In fiscal year 1975, a total of $9 million was spent by the State on homemaker/home care programs. In 1976, this increased to $14 million, in 1977, it increased to approximately $18.5 million. In 1978, we have appropriated $21.3 million, and in 1979, we will be looking for close to $30 million. This rising expenditure level points up one of the major challenges of home care, namely meeting need within fixed resources. The demand for home care can be quite high. In some instances, home care corporations have waiting lists. It is going to be very important to learn how to target the service to those in greatest need, recognizing that others will be demanding and could use the service but their priority is less in light of fixed, limited resources. This calls for a program that is very exquisitely designed and for regulations that are well thought out. It also calls for establishing mechanisms of assessment and evaluation so that targeting can be appropriately accomplished.

Another major need of the home care network is to insure that all of the services within the aging network—the councils on aging, the senior centers, the nutrition program, etc.—are integrated and are called upon to meet the needs of individuals. I feel that in Massachusetts we are one step ahead in this respect as a

number of the home care corporations have been designated as area agencies on aging. In some instances, we have home care corporations receiving funding under the Older Americans Act from title III, title VII (nutrition), and title IX (senior aides). I think that this type of coordination should be most useful.

The relationship of home care services to health services needs to be thought out very carefully. The original thrust of home care was on the provision of nonmedical, social services. This should continue to be its major thrust, as that is its area of greatest expertise. However, with so many of the frail elderly having medical and health related problems, it is absolutely necessary that there be some type of health/home care tie-in.

Should home care corporations add nurses to their staff? Should contracts be written between the home care corporation and the community nursing agencies or hospitals? How should home care corporations relate to the HSA's? This is a subject area that we all are aware of in its implications, and some home cares have begun to work on it independently. This problems is one which will be getting a lot of attention from the department of elder affairs this year.

In the provision of any public service, it is responsibility of some public agency to monitor and to assess the program to insure the quality and the appropriateness of the services. This is a major goal of the department of elder affairs for the coming year to put in place a good monitoring and assessment unit so that we can be sure that the home care system is performing as it is intended.

I do not have a lot of recommendations today for action at the Federal level. We are studying the impact of welfare reform and renewal of the Older Americans Act and will have recommendations around these particular programs. My one recommendation in respect to home care would be that Congress take action to remove the cap on title XX funds where those additional funds are spent on services to the elders. In Massachusetts, we are spending a large amount of title XX funds on the elders which I believe is quite different from many States where the elders receive only a small fraction of title XX funds. The proposal that I make would be an incentive for the other States to develop services for the elderly and they would be most helpful to Massachusetts by providing us with additional matching funds.

Again, I would like to thank you for holding this hearing and if the department of elder affairs can be of assistance to your committee in any way, please be assured that we are available.

Senator BROOKE. I want to apologize to Frank Manning for the fact I will have to leave.

Mr. MANNING. The only thing you will miss will be my ad libs.

Senator BROOKE. Well, I have been listening to Frank Manning for at least 15 years, and his voice is not only probably the most well-heard voice of the senior citizens in the Commonwealth of Massachusetts, but he is frequently in the halls of the Congress of the United States whenever he has something to say, I am sure Jay Callahan can verify this as well. He makes it known to us and we get the message.

So, Frank, I apologize for not being able to stay for your testimony, but I shall read your testimony and your responses to the questions.

Again I want to thank Mayor Proulx, the president of the Community College in Holyoke, president David Bartley, and the Conference of Mayors for their hospitality to this committee, to me and, I am sure, the staff that will conduct these hearings after I have departed.

We will now have a 5-minute recess.

[Whereupon, a short recess was taken.]

AFTER RECESS

Dr. CHAMBERS [presiding]. If we can go on with the hearing now, please.

Mr. Manning needs no introduction.

STATEMENT OF FRANK J. MANNING, BOSTON, MASS., EXECUTIVE DIRECTOR, MASSACHUSETTS ASSOCIATION OF OLDER AMERICANS, INC.

Mr. MANNING. Thank you very much.

I sometimes think that it is a little dangerous to grow old in America; even your doctor can be hazardous to your health. So many things are labeled now as being hazardous to one's health that it is really difficult to decide what to eat and what to drink and so on and so forth, although I don't have too much of a problem with that myself.

Ever since my 75th birthday I have had the feeling of being followed by the little man with the pill. There are a growing number of people who seem to be impatient with us for living so long. However, we like it and we will persist.

America spent $119 billion on health care last year. According to HEW Secretary Joseph Califano, the overall cost of health care in the United States has risen tenfold during the last 25 years, tripled during the last 10, and almost doubled since 1970.

Today the medical care industry is the third largest in the Nation, and projections for 1980 indicate that health-related expenditures will continue to soar, with no end in sight.

Still, in spite of these massive expenditures of money, we have not developed a comprehensive system of health care. A European statesman once observed that war had become too important to leave it entirely to the generals. This is true today of health care which does not involve only pills, tranquilizers, and prescriptions—the problem involves such social issues as sanitation, pollution, and various other environmental factors so necessary to maintain national health. Therefore, the development and execution of national policies relative to health should not be left entirely to medical professionals.

A study of health costs written for the Wage and Price Council by Martin Feldstein and Amy Taylor of Harvard University was published in January. Although loaded with statistics, the conclusion is clear.

> The sustained increase in the cost of hospital care is without parallel in any other sector of the country. The cost of a day of hospital care is currently increasing at an annual rate of more than 15 percent. While the general level of consumer prices has risen 125 percent since 1950, the cost of a day in the hospital has risen more than 1,000 percent.

That is according to these two researchers.

The need for a comprehensive health delivery system is clear but such a program of national health security should not be another bonanza for the medical profession. We might study the Canadian system of health care as a model on which to build a health program which will make health care accessible to all American citizens at a price we can afford to pay. We have the resources to do this. We need only the will and the commitment to accomplish this goal.

SPECIAL TRAINING IN GERIATRICS

We must begin to consider the special problems of older Americans. All medical practitioners need some special training in geriatrics. I do not suggest that geriatrics should be a separate branch of medicine

such as pediatrics is. I do believe that the symptoms in various diseases are not the same as in younger people and the manner of treatment is not always the same; however, basically our needs are the needs of the whole population.

This brings me to the question of alternatives to institutionalization. The development of our highly technological society has transformed our social structure to the point where the closely knit family living under one roof—grandma and grandpa included—has been badly damaged and considerably reduced. However, whenever possible elderly patients should be treated at home and when family resources are limited such home care should be subsidized by the Government. A middle-aged couple paying the mortgage and sending their kids to school have many financial burdens. If they are willing to do this, if they want to keep their mother and their grandmather at home, they should be encouraged to do so if their condition would respond to home treatment.

But the problem goes deeper than that. How do we hold the line on hospital and nursing home care and at the same time provide mechanisms to provide genuine home care? In Massachusetts, as stated before, we have 27 home care corporations to provide home care services to persons whose incomes do not exceed $4,800 yearly, single; $7,200, married couple. In my opinion this income restriction is wholly unrealistic and should be liberalized. The least we could do is to provide a sliding scale of payments so that thousands of persons will not be deprived of home care services.

People could take advantage of these services. Certainly a couple with $7,600 needs as much care as a person with $7,200. What we are doing is, we are so tightly managing our people into little boxes that sometimes it becomes difficult to breathe. Private home care is so expensive that it can only be utilized by persons in the upper income brackets, and I know this from personal experience. Instead of rigid income eligibility requirements, we need a more flexible arrangement.

It is too soon to judge the effectiveness of our home care corporations. It will probably take another year before we can arrive at any definitive conclusions whether we do it that way or some other way. Moreover, considerable implementation and broadening of the program is necessary. It is widely known that many older Americans are in nursing homes because there was no other place for them in the community. At the same time, many are still being placed in nursing homes who do not require round-the-clock medical services.

"Institutionalization Traumatic"

Institutionalization is traumatic for persons who have developed their own style of living and suddenly find themselves in a highly regimented environment where they eat when everyone else does; go to sleep when everyone else does; get a tranquilizer when everyone else does, even though they might prefer a cocktail at that particular hour. Therefore, I cannot overemphasize the importance of community facilities—congregate living with built-in social and medical services. However, I want to warn against the danger of building new institutions to replace old ones. Congregate living facilities should be limited in number and the residents should run it themselves with whatever assistance they might require.

The importance of being able to sustain one's own way of life in the case of older Americans cannot be exaggerated. It is imperative to develop a well-rounded program, not only to keep older persons out of nursing homes, but also to provide the backup services they require. This will need community involvement in a large scale; it cannot be left entirely to professionals.

I mentioned before the problem of maintaining our present health facilities while developing home care services, congregate facilities, and social services. It seems to me that we should move cautiously before weakening or dismantling our present health facilities. It seems to me that our strategy should be to provide nursing homes with the actual number of beds needed; to hold the lines of their expansion during the next few years and put our emphasis and support behind a program of community care. Now I say this with the complete understanding that it has to be shown we are capable of building a sustained, well-rounded program before any drastic action is taken.

However, as I say here, the services should not be developed half-heartedly, and the whole problem of providing mechanisms for service and residence for deinstitutionalized persons should have our full commitment and necessary financial support. I do not think that a rigid list of services, tightly packaged, should be universal. The services provided, the number of hours assigned for the care of our older persons at home should be geared to the needs of the particular client. Home service workers, chore workers, and health aides should be available according to the requirements of the individual.

For example, I do not believe that there is sufficient provision for weekend emergency cases. My telephone rang the other day before I was ready to leave for home. The party at the other end of the phone was frantic. It was Friday night. He said that he had been informed that no service would be provided on Saturday and Sunday. He had only one leg and was recently the subject of a heart and hip surgery.

I immediately called the home care director who told me there was no provision by visiting nurses for weekend services but that he would arrange to have the client's meals prepared. I was able to supplement this service by having a friend spend a few hours on Saturday and Sunday. I feel strongly that home care organizations should make immediate provision for emergency weekend care; or if such arrangements do exist, be certain that they are complied with.

Now what predicament would that man be in if he didn't call me or somebody like me? Yes, it is important to have money, but the attitude and the spirit of those administering that program is of vital importance.

I also agree with Secretary Callahan that we have yet to prove—if that is necessary to prove—that home care will be a substitute cost; we have yet to prove it. If the concept is valid and if the necessary money—I believe the department of elder affairs should have a very sharp increase in their budget for home care services and for other supporting services. I think that we may be able to prove that it is a valid concept both costwise and from the point of view of the main treatment of our elderly. I personally do not exaggerate the cost effectiveness, but I know that there are those in Congress who are looking at this thing very, very sharply. As a matter of fact when I left the office this morning we had 70 Vista volunteers, and I was told that

they had no checks this month, and I asked "Why?" Well, they said the antiabortionists tied up $60 billion appropriations.

You know, it is very amusing to me that they found a way to stop the liberals from filibustering against gas deregulation, but they cannot see the way to stop the antiabortionists. While I am not taking a position on abortion, I am taking the position that the democratic process allows for full discussion, but not to the point where it ties up all functions of Government. I think it is contrary to the national interest for this group to tie the country into a knot, threatening the social service programs, and so forth, and I hope they will shut up pretty soon.

Finally, I would just like to make the observation, if I may, very briefly, that I see a resurgence among a large section of senior citizens— a resurgence which I think is a hopeful sign not only for them but for the country as a whole. My generation has made many mistakes, but it has also made many contributions to the development of this country. I find that there is a growing appreciation, that we are no longer the outcasts of society, that we are beginning to get some recognition.

In the field of social services and nutrition, we have made progress since 1970. However, the basic question of health and the basic question of income maintenance still have many close ends and these, too, are so closely interrelated that it is almost impossible to separate them. If you want to study the health conditions of older people, you will find yourself knee deep in economic and social problems which directly affect the health of the individual. Therefore, it is a two-pronged thing. We shall not solve the problem of health until we have solved the problem of a good income maintenance plan geared to the needs of the seventies.

I like the spirit—I travel all over the country—that I find among the organized senior citizens. I would like to close by telling you about one woman who, at the age of 102, was undergoing a physical examination and the doctor expressed amazement at her physical ability and her mental alertness.

"Well," she said, "don't be surprised. I have taken good care of myself."

He said, "Are you 102?"

She said, "Yes, I certainly am."

He said, "That's hard to believe."

He said, "Will you be back next year?"

"Well," she said, "of course I will."

He said, "For a woman of your age, you have shown remarkable confidence."

She said: "Well, why not? I looked up the statistics and I know what I'm talking about. Damn few women die between 102 and 103." [Laughter and applause.]

Dr. CHAMBERS. Thank you, Mr. Manning.

We will go to questions now for Secretary Callahan and Mr. Manning.

I would like to begin with Secretary Callahan. You discussed the needs in Massachusetts and I would like to ask what the single greatest need is in Massachusetts and what you see is the Federal role in helping to fulfill that need.

Adequate Income Greatest Need

Mr. Callahan. I think the single greatest need we pick up when we hold hearings around the State is the need for adequate income and pensions, particularly with the increased costs of energy which has gone up three times in the last 3 years. That is a tremendous burden. Recently the Community Services Administration had $200 million program around the country to pay fuel bills—a fuel emergency program. We were quite successful in Massachusetts in paying past bills and we would like to see that kind of program set up immediately for the coming year because this is a big item.

The second item has to do with housing—the lack of adequate housing suitable to the needs of older persons. I was just looking at recent material put out by the Bureau of Labor on the three budgets that they use—the low income, the intermediate, and the high-income budget. About 2 months ago, they put out a budget on couples, retired people, people over 65, and just recently the budget came out for the rest of the population. It was very interesting that in Boston the elders' cost of housing is significantly more than the nonelders. In Boston, everybody's housing is significantly more than anybody else in the country except Anchorage, Alaska, or Honolulu. The combination of income and housing, I think, is the major need. Property taxes make a person's home that much more expensive. We have what is known as full value assessments in the State and the communities are being reassessed; this is a tremendous burden. I think those are the major needs that come right to the surface.

Dr. Chambers. Senator Brooke, as you know, is particularly interested in housing. I wonder what recommendations you might have in this area for changes or expansion in the Federal role.

Mr. Callahan. I don't really know that much about the housing laws. We have just added a housing expert to the staff of the department to be involved in this. However, if you look at the costs per unit of public housing, it is extremely high. I think that things like rent subsidies and better income might provide more choices as well as the development of more units. I think the whole housing market has to be expanded.

Dr. Chambers. Mr. Manning, you mentioned the need for low-income housing in your testimony.

Mr. Manning. Yes; I would like to see more emphasis put on that and I would like to see, probably, a certain percentage be used.

Dr. Chambers. A certain percentage of the Federal housing?

Mr. Manning. Yes; I have visited a few. We have a few that have developed here and there. I visited one in Boston run by the Volunteers of America. Now the building itself was not my idea of a perfect facility. However, as I went through it and I talked with the people, some of whom—there were five there—we got out of a nursing home, and there were others being deinstitutionalized there. As I talked to them I noticed the difference in their outlook.

