The original documents are located in Box D33, folder "Michigan Non-Profit Homes Association Conference, East Lansing, MI, September 13, 1972 (1)" of the Ford Congressional Papers: Press Secretary and Speech File at the Gerald R. Ford Presidential Library.

Wednesday, September 13, 1972

Speech before Michigan Non-Profit Homes Association Conference
East Lansing
Kellogg Center

Problems the Association is concerned about:

-- Delay by the State Health Department in dealing with violations of profit-making nursing homes. The Association feels that such violations are unjustly associated with the non-profit homes.

-- Delay in reimbursement for public assistance patients.

Topics the Association would like you to talk about:

-- H. R. 1.

-- Prospects for health care legislation.

~~Paul has more "background" info if you would like it.~~

1st annual convention –
Mich. Non-Profit Homes Assn –
Banquet Sept 13 at Kellogg Ctr.,
MSU, E. Lansing – 6:30?

Nearly 50 nonprofit nursing homes & homes for the aging in State of Mich.

"Motivation for Service –"
(616) 382-5033

Prob. Areas –

Stands. – part. i. pat. care
" need upgrading & enforce.
State Health Dept has been lax
a folo'g thru on viol.'s. Then all
get painted w/ the same brush.
– Non-profit homes are hurt more
& more ea. yr. by fin. stops
hard to get philan. gifts for
oper. deficits. Pub. Assist.
patients – hard to get reimburse
– Int. in know. what may be
in offing on ! Fd. reimburse.
– Inter. in H. R. 1 –
– " " health progs. – what
prospects are for legis.
What assn can do to further
the Adm's prog. of upgrading nurs.
homes. We want to take a more
aggress. role in upgrading stand.

of pat. care.
Bring them up to date on what the gov't - prog. are - Welfare - health, etc.
How the ass'n can help to accomplish the Admin. objectives.

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20 mins. on legis. — then could spend about 10 mins. talking about China - med. field.

5/4021

H.R.1 = incl. a no. of provns for changes in Medicaid & Medicare
- Some will be accepted happily by assns such as this - others hurt

Health legis. — Comm held 4 1/2 wks of hearings in late fall of '71. After .. the comm did not return to it & this yr the Comm occupied w/ other high priority mtrs.
Meantime a no. of new proposals have been advanced to deal w/ catastrophic illness.

H.R. 1 =
1 series of proposals would impr. the prem. payments the pats. make for Part B" — phys. fees —
Would liberalize — fr. the pts. view of the beneficiary — the payments the [illegible] make.
- Under pres. law — the pay. incr. period. when hosp. costs go up —
- Under H.R. 1 — the pay. could only go up to the extent that Soc. Sec. benefits going.
- How. the deducts under Part B would go up fr. $50 to $60 —
- Add'ly — the coinsur. benef. pay under Part A would be impr. post fact an readm [illegible] pt. is in his hosp. stay.

Under Part A - benef. pays deduc eq. to ave. cost of hosp stay = us. $60.

Co-insur. begins on $61st day — eq to 1/4 of the deduc. (or $15)

Under H.R. 1 - co-ins. would begin w/ the 31st day at rate eq to 1/8 of the deduct. (31st thru 60th day) & then 61st day - the pres. rate

To offset this, the so called life time reserve would be dubled under H.R. 1.

c in any spell of illness - covered for 90 days except that the benef. has 60 " of coverage they can use once in a lifetime — (150 days).

For this L.R. - they pay 1/2 of the deduct.

Under H.R. 1 the L.R. would be dubled 90 days + (120) = 210 days total =

Under pres. law the States make the pay. under Medicaid.

Under H.R. 1 - incentives would be prov. to get the States to make contracts w/ H.M.O. & to discourage long stays in institutions.

= Ind of disincentives =

- reduc. in Fed. Medicaid match. by ⅓ after 60 days of care in a skilled nurs. home unless the State could show it had an effec. utilization review prog.

- Reduction of the 1/3 match after 60 days in a gen'l or T.B. hosp.
- Decrease by 1/3 in Fed. match. after 90 days in a mental hosp.
- + avai. of lesser provis.

Enact: dim for now #

H.R. 1 bottled up in Senate Fin. Comm for 14 mo's - because of the Welfare provis. - Comm. has made many changes which it n tent app'd but has not taken a final vote # Don't know future.

No further consid. of health care legis. til next yr - long term outlook is very good, incl. a thorough going review of Medicare.
- Gravs in mind lean toward the Admin plan rather than the Kennedy Plan +

REMARKS TO THE MICHIGAN NONPROFIT HOMES ASSOCIATION CONFERENCE 9/23/72

Apologize for not being present — 3 important votes — Defense Procurement authorization & appropriation

GOOD EVENING. IT IS A PLEASURE FOR ME TO BE TALKING WITH A GROUP OF PEOPLE WHOSE LIVES ARE INSPIRED BY THE MOTTO, "MOTIVATION FOR SERVICE." LET ME SAY AT THE OUTSET THAT I WISH YOU THE GREATEST OF SUCCESS AT THIS CONFERENCE, AND I HOPE THAT [redacted] THIS FIRST ANNUAL CONFERENCE SETS A PATTERN OF ACCOMPLISHMENT FOR ALL OF YOUR CONFERENCES [redacted] IN YEARS TO COME.

IT IS INTERESTING THAT YOURS SHOULD BE THE FIRST GROUP OF ITS KIND THAT I HAVE ADDRESSED SINCE RETURNING FROM A NINE-DAY STAY IN THE PEOPLE'S REPUBLIC OF CHINA. THERE THE ADMONITION YOU SEE EVERWHERE IS THE SLOGAN, "SERVE THE PEOPLE." WHATEVER ONE FEELS ABOUT COMMUNISM AS A FORM OF GOVERNMENT, ONE CANNOT ARGUE WITH THAT SLOGAN. AS A MATTER OF FACT, THOSE WHO OBEY THAT INJUNCTION ARE MUCH TO BE ADMIRED. [redacted] AND SO IT IS THAT I BELIEVE YOUR GROUP DESERVES A SPECIAL SALUTE AS YOU PAUSE TO LOOK AT THE FIELD IN WHICH YOU SERVE AND CONSIDER HOW YOU MAY BEST IMPROVE [redacted] UPON YOUR ACCOMPLISHMENTS.

THIS, I THINK, IS WHAT WE NEED TO SOLVE SO MANY OF THE NATION'S PROBLEMS...A SPIRIT OF SERVICE, A [redacted] SPIRIT OF [redacted] COOPERATION, SUPPORT OF POLICIES WHICH [redacted] PROMOTE THE GOOD OF THE ENTIRE NATION [redacted] RATHER THAN THAT OF SELFISH PRESSURE GROUPS.

IT IS IN THAT [redacted] SPIRIT THAT I SPEAK TO YOU TONIGHT.

I AM AWARE OF YOUR SPECIAL PROBLEMS. I AM TOLD THAT [redacted] DELAY BY THE STATE HEALTH DEPARTMENT IN DEALING WITH VIOLATION OF STANDARDS BY THE "FOR PROFIT" NURSING HOMES RESULTS IN THE NONPROFIT HOMES BEING TARRED WITH THE SAME BRUSH. I AM ALSO TOLD THAT YOU ARE PLAGUED BY DELAY IN REIMBURSEMENT FOR PUBLIC ASSISTANCE PATIENTS.

TONIGHT I WOULD LIKE TO DISCUSS SOME OF THE CHANGES THAT ARE IN THE OFFING IN MEDICARE AND MEDICAID AND THE PROSPECTS FOR IMPROVED HEALTH CARE [redacted] LEGISLATION. I WILL [redacted] ALSO TOUCH ON MY EXPERIENCES IN CHINA, SINCE THAT, TOO, MAY [redacted] INTEREST YOU.

THE FEDERAL GOVERNMENT HAS BECOME INCREASINGLY INVOLVED IN NURSING HOME CARE OVER THE LAST TWENTY YEARS, PARTICULARLY SINCE THE ENACTMENT OF THE MEDICARE AND MEDICAID PROGRAMS IN 1965. THIS INVOLVEMENT CARRIES WITH IT A RESPONSIBILITY TO ASSURE THAT NURSING HOMES DELIVER CARE WHICH AT THE VERY LEAST MEASURES UP TO FEDERAL STANDARDS AND REGULATIONS. THE PRESIDENT ACCEPTED THIS RESPONSIBILITY IN HIS 8-POINT PLAN FOR ACTION TO IMPROVE NURSING HOMES ANNOUNCED JUST OVER A YEAR AGO IN NEW HAMPSHIRE.

THE PRESIDENT'S AIMS WERE SIMPLE AND DIRECT:

--UPGRADE LONGTERM CARE FACILITIES:

--UPGRADE THE WAYS GOVERNMENT AT ALL LEVELS MONITORS [redacted] THESE FACILITIES:

--UPGRADE CHANNELS OF COMMUNICATION BETWEEN THE PATIENT, HIS FAMILY, THE NURSING HOME AND GOVERNMENT AGENCIES CONCERNED WITH LONGTERM CARE:

--UPGRADE THE CAPABILITY AND CONSCIOUSNESS OF LONGTERM CARE PERSONNEL:

--AND, MOST IMPORTANT OF ALL, UPGRADE OUR UNDERSTANDING OF LONGTERM CARE FACILITIES...LEARN WHAT THEY CAN AND CANNOT DO, AND CONSIDER WHAT ALTERNATIVE MODES AND LEVELS OF CARE MIGHT BE DEVELOPED TO ENSURE OUR OLDER CITIZENS THAT THE RIGHT CARE, AT THE RIGHT TIME, AT THE RIGHT PLACE, AND AT THE RIGHT COST WILL BE THERE.

NOW THIS MAY SOUND LIKE A LOT OF UPGRADING...AND IT IS. IT HAS BEEN, AND IS GOING TO BE, AN UPGRADE BATTLE ALL THE WAY. NOT BECAUSE NO ONE IN THE NURSING HOME INDUSTRY OR IN THE GOVERNMENT OR AMONG THE PUBLIC HAS not CARED IN THE PAST, BUT BECAUSE UNTIL VERY RECENTLY THERE HAVE NOT BEEN ENOUGH OF THESE THESE VERY ESSENTIAL ACTORS ON THELONGTERM CARE STAGE TO CREATE AND MAINTAIN A SYSTEM OF QUALITY THAT OUR PEOPLE DEMAND.

IT WAS TO FULFILL THIS DEMAND THAT THE PRESIDENT ORDERED THE FEDERAL GOVERNMENT TO MOVE BOLDLY AND RAPIDLY ALONG SEVERAL FRONTS. THE EFFECTIVENESS OF THAT ACTION IS ALREADY BEING FELT.

WE HAVE SEEN A MARKED IMPROVEMENT IN THE QUALITY OF STATE MEDICAID CERTIFICATION PROHRAMS SINCE LAST NOVEMBER WHEN WE FOUND NO FEWER THAN 39 STATES WITH MAJOR DEFICIENCIES. TODAY WE CAN BE REASONABLY CONFIDENT THAT EVERY STATE HAS A SOUND SURVEY AND CERTIFICATION PROGRAM...AND THE ADMINISTRATION INTENDS TO CONTINUE TO MONITOR THESE PROGRAMS TO MAKE SURE THEY STAY THAT WAY.

THE OBJECTIVE OF THIS FEDERAL EFFORT IS THREE-FOLD:

--TO SERVE NOTICE ON THE STATES THAT FEDERAL STANDARDS ARE TO BE FOLLOWED. ~~TO THE LETTER;~~

--TO SERVE NOTICE ON THE INDIVIDUAL NURSING HOME OPERATOR THAT THE FEDERAL PORTION OF HIS PATIENT CARE DOLLAR IS GOING TO BE PAID ONLY IF THAT PATIENT IS RECEIVING THE QUALITY OF CARE HE OR SHE IS ENTITLED TO;

--AND, THIRD, TO ASSURE THE INDIVIDUAL PATIENT THAT THE FULL BURDEN OF RESPONSIBILITY FOR THE QUALITY AND SAFETY OF HIS OR HER CARE IS NOW TO BE BORNE SQUARELY BY THE FEDERAL, STATE AND LOCAL GOVERNMENT AGENCIES SUPERVISING THAT CARE AND BY THE NURSING HOME PROVIDING THE SERVICES.

THE ADMINISTRATION BELIEVES THESE PURPOSES ARE BEING MET.

THE ADMINISTRATION IS ALSO MAKING PROGRESS ON SEVERAL OTHER FRONTS OF THE FEDERAL LONGTERM CARE PROGRAM.

THERE IS THE PUBLICATION OF FEDERAL MEDICAID STANDARDS FOR INTERMEDIATE CARE FACILITIES WHICH ARE TO BE IMPLEMENTED IN THE FALL.

THERE IS THE DEVELOPMENT OF JOINT MEDICARE-MEDICAID NURSING HOME STANDARDS WHICH WILL COORDINATE AND SIMPLIFY VIRTUALLY ALL COMPLEMENTARY ASPECTS OF THESE PROGRAMS.

XXXXX THERE ARE THE H.E.W. TRAINING PROGRAMS, WHICH HAVE NOW REACHED MORE THAN 700 OF THE 1100 STATE MEDICAID NURSING HOME INSPECTORS IN THE FIELD WITH UNIVERSITY-BASED TRAINING COURSES. MAY I INTERJECT AT THIS POINT THAT I HOPE CONGRESS ACTS ON THE PRESIDENT'S PROPOSAL THAT THE FEDERAL GOVERNMENT ASSUME THE FULL COSTS OF STATE MEDICAID NURSING HOME INSPECTION PROGRAMS.

AND, FINALLY, H.E.W.'S TRAINING PROGRAMS FOR XXXXXXXXXXXXXXXX NURSING HOME PERSONNEL ARE MOVING ALONG RAPIDLY. let me add — inspection is important but, if inspection is not fair + factual you let me know. I will not combat with politics or harassment.

LET ME TURN NOW TO H.R. ~~1~~ 1, THE ADMINISTRATION'S WELFARE REFORM BILL, WHICH CONTAINS MANY PROVISIONS IMPORTANT TO OLDER AMERICANS AND ALL THOSE ENTRUSTED WITH THEIR CARE.

AS YOU MAY KNOW, H.R. 1 PASSED THE HOUSE MORE THAN A YEAR AGO AND IS STUCK IN THE SENATE WELFARE COMMITTEE. H.R. 1 IS TOP PRIORITY LEGISLATION. CONGRESS WILL HAVE FAILED DISGRACEFULLY IN ITS RESPONSIBILITY TO THE NATION IF THIS LEGISLATION IS NOT ENACTED XXXXXXXXX BEFORE CONGRESS ADJOURNS FOR THE XXX YEAR.

XXXXXXXXXXXXXXXX
H.R. 1 ~~is~~ IS A COMPLICATED BILL. ITS PROVISIONS RANGE FROM XXXXXXXX FEDERAL MATCHING FOR MECHANIZED CLAIMS PROCESSING XXX UNDER MEDICAID TO AUTHORITY TO EXPERIMENT WITH ALTERNATIVE MEDICARE REIMBURSEMENT FORMULAS INTENDED TO PROMOTE ECONOMY AND EFFICIENCY.

LET ME BRIEFLY DISCUSS HOUSE-APPROVED CHANGES IN THE MEDICARE PROGRAM WHICH SHOULD BE OF INTEREST TO YOU.

