AUDITING OF NURSING HOMES AND ALTERNATIVES TO INSTITUTIONALIZATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

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The permanent Select Committee on Aging was established on October 2, 1974, when the amendment to H. Res. 988, the Committee Reform Amendments of 1974, was adopted by the House. The amendment was subsequently incorporated in the Rules of the House of Representatives at Rule X.6(g), which reads as follows:

(g) There shall be in the House the permanent Select Committee on Aging, which shall not have legislative jurisdiction but which shall have jurisdiction—

(1) to conduct a continuing comprehensive study and review of the problems of the older American, including but not limited to income maintenance, housing, health (including medical research), welfare, employment, education, recreation, and participation in family and community life as self-respecting citizens;

(2) to study the use of all practicable means and methods of encouraging the development of public and private programs and policies which will assist the older American in taking a full part in national life and which will encourage the utilization of the knowledge, skills, special aptitudes, and abilities of older Americans to contribute to a better quality of life for all Americans;

(3) to develop policies that would encourage the coordination of both governmental and private programs designed to deal with problems of aging; and

(4) to review any recommendations made by the President or by the White House Conference on Aging relating to programs or policies affecting older Americans.

Hon. Wm. J. Randall of Missouri was appointed chairman of the new Select Committee on Aging by Speaker Carl Albert on February 6, 1975. The other 27 members of the committee were subsequently appointed and the committee formally organized itself on February 20, 1975.

In accordance with House rules that committees with membership of 20 or more members have at least 4 subcommittees, the following subcommittees have been established:

Subcommittee No. 1—Retirement Income and Employment, Mr. Randall, chairman; Mr. Wampler, ranking minority member.

Subcommittee No. 2—Health and Long-Term Care, Mr. Pepper, chairman; Mr. Heinz, ranking minority member.

Subcommittee No. 3—Housing and Consumer Interests, Mr. Roybal, chairman; Mr. Hammerschmidt, ranking minority member.

Subcommittee No. 4—Federal, State, and Community Services, Mr. Matsunaga, chairman; Mr. Wilson, ranking minority member.

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AUDITING OF NURSING HOMES AND ALTERNATIVES TO INSTITUTIONALIZATION

SATURDAY, JULY 12, 1975

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
OF THE SELECT COMMITTEE ON AGING,
Field hearing held at Providence, R.I.

The subcommittee met, pursuant to notice, at 12:20 p.m., in the Bishop McVinney Auditorium, Cathedral Square, Providence, R.I., Hon. Claude Pepper (chairman of the subcommittee) presiding.

Subcommittee members present: Representatives Pepper of Florida, and Edward P. Beard of Rhode Island.

Staff members present: James A. Brennan, Martha Jane Maloney, and Bernice King.

Mr. PEPPER. The subcommittee will come to order, please.

We will begin our hearing.

My name is Claude Pepper. I am from Miami, Fla. I am chairman of Subcommittee No. 2 of the House Select Committee on Aging.

Our subcommittee's goal is health maintenance and long-term care for the elderly of our country.

You know, of course, your distinguished Representative here, Mr. Edward Beard, who is a very active and able member of our subcommittee. We are very pleased that upon the invitation of Mr. Beard we could be here today to ascertain some information that we hope will be helpful to us in making recommendations to the full committee, the Select Committee on Aging, of the House of Representatives, and to help that committee to make recommendations to the House of Representatives, leading, we hope, to legislation that will be meaningful to the elderly people of our country.

It brings back many memories to me when I come here to the great city of Providence. The last time I was here I was a member of the Senate and a colleague and friend of one of the greatest men who ever served in public life in this country, the Honorable Theodore Green, the Senator from Rhode Island.

I came over here with a good many of my colleagues to a birthday party for Senator Green. It was a great affair. People extended their appreciation and their affection to Senator Green in a very touching way.

I shall never forget as I walked into Senator Green's home with him—he pointed to the chairs in the reception room of the hall and he said, "Those chairs have been setting there for over 100 years."

They tell a story about Senator Green in Washington. He was a very

popular man on the Senate Foreign Relations Committee. He went to many of the international parliamentarian sessions. One day one of Senator Green's friends saw him looking into his engagement book and said, "Theodore, are you trying to find out where you are going next?"

He said, "No, I am trying to find out where I am now."

So, we are happy to be here.

I am privileged to have known also the Honorable Eldridge Gary, a distinguished Senator. I believe he was succeeded by Attorney Howard. He, too, was my colleague and friend.

You have two great Senators now serving in Washington: Senator Pastore and Senator Pell, and two distinguished Representatives, Mr. St Germain and Mr. Beard. The State of Rhode Island is very ably represented in the Congress of the United States and we are very happy to be here in the city of Providence.

I will make a little statement and then invite Mr. Beard to make any statement that he would like to make.

We are primarily concerned in our hearings today with two questions. One is: What sort of auditing should be required of the nursing homes of the country; who should conduct those audits; and how should the expense of making these audits be borne?

There is legislation pending now in the Congress of the United States of which Mr. Beard and I are among the authors of those bills. And Senator Moss in the Senate has introduced a similar bill to require that nursing homes in the country shall be audited by the several States of the country and contemplating that the Federal Government will pay the cost. The cost would be quite extensive, running up, some estimate, maybe as high as $45 million a year.

The law does not now mandatorily require that kind of an audit either by the Federal Government or by the State. We want to know whether or not the tax would justify Congress passing legislation making it mandatory that such audits be conducted either by the Federal Government—by the way the Federal Government, as will be pointed out later, makes spot checks all over the country—as is the system at present, or whether the Federal Government or the State government or both will be required to make such audits and how the expense shall be borne.

The second question, probably actually more meaningful to more people, deals with the question of home care for the elderly. Our subcommittee is now concentrating on that question in a number of hearings that we have had in Washington and in others that we will have like this in different parts of the country.

Would it contribute to the health and happiness of elderly people to be able to receive care in their home so they could remain with their families; remain in their own housing facilities, their home or their apartment, as the case may be; in their own neighborhoods to which they are accustomed, among their own circle of friends who may have been their friends for a long time?

Would it be in the promotion of health and happiness of elderly people to receive nursing and homemaker services and, if necessary, the delivery of meals and somebody to do various errands for them, a comprehensive list of home services that would enable them to con-

tinue to live in their home instead of having to go to a nursing home? [Applause.]

Mr. PEPPER. I am glad to see that you believe, apparently, that it would be desirable.

That is one of the things we want to hear about this afternoon. In addition to that, we want to know if it would not save a lot of money for the Federal and/or State Governments if we could render those services to the people in their homes and enable them to live healthily and happily there without going to nursing homes.

Would it not save an awful lot of money as well as contribute to the happiness of the individual involved?

Those are the two basic subjects upon which we are to hear some outstanding witnesses this afternoon.

Mr. Beard, would you like to make any opening statement?

Mr. BEARD. Yes.

Mr. Chairman, on behalf of the residents of the State of Rhode Island, I certainly welcome you to the city of Providence and the State of Rhode Island.

One thing, I think, is very interesting about the chairman. He has had many, many outstanding years of public life. He served, as he mentioned, in the U.S. Senate. He was a personal adviser to the late Franklin Delano Roosevelt.

Chairman Pepper has been in the forefront over the years in this concept of home health services. So, I think this is a very, very high point in my career that we have such a distinguished chairman here for the sole purpose, and this is the purpose, and the reason I am here, to gather information in order to be able to legislate or make recommendations that will improve the plight of the elderly people in America.

Mr. PEPPER. Thank you very much, Mr. Beard.

Now, as our first witness, we have the Honorable Peter Franklin, Special Assistant to Secretary Weinberger, Secretary of Health, Education, and Welfare, of the Government.

Mr. Franklin came as a personal favor to Mr. Beard and me today. Obviously, he had other obligations that I think he was concerned about doing, but because of his deep interest in trying to do what can be done, as an important Government official, for the elderly, he has agreed to come here today.

We are going to have to excuse him and his group with him today because they have other obligations when they finish their testimony. But, we have two of the top people in the Department of Health, Education, and Welfare—Mr. Franklin, Special Assistant to the Secretary; and Dr. Abdellah, Assistant Surgeon General and Director of the HEW Office of Nursing Home Affairs. They are accompanied by a number of outstanding experts in this area from the Department of Health, Education, and Welfare.

Mr. Franklin is a very distinguished man and a graduate of Harvard in business administration. He has a lengthy background which I could disclose to you here, but I am sure when you hear him you will agree that he is a very eager man. We are very pleased to have him.

Mr. Franklin, if you will go ahead.

STATEMENT OF PETER FRANKLIN, SPECIAL ASSISTANT TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. FAYE G. ABDELLAH, ASSISTANT SURGEON GENERAL AND DIRECTOR OF HEW OFFICE OF NURSING HOME AFFAIRS; EDWARD A. PARIGIAN, REGIONAL AUDIT DIRECTOR, REGION I, BOSTON; ALBERT T. J. BENZ, ASSISTANT DIRECTOR OF STATE AND LOCAL AUDITS, HEW AUDIT AGENCY; NEAL FALLON, REGIONAL COMMISSIONER, SOCIAL SECURITY ADMINISTRATION; VINCENT GAVIN, ACTING REGIONAL COMMISSIONER, SOCIAL SECURITY ADMINISTRATION, REGION I, BOSTON; THOMAS SULLIVAN, DIRECTOR, OFFICE OF LONG-TERM CARE STANDARDS ENFORCEMENT, REGION I, BOSTON; AND WARREN McFAGUE, ACTING REGIONAL DIRECTOR, REGION I, BOSTON

Mr. FRANKLIN. Mr. Chairman, thank you very much for that kind introduction, sir.

I would like to take a moment to introduce these people with me before I move to my remarks.

Mr. PEPPER. Please do.

Mr. FRANKLIN. As you have mentioned, I have with me Dr. Faye Abdellah to my immediate right. I might just add one of Dr. Abdellah's credentials, which I am sure might be of interest. Dr. Abdellah is the highest ranking woman in the uniform services of the United States and holds the mark of a two-star admiral in the U.S. Public Health Service.

To my immediate left is Mr. Ed Parigian, who is Regional Audit Director, Region I, Boston.

To my far left is Mr. Albert T. J. Benz. Mr. Benz is Assistant Director of State and Local Audits for the HEW Audit Agency in Washington.

Sitting behind me are several colleagues. I will ask them to stand as I mention their names—Mr. Neal Fallon, Regional Commissioner of the Social Security Administration; Mr. Thomas Sullivan, Director of the Office of Long-Term Care Standards Enforcement for this region; Mr. Warren McFague, Acting Regional Director of HEW in this region; and, finally, Mr. Vincent Gavin, Acting Regional Commissioner of the Social Security Administration here in the Boston region.

Mr. PEPPER. We are very happy to have those able assistants of yours here, Mr. Franklin. We appreciate their coming.

Mr. FRANKLIN. Mr. Chairman, I would now like to move to my prepared remarks.

Mr. Chairman and members of the subcommittee, I am pleased to have the opportunity to appear today to testify on the progress being made by the Department of Health, Education, and Welfare in improving long-term care in the Nation and to discuss with you the current situation here in Rhode Island.

The Department's goal is to assure that the residents of nursing homes are given the care they need and are entitled to and that they receive this care in a safe environment. There are a number of fine facilities in this country, but there are far too many facilities that do not even meet minimum standards.

These homes must either be improved or Federal funds must cease to support them. At HEW we have moved to strengthen our enforcement posture by clearly warning the States and providers that we will not continue Federal financial participation for facilities that are not in compliance with the conditions of participation for life safety and health and do not have acceptable plans of correction for the deficiencies.

Unfortunately, the withdrawal of Federal financial participation from a nursing home participating in the medicare and medicaid programs——

Mr. PEPPER. Mr. Franklin, I apologize to you. I would like Mr. Beard to introduce his assistant and I would like to introduce the other staff members.

Mr. Beard, would you care to?

Mr. BEARD. Yes; I have at my right Mr. John Riley, my administrative assistant, who works out of the Rhode Island office, the Providence office.

Mr. PEPPER. To my left, the second one to my left, is Mr. James A. Brennan, Jr., who is staff director of the subcommittee, of which I am chairman, and Mr. Beard is a member.

Over on the end is the executive director, executive assistant to Mr. Brennan, Mrs. Martha Jane Maloney. Here to my left is a member of the staff of my own congressional office, Mr. Paul Friedman.

I am sorry to interrupt. I wanted the audience to know who was here.

Thank you.

Mr. FRANKLIN. Thank you, Mr. Chairman.

When Federal financial participation is terminated an extremely sensitive situation is created. In such a situation, we must assure that it is the nursing home provider and not the nursing home patient or client who is penalized for the substandard facility. Working with the States and other Federal agencies, we must provide owners with a reasonable opportunity to meet our standards which are minimum. We cannot, however, and will not, continue to subsidize homes where environments and health conditions literally endanger the lives of patients.

Mr. Chairman, I would like to discuss the progress the Department has made to date and then we will move on to the current Rhode Island situation.

First of all, the eight-point nursing home initiatives.

Many of the eight-point nursing home improvement initiatives enunciated by the President in 1971 to improve the quality of life and care of the aged and disabled needing long-term care have been accomplished. The emphasis of the original initiatives, which included standards development and enforcement, surveyor and health care personnel training, mechanisms responsive to consumer complaints, and research development and collection efforts, has been modified and expanded to reflect the current crises in nursing home care. I should like to highlight here our progress to date by first discussing the regulations governing skilled nursing facilities, intermediate care facilities, and utilization review.

The skilled nursing facility and intermediate care regulations published in the Federal Register January 17, 1974, consolidate and present many new and uniform standards.

For skilled facilities, significant changes include termination of Federal financial participation for eligible patients and clients, when conditions of participation have not been met and serious deficiencies still exist after a time-limited agreement expires.

Standards have been included which strengthen independent medical evaluation and utilization review. Particularly important is the requirement that the health care of every patient must be under the supervision of a physician who prescribes a planned regimen of total patient care which is reviewed at least once every 30 days.

Other important standards specify requirements for a director of nursing services, charge nurse, 24-hour nursing service, patient care plan, rehabilitative nursing care, supervision of nutrition, administration of drugs by trained personnel, and the meeting of minimum 1967 life safety code standards.

The publication of the October 3, 1974, regulations for skilled nursing facilities [SNF's] adds to the January regulations and includes almost all the recommendations of the Subcommittee on Long-Term Care of the Senate Special Committee on Aging. Particularly significant is the inclusion of required policies regarding patients' rights, seven-day registered nursing services, a medical discharge plan, a qualified consultant dietitian, and medical direction including an organized medical staff.

Disclosure of ownership is now a condition of participation and a facility must supply full and complete information to the survey agency identifying each person who has any direct or indirect ownership interest of 10 percent or more. Requirements for disclosure affecting corporations and partnerships are also included. The provider is required to report promptly any changes in ownership.

Let us move now to the regulation of intermediate care facilities.

Regulations were published January 17, 1974, requiring a new level of care under the medicaid program.

Prior to publication of these final regulations the standards which applied had been those established by the States.

DHEW's regulations require that all intermediate care facilities must be surveyed and certified by May of 1975. The Department has not permitted Federal financial participation to continue for any facility that was not surveyed or certified by this date.

There are special requirements for intermediate care facilities for the mentally retarded. While these particular facilities must have met the survey/certification deadline, all intermediate care facilities for the mentally retarded have to be, until March of 1977, in compliance with the special requirements for the care of the mentally retarded.

Final regulations covering utilization review were issued on November 29, 1974, and became effective July 3 of this year for nursing homes. These regulations were mandated by Public Law 92-603 and govern hospitals and mental institutions as well as nursing homes. The guidelines that have been developed for nursing home care look to functional considerations as well as diagnosis in developing criteria and norms for extended stays. We expect all facilities to benefit from review of the appropriateness, timeliness, and quality of care, and from the requirements to study the aspects of their medical care prac-

tice. These regulations are compatible with the operations of professional standards review organizations that are now being organized throughout the country.

The Nation's consumers and providers have shown a high degree of interest in the area of long-term care. To better communicate and discuss Federal actions with consumers and providers, the Department through the Office of Nursing Home Affairs, which is headed by Dr. Abdellah, has conducted open forum meetings to which representatives of provider, consumer, and professional associations are invited to learn about new regulations and provide input into interpretive guidelines.

Where DHEW receives a specific complaint from individuals or through other sources such as the Congress about a particular facility, the complaint is investigated by the regional offices of long-term care.

As I mentioned earlier, Mr. Tom Sullivan heads the office of long-term care here in region I in Boston. These offices work closely with the appropriate State agencies to investigate complaints.

Unannounced visits are made if indicated.

The interest of concerned individuals, families, groups, communities, and the Congress will help to improve nursing home care. The sense of community presence in homes will not only aid in assuring humane treatment, but also in reassuring residents and patient care staff that they are not a forgotten and neglected segment of the population. No one organization or group can bring about improvement in care alone. There must be a concerted effort by all parts of our national community if we are to achieve an optimal level of care in a safe environment for all who require these services.

In order to discuss DHEW's total long-term care efforts, I feel it is important to have an understanding of how we are organized to meet our mandates, and how we are enforcing our mandates.

The Department's long-term care program, to be effective, must be managed through an organizational structure which offers the highest probability of insuring timely and consistent enforcement actions and of establishing clear lines of accountability for actions taken.

Until recently the approach of the Department to nursing homes had been fragmented along agency lines. Responsibility had been split between the Social Security Administration, the Social and Rehabilitation Service, the Public Health Service, the Administration on Aging, the HEW Regional Directors, and a special Office of Nursing Home Affairs in the Office of the Assistant Secretary for Health.

One year ago, the Secretary took certain organizational steps to rationalize our approach in dealing with the complex problems in nursing homes. As special assistant to the Secretary, I am responsible for coordinating the long-term care efforts of all the DHEW agencies. Under the direction of the Assistant Secretary for Health, the Office of Nursing Home Affairs, the headquarters operating focal point for all activities affecting long-term care provides the direct link between the regional offices of long-term care and the Secretary's immediate office.

Each region has established an Office of Long-Term Care Standards Enforcement. These offices became operational in June 1974, and combine the survey, certification, and standards enforcement responsibilities formerly in the Bureau of Health Insurance, the Medical Services Administration, and the Public Health Service.

With regard to enforcement, over 500 skilled facilities have either voluntarily withdrawn or have had their Federal financial participation terminated. This is since the publication of the January 17, 1974, regulations.

The regulations published by DHEW on November 13, 1974, for the first time allowed the Department to go behind the facility's medicaid provider agreement and to terminate Federal financial participation. Previously the Department could only request the State to resurvey.

The actual survey and certification of a nursing home is a State responsibility. However, it is a Federal responsibility to assure that the States fulfill their obligations.

Under medicare the Department contracts with the State to survey and under medicaid the States are required by statute to survey and certify participating facilities. Under both programs, where a State has failed to perform its duties, the Department has not hesitated to take strong action.

For example, the Secretary has filed suit against the Commonwealth of Pennsylvania to require the State to carry out its contractual responsibilities and assure that nursing homes in that State participating in medicare and medicaid programs are in compliance with Federal law and regulations.

During 1974, major emphasis was placed on improving the enforcement of the Life Safety Code in skilled nursing facilities and intermediate care facilities. In July and August three Life Safety Code survey training sessions were held for State and regional office personnel.

Approximately 230 people attended these sessions which were geared to improving interpretation, documentation requirements, and survey techniques. Our regional offices of long-term care conduct periodic training sessions for State surveyors. This effort has led to a more uniform interpretation of Life Safety Code requirements and stricter enforcement.

In addition, over 2,200 State and Federal surveyor personnel have attended DHEW-sponsored training. This training involves specialized courses normally presented in a university setting. This educational activity is vital if decisions and judgments required of survey personnel are to be made properly.

The quality of the Nation's nursing homes is very much dependent on the quality of the surveyors who inspect homes. We have in each regional office a health facility surveyor improvement program coordinator to identify specific needs in that area for surveyor training and to see that needs are met.

On August 7, 1974, Public Law 93-368 extended for 3 years the 100 percent Federal funding of salaries and training of surveyors for the medicaid program. This continued support was necessary to insure that the States could meet their statutory responsibility to survey all skilled and intermediate care facilities on an annual basis.

Further, the Department has an ongoing effort to provide opportunies for short-term training for nursing home personnel throughout the country. Over 100,000 people have been reached by these opportunities since this initiative was implemented. Nine of our ten regions have identified a "center of excellence" within their jurisdiction, a long-term care facility where onsite training can be given to interdisciplinary teams from other facilities.

In addition to the 1971 nursing home initiatives, the Secretary initiated in June 1974 a long-term care improvement campaign. The initial project was a series of unannounced visits to a random sample of over 300 skilled nursing facilities throughout the Nation.

These visits were made by DHEW teams which included a physician, a registered nurse, a physical therapist, a pharmacist, a nutritionist, a life safety engineer, and an administrator. The findings of this study will give us the first statistically valid picture of conditions in nursing homes. The report has been completed and key findings were announced by the Secretary.

The final text is now being printed. The Department will have a vigorous followup program based on the findings which will guide us in targeting our efforts to upgrade performance, provide technical assistance to States and providers, improve survey-certification procedures and introduce innovations in the delivery of long-term care services.

Another part of the improvement campaign was the development of a management information system responsive to the regional and State needs for long-term care data. Demands for instant information on surveys, certification, status of individual homes, life safety code inspections, termination of Federal financial participation, and other matters of current nursing home concern have now mounted to the point where it is imperative to produce up-to-the-minute answers without delay.

The framework for a computer based management information system has been developed and the system is now on-line linking data gathering at headquarters with that of the regions and the States.

Several other strategies are underway as a part of the long-term care campaign.

The Department is working with the States to develop a program that would lead to the professional credentialing of State surveyor personnel.

Alternatives to institutionalization are urgently needed and DHEW is studying the barriers to the adequate utilization of alternatives to institutionalization such as home health care.

Special needs of the mentally retarded and developmentally disabled populations of all ages are surfacing across the country. The Department is actively involved in upgrading services for this special population.

DHEW plans to develop a cost-of-care index to assure that formula for reimbursement to skilled nursing homes and intermediate care facilities is both appropriate and adequate.

The Department is working to develop a national scorecard system for nursing homes. An "A" rating, for instance, should reflect the same quality of care in whatever part of the country the facility is located.

Mr. Chairman, I would now like to turn to Rhode Island.

In 1973 and again this year the Department of Health, Education, and Welfare Audit Agency performed reviews of selected aspects of skilled nursing facility and intermediate care facility operations under title XIX of the Social Security Act as administered by the State of Rhode Island. The scope of medical services available under the medicaid program is contained in the Rhode Island State plan for medical assistance. The plan, which has been approved by the

Secretary of the Department of Health, Education, and Welfare authorizes skilled nursing facility services and intermediate care facility services for eligible individuals.

From July 1, 1972, through December 31, 1974, the Rhode Island Department of Social and Rehabilitation Services expended $55 million for care in institutional facilities. The Federal Government participated in slightly over 50 percent of these expenditures or $29.5 million.

Mr. PEPPER. Just to make it clear, you are saying from January 1, 1972, to December 31, 1974, the State of Rhode Island through its Department of Social Rehabilitation Services spent $55 million, the Federal Government spent $29.5 million?

Mr. FRANKLIN. Those numbers do not add, sir. The $29.5 million is a part of the $55 million. That is the Federal share, as the Federal part of the Federal match.

Mr. PEPPER. So, the total amount spent was $55 million?

Mr. FRANKLIN. Yes, sir.

Mr. PEPPER. Thank you.

Mr. FRANKLIN. The Audit Agency's May 1975 report on Rhode Island pointed out two fiscal issues that are of particular significance.

The first issue of fiscal abuse relates to the handling of nursing home patients' personal needs funds. As early as July 1973, we pointed out to the State of Rhode Island through an audit agency report the inadequacy of the approach taken in the State and made specific recommendations for improvement. These recommendations were never implemented and our May 1975 audit agency report cites the same problems and again makes specific recommendations for improvement. Proper handling of personal needs moneys is a condition of participation established by Federal regulation. The citation is 45 CFR 405.1121.

The Office of Nursing Home Affairs has issued a directive to all regional offices of long-term care to review State enforcement of this condition and to assure that appropriate Federal validation of this condition of participation is ongoing. We stand ready to offer technical assistance to the State of Rhode Island on the implementation of this regulation.

The second fiscal abuse issue raised relates to misuse of moneys paid to nursing facilities for patient care. We have been disturbed by the dearth of audits of nursing homes by the State of Rhode Island.

We are encouraged, however, by the fact that the State has recently undertaken an audit program. Of the 27 audits that have been conducted by Rhode Island since 1967, 20 were conducted within the last 6 months.

The Department recommends that States perform on-site audits; however, such audits are not mandated by Federal regulation. The Secretary has requested that this policy be reviewed to see if federally mandated audits would either be desirable or statutorily supportable. When this review is completed it will be submitted to the Secretary for his consideration.

Mr. Chairman, this completes my prepared remarks and I would be pleased to answer any questions you or the members of the subcommittee may have.

Mr. PEPPER. Well, thank you very much, Mr. Franklin, for a very able statement.

Mr. Franklin, from your view, as Special Assistant to the Secretary of HEW, about how many nursing homes are there in the country?

Mr. FRANKLIN. In the country, Mr. Chairman, there are 23,000 skilled and intermediate nursing homes. However, of these homes only approximately 16,000 participate in the medicare or medicaid programs. So, those that receive Federal moneys are approximately 16,000 facilities.

Mr. PEPPER. Now, the Federal law at the present time does not require either the Federal Government or the States to make an on-site audit of those nursing homes, does it?

Mr. FRANKLIN. No, sir. It does not.

Mr. PEPPER. HEW, as an agent of the Federal Government—you conduct what I believe you describe as spot checks. You checked about 300 homes of the 16,000 over the country.

Mr. FRANKLIN. Yes, sir.

We do spot checks on homes and I do have available, and this I have discussed before, a listing of the number of medicaid facilities that have been audited by States. That is broken down by State. [Exhibit I.]

Further, I do have a listing of the HEW Audit Agency reports issued by State [exhibit II], and this would give you and the members of the subcommittee a clear picture.

I would be happy to have this material supplied.

Mr. PEPPER. We would be very pleased to have it.

Without objection, it will be incorporated in the record. It will be entered into the record.

[The information referred to follows:]

EXHIBIT I

Number of medicaid facilities audited by State organizations

Alabama	55	Montana	1
Alaska	0	Nebraska	0
Arizona	(1)	Nevada	16
Arkansas	0	New Hampshire	25
California	0	New Jersey	316
Colorado	1	New Mexico	36
Connecticut	0	New York	222
Delaware	24	North Carolina	87
District of Columbia	0	North Dakota	0
Florida	0	Ohio	4
Georgia	0	Oklahoma	0
Hawaii	N/A	Oregon	57
Idaho	3	Pennsylvania	319
Illinois	398	Rhode Island	27
Indiana	0	South Carolina	38
Iowa	0	South Dakota	0
Kansas	36	Tennessee	60
Kentucky	94	Texas	375
Louisiana	206	Utah	0
Maine	75	Vermont	0
Maryland	543	Virginia	170
Massachusetts	600	Washington	0
Michigan	1370	West Virginia	0
Minnesota	51	Wisconsin	487
Mississippi	0	Wyoming	0
Missouri	350	Puerto Rico	0

[1] Does not participate in the medicaid program.
N/A—Information not available.

EXHIBIT II

HEW Audit Agency audit reports issued by State since 1967

Alabama	4	Montana	1
Alaska	2	Nebraska	4
Arizona	(1)	Nevada	1
Arkansas	2	New Hampshire	5
California	11	New Jersey	2
Colorado	7	New Mexico	2
Connecticut	5	New York	20
Delaware	2	North Carolina	1
District of Columbia	2	North Dakota	3
Florida	4	Ohio	3
Georgia	3	Oklahoma	2
Hawaii	3	Oregon	5
Idaho	3	Pennsylvania	7
Illinois	9	Rhode Island	4
Indiana	4	South Carolina	3
Iowa	2	South Dakota	0
Kansas	3	Tennessee	3
Kentucky	3	Texas	2
Louisiana	1	Utah	4
Maine	4	Vermont	2
Maryland	5	Virginia	4
Massachusetts	8	Washington	4
Michigan	4	West Virginia	2
Minnesota	5	Wisconsin	4
Mississippi	3	Wyoming	2
Missouri	4	Puerto Rico	1

[1] Does not participate in the medicaid program.