They seemed more cheerful living under these facilities where they had freedom than they were in the nursing home. There seemed to be more response. So I think even with the limited facility these people found a way of life that was much more comfortable for them, less

restrictions of institutions, and I would like to see that concept carefully developed. I think we have to answer a lot of questions as to just what type of service should be available and how many people.

"ISOLATION OF ELDERS"

As I said in my statement, I am terribly afraid of building new institutions to take the place of old ones. I would add to Secretary Callahan's list—maybe he did include them, I don't know—the isolation of elders in many communities, usually lack of adequate care. For example, I can get a bus to Chicago or an airline to Europe but I cannot get a bus to the church, to the shopping facilities, to the library, or wherever I want to go. If I am not driving a car, I have to call an expensive taxi or hope that a friend will show up to give me a ride.

Dr. CHAMBERS. Mr. Callahan, few States have gone as far as centralizing sources as Massachusetts has, but the program in Massachusetts, I think, has been exemplary in the coordination of the Federal services and State services that you try to bring about through the home care corporation. Yet both you and Mr. Rabbitt have suggested that you would like to go further in coordinating these services. Do you have recommendations for changes in the Federal law that would help you coordinate the services?

Mr. CALLAHAN. Well, within the Older Americans Act, or at least some of the regulations, there are some prohibitions or concerns about area agencies on aging delivering services. In Massachusetts, we are not really violating that, but we are using the Home Care Corp. under title XX and designating it as a title III agency, and in many instances the title VII sponsor. I would suggest that kind of a policy or a law be fluid and see what happens.

I think that is an open question of whether or not we could combine the planning functions into the home care, and in some instances you could argue that planning will be pushed aside and will not really be effective. On the other hand, you can argue that you can do it under the title XX agency. I think there is a lot that needs to be looked at in terms of medicare and medicaid, particularly the concept of a home health aide which is paid under title XVIII and the homemaker under title XX. I know that this requires action on the financing questions, but that type of thing has to be done.

At the local level I am not sure what the mechanism would be. You have councils on aging which, in this State at least, as a first cut, an advocacy organization for people within the community and some of them do provide services. The home care corporations cover a regional territory of a number of cities and towns. You have different functions and responsibilities and I think that some of the coordination has to take place just through the interaction of these people.

Mrs. FAYÉ. Mr. Manning, the President's Commission on Mental Health is going to recommend that the family practitioners, or GP's as we know them, be required to update their medical knowledge with a refresher course in geriatrics. They also hope to include geriatrics during the training period of medical school students. Do you feel that would meet the needs you expressed in your testimony?

Mental Health Programs Limited

Mr. Manning. I think it would certainly be an important factor because it is true that in our society many elders do succumb to the pressure of—perhaps it may not be an extreme mental illness, it is a corroding factor of the human personality, and I think the causes and treatment should be better understood. As a matter of fact, we have just made a study—my association of older Americans—of all the mental cases in the State. We were able to get very limited information, but we did find that the programs for the elderly were very limited and grossly underfunded.

For many years, about 6,000 elderly people lay in the back wards of our mental institutions, often bandied about. Here again we have met with the health commissioner a couple of times to try to stop some of these overnight decisions to move the patients around from one place to another. For example, when they wanted to close the Ocean Hospital, a very fine institution even though it is an old building—the treatment methods and the attitude of the staff and the feeling for patients is far better than any institution I have ever been in. So we raised hell about it and it was not closed. Of course, I don't say we did it alone; others joined with us in the protest. I do feel that the whole question of mental health has to be looked into very deeply; and when they move patients, be sure they are not moving them from a building to a fortress.

Mrs. Fayé. So you think that the whole question of the mental health of the elderly needs to be looked at very carefully because they may be able to receive some treatment that would reverse the trend of mental illness?

Mr. Manning. Yes.

Mrs. Fayé. Thank you.

Miss Deignan. Mr. Callahan, you made quite a statement for current growth and potential for growth in home care services. Have you made any projection of the total need or an estimated projection of the potential eligibility within the Commonwealth for these services? I will tell you what I am thinking of.

There are many good arguments for home care services, but we find that we have to say we really don't know what the service is going to be and who should be served. There is a fear that more and more people in need will appear when a full spectrum of care is offered. I am just wondering what the Commonwealth's experience is in this.

Mr. Callahan. Well, that is going to be the toughest problem in this area, to relate the need for the services to the funds that are available.

Miss Deignan. Given your eligibility criteria, and assuming that unlimited funds were available—that is what I am looking for.

Unmet Need for Home Care

Mr. Callahan. All right. There is not an awfully lot of data. There is one study that has been done at the Joint Center for Urban Studies at Harvard and the Massachusetts Institute of Technlogy. It is a study of the entire State using some 2,000 cases. It was an area of

probability sample more than anything else and that showed that the unmet need for something like transportation was about 7 percent of the elderly at this particular slice in time.

Miss DEIGNAN. The unmet need?

Mr. CALLAHAN. The unmet need. The unmet need in home health—homemaker service is somewhere around 5 percent at this particular time. We are figuring right now we serve roughly 2 percent of the elderly over 60 in the home care network, particularly in the homemaker and chore service program.

Miss DEIGNAN. Leaving another 3 percent, supposedly.

Mr. CALLAHAN. That is right. The figures are not that good and we are working on them to try to get a better definition of who we are serving and what type of service and so forth. We did a projection using roughly 5 percent of the population over 60 and what that would cost over a 5-year period of time, and I could make that available. I don't have that with me.

Miss DEIGNAN. I think that would be very useful to the committee if you could do that.

Mr. CALLAHAN. All right.

Mr. MANNING. Incidentally, at the present time, we are making a study of the home care delivery system, how the 50 States are handling that in their own individual way, and we find a great deal of variety. In some States, public welfare is running this operation. When the study is completed, we are going to make it available to Secretary Callahan and to the committee if you would like to have it. We have already had responses from 47 States, but there is some information that is missing that we have to get at the end of the year.

Miss DEIGNAN. The committee would be interested in that. Thank you.

Dr. CHAMBERS. I want to thank both Secretary Callahan and Mr. Manning for their testimony. We certainly appreciate the information you have given us.

We have another panel now.

Mr. MANNING. Thank you very much.

Dr. CHAMBERS. Sarah Cody, executive director of the Visiting Nurses Association; Amy Anthony, executive director of the Springfield Housing Allowance program; and Dana Wheeler, director, elder day care program.

While the panelists are coming to the table, I might mention that there are others who wish to present testimony who have chosen to present written testimony to the committee, which will be added to the record.

This completes our scheduled panel of witnesses. We will have a short time at the end to hear from those in the audience who have any statement they would like to make for the committee record. In addition, Senator Brooke mentioned to you the fact that the committee will accept written statements [1] if you will take one of the blue slips and mail them to us.

We will begin with Mrs. Cody, please.

[1] See appendix 3, p. 709.

STATEMENT OF SARAH CODY, R.N., B.A., M.P.H., EXECUTIVE DIRECTOR, VISITING NURSES ASSOCIATION, INC., HOLYOKE, MASS.

Mrs. CODY. I would like to respond to Mr. Manning's comment about the need for services more than 8 to 4, 5 days a week. We had talked about this for 5 years. The agency extended our hours from 8 in the morning to 9 at night, 7 days a week. We were a little hesitant to start, but we had been previously serving three or four patients a day on weekends and in 2 weeks it went to five patients a day. The response by staff to this is unbelievable. I had to push the staff in the beginning, and in 3 weeks they came back and said, "You are right; we need to do this."

As an agency director, I would like to know unmet service needs, and if I were you, one of the things I would do is ring bells forever until they do something. I would have loved to have had that information before I took the risk, but I was not sure; I didn't know how much money it was going to cost. I happen to have a beautiful staff who are very young and very flexible and they wanted to try out the 4-day week, so they covered it without adding any expense to my budget at this point.

Mr. MANNING. May I ask where this lady is from?

Mrs. CODY. I am from Holyoke right now. In fact, I am going to be talking to the Massachusetts Nurses Association a week from Monday on extension of services. Home health agencies have stuck their heads under our arm and said "We only want to work 8 to 4:30, Monday through Friday." I think we were looking at our needs and very little else. I am frank in saying that, and I think we need criticism, and I think we need you all to get that criticism to us.

We provide a service to the council on aging for screening clinics. I just talked to the director of the council on aging, saying that we have to do something. We have united city moneys for the health screening clinics and in that budget I can afford 19 hours, but the others are for 24 hours a week. You know, I have to get together with them. I would like to add onto that.

I am going around to each of the housing centers and asking them what they think is needed. I get so much beautiful knowledge with that. They suggested a couple of things that I have to figure out how to do. One is the podiatrist services. Again it is a very well-known fact that our feet get farther and farther away as we get older and they need some assistance with that. There is no fee source for that; it is not covered by medicare nor medicaid. It is out-of-pocket, and if you don't have a pocket, you have a problem. So that is another thing they have told me about.

They have also asked me to extend our health screening clinics to more than 24 hours a week. As I said, my next thing is it would be really nice if I had an ideal group that didn't work for a salary, but we live in a financial world and we have to face that. Again, I have been with the agency for only a year and to look at the increase in people attending these clinics is unbelievable. We had a 30 percent increase in 1 year.

I would dearly love to have a physician there once a month. I think nursing can do so much, but I think again that health needs—

what we do is a lot of referring out, but it would be nice to have a geriatric nurse practitioner or to have a physician available to these people. We have talked with some of the health clinics about possibly doing this.

This particular group also wanted to include one evening clinic for them. As I said, I had to increase my staff by three and I am going to have to have more money from somewhere, but I really would love to respond to those things.

Title III Grant

Our present title III grant, which provides home health aide service and nursing supervision to individuals 60 years of age and over, clearly shows that 37 out of 59 patients needing assistance with personal care also need the assistance of a title XX homemaker. Fortunately, these two bills are administered out of the same office, but separate billing sheets are still required. There are different criteria for each of these, which creates still another problem: Who is eligible for what? When funding sources are other than title III, such as medicare or medicaid, a whole different process and criteria are required.

Dr. Chambers. Mrs. Cody, I have a question to ask in this regard. What is the relationship between the Visiting Nursing Association and the Holyoke Geriatrics Authority? What is your coordination with that entity?

Mrs. Cody. Very little at this point to my knowledge. Again, we have not worked directly with the geriatric authority. We work very closely with the Home Care Corp. We obviously work very closely with home care; we have done a lot with that.

To be very honest, we have not done much with the geriatric authority. One, I am a little confused. I should not be so honest.

I am confused about what the role of the geriatric authority is; what the role of the council on aging is; what the role of CROP is, which happens to be developing some kind of duplicate services. I am very confused here because of the duplication. As I said, they can all send me nasty letters in Chicago, but don't take that out on the person that is going to follow me.

I think that is the thing that needs to be done. It is very confusing for me to know who does what. You know, I am being very honest. I think it is very vital that we look at the certificate of need on home health agencies. I get very frightened that one home care—I always kind of laugh when I talk about the Holyoke visiting nurse. It is a very, very new agency. It started in 1905, but it is exciting in the fact that I was working in home health care about 20 years ago and remember several periods of saying: "Yeah, I live without any check for a couple of months until you give me enough for rent and food and until the next money comes in."

It is beautiful that it is now coming into an exciting period of being funded. I think it is also very exciting, particularly for elderly—to keep them in their homes, but I get very scared because of the duplication of services, the duplication of administrative costs, and the fragmentation of services as the example I just gave with the patient. Until we settle down and look at it, I didn't know that there was that much State and Federal money going into that lady's support at home,

and nobody else knew it either. I was really overwhelmed by that. I feel we cannot afford that; we just can't afford that.

We get caught, and this is an obvious need that I have found recently. Patients who are 60, 70, 80 years old have had eye surgery and come home. They probably have some limitation of movement because of arthritis but they have to get four drops in this eye. It doesn't work. I can't do it and I can't see out of my other eye. There is no funding source for that. Again, we have to work very closely with these people and try to figure out how to cut our fee down. If they have the money, we can do that.

We have protested to medicare. I talked to eye doctors saying, "You need to protest. You put us in a bind." They refer them to us because they need the care, and yet we have no source of getting the money back in, and that is the problem.

Dr. CHAMBERS. I think one of the problems that has turned up in other hearings is the confusion of the funding sources.

The prepared statement of Mrs. Cody will be entered into the record at this time.

[The prepared statement of Mrs. Cody follows:]

PREPARED STATEMENT OF SARA A. CODY

There is little need at this point to spend a great deal of time "selling" home health care. Factual evidence and common sense tells us that individuals, old or young, rich or poor, white or black, find their own home more comfortable and appealing, as well as generally less expensive than an institution.

There are several problems with home health care that I would like to address and suggest recommendations for:

(1) *Certificate of need.*—In order to prevent duplication of services (and consequently increase cost as well as increase fragmentation of services) now is the time to require a certificate of need for services. If duplication is not curtailed now, before numerous agencies develop, we will encounter a similar problem to hospitals today that must close certain sections or manufacture "needs" to stay in business.

(2) *Coordination of funding sources.*—Presently, our nursing staff spends an amount of time equal to one and a half patient visits per day (or equal to two full time fee managers), attempting to decide the appropriate billing source; be it titles III, V, XVIII, XIX, XX, private pay, United Way, or other insurance, etc. It is not uncommon for the billing office to have to bill two or more sources for one patient. This confusion not only complicates a simple process, but increases error and duplication.

Our present title III grant, which provides home health aide service and nursing supervision to individuals 60 years of age and over, clearly shows that 37 out of 59 patients needing assistance with personal care also need the assistance of a title XX homemaker. Fortunately, these two bills are administered out of the same office, but separate billing sheets are still required. There are different criteria for each of these, which creates still another problem—who is eligible for what? When funding sources are other than title III, such as medicare or medicaid, a whole different process and criteria are required.

There is confusion as to who covers what and when. Medicare will cover home health aide service, as long as there is a need for skilled nursing but not a homemaker. Title XX covers only homemaking, but not nursing or home health aides. Private insurance generally only covers nursing care. This confusion requires agencies to provide the service paid for, and some times not the actual service needed.

Recommendations: (1) Coordination of all home health services under one administration with need of the patient being the criteria for which service is provided.

(2) Broader funding of homemaker home health aide, with the requirement of skilled nursing supervision and reevaluation of plan every 4 to 6 weeks.

Needed services of the elderly not covered by funding sources:

(1) Maintenance care.—Cost efficiency should be the criteria for maintaining an individual in his/her own environment versus institutionalization.

(2) Post surgical eye drops and eye care.—Many individuals 60 years of age and over (and many of us under 60 years of age) who have had eye surgery, are not able to safely instill eye drops or ointments required for adequate healing and recovery. Unfortunately, many of the elderly do not have a family or friend close enough to do this three to four times a day, as needed. It is not considered skilled nursing care and therefore not covered by medicare. Legally, it is not safe for agencies to allow home health aides to do this.

Recommendation: Medicare coverage for post operation eye care up to 1 month for normal recovery, or longer as indicated by the patient's physician.

(3) Podiatrist services.