ONE CHANGE IN MEDICARE COVERAGE EXTENDS PROTECTION TO THE DISABLED AFTER THEY HAVE BEEN RECEIVING SOCIAL SECURITY CASH BENEFITS FOR A PERIOD OF TWO YEARS. THIS MEETS A REAL XXX NEED IN A MANNER CONSISTENT WITH CAREFUL CONTROL OF MEDICARE COSTS.

THE HOUSE ALSO VOTED TO XXXX CHANGE THE DEDUCTIBLE AND PREMIUM PAYMENT FORMULA UNDER MEDICARE 'PART B' AND MADE A CHANGE IN THE COINSURANCE PAYMENT FOR IN INPATIENT XXXXXXXX HOSPITAL BENEFITS UNDER 'PART A.'

UNDER EXISTING LAW, THE PREMIUM A PATIENT PAYS UNDER 'PART B' GOES UP PERIODICALLY AS HOSPITAL COSTS GO UP. UNDER H.R. 1, THIS PREMIUM COULD BE INCREASED ONLY TO THE EXTENT THAT SOCIAL SECURITY BENEFITS ARE INCREASED. SINCE HEALTH CARE COSTS HAVE BEEN RISING FASTER THAN ANY OTHER COST ITEM IN THE ECONOMY, THIS PROVISION SHOULD BE OF SUBSTANTIAL ASSISTANCE TO THE ELDERLY AND DISABLED.

HOWEVER, H.R. 1 ALSO XXXXXXX INCREASES THE ANNUAL DEDUCTIBLE UNDER 'PART B' FROM $50 TO $60. THIS DEDUCTIBLE XXXX HAS NOT BEEN INCREASED SINCE THE PROGRAM FIRST WAS ENACTED IN 1965, ALTHOUGH COSTS OF COVERED SERVICES HAVE INCREASED SHARPLY.

ADDITIONALLY, THE COINSURANCE A BENEFICIARY PAYS UNDER 'PART A' WOULD BE IMPOSED AT AN EARLIER POINT IN HIS HOSPITAL STAY. UNDER PRESENT LAW, COINSURANCE PAYMENTS BEGIN ON THE 61ST DAY OF THE XXX HOSPITAL STAY AND IS EQUIVALENT TO ONE-FOURTH OF THE DEDUCTIBLE . UNDER H.R. 1, THE COINSURANCE PAYMENTS WOULD HAVE TO BEGIN WITH THE

31ST DAY BUT XXT AT A RATE EQUIVALENT TO ONE-EIGHTH OF THE DEDUCTIBLE. THIS WOULD APPLY FROM THE 31ST THROUGH THE 60TH DAY, WHEN THE PRESENT RATE ONCE MORE WOULD TAKE EFFECT.

TO OFFSET THIS INCREASE IN COINSURANCE PAYMENTS, THE HOUSE DOUBLED THE SO-CALLED LIFETIME RESERVE UNDER H.R. 1.

UNDER PRESENT LAW, A BENEFICIARY IS COVERED FOR 90 DAYS OF HOSPITALIZATION IN EVERY 'SPELL OF ILLNESS' AND HAS ACCESS TO 60 ADDITIONAL DAYS ON A ONCE-IN-A-LIFETIME BASIS. UNDER H.R. 1, ANOTHER NONRENEWABLE 60 DAYS WOULD BE ADDED. THIS GIVES THE BENEFICIAIRY A ONE-TIME MAXIUMUM HOSPITALIZATION COVERAGE OF 210 DAYS INSTEAD OF THE EXISTING 150 DAYS.

I AM HOPEFUL THAT THESE CHANGES WILL IMPROVE THE EFFICIENCY OF THE MEDICARE PROGRAM WHILE PROVIDING OUR ELDERLY WITH A MEASURE OF FISCAL RELIEF.

SINCE WE ARE TALKING TONIGHT ABOUT THE HEALTH PROBLEMS OF OLDER AMERICANS, AND WHAT ALL OF US CAN DO TO HELP RESOLVE THEM, IT SEEMS APPROPRIATE TO QUOTE FROM THE AMERICAN WRITER AMBROSE BIERCE, WHOSE OWN SPECIAL PROBLEM SEEMS TO HAVE BEEN A CHRONIC BAD MOOD.

SAID BIERCE, 'RESPONSIBILITY IS A DETACHABLE BURDEN EASILY SHIFTED FROM ONE'S OWN SHOULDERS TO THOSE OF GOD, FATE, FORTUNE, LUCK....OR ONE'S NEIGHBOR.'

I HAVE JUDGED FROM THE THEME OF THIS CONFERENCE THAT NO ONE LISTENING TO ME TONIGHT NEEDS TO BE REMINDED OF HIS OR HER SHARE OF RESPONSIBILITY FOR LONGTERM CARE IN MICHIGAN. AND I SENSE FROM THE SPIIRT OF RESPONSIBILITY IMPLICIT IN YOUR CONFERENCE AGENDA THAT IF THERE IS ANY SHIFTING OF THAT BURDEN, IT WILL BE TO TAKE EVEN MORE OF IT UPON YOUR OWN SHOULDERS.

ONE COMMENT NOW ABOUT MEDICAID. AS YOU KNOW, THE STATES MAKE THE PAYMENTS UNDER MEDICAID PAYMENTS UNDER EXISTING LAW.

UNDER H.R. 1, INCENTIVES ARE PROVIDED TO GET THE STATES TO MAKE CONTRACTS WITH HEALTH MAINTENANCE ORGANIZATIONS AND TO DISCOURAGE LONG STAYS IN INSTITUTIONS. ONE OF THE DISINCENTIVES IS A REDUCTION IN FEDERAL MEDICAID MATCHING BY ONE-THIRD AFTER 60 DAYS OF CARE IN A SKILIED NURSING HOME...UNLESS THE STATE CAN SHOW IT HAS AN EFFECTIVE UTILIZATION REVIEW PROGRAM. THERE WOULD BE A REDUCTION OF THE ONE-THIRD MATCHING AFTER 60 DAYS IN A GENERAL OR TUBERCULOSIS HOSPITAL AND A DECREASE BY ONE-THIRD IN FEDERAL MATCHING AFTER 90 DAYS IN A MENTAL HOSPITAL.

AS YOU MAY HAVE HEARD, PROSPECTS FOR SENATE PASSAGE OF H.R. 1 THIS YEAR APPEAR DIM. IT HAS BEEN BOTTLED UP IN THE SENATE FINANCE COMMITTEE FOR 11 MONTHS NOW.

HEALTH CARE LEGISLATION IS DEFINITELY A 1973 ACTION ITEM. THE HOUSE WAYS AND MEANS COMMITTEE HELD 4½ WEEKS OF HEARINGS ON IT IN THE LATE FALL

OF 1971 AND THEN LAID IT ASIDE TO DEAL WITH OTHER MATTERS. THE COMMITTEE DID NOT RETURN TO IT THIS YEAR. MEANTIME A NUMBER OF NEW PROPOSALS HAVE BEEN ADVANCED, DEALING WITH CATASTROPHIC ILLNESS. MY PREDICTION IS THAT THE NEXT CONGRESS WILL PASS HEALTH CARE LEGISLATION AND THAT IT WILL RESEMBLE MOST CLOSELY THE ADMINISTRATION PROPOSALS IN THIS FIELD...BUILDING ON THE PRESENT HEALTH INSURANCE SYSTEM RATHER THAN FEDERALIZING HEALTH CARE. SO THE LONGTERM OUTLOOK IS VERY GOOD, INCLUDING A THOROUGH-GOING REVIEW OF MEDICARE.

SINCE WE ARE TALKING TONIGHT ABOUT THE HEALTH PROBLEMS OF OLDER AMERICANS, IT SEEMS APPROPRIATE TO QUOTE FROM THE AMERICAN WRITER AMBROSE BIERCE, A ONE-TIME OLDER AMERICAN WHOSE OWN SPECIAL PROBLEM SEEMS TO HAVE BEEN A CHRONIC BAD MOOD.

SAID BIERCE, 'RESPONSIBILITY IS A DETACHABLE BURDEN EASILY SHIFTED FROM ONE'S OWN SHOULDERS TO THOSE OF GOD, FATE, FORTUNE, LUCK...OR ONE'S NEIGHBOR.'

I HAVE ALREADY JUDGED FROM THE THEME OF THIS CONFERENCE THAT NO ONE LISTENING TO ME TONIGHT NEEDS TO BE REMINDED OF HIS OR HER SHARE OF RESPONSIBILITY FOR LONGTERM CARE IN MICHIGAN. AND I SENSE FROM THE SPIRIT OF RESPONSIBILITY IMPLICIT IN YOUR CONFERENCE AGENDA THAT IF THERE IS ANY SHIFTING OF THAT BURDEN, IT WILL BE TO TAKE EVEN MORE OF IT UPON YOUR OWN SHOULDERS.

I WOULD LIKE TO MENTION AT THIS POINT THAT THE QUALITY OF ANY CIVILIZATION CAN BE MEASURED BY THE ATTITUDE OF THE PEOPLE TOWARD THE ELDERLY IN THEIR MIDST. I THINK IT IS NO ACCIDENT THAT THE INCIDENCE OF CRIME HAS ALWAYS BEEN LOW IN SOCIETIES WHICH HAVE GREAT REVERENCE FOR FAMILY TIES. AND IT SHOULD ALSO BE REMARKED THAT THESE SAME SOCIETIES...THE JEWISH AND CHINESE, FOR INSTANCE...HAVE ALSO HAD GREAT REVERENCE FOR THE ELDERLY IN THEIR MIDST.

THIS REVERENCE FOR AGE CONTINUES IN THE NEW CHINA, AS IN THE OLD.

IT MAY BE OF SOME INTEREST TO YOU THAT PEOPLE RETIRE EARLIER IN COMMUNIST CHINA THAN IN THE UNITED STATES. FOR WOMEN THE RETIREMENT AGE IS 55; FOR THE MEN, 60.

HEALTH CARE IS A TOP PRIORITY IN COMMUNIST CHINA. THIS IS REFLECTED IN CRASH PROGRAMS FOR THE TRAINING OF DOCTORS AND NURSES. THE TRAINING PERIOD FOR DOCTORS HAS BEEN CUT IN HALF...FROM SIX YEARS TO THREE. NURSE TRAINING HAS ALSO BEEN SLICED IN HALF...FROM THREE YEARS TO 1½. AT THE SAME TIME, THE CHINESE HAVE BEEN TURNING OUT THOUSANDS OF MEDICAL CORPSMEN KNOWN AS 'BAREFOOT DOCTORS' WHO ARE SENT OUT INTO THE COUNTRYSIDE TO PROVIDE THE RUDIMENTS OF MEDICAL CARE. MAJOR CASES, OR COURSE, ARE SENT TO THE HOSPITALS.

ONLY A FEW YEARS AGO, NO MODERN MEDICAL CARE TO SPEAK OF WAS AVAILABLE TO THE GREAT PREPONDERANCE OF CHINA'S INHABITANTS. NOW SOME KIND OF CARE IS PROVIDED TO EVERY CHINESE IN NEED OF MEDICAL ATTENTION. IN MORE REMOTE REGIONS, IT MAY BE ELEMENTAL, BUT IT IS AVAILABLE. THERE IS NO CHARGE FOR MEDICAL CARE TO WORKERS IN THE

CITIES BUT EACH FAMILY XX IN THE COMMUNES PAYS ABOUT 4 CENTS PER MONTH FOR MEDICAL SERVICES.

THERE IS HEAVY EMPHASIS ON PERSONAL CLEANLINESS IN CHINA. AS A RESULT, EPIDEMIC AND INTENSTINAL AILMENTS HAVE BEEN SHARPLY REDUCED. THE PEOPLE HAVE BEEN REPEATEDLY MOBILIZED TO ERADICATE DISEASE*CARRYING SNAILS, FLIES AND MOSQUITOES.

SOME OF THE CHINESE HEALTH TECHNIQUES WOULD HAVE EXCHANGE VALUE FOR THIS UNITED STATES. SO, TOO, XX DOES THE USE OF ACUPUNCTURE AS ANESTHESIA IN OPERATIONS.

I WITNESSED THREE OPERATIONS IN PEKING IN WHICH ACUPUNCTURE ANESTHESIA XX WAS USED. SO I KNOW THAT IT XX WORKS.

DR. FREEMAN CARY, A XXXX PHYSICIAN WHO ACCOMPANIED CONGRESSMAN HALE BOGGSXX AND ME AND OUR PARTY TO CHINA, PREDICTS THAT ACUPUNCTURE ANESTHEXSIA WILL BE EXTENSIVELY XXXXXXXX USED IN THE UNITED STATES WXTHXX WITHIN A YEARXXX OR TWO.

THERE ARE STILL MANY HEALTH CARE SHORTCOMINGS IN CHINA, BOTH IN THE QUALITY OF CARE AND IN THE NUMBER AND QUALITY OF FACILITIES AVAILABLE TO THE XXXX PEOPLE. BUT THE CHINESE HAVE MADE TREMENDOUS ADVANCES.

MEDICINE IN CHINA IS HEAVILY MIXED WITH IDEOLOGY. WHEN THE COMMUNISTS FIRST TOOK OVER IN 1949, THE EMPHASIS WAS ON PROVIDING HEALTH CARE IN THE CITIES, THE CENTERS OF HEAVY INDUSTRY. AND THE PROFESSORS RAN THE MEDICAL SCHOOLS.

WITH THE ERUPTION OF THE CULTURAL REVOLUTION IN 1966 AND IN THE YEARS THAT FOLLOWED, REVOLUTIONARY COMMITTEES WERE SET UP TO RUN THE MEDICAL SCHOOLS, PROGRAMS WERE LAUNCHED TO GREATLY EXPAND MEDICALXX MANPOWER, AND THE EMPHASIS IN HEALTH CARE SHIFTED TO THE RURAL AREAS.

ALL IS IN KEEPING WITH THE TEACHINGS OF CHAIRMAN MAO. BUT THIS MUCH XXXXX MUST BE SAID. HEALTH CARE IN CHINA HAS BEEN REVOLUTIONIZED...AND VERY MUCH FOR THE BETTER.

MAO'S FAVORITE SLOGAN IS A GOOD SLOGAN IN ANY COUNTRY--'SERVE THE PEOPLE.'

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THE FEDERAL PROGRAM FOR LONG-TERM CARE

MARIE CALLENDER

SPECIAL ASSISTANT FOR NURSING HOME AFFAIRS

THIS SEMINAR IS DESIGNED TO INCREASE CONSULTANT SKILLS, AND YOU HAVE BEEN ENGAGED IN THE DISCUSSION OF MANY ASPECTS OF INSTITUTIONAL CARE AND THE REGULATIONS THAT GOVERN IT. I WOULD LIKE TO STEP BACK FROM THOSE SPECIFICS AND DESCRIBE TO YOU SOME OF THE PROBLEMS IN NURSING HOME CARE, THE SCOPE OF THE PRESIDENT'S COMMITTMENT TO SOLVE ~~THOSE~~ nursing home PROBLEMS, AND SOME FUTURE CONSIDERATIONS WHICH WE ARE STUDYING. I THINK THIS DESCRIPTION WILL EMPHASIZE THE IMPORTANCE AND THE HIGH PRIORITY OF THE TASK IN WHICH WE ARE ENGAGED.