Mr. PEPPER. Now, how much of a task would it be for either the Federal Government or the States collectively to conduct an on-site or field audit for all of the nursing homes which participate in Federal funds in the country?

Mr. FRANKLIN. Mr. Chairman, it would be a very substantial task to do a full-scale audit of every home that receives medicaid money on an annual basis.

It would be a very substantial undertaking. This would involve 16,000 facilities. You would have to allow, subject to correction by Mr. Parigian, 2 days in each home, minimum, and it could take up to a week for a team of auditors.

Mr. PEPPER. Would you give your name for the record, please?

Mr. PARIGIAN. My name is Edward Parigian.

Mr. PEPPER. Your position is what?

Mr. PARIGIAN. I am Regional Audit Director for the Department of Health, Education, and Welfare in region I.

Mr. PEPPER. Could you give us some information on the question I asked Mr. Franklin?

Mr. PARIGIAN. Yes.

One of the problems that comes up is that we would have to use an on-an-average basis, because the ICF's particularly run anywhere from a 20-room home to anywhere up to a 75- or 100-room home. So obviously, the audit would be varied according to the size of the home.

But, I would guess that it would take anywhere from 3 to 4 weeks for a couple of auditors to do any kind of in-depth review of a particular nursing home.

Mr. PEPPER. Of the nursing home?

Mr. PARIGIAN. That includes the report and establishment of funds.

Mr. PEPPER. For each nursing home?

Mr. PARIGIAN. I would say so, yes.

Mr. PEPPER. So, with 16,000 nursing homes in the country, two auditors would require 3 to 4 weeks to audit each one. That would be quite a number of auditors and quite a number of auditing days involved.

Mr. PARIGIAN. It certainly would on an annual basis.

Mr. PEPPER. It may not be fair to ask you, but could you give us sort of a ballpark estimate as to what the total cost would be if either the Federal Government or the States collectively paid for such audits?

Mr. PARIGIAN. That would be quite a substantial figure. I really could not answer that question right now, Mr. Chairman, but it would be in the millions of dollars, well into the millions of dollars.

Mr. PEPPER. Mr. Franklin, would you care to make any sort of ballpark estimate?

Mr. FRANKLIN. Mr. Chairman, I have not had a chance to completely work it out. However, if we accept Mr. Parigian's figures that it could take several weeks to audit a home, we could very conservatively estimate around $60 million as an initial cost, and that would be very minimal. It could be substantially higher than that; in fact, very much substantially higher than that.

Mr. Chairman, if I could expand on that just a moment, sir.

We feel that without auditing every home, if proper sampling techniques are used, which have been well developed by the accounting and auditing profession, that you can, on a sampling basis, find out what is going on in a set of nursing homes, say up here in the State of Rhode Island, so that you can get a good feel.

Further, the same way that we go in and validate homes where we suspect poor health care, you can spot things through complaints, through the fact that the general paper that comes in from the home just does not look clean, and there are ways you can identify homes that you should go in and spot audit on-site.

Mr. PEPPER. Now, suppose the Congress were to enact legislation—as I said, legislation is now pending to that effect, some of which has been introduced by Mr. Beard and myself, Senator Moss, and others—would you, as a Federal official, Representative, be disposed to making a statement as whether, if the States were required by Federal law to make those on-site or field audits, the States or the Federal Government should pay the costs of it?

Mr. FRANKLIN. Mr. Chairman, we currently are looking into this, as I mentioned in my prepared remarks. The Secretary has requested that the senior staff review this to see what would be appropriate both in the way of auditing and who should pick up the tab for it, and once our review is completed, we would be able to communicate our feelings to the subcommittee. But, until then we have not taken a stand.

Mr. PEPPER. A study is being made by the Department of Health, Education, and Welfare on that question?

Mr. FRANKLIN. Yes, sir.

Mr. PEPPER. I believe recently Senator Talmadge of Georgia, chairman of the subcommittee of the Senate Appropriations Committee,

made an inquiry into that subject in the State of Illinois and the question was raised there.

So, both HEW and the Congress are considering this question of whether it is desirable to have these field audits for every nursing home and, if so, how thoroughly they should be made and, if they ought to be made, who should pay the cost of them, and, of course, who should make it, the Federal or State Government?

Mr. FRANKLIN. Yes, sir. That is our understanding, sir.

Mr. PEPPER. Now, Mr. Franklin, would you care to make some comment on the other aspect of the hearing in which we are interested today; the desirability of more or, we would like to say, comprehensive home care for the elderly which might eliminate the necessity or certainly postpone the necessity of having to go into a nursing home?

Would you like to make any comment on that?

Mr. FRANKLIN. Thank you, Mr. Chairman.

Yes. I would like to.

As I mentioned, we feel very strongly that home health care is a vital part of the health care delivery system of this Nation and that home health care must be expanded and that we are looking forward to this.

We have, as part of our long-term care improvement campaign, a study looking into the barriers that would prevent the expansion so that we can take concerted action to remove such barriers. Home health care is very important for the health of the individual.

Mr. Chairman, if I can take a moment to give an example.

There is something that, as someone who has been trained in psychology, we were taught to call it the institutional syndrome. When somebody is put into an institution, even should it be a very good institution, certain dependencies develop that would not necessarily develop.

Mr. PEPPER. Can you hear, ladies and gentlemen, back there?

VOICE. Yes.

Mr. PEPPER. What you are saying is so meaningful I wanted to be sure everyone could hear you.

Go ahead.

Mr. FRANKLIN. Thank you, Mr. Chairman.

Certain dependencies develop that are not normal. People become dependent on an institution for services that perhaps if they had remained, say, in their own home that they could have continued to perform for themselves.

This is not a positive situation in helping people actualize their true human potential and certainly that is what it is all about.

Therefore, we find that when a person can stay in their own home or residence or that of a son or daughter, for example, or what have you and are given the proper supportive mechanisms, such as a visiting nurse, meals-on-wheels, things that the Department has been very much supporting, that the personal integrity is much better maintained and their right to achieve a full and healthy life within their own individual potential is so critical.

This is why we are very much supporting the home health care and this is the philosophy behind our support of it.

Mr. PEPPER. Well, from your broad experience as a special assistant to the Secretary, and charged particularly with the nursing home situation in the country, could you give us an approximate figure as to

what the average cost of maintaining a person in a nursing home is, an elderly person in a nursing home?

Mr. FRANKLIN. Mr. Chairman, with your permission, I would like to yield this question to Dr. Abdellah, the Assistant Surgeon General. I feel that she could perhaps give you an even better answer than I could to that.

Mr. PEPPER. We will have Dr. Abdellah after you as a witness.

We will just wait on that, Doctor, so you can go into the whole subject.

Our subcommittee had a witness with whom both you and Dr. Abdellah are well acquainted, a Mrs. Daphne Krause of Minneapolis. Just this last week at a hearing in Washington, she gave most impressive testimony on how much money we would save for the Federal and State Governments if comprehensive home care were provided for the elderly and they would thereby not be required to go into nursing homes.

I think on the whole it turned out that comprehensive care for the elderly in their respective homes, including nursing care all the way down to a handyman to come in and do chores around the house, would cost only about a fourth, roughly about a fourth, of what it would normally cost to keep that person in a nursing home.

So, we are talking about something which you as a psychologist know: things would be psychologically most agreeable and most desirable for the elderly person, and would save a great deal of money for the Federal and the State governments.

Is that correct?

Mr. FRANKLIN. Yes, sir. We feel that is correct.

While there are different numbers bandied about as to the degree of the actual savings, certainly the delivery of many services that can be delivered certainly in an institutional setting can be delivered economically in a home health setting. Certainly, when a person perhaps only needs one skilled service it would certainly cost more to institutionalize the person in a skilled nursing facility and deliver a vast range of skilled services, almost none of which the person would necessarily be in need of, when simply one service would suffice and the person could maintain himself in his own private home.

So, certainly there would be quite a bit of savings in the appropriate administration of a home health program.

Mr. PEPPER. I believe you told me, and Dr. Abdellah also told me she knows Dr. Cosins from England who was visiting in Washington a little while ago. I think you had a meeting or had a dinner for him and we had a luncheon for him over at the Capitol. He told us about the program they have in Oxford where they not only provide these comprehensive services to the elderly, but they also have a program to train the members of the family of the elderly person so they can render better services to the elderly person in question.

So, that well might be an aspect.

Mr. FRANKLIN. It could very well be a part of that, yes, sir.

Mr. PEPPER. Mr. Franklin, well, I think you made a very valuable contribution.

Mr. Beard, would you like to inquire of Mr. Franklin?

Mr. BEARD. Yes.

I also want to congratulate you on your statement. I think it is well thought out and a very good statement on this whole issue.

I think, too, and I am sure we all recognize, that there are a lot of good homes, a lot of outstanding homes in the country, nursing homes, that are doing an excellent job.

It was cited Thursday, July 10, in the New York Times, that it runs into millions in the areas of fraud. Now, the exact amount of money, of course—this is not known in this particular article.

But, I think from what you cited here today, that it is obvious that the recommendations that were made to the State of Rhode Island by HEW were not carried out as far as the field type audit. They make desk audits. I think that not only in Rhode Island, but all over this country, the onsite audit is the best possible procedure because if you go through a home—the professional people—you can see the end results of what they are claiming reimbursement for.

I also appreciate that the Nursing Home Association has taken a position that they have no objection to an auditing procedure and they made statements when this issue first became an issue in Rhode Island. I think that certainly would be a good move, and I think it was the proper position for them to take.

I do not think that from my end, as a Congressman here in Rhode Island, or from HEW's end, that we are out to get each nursing home and try to close that home down. That is not the case.

I do look to the future, and I think Congressman Pepper is on target with his emphasis of home health services. Since people have to die, they want to die in dignity in their own homes. I think if we can bring home health services to the communities, Mr. Chairman, we are going to be a lot better off.

Again, I congratulate you on your statement. I think it was outstanding. It proves that we have problems, not only here in Rhode Island, but we have problems all over the country. I would hope your recommendations would rub off on the State officials and that they would implement the field type procedures.

Mr. PEPPER. Thank you very much, Mr. Franklin.

Would you kindly introduce Dr. Abdellah?

You know, she is one of the outstanding ladies in the world, and a lady of great personal distinction and great dedication to the public interests, particularly in the service of the elderly.

Would you please present Dr. Abdellah?

Mr. FRANKLIN. I would like to turn this over to Dr. Faye Abdellah, the Assistant Surgeon General of the United States, the Chief Nurse Officer of the U.S. Public Health Service and the Director of HEW's Office of Nursing Home Affairs.

We look to Dr. Abdellah very much as one of the key officials in the United States and the world in the field of nursing. We are very fortunate to have Dr. Abdellah involved in the nursing home issues that are facing us now.

They are so difficult that we need people like Dr. Abdellah involved.

Dr. Abdellah.

Mr. PEPPER. Thank you very much.

Dr. Abdellah, now, out of your great experience and knowledge and key interest in this subject, we will welcome you to tell us whatever you will about this matter of the desirability of more comprehensive home services for the elderly.

Dr. ABDELLAH. Thank you, Mr. Chairman.

I do not have a prepared formal statement. I would like to supplement some of the things that Mr. Franklin has spoken to, particularly with relation to alternatives to institutional care.

I would like to clarify one point, namely, that our emphasis in the Department is to think of the kinds of services the elderly need on a continuum so that we do not feel there should be just home health and no nursing homes.

There are times when institutional care is quite appropriate. But, what we are striving to do is bring about a balance so that we found, for example, from our nursing home survey that as many as one-third of the people could benefit from home health services, and this amounts to several hundred thousand individuals. We feel that this is a resource that is not fully utilized. We would like to see a combination of things and perhaps we can suggest these for your consideration.

You might have home health. You might have this combined with day care service. Foster homes also work. We know how well this works for children, and we find that in some States, like Minnesota, this has worked quite well for the elderly and this, again, is a sharing where the State is involved in working and paying for some of the costs.

If we think of the kinds of services that are needed by these individuals, there might be a time when it would be appropriate for that individual to be in an institution, such as a nursing home, and then a period where the individual could return to the home and where, depending upon the potential rehabilitation, potential of the individual, one might again become a part of that community.

We feel anything that can be done to create a natural environment for the individual where that individual can be treated with dignity and provided the essential health care in a safe environment—this is really what we are trying to find; what is the most appropriate way or ways to provide this kind of care.

You asked about the cost of skilled nursing home facilities. Our National Center for Health Statistics does come up with an average cost of $16 to $18 a day. We anticipate that this is probably closer to $20 or higher due to inflation. What this averages out to is about an additional $600. an average of $600 per month, with social security being added to that, bringing it close to $800.

On the medicaid program, as you know, this is a Federal-State matching program of 50–50. These costs are horrendous and we feel that anything that can be done to make sure that the services are provided to the elderly is very important.

I wanted to share with you, Mr. Chairman, what I feel is a milestone in legislation and regulation that was published on June 27, under title XX, for the first time.

Mr. PEPPER. By that title XX, you mean title XX of the Social Security Act?

Dr. ABDELLAH. Of the Social Security Act, yes. Thank you.

For the first time this does provide an opportunity for States to develop their own plans for those services which States feel are quite important. The thing I like about it so much is that the senior citizens have a chance to say whether or not this plan is appropriate.

For example, the State of Florida in 1976, fiscal 1976, and the fiscal period we are already into, $91 million have been allocated for the State of Florida. For Rhode Island $11.5 million have been allocated to this.

Now, within the umbrella of title XX, there are opportunities for the States to develop programs which would be meaningful to the elderly, such as a day care program, a homemakers service.

Very often, as you know, one can stay at home if there are some supplementary services, such as meals-on-wheels, or providing a visiting nurse service on a part-time basis. There are provisions for foster homes, provisions for transportation, and some of these services which heretofore under title XVIII and XIX have not been addressed.

So, we hope very much that all the States will look at title XX and have an opportunity for a State to develop its own social service programs that will be meaningful for that State. The regulation has been stated broadly so the services suggested are really just examples. A State could develop and create its own plan of services and provide different approaches.

I think this is quite exciting and I am particularly pleased as a nurse to see the importance of a community and senior citizens having a chance to participate in what they feel is important to them. So often we feel in the Federal Government, and I am sure you do, Mr. Chairman, that we really do not turn to the senior citizens frequently enough because they have a great deal to say. Under title XX this is an opportunity for a State to really develop its own plan and to shape the kind of services that will be meaningful for the elderly. We would be very glad to provide assistance to States in seeing this implemented.

By the way, the plans are to be developed over the summer. There will be a 45-day comment period for the citizens to participate in that, and we hope that these programs can become activiated by October of this year.

Mr. PEPPER. About what date are these State plans to be submitted under title XX of the Social Security Act?

Dr. ABDELLAH. I could check and give you the specific date for the record.

July 2.

Is Rhode Island already in?

Mr. FRANKLIN. Rhode Island is in.

Mr. PEPPER. October 1 you mean?

Dr. ABDELLAH. The programs would become effective October 1.

But, I understand that Rhode Island's plan has been submitted. That means that now it is out for a 45-day comment period.

I am particularly pleased to see so many of our senior citizens in the audience today. They really should comment and react to this.

Mr. PEPPER. Are the plans submitted by the respective States supposed to be published?

Dr. ABDELLAH. Yes, sir; they are to be published and there is a person to whom to respond and then once these are all in they are submitted to the Secretary.

Mr. PEPPER. Should any citizen desiring to comment make his comment to the State authorities or HEW, or what?

Dr. ABDELLAH. To the State authority, yes. This way the State can react and pull together the comments and make any modifications in relation to its own plan.

Mr. PEPPER. Well, now; the program of medicare in relation to home services allows what?

Dr. ABDELLAH. There are some services provided under home care.

Mr. PEPPER. Those are primarily nursing service.

Dr. ABDELLAH. Primarily nursing, visiting nurse service.

We felt that under both medicare and medicaid that the services in the present legislation and interpretation were much too restrictive, so that during the past few months we have worked with our colleagues and SSA and Social Rehabilitation Service to liberalize and define more specifically what services can be provided, what services are skilled services, what services are unskilled services.

Mr. PEPPER. You mean medicare?

Dr. ABDELLAH. Yes.

Mr. PEPPER. Would Congress have to liberalize the language of the law to permit a wider contribution of home services, or could it be done by HEW regulations?

Dr. ABDELLAH. Initially we were trying to follow the regulation route.

The regulation which was published this last June 3 as a proposed regulation defines skilled level of nursing care quite broadly and we feel liberalizes it much more to permit intermediaries to improve many home health services as they have in the past.

This has gone out for a 30-day comment period. We have been very encouraged. We have received numerous letters not only from the senior citizens about this, but from the nursing home associations, from the professional associations, commenting favorably, and there are some minor modifications that will be necessary on these, but just this week are being made, and we hope in this final form it will go to the Secretary for signoff and become effective early this fall.

Now, we feel that with this more liberal definition in terms of what services can be provided under home health, we hope that many more physicians in communities will take advantage of this. There is a real important job to be done, encouraging physicians to utilize home health services much more than they have in the past.

MR. PEPPER. Now, you told us about the program that is available for rendering home health services to the elderly under medicare.

Dr. ABDELLAH. Yes, sir.

Mr. PEPPER. And how that perhaps may be enlarged or expanded.

You have also told us about a new title XX of the Social Security Act which Congress has just recently enacted.

Now, there are some other programs. There is a Senior AIDE Program.

In my county of Dade, as I recall, we have 60 senior aides and the people down there like that program very much. It gives the elderly a chance to get a job and work with friends in the elderly group.

At the same time they render valuable services to the elderly person.

What comment would you like to make on that Senior AIDES Program?

Dr. ABDELLAH. I think this is a very effective program. We would like to see it utilized more fully and publicized.

Parallel to that, the Administration on Aging is now planning to appoint a full-time person in each State to head up and be the initiator in what we call an ombudsman program. This is really the linkage be-

tween the senior citizen and the Federal Government and the facility providing the care. There have been some experimental ombudsman programs which were found to be quite effective.

By the way, I did want to mention one of the experiments that is going on here in Rhode Island under section 222 of Pub. L. 92-603 and this is an experiment in relation to looking at the combination of home health, day care, and intermediate care and trying to get some realistic costs.

We are very pleased that Rhode Island is one of the six areas selected for this experimental effort, and we are looking forward to the results of these experiments. Once we have the information from that, we will be happy to make this information available to your subcommittee because from the results of these experiments, we can hopefully get a better figure in terms of what these services cost, what, if any, savings are involved, and how we can initiate nationally greater usage of day care, home health care, and a variety of other senior citizen programs.

Mr. PEPPER. Now then, we have the medicaid program which is a program funded jointly by the Federal and State Governments.

Is any home care available under that program?

Dr. ABDELLAH. Yes, sir.

Again, as under medicare, these services have not been utilized as much as we would like. We feel that this broader definition of skilled level of care, which also applies to medicaid and home health under that, will help to liberalize the kinds of services that could be paid under that.

So the home health is now available under both medicare and medicaid, but our effort here in working with the two agencies, the Social Security Administration and the Social Rehabilitation Service, is to train intermediaries to honor services so that those services are not disallowed.

For example, we have been quite concerned about the services not being provided to terminally ill patients and we feel that the terminally ill patient, even with a prognosis which is not good, deserves the best care that is available and in an environment which provides—there are some eight hospices developing throughout the country, one outside of new Haven, patterned after St. Christopher's in New England—which provides a facility particularly designed to address the needs of the terminally ill individual. It was one of the most rewarding experiences I have ever had to visit individuals in one of these hospices.

Here you see an example of where institutional care can be provided at its best with recognition of the individual and his or her wishes by providing an environment where the best quality of care can be provided and still maintain the dignity and individuality of the person.

Mr. PEPPER. Now, would any aid to the elderly in that home be available under the Older Americans Act in addition to the services you have described?

Dr. ABDELLAH. Yes.

The Older Americans Act is a very broad act in terms of providing a number of services, both home health, the transportation, the living services, and so forth, and with the combination of title XX, the Older Americans Act, and the broadening of the definitions related

to skilled levels of care, I do feel, Mr. Chairman, that we have an opportunity here to really make home health services, day care and other kinds of services available to the elderly.

We have to publicize these because I think many of our senior citizens are not aware of these services.

Mr. PEPPER. Now, there are available certain home services for the elderly under the program, which if I may say so, I am the author of, with Senator Kennedy in the Senate. That program provides meals at the home of the individual if he or she is not able to go to a community place for the meals. There are social services to be provided that are contemplated under that act also when we get it fully implemented, get some more funds for it.

Dr. ABDELLAH. Yes.

I think the Older Americans Act will be of assistance there with the provision for some help with providing volunteers as well as some part paid services.

I do feel the meals-on-wheels service is extremely important, but parallel to the importance of the serving of a nutritional meal is the value of having a visitor, someone there to visit with a person and that time can be very, very useful. Again, this is a good example to show that with that type of service within a community we can do a better job in keeping the individual at home.

Mr. PEPPER. Now, there are two questions that occurred to me from your recital.

You mentioned several programs and there may be others under which aid to the elderly in their homes can be provided.

Now, you are aware that in England, where a little bit ago we talked to the top officials there, they have one administrative program, one administrative head, for the dispensing of all of these social services and that is the council, the local council. It may be a county council or a municipal council.

The Federal Government, the National Government, puts up 60 percent of the money, the local council 40 percent of the money.

But, all of these services are administered under the local council, which is close to the people, and it is able to check up on the quality of those services.

Do you think it is desirable that we consider the matter of coordinating a little more effectively the various programs that we now have, including the State programs, so that there might not be a proliferation or duplication and, at the same time, be adequate to meet the needs of the people?

Dr. ABDELLAH. Yes, sir. I think this is critical.

We do have a mechanism under the National Health Resources and Planning Act of 1974 which does provide an arrangement whereby one can coordinate all of these services, whether working at the county or State level, or working with the Federal Government.

Under title XX it is possible, again, to coordinate these services within the State.

Mr. PEPPER. By the way, the Federal and State governments could use the mechanism approved under title XX.

Dr. ABDELLAH. Under title XX and under the National Resources and Planning Act of 1974 at the local level.

So, there are mechanisms available which would be good for States to utilize.

Mr. PEPPER. Now, one other question, Doctor.

Under the present system of medicare that we have, in order for an individual to go into a hospital, of course, he has to be sent there by a physician, but then he has to pay a certain amount of money before he can have even a day or 2 days.

Is that not correct?

Dr. ABDELLAH. That is correct.

Mr. PEPPER. And they cannot get into a nursing home unless they are convalescing from a hospital.

Dr. ABDELLAH. That is correct.

Mr. PEPPER. So, they must first go into a hospital, pay a considerable part of the cost and I regret to say it has been increased in late years, and then they are eligible to go into a nursing home. They are limited to 100 days there, I believe, out of the year.

Now then, in England, they have what I hope to see someday in the United States, a complete comprehensive national health program for the people.

Over there, since they adopted that kind of program, if an individual who has been given care in the home, in the opinion of a physician or nurse, should need to go into a hospital for a couple of days for a checkup, why, of course, it does not cost that individual anything. He or she could be sent over to the hospital, and get the temporary care, maybe an operation or something. It could take 2 or 3 days. Also a physical checkup would be desirable or maybe some attention would be given to a particular ailment that might come to the person. Then they could go right back to the home.

Now, we do not have a mechanism like that at the present time; do we?

Dr. ABDELLAH. Well, we have a somewhat limited one which would help a person in a nursing home who needs a 2- or 3-day checkup in a hospital. About December of 1974 there was a modification in the regulations permitting what we call a furlough of 3 days, six times a year.

Now, the 3 days might be a checkup in the hospital, or it might be visiting members of the family in the home.

We feel that the furlough program has been quite effective in achieving what we like to think of in the nursing homes, as a revolving door concept, so that there might be a period when such a person would spend some time in the hospital for a more intensive checkup and then go back to the nursing home.

Mr. FRANKLIN. Mr. Chairman.

Mr. PEPPER. The people who are residents of the nursing homes are eligible for that temporary hospital service?

Dr. ABDELLAH. Yes.

Mr. PEPPER. But if they are not residents of a nursing home and just stay at home and receive care there, then they would not be eligible to do that, would they?

Mr. FRANKLIN. Mr. Chairman, if I could expand on that for just a moment.

When the medicare legislation was passed, it was passed with the intent of Congress, to our understanding, that it was to be skilled, post acute care and, therefore, the policy is very much in line with

the current governing legislation and we are enforcing the statutes correctly as they are written on the books.

Dr. ABDELLAH. I did want to mention that the six experiments under section 2221, which is in Rhode Island, is an effort—one of the questions being studied in these experiments is whether or not you have to have this prehospitalization before you move into home health day care and so forth. Certainly this has been raised as a very valid question. We hope that under the experiments we will learn a lot more than we know now about this and then take another look at the whole rotation there to see whether or not one can move directly from home health to hospital or vice versa without having the said period as we do now.

Mr. PEPPER. Well, medicare was intended primarily to provide emergency medical care in hospitals for those who had acute illness of some sort. There is a limited length of time that an individual can enjoy that.

Then the nursing home under medicare was really contemplated as a convalescent home. It was not contemplated as a custodial home for a long duration.

One might grow elderly and ill and relatively helpless. Medicare does not cover that kind of case where one would need to spend the rest of one's life in that kind of an institution.

Dr. ABDELLAH. The intent of the legislation in relation to intermediate care facilities was to have intermediary care facilities pick up and provide a setting where skilled, around-the-clock skilled nursing care was not required.

Mr. PEPPER. Now, under medicaid you could put a person in a nursing home for a short period of time if they needed to be there.

Dr. ABDELLAH. If they needed to be there, yes.

Mr. PEPPER. If they needed to be there.

So, we need to examine the law to adapt the law to the needs of the people, do we not?

Like, I believe the Bible says: "The Sabbath was made for man, not man for the Sabbath." The law should really be adapted to the needs of the people.

So, we will have to maybe take a look at our system to fit in, because, undoubtedly, a person receiving care in a home might occasionally either need to have a doctor come there, and the doctors do not ordinarily, as I understand it, make house calls. Now, they might need to go into a hospital for a short time or into a nursing home, but they would not need to stay there all the time if they had nursing care and all these other services that they might need in the home.

That is entirely possible, is it not?

Dr. ABDELLAH. I think we need to study it and see what the problems are and what changes are necessary.

Mr. PEPPER. Thank you very much for your very excellent statement.

Anything else you wanted to add, Doctor?

Dr. ABDELLAH. No. Thank you, Mr. Chairman.

Mr. PEPPER. Mr. Beard, would you like to inquire?

Mr. BEARD. Yes. Doctor, I think what you have mentioned about the need for the two systems, the home health services and also the nursing home, is very, very true.

I think one thing that I recognize, and I have introduced legislation that has been cosponsored by many Members of Congress, I think all of the homes, in inspection procedures, should be done on an unannounced basis. Also, too, I cannot emphasize on this, but I think the on-site auditors of the home should be emphasized throughout the system all over this country. I think that this is the type of legislation that is needed, and I agree, too, with the role or the idea of the ombudsman.

Would you explain to me how you see the person in this role? What would his activities be as an ombudsman?

Dr. ABDELLAH. If I might just comment, Congressman Beard, on the unannounced visit.

You will be pleased to know that the Secretary has asked all of our regional offices to make all of their visits unannounced.

Taking a poll of the States in the region, 50 percent of our regions report that the States, their States within that region, will conduct their visits unannounced.

We hope that within the next year or two all States will be making their visits unannounced and we appreciate and praise you for your leadership in moving ahead in this direction.

On the ombudsman, this is an intent to provide a link, a vehicle, communication, between the senior citizens and the nursing homes.

So this plan under the Administration on Aging is to have a full-time person in each State, but, as an initiator, someone who can work with the resources in that State to see how this can be developed.

So, an ombudsman program might be undertaken, for example, by the National Council for Senior Citizens who has one that is quite active, or it might be undertaken by other volunteer groups in the community.

But, it does provide a way of communicating the concerns of individuals in facilities to those in authority who can do something about it and bring about change.

Mr. BEARD. You would consider this person in an advocate role rather than tied into one agency?

Dr. ABDELLAH. Not tied into one agency.

Mr. BEARD. It should be a neutral role?

Dr. ABDELLAH. Neutral role, right.

Mr. BEARD. Recently I had quite an experience. Last week I was in Greece and in Cyprus. From what I saw there in nursing homes, I cannot emphasize enough the point of the tremendous feeling I received from the family union. I can tell you, Mr. Chairman, in Cyprus, for example, in the refugee camps almost every tent had an elderly parent. In that part of the country where the family structure is so small there is great emphasis to take care of one's parents.