Preliminary report of outcomes of Title III grant:

(1) Need for coordination and control of in-home services.

(a) In title III grant, at least 38 of 58 patients needed homemaker services, as well as assistance with personal care.

(b) Median number of days patients were on service equal 78. Range was from 2 days to 236 days: 11 patients received service from 2 to 20 days; 12 patients received service from 21 to 40 days; 9 patients received service from 41 to 60 days; 11 patients received service from 61 to 120 days; 5 patients received service from 121 to 150 days; 3 patients received service from 151 to 180 days; 7 patients received service from 181 to 236 days.

(c) Average number of homemaker-home health aide hours equal 54.09.

(d) Average number of nursing visits for patients receiving H–HHA services equal 4.01.

(e) Nineteen patients received one nursing visit and were not admitted to service for various reasons—six medicare or medicaid eligible, nine were not in need of either homemaker or home health aide service, three needed homemaking assistance only and had significant other who could help, one was hospitalized on the nurse's referral, for immediate medical care. Cost: $313.50 for nursing visits (plus cost of case manager's visit).

(f) It appears that at least 90 percent of individuals served lived alone or with a significant other who also was ill.

Question: Is it more efficient to have individuals with medical background doing initial evaluation of patients for need for home health assistance?

(g) Seventy-five percent of patients were transferred from medicare A or B when no longer considered skilled nursing.

(h) Fifty percent to sixty percent had "significant other" who was also ill.

Dr. CHAMBERS. We will now hear from Mrs. Amy Anthony, director, HAP, Inc. I would appreciate it if you would summarize your remarks, Mrs. Anthony.

STATEMENT OF AMY ANTHONY, DIRECTOR, SPRINGFIELD, MASS., HOUSING ALLOWANCE PROGRAM, INC.

Mrs. ANTHONY. Thank you very much for giving me the opportunity to speak this morning. I am the director of the housing allowance project and have been with this nonprofit agency since it was founded in 1973 to administer one of the national housing allowance experiments. We are now administering more than 1,500 rental subsidies in the greater Springfield area, including both housing allowances and section 8 existing housing subsidies. During the past year I have chaired the mayor's task force on housing abandonment. This has given me another perspective on the housing problems which especially plague our older northeastern cities and on the need for preventative action in relation to that problem.

In the spirit of this conference which seeks alternatives to institutionalization, let me suggest that large publically subsidized housing projects for the elderly are themselves institutions. As we look for ways to bring service to people where they are, and encourage the con-

tinuity of their lives, those advocates for the elderly should look more carefully at the advantages of using existing housing subsidies to bring affordable standard housing to older citizens.

Rent Subsidies

Based on our agency's experience, I would like to suggest that rental subsidy types of programs deserve more attention and more priority as a resource for housing of the elderly than they have so far received. Elderly taking part in our programs have had much less difficulty in obtaining the participation of their landlords in the program and in being accepted in other apartments than families. They have generally lived in housing in better physical condition and with lower average rents; often rents are held artifically low by owners who do not want to lose them as tenants. Nonetheless, such rents, especially with the high ultility costs of this area, have far exceeded their ability to pay, and our programs assistance, geared to 25 percent of income, has provided welcome relief.

Many elderly persons have been initially hesitant to apply for this assistance and to discuss it with their landlords, not wanting to admit their need for help. The program's growing visibility and popularity among landlords has lessened this problem. The elderly have also been hesitant to negotiate repairs that are needed; our staff has helped to do this, and this is the way in which the program has helped a great deal to improve housing conditions. It has prodded owners to carry out deferred maintenance and other rehabilitation which significantly extends the life of the property.

The first major advantage of the existing housing program has been to offer a choice so elderly citizens can decide where to live, whether to move to a new neighborhood, whether to live entirely or primarily with other elderly, or whether to remain in a well known, well loved neighborhood and still retain the advantage of standard housing conditions and costs geared to their ability to pay.

The second major advantage of existing housing programs is that they offer greater equity. For the same amount of contract funds, fully two and a half times as many households can be helped under existing housing subsidy programs than under new construction programs. For the subsidy cost of one 150-unit elderly building, 359 elderly individuals and families could be subsidized in private housing. For the foreseeable future, all waiting lists will be as long as we let them grow, and demand will far exceed available housing assistance. We can't continue to help the lucky few while the many in need stand in line.

Although I am addressing here the provision of housing help primarily to the elderly able to live independently and not those in need of extensive medical or other services, it should be noted that in many of our existing neighborhoods there are complex webs of interdependence. The elderly help each other, and have arrangements with local stores, with landladies, and with local teenagers who run their errands. These are networks of mutual assistance that are broken up when people are moved into high-rise towers, then reinvented as our social service agencies discuss outreach, homemaker services, et cetra.

The work of the housing abandonment task force which I head has also focused much of its effort on the subject of housing the elderly from the slightly different prospective of its effect on private housing

and on existing city neighborhoods. Our concern with the possible negative effect of subsidized elderly housing on the private housing market led the Elderly Housing Subcommittee to conduct the most thorough survey ever done in Springfield on the vacancy status of large apartment buildings, defined as those with 10 or more units. The vacancy rate of 13.6 percent which we found was considerably higher than expected and tended to confirm that high vacancies were an important part of the serious cash flow problems which are leading to deterioration and eventually abandonment of valuable housing resources.

Elderly Victims of Deteriorating Housing

Elderly residents of our city neighborhoods are, unfortunately, often the first victims of deteriorating conditions, but it may be that the elderly population in existing older neighborhoods are the key to their stability and long-term health. If we are to save them we must aggressively address how to maintain and restore their liveability and attractiveness to elderly residents. The blunt truth which the section 8 program with its existing, new construction and rehab options has brought home to us is that we must make choices with our allocation of scarce resources. To choose to build new high-rise elderly communities may be to signal our willingness to discard our existing neighborhoods. For what may be happening is that we allocate resources to construct elderly housing, taking tenants from private housing, thus undermining the stability of the housing and neighborhoods they leave behind, unless overall demand for housing far exceeds supply.

In addition, allocation of subsidy to new buildings lessens its availability for assisting elderly residents of existing housing and giving a sorely needed shot in the arm to private housing. I have appended the results of our survey[1] and the recommendations[2] of the Elderly Housing Subcommittee .

In summary, I feel that the private rental housing industry has been largely overlooked as the tremendous resource it is, housing as it does more elderly persons than any public sector effort. Until such time as we can afford to build enough housing for all our needy citizens we cannot afford to ignore the signs of premature illness in our neighborhoods and in our private housing, because it will continue to play a dominant role. Nor can we overlook the advantages offered by the existing housing subsidy programs which offer choices to the elderly, are more equitable by serving more of those in need with the same dollars, and which offer some hope of bringing a measure of health to the neighborhoods of our cities.

Dr. Chambers. May I say I think it is very appropriate to have your testimony on housing at this, our last hearing on the alternatives issue, since one of the areas the committee will be turning its attention to over the next year is the severe housing problem.

Our next witness will be Dane Wheeler who is executive director of the retired senior volunteer program, Community and Regional Opportunity Program, Inc.

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[1] Retained in committee files.
[2] See appendix 1, item 4, p. 701.

STATEMENT OF DANE B. WHEELER, EXECUTIVE DIRECTOR, RETIRED SENIOR VOLUNTEER PROGRAM, COMMUNITY AND REGIONAL OPPORTUNITY PROGRAM, INC., CHICOPEE, MASS.

Mr. WHEELER. Although the CROP agency has a number of aging programs, I am here today to speak specifically about the day care project and a proposed project involving elderly alcoholics.

To illustrate the need of CROP's day care center, as well as others, I wish to discuss some relevant statistics on a local level. The Holyoke-Chicopee area considers day care one of the most important and needed programs in the area; in fact, it considers it priority.

The Chicopee Department of Human Service has stated that approximately 500 people within that municipality are "at risk" of institutionalization. Also, the need for the day care project is illustrated by the fact that we are currently serving 50 people. Lastly, we established the program last September and expect to at least double capacity by this time next year.

Our success is partially due to the involvement of area programs and offering of continuum of care to participants within the program. As with other day care centers, the goal of the program is to offer an alternative to 24-hour institutionalization. In fact, some of our people have entered two nursing homes, but the majority of them would enter nursing homes if we were not in existence.

INDEPENDENT LIVING

The objective of the program is to provide the means for independent living for people. The objective as well as the goal is reached by offering a number of services to these participants, whether they be social services, transportation, counseling, or rehabilitative services. We also provide meaningful health care activities.

Each of the CROP programs serves a specific target population. The day care program serves people with chronic disabilities, discharged patients from hospitals, people who, because of their situation—whether it be psychological or physical—would go into a nursing home or some sort of other long-term institution.

Looking at the day care participants as a group, 50 percent come from the community development target area. This is a very important aspect, making the program somewhat different from other day care centers. The community target area is characteristically defined as having poor housing; people living within that area have unmet physical needs, people with low income, as well as being ignorant of community services.

The majority of the participants suffer from physical handicaps. We have 14 blind people, people with partial paralysis, loss of speech, and fractures. Many suffer from two physical handicaps.

Some of the new enrollees are subject to depression and feelings of isolation, alcohol abuse, suicidal tendencies, phychosis, acute depression, and loneliness. We offer these people specific services at the center and some from outside, whether the participant goes to those facilities or professionals to represent his coming to the program.

As I mentioned earlier, we offer many services. Nutrition, such as the noontime meal, snacks, health education, nursing services, and

emergency services. Counseling services, including psychological, financial, legal, and social counseling.

Also recreational activities, such as arts and crafts, field trips, and games. We found that the reason why we accept a person or we determine a person eligible for the program is in fact the need of nursing or health services, although the reason for participants coming to the program is indeed the attraction of recreational or group type activities. We also offer restorative services limited to occupational therapy activities.

We have determined that the day care cost is approximately $13 a day, while homemaker services can go as high as $35 to $50 a day.

Also, a person in a nursing home would cost that person or the Federal or State government upward to $200 a month. The cost effectiveness and the activities offered at the center benefit the participants as well as local governments regarding their allocation of funds.

Dr. CHAMBERS. The geriatric authority is opening a new day care center. I am interested in the involvement of your agency in working with the new director of that center and sharing the information. Is there a coordination of that information between your agency and the geriatric center, or do you think there will be after the center opens?

Mr. WHEELER. At this point, Margaret Zube and Joe Hall have been offered the opportunity to visit and observe how the center works. The Holyoke Geriatric Authority will have a similar function in that they will be serving people from larger cities of the area, as well as many low-income people. There is hope that a cooperative relationship can exist and will exist in the future with the Holyoke Geriatric Authority.

[The prepared statement of Mr. Wheeler follows:]

PREPARED STATEMENT OF DANE B. WHEELER

The goal of the CROP Elder Day Care Center is to provide an alternative to 24-hour institutionalization through an organized program of health care and supervision, restorative services, and socialization. Its objective is to lengthen and provide the means for independent living for the area's "at risk" population. The objective of the program is achieved through the following activities (a) providing a respite service for those families whose elderly parents live in their home; (b) providing social services to clients and families; (c) offering a means to foster independence; and (d) providing meaningful health care activities so that mental and physical deterioration can be improved or maintained.

The program currently serves people who have chronic disabilities, discharged patients from hospitals, mental institutions, and nursing homes, and other individuals who because of their poor physical, psychological, or social situation need to increase their independence and are at a high risk of institutionalization.

To meet the needs of day care participants, the program offers the following services: nutrition, nursing, emergency, counseling, recreational activities, educational, restorative, personal care, and information-referral activities. Another important program service is providing transportation to participants on a regular basis. These services are offered to day care clients by a variety of staff including a registered nurse, activities worker, out-reach worker, custodian, secretary, information-referral specialist, and van driver.

The success of the Elder Day Care Center is due to its very good working relation with area social/health agencies and organizations. AAA, local COA's, the Office of Community Development, CROP, Senior VISTA, VNA, Massachusetts Commission for the Blind, area hospitals, and other programs have assisted the program in a variety of ways in the past and will continue in the future.

Dr. CHAMBERS. Thank you very much.

I want to thank this panel for being with us.

Our time has run out. Senator Brooke did have some other questions that he wanted to address to Mr. Joseph Paul of the Holyoke Geriatric Authority and to Mrs. Dwight who was formerly with the geriatric authority. We will submit those questions in writing and ask for responses.

Now we have just a minute or two before we must close the meeting. I do want to give an opportunity for anyone in the audience who has a statement they want to make to do so. All hearings of the Senate are open and we want to give anyone a chance to respond.

STATEMENT OF MORTON BLUMENTHAL, EXECUTIVE DIRECTOR, NEW ENGLAND NON-PROFIT HOUSING DEVELOPMENT CORP., CONCORD, N.H.

Mr. BLUMENTHAL. My name is Morton Blumenthal. I am the executive director of the New England Non-Profit Housing Development Corp.

We have been privileged over the past 2 years to have a model projects grant from the Administration on Aging to study housing alternatives for senior citizens in New England. We have worked with almost every one of the panelists that has testified today. They have served as panelists or we have used their programs as an example to how to better serve senior citizens.

Our final report is being delivered to the Administration on Aging in Washington today and I will make a copy available to the committee. In summarizing this lengthy report, the key word is "alternatives"; we must give our senior citizens the alternatives and in meeting their housing needs. In many cases today, senior citizens have no option; they have to give up her house or they have to go to a nursing home; there is nowhere in between.

We also believe those States that have good housing assistance programs for seniors, such as Massachusetts, Connecticut, and Maryland that use State money for good innovative housing programs, should be given some sort of incentive—that is, grant matching—to help them carry on and encourage their efforts in using State money for housing. We must encourage all levels of government to participate in the challenge of providing better housing alternatives for senior citizens.

Thank you.

Dr. CHAMBERS. Thank you very much. We appreciate the copy of your report.

Are there any other comments from the floor?

Yes.

STATEMENT OF DR. LEWIS HUBB, DEPUTY ASSISTANT, MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

Dr. HUBB. I am Dr. Lewis Hubb, deputy assistant of the Massachusetts Department of Mental Health.

One of the major issues which I am working on at the moment is trying to find out how many of the elderly in mental hospitals don't belong there, and it looks like most of them don't. The problem of getting them out is a lack of alternatives and a lack of flexibility of putting packages of alternatives together. No agency, in this State at least, has control of all the resources that are distributed around, and the problem of getting packages of things together and meeting an individual client's needs is extremely difficult. So we need alternatives, but we need flexibility in using them. We need to build the system so that, after we get them out of the hospital, the next generation of elderly don't get put in. They got put there because nobody knew what to do with the postsurgical patients coming out of anesthesia who sometimes yelled or got frightened. If they are slightly confused, they may scream. Confused people were put in mental hospitals, and they do not belong in mental hospitals.

You get very transitory behavior by institutionalizing people because the people who work with them don't know how to deal with these phenomena. So we need a flexible system and a system of intervention, of being able to act when a crisis arises in the community. Deal with it there. Once we put somebody in an institution, they are highly likely to stay there. So I plead, in addition, for all the resources and flexibility of putting things together to meet individual needs and not having so many people be told, "Well, we don't have a program for that." Agencies have to have some flexible use of funds and I would urge that we consider this very strongly. I know it is tough to do in billion-dollar Government programs, but somehow we have to figure out how to do it.