THE QUALITY OF ANY CIVILIZATION CAN BE MEASURED BY THE ATTITUDE OF THE PEOPLE TOWARD THE ELDERLY IN THEIR MIDST. THEIR VALUE ECONOMICALLY IS EBBING OR IS AT AN END. THEY REQUIRE A DISPROPORTIONATE SHARE OF MEDICAL AND SOCIAL SERVICES, IN SOME EARLIER CULTURES THEY WERE CUT OFF FROM THE TRIBE AND FORCED TO WANDER WITHOUT FOOD OR SHELTER UNTIL THEY DIED. MOST OF US LOOK WITH REVULSION AT SUCH SOCIAL PATTERNS, AND ACCEPT THE MORAL RESPONSIBILITY OF OUR SOCIETY TOWARD ITS ELDERLY.

TO BE PRESENTED AT THE SEMINAR FOR CONSULTANTS, SPONSORED JOINTLY CHS AND BHI, SSA OF REGION IX, AT SANTA INEZ INN, PACIFIC PALLISADES, CALIFORNIA, MONDAY, MARCH 22, 1972.

GW 2.

THE MAJORITY OF THOSE OVER SIXTY-FIVE ARE ABLE TO LEAD ACTIVIE, INDEPENDENT LIVES CONTRIBUTING VIGOROUSLY TO OUR NATIONAL LIFE. HOWEVER, ALMOST A MILLION OF OUR TWENTY-MILLION PERSONS OVER SIXTY-FIVE REQUIRE THE CARE AND SUPPORT OF NURSING HOMES, AND IT IS THESE WHOSE DEPENDENCE MOST ACUTELY TESTS THE QUALITY OF OUR COMPASSION AND SENSE OF HUMANITY.

THE PRESIDENT HAS APTLY STATED THAT, "FOR THOSE WHO NEED THEM, THE NURSING HOMES OF AMERICA SHOULD BE SHINING SYMBOLS OF CONFORT AND CONCERN." MANY OF OUR NURSING HOMES MEET THIS STANDARD. OTHERS DO NOT, AS TESTIFIED BY RECENT SHOCKING AND TRAGIC NURSING HOME FIRES, AND LESS DRAMATICALLY BY PRIVATE AND GOVERNMENT STUDIES. IN MAY, 1971, THE GENERAL ACCOUNTING OFFICE ISSUED A REPORT ON THE ENFORCEMENT OF MEDICAID AND MEDICARE STANDARDS IN NINETY NURSING HOMES IN OKLAHOMA, NEW YORK, AND MICHIGAN. SERIOUS DEFICIENCIES WERE FOUND IN MORE THAN 50 PERCENT OF THESE HOMES, ALL OF WHICH HAD MEDICAID PATIENTS AND MANY OF WHICH WERE APPROVED FOR MEDICARE. ON NOVEMBER 30, 1971, SECRETARY RICHARDSON ANNOUNCED THAT 39 STATES WERE OUT OF COMPLIANCE WITH TITLE 19 CERTIFICATION PROCEDURES. IN HUMAN TERMS, THESE STUDIES MEAN THAT MANY NURSING HOMES WHICH FAIL TO MEET STANDARDS ARE UNSANITARY AND UNSAFE, OVERCROWDED AND UNDERSTAFFED--LONELY AND DEPRESSING PLACES FOR THE ELDERLY TO LIVE AND DIE.

THE FEDERAL GOVERNMENT HAS BECOME INCREASINGLY INVOLVED IN NURSING HOME CARE OVER THE LAST TWENTY YEARS, PARTICULARLY SINCE THE ENACTMENT OF THE MEDICARE AND MEDICAID PROGRAMS IN 1965. IN 1970 THE FEDERAL GOVERNMENT SPENT OVER $2 BILLION IN SUPPORT OF NURSING HOME PATIENTS, WHILE STATE AND LOCAL GOVERNMENTS SPENT ANOTHER $700 MILLION. THIS INVOLVEMENT CARRIES WITH IT A RESPONSIBILITY TO ASSURE THAT NURSING HOMES DELIVER CARE AT LEAST AT THE LEVELS OF FEDERAL STANDARDS AND REGULATIONS. THE PRESIDENT ACCEPTED THIS RESPONSIBILITY IN HIS 8-POINT PLAN FOR ACTION TO IMPROVE NURSING HOMES ANNOUNCED LAST AUGUST IN NEW HAMPSHIRE.

A MAJOR GOAL OF THE PLAN IS TO IMPROVE FEDERAL ENFORCEMENT OF NURSING HOME STANDARDS. AS YOU KNOW, THE TERM "NURSING HOME" IS APPLIED TO A WIDE RANGE OF FACILITIES, FROM THOSE PROVIDING PRIMARILY CUSTODIAL CARE TO THOSE DELIVERING HIGHLY SKILLED POST-HOSPITAL AND REHABILITATIVE SERVICES. ~~THESE DIFFERENT~~ TYPES OF FACILITIES ARE ACCREDITED THROUGH DIFFERENT MECHANISMS, AND FEDERAL LEVERAGE IN ENFORCING STANDARDS VARIES WIDELY. MEDICARE CERTIFICATION OF EXTENDED CARE FACILITIES IS A FEDERAL PROGRAM MEDIATED THROUGH STATE SURVEY AGENCIES. MEDICAID IS A FEDERAL-STATE PROGRAM, FINANCED AND ADMINISTERED THROUGH BOTH FEDERAL AND STATE FUNDS AND ACTIVITIES. INTERMEDIATE CARE FACILITIES formerly ~~UNTIL RECENTLY~~ WERE REQUIRED TO MEET ONLY STATE LICENSING REQUIREMENTS TO RECEIVE FEDERAL FUNDS. THESE DIFFERENCES HAVE COMPLICATED THE ENFORCEMENT OF STANDARDS. HOWEVER, BOTH MEDICARE

AND MEDICAID HAVE TRADITIONALLY AND STATUTORILY RELIED ON STATE AGENCY INSPECTION OF FACILITIES, AND THE PRESIDENT HAS CHOSEN TO RETAIN THIS EMPHASIS ON THE ROLE OF THE STATE AGENCY. WE BELIEVE THIS APPROACH IS CONSISTENT WITH A HEALTHY FEDERAL-STATE RELATIONSHIP AND AVOIDS UNNECESSARY EXPANSION OF THE FEDERAL BUREAUCRACY. BUT THE FEDERAL GOVERNMENT, WHICH IS RESPONSIBLE FOR THE QUALITY OF CARE ~~WHICH~~ IT FINANCES, MUST AID IN ENHANCING THE CAPABILITY OF THE STATE AGENCIES TO REGULATE AND IMPROVE THE QUALITY OF NURSING HOME CARE. TO IMPROVE ENFORCEMENT OF NURSING HOME STANDARDS, THE PRESIDENT'S PLAN PLEDGED THE FOLLOWING STEPS:

1. CONSOLIDATION OF RESPONSIBILITY FOR NURSING HOME AFFAIRS. NURSING HOME ACTIVITIES HAVE BEEN SCATTERED AMONG SEVERAL BRANCHES OF THE DEPARTMENT OF HEW, INCLUDING THE SOCIAL SECURITY ADMINISTRATION, THE SOCIAL AND REHABILITATION SERVICE, AND THE HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION. THE PRESIDENT ORDERED THAT ALL FEDERAL ENFORCEMENT RESPONSIBILITY BE CONSOLIDATED IN A SINGLE OFFICE, AND DR. MERLIN K. DUVAL, THE ASSISTANT SECRETARY OF HEALTH AND SCIENTIFIC AFFAIRS, WAS DESIGNATED AS THE RESPONSIBLE OFFICIAL. ~~DR. DUVAL APPOINTED ME TO WORK WITH HIM ON THESE ACTIVITIES AND TO FUNCTION AS A FULL-TIME COORDINATOR OF NURSING HOME ACTIVITIES.~~

2. Enlargement of Federal staff for enforcement of nursing home standards. The Social and Rehabilitation Service, which administers the medicaid program, has been assigned 142 additional positions to carry out its increased responsibilities. One hundred ten of these positions were allocated to the Regional Offices of HEW. The Social Security Administration received eight new positions, and HEW's Audit Agency received thirty-four additional positions to increase the their audits of nursing home operations. The National Center for Health Services Research and Development received seven new positions for efforts to improve nursing home data systems and to develop data in special fields relevant to nursing home care.

3. Federal support of 100% of the cost of State Medicaid Inspections. We recognize that an increased level of enforcement activity involves additional costs to the States. Medicare inspection costs have always been fully paid for by the Federal government, but under the Medicaid program States have paid 25 to 50 percent of these costs. Secretary Richardson submitted to Congress in October, 1971, an amendment to H.R.I. authorizing the Federal government to assume 100 percent of inspection costs under Medicaid; this step will

PLACE BOTH PROGRAMS ON AN EQUAL FOOTING AND LESSEN THE FINANCIAL BURDEN TO THE STATES.

4. TRAINING STATE NURSING HOME INSPECTORS. NURSING HOME SURVEYORS HAVE BEEN TRAINED IN SURVEY AND COUNSELLING TECHNIQUES UNDER A PROGRAM SPONSORED BY THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION SINCE MARCH, 1970. ~~SOME OF YOU HAVE ATTENDED THESE COURSES. IN HIS AUGUST SPEECH,~~ THE PRESIDENT PLEDGED AN EXPANSION OF THIS PROGRAM SO THAT 2,000 SURVEYORS WOULD BE TRAINED IN THE ~~ENSUING~~ EIGHTEEN MONTH PERIOD. AS A RESULT OF THE PRESIDENT'S ORDER, THE PROGRAM HAS BEEN ACCELERATED ~~SO THAT 475 SURVEYORS HAVE NOW BEEN TRAINED.~~ CONTRACT NEGOTIATIONS ARE IN PROCESS TO ESTABLISH THREE ADDITIONAL UNIVERSITY CENTERS. IN ADDITION, A STUDY WAS PERFORMED BY MACRO, SYSTEMS, INC., TO EVALUATE THE EFFECTIVENESS OF THE TRAINING COURSES, AND THESE HAVE NOW BEEN MODIFIED TO REFLECT THE RESULTS OF THAT STUDY.

THESE EFFORTS TO ACHIEVE COMPLIANCE WITH FEDERAL STANDARDS AND REGULATIONS ARE NOT DESIGNED TO ELIMINATE FACILITIES AND THUS TO DEPRIVE PATIENTS OF NEEDED NURSING HOME CARE. WE ARE WORKING RATHER TO COORDINATE FEDERAL AND STATE PROGRAMS AND STATE AGENCIES TO SHARE THEIR RESOURCES AND EXPERTISE SO THAT SUBSTANDARD FACILITIES CAN BE UPGRADED. THE FEDERAL PROGRAM

TO TRAIN NURSING HOME SURVEYORS, FOR EXAMPLE, EMPHASIZES THE DEVELOPMENT OF SKILLS TO AID NURSING HOME ADMINISTRATORS IN MAKING NEEDED IMPROVEMENTS. FEDERAL FINANCIAL ASSISTANCE IS AVAILABLE FOR NURSING HOME MODERNIZATION AND NEW CONSTRUCTION FROM THE FEDERAL HOUSING ADMINISTRATION AND SUCH PROGRAMS AS HILL BURTON. THE STANDARDS THEMSELVES ARE BEING REVISED AND STRENGTHENED. WE ARE DEVELOPING PROGRAMS TO IMPROVE NURSING HOMES DIRECTLY- ~~I SHALL DESCRIBE THEM IN A FEW MOMENTS.~~

BUT AS THE PRESIDENT WARNED ~~LAST AUGUST~~ *[illegible] a year ago*," ... LET THERE BE NO MISTAKING THE FACT THAT WHEN FACILITIES FAIL TO MEET REASONABLE STANDARDS, WE WILL NOT HESITATE TO CUT OFF THEIR MEDICARE AND MEDICAID FUNDS." ~~BETWEEN AUGUST 6, 1971, AND FEBRUARY 11, 1972, 13~~ *have been* EXTENDED CARE FACILITIES ~~WERE~~ DECERTIFIED FOR MEDICARE PARTICIPATION. ON NOVEMBER 30, 1971, THIRTY-NINE STATES WERE DECLARED OUT OF COMPLIANCE WITH TITLE 19-MEDICAID--CERTIFICATION PROCEDURES. BY FEBRUARY 1, 1972 IN RESPONSE TO SECRETARY RICHARDSON'S DEADLINE, ALL BUT ONE OF THOSE STATES HAD MADE THE IMPROVEMENTS REQUIRED FOR COMPLIANCE. BY JULY 1 1972, ALL TITLE 19 FACILITIES IN ALL STATES ARE TO HAVE BEEN INSPECTED AND CERTIFIED THROUGH THE CORRECT PROCEDURES. THE FEDERAL GOVERNMENT IS PLEDGED TO MEET ITS RESPONSIBILITY TO ASSURE THAT FEDERAL DOLLARS DO NOT FINANCE SUBSTANDARD CARE.

WHILE WE ARE ENGAGED IN THIS MASSIVE ENFORCEMENT EFFORT, AND WHILE WE ARE CAUGHT UP IN THE RUSH TO MEET THE JULY 1 DEADLINE, I THINK WE MUST RETAIN A SENSE OF PROPORTION IN RECOGNIZING ALL THE THINGS FEDERAL REGULATIONS CANNOT DO TO AFFECT THE QUALITY OF NURSING HOME CARE. THESE LIMITATIONS CAST A SPECIAL LIGHT ON YOUR ROLE AS CONSULTANTS - FOR YOU ARE CONSULTANTS NOT ONLY TO SURVEY AGENCIES AND TO SINGLE STATE AGENCIES, BUT ALSO TO THE NURSING HOMES YOU REVIEW.

FIRST, REGULATIONS OF QUALITY OF CARE TEND TO BECOME A FLOOR RATHER THAN A CEILING. WHILE WE DEMAND THAT AN EXTENDED CARE FACILITY NOT FALL BELOW FEDERAL STANDARDS, WE DO NOT WANT TO DISCOURAGE IT FROM ASPIRING TO ACHIEVE A BETTER QUALITY OF CARE. AND ALTHOUGH YOU INSPECT FOR COMPLIANCE WITH FEDERAL STANDARDS, AS CONSULTANTS YOU ARE NOT LIMITED TO WHAT SHOULD BE CONSIDERED MINIMAL STANDARDS FOR CARE.

SECOND, REGULATIONS TEND TO COVER STRUCTURAL CONSIDERATIONS - THOSE FACTORS IN PROFESSIONAL QUALIFICATIONS, STAFFING, AND ENVIRONMENT WHICH MAKE GOOD CARE POSSIBLE RATHER THAN THE ACTUAL QUALITY OF CARE DELIVERED. AND HERE AGAIN, YOU AS CONSULTANTS CAN IMPROVE THE REGULATORY PROCESS BY EXAMINING THE MEDICAL AND SOCIAL SERVICES ACTUALLY DELIVERED. THE JOB IS NOT EASY. IT CANNOT BE DONE IF THE PHARMACIST LOOKS ONLY AT THE PHARMACY, THE DIETICIAN AT THE KICHEN, THE DOCTOR AT

MEDICAL RECORDS, THE NURSE AT NURSING SERVICES. CONSULTANTS SHOULD CONSIDER ALSO THE PROFESSIONAL COORDINATION IN AN INSTITUTION, AND HOW IT CONTRIBUTES TO PATIENT CARE.