I think in a case where it is possible, let us say, for the patient to go from the hospital to home, if we have a good home health service program—and I know this is what the chairman is very, very much interested in and is pushing very hard in the Congress for—this type of concept is desirable.

I think this can become a reality under national health insurance because I know that many, many sponsors of national health insurance have emphasized that this is the role today, and certainly in the future. We are very proud here in Rhode Island that we had Aime Forand who was instrumental in the foreign aid program.

I hope in the 94th Congress, that we will have national health insurance and we will be able to move toward more home health services. And, for the well-being of the elderly in nursing homes, we will have a strengthening of the regulations and implementations of the regulations with unannounced inspections throughout the system—State and Federal inspections—and then, of course, the final emphasis, and the most important emphasis is to try to save the taxpayers' dollars from winding up in the hands of a few in this industry who are profiteering on the elderly.

Mr. PEPPER. Doctor, just one more question.

Is there a difference between what we have been describing as field audits and on-site audits?

Dr. ABDELLAH. Yes.

In terms of the national field audit, I defer to the gentleman here on my left. But, the inspections are in relation to the health and safety requirements.

In other words, the regional validation visits, as we call them, and also the State certification visits look at and try to assess the quality of care being delivered and the services that are being delivered by the facility as well as the fire safety factors.

Then the audit is something separate from that.

Mr. PEPPER. Thank you very much, Dr. Abdellah. We thank you for coming here today.

Dr. ABDELLAH. My pleasure.

Mr. PEPPER. I know both of you have other obligations, so I promised Mr. Franklin and Dr. Abdellah when they completed their statements we would excuse them with our thanks for coming today.

Mr. FRANKLIN. Thank you very much, Mr. Chairman, for this opportunity.

Mr. PEPPER. Our next witness is the Honorable Philip W. Noel, Governor of the State of Rhode Island.

Governor Noel, we are very pleased to have you appear today and help our subcommittee to ascertain information that will be of help to the Congress in dealing with some of the problems that are the common concern of the Federal and State governments of our country.

I have sort of understood, and I revealed this to Mr. Franklin, that we are primarily concerned about two things. One is: What kind of field auditing or on-site auditing system we should have and who should do it, the Federal or the State government; about how much it would cost, and if the Congress should require, as legislation pending before the Congress now would provide, a State, as a condition of aid under the medicaid program, to make these field audits, whether the Federal Government ought to pay the cost of such audits, federally required.

The second subject of our hearing is perhaps in the long run by far the most significant as far as the elderly in our country are concerned. In my county of Dade, we have about 19 percent of the people in the elderly category, including the present chairman.

It is a question of the quality and comprehensiveness of home care that should be provided to the elderly, not only in order that they may receive good care and remain in their own homes, in their own environments, but a saving of great expense by the Federal and/or State governments by their staying in the home rather than having to go into a

nursing home, which today is a very expensive requirement for those who are there.

So, upon those two general subjects and any other subject in relation to those two that you would like to comment upon, we would welcome your statements.

I will tell you it is very good to be in your great State of Rhode Island. As I said in the beginning, the last time I was here it was at a birthday dinner for Senator Theodore Green, who was my colleague in the Senate and a great American.

I am glad to come back here again.

By the way, let me just tell you this. One day Senator Vandenberg, Senator Green, and I were having lunch together at the Senate restaurant. At the time, Senator Green was at least 75, maybe between 75 and 80. We got to talking about health and he said, "Well, I am having a little trouble with my doctor." I said, "Theodore, what trouble are you having with your doctor?" He said, "He wants me to give up wrestling and high diving." That shows how vital he was.

Governor, will you proceed.

STATEMENT OF HON. PHILIP W. NOEL, GOVERNOR OF THE STATE OF RHODE ISLAND, ACCOMPANIED BY JOHN J. AFFLECK, DIRECTOR, DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES; DR. JOSEPH E. CANNON, DIRECTOR, DEPARTMENT OF HEALTH; AND ELEANOR F. SLATER, CHIEF, DIVISION OF AGING

Governor NOEL. Well, first, Mr. Chairman, I would like to extend a very warm welcome to you on behalf of the people of this State. In your own right, you are a very distinguished American and one who has had a distinguished career in public service to your fellow Americans. It is really a privilege to have you in our State.

On the subject matter of this hearing, I will make some general comments and some more specific comments in relation to how these issues impact on the Rhode Island situation.

First, the issue of whether or not there should be legislation to mandate full field audits of all nursing home facilities receiving Federal and State funds across the Nation, I think that would be the utopian situation if we could have a field audit system for all nursing homes across the Nation.

However, when you contemplate the cost of such a program and the bureaucracy that you would have to put in place to accomplish that kind of detailed comprehensive field audit at least once each year on each home, then I submit that the Congress would have to make a determination as to where priorities lie. If you are going to be spending in excess of $100 million, and I guess it would be at least that, then Congress would have to make a decision as to whether or not they would direct that $100 million or part of it into more direct benefits for the older Americans of this Nation, or whether the older Americans would be better served using that money for this audit system.

Certainly, if we could afford to do all that we would want to do—the utopian situation—we would have such an audit program placed throughout the country.

The home care, comprehensive home care, is a very viable alternative to institutionalized care. We have long recognized that in the State

of Rhode Island, and we have had some modest programs in that regard that have been successful in our State.

At this juncture I should introduce those of my colleagues who will be testifying here today.

I have with me, Mr. Chairman, Jack Affleck [John J.], who is the director of the Department of Social and Rehabilitative Services; Dr. Joseph E. Cannon, who is the director of the Health Department; and Eleanor F. Slater, who is the chief of the Division of Aging of the State Department of Community Affairs.

Mr. PEPPER. We are pleased to have them and we will hear from them later.

Thank you, Governor.

Governor NOEL. When Mrs. Slater testifies, she can talk to you about some of the services we have for elderly people in this State.

Dr. Abdellah talked about title XX; that is of little significance to us in Rhode Island because we have already reached the ceiling.

Congressman Beard alluded to the fact that we have had a history of being in the vanguard of human service programs in this Nation. Certainly men like John E. Fogarty and Aime Forand and their predecessors have also had a commitment to quality health and care programs for people who need special assistance.

So, as a result, Rhode Island and other States in the northeast have done much more in these program areas than have other States in other parts of the country and when the Congress legislates they try to stretch some norms and when they do they usually set that norm at a figure that is not advantageous to those States who have done the most for the people down through the years.

Title XX is an example of that. When the Congress enacted that legislation and fixed the ceiling, we were already almost at the ceiling because we were doing more in this State for those disadvantaged people who came under that legislation than was being done in many other States.

So that any extension of comprehensive home care programs by way of interpretation or new regulation under title XX will be of little assistance to us in Rhode Island unless the Congress legislates more realistic ceilings.

Mr. PEPPER. Well, I am glad to have you tell us that. That is an instance of what you learn at these hearings.

Governor NOEL. Now, I do believe that we should as a country move in the area of developing more comprehensive home care service. I think it is a very enormous undertaking, however, and one that would have to be approached with great care.

I heard some talk today and some comment that it would be much less expensive to have this kind of competence of home care treatment than it would be to take care of these people in institutional settings. That may or may not be so.

For example, in this State and it is an estimate but close to accurate, the cost of one visit to a home by a district nurse, I think, is in the area of $16.

Now, this is not a physician; this is a qualified nurse, a member of our district nursing association.

One visit is on the order of $16.

When you determine what kinds of special care people need in their homes if they are to receive comprehensive home care treatment, I think that if you get to a situation where by category a person required several special skills or caring needs, then the cost would be far more expensive than institutional care.

If you have an older American who only needs limited assistance in order to be able to enjoy the dignity and the happiness of his own home, then I think in that instance it would perhaps be less expensive to provide that kind of service to that person in his home than it would be to treat him in the alternative way of institutionalized care.

But, I think it would take a very comprehensive study and I am sure that is what the Congress envisions before moving too quickly in that area.

Now, I know that maybe the costs in the Northeast may be a little bit higher than they are in other parts of the country, but I would just like to leave on the record that note of caution.

I think it is the way we should go as a country. I think we should move in that direction with diligence, but certainly in a studious way so that we do not become involved in programs that look good on paper, but that we cannot afford to implement in their totality and avoid the great misery that we cause for people when we set a goal that raises their expectations and then, as a government, cannot fulfill those expectations.

I mentioned to Mr. Franklin on the way out that I would prefer that he stay for the remainder of the meeting because when it comes to the comments he had about Rhode Island, I had a different view and I want to spend the rest of my time talking about the Rhode Island situation as it relates to audits.

I have no prepared testimony.

Mr. PEPPER. Excuse me just a minute.

Before you get entirely away from home care, there is no doubt whatsoever that a great many people need to be in a nursing home. There are some who need to be in a hospital. The concern was to try and differentiate between those who might be kept out of the hospital and nursing homes if they had home services and those who could not be so.

As you suggest, it would take intelligent discrimination on the part of competent people to determine which is which and those who need it should certainly go into a nursing home and should be afforded the opportunity to do so. We all agree with that.

Now, go ahead.

Governor NOEL. I have a letter that I have roughed out to Secretary Weinberger. I have not finished the letter. It contains some of my thinking.

I have another letter that I am going to send to the President which deals with some of Secretary Weinberger's comments.

I do not have a prepared statement because I did not have time to put all these thoughts into formal written form.

Unfortunately, this hearing takes place in a setting at a time when we have had a series of newspaper articles and comments that leave many people with the impression that we do not do much of a job when it comes to auditing nursing homes, in this State, health care facilities.

The publicity that we have had recently and some of Mr. Franklin's comments, I think, have inaccurately portrayed our administration as being one that is very neglectful in this area and I feel that quite the contrary is the case, and I want to make that point for the record and take any questions that you or Congressman Beard or anyone else may have on this issue at this hearing.

Ever since the inception of Federal medicare and medicaid and these kinds of programs where taxpayer dollars are paid to private operators to provide care for people who are eligible for Federal and State dollars, we have had a comprehensive audit system in place in this State and every nursing home that receives Federal and State dollars has been audited every year since the program has been in existence.

The reason it is an issue here is because the Secretary, or I mean Mr. Franklin, newspaper reporters, and others, distinguish between types of audits.

We have had for many years what we categorize, or for want of a better term, name, a desk audit system.

When I became Governor approximately 3 years ago, we began to move to supplement that desk audit system with a limited, but complementary, field audit system, and we have made great progress in the development of that latter capability.

Mr. Chairman, I want to explain to you what a desk audit is and give you some of the results of that desk audit because it may give you some guidance as to what some of the options may be for this Nation when it comes to auditing nursing homes across the Nation as a result of any legislation that may be contemplated.

Each facility on an annual basis completes and files a cost report for purposes of yearend settlement and rate determination. Each report is desk audited and the desk audit is doublechecked.

A desk audit is comprised of the following components: (a) Checking for completeness and mathematical accuracy, (b) each line item of census expenditure and revenue is tested, tested for reasonableness; (c) census data reported is compared to: (1) facility's historical occupancy rate pattern; and (2) reported State patient days compared to monthly reported statistics accumulated within the ratesetting unit.

Expenses are reduced by related revenue accounts.

Expenses are tested by comparing each line item to related averages of facilities of like license classification and size.

Salary line items are totaled and compared to copies of the submitted Federal quarterly payroll returns, form 941.

Reported payroll taxes are compared to amounts indicated on the 941 forms.

Depreciation is adjusted to straight line over the useful life of the asset.

Other expenses are adjusted to conform to the principles of reimbursement.

Line item expenditures for each facility are recorded on spread sheets by license classification and size for statistical purposes.

Facilities whose expenditures appear to be significantly higher than the norm are then labeled for followup field audit.

The principles of reimbursement in themselves provide for a number of controls, such as maximum capacity per diem by level of care,

minimum occupancy rate, preset administrative salaries, depreciation allowance on a straight line basis, et cetera.

The principles of reimbursement also provide for the per diem rate to be the full payment rate, which includes many ancillary services, including transportation of ambulatory patients to and from physicians' offices, hospital outpatient areas, laboratory and X-ray service areas.

These ancillary services have reduced the number of dollar amounts for separate charges to the program.

In November of 1973, our ratesetting unit, consisting of two positions merged with the hospital cost unit, consisting of four positions.

The hospital cost and ratesetting units' responsibilities grew in magnitude.

Additional positions were added to the unit on the following dates:

December of 1973, we added one position.

February 1974, we added one position.

March of 1974, one position.

June of 1974, one position.

October of 1974, one position.

November of 1974, one position.

March of 1975, we added five additional positions to this unit.

So, now we have been able to establish three two-man audit teams who have received their training by first learning the procedures involved in the desk audit and the following procedures of the indepth comprehensive field audit practices.

I could go on and explain the system in greater detail, but I think I have given you enough testimony to indicate that a desk audit is more than simply some person checking some figures on a sheet of paper once a year.

As a result of the desk audit for only the calendar year 1974, cost reports have adjusted the total reported expenditures of $35,613,854 to desk audited allowable expenditures of $32,656,471 or a net disallowance as a result of the desk audit process in the one year, 1974, of $2,957,383. That is the gross disallowance expense as a result of the desk audit system for the calendar year 1974 and we have had that desk audit system in place ever since this program was conceived approximately 8 or 9 years ago.

That represents a savings to the medicaid program of $1,843,731.

Now, we heard Dr. Abdellah talk about the average cost for keeping a person in a nursing home and she said it was somewhere between $16 or $18, perhaps $20 a day, the national average cost.

Mr. Chairman, in the State of Rhode Island for 1974, it was $14.07 because we have had these audit practices in place ever since the program was first implemented.

I would also point out that during the period in question going back the 8 years or more that the program has been in place, that 8-year period covering the years 1968 through 1975, our medicaid expenditures ran $82,306,911 for community group medical care. This covers 9,095,090 patient days for an average per diem expenditure over the 8-year period of $9.05.

Now, I think that if you look at our average costs of what the taxpayer pays out in Federal and State tax dollars to keep the patient in a nursing home in Rhode Island and compare that with the national

average cost, look at the quality of care we provide in our nursing home and compare that with the quality of care that may be the norm throughout the Nation, those statistics in and of themselves, Mr. Chairman, will lead you to conclude that we have done a very respectable job of monitoring these expenditures during this 8-year period.

Now, I do not submit that there is not any room for improvement and that is why when I became governor we began a program of checking the desk audit system by having field audit capability and since January we have been building up the staff. We do not have unlimited State resources and although the intent of Congress is honorable and I commend the Congress for reversing some of the proposed recisions that were submitted to the Congress by the Ford administration, our State resources are not limitless.

Since the advent of the Nixon administration, and I do not wish to politicize these hearings, but during the Nixon administration years and now the Ford years, we have not had any great fiscal support from HEW. It may be the intent of Congress to provide those funds, but it is not the intent of the administration and I need not raise here the whole issue of impoundment, recession, deferral of appropriation of moneys that were lawfully appropriated by the Congress of the United States.

So, whatever progress we have made has been painful, Mr. Chairman.

We do not have unlimited State resources. The Congress is of one mind to helping these areas of human concern. The administration is in another posture where they are more interested in saving dollars, curtailing expenditures, and it has been a long and tough process.

We know that there is some improvement that can be made and we want to make it. We now have a field audit capability. It took 3 years to build it.

It is now in place. We cannot audit and do the job properly for 150 nursing homes once a year with the staff that we have put together, but we probably can audit 50 of the 150 nursing homes once a year.

Unless there is a requirement, Federal requirement, that there be a field audit of each home once a year, we will not on our own initiative go that far because we cannot afford to. But what we will do is to combine our new field audit capability on a selective basis with a desk audit system that is one of excellence that we have had 8 years of experience with and get the job done, and I think better than most States will perform in this area.

We look for help and cooperation from our Federal partner.

I am not at all pleased with some of the attitudes that have come out of HEW and although it is a collateral issue, I will cite an example.

Secretary Weinberger came out with a policy and said they would only allow a 3-percent error rate in eligibility for welfare benefits and a 5-percent error rate when it came to overpayment to welfare recipients of benefits. If the States of this country cannot conform with those through criteria, we are penalized by withdrawal of Federal funds and yet when this State chose to have the Federal Government administer the SSI program, we find that the Federal Government cannot even come close themselves to a 5-percent error rate.

Their error rate runs closer to 10 percent.

So, they have more than a 10-percent error rate in the administration of their own SSI program, but they say to us unless we can come down to 3 percent and 5 percent they are going to withdraw Federal dollars.

Now, these are Federal dollars, Mr. Chairman, that are paid to people who are in need. There is no one on welfare, with the exception of the few cheaters that everybody likes to holler and rave about, but most of the people on welfare are not cheats. Most of the people on welfare are people who are in legitimate need and this Department's policy is to take money away from those people who are in legitimate need and they cite as an example if you overpay a family $1 a week, that is cited as a statistic in determining the 5 percent.

We make a lot of mistakes as a government. We must waste billions of dollars in this country. When it comes to the area of welfare, we have people who are destitute and who need some help. If we are going to make some mistakes, I would rather make them there than in billions of dollars of cost overruns to build a destroyer that nobody seems to get too concerned about.

So, the point I want to make, Mr. Chairman, is that we really appreciate your concern and your presence here. We want to work with our Federal partner.

Now, in the executive branch of Government, that is most often not the Congress of the United States, but it is the departments of the Federal Government, HEW, Department of Labor, on down the line, I would hope that in addition to taking a look at what we do, which I think is your responsibility, Mr. Chairman, because we are spending Federal funds, I would also hope that you would take a look at what they do.

And maybe then we can get together in a true spirit of cooperation and do a better job for the people because we all represent the same people.

Thank you very much, Mr. Chairman.

Mr. PEPPER. Thank you, Governor, for a very excellent statement.

I am glad you mentioned—and I should have mentioned it before myself—the names of John Fogarty and Aime Forand. In Washington those two men are regarded as synonymous with health and care for the elderly people.

John Fogarty was for many years chairman of the committee that had to do with appropriations for health services and nobody did more than he did during his lifetime to provide better health care for the people of this country. He has been honored in Washington in various ways, and he will also remain honored in the hearts of his fellow countrymen as well as his fellow Rhode Islanders.

A great lovable fellow, he was probably more responsible for medicare than anybody else in the country and while medicare is not the end of the road, it was a good way down the road and was a step forward in providing health care for the people of this country.

I think the time has come now when we must revise medicare and I hope and I think it is the gentleman's sentiment that we will be able to establish a comprehensive health care program which will make health care which they need available to all the people of this country. And Mr. Fogarty made a great contribution along with Bob Wagner and many others.

Governor, Mr. Franklin pointed out that it was not the requirement of either Federal law or regulations that the States conduct these on-site audits which you spoke of. So, he made that clear. He mentioned some recommendations that he had made here, but he did not in any sense of the word call attention to any failure on the part of the State of Rhode Island to do anything that was required by the laws of this country.

As I understand it, you have already established a considerable staff to carry on these field audits.

Now, that is all paid for by the State of Rhode Island; is it?

Governor NOEL. I would have to ask for some help on that question.

I think there are some Federal funds involved. I do not know just how much.

[Discussion off the record.]

Mr. AFFLECK. Mr. Chairman——

Mr. PEPPER. Will you give your name?

Mr. AFFLECK. I am John J. Affleck, director of the State Department of Social and Rehabilitative Services.

The very comprehensive desk audit and the Federal audit process, which Governor Noel has so ably described, is a cost borne by both Federal and State Governments at the present time. Through an indirect cost method we are able to charge some of those expenditures to our State medical assistance administration program.

Mr. PEPPER. But it is sort of an experimental program.

I mean, you do not purport to put a field audit on every one of the nursing homes in the State under that program.

Governor NOEL. No, because we have built the staff from somewhere around 6 people to now 18. We have done that just in the last 16 months.

Now, with an 18-member staff who have other responsibilities besides these field audits of nursing homes, we also have to do the audits on our own State-owned facilities where we have some 6,000 patients.

We cannot audit all 150 homes once a year and do the job right. Our capability with this new staff would probably be somewhere between 40 and 50 homes a year, and we have about 150.

But, what we will do, we will do the desk audit which was proven to be very effective over the years, and we will use our partial capacity to field audit selectively and in conjunction with the desk audit system, and I think that way we will be able to feel it out, any abuse that may exist in the State.

To set an example, we have done 38 field audits on 27 homes in the last year. As a result of those 38 field audits, we found that we owed many of the operators more money because the desk audit was so severe in cutting down their requests for reimbursement that when we go in with the field audit we find out that we have cut the nursing home operators too much so that we owe money to them.

We also find as a result of field audit, which is a more comprehensive inquiry than the desk audit, that there are some nursing homes that owe us money. I think the net effect of all 38 audits to date has been a flow, or potential flow of money, back to the State of $120,000. But, if we did not have the desk audit perfected, then the field audits

would have surfaced hundreds of thousands of dollars, I am certain, that would have been owed to the State.

But, the desk audit is such a difficult process that when we do the field audit, we find many instances where we owe them money. That is why the nursing home industry wants us to do more field audits; because most of the nursing home operators feel that they are going to get more money as a result of the field audits than they would get if there were no field audits. That is the system.

I am saying I do not think we, as a State, have to have the capability to do every home once a year in order to be able to, you know, "keep everybody honest."

Mr. PEPPER. But, you think Congress should pass legislation requiring the States, as a condition of receiving medicaid funds, to conduct thorough and complete field audits on every nursing home?

Governor NOEL. I think that would be utopian.

You would have to look at the cost of doing that and decide whether or not you should. I think there is some medium ground that would accomplish the same purpose, that would not be as expensive, and perhaps that would be the way to go.

In other words, instead of mandating a program by numbers, pass legislation that would establish the quality of an audit program that would have to be met in order to remain eligible for Federal funds and then if a State can demonstrate a quality program without necessarily field auditing every home once a year, then they would be eligible.

The goal would be accomplished and I think substantial money would be saved for the taxpayers of the Nation.

Mr. PEPPER. If Congress were to pass legislation requiring the States to conduct thorough field audits on all nursing homes as a condition to receiving medicaid funds, how do you think that cost should be provided for?

Who should pay?

Governor NOEL. You know the answer that I am going to give you to that one, Mr. Chairman.

Let me say that I think the Federal Government should bear the cost.

I think we lose sight of something. The States were the first ones in the social welfare business, not the Federal Government.

Then I look back at the history of the country and I am sure you are a better historian of Government than I am, but Federal Government proved one thing early on and that was they had the capacity to raise money and they had preempted that field.

So, what has happened over the years, Mr. Chairman, in my view, is because of a growing lack of capability at the State and local level, the Federal presence has become more profound. But, we still, as a State, and other States, put up half of the money out of State revenue to support these programs.

So that, I think there has to be an attitude of trust that those of us in State service trust those in Federal service and those in the Federal service trust those in State service.

I use the term "trust" in the sense of a belief in competence.

We know how to get the job done and we do not suggest the Federal Government should not take a look at all. We welcome you here.

We hope you come back when you can spend some serious time and take a closer look at our situation.

But, you know, we can get the job done.

Mr. PEPPER. Well, perhaps with the advice of Mr. Affleck, if you would desire him to supplement your own estimate, if the State of Rhode Island were to conduct a thorough on-site audit of all the nursing homes in Rhode Island once a year, and the State of Rhode Island were to have to pay the cost of it, how much do you estimate it would cost?

Governor NOEL. I would say somewhere in the order of $125,000 or $150,000 just for that capability.

We now spend more than that in that audit agency, but to add that capability it would cost us an additional $100,000 to $150,000. We now already spend more than that.

Mr. PEPPER. Governor, one other question: A while ago in going over with Dr. Abdellah the various Federal programs under which some assistance can be given to the elderly in their home, we decided there are five or six of them.

Do you find any evidence in Rhode Island of any need for the consolidation or the coordination of Federal programs in this area?

Governor NOEL. I think that that is a need that continues to emerge and grow as our society begins to put into place more and more programs for our older Americans.

There is a growing need to try to coordinate those programs to put them under a central focus. I think we are at that point in time now when there should be some centralization of focus in this program area.

So, I would answer your question in the affirmative.

Mr. PEPPER. Perhaps you heard me say, in England, or no doubt you already knew, in England the social programs are administered through the local council which would be equivalent, I suppose, in our vernacular here, to the county commission or the municipal authorities in a given area. All of them are run through that same administrative setup or authority. It would seem to me that that probably has some virtue. In my county of Dade we have a great many of these home care programs, but they are proliferated among eight different agencies. And it is kind of hard to know who is doing what and to be sure that the people are getting all that they need, even though we have that large number of agencies.

So, I hope we can find some way to coordinate through the State authority at a relatively local level, of course, under the general supervision of the State, how all of these programs might be implemented with appropriate supervision from the State and the Federal Government.

Governor NOEL. Mr. Chairman, when Mrs. Slater testifies, I think she can more appropriately address that question and give you the benefit of her years of experience. She is truly an outstanding public servant who does great work with the aged of the State.

Mr. PEPPER. Very good.

Well, Governor, in your position not only as Governor, but as chairman of the National Governor's Conference of our country, and well-merited you are in the State of Rhode Island, I know you are in consultation with your fellow Governors about how these Federal

programs maybe should be modified to accomplish the purpose that Congress has in mind.

Governor NOEL. I think if we could get the bureaucrats to run the Federal programs in accordance with the intent of Congress then we would be in good shape.

I do not know how we go about accomplishing that, sir, but just as an observation, there is a fantastic divergence, in my view, in the program by the time it reaches us from the program that was conceived and legislated into place by the Congress and it is that gap that causes Governors all over this country, and mayors and other people that have to work the program, a great deal of concern, sir.

Mr. PEPPER. Well, Governor, I can tell you, confirming what you have seen in the media, that is one of the subjects with which Congress is very much concerned right now. We have tightened up our procedure very sharply in providing oversight. The committee handling a certain piece of legislation is expected to follow up on that legislation as administered, to see, just as you said, whether it is being administered in accordance with the intent of Congress.

Then we have been seeing in some investigative agencies lately the need for the oversight over the people's representatives as to what is going on in this country.

I think we have seen already a distinct tightening up of our oversight jurisdiction, just as you suggested we should be doing.

Thank you very much, Governor, for a very helpful statement, and particularly for your kind hospitality here.

Mr. Beard, do you have any questions?

Mr. BEARD. Yes.

Governor, you mentioned initially that you were hoping that the HEW people could have stayed on in order to answer directly some of your points of criticism.

I think that what we should do, and what we would have to do, not only in the State of Rhode Island, but all over the United States, I think the States will have to work very, very closely recognizing HEW, recognizing the State authorities in this area.

I think there is room for the desk audit, and I think there is room for the field audit procedures in this whole program. But I think that one of the most important points that was not brought out yet is in the reports of July 1973, the Federal people noticed very loose ends on the personal needs market.

Further check in 1975; the recommendations that they had made were not carried out at that point. However, I think that if we can accept the fact that everything is not roses here in the State of Rhode Island, and we can work together as two agencies, Federal and State, I think the people will be better off, and everyone else will be generally better off. We will be able to learn from this incident, or from Federal reports, different reports, and testimony that we will receive today. Maybe we can come up with a mandatory ordinance; not for all field audits because of the possible tremendous expense, whether it is the burden on the State or the burden on the Federal Government.

But we have to recognize, and I think you recognize this, that there is room for improvement. There have been cases of fraud all over this country. New York is a classic example in the most recent history in this industry.

I think that working together on institutions, working together with the nursing home people that are responsible, and could care less, and are just putting the money in their own pockets—I think we should work together and not worry about if we are the best in New England, or anything else, and I think that is what we really have to do.

There has been some negative publicity that this would come to nothing more than a personality clash between you and me. I think it has proven that is not the case.

I have assured the chairman that my interest is to improve conditions for the elderly, not only in my State, but in all the other States.

I think I am living proof, in that I am here, that I also back up the idea of followthrough on legislation.

I think that all these things are important, and I think that the State agency and the Federal agency can work together. They are not perfect. The Federal agency is not perfect, and the State agency is not perfect. But we can work together.

We must work together, and as long as I am in public life I will work hard to make sure that every taxpayer's dollars are well spent, not only in my Second District in Rhode Island, but throughout this country, where in regard to especially this issue, the elderly will not be cheated, regardless of what toes I end up stepping on. Politicians will always be politicians; I could care less what they think.

I think I have proven myself over my 3 years in public life. Regardless of what the situation is we have to work together, and I hope you will accept that.