Thank you.

Dr. CHAMBERS. Thank you.

Any other comments? If not, I want to thank the National Conference of Mayors. I want to thank the city of Holyoke and, particularly, the Geriatric Authority of Holyoke for allowing the Senate Special Committee on Aging to have this look at this most unique and exemplary program.

Thank you very much.

[Whereupon, at 12:03 p.m., the hearing adjourned.]

APPENDIXES

Appendix 1

MATERIAL SUBMITTED BY WITNESSES

ITEM 1. EXHIBITS SUBMITTED BY JOSEPH PAUL,[1] EXECUTIVE DIRECTOR, HOLYOKE GERIATRIC AUTHORITY

EXHIBIT A.—REPORT: THE GERIATRIC AUTHORITY AS A VEHICLE FOR THE PROVISION OF FACILITIES AND SERVICES TO ELDERLY

(Prepared by Margaret Zube, Ph. D., and Joseph Paul)

PREFACE

The development of an authority responsible for geriatric facilities and programs is unusual, if not unique; and its success as a viable structure remains to be proven. In the few short years of its existence, the Geriatric Authority of Holyoke has succeeded in achieving some of its goals and has been thwarted in the attainment of others. This report has been assembled for those interested in the provision of elderly facilities and for those who might be considering the creation of an authority to meet the purposes of their own community. Included are summary descriptions of the history, the structure, the duties, and the powers of this authority. Progress, problems, and features peculiar to the Geriatric Authority of Holyoke are reviewed; and ambiguities in its constitution, vis-a-vis Federal funding programs are discussed.

EARLY HISTORY

Inception

Before the turn of the century, Holyoke had established a facility to care for its infirmed and indigent. Commonly referred to as the city poor farm, its name, structure, administration, and concept of care have undergone changes since then, yet the original purpose remains—that is, to help meet the public's responsibility to provide for its citizens and to insure that those who are unable to meet all of the demands of independent living will receive the aid and care that they require.

For many years the city's welfare commissioners were responsible for the operation of this facility which is now known as the municipal nursing home. In the 1960's the State assumed the administrative responsibility for welfare programs—obviating the need for the welfare commissioners. To assume oversight and policymaking responsibilities of the new defunct welfare commission, the board of the municipal nursing home was created. This board, with considerable vitality, immediately began planning an ambitious expansion program and, with the aid of consultants, a long-range program for the development of a geriatric center evolved.

It was at this point that the board, anticipating the need for a strong and versatile administrative structure, first considered the creation of a geriatric authority. The board felt that an authority with the political and financial autonomy which such a body enjoys, would be an ideal vehicle to undertake the type of extensive development which they had planned. The board of aldermen, however, were hesistant about the advisability of transferring control over a

[1] See statement, p. 643.

facility which had long been a part of municipal government. They were concerned that an autonomous organization such as this would not be sufficiently sensitive to or reflective of the wishes of the electorate. Thus it was only after considerable work, negotiation, and compromise that State legislation in 1971 created the Geriatric Authority of Holyoke as a public body corporate and politic. Permitted considerable autonomy, the actions of the authority are, however, subject to the approval of the major and/or aldermen in several important areas.

Structure

The authority is composed of seven directors who meet as a board to determine policy and to oversee its affairs. Three directors are appointed for 3-year terms by the board of aldermen, three are appointed by the mayor for 3-year terms, and the seventh is selected by the other six members for a 1-year term. Appointments of the mayor and aldermen are to be selected so that in each case one appointment represents the medical, one the legal or financial, and one the geriatric field.

Rights and responsibilities

The authority is charged with responsibility for the operation of the municipal nursing home and for planning and providing for other facilities and services for elderly and handicapped as might be appropriate. It exercises control over the management of the municipal nursing home and any branches thereof which may be established, has jurisdiction of its affairs and properties, including administration, and has charge and control of its financial receipts and expenditures. To carry out its charge of providing for additional facilities, the authority is empowered to acquire within the city by purchase, lease, gift, or eminent domain any land or buildings for its purposes and to plan, construct, and operate any such geriatric facilities.

A GERIATRIC CENTER: THE LONG-RANGE PLAN

Concept

The long-range goal of the geriatric authority is to create a village or campus where the makings of community exist, and where the various facilities, programs, and personnel can create a sense of identity and proprietorship among the participating elderly. Combining of facilities at one location makes it possible to provide a continuum of care which enables the elderly to live, interact, and receive necessary supports in a secure, familiar location regardless of their changing needs. Consolidation and coordination of services and staff makes it possible to meet a multiplicity of needs—social, physical, psychological, medical, and mental—in a variety of residential settings and in an efficient and economical manner. If, for example, it were necessary for an elderly individual to move from an area of more independent living (sheltered apartments) to one offering greater care (nursing facilities), the move would be in the same familiar community and the transition easier. For one fortunate enough to move from the nursing care situation back to an apartment, various forms of supportive and rehabilitative services would be available, again in familiar territory where good followup could be assured. As planned, there would be a flow of services and residents back and forth between the various campus units, as well as a reciprocal movement to and from the Holyoke community itself.

It is expected that a sense of security should evolve upon the knowledge that:

(1) One is living in a familiar community where supports are available which enable him to cope at the level of his abilities.

(2) One is in a community designed to be barrier free and designed to meet the abilities and frailties of the elderly.

(3) Surveillance and security are in force to protect individuals from theft or harm.

In addition, the variety of programs, types of residential choices, and the day-to-day traffic within the site should minimize the ubiquitous institutional quality which seems a characteristic feature of nursing homes today.

Facilities planned

The long-range plan for the geriatric center includes the following components:

(1) Nursing care:

(a) Skilled nursing care.—A new 120-bed skilled nursing care facility will be ready for occupancy in November 1977.

(b) Intermediate nursing care.—The renovation of the existing nursing home, which will accommodate 120 residents, will be completed in April, 1978.

(2) Sheltered housing: 100 apartment units designed for independent living but which also includes the option for such supports as meals and housekeeping services, emergency medical services, and personal care.

(3) Adult day care center: This will serve elderly or handicapped daytime maintenance and rehabilitative services in a supervised care situation. This satellite center is to be located in downtown Holyoke; the center will be completed in November 1977.

(4) Outpatient clinic services: This clinic, which will specialize in geriatric treatments, will be located in the geriatric center and will open in February 1978.

(5) Supportive services: The foundation upon which all facilities and services are developed. This unit will provide necessary facilities and services to residential and nonresidential programs. It will include occupational therapy, physical therapy, dining room/meeting room, kitchen, beauty/barber shop, pub, activities rooms, library, social services, administration, and other services as needed. This unit will be shared by and accessible to all other areas of the facility.

(6) Transportation services: The focus of service will be the low and moderate income handicapped, frail, and/or institutionalized elderly, or individuals who require specialized transportation, special care, and special understanding.

DEVELOPMENTS THUS FAR

First steps

In 1973, a gerontological planning firm was retained to aid the authority in the realization of its long-range plans. This firm conducted a community survey, assessed existing services, prepared a report which identified the needs of Holyoke's elderly, and made recommendations on the direction which the future development should take. Encouraged to proceed with the center they had earlier envisioned, the board of directors commissioned an architect to design a geriatric center for them.

The original plans were far too ambitious from an economic point of view, but after considerable rethinking and reworking, a feasible approach eventually evolved. At this point, as the activities moved from long-range planning and design to implementation, the securing of financing for construction was perhaps the major problem confronting the authority. It became apparent that there was a need for a small staff which could not only seek funding but could also attend to the development, direction, and management of the overall program. During the early stages the administrator of the nursing home had provided the direction required, but as the scope and pace of activities escalated, the project required more time and attention than the demands of the nursing home would allow.

In December 1973, two consultants were retained. They recommended a phased approach to Center development with the construction of additional long-term care facilities as the first phase. After considerable research on various alternatives, a decision was made to finance the long-term care facility via a municipal bond. While the authority is not empowered to issue bonds, it may petition the city to do so in its name. These bond moneys were supplemented by a Hill-Burton Federal grant which made the inclusion of important additional amenities possible. And finally, in the fall of 1974, the Administration on Aging awarded the authority a grant (section 308, title III, Older Americans Act) which enabled it to establish a small staff to direct the ongoing development activities and to proceed toward the more distant goal of a multifacility complex.

Progress has been slow. This should perhaps in part be attributed to an overly optimistic setting of target or completion dates, but it has also been due to delays resulting from unanticipated actions by legislative and executive branches of government, slowness in the processing of applications and in decisionmaking by government agencies, and the unexpected problems which should be expected in any development program.

Construction financing problems

The long-term care facility.—The task of obtaining construction financing for the long-term care facilities was long and arduous. A seemingly logical approach was soon discarded (a Federal mortgage insurance program for nursing homes, section 232) for it is not available to public bodies. The eventual decision to finance construction via a municipal bond issue proved to be sound, although a major roadblock did raise doubts for a time. The problem centered around the

State's municipal finance laws which require that interest payments on bonds commence within 6 months of issue and that principal payments begin within 12 months of issue. Since the authority has no financial reserves and since no additional revenues will be earned until the new facility is completed, there was no apparent way in which these early principal and interest payments could be met. Fortunately a far-sighted State commission responsible for regulating medicaid rates recognized the ramifications of the authority's problem and through a special ruling (which ultimately was translated into a regulation) provided a mechanism whereby these front-end expenditures could be incorporated into the regular medicaid reimbursement calculations for the municipal home during the construction period (over 95 percent of the residents receive medicaid supports) rather than waiting to incorporate them into the resident rates on the completed facility. A unique solution by a commission which recognized the economies of municipal bonding and the long-range savings to be realized by the medicaid program.

Sheltered housing.—Finding a vehicle for the financing of the sheltered housing phase has proven no less difficult. To insure that the housing planned would be within the reach of the lower income elderly some form of subsidization is necessary. Thus far two major approaches have been attempted, one through State subsidized housing, the other via a Federal program for private, nonprofit corporations. In neither case was the geriatric authority itself eligible to be the applicant! In the first instance it entered into a cooperative arrangement with the eligible applicant, the local housing authority, and in the second instance it created the required nonprofit corporation. Because of the nature of the problems encountered in each approach it is of value to view the recital of these attempts in the light of the structure of the authority, its advantages and hindrances, and its need to have autonomy and yet remain accountable to the public.

State program

The first approach, undertaken in 1975, in cooperation with Holyoke Housing Authority, would have resulted in housing constructed and operated through the State public housing program. Under this program, construction and rental subsidy moneys are channeled through the local housing authority. Consequently, a contractual arrangement was developed whereby the housing authority would assume the administrative responsibilities for the financial arrangements with the State (construction financing, rent subsidies, building operation costs) while the geriatric authority would be responsible for the management of the facility. Unexpectedly, after months of planning by the two authorities, the State, due to economic considerations, eliminated at least temporarily the financing of any additional construction of State-supported housing.

Federal program

The second approach was via the Federal section 202 housing loan program which has associated with it section 8 rental subsidies. Like the above-mentioned section 232 nursing home loan program, section 202 is only for private nonprofit sponsors. In anticipation of just such a limitation, section 8(o) of the authority's legislation provides that the geriatric authority may organize and control the activities of any such nonprofit corporation as might be necessary and appropriate to receive loans and grants from Federal or State governments or nonprofit agencies for purposes related to geriatric facilities and services. To insure that the corporation not be completely independent of either the municipality or the geriatric authority board, the legislation further provides that the organization of any such corporation requires the approval of the aldermen, that any action of the corporation which, if taken by the geriatric authority would require aldermanic approval, requires like approval by the aldermen, and that the trustees of such corporation be the same as members of the authority.

Thus a private nonprofit corporation was formed in compliance with the geriatric authority legislation, and an application was made to the Department of Housing and Urban Development for a section 202 fund reservation. The application was processed, but it was subsequently determined by the Department that the corporation was an ineligible applicant. Because of the above-cited limitations placed upon its autonomy by the authority's legislation, the corporation was declared to be an instrumentality of a public body and consequently ineligible.

Learning from the above experience, the geriatric authority sought a partner that would meet the eligibility requirements of HUD's section 202 program and also which had a successful track record in the construction and management of elderly housing. The Holyoke Community Development Corp. was such an organization. This organization, Holyoke Community Development Corp. (HCDC), submitted an application to the section 202 program. The application, which was submitted in May 1977, suggested a relationship in which the geriatric authority had the concept of care and would lease or sell the land on which the facility would be constructed to this private nonprofit corporation. The HCDC would establish a third-party corporation which would hold the mortgage and provide initial financing. Unfortunately, this application was not funded.

Combination State and Federal program

The geriatric authority of Holyoke was created as a result of chapter 554 of the general laws of the Commonwealth of Massachusetts, 1971, as amended. Being a public authority and having access to municipal financing, the authority is presently investigating the possibility of using a municipal bond to finance the housing phase of our project. With the availability of some form of subsidy (section 8), it would be possible to make this housing available to the low-income, frail elderly.

Outpatient clinic services.—An integral component of the proposed geriatric center will be an outpatient clinic which will provide rehabilitative and restorative services to non-residents of the nursing home. The geriatric authority has a certificate of need, architectural drawings, and the necessary financing. Construction of this facility, which is part of the long-term care facility, is nearly completed. The authority is presently filing an application with the department of public health to operate this program; we anticipate that this phase will be operational in February 1978.

Adult day care.—With financing made possible through the community development block grant program, the authority will open (November 1977) an adult day care center in downtown Holyoke. This program will be for older adults whose functional capabilities (cognitive, physical, emotional) are impaired to an extent requiring day services, whether sustained or time-limited, that involves human assistance in order to attain or maintain their individual potential for functioning and successful maintenance in community living arragements. Recently the program was certified as being eligible for medicaid.

Transportation services.—The focus of the transportation services will be the low- and moderate-income handicapped, frail and/or institutionalized elderly, or individuals who require specialized transportation, special care, and/or special understanding. Through the community development block grant program and title III of the Older Americans Act as administered by the Holyoke/Chicopee Home Care Corp., the authority has obtained specially equipped and designed vans to provide this service.

AUTONOMY AND CONSTRAINTS

As an authority, the Geriatric Authority of Holyoke has certain characteristics which allow it to operate in a manner which differs from a municipal department. In difference to the municipal department, the authority is not tax supported and it exercises autonomy in the administration of its affairs. It is exempt from municipal taxes but it does make payments to the city in lieu of taxes. It may utilize services of the various city departments (on a reimbursable basis). And, as many authorities do, it has the power of eminent domain.

In the area of financing, the authority is empowered to issue notes, but they must be payable within 1 year, are for operating expenses only, and if in excess of $200.000, require aldermanic approval. For borrowing large sums of money, the authority may petition the city to issue bonds or notes in its name; the authority then reimburses the city annually for the principal and interest. In the event that the mayor and a majority of the aldermen determine that the financial condition of the authority does not warrant payment for a given year, that payment may be deferred. Consequently, on the one hand the authority enjoys the backing and good name of the city while on the other the city has a vested interest in the financial health of the authority.