THIRD, REGULATIONS FREQUENTLY DO NOT CONSIDER THE RELATIVE IMPORTANCE OF DEFICIENCIES. IN THE REAL WORLD, ADMINISTRATORS WITH LIMITED BUDGETS--AND FEW HAVE UNLIMITED BUDGETS, EVEN IN THE FEDERAL GOVERNMENT-MUST OPERATE WITH A LIST OF PRIORITIES. CONSULTANTS SHOULD BE ABLE TO ASSIST A NURSING HOME IN ESTABLISHING PRIORITIES. AGAIN, THE JOB IS NOT EASY, FOR IT REQUIRES THE SPECIALIST TO LOOK BEYOND HIS OWN AREA OF EXPERTISE TO RECOGNIZE OTHER NEEDS. IS AN IN-HOUSE PHARMACY MORE IMPORTANT THEN AN OCCUPATIONAL THERAPY PROGRAM? MIGHT SUGGEST AN EXERCISE FOR THIS SEMINAR? SPECIALISTS IN THE VARIOUS FIELDS OF CONSULTION CAN EACH DRAW UP LISTS OF FIVE MAJOR INSTITUTIONAL DEFICIENCIES IN THEIR AREA OF REGULATION. THEN IN A GROUP SESSION DEFICIENCIES IN SEVERAL AREAS OF REGULATION BE RANKED ACCORDING TO PRIORITY. THIS PROCESS OF COMPARING APPLES AND ORANGES-HOWEVER DESPISED IN THE CLASSROOM-IS AN EVERY DAY EXPERIENCE FOR THE ADMINISTRATOR.

LAST, REGULATIONS ARE SLOW TO RECOGNIZE AND TAKE ACCOUNT OF CHANGE AND IMPROVEMENT. AS CONSULTANTS, YOU SEE AND CAN ASSESS WHAT IS NEW, AND YOU HAVE THE OPPORTUNITY TO CROSS-POLLINATE WORTHWHILE IDEAS AND TECHNIQUES. AS YOU KNOW, NURSING HOMES HAVE

BECOME A VERY COMPLICATED INDUSTRY, AND IN MANY SENSES HAVE BECOME "BIG BUSINESS." THIS IS NOT ENTIRELY BAD. NEW MANAGEMENT AND ADMINISTRATIVE SKILLS HAVE BEEN INTRODUCED, AND SOME OF THESE OFFER PROMISE. IF YOU ARE TO DEAL WITH NURSING HOME ADMINISTRATORS AND ASSESS THEIR MANAGEMENT, YOU MUST UNDERSTAND THEIR SKILLS SO THAT YOU CAN SERVE MORE EFFECTIVELY YOUR CONSULTANT ROLE.

TO RETURN TO THE PRESIDENT'S PLAN, SO FAR I HAVE DISCUSSED IMPROVED ENFORCEMENT OF NURSING HOME STANDARDS. TWO OTHER POINTS IN THE PLAN INITIATED MORE DIRECT STEPS TO IMPROVE NURSING HOME CARE. THE PRESIDENT DIRECTED THE DEPARTMENT OF HEW "TO INSTITUTE A NEW PROGRAM OF SHORT-TERM COURSES FOR PHYSICIANS, NURSES, DIETICIANS, SOCIAL WORKERS AND OTHERS WHO ARE REGULARLY INVOLVED IN FURNISHING SERVICES TO NURSING HOME PATIENTS." HEW HAS SUPPORTED SUCH TRAINING FOR SEVERAL YEARS, AND HAS DEVELOPED CLOSE WORKING RELATIONSHIPS WITH PROFESSIONAL ASSOCIATIONS AND WITH TRAINING CENTERS. IN RESPONSE TO THE PRESIDENTS' DIRECTIVE, SUCH PROGRAMS HAVE BEEN EXPANDED UNDER THE LEADERSHIP OF THE COMMUNITY HEALTH SERVICE, HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION, AND ~~IT IS ANTICIPATED THAT~~ APPROXIMATELY 20,000 PERSONS ~~WILL BE~~ were TRAINED IN FISCAL YEAR 1972 AT A COST OF $2.5 MILLION. TRAINING PROGRAMS ~~WILL~~ FOCUS ~~INITIALLY~~ ON FOUR MANPOWER AREAS SELECTED BECAUSE OF THEIR DIRECT DAY-TO-DAY RELATIONS WITH NURSING

HOME PATIENTS: NURSING HOME ADMINISTRATORS, PHYSICIANS, NURSES, AND PATIENT ACTIVITIES DIRECTORS. MANY OF THESE TRAINING PROGRAMS WILL BE OPERATED UNDER CONTRACTS WITH PROFESSIONAL GROUPS. APPROACHES TO MENTAL HEALTH PROBLEMS OF NURSING HOME PATIENTS WILL BE DEVELOPED BY NATIONAL INSTITUTE OF MENTAL HEALTH STAFF WORKING WITH THE GERONTOLOGICAL SOCIETY. OTHER TRAINING MECHANISMS WILL ALSO BE EXPLORED, SUCH AS PROGRAMS SPONSORED BY STATE HEALTH DEPARTMENTS AND STATE AGENCIES. THESE PROGRAMS WILL BE DIRECTED TOWARD MAKING NURSING HOME STAFF-BOTH PROFESSIONAL AND ALLIED HEALTH-MORE SENSITIVE AND EXPERT IN THE SPECIAL PROBLEMS OF CARE FOR GERIATRIC PATIENTS AND THE CHRONICALLY ILL. THEY ARE INTENDED TO BE THE BEGINNING OF A SYSTEM FOR NATIONWIDE, CONTINUOUS TRAINING FOR NURSING HOME PERSONNEL WHICH WILL BECOME STANDARD PRACTICE IN THE NURSING HOME INDUSTRY OF THE FUTURE.

AS THE SEVENTH POINT IN HIS PLAN, THE PRESIDENT DIRECTED THE DEPARTMENT OF HEW "TO ASSIST THE STATES IN ESTABLISHING INVESTIGATIVE UNITS WHICH WILL RESPOND IN A RESPONSIBLE AND CONSTRUCTIVE WAY TO COMPLAINTS MADE BY OR ON BEHALF OF INDIVIDUAL PATIENTS." SINCE I ASSUMED MY NURSING HOME RESPONSIBILITIES, I HAVE RECEIVED MANY LETTERS FROM NURSING HOME PATIENTS-TOUCHING IN THEIR APPEAL FOR CARE OFFERING SIMPLE DIGNITY AND RIGHTS OF PRIVACY, HARROWING SOMETIMES IN THEIR DESCRIPTIONS OF PHYSICAL OR PSYCHOLOGICAL ABUSE. THESE

PATIENTS ARE OFTEN HELPLESS IN THEIR DEPENDENCE ON THE INSTITUTION IN WHICH THEY LIVE. THEY DESERVE A FAIR HEARING, AND AN ADVOCATE WHEN THEY ARE POWERLESS. THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION HAS DEVELOPED FIVE MODELS FOR OMBUDSMAN UNITS TO FILL THIS ROLE, PLACED AT VARIOUS LEVELS WITHIN THE STATES AND DEMONSTRATING DIFFERENT MECHANISMS FOR ACTION. CONTRACT PROPOSALS TO TEST THESE MODELS ARE BEING SOLICITED, AND $600,000 HAS BEEN BUDGETED FOR FISCAL YEAR 1972 FOR THIS ACTIVITY.

IT WILL TAKE TIME TO TEST AND DEVELOP SUCH AN OMBUDSMAN SYSTEM, TIME INAPPROPRIATE TO THE URGENCY OF THE PROBLEM. SO AN INTERIM OMBUDSMAN MECHANISM HAS BEEN ESTABLISHED WITH THE 855 SOCIAL SECURITY ADMINISTRATION DISTRICT OFFICES DESIGNATED TO RECEIVE AND INVESTIGATE COMPLAINTS. THIS MECHANISM IS CURRENTLY IN EFFECT, AND HAS RECEIVED OVER A THOUSAND RESPONSES.

FOR THESE NURSING HOME INITIATIVES, A SUPPLEMENTAL APPROPRIATION OF $9,572,000 HAS BEEN REQUESTED FOR FISCAL YEAR, 1972. WE FEEL THAT BY MEANS OF THESE PROGRAMS A SIGNIFICANT IMPROVEMENT IN NURSING HOME CARE CAN BE ACHIEVED IN A RELATIVELY SHORT PERIOD OF TIME.

WE RECOGNIZE ALSO, HOWEVER, THAT WHILE THESE INITIATIVES CAN RECTIFY SOME OF THE MOST PRESSING PROBLEMS OF NURSING HOME CARE, THERE ARE OTHER DEFICIENCIES-SOME FUNDAMENTAL-THAT REQUIRE FURTHER SOLUTIONS. FROM A BROADER PERSPECTIVE, IT IS APPARENT THAT NURSING HOMES ARE ONLY ONE ELEMENT IN THE SPECTRUM OF LONG TERM CARE-AN ELEMENT WHICH HAS BEEN FORCED TO BE TOO MANY THINGS TO TOO MANY PEOPLE. IT IS IN THIS PERSPECTIVE THAT THE LAST POINT IN THE PRESIDENT'S PLAN IS FRAMED; HE HAS DIRECTED THE SECRETARY OF HEW TO UNDERTAKE A COMPREHENSIVE REVIEW OF THE USE OF LONG-TERM CARE FACILITIES AND TO RECOMMEND ANY FURTHER REMEDIAL MEASURES THAT ARE APPROPRIATE. I HAVE BEEN CHARGED WITH ORGANIZING AND CHAIRING THAT TASK FORCE ON LONG TERM CARE.

ON ONE LEVEL, THE TASK FORCE ~~WILL EXAMINE~~ is going to examine THE ROLES OF MEDICARE AND MEDICAID IN NURSING HOME ACTIVITIES. MOST OF YOU ARE AWARE, AND THE WHITE HOUSE CONFERENCE ON AGING HAS EMPHASIZED, THAT THESE FEDERAL PROGRAMS HAVE BEEN A MIXED BLESSING TO THE NURSING HOME INDUSTRY. SOME OF THE PROBLEMS HAVE BEEN PRIMARILY ADMINISTRATIVE, BUT HAVE PRESENTED DIFFICULTIES TO NURSING HOME ADMINISTRATORS AND TO STATE PROGRAMS. AN EXAMPLE OF SUCH A PROBLEM IS THE VARIATION IN STANDARDS FOR EXTENDED CARE FACILITIES UNDER MEDICARE AND SKILLED ~~NURSING~~ HOMES UNDER MEDICAID. ~~WE WILL~~ The Task Force is going to EXAMINE THOSE

STANDARDS AND DETERMINE WHETHER THESE DIFFERENCES ARE NECESSARY OR USEFUL.

BUT MORE FUNDAMENTAL ISSUES HAVE ALSO BEEN RAISED WITH REGARD TO THESE PROGRAMS. FOR HISTORICAL AND STATUTORY REASONS BASED ON THEIR ORIGINS AS HEALTH INSURANCE PROGRAMS, MEDICARE AND MEDICAID HAVE EMPHASIZED HEALTH ASPECTS OF NURSING HOME CARE. ACUTE ILLNESS IN WHICH THE PATIENT IS EXPECTED TO RECOVER AND REGAIN ALL OR MOST OF HIS INDEPENDENCE HAS SERVED AS THE MODEL FOR HEALTH DELIVERY. CONSEQUENTLY, THESE PROGRAMS HAVE FAVORED INSTITUTIONAL CARE OVER NON-INSTITUTIONAL ALTERNATIVES, AND WITHIN INSTITUTIONS, HEALTH AS OPPOSED TO SOCIAL AND PERSONAL CARE.

IN MANY WAYS, THE CONSEQUENCES OF THIS CARE FOR THOSE WITH CHRONIC ILLNESS AND FOR THOSE WITH THE INCREASED DEPENDENCY OF OLD AGE-HAVE BEEN TRAGIC. COSTS HAVE BEEN INCREASED BY THE SUBSTITUTION OF INSTITUTIONAL FOR NON-INSTITUTIONAL CARE, AND BY SOMETIMES INAPPROPRIATELY HIGH LEVELS OF MEDICAL SERVICES FOR PATIENTS WHO DO NOT REQUIRE THEM. BUT EVEN MORE IMPORTANTLY, EPIDEMIOLOGY AND THE SOCIAL SCIENCES ARE PROVIDING EVIDENCE THAT DEPENDENCY FACTORS - LOWERED INCOME, DISPLACEMENT, LOSS OF STATUS, ISOLATION - MAY EXACERBATE IF NOT PRECIPITATE ACTUAL PHYSIOLOGIC DISEASE. OLDER

PERSONS PLACED IN INSTITUTIONS EXPERIENCE SUBSTANTIALLY HIGHER AGE - SPECIFIC MORBIDITY AND MORTALITY RATES THAN THOSE WHO REMAIN AT HOME. SO THE TRANSFER OF A PERSON FROM HIS HOME TO AN INSTITUTION, OR FROM AN INSTITUTION IN WHICH HE IS RELATIVELY AUTONOMOUS TO ONE IN WHICH HIS DEPENDENCY IS INCREASED, MAY MAKE HIM MORE ILL AND MORE DEPENDENT.

THE ISSUE OF THE BALANCE OF MEDICAL AND PERSONAL SERVICES WITHIN INSTITUTIONS CANNOT BE POSTPONED. ON DECEMBER 28, 1971 PRESIDENT NIXON SIGNED INTO LAW PUBLIC LAW 92-223, WHICH AUTHORIZES THE TRANSFER OF INTERMEDIATE CARE FACILITIES INTO THE MEDICAID PROGRAM. AN INTERMEDIATE CARE FACILITY PROVIDES HEALTH RELATED SERVICES FOR PATIENTS WHO DO NOT REQUIRE CARE IN SKILLED NURSING HOMES, BUT NEED INSTITUTIONAL CARE BEYOND ROOM AND BOARD. ICF'S WERE PREVIOUSLY FINANCED BY PUBLIC ASSISTANCE PROGRAMS FOR THE AGED, THE BLIND, AND THE DISABLED, AND WERE SUBJECT ONLY TO STATE LICENSING. TRANSFER OF FINANCING TO THE MEDICAID PROGRAM MEANS NOT ONLY THAT A LARGER GROUP OF PEOPLE - INCLUDING THE "MEDICALLY NEEDY" - MAY POTENTIALLY BE ELIGIBLE FOR BENEFITS, BUT ALSO THAT THE FEDERAL GOVERNMENT IS EMPOWERED TO SET PHYSICAL AND SAFETY STANDARDS AND DEFINE THE CARE AND SERVICES THAT MUST BE PROVIDED. THE MEDICAL SERVICES ADMINISTRATION OF THE SOCIAL AND

REHABILITATION SERVICE AND MY OFFICE OF NURSING HOME AFFAIRS ARE CURRENTLY EXAMINING SUCH ISSUES AS WHO SHOULD BE IN THESE FACILITIES, WHAT SERVICES MUST THEY PROVIDE, AND WHAT SHOULD BE THE LEVEL OF BENEFITS IN ATTEMPTING TO DEVELOP STANDARDS FOR INTERMEDIATE CARE FACILITIES.