Congressman, I have a letter here, and this is one of the reasons I am sorry Mr. Franklin left, because of his statement concerning the way personal need funds were handled and the systems that were recommended in the audit, and were implemented. That is why I am going to write to the President of the United States and complain about the letter that was written to you over the signature of Caspar Weinberger; because we did follow the recommendations in that first audit statement, and did implement most of those recommendations, and have worked since that first audit statement to prepare a better system, which is practically ready for full implementation now.

Peter Franklin wrote that letter for the signature of Caspar Weinberger. I have a letter here that I am sending to the President. I want a confrontation with Caspar Weinberger.

Why should he sign a letter saying we did something that we did not perform?

I know what the personal needs issue is. But if you take a letter written to you by Caspar Weinberger saying we did not do anything, and then without asking us, conclude that we did not do it, then I say we need a little bit of communication, because we did begin the process of implementing those recommendations that were contained in that audit report.

But there is a much larger issue. We are talking today about home health care. We have over 150,000 older Americans in this tiny State. There are only about 5,000 or 6,000 in nursing homes.

When you stop to talk about a system to protect their private funds, when those funds come from the Federal Government, are you only going to talk about a system to protect the private funds of the 5,000 who at any point in time happen to be in a nursing home, or are you

going to talk about a system to protect the funds of the 150,000 older Americans in this State? It is a very complex issue.

The SSI program in this State is administered totally by the Federal Government. So that the $25 set aside of personal need allotment that goes to most people in our nursing homes goes to them from the Federal Government. It is not paid to them by the State Government, because the Federal Government administers our SSI program.

Now, whose responsibility is it to have a system to track that money? Is it the State's responsibility, or the Federal Government's responsibility? It is the Federal Government that pays them the money.

Now, if the Federal Government decides in its wisdom that it is a State responsibility, so be it. We will work cooperatively with them.

But it is not a simple issue, and for HEW to take the very unrealistic position that they have taken all over this Nation is not going to solve that issue and I, for one, am not going to sit here and let somebody down there tell me that they have the only answer to this problem when the answer that they provide is, obviously, unacceptable, unacceptable to me, unacceptable to the Governors of 49 other States, and most people who have thoroughly viewed the issue.

Now, I am not trying to be arbitrary. I will work with you, with the chairman, with Secretary Weinberger, with people on the President's staff, to design a system to protect these funds, and I think we have to do it.

I am willing to participate. But, you know, Eddie, I am not a clinging violet, and I do not stand here and let somebody from the Harvard Business School tell me that our system stinks when he does not know what the hell he is talking about to begin with.

Mr. PEPPER. Governor, for your information, I think it would be interesting for you to know this.

Mr. Franklin left a statement here as to the States that made these onsite audits of medicaid funds, and I have just roughly run over the list and counted them.

Only 22 States in the country have put in more audits than you have here in the State of Rhode Island. The following States have done little or nothing at all:

Alaska, Arkansas, California and Colorado did one; Connecticut, none; District of Columbia, none; my State of Florida, none; Georgia, none; the State of Idaho, three; Indiana, none; Iowa, none; Mississippi, none; Montana, one; Nebraska, none; North Dakota, none; Ohio, four; Oklahoma, none; South Dakota, none; Utah, none; Vermont, none; State of Washington, none; West Virginia, none; Wyoming, none; and Puerto Rico, none.

So what we are here for is not in any way for accusation or recrimination. We are here to learn what we can, as you said, as to what sort of programs we should have in the future to give the best service to the elderly, and how those programs should be paid for, and how they should be administered.

Mr. BEARD. What the Chairman has just cited proves the fact that things are a lot worse elsewhere in this country.

The point I just want to leave with you before I close my final statement on this is, regardless of the fact that I come here from Rhode Island, and I am in the second district, I am here, and the chairman is here only because this is a nationwide issue.

The members of Congress would not travel here just for the State of Rhode Island, because it would be an isolated situation. That would really be HEW's responsibility.

But since we have to legislate nationally, and since I have a national responsibility, and I recognize it, my criticism today is that the chairman gave you examples of what is elsewhere. Elsewhere very few field audits are being done, down to zero.

Regardless of what has been said in the paper, I accept things as I see them, and as I read them, and as things have been proven to me, and I am just saying that things are not roses here completely. They are not all roses.

If we can accept that on that basis, and work together, the State, the people of the State, and throughout the United States, you, as the Governor, and other Governors throughout the United States, will all be better off in the long run.

Mr. PEPPER. Governor, we want to thank you very much. You have honored us by coming here today and giving us some very valuable testimony.

Governor NOEL. Thank you very much, Mr. Chairman.

Mr. PEPPER. Thank you very much.

The next witness will be John J. Affleck, who is director of the Department of Social and Rehabilitative Services of the State of Rhode Island.

Mr. Affleck, we welcome your statement.

STATEMENT OF JOHN J. AFFLECK, DIRECTOR, DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES, STATE OF RHODE ISLAND

Mr. AFFLECK. Thank you very much, Mr. Chairman.

Following Governor Noel in this particular area in many respects leaves little to add to his comments delivered with his usual very comprehensive style and vigor.

For the record, I am John J. Affleck, director of the Rhode Island Department of Social and Rehabilitative Services, and indeed, I very much appreciate, Mr. Chairman, the opportunity to meet with your subcommittee in Providence today, and to offer my observations, specifically on the question of whether there should be congressional enactment of legislation to require field audits of nursing homes receiving medicaid funds, and whether such audits should be made by the Federal or the State governments.

As I indicated, I think Governor Noel has certainly treated this subject with great comprehensiveness.

In addressing myself to the question, however, I would like to personally compliment the subcommittee and, as you have indicated, Congressman Beard, thank you for your interest in coming to Rhode Island to examine questions of long-term care.

The department I have the privilege of directing has multiple responsibilities in the area of services to patients in need of long-term care, both in our public institutions and in our community facilities. Both the social services for such individuals and payments for their care is appropriated through our medicaid program.

I might note, Mr. Chairman, as undoubtedly you know, we have one of the most comprehensive medicaid programs in the entire Nation. We have the highest eligibility levels in the entire Nation. This is a mark of credit, I believe, to our Rhode Island Legislature, and Rhode Island leadership.

We appreciate the concern of your subcommittee in all facets of long-term care which, as the Governor has indicated, and others, is a very complex and complicated area. We trust that your deliberations and considerations will indeed result in viable recommendations to the Congress for comprehensive effort to insure patient care of a high quality with fiscal and program accountability.

May I note that I do regret that the Federal officials were unable to remain for this total discussion. We have many ongoing discussions with them. I think our discussion today would have been enhanced had it been possible for Dr. Abdellah, for example, to have participated longer, to hear the remarks that Dr. Cannon will be delivering in the area of comprehensive service.

I would, however, draw to your attention, and the Governor alluded to it also, that the opportunities which Dr. Abdellah and others have suggested exist in title 20 of the new social security amendments are indeed significant in terms of care of individuals in their homes.

However, the ceiling that the Federal Congress has established for title 20 is $22.5 billion nationally, and it is my judgment that HEW anticipates perhaps only about 1.7 or 1.8 of that being spent, and Rhode Island is one of the States at the ceiling.

So the opportunities for us to be further innovative in our efforts here in our further commitment to home care services is conditioned in part by this factor, which I hope your committee will, and I am sure you will, be mindful of.

It is in the context, however, of quality patient care that I will address the question of field audits.

In order to be responsive to the question, however, I would like to identify very briefly, because the Governor has covered it quite comprehensively, I believe, our process in Rhode Island, and the way in which that process has evolved to our present point.

Prior to 1967, indeed in 1958, we established a special unit in our Department of Social Welfare for the principal purpose of providing the classification of patients' prior authorization for medical care in group care facilities and to insure the prompt and adequate payment to the facilities for the care delivered.

Through the years, to 1967, this system prevailed with gradual increases in the level of payments that were being made. They happened to be at $6 per day in 1958.

It was recognized, however, that this flat method of reimbursement simply did not address the question, and had no relationship to the question of actual cost of care, or more importantly, to the issue of the quality of care.

It was for this reason that Rhode Island developed, in 1967, the system we have today, moving from the flat rate system of reimbursement for nurses and intermediate care to the cost based rating system, a system, I might say, which I believe has been modeled, used as a model, by several other States.

Mr. PEPPER. Excuse me.

If I understand you correctly, that means if you just give everybody, or allow for everybody in the nursing home, let us say, $18 a day, that would mean that a person in good health, and who is getting along pretty well, and does not need much care, will get $18, but another person who needs a great deal of therapy, which is rather expensive, will only get $18, and when you use up the $18, that is all that individual could get.

Is that correct?

Mr. AFFLECK. It is essentially correct, Mr. Chairman, and it is for that very reason that in 1967, long before any interest of the Federal Government, in my judgment, in this area, we moved from this so-called flat rate to a cost reimbursement formula.

Mr. PEPPER. You mean you pay whatever the need of the individual is?

Mr. AFFLECK. Exactly correct, Mr. Chairman, and the Governor has described in detail the way in which we receive a detailed cost data from the individual home to establish our reimbursement levels.

The Governor has described this in a very comprehensive, and, I think, sufficient fashion.

The results of the desk audit, conducted by our principal rate analyst and his supporting staff, have indicated the disallowance of very substantial reported costs running approximately 12 percent in the last calendar year.

That desk audit indeed was complemented by too infrequent field audits because of staff limitations until, as we indicated, some 3 years ago we began to develop our capability, and to enlarge our capability for field audit.

As has been indicated, we are extremely pleased to have been able to add staff since December of 1973 in sufficient numbers to extend this process of field audit to all facilities serving medicaid on a selected basis.

We see the opportunity for field auditing as a very strong complement to our desk audit process, and we will continue to give priority to the allocation of our limited resources as has been noted in this area.

As has already been indicated, we have conducted some 38 field audits on 27 facilities in the 13-month period ending May 31 of this year. Others are continuing to be ongoing.

The specific question of——

Mr. PEPPER. Excuse me.

Do you recall offhand how much that cost the State of Rhode Island to make those audits?

Mr. AFFLECK. This could be determined.

We probably have personnel expenditures in the unit which conducts both our desk audit and field audit of approximately $150,000 annually.

These would be personnel services only, Mr. Chairman.

If it would be of interest to the committee, I would be pleased to try to better identify the cost. It may be possible.

It was interesting to me that Mr. Parigian noted that a field audit could take as much as 3 to 4 weeks. This seems to me, as a nonauditor, to be extremely heavy.

We, in a most, most comprehensive field audit process, run approximately 5 to 7 days. It would take a professional auditor, obviously, to make a judgment here.

When Mr. Parigian speaks of 3 to 4 weeks, and 16,000 facilities throughout the entire Nation, I wonder where all the qualified auditors could possibly come from to undertake this.

I could conceive of another total department consisting of auditors only, and I would have to wonder what the cost benefit might be in the whole area.

But on your specific question, Mr. Chairman, I believe the question of mandating field audits concerns really the resources that are necessary to accomplish such a responsibility.

In our own State it is very clear that we have committed ourselves to the development of resources sufficient to accomplish hopefully annual field auditing. We are able, with our present resources, to handle, as the Governor indicated, perhaps 50 of the 150. Perhaps all of the skilled nursing homes.

I think a better use of personnel, rather than saying we audit all skilled nursing homes, and no intermediate facilities, would be a selective mix, perhaps on a responsible sampling basis.

Mr. PEPPER. Excuse me.

Let me ask if I am correct in this assumption.

When we talk about a field audit, that is an accounting proposition where you determine whether the nursing home provider has been adequately paid, or has been overpaid, or whether they submitted charges that are not substantiated, made claims that they are not entitled to receive the money on, and that sort of thing.

The auditors do not go into the question of the quality of the care given to the people in the nursing home, do they?

Mr. AFFLECK. That would be an entirely distinct issue, and addressed by different units of State government, located primarily in the health department, dealing with utilization review, medical review.

Mr. PEPPER. That is what I thought.

Mr. AFFLECK. The field audit would be a fiscal process.

Mr. PEPPER. It is a fiscal matter——

Mr. AFFLECK. Yes, sir.

Mr. PEPPER [continuing]. Whether the accounting is correct or not.

But whether or not they are given the proper care, the proper nursing care, they are treating the patients humanely, giving them decent food, and whether they are properly cared for, and all that sort of thing, that comes under another category?

Mr. AFFLECK. This is of concern to me, of intimate concern, but I address the question of only fiscal accountability today, Mr. Chairman.

Mr. PEPPER. Please go ahead.

Mr. AFFLECK. Our commitment to field auditing has been accomplished only with difficulty in the reallocation of resources here, and I would say, Mr. Chairman, that other States like ourselves would find it difficult to reallocate always scarce limited resources in times of such fiscal pressure on State government.

With this in mind, and directing my remarks to your specific question of mandating, it would appear to me that if you were to consider the question of mandating as such field audit, physical field audit, you would have to examine the cost benefit related thereto, the number of

auditors that conceivably could be required and, indeed, the cost that would be represented thereto.

In terms of the expenditures related, I would, however, draw your attention to the fact that where there have been mandated responsibilities by the Federal Government in the survey and certification process; for example, of the facilities participating in medicaid, there has been, and is, 100-percent Federal reimbursement.

The certification in medicaid at 100 percent runs through to July of 1977. I would trust that this would be extended.

It would certainly be my recommendation, that if field audits are to be mandated, or that some middle ground be found here, then that strong consideration be given to the possibility of 100-percent Federal participation in the expenditure.

This, Mr. Chairman, might be incorporated in a number of bills that are pending in this general area, Representative Koch's bill that I know you have cosponsored with Senator Beall, and Senator Moss' identical bill in the Senate.

Essentially, who should finally do the audit, it would seem clear to me, because title 19 is a State administered program with Federal participation, I believe that the field audit should be a State responsibility, with the recommended 100-percent reimbursement, because beyond the State level, beyond the State agency itself, we have built in several layers of auditing within our own State government, and beyond us, of course, the HEW audit and the General Accounting Office.

Mr. Chairman, I am very pleased to have the opportunity to make these observations and remarks to you this afternoon, and would be pleased to respond to any comments or questions.

Mr. PEPPER. You have given us an excellent statement, Mr. Affleck and we are very grateful to you for appearing here this morning.

I think you pretty well covered the subject, as far as I am concerned.

Would you ask Mr. Beard if he would care to ask any questions?

[Discussion off the record.]

Mr. PEPPER. Mr. Beard will be back.

[Discussion off the record.]

Mr. PEPPER. We will go back on the record.

Mr. Beard, do you have any questions?

Mr. BEARD. Yes.

Mr. Affleck, I think one thing I would hope that we all agree on is that we need mandatory audits around the country.

The chairman has cited some States where they have none at all.

I think, as a starter, that is definite. I think in some cases sometimes it works in reverse against the nursing homes. I am just looking from the nursing home point of view. Sometimes they can submit, for example, their bills, and what they feel that they should be paid for, but if there is actually no visit let us assume that they have had a project on which they spent an awful lot of money, or something that is very, very legitimate, if there is no field audit in this procedure they could very well be denied at the desk audit.

The only thing you have to work by is what has been submitted from the nursing home to your office, or to the person who is doing the desk audit.

I think sometimes in that case it works in reverse against the home.

Now, on the other side of the coin, I think too that in a case of maybe personal needs, money, let us take a home that maybe is not doing what they should be doing; one of those homes that is off the track and is just trying to profit here at the expense of the elderly. I think if you have a field audit procedure, whether it is 100 percent, or 50 percent, at least there is going to be more of an impact than there is now in the United States.

I was shocked when the chairman read the States that have no procedures at all. I think that is ridiculous when you are dealing with taxpayer's dollars. I think there should be an accountability of the money, a bank account, or some positive identification that that money is being spent.

I am talking now, of course, of the $25 that they are entitled to.

So at least I feel that it is necessary all over this country to have every State required, by Federal statute, to be this way, or State-with-State cooperation that we have a mandatory audit of the procedures of every single nursing home, long-term care facility, and institution facility that receives Federal or partial Federal and State funds.

I think it is going to be a question of what degree. It may be 50 percent, 70 percent, or whatever that point is. I think it is necessary, but I think I have proven, too, and I think it has been proven in the past, that some homes, in the case of the nursing homes that are doing a good job, they have been shortchanged on projects that they have spent a lot of money on, but could not prove because the field audit procedures did not take place.

What I am referring to, Mr. Chairman, you could have a renovation, certain renovation on a certain room in a nursing home. Unless that agent that is responsible for the distribution of the Federal or State funds comes out to the site, he could challenge you on how much money, and what actually took place, if he is not actually there.

That is the purpose of the field auditors, to match the papers and the bills to the actual job, or the actual things that they are claiming.

Some areas I am very concerned about.

Do you reimburse, for example, for liquor?

Mr. AFFLECK. Liquor for whom, Congressman?

Mr. BEARD. For homes. Let us say beer or wine or hard liquor.

Mr. AFFLECK. I would not think so, Congressman Beard. I am not personally familiar with that.

We include, as an item of cost, obviously, the food served to patients. I do not know of any nursing homes that have liquor as a conditional piece of the food diet.

Mr. BEARD. Do you have some check system on traveling?

Mr. AFFLECK. For whom?

Mr. BEARD. In other words, the travel by the nursing home administrator, or nursing home personnel of, let us say, a home again that is not doing the right thing, that is going to travel in the name of the best interest of the patients, but it could be in their own best interest.

Do you have some check system?

Mr. AFFLECK. Yes. I think, Congressman Beard, if I could draw your attention back, and invite your review with us at some appropriate point of the depth of information we received, cost data, at

the initial point. I think it would give you a better handle on the detail and the cost data we secured from the homes in the first instance.

If I may further, Congressman Beard, I think that we can concur entirely on the essential need of fiscal accountability in terms of expenditures made to homes. There needs to be an auditing process.

You have indicated the question of degree needs to be addressed. I concur. It is the question of whether there needs to be the 100-percent field auditing to complement, as in our State, for example, the very comprehensive desk review process.

But I think that is one distinct issue that I addressed today in my remarks and my comments, a very distinct piece of this, and separate from it in its entirety is the reference you make to personal needs allowance.

That is another piece of the pie that needs the most careful program and fiscal accountability, but it is distinct from the issue of reimbursement to the home for the care delivered to the resident patient.

Two distinct issues, Congressman Beard, and I am sure you recognize that.

Mr. BEARD. One last question.

Under the present system that we have, do you recognize there is a possibility for fraud?

Mr. AFFLECK. I think in any human system there is, obviously, the possibility of fraud, Congressman Beard, whether it be in nursing home operation, or any other human endeavor.

I think our concentration with our comprehensive desk audit, now complemented by field auditing, is to reduce that possibility to the irreducible minimum.

However, I am sure any human endeavor—I have never seen one yet where it is not possible for people to try to "beat the system."

Mr. BEARD. I am recognizing, of course, the national surveys that have been done, and thorough investigations by HEW, and by people very concerned on this issue that is cited.

For instance, in New York, there were millions of dollars involved in fraud in this industry.

But I want to recognize—and I think I mentioned this earlier in my presentation—that I do not really believe the majority of the homes in Rhode Island are not working in the best interest of our elderly.

I think there are tremendous people in this industry trying to do a good job. I tried to recognize that right along, but as long as there are a few, even if it is only a few, there are problems.

We have to work to eliminate these problems, and we cannot, in the United States, and in the Congress turn our backs on the fact that it has been proven in New York; it has been elsewhere in this country. There are question marks here in our own State, question marks which show that the system has to be improved to eliminate possibilities of fraud.

I think when we are dealing with taxpayers' dollars it may take a 50-percent auditing procedure in the field and 50 percent working on a desk type system. It may take a higher degree. It may be 100 percent that may prove necessary in order to hopefully eliminate this fraud against the taxpayers, because in the last 8 years, Mr. Chair-

man, it was in the millions of dollars that came in from the Federal and State funds that were disbursed to nursing homes, and I think that you know we have to have definite accountability, and that really is the purpose of this hearing.

I think that, in my opinion, this has been a tremendous hearing, because we have had a chance to listen to the Governor, to the HEW people, to your testimony, and to other people who will testify today.

The ultimate goal is, of course, to come up with a system. Federal and State and private industry should be able to work out a system that certainly will be to the betterment of all mankind, especially our 20 million elderly Americans in this country.

That is why I am sitting here, and I know that is why the chairman is sitting here today.

Mr. PEPPER. Mr. Affleck, just for the record, and my own understanding, you said you must make a distinction between the onsite audit about which we have been talking, and the audit of the claims for reimbursement, did you not?

Mr. AFFLECK. Sir——

Mr. PEPPER. You made a distinction between the two?

Mr. AFFLECK. I drew the distinction, sir.

Mr. PEPPER. What are the two cases?

Mr. AFFLECK. I believe Congressman Beard was identifying the accountability for the patients' personal funds, those funds which may be received, as the Governor indicated, from SSI, or social security, or from some other source. That is one distinct issue and responsibility.

The second issue to which I addressed my own remarks directly is the issue of the auditing of the cost of care for patients in the facilities.

Mr. PEPPER. That means the total cost per patient in the nursing home?

Mr. AFFLECK. Correct, sir, and I have indicated that in Rhode Island we have the desk audit, and I will complement it by a field audit process. I would suggest to you that we have a very responsible system, a very tight system; one that can be further improved, of course, but I think we have a strong one. In my judgment, in the nursing home industry, both the proprietary and the nonprofit facilities, in the State of Rhode Island, we have some people who are very committed and dedicated to patient care.

Mr. PEPPER. Well, thank you very much, Mr. Affleck. We appreciate your being with us.

We will take a recess for 10 minutes for the accommodation of the reporter.

[Short recess.]

Mr. PEPPER. The committee will come to order, please.

Our next witness is Dr. Joseph E. Cannon, Director of the Department of Health.

Doctor, we are pleased to have you here.

STATEMENT OF DR. JOSEPH E. CANNON, DIRECTOR, DEPARTMENT OF HEALTH OF THE STATE OF RHODE ISLAND

Mr. CANNON. Thank you, Mr. Chairman.

I am here not only as the director of health, but, I suppose, like yourself, as a senior citizen.

Mr. PEPPER. Yes.

Well, you and I both occupy that role. I am only 74, but I think I am old enough to become a senior citizen.

Mr. CANNON. I made some notes last night.

I know, as others know that here you have had a very distinguished career. I would like to just mention a couple of those things.

Mr. PEPPER. Will you pull the microphone a little closer?

Mr. CANNON. Yes, sir.

Mr. PEPPER. All right.

Mr. CANNON. Did you not get the Albert Lasker Award for public service back in 1967?

Mr. PEPPER. Yes.

Thank you.

Mr. CANNON. It seems to me you were one of the people who had perhaps the main influence in developing the National Institutes for Health.

Mr. PEPPER. Thank you, Doctor.

Mr. CANNON. So, you are welcome here.

Mr. PEPPER. Thank you.

Mr. CANNON. I just want to say a couple of words and the focus of my presentation today will relate to community-based home services for the elderly and the disabled, as alternatives to traditional institutionalization.

For many years it has been the policy of this department—parenthetically, I have been in this job too long. I have served under Republican Governors and Democratic Governors, and I am not particularly political. Some people say I am Congress.

I do not know. I am not actually.

But, for many years it has been our policy to promote, foster, and finance such services for Rhode Island's elderly and handicapped citizens.

The kinds of programs to which I am referring are outpatient rehabilitation; physical, occupational, and speech therapy; home nursing; nutrition counseling and homemaker services.

In the early 1960's we adopted the position that community-based services were more preferable, when possible, than the less personal institutional model.

Rather than generalize, however, let me outline a few of the programs established for this purpose in the State of Rhode Island.

As an example—unfortunately, I only have this one copy left—this is a publication of the Public Health Service. It is entitled "Portraits of Community Health, the Dexter Manor Story," published by the Department of HEW.

This booklet describes what was done in Rhode Island by accomplishing an interdigitating program of public health nursing, nutritional and health counseling, preventive health services, and information referral services into a public housing project.

The planning for this program began more than a year before the facility was dedicated in 1962 and its success was of such national significance that the U.S. Department of Health, Education, and Welfare cited the program through various publications.

The concluding passage in this pamphlet follows:

Hopefully, the knowledge gained through this program will stimulate and inspire communities throughout the Nation to give further thought to developing services aimed at promoting and maintaining maximum health and independence for the elderly.

Unfortunately, the lessons learned at Dexter Manor, despite proven effectiveness, have not been afforded the widespread application one would have anticipated.

I have specifically cited the Dexter Manor program and the data was introduced as evidence of the long established commitment which the State of Rhode Island has manifested toward community-based health care services for the disabled and the elderly.

Let me list a few other things that have been accomplished in the State of Rhode Island.

Every citizen in the State of Rhode Island has access to Federally certified home health services. This was achieved by the consolidation of 27 smaller limited visiting nurse agencies into 9 agencies of sufficient size to provide comprehensive services, efficient management while also complying with the Federal standards.

Our department financed the creation of a uniform reporting system for all home health service agencies.

We established, through State funds, one of the first hospital based home care programs in the State and as a result of that there has been further growth, but, unfortunately, not enough.

We have established and distributed on a Statewide basis a uniform interagency referral form for all home health agencies.

It is of interest to know that our department is currently financing approximately 37 percent of the total budgets of all home health agencies in the State.

Over and above that basic support there, the Department of Health has granted over $400,000 to home health agencies during the past 10 years, to expand their scope of services and to strengthen management practices.

Parenthetically, at this time, I would like to add that one of the main sources of strength we had in that area was the home health grant that was done away with when the block grant became available.

It so happened that I served on a national task force for about 3 years that worked on the legislation which resulted in the partnership for health.

There were four of us, and one of them was your own State health officer, and we had hoped that block grant money, so-called, would increase so the States recognizing their own problems, could use that money in a wide variety of areas, something like development money.

Unfortunately, that funding level has been maintained at the same level over the years, so there has been very little flexibility and when you consider the increase in costs of all services, we have to do less with that money.

Mr. PEPPER. Did I have some information from the Comptroller General of the United States not long ago that only two-tenths of 1 percent of the revenue sharing funds that are made available to the States by the Federal Government and the counties and cities, is used for the care of the elderly?

Mr. CANNON. I have not seen that, Mr. Chairman, but I would be more than willing to accept it as an example.

Mr. PEPPER. Well, I would hope that the State and the local, the counties and the cities, would take account of the fact that when this revenue sharing is to be renewed, they are going to be asked how they have spent the money, and then Congress is going to want to be assured that the money has been wisely spent.

I am sure that we all hope that the share of the revenue funds in the future will be more generously bestowed upon the elderly.

Mr. CANNON. I would certainly like to see that.

It may be of interest to you to know, too, that despite all the mandates coming from the Federal Government to X, Y, and Z, and despite the wishes of Congress, these are not always carried out.

The Federal Government only puts about 20 percent of health money into the communities and the States and local governments put in over 80 percent.

Let me bring to your attention a booklet which we just published within the last month.

We have not published it actually. It is for distribution.

It is "A Community Facility for Disabled Citizens of Rhode Island." It is a publication of the Department of Health.

I think it is quite good and there are some significant quotations in it which might be of interest to you. I should have turned down the pages, but, again, time was short.

This is a quotation by John E. Fogarty, whom I had the privilege of knowing long before I returned to my native State of Rhode Island.

> The group of aging citizens who do not require hospitalization, but who, with a bit of rehabilitation, could live happily with others, holds a great potential.

Another quite significant quote is this one by John F. Kennedy.

> No costs have increased more rapidly in the last decade than the cost of medical care. And no group of Americans has felt the impact of these skyrocketing costs more than our older citizens.

I am sure that many of the people in this room, particularly those who have lived on fixed incomes or pensions, feel the same.

I think here is where some of the material which you have in documents which I have before me, which indicates so clearly the need to liberalize the medicare restrictions and the medicaid restrictions in the area in the care of citizens outside of the hospital, documenting your own documents, needs your very close attention.

I could not agree with them more.

Mr. PEPPER. Thank you.

Doctor, we will add those publications to the record if you can give them to the reporter. If you can spare them, they will be retained in our files so we will have access to them.

Mr. CANNON. I cannot spare this one publication because it is the only one I have, but I will supply the other for the record.

[The booklet entitled "A Community Facility for Disabled Citizens of Rhode Island" was later supplied and is retained in committee files.]

Mr. PEPPER. Doctor, you were speaking of the value of these services.