The most succinct statement regarding the autonomous nature of the author-

ity appears in section 4 of the legislation which created it.[1] This section states that the authority shall have jurisdiction of its affairs and the property under its control. It establishes and enforces all necessary rules and regulations for the administration, admission, government, and removal of residents in the municipal nursing home and any other such facility which it may control. It has charge and control of all its financial receipts and expenditures.

Specifically, the authority is authorized to:

Issue temporary notes not to exceed $200,000 outstanding at any one time; to be used for operating expenses only.

To receive and disburse funds and to maintain financial reserves.

To receive and apply any grants or gifts for its purpose.

To enter into agreements with any other city or town, district, authority, public or private corporation, nonprofit agency, partnership, association, or individual providing for or relating to any geriatric facility or system under its jurisdiction, control, or supervision, and to accept from the Commonwealth or any agency or instrumentality thereof, and to enter to agreements with such agency respecting any such loans or grants, and to receive and accept aid and contributions from any source of either money, property, labor, or other things of value.

To acquire within the city by purchase, gift, or eminent domain, by lease or otherwise, any land or buildings or interest in land, air or water for the purposes of the authority to plan, design, acquire, construct, reconstruct, improve, extend, equip, repair, maintain, and operate geriatric facilities.

Autonomy is limited in several ways. Approval by a two-thirds vote of the aldermen is required for:

Lease agreements.
Major construction totaling $100,000 or more.
Acquisition of real property.
Disposal of real property.

Approval of both the mayor and a two-thirds vote of the aldermen is required for:

The issuance of temporary notes in excess of $200,000 (to be used for operating expenses only).

The entry into agreements with the Federal Government relative to the acceptance of grants or borrowing of funds for any project the authority is authorized to undertake. Like approval is required for the convenants, terms, and conditions of that agreement.

Both the mayor and the aldermen exercise some control over the composition of the authority board. Three members are appointed by the aldermen, three by the mayor, and one by the members sitting on the board. And finally, as noted above, the authority may organize and control the activities of such nonprofit corporation as may be necessary and appropriate to receive loans and grants from the Federal or State government or from any nonprofit agency provided that the trustees of such corporation shall be the same persons who hold office as members of the authority. The organization of such a corporation requires approval, however, by a two-thirds vote of the aldermen, and in addition, any action of such a corporation which, if taken by the authority would require aldermanic approval shall also require aldermanic approval.

SUMMARY

The lessons learned by the Geriatric Authority of Holyoke are many, perhaps the most significant of which has been the realization that even an extremely involved voluntary body will have difficulty in carrying out an extensive development program without the support of adequate staff. Delays and the slow pace of progress suggest it is desirable that the organization have sufficient resources to support and maintain continuity in development over a prolonged and not very predictable period of time if it is to undertake a relatively complex, phased development. If in addition the organization intends to serve low-income populations it must be prepared to expend time and energies searching for the financial resources to support not only the building program but also the delivery of services. Overhead for "waiting time" can be considerable, and an organization which can absorb such costs while at the same time directing ener-

[1] Chapter 554, General Laws, 1971, as amended (see exhibit C).

gies and resources into succeeding phases of its development will be the most efficient and most likely to survive.

In the case of the Geriatric Authority of Holyoke, the demonstration grant of the Administration on Aging provided an excellent mechanism by which the Federal Government facilitated the extension of geriatric facilities and services. It should be pointed out that a commitment to see the geriatric authority through several years of development was critical.

The desirability of creating a public body such as a geriatric authority to permit autonomy is recognized. The need for public accountability is also recognized. The experience of the geriatric authority, particularly in seeking government aid for housing, suggest that the successful resolution of the conflicts between the two is difficult and that unforeseen difficulties may arise from the compromise.

To summarize the tentative conclusions derived from experience thus far:

(1) A public body which exercises significant autonomy and yet remains accountable to an electorate is difficult to achieve.

(2) The public nature of an authority is a source of strength and of weakness. Eligibility for funding programs and adequate flexibility and latitude in an authority's ability to obtain monies is a serious consideration. This is in part dependent upon the philosophies of the funding agencies.

(3) Staff assistance for a develoment program is essential.

(4) Long-term commitment and financial resources are important in enabling an agency to absorb the costs of the delays which must be anticipated.

EXHIBIT B.—REPORT: GENERAL OVERVIEW OF THE HISTORY AND ROLE OF THE PUBLIC AUTHORITY

(Prepared by Margaret Zube, Ph. D.)

Primary sources: Bollens, J. C., "Special District Government in the United States," Berkeley, University of California Press, 1957. Caro, Robert A., "The Power Broker," New York, Alfred Knopf, 1974, Encyclopedia Brittanica, Smith, Robert G., "Ad Hoc Governments," Beverly Hills, Sage Publications, 1974.

There is a certain vagueness surrounding the public's understanding of the definition and role of the public authority. Smith suggests that their use in "widespread functions, often in default of action by the more conventional governments, has served to blur any conception of them collectively as a functional level of government." They are generally viewed to be an extension of the bureaucratic arm, but somewhat further removed from public accountability than general purpose government. A commonly accepted definition is that of the Council State Governments (1953):

"Public authorities generally are corporate bodies authorized by legislative action to function outside of the regular structure of State government in order to finance and construct and usually to operate revenue-producing public enterprises. Their organizational structures and powers are of the type usually associated with public corporations and like the latter they have relative administrative autonomy. Public authorities are authorized to issue their own revenue bonds, which ordinarily do not constitute debt limitations since they are required to meet their obligations from their own resources. They lack the power to levy taxes, but are empowered to collect fees or other charges for use of their facilities, devoting the resulting revenue to payments of operational expenses and of interest and principal on their debts."

The census of governments published by the Bureau of the Census lists authorities under the rubric of special districts. Smith differentiates among the over 23,000 special district governments as follows:

(1) Special districts.—designed to accomplish a single function but with reliance primarily on a special tax levy (e.g. a sanitation district).

(2) Public authority.—a special purpose body without power of taxation. Financed by bond issue and with revenues obtained from tolls and other charges to users of the service or facility (e.g. turnpike authority).

(3) Authority-district.—a recent development, a body with broader responsibilities which are frequently regional in nature. Supported in same manner as an authority. However, since it is created to perform in an area where deficits are anticipated, it is also supported by some form of taxation (e.g. regional transit authority).

The authority is established by a government to conduct, build, or administer an enterprise, function, or service, in the public interest. Its design facilitates its political autonomy and its freedom from certain cumbrous legislative and other related controls. Roosevelt, when recommending establishment of the TVA in 1933, aptly described the special purpose unit of government as an agency "clothed with the power of government but possessed with the flexibility and initiative of private enterprise." Each authority is created by special legislation which defines its powers, duties, and immunities, and establishes its relationship to various governmental entities. In essence, each is unique to the situation it is designed to occupy.

HISTORY

It is claimed that early forms of the special purpose government have been in existence in England for 500 years and in this country for 180. There is general agreement that it is first found in modern form in the Port of London Authority (1908) and secondly in the Port Authority of New York and New Jersey (1921). The few small authorities found in our earliest years were simple and devoted to such minor activities as the collection of tolls on a few rural roads. Robert Caro reports that Jimmy Walker, upon learning of the existence of such a potential source of revenues, is said to have contemplated setting up one in New York for the purpose of enriching his friends!

Many authorities have been created to fulfill a single purpose, such as the construction of a road, bridge, etc. When its debt is retired the facility is turned over to the local government and the authority ceases to exist. Other authorities are created to develop and operate a series of related facilities and services. They may be found at municipal, regional, State, interstate, and municipal levels. Some are extremely large as is the Port Authority of New York which in its 1971 annual report listed almost $2.8 billion invested in its facilities.

The number of authorities multiplied during Depression years. Franklin Roosevelt, believing that States and localities required building programs to help pull the country out of the depression, developed the mechanisms and programs which enabled these governments to institute public works programs. The public authority, because it could incur indebtedness outside the statutory debt limitations placed upon states and municipalities, became a vehicle which undertook development programs. Unfortunately, to some extent at least, this proliferation of authorities occurred in a very unsystematic way to meet one contingency after another. In the late 1930's, for example, municipal authorities were chartered in Pennsylvania under the title "No Known Purpose Authorities" apparently as a hedge against the possibility of their need in the future. A report of the Pennsylvania Department of Internal Affairs (1960) listed 49 such authorities but stated it was "unable to list an objective" for any of them. Never had any of these authorities ever issued a bond!

According to the report of the Advisory Commission on Intergovernmental Relations in 1964, the Federal Government has played an important role in the proliferation of these special purpose units of government. Encouraged, and sometimes required, by about one fourth of all Federal programs (1964), they include public housing and urban renewal authorities, State and local planning agencies, and industrial development authorities, among others. The Commission report explained that Federal departments found it preferable to work with such special purpose units because of their "professional quality performance"—a performance that general purpose governments often could not assure because of staffing problems, local political problems, and limitations on their taxing and borrowing authority. The Commission, concerned over this situation recommended that the Federal Government take action to remove from Federal aid programs for urban development all limitations which would result in the promotion of special purpose rather than general purpose government. (It might be noted that a 1970 report reiterated this feeling and elaborated upon the difficulty of developing continuity and coordination in the planning and servicing of comprehensive geographic and political areas.)

Projections are that many more authorities will be chartered in the future. For example, the Federal Aviation Agency in 1973 announced that 700 new airports would be needed over the next 10 years (airport construction is frequently undertaken by authorities). And further, it is reported that numerous authorities are being formed in the mushrooming area of pollution control in order to finance and construct needed pollution control facilities.

CHARACTERISTICS

Authorities are special purpose governments. Ordinarily incorporated, they are created by enabling legislation which spells out their purpose and powers. They are also structured so as to have some of the flexibility and autonomy of private enterprise. They are considered as semiautonomous, with limited governmental powers and certain freedoms from traditional political influences. They are sometimes described as quasi-public bodies. If so constituted, authorities can transcend traditional political boundaries and serve more than one political area.

They are not tax supported; they provide and support their facilities by the issuing of bonds and the collection of revenues through tolls and other charges on the users of their service or facility. They base their operations on the need for efficiency and because they have a legal personality separate from the government they have some of the operational flexibility of the private corporation. Unlike profit motivated private enterprise however, their purpose is the public good and their services normally provided at cost.

Authorities generally exercise at least some autonomy over the management of their affairs including general administration, personnel selection, and freedom in whole or in part from civil service requirements. They ordinarily also enjoy some freedoms from statutory and regulatory government controls in areas of supply, budget, accounting, and audits.

VALUE OF THE AUTHORITY STRUCTURE

There are numerous reasons for the origin of authorities and for their continuing popularity, some of which are implicit in the discussion of their characteristics above. An important factor not only in their genesis but also in the rise in their popularity is the fact that they can borrow outside the statutory debt limitations imposed upon states and municipalities. A second important factor is that the user of the facility or service rather than the taxpayer pays for the cost of the operation. This is viewed as a more equitable manner for the provision of certain kinds of facilities.

There is firm belief on the part of many that the benefits of the authority structure far outweigh its liabilities. Because it must be operated as a business it is considered to be more efficient than general purpose government. Proponents also argue that such a structure is better insulated from the constraining effects of public bureaucracy and partisan politics. Because of its business approach and its political autonomy it is argued that authorities can attract high quality professionals and businessmen who would not enter public service nor run for public office. The authority has in fact been described as a special government framed around a group of specialists.

Authorities can and do tend to step in where general purpose governments are unable or unwilling to handle a problem or assume a responsibility. This can occur, for example, where taxpayers are unwilling to be assessed for the provision of a certain kind of needed facility. It can occur also where a service or facility requires a more regional approach and where the authority can operate in several political arenas.

CRITICISMS

Critics of authorities generally do not quarrel with the above-stated advantages. They point out however some inherent weaknesses and abuses that can occur. A most frequently stated concern regards the problem of accountability. Critics contend that operations of an authority are not completely scrutinable to the public eye and that the directorship of an authority does not answer directly to an electorate. A parallel concern is voiced over the fact that the authority is, of necessity more sensitive to its bondholders (and high bond ratings) than to a public constituency. Other critics have noted the fragmentation of services and facilities which can occur with the result that various locations or services may be by-passed or ignored. The authority by its very nature is single purpose and not equipped to perform broad-range planning. It may, in fact, serve to hinder planning capabilities of general purpose government.

Since the ramifications of these criticisms might be of interest to conference participants contemplating an authority in their community, a brief elaboration of several of the issues concludes this overview.

ACCOUNTABILITY

Because the public authority cannot rely on taxes but must raise revenues through bonding and user charges, it takes on only those functions which will have adequate return by persons using their facilities. As a general rule, then, only projects capable of amortizing themselves through tolls on the users are undertaken by public authorities. It becomes the responsibility of general purpose government with its powers of taxation to undertake projects which are deficit in nature. The net result has been the development of some of the most self-sustained governmental units in the country, for authorities have had to gain the support of their bonds in the open market by proving their fiscal soundness. Bondholders have been a most clearly definable constituency and "government by bond resolution" has been identified as the authorities' method of decision-making.

Carrying this argument to its conclusion would suggest that the authorities' decisions regarding operations and development are in large measure determined by purchasers of bonds (frequently large syndicates). The issue of accountability is complex. To whom are authorities accountable? One would like to think that they are responsive to the electorate, taxpayers, government functionaries, and to those persons living or working in the area affected by the authorities' facilities. In most cases they no doubt are. But it is obvious also that they have a primary responsibility to operate a fiscally sound facility which will attract the user and the purchaser of bonds—a rather anonymous and often transient constituency at best.

FRAGMENTATION OR UNEVEN PROVISION OF FACILITIES AND SERVICES

An important function of general purpose government is to bring together all means of the public dollar on some kind of competitive basis in order to demand what they feel is their proper appropriation in the annual public budget. Each must justify its need and compete with others for its share, and after a fair hearing monies are allocated as adjudged appropriate. This has proven to be a suitable approach to establishing priorities, planning and the equitable distribution of resources. Smith states that "the budget has been called the greatest instrument for democracy on all levels of government." The public authority however is outside this process and does not then compete on a "worth of function" basis. It perpetuates as long as it operates a sound fiscal enterprise and it is entirely possible that the need for its facilities would be far less than other community needs. This is a situation which, in the long run, can weaken the general government's ability to bring together the complementary and divergent interests in the community on an equal basis and to coordinate and complement that which is needed.

An example of what can occur is that of the transportation network in New York City in 1966. A brief review of the problem and an approach to its resolution concludes this discussion.