JUST AS THE BALANCE BETWEEN MEDICAL AND PERSONAL SERVICES WITHIN INSTITUTIONS MUST BE RE-EXAMINED, SO MUST THE ALTERNATIVES TO INSTITUTIONAL CARE BE EXTENDED FOR THOSE SUFFERING FROM CHRONIC ILLNESS. THE ELDERLY SHOULD HAVE MORE OPTIONS AVAILABLE. IF A NURSING HOME IS NOT THE MOST APPROPRIATE PLACE FOR A PERSON'S PARTICULAR NEEDS, THEN HE SHOULD NOT BE REQUIRED TO GO THERE. IF IT IS PERSONAL CARE RATHER THAN HEALTH CARE THAT IS REQUIRED, THEN THE OPTION SHOULD PROVIDE THAT EMPHASIS. IF IT IS APPROPRIATE HOUSING RATHER THAN INSTITUTIONAL CARE THAT IS NEEDED, THEN THE EMPHASIS SHOULD BE ON HOUSING.

MANY FEDERAL PROGRAMS HAVE EXPLORED ALTERNATIVES TO INSTITUTIONAL CARE. THESE ALTERNATIVES HAVE BEEN A PARTICULAR THRUST OF THE ADMINISTRATION ON AGING, WHICH HAS RECEIVED NEW SUPPORT AND PRIORITY IN THE PRESIDENT'S BUDGET FOR 1972 IN THE FORM OF A FIVE-FOLD INCREASE IN ITS FUNDING LEVEL. THE AoA HAS ESTABLISHED PROGRAMS SUCH AS TRANSPORTATION FOR THE ELDERLY, SENIOR CENTERS, MEALS-ON-WHEELS, TELEPHONE RE-

ASSURANCE, IN-HOME SERVICES, AND OPPORTUNITIES TO SERVE. THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT HAS DEVELOPING HOUSING PROGRAMS DESIGNED TO MEET THE SPECIAL NEEDS OF THE ELDERLY. MEDICARE AND MEDICAID PROVIDE HOME HEALTH BENEFITS.

BUT THE CONCERTED IMPACT OF THESE PROGRAMS HAVE NOT BEEN ENOUGH, AS WE HEARD ONCE MORE AT THE WHITE HOUSE CONFERENCE ON AGING. THE PRESSURE FOR INSTITUTIONALIZATION CONTINUES TO PLACE STRAINS ON NURSING HOMES, WHICH ARE ASKED TO SERVE TOO WIDE A VARIETY OF FUNCTIONS, AND CONTINUES TO PUSH THE ELDERLY INTO SOMETIMES PREMATURE DEPENDENCY. THE PROBLEM OF DEVELOPING A WIDER SPECTRUM OF OPTIONS FOR THE CHRONICALLY ILL AND FOR THE ELDERLY WILL BE A CENTRAL FOCUS OF THE TASK FORCE ON LONG TERM CARE.

AN IMPORTANT REASON FOR THE INSUFFICIENT AND SOMETIMES INAPPROPRIATE IMPACT OF FEDERAL PROGRAMS FOR LONG TERM CARE HAS BEEN THE LACK OF PLANNING AND COORDINATING BETWEEN FEDERAL, STATE, AND LOCAL PROGRAMS. PLANNING FOR LONG TERM CARE SHOULD MOVE FROM IDENTIFICATION OF AN ISSUE OR PROBLEM TO ITS SOLUTION, WITH IDENTIFIABLE GOALS GUIDING THE PROCESS. MOVEMENT TOWARD A GOAL SHOULD NOT BE INTERRUPTED BY CHANGES IN ADMINISTRATION. WHAT IS TRULY IMPORTANT TODAY SHOULD NOT BE CAST ASIDE TOMORROW. NEW PROGRAMS SHOULD NOT BE APPENDAGES TO

SATISFY THE INTERESTS OF A FEW, NOR SHOULD THEY BE ADDED AS PACIFIERS TO THE MANY. PROGRAMS DEVELOP THROUGH A RATIONAL PLANNING PROCESS SHOULD THEN BE ADMINISTERED THROUGH AN EFFECTIVE AND COORDINATED MECHANISMS.

THE ESTABLISHMENT OF THE OFFICE OF NURSING HOME AFFAIRS WITHIN HEW WAS A STEP TOWARD IMPROVING COORDINATION. BUT THE MANDATE FOR THE TASK FORCE ON LONG TERM CARE IS BROADER: TO RE-EXAMINE THE ISSUES AND SET NEW GOALS, TO DEVELOP A NATIONWIDE DATA SYSTEM NECESSARY FOR POLICY FORMULATION, AND TO RECOMMEND AN ORGANIZATION FOR LONG TERM CARE WITHIN HEW AND OTHER FEDERAL AGENCIES, AND STATE AND LOCAL PROGRAMS WHICH CAN ACHIEVE ITS GOALS MOST EFFECTIVELY.

A NATIONAL POLICY COURSE FOR THE CHRONICALLY ILL AND FOR THE ELDERLY SHOULD BE SET. IT SHOULD BE SET BY GOVERNMENT. SET BY GOVERNMENT WITH THE FULL AND CREATIVE CONTRIBUTION OF THOSE IN OTHER AGENCIES AND ORGANIZATIONS, THOSE IN ACADEMIC TEACHING AND RESEARCH, THOSE IN VOLUNTARY AND UNSALARIED SERVICE, AND THOSE WHO RECEIVE THAT CARE. AND YOU WHO ARE IN DIRECT CONTACT WITH HEALTH FACILITIES HAVE A SPECIAL RESPONSIBILITY. ON THE ONE HAND, TO TRANSLATE REGULATIONS INTO AN EFFECTIVE INSTRUMENT FOR CONTROL OF THE QUALITY OF CARE. ON THE OTHER, TO TRANSMIT TO THOSE OF US IN GOVERNMENT THE PROBLEMS AND ACHIEVEMENTS OF THESE FACILITIES SO THAT WE CAN PLAN MORE EFFECTIVELY FOR THE CARE OF OUR SICK AND ELDERLY

The Federal Regulations of Nursing Homes

Marie Callender
Special Assistant for Nursing Home Affairs

The quality of any civilization can be measured by the attitude of the people toward the elderly in their midst. Their value economically is ebbing or is at an end. They require a disproportionate share of medical and social services. In some earlier cultures they were cut off from the tribe and forced to wander without food or shelter until they died. Most of us look with revulsion at such social patterns, and accept the moral responsibility of our society toward its elderly.

The majority of those over sixty-five are able to lead active, independent lives contributing vigorously to our national life. However, almost a million of our twenty-million persons over sixty-five require the care and support of nursing homes, and it is these whose dependence most acutely tests the quality of our compassion and sense of humanity.

To be presented at the Annual Meeting of the General Conference in San, Antonio, Texas, March 21, 1972

THE PRESIDENT HAS APTLY STATED THAT, "FOR THOSE WHO NEED THEM, THE NURSING HOMES OF AMERICA SHOULD BE SHINING SYMBOLS OF COMFORT AND CONCERN.". MANY OF OUR NURSING HOMES MEET THIS STANDARD. OTHER DO NOT, AS TESTIFIED BY RECENT SHOCKING AND TRAGIC NURSING HOME FIRES, AND LESS DRAMATICALLY BY PRIVATE AND GOVERNMENT STUDIES. IN MAY, 1971, THE GENERAL ACCOUNTING OFFICE ISSUED A REPORT ON THE ENFORCEMENT OF MEDICAID AND MEDICARE STANDARDS IN NINETY NURSING HOMES IN OKLAHOMA, NEW YORK, AND MICHIGAN. SERIOUS DEFICIENCIES WERE FOUND IN MORE THAN 50 PERCENT OF THESE HOMES, ALL OF WHICH HAD MEDICAID PATIENTS AND MANY OF WHICH WERE APPROVED FOR MEDICARE. ON NOVEMBER 30, 1971, SECRETARY RICHARDSON ANNOUNCED THAT 39 STATES WERE OUT OF COMPLIANCE WITH TITLE 19 CERTIFICATION PROCEDURES. IN HUMAN TERMS, THESE STUDIES MEAN THAT MANY NURSING HOMES WHICH FAIL TO MEET STANDARDS ARE UNSANITARY AND UNSAFE, OVERCROWDED AND UNDERSTAFFED--LONELY AND DEPRESSING PLACES FOR THE ELDERLY TO LIVE AND DIE.

THE FEDERAL GOVERNMENT HAS BECOME INCREASINGLY INVOLVED IN NURSING HOME CARE OVER THE LAST TWENTY YEARS, PARTICULARLY SINCE THE ENACTMENT OF THE MEDICARE AND MEDICAID PROGRAMS IN 1965. IN 1970 THE FEDERAL GOVERNMENT UNDER MEDICAID SPENT OVER $2 MILLION IN SUPPORT OF NURSING HOME PATIENTS, WHILE

STATE AND LOCAL GOVERNMENTS SPENT ANOTHER $7 MILLION. MEDICARE SPENT 247 MILLION. THIS INVOLVEMENT CARRIES WITH IT A RESPONSIBILITY TO ASSURE THAT NURSING HOMES DELIVER CARE AT LEAST AT THE LEVELS OF FEDERAL STANDARDS AND REGULATIONS. THE PRESIDENT ACCEPTED THIS RESPONSIBILITY IN HIS 8-POINT PLAN FOR ACTION TO IMPROVE NURSING HOMES ANNOUNCED LAST AUGUST IN NEW HAMPSHIRE.

A MAJOR GOAL OF THE PLAN IS TO IMPROVE ENFORCEMENT OF FEDERAL NURSING HOME STANDARDS. THE TERM "NURSING HOME" IS APPLIED TO A WIDE RANGE OF FACILITIES, FROM THOSE PROVIDING PRIMARILY CUSTODIAL CARE TO THOSE DELIVERING HIGHLY SKILLED POST-HOSPITAL AND REHABILITATIVE SERVICES. THESE DIFFERENT TYPES OF FACILITIES ARE ACCREDITED THROUGH DIFFERENT MECHANISMS, AND FEDERAL LEVERAGE IN ENFORCING STANDARDS VARIES WIDELY.

MEDICARE IS A FEDERAL RROGRAM. IT CONTRACTS WITH - STATE HEALTH DEPARTMENTS - TO SURVEY NURSING HOMES FOR COMPLIANCE WITH FEDERAL STANDARDS. THE RESULTS OF THE SURVEY AND RECOMMENDATIONS ARE THEN PASSED ON TO FEDERAL PERSONNEL IN THE HEW REGIONAL O-FICES, WHERE A FINAL DECISION IS RENDERED FOR CERTIFICATION OF THE NURSING HOME AS AN EXTENDED CARE FACILITY ELIGIBLE TO RECEIVE MEDICARE FUNDS. THUS, THE FEDERAL ROLE AND THE FEDERAL ENPORCEMENT POWER ARE CLEAR AND UNEQUIVOCAL.

MEDICAID, ON THE OTHER HAND, IS A FEDERAL-STATE PROGRAM, FINANCIED AND ADMINISTERED THROUGH BOTH FEDERAL AND STATE FUNDS AND ACITIVITIES. TO QUALIFY FOR MEDICAID FUNDS AS A SKILLED NURSING HOME, AN INSTITUTION MUST MEET FEDERAL STANDARDS. HOWEVER, THE PROCESS OF ENFORCING STANDARDS DIFFERS FROM THE MEDICARE PROGRAM. UNDER MEDICAID, ADMINISTRATION OF STATE PROGRAMS - INCLUDING THE ENFORCEMENT OF STANDARDS - IS ASSIGNED BY CONTRACT TO A SINGLE STATE AGENCY. IN THE MAJORITY OF STATES, THE SINGLE STATE AGENCY IS THE STATE WELFARE DEPARTMENT. THE SINGLE STATE AGENCY, AS IN MEDICARE, USUALLY CONTRACTS WITH ANOTHER AGENCY TO SURVEY NURSING HOMES FOR COMPLIANCE WITH FEDERAL STANDARDS. IN MOST STATES, THE SAME AGENCY SURVEYS FOR BOTH MEDICARE AND MEDICAID. UNDER MEDICAID, THE RESULTS OF THE SURVEY AND RECOMMENDATIONS ARE THEN SUBMITTED TO THE SINGLE STATE AGENCY - STATE RATHER THEN FEDERAL PERSONNEL-WHERE A DECISION IS MADE WHETHER THE NURSING HOME QUALIFIED AS A SKILLED NURSING HOME FOR MEDICAID FUNDS. THIS PROCESS DIFFERS FROM MEDICARE, IN WHICH FEDERAL PERSONNEL REVIEW SURVEY RESULTS TO DETERMINE WHETHER AN INDIVIDUAL HOME QUALIFIES. IN MEDICAID THE ENFORCEMENT OF STANDARDS IS DELEGATED TO THE STATES, WITH THE FEDERAL MEDICAID PROGRAM RETAINING ONLY THE UTLIMATE NECESSITY OF FINDING AN ENTIRE OR PART OF A STATE

STATE PROGRAM OUT OF COMPLIANCE WITH FEDERAL STANDARDS AND HENCE INELIGIBLE FOR FEDERAL FUNDS. THESE PROCESSES REFLECT THE DIFFERENCE IN FUNDING SOURCES BETWEEN THE TWO PROGRAMS - THE FEDERAL GOVERNMENT BEARS THE ENTIRE BURDEN OF MEDICARE NURSING HOME FUNDING, WHILE IT PAYS ONLY A PORTION OF MEDICAID SUPPORT FOR NURSING HOME CARE.

THE MEDICARE PROGRAM, WHILE NOT ENTIRELY ABOVE REPROACH, HAS DONE A CREDITABLE JOB OF ENFORCING NURSING HOME STANDARDS. MEDICAID HAS BEEN A DIFFERENT STORY. TO SPEAK BLUNTLY, MANY STATES HAVE SIMPLY FAILED TO ENFORCE FEDERAL NURSING HOME STANDARDS. WE HAVE BEEN FACED WITH AN INEQUITABLE SITUATION IN WHICH THE MEDICARE PATIENT CAN BE ASSURED THAT HIS NURSING HOME IS BEING CAREFULLY WATCHES; WHILE ANOTHER PERSON WHOSE CARE IS PAID FOR BY MEDICAID MAY LIVE IN A NURSING HOME WHERE INSPECTIONS ARE INFREQUENT, INEFFECTIVE, OR ABSENT.

THE PROBLEM OF ENCOURAGING STATES TO ENFORCE FEDERAL STANDARDS HAS BEEN DIFFICULT. THE BLUDGEON APPROACH OF DECLARING A STATE OUT OF COMPLIANCE AND HENCE INELIGIBLE FOR FEDERAL MATCHING FUNDS MAY PENALIZE THE INDIVIDUAL NURSING HOME PATIENT OR THE GOOD NURSING HOME FOR THE SINS OF STATE AND

FEDERAL MEDICAID PERSONNEL. SO THIS CLEARLY IS AN ACTION OF LAST RESORT. WE RECOGNIZE ALSO THAT SOME STATES - WITH THE BEST OF INTENTIONS - HAVE FACED REAL PROBLEMS IN ENFORCING STANDARDS, ESPECIALLY LACK OF TRAINED PERSONNEL AND FINANCIAL RESOURCES. FOR THIS REASON, THE PRESIDENT'S NURSING HOME ACTION PLAN OFFERRED SEVERAL FORMS OF ASSISTANCE TO THE STATES IN MEETING THEIR RESPONSIBILTIES.