Mrs. Krause, who conducts a home health service program in Minneapolis, told us last week about two or three cases where the lives of some elderly people were saved because they had checkups in the

clinic that is operated under the direction of the Abbott-Northwestern Hospital in cooperation with MAO.

In one instance, after a checkup, it was discovered that a certain person had a brain tumor, and the brain tumor was removed.

Fortunately, they discovered it early. The medical authority said if it had been found 3 months later it probably would have been too late.

Now, many of us are able to afford a private general checkup—or some of us in Congress can get it down in Washington at Walter Reed or Bethesda, but every elderly person does not have the money to go to a doctor and pay $100 or $200 to get a checkup; and all of them do not have clinical facilities available to them.

I hope this way or another way, maybe you do provide the care, but under a home services program with the clinic as an adjunct of it, in cooperation with the hospital, they could get these checkups, which might enable them to save their lives or avoid serious illness by detecting something that is causing concern.

Dr. CANNON. It may be of interest to you to know that this State was the only State as a State, rather than as a medical institution, that had the first multiphase screening unit in the country, and we were funded at that level.

It was a very interesting and worthwhile experiment, which still continues in one of our hospitals.

Unfortunately, we are not able to provide that service without cost. At one time we did.

Every citizen over the age of 45 was permitted to go to that, then referred back to their physician.

The mechanism itself is still excellent.

I would like to go on a minute without my notes.

I may go back to them.

Mr. PEPPER. Go right ahead.

Dr. CANNON. I would like to indicate to you that there have been and there are now, in this State, more developments in the area of home health programs, hospital based, which have the desirability of continuity.

There certainly should not be any substitute for the existing visiting nurse agencies or home health agencies that tie in and link with them very closely, as they do.

We have had success in recent months of establishing—or getting hospitals to establish this.

We started off with one on the South County, which has a very interesting and innovative facility for long-term care.

Unfortunately, restrictions on the medicare formula do not permit it to operate except without their aid and there is another area that needs change.

That has now been accepted in recent months on the basis of availability of beds. If you want more beds rather than very general hospital beds, we have said that those beds must be skilled nursing home or extended care beds within the hospital.

So, outstanding Miriam Hospital has gone that route.

The Osteopathic Hospital has gone that route within the past year and we have very firm indications that one of our larger Catholic hospitals will also go that route.

I want to make one more comment.

I am not a Johnny-come-lately, nor are you, to the health care scene.

I have been in public service almost 40 years. My original interest in the elderly came about in the summer of 1935 when I served as an intern in what was our State Infirmary. We now call it our Center General Hospital.

If we think of the Dark Ages and conditions, all one has to do is look at that. I can never forget and never have forgotten the gratefulness, the gratitude of the old in that institution who were clean but not adequately fed, no influence or care for the diabetics, no diets, but the gratitude which those lonely old people had when you just sat by their bed, by their chair, and talked with them briefly.

I have had further experience over the years in the field of mental retardation and when we had that program we did develop in the States outstanding resources, day care, home care, and institutional care, outside the big State institutions for the retarded.

I will go back again to an early experience in medical school at the old Boston Dispensary, and I know, as you went to Harvard Law School, you may well remember that place.

We had the experience there where we had to take a period of training out of the Boston Dispensary in home care. We saw the kids with measles in the home. We saw the old person that was bedridden.

I go back again in this little document that we have recently prepared. It is headed, An Alternative Approach.

First: The sick without being pained by a separation from their families may be attended and relieved in their own houses.

Second: The sick can in this way be assisted at less expense to the public than at a hospital.

Third: Those who have seen better days may be comforted without being humiliated and all the poor receive the benefits of a charity which is more refined as it is the more secretive.

I do not know that we have come too far a distance since then.

I do want to note for you, Mr. Chairman, and let us consider for a moment what the United States Senate Committee on Labor and Public Welfare, chaired by Senator Edward Kennedy, expressed in report 94–29, on March 6, 1975, regarding community based health services, and it states:

> The Committee notes that both Medicare and Medicaid have been criticized by all expert observers of our health care delivery system for not providing greater encouragement for the use of home health services as a lower cost alternative to hospital and nursing home care.

I know that you are tight for time.

I have many other things to talk about, but I just want to make a couple of comments and I will leave all this and answer any questions that you may have.

I want to say that I am a bureaucrat and have been for many years, but I hate bureaucrats. I do not consider all that is written and comes down from HEW, the Department of Agriculture, or the Food and Drug Administration—all of which agencies we feel are in our Department—to be the graven word and the last word.

I am not convinced that congressional intent is always carried out. I can see this in many areas. One of the prime examples, I think, is a

very good article in Readers' Digest about the Federal Register and what it means.

I do not mind a good fight at all, and I fight almost every day with people at the Federal level about some of their programs.

Mr. Franklin, for example, was appointed a Special Assistant to the Secretary with the expressed intent, I think, of trying to establish some coordination of activities.

We have held off in the Department of Health, writing revised nursing home regulations for some 2 years because we were always hearing that we were going to get revised regulations, which will be similar in content for both medicare and medicaid.

That still has not happened.

I think those things need looking into.

I have had the recent experience of dealing with another Federal agency which said I was in violation of water standards on a particular stream, and when questioned, they agreed that this was not a violation because the standard was not supposed to be met until 1985. So, it is hardly a violation.

I think I am saying to you, Mr. Congressman, that we in the States have some capabilities, some interests, and some obligations. We feel as strongly as anybody else a responsibility to care for others, and we know that you have that feeling.

We have seen it many times over the years and I think, basically, as the Governor expressed in his recent delivery, we are frustrated perhaps more than Congress is by the roadblock and the many differing opinions.

I do not know who to call on some of these things when I go to talk to Boston about nursing homes.

Now, believe me, I am not being critical of the poor public servant, the Federal bureaucracy. He can't blow his nose without getting approval from somebody at a higher level.

But, I do think that the steps you are taking in Congress to look at the Federal bureaucracy at the upper level is most important, where people change. Today it is Faye Abdellah, whom I have known for many years; a year or two ago Dr. Marie Calendar of Yale was in the same program.

A little bit of consistency and continuancy would help us, too.

Mr. PEPPER. Thank you very much, Doctor.

I appreciate what you have said and especially the emphasis you are putting on the profession of home care for the elderly.

That is one of our very serious concerns and we hope it will lead to setting up a better program for the elderly in the country.

Dr. CANNON. Let me ask one more favor, if I may.

Mr. PEPPER. Certainly.

Dr. CANNON. You know we have some public health service money or public health programs that we would like to develop. Please vote for these appropriations when you go back to Washington.

Mr. PEPPER. Nathan Hale said he was sorry he had but one life to give for his country. I am sorry I have only one vote.

Mr. Beard, do you have any questions?

Mr. BEARD. No questions.

It was a very good presentation, Dr. Cannon.

Dr. CANNON. Thank you, sir.

Mr. PEPPER. Thank you very much, Doctor.

Dr. COHEN. Mr. Chairman.

Mr. PEPPER. Our next witness——

Dr. COHEN. Mr. Chairman.

I did not receive the call for the meeting, so I was not knowledgeable as to how a physician or a person in the community would get the opportunity to be heard here.

I do not mean to disrupt the procedure, but I note that the time is going on and the people have not yet been heard from, Mr. Chairman.

Mr. PEPPER. Are you Dr. Cohen?

Dr. COHEN. Yes.

Mr. PEPPER. Well, Doctor, thank you very much for your interest in the hearing.

We have invited a number of people who are on the list.

Dr. COHEN. Mr. Chairman, I worry that you will not get through by 4:30.

Mr. PEPPER. I will stay here and hear anybody who would like to be heard for any reasonable length of time after we finish the list of the witnesses.

I am glad to have you interested.

Dr. COHEN. Thank you.

Mr. PEPPER. Now, our next witness is Mrs. Eleanor Slater, chief of the Division of Aging.

We will be pleased to have your statement.

STATEMENT OF ELEANOR F. SLATER, CHIEF, DIVISION OF AGING, STATE OF RHODE ISLAND

Mrs. SLATER. Thank you, Congressman Pepper.

Also, Congressman Beard.

As chief of the Division of Aging, I might say at the outset that the Governor has designated the Division of Aging as the agency which implements the various titles of the Older Americans Act.

The thrust that the division has had for many years is to maintain people, older people, in their homes to the greatest extent possible, and with that in mind I would first like to tell you briefly some of the services that are brought through the Older Americans Act, and because they are so closely interrelated and interlocked, I will then speak of them in an individual way and elaborate.

But, I do not want you to get the idea, Mr. Congressman, that they are services that are brought in toto of themselves, but rather interdependent.

We have in this State four day care centers for the elderly. These are day care centers where people go as often as 5 days a week if they so want, from about 9 in the morning until 4 in the afternoon.

We also have a system of transportation for the elderly, 34 minibuses, 2 of which have hydraulic lifts for people who are in wheelchairs, and most of the people who attend the day care centers are given a demand response, that is, they are picked up at their door and they are delivered back to their door in these particular vehicles.

We also have 65 direct service aides who work out in the field directly through the agencies with which we contract and go into the homes of so many of these elderly.

Thirty-five of these direct services aides are paid for. Their salaries are paid for their services and are paid for under the Older Americans Act.

But, it is very interesting, Mr. Congressman, I think, for you to know that 30 of them are CETA people, the people who are employed under the Comprehensive Employment Training Act.

The success of using the direct service aides has been so great that we have put in an application for 20 more CETA direct service aides and I believe they are going to be approved in the next round and we hope to have more direct service aides.

Now, in conjunction with the service aides, it is also important for you to know that title 4A, under the Older Americans Act, is for training.

We have used this money, I believe, wisely and well because these direct service aides are trained.

The ones that were employed under CETA came aboard on April 15 of this year.

We gave them a 2-day orientation.

We let them know, as people who were completely uninformed, about social security, about food stamps, about the various services out there in the field for the elderly who are isolated in their homes, and we knew that this was not going to sink in too much because these were people who were completely new to this field. Six months later we had them back and had a 3-day training period for each of them. They really caught on beautifully because they got their feet wet in the service of the elderly and actually had some experience with what some of the problems are.

So, I want to emphasize to you, Mr. Congressman, how important it is to have these training funds because these are the funds that our own agencies use by getting people who do have expertise, for instance, in helping older people with their social security, or with SSI.

We have people come in from the State office of social security to do the lecturing on that particular area.

That is just an illustration of the kind of personnel we have doing the training, but we coordinate it and supervise it.

So, training funds are terribly important.

We also have, in conjunction with the direct service aides, an information and referral service. It is very interesting.

This is what developed and became really effective January 1 of this year.

The numbers of calls really proliferated so much that in the beginning there would be 100, or possibly 150, a month; now we are up to 900 calls within a 6-month period of time.

We have used a little telephone sticker that we give out at all the meal sites.

We give them out to all the elderly wherever we can reach them and ask them to stick this on the telephone. This is what they do, so that number is always there for them to call to get any kind of information in conjunction with any service that is available to them.

Now, in addition to the informational referral service we have a health maintenance program in which we work directly with the visiting nurse agencies of the State.

You are going to hear about it a little later, I believe, from one of the people who is going to talk with you, Mr. Congressman.

We call it AHHA [Association of Home Health Agencies]. It is the home health agency which is the State organization of all the visiting nurse agencies who work directly with them to bring health services into the homes.

Also, I want to speak about our meals program under title VII.

To my own astonishment, when I got the latest statistics for the month of May in preparation for this hearing. I found that we are now serving, in the State of Rhode Island, 27,782 meals a month under title VII of the Older Americans Act.

We are most appreciative, Mr. Congressman, for the increase. We are getting an additional 50 percent over what we had been getting for our meals in the State.

Mr. PEPPER. We finally got the appropriation up to the authorization of $150 million.

MRS. SLATER. That is right.

Mr. PEPPER. We are trying to push it forward just as fast as we can to make it available to all the people who need that service.

MRS. SLATER. Well, this is one of the programs, nutrition, which is really very helpful in keeping people in their homes.

It may be interesting to you also to know that men use the meals as individuals much more frequently than women.

We have found with some of the daily gatherings we have that women like to attend on the average of two, possibly three times, or two and a half times a week, whereas men enjoy the meals five times a week.

Mr. PEPPER. Doctor, there is one thing I mentioned awhile ago.

That bill provided for the nutrition aid of the elderly people of the country in the rendition of social services.

I want to know if you have been able to get a facility like that in Rhode Island.

What we had in mind was, the Government puts up 90 percent of the cost of this program, the local authorities, municipal or county, or both, maybe with the aid of private charity or contributions puts up the balance to obtain a home or facility which would be appropriate for these people to use as a meeting place.

It would belong to them.

Now, if you have it in a school building or somewhere, they go and eat the meal and they go home.

In addition to the meal, people should have a library with books, magazines, and newspapers.

Motion pictures and slides should be provided for them.

They should have recreational opportunities and lectures on social security and other subjects of interest.

It would be sort of an elderly people's club.

That is what we intend that program to provide when we can get it properly implemented.

MRS. SLATER. Well, Congressman Pepper, we are very proud in Rhode Island to say that we have numerous such centers in the State.

We have one over on the east side of Providence. The house itself is a French chateau and it was left by a person to one of the churches

there. The church authorities came to our staff and said, we can turn this over to you for a senior citizens center.

I like to use the words "older Americans," so an older Americans center.

They asked if we would come in and establish a program and we said, "yes." We went up and we worked with them for about 6 months. Certain physical changes had to be made, like a fire door, other bathroom facilities, and this type of thing.

It required an additional investment of $50,000 on the part of the people of the church.

This was done. It is now finishing its third year, Congressman Pepper, not quite. This fall it will have its third year of life.

It started off with about 200 members. The most recent number that I know was 2,300 members. Numerous amounts of them are people who frequented Brown, retired members, the faculty, who in turn, give much of their time as volunteers for all kinds of courses.

There is a course in astronomy, advanced German. There is a bookbinding class. Somebody there had a facility for bookbinding, fine leather bookbinding.

The women are doing macrame.

I could almost be silly with it. Some are even in their black leotards; they are doing the national dance.

There was a very fine carpenter shop and—I will use the name of the firm—Black and Decker came in and gave them a complete set of tools, heavy tools. The people are doing some marvelous things.

That place has been put on the Federal Register of Historic Places now.

We have the same type of facility in Newport and in my own town, which is a small town in North Kingstown.

We have a former summerhome owned by the town used by the Governors of the State of Rhode Island and the town turned it over to be used as a center. We started off with about 25 people, less than 2 years ago.

I went to their second anniversary and there are now over 825 people. You cannot get them all in the place anymore.

So, Congressman Pepper, those are just three examples.

Mr. PEPPER. Well, I certainly congratulate you. That is what we were hoping to see all over the country.

Do you have motion pictures there?

Mrs. SLATER. Yes.

We have there what the people themselves who frequent the place want.

We have found, Congressman Pepper, that the quality of the program of that type is in direct proportion to the leadership of the particular director that the people have.

The director has some innovative ideas.

Mr. PEPPER. What I had in mind, again, some of the large motion picture people could give you some equipment to let you use, some film, and you could go see the movie.

Mrs. SLATER. You just put a bee in my bonnet.

Mr. PEPPER. Very good.

I compliment you on the things you have told me about.

Mrs. SLATER. All right.

I just want to tell you another thing that we did under the house maintenance program.

We have a flu immunization clinic every fall. This will be the fourth year. Last year we had 72 clinics around the State.

I am sure there will be more.

But, we do ask for a contribution, which is nothing, really. It was the visiting nurses with many of the physicians in the State who set up these clinics and the older people usually put a dollar in a big glass.

Mr. PEPPER. You are talking about clinics that are set up?

Mrs. SLATER. Well, they are just like 1-day clinics or half-day clinics where the older people can come in.

It gets plenty of publicity.

Mr. PEPPER. They can go and get a checkup?

Mrs. SLATER. No. A flu immunization shot.

Mr. PEPPER. It is just once a year in the fall?

Mrs. Krause from Minneapolis told us this week in a hearing in Washington, that they have clinics in the city of Minneapolis, and they developed a clinic along with this program and, interestingly enough, the clinic is operated by the Abbott Hospital system.

They have 841 beds. They have some extra beds and they wanted to serve the elderly people.

Now, they provide the medical personnel in these clinics so that an elderly person can go to that clinic free of charge and get a general checkup or get medical care and the only pay that the clinic will get is whatever medicare will provide.

They do not charge the patient anything extra.

The hospital does the same thing for beds in the hopsital for the elderly.

They say that is all we will charge if you come in this hospital properly certified by a physician.

All you have to pay is what medicare pays.

You would not have to pay anything extra.

They justified that on the grounds that about 25 percent of their beds are vacant anyway and they might just as well get the 80 percent or whatever it is that medicare pays from the patients that are in there, and it is better to do that than to leave the rooms idle.

I wonder if you contacted any hospitals in Rhode Island, as I am going to do at home, to see if they could work out a similar program.

Mrs. SLATER. Well, I am not knowledgeable that such is happening in Rhode Island, Congressman Pepper.

However, I am on the board of directors of the Health Clinic Council.

I think you are going to hear from the Health Clinic Council a little later today.

I believe that one of the problems that we have here in our State is that we just do not have that many vacant hospital beds.

Mr. PEPPER. Well, that may be true.

Mrs. SLATER. But, I think someone more knowledgeable about this may be able to enlighten you a little more than I.

I touched on the nutrition program.

Incidentally, when I said the 27,700 and some odd meals, this means meals in a social setting, Congressman, and we have had a meals-on-wheels program.

We are now beginning the seventh year of the meals-on-wheels program.

Under title III of the Older Americans Act, the meals-on-wheels program statewide has been implemented or financed for 5 years. Five years were long enough because title III money, as you well know, was seed money.

Our own State legislature has appropriated each year sufficient funds, $50,000 last year and certainly the same amount this year, to keep the meals-on-wheels program going.

So, our own State did take up that and there was no diminishing of the service.

Mr. PEPPER. That is good.

Mrs. SLATER. We have a 34 vehicle demand-response system in the transportation program.

This has been under model project money from AOA in Washington. We hope to have this continue and I know that it will for another year.

We are working closely with our own State Department of Transportation and the National Department of Transportation to get money for that system from DOT.

However, we find in our information and referral service, Mr. Congressman, that transportation is the number one single problem that the elderly have.

Health services are next.

I call the transportation system that we have the glue that keeps together the success of the other programs that we have.

One-third of the people who enjoy the meals in the social setting can get there only because of the transportation that is provided for them.

Mr. Congressman, I know time is running short. I would just like to say something about home maintenance. Also I would like to give you a publication that we put out.

It is a brochure which lists all our title 3 and title 7 programs that are financed through the Division on Aging.

There are several copies there.

Mr. PEPPER. If you file it with the reporter, it will be made a part of the record.

Mrs. SLATER. Thank you.

[The brochure entitled "Programs for the Elderly" is retained in committee files.]

Mrs. SLATER. We do have a home maintenance program in a limited area in the State.

We implemented it last winter. It is particularly for winterizing homes. We have had several retired men who are carpenters, electricians, and this kind of thing, supervising younger people, particularly VISTA, who have actually gone out and have winterized and done work such as painting, building another set of steps where the steps were broken down on a house, et cetera.

We learn about all of these places that need to be repaired from the building inspector of this particular city. It is proving to be a tremendously successful program in keeping elderly people in their homes.

The problem is, Mr. Congressman, we could do so much more, but the problem is money. We know that you are supporting more funds.

We could not expand any of the programs we have because of the limitation of funds.

Mr. PEPPER. You need more money?

Mrs. SLATER. We would like to do a lot more and expand what we are doing, but we are now to the *n*th degree and the saturation fund, and we do feel we spend the money efficiently in the State of Rhode Island.

Mr. PEPPER. Mrs. Slater, do you agree that it would be psychologically and physically desirable from the viewpoint of the elderly person to stay in his or her own home when they properly can, if they could get comprehensive health services and other services there, rather than going into a nursing home, and, secondly, if you could keep people longer in their own home, would it save money as against the cost of that person being kept in a nursing home?

Mrs. SLATER. The answer to your first question, Mr. Congressman, is absolutely.

There is no doubt whatever that the people are happier in their own homes.

However humble the supportive care, they should remain in their own homes as long as possible.

Mr. PEPPER. I will never forget my dear mother used to say to me, "Son, do not ever let them put me in one of these nursing homes."

Well, fortunately, she never did have to go to one, but she had a fear.

I am sure no matter how excellent the nursing home was, she just did not want to leave her own environment, her friends, community.

That is what you are talking about.

Mrs. SLATER. Absolutely, Congressman.

The answer to the second question, as to how it would be economically, or how the costs will compare, I do not think all the facts are in yet and I think like Dr. Abdellah referred to in her testimony, the demonstration projects that are going on now to make cost comparisons is the only way you are going to find an accurate answer to that question.

Mr. PEPPER. Well, thank you very much, Mrs. Slater.

You have given an excellent statement.

Mr. Beard.

Mr. BEARD. I just want to say, too, that Mrs. Slater has brought out many things that are being accomplished in Rhode Island.

Transportation is one, of course, that is very, very close to me. As a matter of fact, I am sure there are people here today who provide the free transportation we have now in Rhode Island under certain conditions, certain hours.

I was very happy, Mr. Chairman, when I introduced this legislation in my last year in the general assembly, and it was finally introduced in the last session by two friends of mine from Pawtucket and Central Falls.

One last point was about the activity centers.

Through the efforts of the former mayor, Joseph Dalton, in Providence, there was granted $50,000 obtained for recreation facilities, that presently are in Providence. I think this was one of his last efforts.

So, in this area, they have certainly done a tremendous job.

Mr. PEPPER. Thank you, Mrs. Slater.

Mrs. SLATER. Thank you.

Mr. PEPPER. Our next two witnesses are from the Rhode Island Council of Senior Citizens.

The first is Mrs. Elizabeth Curley.

Mrs. Curley, we are pleased to have you here. Will you give your address, please?

I should have asked all the witnesses. We usually ask for the name and address.

Mrs. CURLEY. I am Elizabeth Curley.

My address is 98 Stedman Avenue, Pawtucket, R.I.

Mr. PEPPER. You are the former president of the Rhode Island Council of Senior Citizens?

Mrs. CURLEY. Right.

Mr. PEPPER. We are pleased to have you here and welcome your statement.

STATEMENT OF ELIZABETH CURLEY, FORMER PRESIDENT, RHODE ISLAND COUNCIL OF SENIOR CITIZENS

Mrs. CURLEY. My statement is going to be very brief.

I just serve in a minor role as one of the inspectors of the nursing home.

I am also a member of the Governor's Task Force on Monitoring Bi-Monthly Inspections of Nursing Homes.

I am also a senior aide on Dr. Mary Mulvey's education program.

I would like to relate to this panel some of my experiences while carrying out inspection of the homes.

Most of the owners are very cooperative, but their only concern seems to be that I should be sure to give them a good report.

Some of the violations were minor ones, while others were not.

For instance, I question their judgment in placing real elderly patients on the third floor of old wooden buildings and tied in their chairs while the younger ones who were on the first floor were able to walk around and sit on the porch.

When I suggested they would be much safer on the first floor in case of an emergency, especially fire, the nurse callously replied, "Oh, they are too much trouble, and we do not have enough help to keep them quiet."

In another home I was told, "You cannot come in. The owner is away."

I showed my credentials and insisted very gently, but firmly, that I was already in and I intended to stay. She replied, "Well, it is lunchtime anyway, and I am too busy to bother with you."

This was at 2 p.m.

I have received numerous telephone complaints which have been investigated. The most recent one, which I turned over to Congressman Beard's office, really bothered me.

Because of a nurse shortage, real old people, some in their nineties, are aroused from their sleep, taken from their beds, and tied in chairs, starting at 2:30 a.m., where they must remain until 6:30 for breakfast.

These poor souls are existing like this because there are only two night nurses for that entire nursing home.

I feel very strongly that if this one instance of cruelty is corrected, I would not have been working in vain.

Knowing Ed Beard as I do, I can guarantee that steps have already been taken to remedy that situation.

On the brighter side, there is no price high enough to compliment the personnel at the Sam Burano Hospital at Walton Lake. This is not a nursing home; it is a State hospital.

I have had experience there with my sister who has been bedridden for 2 years. I have seen the wonderful care, cleanliness of the ward, and personal attention given to the patient, which is really something.

My only problem there is the lack of transportation from Providence.

I have talked to husbands and wives who have not seen their mates in months. Only one bus a week would mean so much to the people traveling there.

There are many excellent nursing homes, but the prices are prohibitive. A year in one of them would deplete the finances of the average person.

When the elderly poor fall prey to terminal illnesses, and mental disorders, the only thing is a medical center.

I have seen firsthand the conditions under which they have existed and, again, thanks to Congressman Beard there have been many improvements made.

In closing, I was privileged to be a delegate from Rhode Island along with 23 other members of the Rhode Island Council of Senior Citizens, at our National Legislative Conference in Washington, on June 9 to 11.

We journeyed there to let Congress and the executive branch feel the strength of America's elders and to endorse the program for the 94th Congress.

We went all the way and on June 10 every member went to Capitol Hill and each member was handed a copy of this document.

We asked for and received a commitment from our leaders.

One of the aims included the cleaning up of the nursing home scandal. I can think of nothing more useful than exercising our rights as citizens to present our grievances to our Government.

This calls to mind the story of a minister who was traveling through a small southern town and he was very tired and dusty.

He pulled up to a fence. There was a little boy sitting there and he said to him, "Can you tell me how I can get back on the main road?"

The boy said, "No."

The minister said, "Do you know where St. Stephens Church is?"

The boy said, "No."

The minister said, "Do you know the name of the next town?"

The kid said, "No."

The minister said, "You really do not know very much, do you?"

The young boy said; "I do not know very much, but I am not lost."

I am also not lost. I intend to hang in there and stand up for our rights and if we can all pull together, we can make it.

Mr. PEPPER. Mrs. Curley, we are delighted to have you with us today and appreciate your statement.

Mrs. CURLEY. Thank you, Mr. Congressman.

Mr. PEPPER. Mr. Beard, any questions?

Mr. BEARD. No questions.

I would like to say, she is a very nice woman and also has worked very, very hard as long as I have known her, since I have been involved in public life, in the interests of the elderly.

We are right now approaching almost 20 million elderly.

There could be more bills passed by Congress than you can shake a stick at.

Mr. PEPPER. I thoroughly agree.

I like to go to the senior citizens' meetings, as we call them, and see them wear that button, senior power, and vote for the things in the best interest of the people of this country.

Thank you so much.

Mrs. CURLEY. Thank you, Congressman.

Mr. PEPPER. Dr. Mulvey.

You are Dr. Mulvey, cochairman of the Governor's Task Force to Monitor Bimonthly Inspections of Nursing Homes, and director of the Rhode Island Council of Senior Citizens, and board member of the National Council of Senior Citizens.

That is a very fine organization with which we work very closely in Washington.

We are glad to have you, Dr. Mulvey.

I notice you have a written statement here.

It is the practice of the committee to give the witness a choice of whether to read his or her statement in full or to put it in the record in full and summarize it orally.

What is your pleasure?

Dr. MULVEY. Well, Congressman, I would like to read it and if I go on too long, then you can cut me off.

Mr. PEPPER. All right.

We will be pleased to have you read it.

Go right ahead.

STATEMENT OF DR. MARY C. MULVEY, COCHAIRMAN, GOVERNOR'S TASK FORCE TO MONITOR BIMONTHLY INSPECTIONS OF NURSING HOMES; DIRECTOR, RHODE ISLAND COUNCIL OF SENIOR CITIZENS; AND BOARD MEMBER OF THE NATIONAL COUNCIL OF SENIOR CITIZENS

Dr. MULVEY. I would like to respond to a question of yours of Mrs. Slater, and I would like to react to Congressman Beard's statements on the Senior Citizens Center.

You know, Congressman Beard is young. I go back to 1953 when I was chairman of the Governor's Commission on Aging and to 1954, when it was Bonnie Reynolds.

The mayor, with funds from the Providence Recreation Department, no Federal help at all, set up a senior center such as you described, a beautiful place. They have carried it along.

Then, when the Older Americans Act came along, as Congressman Beard mentioned, they did get some financial help under the Older Americans Act. I do not think anybody here today has mentioned that the author of the Older Americans Act is the late Congressman John E. Fogarty.

Mr. PEPPER. That is right.

Dr. MULVEY. Well, I am happy to give testimony today.

As you said, I serve as cochairman, with Congressman Beard as chairman, of the Rhode Island Task Force To Monitor Bimonthly—unannounced—Inspections of Nursing Homes.