In 1966 there was much concern in New York about the state of mass transit. On either side of Manhattan large public authorities catering to the auto—the Port of New York Authority to the west, the Triborough Bridge and Tunnel Authority to the east. Caught in the center was the New York City Transit Authority, and feeder lines made their way through Manhattan, Brooklyn, and Queens via the bankrupt Long Island Railroad. The Port and Triborough Authorities were in excellent financial condition, the mass transit authority debtridden and unable to collect sufficient revenues. The problem compounded as the two fiscally healthy and active authorities brought more and more autos into the city causing fewer riders to use the ailing and deteriorating mass transit facilities. The ultimate resolution involved the development of a new structure which most resembles what Smith calls the authority-district. This is in actuality a regional transit authority which coordinates the functions and resources of the auto and the mass transit authorities in such a way that the surplus revenues of the auto authorities can be transferred to the city for use in the support of the mass transit operation.

EXHIBIT C.—PRÉCIS OF CHAPTER 554, MASSACHUSETTS GENERAL LAWS, 1971, AS AMENDED, AUTHORIZING THE ESTABLISHMENT OF THE GERIATRIC AUTHORITY OF HOLYOKE AND PROVIDING THE FINANCING THEREOF

Section 1. Declares that the establishment of a geriatric authority is a public purpose.

Section 2. Creates the Geriatric Authority of Holyoke as a public body corporate and politic for the purpose of maintaining and operating the municipal nursing home and any other facilities authorized by this act.

Section 3. Membership—consists of 7 members appointed as follows:

Three appointed by the mayor for a 3-year term;

Three appointed by the board of aldermen for a 3-year term;

One appointed by the six other members of the authority for a 1-year term.

The appointments of the mayor and aldermen are to be selected so that in each case one appointment represents the medical, one the legal or financial, and one the geriatric field. Any member may be removed by the aldermen for cause.

Section 4. Rights and responsibilities: The authority has general management and control of the municipal nursing home and any branches thereof which may be estabilshed. It has jurisdiction of its affairs and properties, including administration, and shall have charge and control of all its financial receipts and expenditures. It shall reimburse the city annually the amount of principal and interest paid by the city on bonds and notes issued by the city in the name of the authority unless in the opinion of a majority of the aldermen and the mayor, the financial condition of the authority does not warrant such.

Section 4(a). All municipal nursing home employees transferred to and made employees of the authority maintain rank, compensation, benefits, and other rights in the position held by them on January 1, 1972.

Section 5. This section sets forth the officers of the board, their election and terms.

Section 6. This section lists the standing committees and method of appointment.

Section 7. This section details the responsibilities and duties of officers of the board.

Section 8. This section details the powers and duties of the authority which are:

(*a*) To adopt a seal;

(*b*) To sue and be sued only under the same conditions as a city may be sued;

(*c*) To acquire and to create and maintain geriatric properties as specified herein and subject to approval of a two-third vote of the aldermen for: (1) any lease agreements, (2) any major construction totaling $100,000 or more not requiring issuance of bonds or notes, and (3) acquisition of real property;

(*d*) To dispose of property; disposal of any real property subject to approval of two-thirds of the aldermen;

(*e*) To maintain an office within the city;

(*f*) To receive and disburse funds and to maintain financial reserves.

(*g*) To receive and apply any grants or gifts for its purpose;

(*h*) To make and enforce necessary rules and regulations for operation of any of its geriatric facilities or geriatric systems;

(*i*) To issue temporary notes not to exceed $200,000 unless approved by a two-thirds vote of the aldermen and by the mayor, and subject to conditions specified herein;

(*j*) To employ and fix compensation for consultants and others deemed necessary in the performance of its duties;

(*k*) With approval of a two-thirds vote of the aldermen and mayor, to enter into agreement with the Federal Government for the purpose of accepting Federal grants and loans and pursuant to any such agreement, to borrow from a duly authorized source;

(*l*) To enter into agreements with various entities specified herein, providing for or related to geriatric facilities or systems, and to accept from the Commonwealth or any instrumentality thereof, or from nonprofit agencies, grants, loans, and other aid for planning, construction, or acquisition of geriatric facilities;

(*m*) To utilize city services and to reimburse for such services;

(*n*) In cooperation with the Holyoke Housing Authority, to provide for low-income housing for elderly or handicapped as authorized under this act or Chapter 121(B) of the general laws;

(*o*) To organize and control a nonprofit corporation for the purpose of receiving loans and grants, and subject to approval by a two-thirds vote of the aldermen, and provided that the trustees shall be the same as those of the authority. Any action taken which, if taken by the authority, would

require approval by a two-thirds vote of the aldermen shall require like approval;

(p) To carry out the provisions of this act.

Section 9. Bonds, notes, or certificates of indebtedness of the geriatric authority are declared negotiable instruments. Details and procedures relative to their issuance and tax exempt status are contained in this section.

Section 10. Employment practices of the authority shall be subject to the terms of sections 1 to 11 inclusive and subsection (o) of section 14 of chapter 151(A) of the general laws. Employees are eligible to participate in the contributory retirement system and the group insurance plan authorized under chapter 32 and 32(B) of the general laws, if authorized by the authority, and to the same extent as if they were employees of the city.

Section 10(A). This section authorized the city to issue bonds or notes, not to exceed $10 million in the name of the geriatric authority with proceeds to be used for the purposes of this act. It further specifies the provisions of chapter 44 of the general laws which apply.

Section 10(B). Municipal taxation is forbidden, but a payment in lieu of taxes, arrived at by applying the tax rate of the city to the assessed valuation of the facility or system, is required.

Section 10(C). This section proclaims the constitutionality of the act.

EXHIBIT D

GERIATRIC AUTHORITY OF HOLYOKE

Purpose	Source of funds	Amount
(1) Development	Older Americans Act	$75,525
(2) Construction:		
Renovation of existing build'ng	Municipal bond	1,300,000
Construction of skilled nursing facility	do	2,600,000
Construction of skilled nursing facility	Hill-Burton program	700,000
(3) Adult day care (including health clinic):		
Construction	Community Development Act	457,000
Operation	do	79,000
(4) Outpatient clinic:		
Construction	See (2) above	
Operation		
(5) Geriatric center: Operation	Medicaid title XIX, Massachusetts Rehabilitation Commission, Massachusetts Division of the Blind, Veterans Services, Private Fees, CETA.	1,300,000
(6) Transportation: Purchase and operation of vans	Title III, Older Americans Act	20,200
	Community development	16,100
(7) Sheltered housing	Source not yet identified	
Total		6,547,825

ITEM 2. QUESTIONS SUBMITTED TO JOSEPH PAUL BY SENATOR EDWARD W. BROOKE

Question 1. Do you have cost data regarding keeping a person at home in relation to costs in a nursing home?

Response. The cost data regarding keeping a person at home versus the cost of providing nursing home care has to be interpreted in its proper context. The cost of keeping a person at home in the greater Holyoke-Chicopee area varies from $16 to $42 per day, as compared to approximately $28 to $35 per day for nursing home care. The range quoted for home care varies with the service provided. In this area, an elderly individual with some health-related problem may be the recipient of a variety of services. These services may include: meals from the title III program, homemaker services, transportation, chore services, specialized care from the local Visiting Nurses Association, and adult day care services.

Obviously, if an elderly individual received all of the services mentioned above, the cost would be close to the $42 per day previously quoted, and in some cases even higher. Nursing home care, which in my opinion should be the last alternative of health care, can be quite expensive.

I am of the opinion that every effort should be made to maintain a comprehensive network of community oriented programs so that the nursing home alternative will be used only when it is absolutely necessary.

If this premise of community based service programs for the elderly is emphasized, rather than nursing home care, it is quite possible that keeping a person at home may indeed be more expensive than nursing home care.

Question 2. What is the relationship of the Geriatric Authority—a more or less public authority—with private nursing homes in the area?

Response. There is no formal or organizational relationship between the Geriatric Authority of Holyoke and the private nursing home industry in the area. The Geriatric Authority is developing a continuum of care in which some of the private nursing homes may participate. It is alleged that the publicly aided nursing home resident does not generate sufficient income for the private nursing home industry. The Geriatric Authority, being a quasi-public nonprofit agency, can provide nursing home care at cost. The client population that it serves is publicly aided (medicaid, medicare, etc.). Also, many of the private nursing homes do not have a comprehensive system of care like the authority; and many of them have expressed a desire to purchase some of the authority's services, i.e., physical and occupational therapy, nutritional, and transportation services.

Question 3. Two for-profit nursing homes recently indicated that they could not afford to continue serving medicaid patients. Will your operations be supplemented with funding sources other than medicaid? Can you provide the kind of services you plan under medicaid funding only?

Response. The 240-bed multi-level care nursing home operated by the Geriatric Authority serves a population that is predominately eligible for medicaid assistance. The nursing home is a public nonprofit facility that emphasizes quality patient care. Inasmuch as the philosophy of the facility is service oriented and not profit oriented, all of the services provided at the facility are reimbursable in the per diem rate. The rate setting commission (the Massachusetts agency that determines reasonable costs for patient care for the department of care) has allowed in the approved rate for nursing care all of the services that are related to patient care for the publicly aided residents.

The nursing home is focusing on rehabilitative and restorative services with the goal of returning to the community those individuals who have the potential to become self-sustaining.

Question 4. What is the savings to the residents of Holyoke because of the existence of the authority?

Response. The selection of a public authority as the vehicle to provide services to the frail elderly of the greater Holyoke area will result in savings to the residents of Holyoke. Authorities are special purpose governments. They are not tax supported; they provide and support their facilities by the issuance of bonds and the collection of revenues by charging clients for the use of services and facilities. Because the Geriatric Authority has a legal personality separate from government, it can operate with a high degree of efficiency. Unlike profit motivated organizations, the Geriatric Authority has as their purpose the good and welfare of the public; the services of the organization is provided at cost.

The Geriatric Authority has stepped in where general purpose governments are unable or unwilling to assume a certain responsibility. This can happen where tax payers are unwilling to be assessed for the provision for a certain kind of a facility.

ITEM 3. CASE STUDIES SUMBITTED BY WILLIAM RABBITT[1] EXECUTIVE DIRECTOR, HOLYOKE-CHICOPEE REGIONAL HOME CARE CO., INC.

Case No. E182

Clients: Alice R. and Mary T. (sisters).

Ages: Alice, 88; Mary, 90.

Income: Alice, $90 per month from social security and bank interest; Mary, $316 per month from social security and SSI/OAA.

Problem: Alice, recent hospitalization for pneumonia, arteriosclerotic heart disease; Mary, weakness, progressive geriatric degeneration. Nursing home placement for clients versus home care.

Health: Alice was recently released from the hospital following a case of pneumonia. She was still weak. Arteriosclerotic heart disease and congestive heart failure limit her physical activity.

Mary is mainly subject to progressive geriatric degeneration which will continue to further limit her physical activity.

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[1] See statement, p. 651.

History: Both Alice and Mary have been widowed for several years. They now share a six-room apartment. Alice has one son who lives in New Hampshire and is employed by the Federal Government. She has several grandchildren and great grandchildren. Mary has a son and a daughter, and grandchildren. Alice and Mary are visited by their families frequently, but try to function as independently as possible. Their families can offer only limited assistance due to distance of residence and immediate family obligations.

Narrative: When Alice was about to leave the hospital after her case of pneumonia, she was contacted by the Visiting Nurse Association. The visiting nurse made a referral to HCRHC for homemaker assistance for Elizabeth and her sister, as both were finding it more and more difficult to keep up their own residence.

A HCRHC caseworker was sent to make a needs evaluation of Alice and Mary. It was decided that a minimal amount of homemaker service and occasional chore work would enable Alice and Mary to remain in their own home. Neither Alice nor Mary's conditions warranted health aide service but the homemaker service was needed. Alice and Mary were assigned a homemaker for 4 hours a day, 1 day a week to assist with the following: (a) General light housekeeping, (b) laundry, (c) meal preparation, (d) occasional shopping.

Human effectiveness: Alice has been able to stay at home and avoid institutionalization. Mary remained at home for a year until her health deteriorated to an extent that a nursing home placement was the best way to care for her extensive needs.

Case No. E177

Clients: Mary and Elizabeth M.

Ages: Mary, 73; Elizabeth, 70.

Income: $500 per month from social security; one small pension each.

Problem: Terminal cancer patient (Mary); choice of hospitalization versus home care.

Health: Client (Mary) lung cancer was diagnosed 6 months ago; client died 2 months ago. Client (Elizabeth) breast cancer was diagnosed 1 year ago and a radical mastectomy was performed; client undergoing periodic chemotherapy treatments.

History: Mary and Elizabeth lived in the same five-room apartment for 35 years. Neither ever married. A widowed brother, who used to do all the heavy chores, lived with them until his death 2 years ago. Since that time, they have been alone, with no relatives living nearby.

Narrative: Until the onset of their illnesses, Mary and Elizabeth were quite active in community programs for the elderly. Since then, neither felt well enough to leave the apartment. Mary was confined to a chair by the window where she could watch all the activity on the street below; Elizabeth has difficulty climbing the stairs to the second floor apartment due to the chemotherapy treatments, which frequenly leave her feeling nauseous and dizzy.

As Mary's health deteriorated, Elizabeth found herself burdened by the responsibilities of having to be a nurse to her sister and a housekeeper as well. She confided to the American Cancer Society aide, who drove her to the hospital for chemotherapy treatments, that she could see no alternative to moving Mary into a hospital or nursing home. At this point, the American Cancer Society referred Elizabeth to Home Care.

The aim of the Home Care caseworker who visited Mary and Elizabeth was to provide assistance in their apartament so that neither would be separated from her familiar surroundings.

The heavy cleaning "chore" service contracted by Home Care was sent to the sisters' apartment to clean the extensive woodwork, numerous windows and floors.

A homemaker was also provided for 9 hours per week of service. She prepared hot, nutritious meals for lunch in addition to others which Elizabeth could easily heat up in the oven. The homemaker was also able to assume the light housekeeping duties as well as the weekly grocery shopping and laundry. She assisted in bathing Mary's back and feet and reminded both sisters to take their prescribed medication.

In addition, the caseworker made frequent visits to assess the homemaker's work and was easily accessible by telephone.

Relieved of exhausting housekeeping duties, Elizabeth was able to quietly spend time with and talk to her sister. Mary died 2 months later in her own bed with her sister close by.

Elizabeth, who has had no recurrence of cancer in a year is still receiving homemaker service, although on a less frequent basis. She has repeatedly asserted to her caseworker that, in addition to allowing her sister to die amid familiar surroundings, Home Care has enabled her to stop worrying that she would move to a smaller apartment in elderly housing.

Human effectiveness: Clients were able to stay at home and avoid institutionalization, which they greatly preferred. One sister was able to die with dignity in her own home.

Case No. E178

Clients: Sam and Rebecca J.

Ages: Sam, 83; Rebecca, 82.

Income: Both are SSI/OAA; Total of $590 per month.

Health: Rebecca, failing eyesight; arthritis; Sam, nothing at present. Neither has been to see a doctor since their last one died 12 years ago.

History: Sam and Rebecca have been married for over 60 years. They were married at the end of Sam's first year of law school, despite the disapproval of both sets of parents. Their parents then refused to loan the young couple any more money, forcing Sam to quit school to begin a career as a door-to-door vacuum cleaner salesman. They have one son, a wealthy self-made businessman. Their son sees his parents infrequently as he spends 3 months in a nearby town and the remainder of the year in California. He is also married to a woman the J's say is "not congenial." For this reason and because of their stated need to remain independent, the J's refuse to accept any monetary assistance from their son.