1. THE PRESIDENT PROMISED TO SEEK AUTHORIZATION FOR FEDERAL SUPPORT OF 100% OF THE COST OF STATE MEDICAID INSPECTIONS. WE RECOGNIZE THAT AN INCREASED LEVEL OF ENFORCEMENT ACTIVITY INVOLVES ADDITIONAL COSTS TO THE STATES. MEDICARE INSPECTION COSTS HAVE ALWAYS BEEN FULLY PAID FOR BY THE FEDERAL GOVERNMENT, BUT UNDER THE MEDICAID PROGRAM STATES HAVE PAID 25 TO 50 PERCENT OF THESE COSTS. SECRETARY RICHARDSON SUBMITTED TO CONGRESS IN OCTOBER, 1971, AN AMENDMENT TO H.R.I. AUTHORIZING THE FEDERAL GOVERNMENT TO ASSUME 100% OF INSPECTION COSTS UNDER MEDICAID, THIS STEP WILL PLACE BOTH PROGRAMS ON AN EQUAL FOOTING AND LESSEN THE FINANCIAL BURDEN TO THE STATES.

2. THE PRESIDENT PLEDGED TO TRAIN 2,000 STATE NURSING HOME INSPECTIONS IN THE 18 MONTH PERIOD AFTER HIS AUGUST SPEECH,

ENTIRELY AT FEDERAL EXPENSE. THIS EFFORT IS WELL UNDER WAY, AND 475 STATE INSPECTORS HAVE ALREADY ATTENDED THOSE COURSES.

3. THE PRESIDENT HAS ENLARGED THE FEDERAL STAFF FOR ENFORCEMENT OF NURSING HOME STANDARDS. ONE HUNDRED NINETY-ONE PERSONNEL HAVE BEEN ADDED, ONE-HUNDRED TEN OF THESE TO THE REGIONAL OFFICES OF THE SOCIAL AND REHABILITATION SERVICE WHICH ADMINISTERS THE MEDICAID PROGRAM. THESE FEDERAL PERSONNEL WORK CLOSELY WITH STATE MEDICAID PROGRAMS.

4. THE FEDERAL ENFORCEMENT EFFORT HAS BEEN REORGANIZED TO ACHIEVE IMPROVED COORDINATION AND HIGHER PRIORITY. NURSING HOME RESPONSIBILITIES HAVE BEEN CONSOLIDATED IN A SINGLE OFFICE - DR. MERLIN K. DUVAL, THE ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS IS THE RESPONSIBLE OFFICIAL. HE HAS INTURN DELEGATED THAT RESPONSIBILITY TO ME TO WORK WITH HIM TO BE RESPONSIBLE AND ACCOUNTABLE FOR ALL DHEW NURSING HOME AFFAIRS.

SO THE PRESIDENT'S PLAN OFFERS ASSISTANCE TO THE STATES IN ENFORCING NURSING HOME STANDARDS. BUT AS THE PRESIDENT WARNED LAST AUGUST, "....LET THERE BE NO MISTAKING THE FACT

THAT WHEN FACILITIES FAIL TO MEET REASONABLE STANDARDS, WE WILL NOT HESITATE TO CUT OFF MEDICARE AND MEDICAID FUNDS." AS A RESULT OF A CRASH PROGRAM TO ASSESS THE STATE MEDICAID CERTIFICATION AND ENFORCEMENT EFFORT, SECRETARY RICHARDSON ANNOUNCED ON NOVEMBER 30, 1971, THAT THIRTY-NINE STATES WERE OUT OF COMPLIANCE WITH MEDICAID CERTIFICATION PROCEDURES. HE ALSO ANNOUNCED TWO DEADLINES: BY FEBRUARY 1, 1972, ALL STATES WERE TO DEMONSTRATE THAT THEIR INSPECTION AND CERTIFICATION PROCEDURES WERE IN COMPLIANCE WITH MEDICAID REGULATIONS. ON THAT DATE, THIRTY-EIGHT OF THE THIRTY-NINE STATES CITED HAD CORRECTED THEIR DEFICIENCIES AND WERE FOUND TO HAVE IN EFFECT THE CORRECT PROCEDURES. BUT BY JULY 1, 1972, ALL MEDICAID FACILITIES IN ALL STATES ARE TO HAVE BEEN INSPECTED AND CERTIFIED THROUGH THE CORRECT PROCEDURES.

THE JULY 1 DEADLINE HAS HIGH HEW PRIORITY, AND WE ANTICIPATE THAT AS IT NEARS, THE PUBLIC, THE PRESS, AND THE CONGRESS WILL BECOME INCREASINGLY INTERESTED. THE NUMBER OF NURSING HOMES WHICH MUST BE SURVEYED AND CERTIFIED TO MEET THE DEADLINE VARIES WIDELY FROM STATE TO STATE, AND IN MANY PRESENTS A MOST FORMIDABLE WORKLOAD. IF THE DEADLINE IS TO BE MET, AN UNUSUAL CONCENTRATION AND COORDINATION OF HEW REGIONAL OFFICE, SURVEY AGENCY, AND SINGLE STATE AGENCY RESOURCES MUST BE ACHIEVED IN MOST STATES.

TO THIS END, A STRATEGY TO ASSIST THE SINGLE STATE AGENCIES HAS BEEN DEVISED BY MY OFFICE. THE REGIONAL DIRECTORS OF HEW REGIONAL OFFICES HAVE BEEN NAMED THE RESPONSIBLE OFFICIALS FOR NURSING HOME INITIATIVES. THEY ARE RESPONSIBLE FOR DETERMINING THAT SINGLE STATE AGENCIES DEVELOP REASONABLE TIMETABLES TO ACHIEVE ACCREDITATION GOALS AND ADHERE TO THEM; THAT THE REQUIRED RESOURCES ARE AVAILABLE; THAT CORRECT SURVEY AND CERTIFICATION PROCEDURES ARE FOLLOWED; THAT THE PERIODIC REPORTING REQUIREMENTS ARE MET. WE ANTICIPATE THAT MANY STATES WILL FACE PROBLEMS OF COORDINATION - FOR EXAMPLE, SURVEYORS MAY HAVE TO BE "BORROWED" FROM THE MEDICARE PROGRAM, OR FUNDING MAY HAVE TO BE NEGOTIATED WITH THE GOVERNOR'S OFFICE. WE WILL MONITOR THEIR PROGRESS CONTINUOUSLY FROM MY OFFICE, AND WILL OFFER AS MUCH SUPPORT AS WE CAN. BUT THE TASK PRESENTS A GREAT CHALLENGE TO THE STATES AND A TEST FOR THE MEDICAID PROGRAM. IF WIDESPREAD ABUSES CONTINUE TO EXIST, WE WILL HAVE NO ALTERNATIVE BUT TO FIND WHOLE STATES OUT OF COMPLIANCE - MEANING THEIR FEDERAL FUNDS CAN BE HELD BACK.

THERE IS ANOTHER ISSUE OF MAJOR SIGNIFICANT IN THE FEDERAL REGULATION OF NURSING HOMES, AN ISSUE WHICH HAS BEEN SOMEWHAT OVERSHADOWED BY THE PRESS OF JULY 1 DEADLINE ACTIVITIES. ON DECEMBER 28, 1971, PRESIDENT NIXON SIGNED INTO LAW PUBLIC LAW 92-223, WHICH AUTHORIZES THE TRANSFER OF INTERMEDIATE CARE FACILITIES INTO THE MEDICAID PROGRAM. AN INTERMEDIATE CARE FACILITY PROVIDES HEALTH RELATED SERVICES FOR PATIENTS WHO DO NOT REQUIRE CARE IN SKILLED NURSING HOMES, BUT NEED INSTITUTIONAL CARE BEYOND ROOM AND BOARD. ICF'S WERE PREVIOUSLY FINANCED BY PUBLIC ASSISTANCE PROGRAMS FOR THE AGED, THE BLIND, AND THE DISABLED, AND WERE SUBJECT ONLY TO STATE LICENSING AND STATE STANDARDS. TRANSFER OF FINANCING TO THE MEDICAID PROGRAM MEANS NOT ONLY THAT A LARGER GROUP OF PEOPLE - INCLUDING THE "MEDICALLY NEEDY" - MAY POTENTIALLY BE ELIGIBLE FOR BENEFITS, BUT ALSO THAT THIS LARGE GROUP OF NURSING HOMES WILL FALL UNDER THE UMBRELLA OF FEDERAL STANDARDS, FROM WHICH THEY WERE PREVIOUSLY EXEMPT. THE MEDICAL SERVICES ADMINISTRATION OF SOCIAL AND REHABILITATION SERVICE AND MY OFFICE OF NURSING HOME AFFAIRS ARE CURRENTLY EXAMINING SUCH ISSUES AS WHO SHOULD BE IN THESE FACILITIES, WHAT SERVICES MUST THEY PROVIDE, AND WHAT SHOULD BE THE LEVEL OF BENEFITS IN ATTEMPTING TO DEVELOP STANDARDS FOR INTERMEDIATE CARE FACILITIES.

I HAVE CENTERED MY REMARKS ON THE ENFORCEMENT OF FEDERAL NURSING HOME STANDARDS, BECAUSE THESE ISSUES ARE THE ONES MOST LIKELY TO FIND THEIR WAY TO YOUR DESKS. BUT I DO NOT WANT TO LEAVE THE IMPRESSION THAT THIS IS THE SUM SUBSTANCE OF THE PRESIDENTS' PLAN OR OF MY HOPES FOR THE FEDERAL PROGRAM FOR LONG TERM CARE. WE ARE DEVELOPING IN FULFILLMENT OF THE PRESIDENT'S PLAN PROGRAMS TO TRAIN NURSING HOME PERSONNEL AND MODELS FOR OMBUDSMAN UNITS TO SERVE AS ADVOCATES FOR DEPENDENT AND SOMETIMES HELPLESS NURSING HOME PATIENTS. THE PRESIDENT HAS GIVEN ME A MANDATE TO HEAD A TASK FORCE STUDYING PROBLEMS OF LONG TERM CARE FROM A BROAD PERSPECTIVE. THE TASK FORCE WILL MAKE RECOMMENDATIONS FOR CORRECTING DEFICIENCIES IN EXISTING PROGRAMS AND ORGANIZATIONS AND FOR DEVELOPING NEW ONES. I HAVE BEEN MOST INTERESTED IN ENCOURAGING ALTERNATIVES TO INSTITUTIONAL CARE FOR THE ELDERLY, SO THAT THEY ARE NOT FORCED PREMATURELY INTO NURSING HOMES WHEN THE COULD LIVE INDEPENTLY WITH FEASIBLE AND LESS COSTLY SOCIAL SERVICES. WE CAN DO MUCH BETTER FOR OUR ELDERLY. WE MUST OF COURSE PROTECT THEM FROM INSTITUTIONAL ABUSES, RECOGNIZING THAT SOME ARE WEAK AND DEPENDENT. BUT WE CAN ALSO MAKE POSSIBLE A WIDE VARIETY OF SUPPORTING SERVICES AND LIVING ARRANGEMENTS, SO THAT THE INFIRMITIES OF ADVANCING AGE DO NOT BECOME A PRISON OF THE SPIRIT. THE ELDERLY WITH OUR HELP CAN HAVE ACCESS TO THE VARIETY AND FREEDOM WE ASK FOR OURSELVES.

THE FEDERAL PROGRAM TO IMPROVE CARE OF LONG-TERM PATIENTS IN INSTITUTIONS

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*TO BE PRESENTED AT THE NATIONAL CONFERENCE ON SOCIAL WELFARE, CHICAGO, ILLINOIS, WEDNESDAY MAY 31, 1972

THE FEDERAL PROGRAM TO IMPROVE CARE OF LONG-TERM PATIENTS IN INSTITUTIONS

THE QUALITY OF ANY CIVILIZATION CAN BE MEASURED BY THE ATTITUDE OF THE PEOPLE TOWARD THE ELDERLY IN THEIR MIDST. THEIR VALUE ECONOMICALLY IS EBBING OR IS AT AN END. THEY REQUIRE A DISPROPORTIONATE SHARE OF MEDICAL AND SOCIAL SERVICES. IN SOME EARLIER CULTURES THEY WERE CUT OFF FROM THE TRIBE AND FORCED TO WANDER WITHOUT FOOD OR SHELTER UNTIL THEY DIED. MOST OF US LOOK WITH REVULSION AT SUCH SOCIAL PATTERNS, AND ACCEPT THE MORAL RESPONSIBILITY OF OUR SOCIETY TOWARD ITS ELDERLY.

THE MAJORITY OF THOSE OVER SIXTY-FIVE ARE ABLE TO LEAD ACTIVE, INDEPENDENT LIVES CONTRIBUTING VIGOROUSLY TO OUR NATIONAL LIFE. HOWEVER, ALMOST A MILLION OF OUR TWENTY-MILLION PERSONS OVER SIXTY-FIVE REQUIRE THE CARE AND SUPPORT OF NURSING HOMES, AND IT IS THESE WHOSE DEPENDENCE MOST ACUTELY TESTS THE QUALITY OF OUR COMPASSION AND SENSE OF HUMANITY.

THE PRESIDENT HAS APTLY STATED THAT, "FOR THOSE WHO NEED THEM, THE NURSING HOMES OF AMERICA SHOULD BE SHINING SYMBOLS OF COMFORT AND CONCERN." MANY OF OUR NURSING HOMES MEET THIS STANDARD. OTHER DO NOT, AS TESTIFIED BY RECENT SHOCKING AND TRAGIC NURSING HOME FIRES, AND LESS DRAMATICALLY BY PRIVATE AND GOVERNMENTAL STUDIES. IN MAY, 1971, THE GENERAL ACCOUNTING OFFICE ISSUED A REPORT ON THE ENFORCEMENT OF MEDICAID AND MEDICARE STANDARDS IN NINETY NURSING HOMES IN OKLAHOMA, NEW YORK, AND MICHIGAN. SERIOUS DEFICIENCIES WERE FOUND IN MORE THAN 50 PERCENT OF THESE HOMES, ALL OF WHICH HAD MEDICAID PATIENTS AND MANY OF WHICH WERE APPROVED FOR MEDICARE.

On November 30, 1971, Secretary Richardson announced that 39 States were out of compliance with Title 19 certification procedures. In human terms, these studies mean that many nursing homes which fail to meet standards are unsanitary and unsafe, overcrowded and understaffed--lonely and depressing places for the elderly to live and die.

The Federal government has become increasingly involved in nursing home care over the last twenty years, particularly since the enactment of the Medicare and Medicaid programs in 1965. In 1970 the Federal government spent over $2 billion in support of nursing home patients, while State and local governments spent another $700 million. This involvement carries with it a responsibility to assure that nursing homes deliver care at least at the levels of Federal standards and regulations. The President accepted this responsibility in his 8-point Plan for Action to improve nursing homes announced last August in New Hampshire.