This task force was appointed in August 1973, by Governor Noel upon the insistence and crusading of Congressman Beard to implement Congressman Beard's legislation for a bimonthly unannounced inspection of nursing homes when he was a freshman State legislator.

Despite our task force efforts, and despite newspaper and other media exposés, and despite numerous Federal and State programs to improve care, the quality of care in numerous nursing homes continues to be a disgrace in Rhode Island as in the Nation. There are various reasons for the persistence of poor care.

First, the legislative and regulatory framework is complex. Different aspects of long-term care are regulated by different agencies within HEW—medicare, medicaid, SSI, PSRO's, Community Health Planning, and others. These various agencies within HEW are complex within themselves and have overlapping jurisdictions, a situation which results in dealing piecemeal with the many aspects of long-term care. This complexity makes it difficult for concerned groups to have intelligent input into the decisions made in HEW and in Congress, because it takes considerable background and training to be able to understand the interrelatedness of laws, regulations, and ramifications of any specific action. Consumer groups are needed to bring about the changes, but do not have the manpower to develop the expertise in knowledgeable advocacy to improve nursing home care. How can consumers effect needed reforms when responsibility is so fragmented within government that few government officials themselves understand the entire program and its overall objectives?

The National Council of Senior Citizens is the only national advocacy group which has taken an overall interest in nursing home laws and regulations from the perspective of the patient—through its Nursing Home Ombudsman Program.

Another reason for deficiencies in nursing home care is the inordinate influence of associations of nursing home owners and the nursing home industry itself over nursing home laws and regulations.

These associations have become powerful since the enactment of medicare and medicaid, since they are supported indirectly by medicare and medicaid funds in the form of dues from member nursing homes. The nursing home industry has taken advantage of the complexity of the regulatory framework to make itself virtually the only knowledgeable nongovernmental party to the regulatory process. These groups are completely familiar with the legislation and regulatory framework for nursing homes, and are virtually the only groups that seek actively and constantly to influence legislation and regulations, with most of their efforts going toward increasing medicaid reimbursement rates and minimizing and/or thwarting effective enforcement of regulations.

The recent exposes of nursing homes have made it increasingly clear that good regulations, although important, do not assure good care, unless accompanied by a strict enforcement system. HEW has statutory authority to inspect nursing homes and to cut off Federal financial participation from noncomplying homes. It has scarcely used this authority in the past—and needs to be prodded into doing so.

The growth of the nursing home industry has been phenomenal. Between 1960 and 1970, nursing home facilities increased by 140 percent, beds by 232 percent, et cetera. From 1960 through 1974 expenditures increased almost 1,400 percent.

Medicaid now pays about 50 percent of the Nation's more than $7.5 billion nursing home bill, and medicare pays another 3 percent which is more than $1 out of every $2.

Yet, nursing homes are quasipublic institutions, and differ from most other institutions which derive most of their income from Government sources, in that they are privately owned and operated, are insulated from public accountability, and are accountable only to their owners, boards of directors, or to their private sponsoring organizations.

It is essential for HEW to learn the facts about nursing home finances. Public Law 92–603 requires the medicaid program to have a cost-related reimbursement system by July 1, 1976, so the question for the new reimbursement system will occupy considerable time during the next year. The new reimbursement system will offer HEW an opportunity to truly regulate the nursing home industry for the first time—if HEW develops a system that requires accurate cost-reporting and permits Government to determine what are essential costs. However, the nursing home industry is pressuring HEW to adopt a loose cost-control system, and informed pressure from the consumer side will be needed if the new reimbursement system is to incorporate adequate controls, and work to promote good care. HEW should reconsider whether it should continue to reimburse for expenses such as advertising, public relations, dues to trade associations, and legal fees.

In no area is enforcement of standards more important than in nursing home care since the victims of the Federal policy failures are those who are desperately in need of help. The average age of nursing home patients is 82.

Despite the Federal commitment to long-term care, HEW has been reluctant to assure forthright standards to provide patients with minimum protection; and their standards are so vague as to defy enforcement.

On our State level, it is disheartening to report that the Rhode Island State Legislature, in its 1975 session, failed to pass H. 5828, a Bill of Rights for Patients in Nursing or Personal Care Homes, which would require observance of established legal precedents, and considerate, respectful care for each patient.

Our Rhode Island task force to monitor nursing home inspections made a vigorous effort to get this bill passed.

Our group are concerned in our visitations not only with substandard facilities but primarily with the personal care given to the patient. Our task force has accumulated a litany of abuses, including negligence, unsanitary conditions, poor food or poor preparation, hazards to life or limb, reprisals against those who complain, et cetera.

A third cause for the problems is the split in authority between the Federal Government and State governments. Under the medicaid program—which now accounts for the bulk of the money spent for nursing home care—HEW sets minimum standards which States must apply to nursing homes as a condition to receiving matching Federal medicaid funds.

But HEW does not regularly inspect nursing homes to see if standards are met; instead, it has delegated to the States direct responsibility for enforcing Federal standards, and has not exercised its oversight authority in enforcing the standards. The States' failure to enforce standards is in part due to the power of the nursing home industry, which is even greater on the State level than on the Federal level.

HEW must become actively involved in the area of nursing home finances and the structure of the nursing home industry, because many corporate nursing home chains own facilities in many States; thus Federal authority is needed to monitor their interstate activities. For example, one large corporation is ARA, the largest vending machine company in the country, which in the last 2 years has purchased several nursing home chains and now owns about 200 nursing homes. Other nursing home chains are owned by companies with real estate and hotel/motel interests.

In Rhode Island, recent exposes of the investigation of one nursing home group revealed that the group has defrauded medicare by making payments to related corporations and then reporting those costs to medicare for reimbursement. Such costs are not legally reimbursable, under medicare, if the profits go to a related corporation.

In spite of Congressman Beard's State legislation which requires bimonthly unannounced inspection of nursing homes and which precipitated the establishment of our task force, Rhode Island nursing home inspections, like on the national scene, are a farce. It took 2 years for the health department to order removal of all medicaid patients from 13 nursing homes having violations of the Federal Life Safety Code, and to cite 40 more for not meeting Federal codes of fire, safety, and staffing requirements; but, most flagrant of all, Federal officials have recently disclosed that patients' personal need funds have been pocketed by at least two nursing home operators in fiscal 1974, with no safeguards by the responsible State agency (SRS) to prevent others from doing the same.

Now the U.S. Attorney's Office has launched an investigation of the Rhode Island nursing home industry to determine whether nursing home owners have defrauded the medicaid and medicare programs by applying for and receiving overpayments, and have also stolen patients' personal money.

I would respectfully request the investigators to examine the purchase and use of drugs in nursing homes, with specific reference to the possible misuse, high costs, and kickbacks. My concern in this respect has been generated by the disclosures of the U.S. Senate Special Committee on Aging, which is your counterpart in the Senate.

Here are excerpts from the report: [1]

> The average nursing home patient takes from four to seven different drugs a day * * *; almost 40 percent of the drugs are central nervous system drugs, painkillers, sedatives, or tranquilizers * * *; drug distribution systems used by most nursing homes are inefficient and ineffective * * *; 20 to 40 percent of nursing home drugs are administered in error; other serious consequences include theft * * *.

Widespread kickbacks prevail. Pharmacists are forced to pay a certain percentage of the price of nursing home prescription drugs back to the nursing home operator for the privilege of providing those serv-

[1] Nursing Home Care in the United States: Failure in Public Policy. Supporting Paper No. 2.

ices. The atmosphere for abuse is particularly inviting when reimbursement systems under Federal and State programs allow the nursing home to act as the middle man between the pharmacy and the source of payment of the patient.

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

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

There is a law on the books, if implemented, that would deal with this abuse.

It is section 242 enacted by Congress in 1972.

This section makes offering or accepting a kickback a crime punishable by $10,000 fine, a year in jail, or both.

The law has not yet been implemented or enforced.

We, in Rhode Island, are entitled to know whether or not the foregoing abuses in the use, misuse, and kickbacks of drugs prevail, to what extent and where.

Another block to providing high quality care is lack of adequate government funding.

States are responsible for setting medicaid reimbursement rates, with most States having low rates, due in part to the fact that high quality long-term care is necessarily expensive. Inadequate Federal funding may be due to the fact that, at the moment, Government does not seem to include this among its highest national priorities and also that HEW, OMB, and the Congress are too aware that money is not the only answer, since conditions in nursing homes are terrible even in States with high reimbursement rates.

If there were some assurance that quality care could be provided, it would be easier to persuade Government to devote more money to this crucial area. Nursing homes continually plead poverty in arguing for higher reimbursement; yet these same corporations continue to build new nursing homes and there continue to be reports of high profits in the nursing home field. Large, multi-State corporations are not amenable to State control, and yet HEW has not become involved. In fact, to the best of our knowledge, none of the regulatory agencies within HEW has any systematized information about the financial structure of the nursing home industry. Having this information is essential in order to devise a reimbursement system that pays enough money to provide good care and that contains internal controls to assure that the money is used for patient care and not investors' profits.

Most people can be better rehabilitated in their own homes with proper care. This can be made possible if family members could be reimbursed for providing care as an institution is, and for far less money.

Our acquainted subjects have shown that by paying the family members for caring for their family and with the care that is brought

into the home, that it can be done at three-fourths of the cost of institutional care, to my knowledge.

As a result of nursing home scandals and of studies showing that many patients are in inappropriate facilities and other patients do not need institutionalization, there is a growing realization that thousands of elderly can be better cared for in their own homes at far less money if viable home health care and supportive services existed.

However, HEW has given only token support for such programs. For example, in 1973, medicare paid only $75 million for home health services or less than 1 percent of medicare's $12.1 billion expenditures in that year. Moreover, while all States are required to provide home health services under medicaid, 1972 outlays came to only $24 million out of medicaid's $5 billion total. To cite our local situation, a cut of 25 percent in home health care services for many elderly and disabled persons has been announced, although these services are essential for those who would otherwise be forced into nursing homes or other custodial facilities.

A good noninstitutional program must offer sufficient services and be sufficiently flexible to meet the very different needs of different clients, including those with similar medical diagnoses. For example, one client may be sufficiently competent to administer medication himself, while another, who takes the same medication, may require a nurse to administer it.

Similarly, a client who lives alone may need help in marketing, while another client with the same illness may live with a spouse who can do the marketing.

The problem in this area is to determine the range of services that must be offered, and to devise ways of screening patients to assure that they receive all needed services but do not abuse the program.

Another issue is to determine what role—if any—profitmaking agencies should play. The original medicare law limited reimbursable home health care to nonprofit agencies, but pressure has been mounting lately to remove this restriction. Proprietary nursing homes are particularly interested in receiving funding for senior citizen day-care centers.

Major policy decisions must be made now concerning funding and monitoring devices in view of their poor record in the provision of nursing home care.

A logical approach to solving the current problem of providing proper care for nursing home patients is to create a consumer force that will help the Federal Government to focus on the needs of the long-term care population and to develop programs that will meet those needs. There is little indication that the system as it is currently working will focus on this broad area. Only a consumer group that knows the needs of the eligible population will be in a position to influence Federal authorities on how to meet the long-term care needs of the elderly, for example, an effective ombudsman program.

We hope that the $20,000 in ombudsman money coming to each State Agency on Aging will be used to develop a productive consumer advocate program and will be free from the charge of "conflict of interest" if one State agency places a watchdog over another State agency.

The nursing home ombudsman program of the National Council of Senior Citizens takes the consumer advocacy approach. It was launched in Michigan under an HEW grant 3 years ago, and it has recruited a group of elderly volunteers who visit assigned nursing homes to talk to patients, et cetera.

The nursing home ombudsman program of the National Council of Senior Citizens has focused particularly upon improvement of Federal regulations for nursing homes. The program was largely responsible for coordinating the effort that resulted in HEW's changing its regulations to require skilled nursing homes to have a registered nurse on duty 7 days a week, instead of only 5.

The program was also instrumental in bringing to HEW's attention loopholes in the nursing home reimbursement regulations that enable nursing home administrators—under the guise of obtaining "training"—to receive reimbursement from medicaid or medicare for conventions and other travel. No change has yet been made in the regulations, but officials are now working on a revision.

The national council's ombudsman program will carry forward, with continued funding, some of its past efforts on regulatory change, and other people have asked for funding here today, so I am going to respectfully request that you do your part to see that the national council gets re-funded for this very valuable national program.

It was the first in the country.

You are probably acquainted with Marilyn Schiff. I know Congressman Beard is. She is the director.

It will focus more in the past on systematic reform, enforcement by HEW, and revision of reimbursement procedures.

During its operation, the nursing home ombudsman program has developed expertise in all areas of nursing home regulation and has become acquainted with the personnel and agencies within HEW that work on long-term care.

The national council itself is an outstanding consumer advocacy group; and its ombudsman program has developed working relationships within HEW and the Congress and has brought to their attention problems in nursing home programs which they would not otherwise have known and has suggested solutions for them.

The program also has worked with other national groups involved in long-term care. It has served as the rallying point for other consumer groups to work on long-term care issues.

As stated in the beginning of my testimony, the relative lack of involvement by consumer groups on long-term care issues is not the result of disinterest, but rather the result of the complexity of the regulatory program and makes it exceedingly difficult to formulate constructive suggestions.

The nursing home scandals have prompted considerable interest in nursing home reform from legislators; but they have also been stymied by the complexity of current programs, and have found it difficult to devise laws that will be more than palliatives. Many legislators have turned for advice to the National Council of Senior Citizens because of their experience and findings through their ombudsman program.

The unfocused search for "solutions" and the difficulty in finding them is perhaps best illustrated by the fact that more than 43 nursing home reform bills have been introduced into the current Congress,

dealing with matters ranging from training of nursing home staff to providing low-interest loans for nursing home renovations.

Passage of some of the bills might help improve the quality of nursing home care, but most of them fail to deal with the core issue of how to assure that a nursing home receiving adequate reimbursement—which is the case in many States—will provide good care and humane treatment for patients.

Thank you.

Mr. PEPPER. Dr. Mulvey, that is an excellent statement, and an excellent criticism, and I use it in the sense of an analogy of the whole nursing situation.

It is a very excellent statement, and I commend you for what your task force has been doing.

I wish we had more of the effective ones like that all over the country.

It is difficult to get at it, the proliferation of the various agencies to which you refer. With the bigness of the problem and the numerous people that are involved, it is very difficult.

I think we have to find a way to coordinate and consolidate these elderly care services and programs and have human consideration as to whether there should be a Cabinet office set up, a department of the aged, that would have the responsibility of coordinating all of the aging programs or, at least, an agency set up, an agency for the aged, or something.

It would have all the administration of all these elderly programs under it, so there could be better coordination.

So, you are certainly on the right track in making that suggestion and this committee will do what we can with this huge job to implement the recommendations that you make.

Mr. Beard, do you have any questions?

Mr. BEARD. No.

I have no questions, Mr. Chairman, outside of the fact that I have recognized ever since I have become involved in government, the tremendous dedication that Dr. Mulvey has shown for the State of Rhode Island, as well as around the country.

I mentioned earlier to you that Dr. Mulvey was instrumental in the very early days of the National Council of Senior Citizens, in working with the late John Fogarty and many other members around this country for the passage of medicare.

I can only say that she has done a good job here in Rhode Island. She is working hard doing her best on this task force that was established by the Government.

Unfortunately, in my case, being a Member of Congress, being away 5 days a week, it has been very difficult for me to be very actively involved in it, but the work is going on and I am very concerned, as she mentioned, about the 20,000 coming into the State of Rhode Island.

This should be a separate ombudsman type program, whether it is the task force that was established as a monitoring agency, or a separate agency. It should be separate to be very effective.

I do not feel that one State agency, as has been mentioned, can overlook the other agency and be a very effective ombudsman program.

So, I congratulate Dr. Mulvey for her long years of service.

I apologize that I was not aware of the fact that the former Mayor Reynolds of Providence was initially responsible for this.

Again, your testimony is certainly welcome.

I welcome it and I know the chairman is definitely impressed with your statements.

Dr. MULVEY. I didn't mean to be critical.

Mr. PEPPER. Some of us have worked on this program a long time.

In 1938 Senator Wagner of New York introduced the first thing that might be considered national health insurance, because it used the social security concept or approach.

I was chairman of a Senate subcommittee from 1943 to 1946, called the Wartime Health and Education Subcommittee of the Senate Committee on Education and Labor. We analyzed the medical needs of the people of this country, the facilities that were available to serve them, the medical personnel that was available to serve them, the cost of such services, and the ability of the people to pay those costs.

Then we examined the private insurance programs that were in effect and we found that they were inadequate and that people were not able to pay according to the present system for the medical services they needed.

We concluded in 1945 or 1946, that there should be a national health insurance program, comprehensive in character, for the people of this country.

Finally, we got medicare in 1965, I believe it was, and we still have to perfect that. We still have to keep on working to get the Congress to pass a national health insurance program which will be comprehensive for all these various programs that we have been talking about.

So, what we have to have is dedicated people like you and our citizens to keep pressing upon our representatives this need.

Fortunately, you do not need to press yours and my people do not need to press me very hard because we are already trying to move as fast as we can in that direction.

But, there is a lot to be done, so keep up your good work.

Dr. MULVEY. Congressman, we have a very active committee in Rhode Island, the Rhode Island Committee for National Health Security, and I am lucky enough to be the chairman of that.

We had a tremendous meeting in this hall on April 5.

We packed it right in a blizzard and we had all of our congressional delegation there supporting the Kennedy bill.

That is what we were supporting.

I do not mean to be critical of Congressman Beard, but how old were you in 1954?

Mr. BEARD. Not too old; fourteen.

Dr. MULVEY. I do have some documents to submit later to your committee for your files.

I have a blow-by-blow description of our advocacy activities to get Congressman Beard's bimonthly inspection of nursing homes passed and also the struggle afterwards to get it implemented up to the appointment of a task force and then our expanding into the field of the State institutions.

Mr. PEPPER. Thank you very much, Dr. Mulvey.

We appreciate very much your excellent statement.

The next witness is Mrs. Beverlie Woulfe, director of the Scandinavian Home, and president of the Rhode Island Association of Facilities for the Aged.

Mrs. Woulfe, we are very glad to have you.

Please go ahead with your statement.

STATEMENT OF BEVERLIE WOULFE, DIRECTOR, SCANDINAVIAN HOME, AND PRESIDENT FOR THE RHODE ISLAND ASSOCIATION OF FACILITIES FOR THE AGED

Mrs. WOULFE. I know time is going on.

On behalf of our own home and homes of Rhode Island, I think it is so easy to condemn us all and we are really trying very hard to do a good job.

The Rhode Island Association for Facilities for the Aged is an association of 16 voluntary, nonprofit agencies that provide health and welfare services primarily to the aged. The facilities represent a total of about 1,297 nursing home beds of which about 677 are presently occupied by medicaid patients.

As voluntary, nonprofit institutions, we have moved far beyond mere token compliance by providing the highest possible quality of care.

As various State Department of Health and Federal inspections and surveys indicate, we have already demonstrated a moral and ethical commitment, not only to comply in full measure with expanding Federal and State regulations, but to assume a leadership role in the care of the elderly.

The association would support any and all procedures at either State or Federal levels that would bring a uniformity of standards.

Our concern is with care of people and we do have rigid inspections bimonthly, as many as three and four times in a week's time.

As far as our auditing, it is an audit system where we fill in all the documents that they need.

I think it is truly a good system as far as our State is concerned and we are for anything that would make a better unit.

Mr. PEPPER. Mrs. Woulfe, how are the nursing homes of Rhode Island divided between nonprofit and profit?

Mrs. WOULFE. Proprietary and nonprofit.

There are only 20 in the State of Rhode Island. A lot of them are church affiliated as well as civic groups.

But, we are very concerned with the care of our people and we love our people very much. Of course, we have tried to do all we can to give the best possible care and when we hear people condemning the homes, it kind of hurts because we are really trying hard to make our elderly people happy and secure.

Mr. PEPPER. Do you get enough money from the State and Federal authorities to provide good care?

Mrs. WOULFE. It costs a lot of money and there is no way of getting around it because in order to comply with all the regulations, you have to pay your nursing staff a decent salary, just like your hospitals would have to pay them, and to keep them staffed 24 hours a day around the clock, it is costing a lot of money. Naturally, I am sure the State could not afford this year to reimburse us, to give us any increases and, of

course, this does hurt because we all rely on these funds to help pay for our expenses, too, even though we are not making any profit on it at all.

Thank you.

Mr. PEPPER. Thank you very much.

Mr. Beard, do you have any questions?

Mr. BEARD. Yes.

I think I mentioned, Mrs. Woulfe, consistently throughout my statements today, I do recognize that there are an awful lot of good homes not only here but all over the country that are doing a very dedicated job.

It is unfortunate that there are homes here and there throughout the country that have taken advantage.

It is the same way then with the bureaucrats in the Government.

Some people work 17 hours and work hard and some work 3 hours and take advantage of the Government's money.

It is unfortunate, but we have to dig in, we have to work, we have to eliminate fraud where it exists; whether it is in the nursing homes, or whatever level.

That is the responsibility we have and we will certainly carry it out.

Thank you.

Mr. PEPPER. Thank you very much.

The next witness is Mr. Edmond A. Perregaux, executive director, Homemaker and Home Health Aide Services of Rhode Island.

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

You may proceed with your statement.

Will you give your address?

STATEMENT OF EDMOND A. PERREGAUX, JR., EXECUTIVE DIRECTOR, HOMEMAKER-HOME HEALTH AIDE SERVICES OF RHODE ISLAND

Mr. PERREGAUX. Thank you very much, Congressman.

My name is Edmond A. Perregaux, Jr.

I am executive director of Homemaker-Home Health Aide Services of Rhode Island, 265 Melrose Street, here in Providence.

Mr. PEPPER. Very good.

Mr. PERREGAUX. In the interest of time, I would like to make a couple of comments before going into my formal text on some of the things that have come out this afternoon.

Number one, if you are going to have a series of such meetings, I would request that you separate them. You are dealing with two completely diverse items in your agenda; one in terms of auditing of nursing homes, and the other in terms of home care.

It makes an awfully long day for you and for us.

I realize it is very difficult for you and your time, but if you could schedule separate meetings, I think it would be easier for you and for the witnesses.

Second, I think there is a real problem that we have, whether we are talking about home care, nursing home care, or any other type of health or welfare service. When we talk about the service and the standards that are involved with it and when we start talking about costs—even with two professionals working in the field, we cannot agree on the terminology.

It is as if you have a Frenchman speaking to an Italian and neither understands the other's language.

So, when we have these questions about the standard of care that is required, whether we are talking about a nursing home or home health care, skilled nursing, paraprofessional care, and then we start talking about the costs of these and what kind of training is required, it is very difficult. I know it makes your job doubly hard here.

Homemaker-Home Health Aide Services of Rhode Island is a nonprofit agency incorporated in 1966 to provide a statewide service to the citizens of the State of Rhode Island. It was established to set up and maintain a statewide set of standards to recruit and train the staff for this purpose and to provide service in areas where it was not provided and also to provide the trained staff to other people.

We provide in-home paraprofessional services to residents throughout the State of Rhode Island, except on Aqidneck Island and the city of Woonsocket, to individuals who are homebound because of illness, accident, age, or where a social problem has created a period of stress. We provide service from 1 to 5 days a week, 2 to 8 hours per day.

We are 1 out of 80 agencies who have finally been certified to meet the national standards of the National Council of Homemaker-Home Health Aide Services.

In order to do this certification it costs money because there are minimum standards in terms of training and in terms of the cost of supervision.

We provide service to three major groups of clients here in Rhode Island: Public assistance and eligible SSI clients; medicare patients; and private clients.

We receive an allocation each year from the United Way to make up the difference from what these clients pay us and what it costs us.

The difference in each of these services is based on the method of reimbursement and the method of supervision of the homemaker-home health aide in the individual case.

Each of the individual groups of clients create problems for us, the referring agency or individual, and the individual.

I will discuss each of these separately and try to summarize the basic problem created by the present legislation and/or method of providing service and constraints.

Mr. PEPPER. Did you say you provide nursing care also?

Mr. PERRAGAUX. No. I said we do not. Just homemaker and home health service.

Our largest group of patients are those who are referred to us under our contract with the department of social and rehabilitative services. At the present time, we are providing roughly 2,000 hours of service per week to over 300 clients of whom more than 80 percent are over 65 years of age. The average client is receiving 2 to 3 hours of service 2 to 3 days a week, a bare minimum of maintenance to enable them to stay in their own homes or apartments.

Until last year, the agency negotiated each year a contract rate based on the cost of service to the agency. The last negotiated rate was in 1972 and was at the rate of $4.50 per hour.

In 1974, we began negotiating on a new rate and had worked out with the State rate setters, a new rate of $4.72 an hour, a 5 percent increase over 2½ years. We received notification in January, that because of the freeze on Federal and State dollars available, that the

State was not going to be able to recognize the new negotiated rate and would have to freeze our rate at the previously agreed upon rate of $4.50 an hour.

The board of directors felt that there were two alternatives; either we would have to reduce the quality of service by reducing the training of the staff and the supervision of the aides in the home, or by attempting to secure alternate forms of funding to make up the difference between the cost of service of $5 an hour at that point and the agreed upon rate of $4.50 an hour.

Initially, it had been hoped that under the new title XX, as it was initially reported in the news media, there would be opportunities for solving the problem of the contract rate. However, when the Federal Register information was published, the legislation, as it was passed, froze Rhode Island's available dollars because we were already matching all of the available Federal dollars with State dollars as Mr. Affleck and the Governor told you earlier. The net effect of this will be that over the next 2 years, fewer people in Rhode Island will be receiving services because of inflation with the same number of dollars being available.

In other words, we would have to reduce the training of our staff. We will have to reduce the number of supervisors. The same thing will happen with day care and the other programs because there are no dollars available to increase the service.

The second group of patients being served by our agency is that in which we subcontract with six of the nine district nursing associations in Rhode Island to provide home-health aide service under a subcontract. These cases are referred to us by the district nurse, are supervised by her, and we supply a trained individual and do the scheduling of the individual staff member. We provide approximately 1,500 hours of service to approximately 250 patients per week under this program.

The problem in this program is that the nurses are only able to authorize service under medicare reimbursement when a patient needs skilled nursing care in addition to the home-health aide service; and, can only authorize a very limited number of hours which specifically and only can be used to provide personal care, that is, a bed bath, shampoo, cleaning of the immediate environment—in other words, the bedroom or bathroom of the individual patient. Most of the nurses will refer a patient to us under medicare reimbursement and indicate on the referral that we should also take these patients on as private clients to provide additional service of a homemaker in order that those patients can remain in their own homes with their own facilities.

Because of our experience in this area, our certification as a nationally accredited Homemaker-Home Health Aide Service and the quality of our service, we are the agency that has been referred to by several previous speakers as one of six demonstration projects funded under section 222 of the Older Americans Act to demonstrate the need for expanded service under the medicare program. We will have 50 patients in a control group who will receive the present service and 50 patients who will be eligible for an expanded medicare coverage, which will include this homemaker service in addition to home-health aide service. Then what this will mean is, that the patient can receive medicare reimbursement under this demonstration, even though they may

not require skilled nursing care at home; and they may receive additional hours of service other than that required to provide individual personal care. This would mean that the home-health aide could go shopping, could do light housekeeping in other areas of the house, and similar services in order for that patient to be at home and to maintain his own home or apartment.

Our third group of patients are those that we call private patients. These individuals make up approximately 15 percent of our patient load. We receive an annual allocation from the United Way to provide service to individuals who cannot afford to pay for service or to pay the difference between what an individual can pay and what it costs us to provide the service.

We ask the private clients to pay for as much of the service as they can afford.

We have been able to expand this by hiring employees under various inservice or on-the-job training programs, such as WIN, and CETA, Comprehensive Employment Training Act.

The agency has never been able to provide all of the service requested by private individuals who could not afford to pay for the cost of service.

We have tried to provide for the most needy individuals, but this is becoming more and more difficult to do in the present economy.

I might also add that many of these people would qualify under the new regulations of title 20.

In fact, all of our private clients would be able to qualify under the median income, so we would not have any problem if this were possible.

The following three case histories typify the type of patient or family unit in which we are able to provide help and the specific type of services that we provide to these individuals.

Case 1 was referred in 1971. Serviced under Kent County Visiting Nurse Association, one of our local associations, under medicare, for almost a year when medicare payments ran out.