Narrative: For the past 30 years, Sam and Rebecca have lived in the same substandard 2½ room apartment. The J's have not had a very cordial relationship with their landlord, who has made only minor alterations in all the years they have lived there. The apartment fell into disrepair. The walls were dirty and peeling. The linoleum on the kitchen floor decayed into pieces with dirt from the underfloor showing through.

The welfare department referred the J's to Home Care. At first, the caseworker had difficulty contacting the J's. Often they would refuse to open the front door. Gradually, they would allow short visits, although both would deny that they needed any help. Sam insisted on doing all of the housework, shopping, and cooking, although much of the monthly income appeared to buy the ever-present beer and wine bottles.

The J's refused to move into a better apartment, citing the proximity of the drugstore and grocery store in the next building. Their caseworker determined that the J's' parakeet and terrier, which they call their "watch dog," would preclude them from living in elderly housing. The J's have stated that they will live in their apartment until thye are "carried out in a box to the undertaker's place down the street."

After vising with the J's son and realizing his concern for his parents' well-being, the caseworker decided to try to re-establish regular contact between him and his parents. First, it was necessary to dissuade the son from attempting to place his parents in a nursing home, which was accomplished by informing him about Home Care's services and its viability as an alternative to institutionalization. The son agreed to contact the landlord for the purpose of having him furnish paint for the J's apartment. Home Care had its chore service thoroughly clean and then paint the entire apartment, which greatly pleased the J's. Not only did they feel they were living in a new environment, but they realized that their son cared enough to help them in deed and not just with money.

The caseworker is presently using a similar procedure in order to induce the landlord to put in a new kitchen floor.

The J's finally agreed to "try out" a homemaker once a week and see how the service would work out. At last report, there have been no problems. Although Mr. J. still insists on doing as much as possible, he now works with the homemaker and occasionally allows her to use his special vacuum cleaner.

Human effectiveness: Clients are able to stay at home and avoid nursing home placement. Contact with family is an emotionally stabilizing influence on their lives.

Case No. E179

Client: Louise B.

Age: 86.

Income: $250 per month from social security and bank interest.

Problem. Legally blind, severe arthritis, balance problem.

Health: Louise has been blind for almost 20 years. The arthritis, especially in her legs, causes her much pain and functional limitations. Her knees are extremely swollen and quite bowed. She has fallen many times due to lack of balance, but her general health is good. Her prognosis is poor.

History: Miss B. never married and is the eldest of the three remaining members of her family. She has two 80-year-old brothers who are of limited assistance to her. One brother is able to cash her checks and pay the monthly bills. There are many friends who call or visit frequently.

Louis lives in an older two-story home which has seven large rooms. In spite of the disadvantages of up and down stairs, heating and maintenance, she will not move, for she has always lived there.

Narrative: Miss B.'s brother was extremely concerned about Louise burning herself around the stove. Family had tried obtaining a women privately, but it was impossible to find anyone, especially someone she could afford.

The brother was no longer able to do the shopping, cooking and laundry and didn't want to place his sister in a nursing home. There was much emotional strain between the family members because of this.

The caseworker met with the client and her brother to set up the best possible assistance to meet the needs of the family as well as the client.

Chore service was implemented immediately, so that the homemaker would not be overwhelmed with the housekeeping.

A homemaker was initiated four times weekly for light housekeeping, meal preparation, laundry, and shopping.

Family will be available on the other days and evenings.

Caseworker helped with application for fuel assistance.

Caseworker and homemaker will reinforce emotional stability and independence.

Human effectiveness: All elderly members of this family are better able to cope with their lives and the future.

Case No. E180

Clients: Arthur and Isabelle F.

Ages: Arthur, 79; Isabelle, 74.

Income: $496 per month from social security and bank interest.

Problem: Mr. F., hemiplegic confined to wheelchair, poor vision. Nursing home placement versus home care.

Health: Mr. F. suffered a stroke in 1975, leaving his right side paralyzed. He underwent leg vein surgery twice in the same year to restore circulation. Being unable to use his right hand from the stroke, three missing fingers on the other hand became quite an inconvenience.

In June 1976, Mr. F. had his leg amputated above the knee. After 3 months, he returned home with his prosthesis, but was unable to walk by himself and now is totally confined to a wheelchair.

Mr. F. suffered two heart attacks between January and February 1977, and his prognosis is not encouraging. There is little that increased physical therapy can do in this case. His general health does not permit him to again be fitted for a lighter, prosthesis.

Mrs. F. underwent a radical mastectomy in 1968 and has since suffered with unceasing pain. She never received therapy, consequently fluid back up in her right arm and hand. Minor surgery was required to drain the fluid in April 1977. She has no sight in her right eye and the vision in the other is extremely poor. Her emotional state is rather depressed since her husband could have been taken from her by death or institutionalization.

History: Arthur and Isabelle have one daughter who lives in Ohio with her family and is unable to be of assistance to her parents. Mr. F. had no brothers or sisters. Mrs. F. had three brothers who were a constant worry to her for years, due to their inability to cope with life and reality. In November 1976, she buried two of the brothers and the third went into an institution.

Mr. and Mrs. F. live in a lovely 3½ room subsidized apartment. They live close to bus lines and have easy access to laundry facilities, and small stores.

Neither found the need to develop new friendships during their lifetime, consequently there are very few friends for emotional support.

Narrative: When the caseworker first met with this family, there was not a great need for constant assistance. Mrs. F. was able to care for her husband's needs and do a fair job with maintaining her home. Heavy duty chore work was scheduled every few months.

As the health of both deteriorated, more reinforcement for emotional stability was required by frequent visits of the caseworker.

Mrs. F. was not going to let her husband go to a nursing home after the rehabilitation center, therefore a service plan was set up with the caseworker before his return home. She wanted to handle his personal care and only wanted assistance with the household duties.

A homemaker was initiated twice weekly to assist with laundry, shopping and light housekeeping duties.

The Visiting Nurse Association therapist was unable to make adequate progress, for the prosthesis was much too heavy and not really correctly fitted. Mr. F. progressed to remaining in the wheelchair.

A nursing assistant goes into the home 2 hours per week for bathing, since the care was more than Mrs. F. could handle.

The coordination of services has worked extremely well with these two clients. There is enough care without creating a dependency. If and when more assistance is needed, all those involved will handle the matter accordingly.

Continued monitoring and service is essential to both clients so that they can remain together in their own home.

Human effectiveness: Clients are able to remain at home with a minimum amount of assistance and reinforcement.

Case No. E181

Client: Irene R.

Age: 75.

Income: $316 per month from social security and SSI/OAA.

Problem: Chronic arthritis and hypertensive heart disease. Home care as viable method of preventive care.

Health: This client has had acute degenerative arthritis since June 1952 and presently has minimal use of her left leg. In October of 1976, client underwent gall bladder surgery and in February of 1977 a stomach operation. Present prognosis is poor especially in regards to improvement in ambulation.

History: Mrs. R. lives in an older tenement building which is in close proximity to her granddaughter's home. When approached with the idea of moving into an elderly housing project, she indicates that she would prefer to live close to her granddaughter.

Her apartment is heated by a gas stove and oil heat. She uses the gas stove as a supplement to her regular heat when there are very cold days during the winter. She pays for the heat in addition to the rent.

Mrs. R's family relationship is supportive but contact is limited because her relative works to help support her family. The client does go shopping with her granddaughter when she is able.

Narrative: When Mrs. R. first contacted the home care agency, she was unable to do the heavy cleaning in her apartment. After her subsequent operations, a home health aide was provided to care for her personal needs. After these services were no longer required, the home care caseworker re-evaluated her situation. Upon this visit, the client and caseworker decided that due to a deterioration in her physical condition, a homemaker would be provided to alleviate some of the physical burden, thereby preventing or at least delaying any further physical complications.

Other assistance that was provided to this client was as follows:

(1) Continued assistance with heavy work when necessary.

(2) Client was informed of the other services offered through agencies such as the council on aging.

(3) Client assisted in applying for supplemental fuel assistance.

(4) Continued followup visits by the caseworker for continued evaluation of the client's physical and emotional status.

Human effectiveness: This client continues to remain in her apartment and retain her independence.

ITEM 4. REPORT OF THE MAYOR'S HOUSING ABANDONMENT TASK FORCE, ELDERLY HOUSING SUBCOMMITTEE, SPRINGFIELD, MASS., SUBMITTED BY AMY ANTHONY[1]

The committee's major work involved a survey of vacancies in the private rental market. With the help of several agencies, landlords were surveyed regarding vacancies in buildings of 10 or more units. Survey results representing 4,320

[1] See statement, p. 677.

units or 63 percent of the total units in buildings of this size were gathered. The overall vacancy rate exceeded 13.6 percent.

This survey was the largest, most successful undertaking of its kind in the city's history. It does have several drawbacks including: no accurate measure of housing conditions, no verification of landlord data. The subcommittee will attempt to follow through in these areas to further refine the data, however, the subcommittee is unanimous in its conclusion that: There appears to be an excessively high vacancy rate in Springfield's private rental market, particularly in large apartment buildings in inner-city neighborhoods and smaller units. It is clear that there are many one- and two-bedroom units available in Springfield at quite modest cost. The high vacancy rate means that many apartment buildings are in jeopardy and that abandonment of such buildings will continue to plague the city. Since it is not possible to replace all existing housing and that it is a precious resource that we must maintain, the following recommendations are made.

RECOMMENDATIONS

(1) Priority must be given to funding of the section 8 subsidy program for existing housing. Available Federal housing money should go to existing housing, and the city should press for increased funding for existing housing programs on both the State and Federal levels. This is vital in view of the high vacancy rate and the importance of preserving Springfield's irreplaceable existing housing inventory. Current Federal procedures involve a "fair share" concept to encourage equitable distribution of housing money among the regions of the State. If money is allocated to new construction of subsidized housing, there will be considerably less money available to Springfield for other housing programs in the future.

Subsidy programs for existing housing will allow landlords to change adequate rents to cover their costs while lowering the costs to tenants. This will help equalize the current attraction of newer subsidized housing where tenants pay 25 percent of their income for rent, and will assist in the effort to preserve urban neighborhoods by encouraging long term, stable tenants to remain. The structure of the section 8 program is such that through the existing housing program, significantly more families can be helped with the same amount of funding than with new construction (approximately 2 to 3 to 1) since the annual subsidy cost in existing housing is so much lower.

Second priority for funding should be given to rehabilitation efforts, particularly in neighborhoods where abandonment of one or two large apartment blocks has had a detrimental effect on an otherwise viable urban neighborhood. This approach will maximize the impact of limited funding resources in the effort to preserve neighborhoods. New construction or modification of units through rehabilitation will be necessary to meet much of the need for larger units (three or more bedrooms). There may also be justification for the new construction of small units under special circumstances.

(2) Neighborhood revitalization in inner-city neighborhoods must move ahead if older housing is to survive. Existing housing in large, older apartment blocks may be "standard" but if other aspects of the neighborhood are undesirable, the units will not be marketable. Physical improvements (sidewalks, lighting), city services (police, sanitation) and neighborhood service programs all contribute to neighborhood viability. If increased city efforts to provide quality services are coupled with subsidy programs and efforts to modernize individual apartment units, the goal of revitalization for urban neighborhoods can be reached.

(3) Priority for any new construction should be assigned to large units (three-plus bedrooms). Also, all proposals should be reviewed by a mayoral committee early in their development. There is an acknowledged need for housing suitable for larger families and this need will have to be served, at least in part, by new construction. Any developer with a new construction proposal should be required to submit it to the mayor simultaneously with submission to HUD or MHFA. The proposal should be reviewed to insure that it fits with the city's housing goals and priorities.

ITEM 5. ADDITIONAL STATEMENT SUBMITTED BY DANE B. WHEELER,[1] EXECUTIVE DIRECTOR, RETIRED SENIOR VOLUNTEER PROGRAM, COMMUNITY AND REGIONAL OPPORTUNITY PROGRAM, INC., CHICOPEE, MASS.

THE DOUBLE DENIAL OF THE ELDERLY ALCOHOLIC

While it is doubtless true that in recent years the elderly in general have been "discovered" and more concern shown for them, there is one subgroup among them which continues to be ignored—elderly alcoholics. Though neglect is still the plight of so many elderly persons, it is doubly certain for elderly alcoholics. In their case, "beyond help" is often added to "over the hill" to constitute the comfortable social attitude of avoidance. It is as though the shadow of death—the ultimate symbol of powerlessness, which is an ever present companion to the senior citizen—is magnified a thousandfold in the powerless visage of the aged alcoholic, at whose sight so many turn away in fear and disgust, reminded as they are of the face of death turned toward us all. Yet despite common assumptions, elderly alcoholics don't fade away, nor do they die at 65 years of age; they live on, hidden away in the dirty little lonely rooms of flop-houses or ensconced in their homes or apartments, desperately watching the clocks tick away their few remaining years, or days, or minutes.

It is we who have turned away. Yet if we only cared enough to look, if we did not turn our backs in fear, we would see them, see them all, those behind closed doors and those who lie this very minute like crumpled dirty laundry in the doorways and in the streets and in the parks of Holyoke and Chicopee and Springfield. It is time we took a look.

Their numbers are legion. Extremely conservative estimates place the number of elderly alcoholics in this area at between 3,000 and 4,000. During a recent 6-month period are detoxification units (excluding Western Masschusetts Hospital) treated and released 281 persons 60 years and over. That averages 10 persons per week. Most are released to the same depressing environments from whence they came in the hopes of becoming sober. Thus, inevitably, they become recidivisits; many return 20, 30, or 40 times. Area experts emphasize, therefore, that an integral element of services to elderly alcoholics must be the resolution of the problem of permanent housing, securing residences conducive to sobriety for the great number of elderly alcoholics who now reside in flophouses or out on the streets.

Through our own and other area facilities serving alcoholics and the elderly, CROP has become acutely aware of the extent of elderly alcoholism in our area (Chicopee, Holyoke, Springfield, and environs). The deficit in treatment programs specifically designed for the elderly—something which experts in the field see as necessary—is not just great, it is complete. There are no such services within Massachusetts Public Health Region I. Existing halfway houses do not meet the elderly's needs; in fact, most of the elderly are excluded because of the work requirement for admission. Yet our extensive research indicates thousands of geriatric alcoholics in dire need of service. This is so despite the plethora of reasons for the exclusion of the elderly from alcoholism statistics.

CROP believes the time has come to offer assistance to the elderly alcoholic. We therefore propose to establish a unique demonstration project to serve the needs of elderly alcoholics. We feel we are in a unique position to institute and coordinate multiple services for them. Presently we successfully run 25 programs with funding from the Federal Government in excess of $3 million. These include elder day care, the retired senior volunteer program, our title VII nutrition programs, a halfway house for male alcoholics in Holyoke, dial-a-van services, etc., serving more than 1,100 seniors. All of these programs would be intimately tied in with our elderly alcoholism program.