A major goal of the plan is to improve Federal enforcement of nursing home standards. As you know, the term "nursing home" is applied to a wide range of facilities, from those providing primarily custodial care to those delivering highly skilled post-hospital and rehabilitative services. These different types of facilities are accredited through different mechanisms, and Federal leverage in enforcing standards varies widely. Medicare certification of extended care facilities is a Federal program mediated through State agencies. Medicaid is a Federal-State program financed and administered through both Federal and State

FUNDS AND ACTIVITIES. INTERMEDIATE CARE FACILITIES UNTIL RECENTLY WERE REQUIRED TO MEET ONLY STATE LICENSING REQUIREMENTS TO RECEIVE FEDERAL FUNDS. THESE VARIATIONS HAVE COMPLICATED THE ENFORCEMENT OF STANDARDS. THE DIFFERENCES ARE CURRENTLY BEING RESOLVED TO CREATE A MORE RATIONAL AND EASILY ADMINISTERED BASIS FOR NURSING HOME STANDARDS.

ON DECEMBER 28, 1971, PRESIDENT NIXON SIGNED INTO LAW PUBLIC LAW 92-223, WHICH AUTHORIZES THE TRANSFER OF INTERMEDIATE CARE FACILITIES INTO THE MEDICAID PROGRAM. AN INTERMEDIATE CARE FACILITY PROVIDES HEALTH RELATED SERVICES FOR PATIENTS WHO DO NOT REQUIRE CARE IN SKILLED NURSING HOMES, BUT NEED INSTITUTIONAL CARE BEYOND ROOM AND BOARD. ICF'S WERE PREVIOUSLY FINANCED BY PUBLIC ASSISTANCE PROGRAMS FOR THE AGED, THE BLIND, AND THE DISABLED, AND WERE SUBJECT ONLY TO STATE LICENSING. TRANSFER OF FINANCING TO THE MEDICAID PROGRAM MEANS NOT ONLY THAT A LARGER GROUP OF PEOPLE - INCLUDING THE "MEDICALLY NEEDY" - MAY POTENTIALLY BE ELIGIBLE FOR BENEFITS, BUT ALSO THAT THE FEDERAL GOVERNMENT IS EMPOWERED TO SET PHYSICAL AND SAFETY STANDARDS AND TO DEFINE THE CARE AND SERVICES THAT MUST

BE PROVIDED. THE MEDICAL SERVICES ADMINISTRATION OF THE SOCIAL AND REHABILITATION SERVICE AND MY OFFICE OF NURSING HOME AFFAIRS ARE CURRENTLY EXAMINING SUCH ISSUES AS WHO SHOULD BE IN THESE FACILITIES, WHAT SERVICES THEY SHOULD PROVIDE, AND WHAT LEVEL OF BENEFITS THEY SHOULD OFFER. REGULATIONS FOR INTERMEDIATE CARE FACILITIES WILL BE AVAILABLE IN THE FEDERAL REGISTER BY JULY 1.

THE DIFFERENCE IN THE STANDARDS FOR SKILLED NURSING HOMES UNDER MEDICAID AND FOR EXTENDED CARE FACILITIES UNDER MEDICARE HAVE CAUSED CONFUSION TO THOSE PROVIDING SUCH CARE AND FOR THOSE ENFORCING STANDARDS. ALTHOUGH THE PHILOSOPHIC INTENT IN THE TWO PROGRAMS ~~WERE~~ WAS SOMEWHAT DIFFERENT, IN PRACTICE THE LEVELS OF NURSING CARE AS DEFINED FOR THE TWO INSTITUTIONS HAVE BEEN ROUGHLY EQUIVALENT. WE BELIEVE THAT DIFFERENCES IN STANDARDS CAUSE NEEDLESS CONFUSION. THEREFORE, THE DEPARTMENT OF HEW AND THE OFFICE OF NURSING HOME AFFAIRS HAVE BEEN MOVING TO ESTABLISH A SINGLE DEFINITION AND SET OF STANDARDS FOR EXTENDED CARE FACILITIES UNDER MEDICARE AND SKILLED NURSING HOMES UNDER MEDICAID. CONGRESS HAS AMENDED H.R.I. TO CALL FOR THESE CHANGES IN A REDEFINED ENTITY TO BE CALLED A "SKILLED NURSING FACILITY." IN ANTICIPATION THAT THAT THESE AMENDMENTS WILL BE ENACTED INTO LAW, WE ARE ALREADY DEVELOPING A COMMON SET OF STANDARDS. A BASIC PRINCIPLE UNDERLYING THIS EFFORT IS THAT WHERE STANDARDS BETWEEN THE TWO PROGRAMS DIFFER, THE HIGHER WILL BE INCORPORATED INTO THE NEW REGULATIONS.

CONGRESSIONAL AMENDMENTS HAVE ALSO INTRODUCED SOME CHANGES IN CERTIFICATION PROCEDURES TO MAKE THE TWO PROGRAMS MORE UNIFORM. A PROVISION HAS BEEN ADDED UNDER WHICH THE SECRETARY OF HEW WOULD DECIDE WHETHER A NURSING HOME QUALIFIES TO PARTICIPATE AS A "SKILLED NURSING FACILITY" IN BOTH THE MEDICARE AND MEDICAID PROGRAMS. THE

SECRETARY WOULD MAKE THAT DETERMINATION BASED PRINCIPALLY UPON THE APPROPRIATE STATE AGENCY EVALUATION. IT WILL BE REQUIRED THAT THE SAME STATE AGENCY CERTIFY FACILITIES FOR BOTH MEDICARE AND MEDICAID. A STATE COULD FOR GOOD CAUSE, REFUSE TO ACCEPT AS A PARTICIPANT IN THE MEDICAID PROGRAM A FACILITY CERTIFIED BY THE SECRETARY. BUT A STATE MEDICAID PROGRAM COULD NOT RECEIVE FEDERAL MATCHING FUNDS FOR ANY INSTITUTION NOT APPROVED BY THE SECRETARY.

ANOTHER ISSUE IN ACHIEVING UNIFORMITY BETWEEN MEDICARE AND MEDICAID NURSING HOME PROGRAMS IS THE PROBLEM OF REIMBURSEMENT. WE ARE STUDYING ALTERNATIVE MECHANISMS TO DEVELOP A SYSTEM WHICH IS UNIFORM AND IS WEIGHTED TO SLOW THE RATE OF "MEDICAL INFLATION." THE SENATE FINANCE COMMITTEE HAS AMENDED MEDICAID LAWS TO REQUIRE THAT SKILLED NURSING AND INTERMEDIATE CARE SERVICES BE REIMBURSED ON A REASONABLE - COST RELATED BASIS, AND THIS IS ONE APPROACH HEW IS ~~WE ARE~~ CONSIDERING.

THE DEPARTMENT OF HEW HAS BEEN WORKING TOWARD THE DEVELOPMENT OF HIGHER STANDARDS WHICH CAN BE ENFORCED MORE FAIRLY. [redacted] SOME OF THE CONGRESSIONAL AMENDMENTS TO H.R.I. REPRESENT PROGRESS IN THIS DIRECTION, AND HEW IS ~~WE ARE~~ DEVELOPING APPROPRIATE PLANS FOR IMPLEMENTATION. THESE ARE ISSUES WHOSE RESOLUTION WILL BENEFIT EVERYONE - THE PROVIDER, THE CONSUMER, AND GOVERNMENT OFFICIALS CHARGED WITH ADMINISTERING THESE PROGRAMS.

BOTH MEDICARE AND MEDICAID WILL CONTINUE TO RELY ON STATE AGENCY INSPECTION OF FACILITIES. [redacted] THIS APPROACH IS CONSISTENT WITH A HEALTHY FEDERAL-STATE RELATIONSHIP AND AVOIDS UNNECESSARY EXPANSION OF THE FEDERAL BUREAUCRACY. BUT THE FEDERAL GOVERNMENT - WHICH IS RESPONSIBLE FOR THE QUALITY OF CARE WHICH IT FINANCES - MUST AID IN ENHANCING THE CAPABILITY OF THE STATE AGENCIES TO REGULATE AND IMPROVE THE QUALITY OF NURSING HOME CARE. TO IMPROVE ENFORCEMENT OF NURSING HOME STANDARDS, THE PRESIDENT'S PLAN FOR ACTION PLEDGED THE FOLLOWING STEPS:

1. CONSOLIDATION OF RESPONSIBILITY FOR NURSING HOME AFFAIRS

NURSING HOME ACTIVITIES HAVE BEEN SCATTERED AMONG SEVERAL BRANCHES OF THE DEPARTMENT OF HEW, INCLUDING THE SOCIAL SECURITY ADMINISTRATION, THE SOCIAL AND REHABILITATION SERVICE, AND THE HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION. THE PRESIDENT ORDERED THAT ALL FEDERAL ENFORCEMENT RESPONSIBILITY BE CONSOLIDATED IN A SINGLE OFFICE, AND DR. MERLIN K. DUVAL, THE ASSISTANT SECRETARY OF HEALTH AND SCIENTIFIC AFFAIRS, WAS DESIGNATED AS THE RESPONSIBLE OFFICIAL. DR. DUVAL DELEGATED TO ME THESE RESPONSIBILITIES AND THE FUNCTION OF FULL-TIME COORDINATOR OF NURSING HOME ACTIVITIES. ALSO, TO AMPLIFY THE VOICE OF THOSE OUTSIDE GOVERNMENT, AN OLDER AMERICANS ADVISORY COMMITTEE HAS BEEN NAMED TO ASSIST THE SECRETARY OF HEW.

2. ENLARGEMENT OF FEDERAL STAFF FOR ENFORCEMENT OF NURSING HOME STANDARDS.

THE SOCIAL AND REHABILITATION SERVICE, WHICH ADMINISTERS THE MEDICAID PROGRAM, HAS BEEN ASSIGNED 142 ADDITIONAL POSITIONS TO CARRY OUT ITS INCREASED RESPONSIBILITIES. ONE HUNDRED TEN OF THESE POSITIONS WERE ALLOCATED TO THE REGIONAL OFFICES OF HEW. THE ASSISTANT SECRETARY COMPTROLLER RECEIVED EIGHT NEW POSITIONS, AND HEW'S AUDIT AGENCY RECEIVED THIRTY-FOUR ADDITIONAL POSITIONS TO INCREASE THEIR AUDITS OF NURSING HOME OPERATIONS. THE NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT RECEIVED SEVEN NEW POSITIONS FOR EFFORTS TO IMPROVE NURSING HOME DATA SYSTEMS AND TO DEVELOP DATA IN SPECIAL FIELDS RELEVANT TO NURSING HOME CARE.

3. FEDERAL SUPPORT OF 100% OF THE COST OF STATE MEDICAID INSPECTIONS.

WE RECOGNIZE THAT AN INCREASED LEVEL OF ENFORCEMENT ACTIVITY INVOLVES ADDITIONAL COSTS TO THE STATES. MEDICARE INSPECTION COSTS HAVE ALWAYS BEEN FULLY PAID FOR BY THE FEDERAL GOVERNMENT, BUT UNDER THE MEDICAID PROGRAM STATES HAVE PAID 25 TO 50 PERCENT OF THESE COSTS. SECRETARY RICHARDSON SUBMITTED TO CONGRESS IN OCTOBER, 1971, AN AMENDMENT TO

H.R.1. AUTHORIZING THE FEDERAL GOVERNMENT TO ASSUME 100 PERCENT OF INSPECTION COSTS UNDER MEDICAID. THE SENATE FINANCE COMMITTEE HAS ACCEPTED THIS AMENDMENT. THIS STEP WILL PLACE BOTH PROGRAMS ON AN EQUAL FOOTING AND LESSEN THE FINANCIAL BURDEN TO THE STATES.

4. TRAINING STATE NURSING HOME INSPECTORS.

NURSING HOME SURVEYORS HAVE BEEN TRAINED IN SURVEY AND COUNSELLING TECHNIQUES UNDER A PROGRAM SPONSORED BY THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION SINCE MARCH, 1970. THESE FOUR-WEEK COURSES HAVE BEEN PRESENTED IN UNIVERSITY CENTERS IN NEW HAMPSHIRE, LOUISIANA, AND CALIFORNIA. IN HIS AUGUST SPEECH, THE PRESIDENT PLEDGED AN EXPANSION OF THIS PROGRAM SO THAT 2,000 SURVEYORS COULD BE TRAINED IN THE ENSUING EIGHTEEN MONTH PERIOD. AS A RESULT OF THE PRESIDENT'S ORDER, THE PROGRAM HAS BEEN ACCELERATED SO THAT MORE THAN 700 SURVEYORS WILL HAVE BEEN TRAINED BY JULY OF THIS YEAR. CONTRACT NEGOTIATIONS ARE IN PROCESS TO ESTABLISH THREE ADDITIONAL UNIVERSITY CENTERS. IN ADDITION, A STUDY WAS PERFORMED TO EVALUATE THE EFFECTIVENESS OF THE TRAINING COURSES, WHICH HAVE NOW BEEN MODIFIED TO REFLECT THE RESULTS OF THAT STUDY.

THESE EFFORTS TO ACHIEVE COMPLIANCE WITH FEDERAL STANDARDS AND REGULATIONS ARE NOT DESIGNED TO ELIMINATE FACILITIES AND THUS TO DEPRIVE PATIENTS OF NEEDED NURSING HOME CARE. WE ARE WORKING RATHER TO MAKE GOVERNMENTAL STANDARDS AND PERSONNEL MORE AFFECTIVE RESOURCES FOR THE UPGRADING OF SUBSTANDARD FACILITIES. THE FEDERAL PROGRAM TO TRAIN NURSING HOME SURVEYORS, FOR EXAMPLE, EMPHASIZES THE DEVELOPMENT OF CONSULTANT SKILLS TO AID NURSING HOME ADMINISTRATORS IN MAKING NEEDED IMPROVEMENTS. FEDERAL FINANCIAL ASSISTANCE IS AVAILABLE FOR NURSING HOME MODERNIZATION AND NEW CONSTRUCTION FROM THE FEDERAL HOUSING ADMINISTRATION AND SUCH PROGRAMS AS HILL-BURTON. THE STANDARDS THEMSELVES ARE BEING REVISED AND STRENGTHENED. WE ARE DEVELOPING PROGRAMS TO IMPROVE NURSING HOMES DIRECTLY - I SHALL DESCRIBE THEM IN A FEW MOMENTS.

BUT AS THE PRESIDENT WARNED LAST AUGUST," ... LET THERE BE NO MISTAKING THE FACT THAT WHEN FACILITIES FAIL TO MEET REASONABLE STANDARDS, WE WILL NOT HESITATE TO CUT OFF THEIR MEDICARE AND MEDICAID FUNDS." BETWEEN AUGUST 6, 1971, AND FEBRUARY 11, 1972, 13 EXTENDED CARE FACILITIES WERE DECERTIFIED FOR MEDICARE PARTICIPATION. ON NOVEMBER 30, 1971, THIRTY-NINE STATES WERE DECLARED OUT OF COMPLIANCE WITH TITLE 19-MEDICAID--CERTIFICATION PROCEDURES. BY FEBRUARY 1, 1972, IN RESPONSE TO SECRETARY RICHARDSON'S DEADLINE, ALL BUT ONE OF THOSE STATES HAD MADE THE IMPROVEMENTS REQUIRED FOR COMPLIANCE. BY JULY 1, 1972, ALL TITLE 19 FACILITIES IN ALL STATES ARE TO HAVE BEEN INSPECTED AND CERTIFIED THROUGH THE CORRECT PROCEDURES. THE FEDERAL GOVERNMENT IS PLEDGED TO MEET ITS RESPONSIBILITY TO ASSURE THAT FEDERAL DOLLARS DO NOT FINANCE SUBSTANDARD CARE.