The husband was 70 years of age and the wife 78 years of age, living alone in private home. Mrs. R has severe emphysema and arthritis, is bedridden, and on constant oxygen. Mr. R also has emphysema. Mr. and Mrs. R's children are married. All live out of State except one who has a large family and is unable to give much time to her parents.

The homemaker-home health aide goes in twice a week to give Mrs. R. a bath and change bedding. She also does household chores and laundry. The family uses meals-on-wheels. While the homemaker-home health aide is in the home, Mr. R. is relieved of 24-hour-a-day care and is able to leave the home for a brief period of time while the homemaker is there.

When medicare payments ran out, homemaker service was still needed, but the family was unable to pay the full fee. A supervisor from our agency made a home visit, discussed the situation with Mr. and Mrs. R. and they agreed to a fee of $2 per hour. The agency continued to provide service.

During the time the homemaker was in the home, the family moved from their private home into the housing for the elderly. The homemaker assisted with the move—she even rode in the ambulance with Mrs. R. from her home to the new apartment.

If the homemaker was not going into the home, Mrs. R. would have had to be placed in a nursing home as Mr. R. is physically unable to care for his wife and home without assistance.

The second case was referred by daughter. We received a telephone call from Dr. Charles Canaan requesting homemaker service for his patient.

Mrs. E. is 68 years old and lives with her daughter who is a widow with no children. Mrs. E. weighs 300 pounds, has congestive heart failure, is hyperthyroid, and has cancer of the uterus with metastasis. The daughter works and needs help primarily with personal care. She also needs an opportunity to leave her home to pick up and deliver merchandise for her business which she conducts from an adjoining garage.

The homemaker-home health aide goes in three times a week to give Mrs. E. a bath, change linens, and clean the room.

The family is able to pay $1 an hour for the service.

If the homemaker was not going into the home, nursing home placement would be needed. The daughter has repeatedly refused nursing home placements, preferring to care for her mother in her own home.

Other family members assist with meal preparation and household chores but are unable to do the personal care due to Mrs. E.'s size and severity of illness.

The third case was referred by a social worker at Miriam Hospital.

Miss K. is 66 years of age and has had heart surgery for the second time, a valve replacement. She is weak and unable to do any physical work. Miss K. has arteriosclerosis and has severe hearing disability. Miss K. is very limited with physical activity because of severe discomfort in her legs. She and her 89-year-old mother live in a three-room apartment in the Hartford Project, one of our local housing projects.

They collect social security benefits as their only source of income. There is one other sister who gives little support because of illness in her husband's family.

The homemaker-home health aide goes in once a week for 3 hours. She assists with personal care, does household chores and laundry. The homemaker-home health aide gives a great deal of moral support which is badly needed by the daughter who feels so frustrated because of physical limitation.

The client is unable to pay anything for the service. She tried paying the $1 an hour but could not continue for an extended period of time. She is extremely proud and wanted to cancel the service when she was unable to pay.

If the homemaker was not going in, the family would exist in a dirty apartment with inadequate meals, linens and clothes would not be laundered, and mother and daughter would not be bathed properly.

To this point I have briefly tried to explain the services by our agency, the type of individuals that we serve, and the problems that we have in trying to provide service to the many needy individuals who are residents of the State of Rhode Island. In 1971, we had a staff of 20 homemakers; today we have a staff of over 170 and we still cannot meet the increasing demand as people become more and more aware of the advantages of this type of service to the individual, the family, and the community from both a social and economic standpoint.

Legislative constraints and State policy have restricted the availability of third-party reimbursement for many Rhode Island residents who would otherwise be eligible for service. I will briefly summarize each of these, and then, in my closing remarks, make recommendations which I feel are vital not only to our Rhode Island residents but to the entire service throughout the United States.

Gentlemen, this is a truly grave situation.

It has long been recognized by many authorities that psychologically and sociologically it is far better for an elderly individual to be maintained in his own home environment for as long as possible. There have been some studies which have also proved that under proper constraints in terms of authorization of service, that it is also economically less costly.

Since the advert of medicare, health providers, health educators, and health administrators have recognized that the law as it is presently written is far too constrictive and that basically it is designed to maintain the present medical model in the community, that is, the most expensive hospital-based program. All third party insurers state that it will cost more money to provide home care than it presently costs——

Mr. PEPPER. Excuse me. Would you wait a moment, please?

We will take a 5-minute recess.

[Short recess taken.]

Mr. PEPPER. The committee will come to order, please.

You may proceed, Mr. Perregaux.

Mr. PERREGAUX. The third party insurers state that it will cost more money to provide home care than it presently costs, because they are only covering the cost of the physician and the hospital expenses under their program.

This does not take into account the many dollars that are expended by the individual, the individual's family, or public assistance for other medical costs. For the first time, an attempt is being made under the medicare demonstration program I referred to previously, to attempt to show exactly how much it is costing each individual patient and how much potentially could be saved.

Each patient enrolled in the project will be keeping an individual log of his expenses including travel to and from the physician, the hospital, and the drugstore as well as many prescription costs, optometric costs, or other medical expenses. We will also be estimating how many hours a patient normally would be in the hospital and how many hospital days were saved by discharging patients from the hospital into their homeservice type of program. Unfortunately, however, it will take us at least 18 months to collect the raw data and based on my previous experience with such Federal studies, it would be another year at least before this could be available for any change in legislation, which will mean that we would have to wait, if we are going to use these statistics in order to change the legislation for at least 3 years. We cannot wait that long for these statistics and I hope the Congress will act before that.

As I mentioned previously, title XX was seen as the answer to many of the problems for people who are under public assistance or the SSI program. Unfortunately, because of the constraints enacted by Congress, for at least 15 of the States, this is going to cause a hardship and will not provide any answers that are desperately needed.

Let me explain, using Rhode Island as an example. Under the present legislation, each State is assigned a Federal dollar quota based on the population of the State. It does not take into consideration the average age, the number of individuals over 65 or the number of individuals presently on welfare. Rhode Island is number 12 of 50 States in population over 65 with 11 percent of the population in this age group. Congressman Pepper's State of Florida leads the country.

Rhode Island is number 6 of the 50 States in median age and population with a median age of 29.6 years. These figures are based on the 1970 census, and I'm sure that within the last 5 years that we are higher than that, although I was not able in the short time I had to prepare this presentation, to document it for you.

What this means is that we have many more people who are eligible and in need of our program, but on a prorated basis, Rhode Island is not able to receive its share of the dollars available.

Second, when the law was enacted, in addition to these ceilings that were established per State, the Congress specifically stated under Pub. Law 93-647, title XX, that no reallocation of unspent dollars would be allowed for unused funds except to Puerto Rico, Guam, and the Virgin Islands. Since only 15 States out of the 50 have come up with the matching funds, there are moneys that are unallocated, but these cannot be touched or applied for by individual States who might wish to go after their allocation, because of these constraints. It is now possible under the new guidelines for a State to rewrite their plan and make more individuals eligible for service because they can include all individuals whose income is up to 115 percent of the State median income.

Rhode Island and many other States will be unable to take advantage of this option because it would just increase the number of eligible clients with no opportunity at all for additional service for these individuals or dollars to pay for them.

It is only fair to compliment the State Department of Social and Rehabilitative Services, the Health Department, the local administrators, fiscal intermediaries for medicare, and our fellow agencies for trying to cooperate in providing the most services to the largest number of needy individuals in the community, with a limited number of dollars available. However, consumer groups are becoming more and more vocal in initiating or requesting, and more and more demanding, the services which they feel are their right and are vitally needed by the elderly. You have heard from two of them at least today.

There are three major recommendations which can assist in providing options to health and welfare planners, providers, and clients.

Recommendation number one which could be instituted immediately by the Congress in September, would be to change Public Law No. 93-647, title XX, to allow for the reallocation of unspent dollars. This would provide immediate relief and breathing room for the 15 States who have already matched the dollars available and also would provide alternatives for the States who are approaching these figures. This can and should be amended this fall.

Recommendation number two, to raise the $2.5 billion originally authorized of which many were not allocated. We realize that this is a long-range goal and we do feel that it will be necessary in the near

future in order for individual States to provide the services that are vitally needed so that we do not have to put these individuals into far more costly health care models.

Recommendation number three, changing the medicare regulations to expand and provide for homemaker service in addition to home health aide service under the present regulations.

I realize that you and your fellow Members of Congress have a very difficult job, especially in the current economy, and with the restrictions of the executive branch; however, if we can afford guns for Turkey, planes for Israel, and ships for our allies, I certainly hope that we can provide a few dollars to provide for the dignity, the health, and the care of our senior citizens.

Thank you for this opportunity to appear before you this afternoon. I will be glad to answer any questions.

Mr. PEPPER. Well, I thoroughly agree with you, Mr. Perregaux.

I told Mrs. Krause the other day in Washington when she talked about all that they were able to do, that I feel guilty for my country, that we have been so long, so delinquent in doing so many things, that we could and should do, not only for the elderly, but for others, but especially for the elderly of this country.

You just do not realize. It is like moving a mountain there when we try to get done all that should be done because, of course, there are many demands upon the Government.

I agree with you, we should be more selective and if we have not got enough dollars to do all of the many things we are now doing, we should decide what we are going to cut out.

I would not drop out a humanitarian program like that.

Your agency is doing an excellent service.

Mr. PERREGAUX. Thank you.

Mr. PEPPER. Thank you.

Mr. Beard.

Mr. BEARD. I can only say that I, in the last 6 months in the Congress, felt proud when I voted down additional military aid to Vietnam when that was still going on.

It was ridiculous at that point in time. This was 2 months ago when it was clearly near the end of the war.

This Government wanted to pour additional funds into Vietnam.

Next week or the week after I will vote again against aid to Turkey, for additional military aid for Turkey.

I think the money we have spent in the foreign countries could be well spent very wisely here in programs not only for our elderly, but for all people that need help in this country.

Mr. PERREGAUX. Well, I would respectfully disagree with you, Congressman, because I happen to personally believe that we should spend this foreign aid, but we should come up with some money also for our own people.

Mr. PEPPER. We can.

Thank you very much.

The next witness is Mr. Charles Kalina, assistant director, Health Planning Council, Inc.

Mr. Kalina and the other witnesses, perhaps due to our proceeding too slowly, asking too many questions, it is now 5:25. We were sup-

posed to have stopped at 4:30 and our reporter is getting quite fatigued. She has been going steadily since a little after noon today.

We have three more witnesses, Mr. Kalina, Mr. Boday, and Mr. DiDomenico.

Mr. PEPPER. Mr. Kalina, will you please give your statement.

STATEMENT OF CHARLES R. KALINA, ASSISTANT DIRECTOR, ON BEHALF OF HEALTH PLANNING COUNCIL, INC.

The Health Planning Council, Inc., the statewide voluntary health planning agency in Rhode Island, has since 1968 assigned high priority to development of long-term care services in Rhode Island. It recognizes that the community's lay and professional interest in long-term care has not kept pace with its interest in acute care. Moreover, the problems in provision of long-term care cannot be resolved at the community level alone.

Meaningful action requires Federal responses as well as responses by State government, private third parties, and providers. Nonetheless, it would be helpful for a community to define the problem issues surrounding delivery of long-term care more specifically and to identify specific steps or directions which might be taken by the community in their resolution.

The Health Planning Council therefore appointed a committee in the spring of 1974, to make recommendations to the Board of Directors concerning the development and financing of long-term care services in Rhode Island. The committee on long-term care made its report to the board of directors in June 1975. I would like to submit the report for the record [1] and to summarize its conclusions and recommendations.

The committee defined long-term care as the medical, nursing, and supportive care services, frequently in combination, provided for a prolonged period of time for an individual with physical or mental illness, deterioration, or disability, or for an individual who requires an extended period of convalescence because of an acute illness, injury, or resulting complications. Long-term care encompasses a spectrum of services, with varying proportions of medical and social service components, provided in both institutional and noninstitutional settings.

Long-term care is chiefly a need of the aged, a population group increasing in size and much more subject to disabilities and impairments than other age groups. The distribution of impairments and chronic conditions in the population shows that proportionately more of the elderly suffer from activity limitation because of physical impairments and chronic conditions.

The elderly represent the largest single segment of the population unable to carry on major activity of daily living. In 1975 some 66 percent of people in Rhode Island estimated as being so limited are over 65.

Health-oriented long-term care is best seen in the context of a broader set of social needs. In addition to their proportionately greater burden of illness and disability, the elderly confront certain special problems peculiar to the aged, such as generally unfavorable

[1] The 52-page report is retained in committee files.

attitudes on aging and disability in a youth-oriented society, building architectural barriers, transportation problems, pressures on a fixed income, coping with administrative and bureaucratic barriers, and fear of personal crises amidst social isolation in a mobile society.

Current approaches to long-term care address many types and kinds of patient needs, but in fragmented fashion, without a mechanism which is accountable for comprehensively meeting patients' total needs.

The Health Planning Council recommends that development of noninstitutional long-term care services in the home be emphasized as appropriate for the greatest proportion, or 80 percent, of people limited in capacity for self-care and needing long-term care. Such services can serve as an effective alternative for many patients who now are or would otherwise have to be institutionalized. Assuming the availability of such services and with appropriate placement of patients, institutional long-term care bed needs in Rhode Island appear to be met now and in the foreseeable future.

The Health Planning Council sees a need for patient-centered comprehensive care programs which would overcome the historical boundaries of services and agencies. Such comprehensive programs should assure the patient continuity of care to meet his needs under the direction of an entity responsible for the outcome of treatment.

Practical limitations speak against establishing a single coordinating agency responsible for integrated provision of all health and welfare services, however ultimate an expression of continuity of care that might be.

The Health Planning Council recommends that long-term care services be provided by long-term care networks, organized through formal agreements for programmatic linkages among groups of providers in local geographical areas. Should more general health service networks be developed, with primary, acute, and mental health care elements, these local networks could readily be linked to them.

Typical network affiliates would be a hospital, several skilled, intermediate, and custodial care facilities, the area visiting nurse association, home health care, and homemaker agencies. Patient treatment plans are necessary if comprehensive services are to be provided. Appropriate network providers would participate in the development of such a plan for each patient and agree to provide services according to the plan.

Responsibility for ongoing assessment of patient status and for the management of care would rest administratively with one of the network affiliates, regardless of the patient's initial point of entry into the system.

The Health Planning Council believes that a network's home care agency, experienced in linkage activity, in facilitating patient movement between appropriate levels of care, and skilled in utilizing the home as the optimum focus of care would be in the majority of cases the most appropriate patient management agency.

Responsibility for the patient should not end with his recovery or stabilization. The patient management agency should periodically review the status of patients whose active treatment phase has been completed and monitor the status of those under active treatment.

The agency may arrange for and utilize services beyond those offered by the network.

The Health Planning Council has received expressions of interest in implementing this approach to provision of long-term care from the community. The council is planning a pilot project to implement such a network in one health service area of Rhode Island.

The Health Planning Council encourages development of alternative services to institutionalization to enable patients to remain in the community. It believes such development must proceed as a response to demonstrated need.

The need for these services can be identified from the experience of the long-term care networks as they continue to assess the total care requirements of their patients. With the need for content and volume of services established on the basis of operational experience, rational development of specific services can proceed concurrently with expansion of the networks.

The Health Planning Council recommends that reimbursements for long-term care be designed to reimburse networks for programs of comprehensive care, rather than to reimburse individual providers for episodes of service.

Long-term care services will be more likely to meet third-party reimbursement criteria when it can be demonstrated that reimbursement can be made for a definable outcome rather than for an ongoing process of treatment. The patient treatment plans would be the base for reimbursement to the network for each patient's comprehensive program of care. The Health Planning Council recommends that third parties reimburse long-term care on the basis of their outcome rather than for ongoing services.

The Health Planning Council recommends that third-party reimbursement of networks ultimately be prospective, after the network has developed sufficient body of data to permit projection of experience. The Health Planning Council believes that reimbursement to the network for a total program of comprehensive care to an identified population can serve as an incentive for provision of integrated comprehensive long-term care services and as a catalyst for network development.

The Health Planning Council recommends that State and Federal agencies include requirements for network programmatic linkages as a condition for licensure and certification to assure development and maintanance of such linkages. The Health Planning Council further recommends that licensure of all new skilled, intermediate, and custodial care facilities should be conditional upon (1) their affiliation through formal agreements in a network of long-term care providers, and (2) provision of alternative services integrated within the residential facility, or (3) agreements for provision of such services with appropriate agencies providing alternative services within the network. Ongoing adherence to network policies particularly with regard to provision of services according to treatment plans with stated desired outcomes should be a condition for license renewal.

The Health Planning Council also recommends that by a specific time to be determined by the State, those conditions of licensure should be retroactively extended to already established residential treatment facilities at all levels of long-term care.

The Health Planning Council believes that its recommendations, because they basically address a reallocation of resources, are amenable to implementation over a period of time within the existing administrative and financial capabilities of the long-term care system. It believes it necessary, however, that research and developmental seed funding be provided in the initial stages of implementation of pilot demonstration projects, beyond presently committed operational moneys.

The Health Planning Council has developed its recommendations with the underlying principles that there would be:

Evolutionary implementation within a realistic period of time, with no massive reorganization of the long-term care system.

No massive infusion of new resources or of governmental involvement in long-term care.

Implementation of the recommendations by decentralized efforts capitalizing on local interests, available strengths and resources to resolve manageable problems.

The Health Planning Council recognizes that in addition to interest in the capacity of existing long-term care services and their future requirements, there are deep concerns in the community about the assurance of quality of long-term care. Organization and financing of the health care system have a direct bearing on the quality of care provided. The Health Planning Council believes that its recommendations on organization and financing of the health care system will enhance the quality of care offered by individual providers.

In conclusion, the Council believes that organization of long-term care services identified as needed which assures responsibility and accountability for a total program of care is crucial to provision and equitable reimbursement of quality care.

Mr. PEPPER. Mr. Kalina, we know about the Health Planning Council and how important it is, and it has been suggested to me by some that maybe the Health Planning Council could be a coordinating agency in some of the communities of all the various programs that have to do with aid to the elderly.

Do you have anything to add?

Mr. KALINA. I think the Health Planning Council is really a planning agency, not an operating body. It can and will act as a catalyst in the development of these networks and especially in the pilot project.

I mean, ultimately it would be appropriate for it to operate in one of these networks, certainly. But it is the council's intent to be very intimately involved in the initial development stages.

Mr. PEPPER. We appreciate your appearance here and thank you for the benefit of your testimony. I wish we had 2 hours just to talk to you because I know you would make a very valuable contribution.

Mr. Beard, do you have any questions?

Mr. BEARD. No.

Mr. PEPPER. Thank you very much, Mr. Kalina.

Mr. KALINA. I would like to emphasize there is a lot of good work being done in the community and much of how it is brought together depends upon the appropriate organization and financing of it.

Mr. PEPPER. We may be calling on you later to give us some more advice when we make our recommendations.

Mr. KALINA. Thank you.

Mr. PEPPER. Thank you very much.

The next witness is Mr. Michael Boday.

I was pleased to see Mr. Boday here again. I used to see him at the National Conventions of the Textile Workers. I am pleased to see that he is here with us today.

Mr. Boday, please give your statement.

STATEMENT OF MICHAEL BODAY, COCHAIRMAN, RHODE ISLAND GRAY PANTHERS, AND CHAIRMAN, SENIOR CITIZENS BUSING

Mr. BODAY. I have a very short statement for the senior citizens. I am not going to take much time. Time is very valuable.

We want action in our group as an action group.

We do not have a history book. We have one page. That is all that we want and that is what the senior citizens of Rhode Island want.

We are an action group and do not have 10 or 40 pages to be read here which amounts to nothing.

Dear Chairman Pepper, Representative Beard, and other members of the panel:

We, the Gray Panthers of Rhode Island, welcome your committee to Rhode Island. As you know, Maggie Kuhn, our founder, and Gray Panther groups throughout the country have been interested in improving the quality of nursing home care.

We would like to make two points.

We completely agree that there has to be a better, more complete system of State and Federal auditing of the nursing home operators. There are too many loose ends, loopholes, and too much money going into the pockets of a few rich corporation owners. Some of the money should be given directly to the elderly in increased SSI benefits, and a higher level of medicaid which has been raised only once.

We need stricter State laws also so that these rich corporations can't build at will. No wonder the medicaid costs are zooming up all the time. Some of these corporation heads are getting fat on the sicknesses of the elderly. Furthermore, we want a strict account of the personal needs bank accounts of the patients in these nursing homes. Some of them are having their pockets picked by the nursing home owners, just like many patients at the State institutions have had their pockets picked by the State for many years. We want these loose methods of accounting ended.

Second, Representative Pepper, the Rhode Island Gray Panthers want to go on record as demanding that more title 20 money be used to pay community people so that some of the elderly can remain in their own homes or in the homes of their relatives. In the fiscal year 1974–75 Rhode Island did not spend $800,000 Federal that were available to them in title IV–A funds.

Can you imagine how many elderly people could have remained in their homes or the homes of their relatives if that money had been used to supply home health care services instead of the much more expensive nursing home care? Also, the Rhode Island economy could have benefited from $800,000 spent in Rhode Island.

We are tired of money that is available under IV–A not being used. It wasn't all used in 1974–75. But we want to put the State on notice

that the Gray Panthers of Rhode Island will be looking over their shoulders to see to it that they spend more money on home health care in the new title 20 program.

Representative Pepper, we would like your committee to try to get more money allocated from Washington in the title 20 budget so that Rhode Island will receive more than the $11.5 million allocated to them in 1975–1976.

We are tired of our fellow senior citizens being ripped off of their life savings by these nursing home operators.

If Rhode Island does not do a better job of demanding stricter open accounting of these nursing home operations and put more money into helping seniors remain at home, we will ask Maggie Kuhn of the Gray Panthers to come back to Rhode Island and help in a campaign to straighten out the nursing home and home health care program of Rhode Island.

She helped us launch our successful campaign for free busing in Rhode Island for the State's elderly. Remember, we are not too old that we can't raise a little hell to correct injustices.

Thank you.

Michael Boday, chairman of the Rhode Island Gray Panthers.

Mr. BODAY. Mr. Pepper, we worked 504 hours for the elderly.

We had a battle with the State House of Rhode Island to get transportation for the elderly. We have absolutely had a battle.

We started this year and we worked 504 hours. We spent a lot of time of our own.

They are talking about the senior citizens.

Congressman Pepper, we went to some of the towns where people have to spend 4 hours for doctors and transportation, and they need $12 or $14 out of their social security to go to doctors and for transportation, right here in the State of Rhode Island.

This is what we are fighting, Congressman Pepper. The truth is not heard. We have this, but the people do not know about it.

We went into towns and we finally found out that people did not even know what revenue sharing was.

The Federal law allows the citizen to know what the sharings are.

I had a mother who was in a wheelchair for 12 years. We did not put her in a nursing home. We do not want people in a nursing home. We want people at home where they can spend the rest of their lives.

Our Gray Panthers intend to have that. We do not care whose feet we step on. We are going to step on them because we have 149,000 senior citizens in Rhode Island and this is a battle we are starting right now and we do not care who we are stepping on.

We want these people.

I will say this much, Congressman Pepper; we have a wonderful man here at the present time.

I want to thank Congressman Beard.

He has attended all our rallies.

He has been a wonderful help to us.

I will say that I talked to people and if that man ever ran for office the senior citizens will go out and help this man and we will ask for no money at all.

This is going to be another Mr. Fogarty. Do not let anyone fool you.

Congressman Pepper, as my old friend of 17 years ago at my con-

vention, I wish to thank Congressman Beard and if there is any help the senior citizens can do for Congressman Beard, we are not asking for money.

We are asking for action and we can get action through you.

I wish to thank everybody here tonight.

Mr. PEPPER. Well, thank you very much.

I know Mr. Beard appreciates your valuable friendship.

I am glad to see fighting seniors like you get the things you are entitled to have.

I am for that.

We have one more witness scheduled.

Our next witness is Bob DiDomenico, executive director of the Rhode Island Association of Home Health Agencies.

Mr. DiDomenico, would you please put your statement in the record, and then tell us above that whatever you would like to say.

We would appreciate that.

STATEMENT OF ROBERT J. DIDOMENICO, EXECUTIVE DIRECTOR, ASSOCIATION OF HOME HEALTH AGENCIES OF RHODE ISLAND, INC.

Mr. DIDOMENICO. Thank you, Mr. Chairman.

[The statement of Mr. DiDomenico follows:]

Prepared Statement of Robert J. DiDomenico

Mr. Chairman and members of the subcommittee of the House Select Committee on Aging, I am Robert J. DiDomenico, Executive Director of the Association of Home Health Agencies of Rhode Island, Inc. (AHHA). With me today also is Mr. Normand Plante, President of the same organization. We are here today to represent AHHA's member agencies which consist of all the nine Visiting Nurse Associations of Rhode Island, all certified by Medicare as Home Health Agencies. Visiting Nurse Services have been offered to Rhode Island's citizens for over 70 years.

For clarification, I would like to define home health service as it was developed by a task force composed of representatives of the Assembly of Outpatient and Home Care Institutions, American Hospital Association; the Council of Home Health Agencies and Community Health Services, National League for Nursing; the National Association of Home Health Agencies; and the National Council for Homemaker-Home Health Aide Services, Inc.

> "Home health service is that component of comprehensive health care whereby services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health, or minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated and made available by an agency/institution, or a unit of an agency/institution, organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administrative patterns.
>
> "These services are provided under a plan of care which includes appropriate service components such as, but not limited to, medical care, dental care, nursing, physical therapy, speech therapy, occupational therapy, social work, nutrition, homemaker-home health aide, transportation, laboratory services, medical equipment and supplies."

For the calendar year 1974 the professional personnel in the AHHA member agencies of R.I. made over 164,000 home visit encounters for which over 70% of the visits were made to senior citizens. A total of over 206,000 patient encounters were made including over 42,000 patient encounters in clinics and other settings other than the home environment. Under the auspices of AHHA, through a grant from the Division on Aging an immunization program for senior citizens was conducted during October-November 1973 and 1974. Twenty agencies participated at 69 sites thoughout the State, to immunize a total of 12,173 persons in 1973 and 13,437 in 1974. For 1975, we are estimating 17,000 senior citizens will be immunized against influenza. AHHA also administers a contract with the Division on Aging for a Statewide Health Maintenance Program for senior citizens. Services supplied include health education at the nutritional meal sites, screenings, health evaluations, assessments and counselling and assessment visits in home where necessary and podiatry services. The total amount of the contract is $84,180. For the first 6 month period, our nurses saw 2,970 new patients, 5,324 returned patients or a total of 8,294 encounters.

On July 9, 1974, in the Report to the Congress concerning Home Health Care Benefits Under Medicare and Medicaid, prepared by the Comptroller General of the United States, it is stated

> "...Home health care...is generally a less expensive alternative when such care would meet the patient's needs. The Congress and the health field have realized the need for developing alternatives to institutional care." (pg i)

Examples are further given in this report in Chapter 2 entitled Home Health Care as an Alternative To Institutional Care. One specific study states a July 1973 paper on the status of home health services in the United States issued as a committee print by the Senate Special Committee on Aging summarized proceed-

ings of a June 1972 Conference on "In-Home Services" and pointed out that these services are a major component of a comprehensive system of health care services and that in the absence of in-home services, no system may be considered either comprehensive or effective. The study also stated that top national priority must be given to developing a system of comprehensive in-home services for the whole population. (pg 8)

HEW has recognized the need for alternatives to institutional care and has funded projects to study this area. Such projects are listed in the aforementioned Report to Congress.

In a policy statement of the American Public Health Association regarding Home Health, in October, 1973, it was said that it is estimated that at least 10-25 percent of the population now in institutional homes of varying kinds could be cared for in their own homes. In a very recent report, May, 1975, of the Rhode Island Health Planning Council, Inc.; i.e., the Report of the Committee on Long-Term care to the Board of Directors of the Health Planning Council, Inc. many interesting facts were shown and conclusions drawn. Some pertinent examples are:

> "A number of recent studies found that many residents of institutions do not need as high a level of care as that at which they are placed." (pg. 32)

> "There is evidence that up to a fifth to a quarter of all patients in the census of general hospitals could be more appropriately placed at a lower level of care. Up to a half of nursing home residents would be more appropriately placed at an intermediate level of care. Between 7 and 14 percent of them could be at home. One quarter of the residents of intermediate care facilities could be at home. The Committee believes that increased availability of services in the home and of sheltered housing could be particularly effective alternatives to intermediate residential care. A projection of these findings to the 1975 census of 5,557 residents 65 and over in skilled nursing and intermediate care facilities in Rhode Island indicates that some 999 of them could have been cared for at home -- 738, or a quarter of the ICF residents, and 261, or 10 percent, of the SNF residents." (pgs. 32 and 33).