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[1] See statement, p. 680.

Today, however, we wish not to explain the details of this project, but rather to share our concern with you, and to point to a problem that has long been overlooked. The elderly have been ignored far too long; elderly alcoholics longer still. The social attitude of avoidance can no longer be countenanced; not only is it unethical, but the attitudes which underlie it are, in fact, wrong. For, ironically, research indicates that the prognosis is better for elderly as opposed to younger alcoholics.

We therefore urge this committee and all those concerned for the elderly to encourage the National Institute on Alcohol Abuse and Alcoholism to designate the elderly as a special category of concern, as they do in the case of women, youth, et al. Surely it is true that a society reveals itself by the fate is allots to its members who can no longer work, and it is our hope that the mirror image we encounter in the future will be commensurate with the picture we have of ourselves and the ideals we profess to cherish. They will, if we no longer deny the reality and the needs of elderly alcoholics.

Appendix 2

STATEMENTS FROM INDIVIDUALS

ITEM 1. STATEMENT OF TERRY COURNOYER, COMMUNITY AND REGIONAL OPPORTUNITY PROGRAM, INC., CHICOPEE, MASS.

Nutrition projects funded under title VII began serving meals to the elderly in July 1973. The CROP/Regional Nutrition Program started operation in February 1974. $98.6 million was released by the Administration on Aging in 1974, $123,750,000 was allotted for nutrition programs in 1975.

The three main purposes of the program are: (1) To promote nutritious meals in a group setting (providing RDA requirements); (2) to encourage social interaction and reduce isolation; (3) to make needed supportive services available and accessible to participants.

The following supportive services are available to the participants as needed: Transportation to and from lunch, escort service, information and referral, nutrition education, shopping assistance, and recreational activitives.

Those persons over 60 have had to adjust to slower reflexes, impaired vision and/or hearing, loss of mobility.

Changes in their daily living situations may include the loss of family, more freedom, more time, less money, increased isolation. Some take these changes in stride, however others feel there is no answer to their problem.

It is at this point that the elderly person needs reassurance that it is all right to be dependent. Although it is very hard for the person to face dependency on others, especially if it is a stranger or a community program, such as nutrition.

Title VII staff has become sensitive to these changes; a smile, a listening ear, patience, trust, and availability put them in the role of helping older people, keep or regain their sense of independence.

The title VII congregate program helps the older isolated person become involved with other people, enjoy better health through improved nutrition and remain self-sufficient and independent as long as possible.

The title VII home delivered meal program offers nutritious assistance and in conjunction with other agencies, such as the Home Care program, the recipient is able to maintain their independence at home as long as possible.

ITEM 2. STATEMENT OF JOHN W. ANDERSON, COMMUNITY AND REGIONAL OPPORTUNITY PROGRAM, INC., CHICOPEE, MASS.

NUTRITION AND THE ELDERLY

The CROP/Regional Nutrition Program is funded under title VII of the Older Americans Act of 1972, as amended and has been operational since March of 1974. The project currently serves a mixed urban and rural area consisting of the communities of Holyoke, Chicopee, Ludlow, Granby, and Ware.

Today, the project provides an average of 625 meals daily, of which 500 are congregate and 125 for home delivered meals.

Since the project's initiation or shortly thereafter (June 1974) the project has maintained a waiting list of individuals requesting admittance to the project. This waiting list has been as high as 650 individuals and currently stands at approximately 400 individuals. The average waiting list time between initial contact and intake into the project is between 2 and 2½ years.

The initial budget for the project was $262,615 Federal dollars and the current budget for the project is $302,615 Federal dollars. On a national level, the title VII has increased from $78.6 million to $250 million in the fiscal year 1978 proposed HEW/Labor Appropriation Bill. On a national level, Title VII serves 400,000 older Americans daily.

As the legislation for the project directs; the project provides a hot and nutritious meal (meeting one-third required daily allowance) at congregate sites on a 5-day-per-week basis and a myriad of supportive services including nutrition education, shopping assistance, transportation, information and referral, counselling, recreation and outreach. It is in the above perspective that the project operates.

A byproduct of the project is that food acts as a catalyst for social interaction and provides a media for the building of relationship and friendship between individual participants who in many cases are alone in life. This inaction contributes to the psychological and sociological well-being of the individual. At the same time, the nutrition needs of the participants are being met contributing to the psychological well-being of the participant.

Until this point, I have discussed the current operation of the ongoing title VII program. However, I would like to reorientate this presentation to include a future perspective.

Although the title VII project serves as a preventative program in some perspectives such as nutrition (i.e., the provision of a meal) it does not serve a total preventative end, in fact the program by it's current nature, must perpetually deal with crisis on a participant level.

In light of the fact that title VII is the largest direct service program in the United States serving older Americans (on a national level 400,000 participants daily), the concept of title VII should be reorientated toward one of prevention of crisis on a physiological, psychological and sociological level.

To achieve this end programmatically the project must take the following assertive steps.

(1) Draw into the project structure resources that provide preventative health screening for the full spectrum of potentially devastating illness (i.e., blood pressure clinic, glaucoma clinic, etc.). Provide these services free of charge to participants.

(2) Draw into the project structure resources that reduce anxiety (i.e., legal services, social security, etc.).

(3) Training all staff in the area of observation of physical and psychological traits that could indicate potential problems and appropriate referral mechanisms.

(4) Development of more enlightening and interesting material on nutrition education and shopping assistance that more clearly bring the object across.

The above steps represent only the broadest base that can and should be developed to reorientate the project to achieve a more constructive and preventative end; thereby better servicing those individuals the program was designed to serve.

ITEM 3. STATEMENT OF DONALD W. BARTON, DEVELOPMENT DIRECTOR, LOOMIS HOUSE DEVELOPMENT PROGRAM, HOLYOKE, MASS.

Senator Brooke, Mayor Cezares, Mayor Proulx, and other distinguished members of the Senate Committee on Aging, I am Donald Barton, presently the development director for the Loomis House Development Program, a nonprofit, operating foundation incorporated on October 8, 1902.

It is with particular pleasure that I address this group today on "health care for older Americans: The "Alternatives" Issue. I came to Holyoke to work on this project about 1½ years ago from Clearwater, Fla., after completing a 13-story, 253-unit retirement apartment complex with a 60-bed health center as an integral part (the second floor) of the facility. (It is just across the street from Gabe's office.)

We used the term health center, even though it was a medicare/medicaid approved, licensed nursing home, because we did not want it, nor our residents who were there on life-term contracts, to think of the health center as "the end of the road." Rather, our emphasis was on "healthful living" and the health center as a place for "rest and rehabilitation" if necessary. We emphasized regular health examinations, preventive medical measures, at least on dietetically balanced meal, all of the available therapies, on doctor's order, as needed.

The medical director was available daily for consultation and referral purposes. An occupational therapist directed the program of the activities director and the social director in numerous programs, arts, crafts, and other activities in which they had an interest. Programing was "resident centered" in that they, through the "resident's council" determined what they wished to do and

the manner in which the programs would be structured. Programs were not only to be "rehabilitative" and "health maintenance" oriented but emphasised prevention of problems as far as humanly possible.

We were fortunate in having legal referral services for those who needed to have wills changed or updated to meet the laws of the State (several residents were recent out-of-State move-ins). A local bank offered consultation services for investment and/or money management at no cost.

We were not thinking of the nursing home as the "catch-basin" for the drop-outs of society (mentally, physically, or financially or just plain "too old"). Our emphasis was always on how could we best match the services we had available to the needs of our people. We began by focusing our attention on people as individuals—human beings—each one at a different place in life.

Believe me, there are no pat answers. Setting inflexible rules and arbitrary "levels of care" or classifications of "acute," "skilled nursing," or "immediate level of nursing" is an inhumane tool of government. To compel "compliance with the regulations" demeans all professional persons and leads only to "paper compliance" by staff and the resultant neglect of good patient care. When a registered professional nurse has to spend more time filling out paper squares than she does giving direct patient aid—person-to-person with a lot of TLC added, something is wrong with our system of delivery of care. A person, by the will of the Almighty (not the regulatory agency) may today be very much "ambulatory/well," a few moments later "acutely ill." The speed with which medical help is available may well determine how long he will need "acute" care (as well as other forms of therapy). His home life/mileau may determine if he will need "skilled" or "intermediate level" of care services. His recuperative process may well be fashioned around the intermediate surroundings in which he finds himself. In a word, his environment can dictate how speedily he will become "ambulatory/well" again and whether or not he will ever become a functioning person.

Our project gave that "continum of care" concept to the elderly as one of the "alternatives to institutionalization." Costs were reduced dramatically when the person (patient) at the hospital knew he had a place to which he could return early in the convalescent period, had the peace of mind that there he would be among friends and know that excessive hospital bed costs were not going to accumulate because there was "no place to send him."

Further, the person was more likely to be released early because the doctors at the hospital knew he would have expert attention at the health center. The patient was more at ease, for if he had a spouse, she would be close at hand 24 hours a day. Once he was back to the apartment, he knew he had 24-hour nursing service as close as his bedside emergency cord. Meals were no problem for the folks in dietary department could deliver to bedside. Friends and visitors—long time or newly made, were always around and could visit at will—making life a reality in either sickness or health.

Now that I am here in Holyoke, we are planning a "campus type program," utilizing the same continuum of care concept for which the Loomis House has been famous for 75 years. Our residents will be in a very residential setting in one of the better residential areas of the city. We have nearly six acres of land on which to develop. We will begin at the street fronting, with homes that blend into the community for the well elderly in eight-unit, two-story houses, next going to a one-story unit with apartments from studios to two-bedroom combinations according to the desires of the individuals. Next will be the community center for the residents, where they may share in the main meal of the day, crafts, programs, discussions, clinics or whatever seems to be their interest at the time. Further on, a section for the frail elderly; those not wanting to be "too-far" from health care, but not needing it on a regular basis. Then, adjacent will be the health center, providing care for levels II–IV.

We are again concerned with the "humaneness" of services. The setting is an old estate, surrounded with trees and shrubs, in a quiet neighborhood where there will be opportunity for even the frail to get out into nature in a protected environment, but close to nature. In terms of dollars—upon which so much of our delivery of care services is predicted—we feel that we can give a superior service at a significant saving. We can treat the person as he needs; rather than to shove him off onto a shelf, artificically contrived and inhumanely administered.

In my past 15 years of work in this field, and with these concepts as priorities, I have found very few persons who did not adapt to the sense of "community" in this concept. We never tried to "high-pressure sell" the idea, nor did we let family members pressure a parent. Prerequisites were minimal: relatively good health for the age, and sufficient funds at entry for your projected care. Some Federal and State funds were utilized for those who could not make full funds.

An important factor in any long-term care facility is a consistently revised and updated structured escrow fund for the care plan and a plan to adapt to rising costs as necessary. Residents should be made aware of this at entrance. This plan and project is definitely above the "poor class" but fits well into the midde an upper income elderly who need services every bit as much, if not more, than the elderly poor for whom all types of government programs exist.

Mr. Paul of the GAH and I have no conflicts with our proposed projects, we serve people at both ends of the scale, and see the common needs of both. Ironically, we are also at the opposite ends of town.

Enclosed with these comments is a copy of the architects layout[1] of the proposed plan which I wish could be included in the printed record, for it shows the progression possible for the person from "well/ambulatory" through to full nursing care.

When our new facility is completed we hope to make use of the existing facility for the members of the community whose needs are not being met by the existing programs of the city in the Highlands area. "Long-term care" to me is care from 65–100 plus—more than a 35-year lifespan—3½ decades of life. What shall their quality of life be? It has to be flexible, innovative, and have a real "continuum of care" attached to it. We cannot continue to be fragmented and running in every direction to make life meaningful.

We try to speak of "quality of care" but few know what we mean. By what measure do we come to the "quality of care" we would desire for ourselves?

For some here today, retirement has become a reality . . . for others it is only around the door. Certainly an effective "quality of care" cannot be achieved in the sterile confines of hospitals and nursing homes. I offer one viable alternative, knowing there are many others. Even ours shall undergo much change in the years to come, striving to meet the needs of our people to whom we have dedicated our lives in service. We must move out into the community and reach the multitude who need assistance.

Mayor Proulx, thank you and may we encourage you to be supportive of our efforts. Mayor Cezares (I'd rather call you Gabe), as you look across the street remember the over 300 persons being served. Senator Brooke, thank you and please keep in mind our elderly and put them at the top of your priority list for services needed and use your good wisdom and office and power to help.

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[1] Retained in committee files.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR BROOKE: If there had been time for everyone to speak at the hearing on "Health Care for Older Americans: The 'Alternatives' Issue," in Holyoke, Mass., on October 12, 1977, I would have said:

The following replies were received:

DOLORES BERSELL, RUTLAND, VT.

Special consideration should be given to the unique problems of the elderly who live in rural areas. Isolation, transportation, and the high cost of service delivery are all different in a nonmetropolitan area and any laws or regulations should consider these facts.

Vermont is one of the few States in the Union that does not have an SMSA and sometimes loses Federal programs because of this fact, but all elderly are in as great or greater need than the urban elderly.

HENRY C. ENGELHARDT III, SOUTHWICK, MASS.

I feel that there is a need for some type of matching funds for senior citizens activities centers in areas where renovation of facilities is not feasible. As a case in point I offer Southwick Mass. There is no building that is reasonable to renovate as a senior center. For this reason the seniors go from Grange Hall to churches and back to have meetings and activities. None of these places is well suited for different reasons.

A new project for housing persons of the community who are elderly is in the final planning stages. That this project seems to be succeeding is in no small part due to the efforts of Senator Brooke and his staff. This project, funded by the Farmers Home Administration, includes $50,000 for use in building a community room of some type. The community is able to provide and will donate approximately $20,000 more toward a community center that would serve the entire community. The total cost of such a facility, however, would be about $150,000. Without a grant from somewhere, the idea of a community center to serve all of the elderly in this area must fail. It was first thought that a grant could be obtained from title V funds. It was later found that such funds cannot be used on new construction. No other source of funds has now been identified that can help us. If a procedure for matching funds were available, I am sure the town could somewhere find the extra $5,000 needed to realize a $75,000 grant. I am also certain that if such a program were available the chances of program abuse would be very low because of the amount of money that would have to be found locally.

CLARA E. VANE, SPRINGFIELD, MASS.

Home care is a great thing—anything to help keep folks out of nursing homes.

I have worked with home care in nutrition and the clinics before I joined Vista—they are great.

DIANE M. WICKS, MANCHESTER, CONN.

I am strongly in favor of congregate living facilities, in which meals would be available on the site of the housing facility. This serves those who cannot totally care for themselves but do not need convalescent care.

Transportation relates closely to health care—the ability for the elderly to get proper health care is a big problem with the elderly.

Outreach programs are important to the elderly. Outreach workers and Vista volunteers have the ability to reach elderly people on a very personal level and encourage them to use existing services. They can treat them as whole, dignified people and not fragmented by needs. They can also help with confusing insurance forms, et cetera.

Elderly people need to keep their pride and dignity.

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