This same study further states that it has been estimated nationally that 15% of all non-institutionalized population 65 and over are limited in varying degrees in their capacity for self-care. Application of this estimate to the 1975 Rhode Island elderly population indicates that 15,145 people can be expected to be so limited. (This is 15 percent of 100,966 people, the 104,728 total population 65 and over, less the 3,762 with institutional disability). These 15,145 are a segment of the total of 39,024 people not in long-term institutions but with short-term and long-term non-institutional disability and other major activity limitations. The 15,145 estimated as limited in capacity for self-care represent the first priority for non-institutional services that would support their remaining in the community, although others of the 39,024 may at some time also be potential clients for such services.

In conclusion, Mr. Chairman, I would like to summarize my short presentation by stating that I have attempted to depict for the committee the home health activity in the State of Rhode Island, the need for such services as clearly indicated in documented studies, the improper use of inappropriate levels of care for the elderly, and the limitation of the home health agencies in Rhode Island and nationally to expand their services to meet the needs of the Senior Citizens and the long-term care patients.

Medicare and Medicaid have erected barriers to the development of home health programs which can enable many ill or incapacitated persons to remain at home. Because of restrictive HEW policies since 1969, the number of home health agencies has declined and the percentage of Medicare funds for home health services is now less than one percent. Even in the Report to Congress which I quoted at the beginning of my testimony it is stated:

> "Medicare is oriented, by law, to the need for skilled care and does not cover services considered non-skilled in nature regardless of the patient's needs." (pg. 16)

We have found that many of the Senior Citizens are denied by Medicare home health services, because of priorities set by Medicare and because of the skilled nursing criteria. The patients may need nursing or other therapeutic and supportive services.

The Commissioner of SSA stated in a January 1971 report to the Secretary of HEW that,

> "while it is recognized that many people who are not in need of either skilled nursing care of of physical or speech therapy could be maintained in their homes if the services of a home health aide were available to them on a regular basis, thereby preventing their institutionalization, the law does not cover these types of cases nor would any of the legislative proposals which have been under consideration."

In Rhode Island, the Department of Social and Rehabilitative Services reimburses the home health agencies only a percentage of the home health visit and limits the amount of visits to the patients.

So, Mr. Chairman, you can see that still today we are talking about alternatives to institutionalization while the costs for health care services continue to escalate. On numerous occasions, the problems in making services available to the citizens because of reimbursement have been cited, and yet, the home health agencies continue to serve as many persons as possible and offer high quality of care to patients, professional coordination of the various services delivered to the individual patient and family, evaluate techniques to insure

the appropriateness and the quality of care provided, and offer appropriate administrative controls. Home Health:

1. Contributes to the health and well-being of the patient and his family;

2. Restores the patient to health and/or maximum functioning;

3. Prevents costly and inappropriate admission to institutions;

4. Reduces readmission to institutions; and

5. Enables earlier discharge from hospitals, extended or intermediate care facilities, or nursing homes.

CONTINUED

1 OF 2

Mr. DiDomenico. It is an honor for me to be here. I have been here since 12 noon, but I will summarize and I will be no longer than 4 minutes.

I am here today representing all of the visiting nurse agencies in the State of Rhode Island, all certified by medicare as home health agencies.

The services are visiting nurse services that have been rendered to the citizens of Rhode Island for over 70 years.

I would like to just state some facts and give you some statistics as far as our services for 1974.

During the calendar year 1974, the professional personnel in the AHHA member agencies in Rhode Island made over 64,000 home visit encounters for which over 70 percent of the visits were made to senior citizens.

I think this is very important to note.

A total of over 206,000 patient encounters were made, including over 42,000 patient encounters in clinics and settings other than the home environment.

Mrs. Eleanor Slater had mentioned to you about the flu immunization program and the health maintenance program which our visiting nurse and home health agencies have in the State of Rhode Island.

This year we hope to immunize over 17,000 senior citizens.

You had asked about clinics when Mrs. Slater was here.

We have some screening clinics provided to the elderly in home care in Rhode Island—senior citizen homes.

Through this special grant contract that we have with the division on aging, we provide health education at the nutritional meal sites, screenings, evaluations, assessments and counseling, and assessment visits in home where necessary, and podiatry services.

Mr. Kalina from the council had mentioned a recent study on long-term care. I wish just to bring out a few facts on the study, which I think is very important.

I am quoting:

> There is evidence that up to a fifth to a quarter of all patients in the census of general hospitals could be more appropriately placed at a lower level of care.

This is in Rhode Island.

> Up to a half of nursing home residents would be more appropriately placed at an intermediate level of care. Between 7 and 14 percent of them could be at home. One quarter of the residents in intermediate care facilities could be at home. The Committee believes that increased availability of services in the home and of sheltered housing could be particularly effective alternatives to intermediate residential care. A projection of these findings to the 1975 census of 5,557 residents 65 and over in skilled nursing and intermediate care facilities in Rhode Island indicates that some 999 of them could have been cared for at home * * *.

Mr. Pepper. That would save a lot of money; would it not?

Mr. DiDomenico. It certainly would.

The same study further states:

> It has been estimated that 15 percent of all non-institutionalized population 65 and over are limited in varying degrees in their capacity for self-care.

If we apply this estimate to the 1975 Rhode Island elderly population, 15,145 people can be expected to be so limited.

These people in their capacity for self-care represent the first priority for noninstitutional services that would support their remaining in the community, although others of these 39,024 in Rhode Island may at some time also be potential clients for such services.

In conclusion, Mr. Chairman, I would like to summarize my very short presentation by stating that with some of the statistics I have presented, I have attempted to depict to you and to the whole committee the home health activity in the State of Rhode Island, the need for such services, as clearly indicated in documented studies—and we have heard various people today refer to them—the use of inappropriate levels of care for the elderly, and the limitation of the home health agencies in Rhode Island and nationally to expand their services to meet the needs of senior citizens and the long-term care patients.

Specifically, I am referring to the medicare and medicaid barriers on the development of home health programs as was mentioned earlier; skilled nursing, for example.

We have found that many senior citizens are denied home health services by medicare because of the priorities set by medicare and because of the skilled nursing criteria.

In Rhode Island, the Department of Social and Rehabilitative Services reimburses the home health agencies only a percentage of the home health visit and limits the amount of visits to the patients.

So, Mr. Chairman, you can see that still today we are talking about alternatives to institutionalization, while the costs for health care services continue to escalate.

On numerous occasions, the problems in making services available to citizens because of reimbursement have been cited, and yet, the home agencies continue to serve as many persons as possible and to offer high quality of care to patients.

Mr. PEPPER. Well, thank you, Mr. DiDomenico.

That is an excellent statement and we will read it very carefully.

I will read your statement and also the one by Mr. Kalina tonight on the way back.

Mr. Boday has already given us his excellent statement here.

Mr. Beard, do you have any questions?

Mr. BEARD. I cannot add to what the chairman has said.

It certainly is an excellent statement and we will be reviewing it very carefully.

Mr. PEPPER. Thank you very much.

Now, a little while ago, Dr. Cohen said that he wanted to say something.

Is there anyone else here who wanted to say something?

Well, that is two.

Wait a minute. How many are there?

Ladies and gentlemen, I do not want to be arbitrary about it, but I am going to have to limit you to 5 minutes.

So, I am awfully sorry, but I would like you to summarize. In the House we are limited to 5 minutes also.

Dr. COHEN. That will be more than adequate.

Mr. PEPPER. So, we know you have to crowd it in.

Dr. Cohen, you give us 5 minutes of whatever you would like to say.

We appreciate it.

STATEMENT OF EARLE F. COHEN, M.D., PRACTICING PHYSICIAN IN RHODE ISLAND

Dr. COHEN. Mr. Chairman, and Congressman Beard, and others who have stayed to this late hour, I do appreciate the attention and the time that you people have put in.

I would like to say first I am a physician. I am a pediatrician, though. I do not take care of the elderly, but practically no day goes by that I do not visit some of the elderly in nursing homes or in hospitals or in other areas.

Today I visited an 85-year-old man and I had the opportunity to observe objectively what is going on.

I run two private offices and work in a neighborhood health center, so I am in contact with the community. I will be brief.

There were a few things that I think your attention should clearly be drawn to, and they have been brought to you here.

I hope while you are taking these pamphlets along to read in the airplane, that you will take Dr. Mulvey's. She really spoke to the issue.

Mr. PEPPER. I have Dr. Mulvey's statement.

I read it as she gave it.

Dr. COHEN. I followed carefully what she said.

We have a big business in the nursing home business and the home health care business is also coming to be a large business.

We need a few things. We need controls. We need inspection. We need enforcement. We need auditing controls.

By the way, I do not believe the auditing of the State of Rhode Island records were made available here today.

There was, as I recognized, a protective mood on the part of the Governor in his recent conversation in our community to protect the audit of the nursing homes and there were reasons behind that.

One would find the Governor has in the past been quite close to principals and leaders in the nursing home community and may still be.

We need patient care controls.

I have looked at what happened. I have seen even my own father, who was a physician also, not seen in over 6 months by his own physician while in a nursing home in our community and I, personally, as a practicing physician, and a past member of such staffs as Children's Hospital in Boston and the Harvard Medical School, found myself not being listened to by his own physician who just did not show up in over 6 months.

We need the patient controls.

We need the home health care controls.

We need people who will be in front in this and people who normally have not in the past been given an opportunity to be heard.

Money is not the big problem here. I work in clinics. I can tell you that we are running a health care cost per patient visit right now in the neighborhood health center that I run at only $4 plus per patient.

In the neighboring city similar service, and I like to feel not as good as I am giving, is costing $28 per patient visit.

There is a difference.

Do not fear. You said you feared for your mother going to a nursing home. Do not fear. There are some excellent ones and some are very well run by some very competent people.

Mr. PEPPER. I do not mean to disparage it.

I was just reporting psychologically.

Dr. COHEN. I want to assure you, do not fear; there are good ones. I do want you to know.

We all must compliment Congressman Beard.

Things are better in Rhode Island.

You heard all these people tell you how good they are, except maybe three of us. They are still pretty bad, though.

There is a long distance to go. Progress has been made here and we are looking forward to more.

Reimbursement regulations have been a problem lately, but until the leadership is improved, and the leadership that I am particularly noting is the leadership in the person of Dr. Joseph Cannon, the Director of Health, who, 2 years ago, sponsored a bill for his own retirement, which I helped block in the legislature.

We need people like that out of there.

We recently worked together with the attorney for the nursing home group to get legislation which our Governor approved of enacting, which was not in the best interests of the people that you and I represent.

Let me close by saying that there are people influencing the legislative process, but that is the American way. We recognize it, and the American way is to let people like me speak.

I accept it; I appreciate it. I hope I have not taken too much time.

Please read Dr. Mulvey's statement. It was a good one.

She and I do not always agree, but at least today we do.

Thank you for this opportunity.

Mr. PEPPER. Thank you, Dr. Cohen.

I will read Dr. Mulvey's statement again.

Dr. COHEN. Thank you.

Mr. PEPPER. Thank you so much.

Who was the other gentleman? Mr. Joseph N. Brown, Meals-on-Wheels, Inc.

Mr. BROWN. Right.

Mr. PEPPER. I hope you understood what I told the other gentleman, Mr. Brown.

STATEMENT OF JOSEPH N. BROWN, MEALS-ON-WHEELS, INC.

Mr. BROWN. Thank you for your patience and your endurance.

I briefly wanted to make a few remarks pertaining to the home care in Rhode Island.

Now, Rhode Island Meals-on-Wheels is the only statewide meals-on-wheels program in the country and the past year our volunteers, of which we have 400 wonderful volunteers, delivered over 122,000 meals to the homes of elderly throughout the State.

Mr. PEPPER. That is a wonderful thing.

A great commendation to all the people that did that.

Mr. BROWN. Well, our 400 wonderful volunteers are the heart and soul of the program.

One of the things that I wanted to touch on is for your encouragement and Representative Beard's, to encourage legislation so that title 7 program funds can work cooperatively with private organizations, like Meals-on-Wheels.

Now, I am speaking wearing two hats, because as well as being executive director for Meals-on-Wheels, I am also the first national president of the national association of home delivered meal programs and one of our main efforts is to work together with title VII programs and title III and also the private, and this has worked out very well here in Rhode Island where we have had a very close relationship with Mrs. Slater's office.

Our home delivered meals program, with our volunteers delivering to the elderly throughout the whole State, are part of the title VII money. This is one of the things that I want to stress; in other States rather than try to set up a competing organization to the existing meals-on-wheels program, that they work together cooperatively and we can accomplish much more for less money because the 122,000 meals that were delivered in Rhode Island last year was at a total cost of less than $2 for a meal for the entire program.

Mr. PEPPER. Is your organization a profit or nonprofit organization?

Mr. BROWN. We are a nonprofit organization.

You also mentioned several times Mrs. Daphne Krause in Minneapolis. She is one of our regional representatives for the National Association of Home Delivery and Congregate Meal Programs.

Of course, the big thing of this whole program is the preventive nature of it because thousands of people in Rhode Island are able to stay in their own homes because of the meals-on-wheels program, because here they are not only getting good nutrition, but they are getting, almost of equal importance, the daily visit by the volunteers. The third one, which more and more we are finding is important, is that it is also a protective service in that in a number of cases our volunteers have found an elderly person who has fallen or is hurt or is unconscious and they have saved their lives.

Mr. PEPPER. Some people get so lonely they just welcome anybody coming in.

Mr. BROWN. I want to encourage the cooperative effort between title VII and private organizations.

Thank you.

Mr. PEPPER. Well, that is very kind of you. I agree. You made an excellent statement, Mr. Brown. We appreciate it. Thank you very much.

Now, the last witness is Mr. Johnson, senior citizen.

Mr. Johnson, we will be pleased to have you come up.

Is Mr. Johnson still here?

Well, I guess he had to go.

Well, I want to say how much I have not only profited by the hearing we have had here today, but how much I have enjoyed it.

People are deeply interested in the subject they were talking about and were very knowledgeable. They are deeply dedicated to the subject of the elderly people.

They are aware of the problems that we have, many of which we have to find a solution for.

I think it has been a very profitable hearing.

Mr. Beard, it has been a privilege to be here in your district with you.

It was a pleasure to accept your invitation to come here.

I hope that it will be regarded, as we regard it, by our colleagues, as a very profitable thing.

Mr. BEARD. Yes, Mr. Chairman.

On behalf of the people of the State, I want to thank you for coming to Rhode Island.

I know the testimony today will be a benefit to all of us in the Congress in formulating plans for making the system better for the elderly in the country.

This is a wonderful committee that we serve on.

The full committee is very exciting and covers many, many different areas of problems pertaining to the elderly people and one thing is, whether it is in Cyprus, Greece, or in Rhode Island, or the Chairman's home district in Florida, elderly people have basically the same problems.

They are looking to the members of their own government, whether it is in the United States or on the distant shores, for help, because it seems to me in our society today that sometimes when you reach 65 you become a second-class citizen only to be first-class on election day, and we want to change that.

Mr. PEPPER. Thank you very much.

The hearing is concluded.

Thank you all very much.

By the way, I want to thank all of those who made arrangements here and thank Mr. Beard for making arrangements for us to have this hearing at this very spacious and very beautiful auditorium.

[Whereupon, at 6 p.m., Saturday, July 12, 1975, the hearing was adjourned.]

APPENDIX

STATEMENT SUBMITTED BY KENNETH DUPRE OF THE CATHOLIC INNER CITY CENTER OF PROVIDENCE, R.I.

As an organization which works with many locally based and statewide senior citizen groups we are naturally concerned about the quality and levels of care provided by the nursing facilities located in Rhode Island.

This statement will concern itself with the non-profit facilities which have been in receipt of Federal funds under the Hill-Burton Act of 1946.

There are several areas in which we feel that there has been serious negligence on the part of the State Department of Health, which is the State agency charged with regulating the facilities which have received Hill-Burton monies. The Rhode Island Department of Health indicated to us that nursing facilities had been unregulated by direction of the Department of Health, Education and Welfare, therefore there had been no State regulation. HEW, when asked by our staff, denied this. Mr. Realin of HEW stated that when Hill-Burton monies came into Rhode Island the State had agreed in writing to regulate the facilities. After being assured that the responsibility was indeed the State's, we attempted, by visiting the Department of Health, to again access to the Hill-Burton materials and documents relating to those nursing facilities which have received Federal funds. According to the Hill-Burton Act these documents are public record. The Rhode Island Department of Health denied access to these documents.

Since we were unable to get any information from the State we decided to visit some of the nursing facilities. The administators of two of these facilities met with and discussed this issue with a researcher from our office. Mr. Holder of Hallworth House in Providence indicated that when his facility received the Hill-Burton funds they asked the State for a definition of the regulation which requires a "reasonable amount of care" be provided. The State would not define what was meant by reasonable amount. Instead they said "not to worry about it." Later he was informed by the State that the Hill-Burton obligations did not apply to nursing facilities because they did not have emergency rooms. HEW says that this was never the case and that the facilities should have been regulated.

At St. Elizebeth Home in Providence, Mr. O'Connor stated that even as a member of the board of directors when Hill-Burton monies were received by his facility he was not aware and was never informed that the obligation to provide uncompensated or reduced cost care was involved in the acceptance of the funds.

Clearly this shows that any lack of compliance of the part of these non-profit institutions was the fault of the State and Federal agencies involved. In fact, until March 11, 1975, the State had not formally informed these institutions as to their responsibilities under the Hill-Burton Act.

Our researcher found that there are two areas where these facilities may not be in compliance with the act. First is the requirement to have on file, and available for the public to examine, a board-of-directors-approved free services policy. Second is the manner in which Hill-Burton obligations are written off.

According to the State Hill-Burton plan for health care facilities, institutions are required to provide free or reduced cost care at a charge which is less than the reasonable cost of such services. The State plan also defines reasonable cost as that set under the Social Security Act. The practice of the nursing facility, to write-off the difference between what is charged a private patient and the reasonable cost set by the Social Security Act, we feel is not in accordance with the meaning of the Hill-Burton Act for providing uncompensated services for the indigent.

Even if the facilities are able to show that they provide free services in excess of the amount of Hill-Burton obligation (which they claim is the case), they should know clearly what is and is not allowed under the Hill-Burton Act.

We do not believe that these non-profit facilities are in any way attempting to defraud or misrepresent themselves. Rather, we feel that the facilities simply have not been adequately informed as to their responsibilities. For this the blame must be laid directly on the State and Federal agencies which have been charged with regulating the facility.

To insure that those individuals who are truly in need of these free services receive them, State and Federal agencies should be immediately directed to insure that all facilities receiving Hill-Burton funds are in compliance with these already existing Federal laws.

STATEMENT SUBMITTED BY KENT COUNTY MEMORIAL HOSPITAL

KENT COUNTY
MEMORIAL HOSPITAL

455 TOLL GATE ROAD • WARWICK, RHODE ISLAND • 02886
(401) 737-7000

July 18, 1975

Select Committee on Aging
Sub-Committee on Health and Long Term Care
Room 1740 A
Longworth House Office Building
Washington, D. C.

Dear Representative Pepper:

The congressional hearing on Home Care held in Providence, R. I. on July 12, 1975 was so long and arduous that it seemed best to submit our statement to your committee in writing.

Much was said at the hearing by various groups about the desirability of care at home for the sick and elderly as opposed to care in institutions. Certainly the spokesmen for the elderly made it clear that home care is their choice when ever possible. This choice would be possible far more often if supportive services for such care received adequate financial support to allow them to provide sufficient help rather than token aid.

The need for coordination of the services provided in the home was mentioned by several speakers. Kent County Memorial Hospital was the pioneer in Home Care in Rhode Island with an organized Home Care Program in operation since July 1, 1964, pre-dating Medicare. The program has grown steadily in number of patients served, services provided, and physician participation. Enclosed are our latest statistics and our information brochure.

Since we have had considerable experience in Coordinated Home Care, we would like to share some of our findings with the Committee. The use of Coordinated Home Care as an alternative to continued hospital care or nursing home care is a very realistic and humane approach to the problems of the sick elderly. By providing and coordinating professional and supportive services, Home Care programs assist families in caring for their loved ones at home thus enabling the patients to keep their identity and dignity, and sparing the families the agonies of guilt that frequently accompany the institutionalization of a relative. One of the doubts expressed at the hearing referred to the relative costs of providing Home Care as opposed to institutional care. Our most recent audit indicated that the cost of a day of Home Care was $15.84 including all services provided and the administrative costs of the program. This is less than 1/6 the cost of a hospital day at Kent County Memorial Hospital and considerably less than the cost of a Medicare certified skilled nursing facility or an intermediate care facility.

Medicare has proved to be a mixed blessing in financing the many services which a hospital-based Home Care Department provides. The limitations of the law have applied to the hospital programs just as to the community Home Health Agencies (Visiting Nurse Associations) even though the hospital programs are providing and coordinating more and more complex services. For example, a glance at the accompanying statistical report will show that 1,936 visits to patients homes were made last year by a hospital laboratory technician, and 4,397 prescriptions were filled. Neither of these services is reimbursable as a Home Health service. Many of the items of equipment and supplies provided are not reimbursable, although they are needed to enable patients to be cared for and rehabilitated at home. Examples of important but non-covered items used frequently are incontinent pads and toilet rails.

The frustrating inadequacy of reimbursement for Home Health Aides and complete lack of coverage for Homemaker service was mentioned by one of the speakers. There are many people in institutions who could be cared for at home if adequate help with housekeeping, shopping and home maintenance were available. Provision of intermittent registered nurse visits, physical therapists and speech therapists is no help to the elderly sick couple who are too weak to keep their house clean, and too debilitated to shop for food.

In the 10½ years that Home Care has existed at Kent County Memorial Hospital we have provided physician-directed care to 3300 patients. By coordinating hospital and community services and by planning for the patients' continued care even after discharge from the Home Care program we have saved an estimated 50,000 hospital days and many additional nursing home days.

We urge the committee to consider Home Care as a desirable and preferable alternative to institutional care, and to work toward adequate reimbursement for the agencies which are struggling to provide such care.

Yours truly,

Virginia B. Bainton

(Mrs.) Virginia Bainton, R. N.
Home Care Coordinator

Enclosures
cc: Representative Beard

KENT COUNTY MEMORIAL HOSPITAL
455 Toll Gate Road
Warwick, Rhode Island

HOME CARE DEPARTMENT
Statistical Report
October 1, 1973 - September 30, 1974

Active census as of October 1, 1973	39	
*Accepted for Home Care	505	
**Not accepted for Home Care	30	
Days of Home Care	15,897	(Disch. pts. - 15,957)
Estimated number of hospital days saved	7242	(Disch. pts. - only)
Average daily census	44	
Average length of time carried	31	days
Discharged from Home Care	512	
Active census as of September 30, 1974	32	

*Accepted from home - 79; from other hospitals - 6; from emergency room - 3; from nursing homes - 0;

**Reasons for non-acceptance:

This figure represents only written physicians referrals which were not accepted - it does not include the many telephone inquiries regarding patient eligibility for Home Care.

Patient needed VNA only	9
Patient expired in hospital	2
Patient needed equipment only	2
Patient went to Nursing Home	3
Patient lived outside geographical area	7
Patient remained in hospital	1
Patient refused Home Care services	3
Patient did not need any Home Care services	1
Patient able to come in to P. T. Department	1
Patient not home-bound	1

Services used	Number of visits	
Xray at KCMH	70	
Inhalation Therapy	76	
Physical Therapy	1000	
Electrocardiograms	259	
Nutritionist (contacts 110)	1	
Orthopedic (traction, trapeze, etc.)	69	
Speech Therapy	36	
Male LPN (foley catheter changes)	5	
*Visiting Nurse	4843	
Social Worker (contacts 650)	14	
Physician	545	
Laboratory (tests 5,987)	1936	
Pharmacy	4397	prescriptions
Equipment	450	items
*Homemaker Home Health Aide	554	
Meals on Wheels	2	patients
I. V., transfusions and clysis	11	

*reported to date

Sex and Ages of Accepted Patients					Under 65 - 263			Over 65 - 242		
Age:	(0-4)	(5-10)	(11-15)	(16-24)	(25-34)	(35-44)	(45-54)	(55-64)	(65-74)	(75+)
Male:	0	5	9	7	11	17	35	49	67	44
Female:	0	0	3	13	14	21	32	47	72	59

Methods of Payment for Home Care Service:

Patients over 65 years of age:	242
Federal Medicare only	36
Federal Medicare plus Medicaid	40
Federal Medicare plus other Public Assistance (OAA, AD)	4
Federal Medicare plus Blue Cross #65	145
Federal Medicare plus Private Insurance	13
Private Insurance only	0
Public Assistance	0
Blue Cross only	4
Patients under 65 years of age:	263
Blue Cross	147
Blue Cross plus Medicaid	3
Blue Cross plus Public Assistance	3
Medicaid	9
Medicaid plus Private Insurance	1
Public Assistance	21
Workman's Compensation	17
Private Insurance	46
Private Pay	3
Federal Medicare (Disability)	13

*Patients' Condition upon Discharge

Improved	381
Referred to VNA or other community services	189
Re-admit to hospital	11
Admit to Medical Center or Nursing Home	0
Unimproved	117
Re-admit to hospital	105
Admit to Medical Center or Nursing Home	9
Stayed at home	3
Expired	14

*64% of discharged patients were referred to other agencies for further care (or expired).

Patients have been referred by 66 *physicians, representing 73% of those likely to participate in the Home Care Program.

*This excludes physicians whose specialty would indicate that they would not use the service i.e., Pathologist, Anesthetist, Radiologist, etc.

(Plus six physicians not on KCMH Medical Staff but on staff of other hospitals)

Classification by Diagnosis for which treatment was given (most patients have multiple diagnoses):

Blood Dyscrasias		10
Cardio-vascular Diseases		197
Myocardial Infarction	63	
Peripheral Vascular Disease	27	
Cerebrovascular Accident	52	
Arteriosclerotic Heart Disease	54	
Hypertensive C. V. Disease	1	
Infectious Diseases		7
Endocrinopathy		24
Malignancies - Surgical & Medical		40
Neurological Disorders		13
Orthopedic Problems (including discs)		99
Respiratory Diseases		37
Pulmonary Embolus		9
Surgical Problems		56
Urological Diseases		7
Collagen Diseases		1
Dermatology		1

Description of Equipment and Apparatus loaned: 450 pieces

Bed pans	Commode platform
Urinals	Over-head bed frame & trapeze
Bedboards	Walkers
Fracture pans	Canes
Commodes	Raised toilet seats
Cradle for bed clothes	Wheel chairs
Suction apparatus	Hospital beds
Oxygen tank and mask	Over-bed tables
Intermittent Positive Pressure Machine	Side rails
Crutches	Traction apparatus
Sitz Bath Chair	Quadricanes
Maximist Unit	I. V. Poles
Shampoo Board	Shoulder Wheel
Air Mattress	Toilet rails

Outside agencies cooperating in furnishing supplies, equipment and services:

American Cancer Society

American National Red Cross

Community Homemaker Service

FISH

Hearing and Speech Services of Rhode Island

Homemaker Home Health Aide Services of Rhode Island

Meals on Wheels

Multiple Sclerosis Society

Rhode Island Heart Association

Retired Senior Volunteer Program

State of Rhode Island:

- Division on Aging
- Warwick Community Action
- R. I. Medical Center
  - a) General Hospital
- Public Assistance
- Vocational Rehabilitation

Veterans Administration Hospital

Visiting Nurse Associations

a) Kent County VNA

b) Metropolitan Nursing and Health Services Association of R. I.

c) Northwest Community Nursing and Health Services

d) Washington County Public Health Nursing Association

Warwick Mental Health Center, Inc.

Warwick Sunshine Society

Guests at Team Conference or to the Home Care Department to observe program	46
Division of Vocational Rehabilitation	2
Fogarty Hospital	3
Kent County Visiting Nurse Association	1
Medical Student from Scotland	1
Metropolitan Nursing and Health Services Association	3
Greater Providence Home Care Association Consultant	1
St. Joseph's Hospital School of Nursing	22
Southeastern Massachusetts University School of Nursing	1
Physical Therapy Student	1
URI College of Nursing	4
Woonsocket Hospital	4
Woonsocket Visiting Nurse Association	3

END