IN ADDITION TO THESE STEPS FOR IMPROVEMENT IN NURSING HOME STANDARDS AND THEIR ENFORCEMENT, TWO OTHER POINTS IN THE PRESIDENT'S PLAN INITIATED MORE DIRECT STEPS TO IMPROVE NURSING HOME CARE. THE PRESIDENT DIRECTED THE DEPARTMENT OF HEW "TO INSTITUTE A NEW PROGRAM OF SHORT-TERM COURSES FOR PHYSICIANS, NURSES, DIETICIANS, SOCIAL WORKERS AND OTHERS WHO ARE REGULARLY INVOLVED IN FURNISHING SERVICES TO NURSING HOME PATIENTS." HEW HAS SUPPORTED SUCH TRAINING FOR SEVERAL YEARS, AND HAS DEVELOPED CLOSE WORKING RELATIONSHIPS WITH PROFESSIONAL ASSOCIATIONS AND WITH TRAINING CENTERS. IN RESPONSE TO THE PRESIDENTS' DIRECTIVE, SUCH PROGRAMS HAVE BEEN EXPANDED UNDER THE LEADERSHIP OF THE COMMUNITY HEALTH SERVICE, HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION, AND ~~IT IS ANTICIPATED THAT~~ APPROXIMATELY 20,000 PERSONS ~~WILL BE~~ TRAINED IN FISCAL YEAR 1972 AT A COST OF $2.5 MILLION. TRAINING PROGRAMS WILL FOCUS INITIALLY ON FOUR

MANPOWER AREAS SELECTED BECAUSE OF THEIR DIRECT DAY-TO-DAY RELATIONS WITH NURSING HOME PATIENTS: NURSING HOME ADMINISTRATORS, PHYSICIANS, NURSES, AND PATIENT ACTIVITIES DIRECTORS. MANY OF THESE TRAINING PROGRAMS WILL BE OPERATED UNDER CONTRACTS WITH PROFESSIONAL GROUPS. APPROACHES TO MENTAL HEALTH PROBLEMS OF NURSING HOME PATIENTS WILL BE DEVELOPED BY NATIONAL INSTITUTE OF MENTAL HEALTH STAFF WORKING WITH THE GERONTOLOGICAL SOCIETY. OTHER TRAINING MECHANISMS WILL ALSO BE EXPLORED, SUCH AS PROGRAMS SPONSORED BY STATE HEALTH DEPARTMENTS AND STATE AGENCIES. THESE PROGRAMS WILL BE DIRECTED TOWARD NURSING HOME STAFF-BOTH PROFESSIONAL AND ALLIED HEALTH-MORE SENSITIVE AND EXPERT IN THE SPECIAL PROBLEMS OF CARE FOR GERIATRIC PATIENTS AND THE CHRONICALLY ILL. THEY ARE INTENDED TO BE THE BEGINNING OF A SYSTEM FOR NATIONWIDE, CONTINUOUS TRAINING FOR NURSING HOME PERSONNEL WHICH WILL BECOME STANDARD PRACTICE IN THE NURSING HOME INDUSTRY OF THE FUTURE.

AS THE SEVENTH POINT IN HIS PLAN, THE PRESIDENT DIRECTED THE DEPARTMENT OF HEW "TO ASSIST THE STATES IN ESTABLISHING INVESTIGATIVE UNITS WHICH WILL RESPOND IN A RESPONSIBLE AND CONSTRUCTIVE WAY TO COMPLAINTS MADE BY OR ON BEHALF OF INDIVIDUAL PATIENTS." SINCE I ASSUMED MY NURSING HOME RESPONSIBILITIES, I HAVE RECEIVED MANY LETTERS FROM NURSING HOME PATIENTS - TOUCHING IN THEIR APPEAL FOR CARE OFFERING SIMPLE DIGNITY AND RIGHTS OF PRIVACY, HARROWING SOMETIMES IN THEIR DESCRIPTIONS OF PHYSICAL OR PSYCHOLOGICAL ABUSE. THESE PATIENTS ARE OFTEN HELPLESS IN THEIR DEPENDENCE ON THE INSTITUTION IN WHICH THEY LIVE. THEY DESERVE A FAIR HEARING, AND AN ADVOCATE WHEN THEY ARE POWERLESS. THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION HAS DEVELOPED FIVE MODELS FOR OMBUDSMAN UNITS

TO FILL THIS ROLE, PLACED AT VARIOUS LEVELS WITHIN THE STATES AND DEMONSTRATING DIFFERENT MECHANISMS FOR ACTION. CONTRACT PROPOSALS TO TEST THESE MODELS ARE BEING SOLICITED, AND $600,000 HAS BEEN BUDGETED FOR FISCAL YEAR 1972 FOR THIS ACTIVITY.

IT WILL TAKE TIME TO TEST AND DEVELOP SUCH AN OMBUDSMAN SYSTEM, TIME INAPPROPRIATE TO THE URGENCY OF THE PROBLEM. SO AN INTERIM OMBUDSMAN MECHANISM HAS BEEN ESTABLISHED WITH THE 855 SOCIAL SECURITY ADMINISTRATION DISTRICT OFFICES DESIGNATED TO RECEIVE AND INVESTIGATE COMPLAINTS. THIS MECHANISM IS CURRENTLY IN EFFECT, AND HAS RECEIVED OVER A THOUSAND RESPONSES.

FOR THESE NURSING HOME INITIATIVES, A SUPPLEMENT APPROPRIATION OF $9,572,000 HAS BEEN REQUESTED FOR FISCAL YEAR, 1972. WE FEEL THAT BY MEANS OF THESE PROGRAMS A SIGNIFICANT IMPROVEMENT IN NURSING HOME CARE CAN BE ACHIEVED IN A RELATIVELY SHORT PERIOD OF TIME.

WE RECOGNIZE ALSO, THAT WHILE THESE INITIATIVES CAN RECTIFY SOME OF THE MOST PRESSING PROBLEMS OF NURSING HOME CARE, THERE ARE OTHER DEFICIENCIES - SOME FUNDAMENTAL - THAT REQUIRE FURTHER SOLUTIONS. FROM A BROADER PERSPECTIVE, IT IS APPARENT THAT NURSING HOMES ARE ONLY ONE ELEMENT IN THE SPECTRUM OF LONG TERM CARE - AN ELEMENT WHICH HAS BEEN FORCED TO BE TOO MANY THINGS TO TOO MANY PEOPLE. IT IS IN THIS PERSPECTIVE THAT THE LAST POINT IN THE PRESIDENT'S PLAN IS FRAMED; HE HAS DIRECTED THE SECRETARY OF HEW TO UNDERTAKE A COMPREHENSIVE REVIEW OF THE USE OF LONG-TERM CARE FACILITIES AND TO RECOMMEND ANY FUTHER REMEDIAL MEASURES THAT ARE APPROPRIATE.

I HAVE BEEN CHARGED WITH ORGANIZING AND CHAIRING THAT TASK FORCE ON LONG-TERM CARE.

ON ONE LEVEL, THE TASK FORCE IS EXAMINING THE ROLES OF MEDICARE AND MEDICAID IN NURSING HOME ACTIVITIES. MOST OF YOU ARE AWARE, AND THE WHITE HOUSE CONFERENCE ON AGING HAS EMPHASIZED, THAT THESE FEDERAL PROGRAMS HAVE BEEN A MIXED BLESSING TO THE NURSING HOME INDUSTRY. SOME OF THE PROBLEMS HAVE BEEN PRIMARILY ADMINISTRATIVE, AND HAVE BEEN OR ARE BEING CORRECTED AS I DISCUSSED BEFORE.

BUT MORE FUNDAMENTAL ISSUES HAVE ALSO BEEN RAISED WITH REGARD TO THESE PROGRAMS. FOR HISTORICAL AND STATUTORY REASONS BASED ON THEIR ORIGINS AS HEALTH INSURANCE PROGRAMS, MEDICARE AND MEDICAID HAVE EMPHASIZED HEALTH ASPECTS OF NURSING HOME CARE. ACUTE ILLNESS IN WHICH THE PATIENT IS EXPECTED TO RECOVER AND REGAIN ALL OR MOST OF HIS INDEPENDENCE HAS SERVED AS THE MODEL FOR HEALTH DELIVERY. CONSEQUENTLY, THESE PROGRAMS HAVE FAVORED INSTITUTIONAL CARE OVER NON-INSTITUTIONAL ALTERNATIVES, AND WITHIN INSTITUTIONS, HEALTH AS OPPOSED TO SOCIAL AND PERSONAL CARE.

IN MANY WAYS, THE CONSEQUENCES OF THIS CARE FOR THOSE WITH CHRONIC ILLNESS - AND FOR THOSE WITH THE INCREASED DEPENDENCY OF OLD AGE - HAVE BEEN TRAGIC. COSTS HAVE BEEN INCREASED BY THE SUBSTITUTION OF INSTITUTIONAL FOR NON-INSTITUTIONAL CARE, AND BY SOMETIMES INAPPROPRIATELY HIGH LEVEL OF MEDICAL SERVICES FOR PATIENTS WHO DO NOT REQUIRE THEM. BUT EVEN MORE IMPORTANTLY, EPIDEMIOLOGY AND THE SOCIAL SCIENCES ARE PROVIDING EVIDENCE THAT DEPENDENCY FACTORS - LOWERED INCOME, DISPLACEMENT, LOSS OF STATUS, ISOLATION - MAY EXACERBATE IF NOT PRECIPITATE ACTUAL PHYSIOLOGIC DISEASE. OLDER

PERSONS PLACED IN INSTITUTION EXPERIENCE SUBSTANTIALLY HIGHER AGE - SPECIFIC MORBILITY AND MORTALITY RATES THAN THOSE WHO REMAIN AT HOME. SO THE TRANSFER OF A PERSON FROM HIS HOME TO AN INSTITUTION, OR FROM AN INSTITUTION IN WHICH HE IS RELATIVELY AUTONOMOUS TO ONE IN WHICH HIS DEPENDENCY IS INCREASED, MAY MAKE HIM MORE ILL AND MORE DEPENDENT. WE MUST REEXAMINE THE BALANCE BETWEEN MEDICAL AND SOCIAL SERVICES WITHIN INSTITUTIONS TO MEET THE NEEDS OF LONG-TERM PATIENTS. THE RESTRUCTURING OF THE INTERMEDIATE CARE FACILITY PROGRAM IS A STEP IN THIS DIRECTION.

JUST AS THE SERVICES WITHIN INSTITUTIONS MUST BE RE-EXAMINED, SO MUST THE ALTERNATIVES TO INSTITUTIONAL CARE BE EXTENDED FOR THOSE SUFFERING FROM CHRONIC ILLNESS. THE CHRONICALLY-ILL AND ELDERLY SHOULD HAVE MORE OPTIONS AVAILABLE. IF A NURSING HOME IS NOT THE MOST APPROPRIATE PLACE FOR A PERSONS PARTICULAR NEEDS, THEN HE SHOULD NOT BE REQUIRED TO GO THERE. IF IT IS PERSONAL CARE RATHER THAN HEALTH CARE THAT IS REQUIRED, THEN THE OPTION SHOULD PROVIDE THAT EMPHASIS. IF IT IS APPROPRIATE HOUSING RATHER THAN INSTITUTIONAL CARE THAT IS NEEDED, THEN THE EMPHASIS SHOULD BE ON HOUSING.

MANY FEDERAL PROGRAMS HAVE EXPLORED ALTERNATIVES TO INSTITUTIONAL CARE. THESE ALTERNATIVES HAVE BEEN A PARTICULAR THRUST OF THE ADMINISTRATION ON AGING, WHICH HAS RECEIVED NEW SUPPORT AND PRIORITY IN THE PRESIDENT'S BUDGET FOR 1972 IN THE FORM OF A FIVE-FOLD INCREASE IN ITS FUNDING LEVEL. THE AoA HAS ESTABLISHED PROGRAMS SUCH AS TRANSPORTATION FOR THE ELDERLY, SENIOR CENTERS, MEALS-ON-WHEELS, TELEPHONE REASSURANCE, IN-HOME SERVICES, AND OPPORTUNITIES TO SERVE. THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT HAS

DEVELOPING HOUSING PROGRAMS DESIGNED TO MEET THE SPECIAL NEEDS OF THE ELDERLY. MEDICARE AND MEDICAID PROVIDE HOME HEALTH BENEFITS.

BUT THE CONCERTED IMPACT OF THESE PROGRAMS HAVE NOT BEEN ENOUGH, AS WE HEARD ONCE MORE AT THE WHITE HOUSE CONFERENCE ON AGING. THE PRESSURE FOR INSTITUTIONALIZATION CONTINUES TO PLACE STRAINS ON NURSING HOMES, WHICH ARE ASKED TO SERVE TOO WIDE A VARIETY OF FUNCTIONS, AND CONTINUES TO PUSH THE ELDERLY INTO SOMETIMES PREMATURE DEPENDENCY. THE PROBLEM OF DEVELOPING A WIDER SPECTRUM OF OPTIONS FOR THE CHRONICALLY ILL AND FOR THE ELDERLY WILL BE A CENTRAL FOCUS OF THE TASK FORCE ON LONG TERM CARE.

AN IMPORTANT REASON FOR THE INSUFFICIENT AND SOMETIMES INAPPROPRIATE IMPACT OF FEDERAL PROGRAMS FOR LONG TERM CARE HAS BEEN THE LACK OF PLANNING AND COORDINATION BETWEEN THOSE PROGRAMS. PLANNING FOR LONG TERM CARE SHOULD MOVE FROM IDENTIFICATION OF AN ISSUE OR PROBLEM TO ITS SOLUTION, WITH IDENTIFIABLE GOALS GUIDING THE PROCESS. MOVEMENT TOWARD A GOAL SHOULD NOT BE INTERRUPTED BY CHANGES IN ADMINISTRATION. WHAT IS TRULY IMPORTANT TODAY SHOULD NOT BE CAST ASIDE TOMORROW. NEW PROGRAMS SHOULD NOT BE APPENDAGES TO SATISFY THE INTERESTS OF A FEW, NOR SHOULD THEY BE ADDED AS PACIFIERS TO THE MANY. PROGRAMS DEVELOPED THROUGH A RATIONAL PLANNING PROCESS SHOULD THEN BE ADMINISTERED THROUGH EFFECTIVE AND COORDINATED MECHANISMS.

THE ESTABLISHMENT OF THE OFFICE OF NURSING HOME AFFAIRS WITH HEW WAS A STEP TOWARD IMPROVING COORDINATION. BUT THE MANDATE FOR THE TASK FORCE ON LONG TERM CARE IS BROAD: TO RE-EXAMINE THE ISSUES AND SET NEW GOALS, TO DEVELOP A NATIONWIDE DATA SYSTEM

NECESSARY FOR POLICY FORMULATION, AND TO RECOMMEND AN ORGANIZATION FOR LONG TERM CARE WITHIN HEW, OTHER FEDERAL AGENCIES, AND STATE AND LOCAL PROGRAMS WHICH CAN ACHIEVE ITS GOALS MOST EFFECTIVELY.

A NATIONAL POLICY COURSE FOR THE CHRONICALLY ILL AND FOR THE ELDERLY SHOULD BE SET. IT SHOULD BE SET BY GOVERNMENT. SET BY GOVERNMENT WITH THE FULL AND CREATIVE CONTRIBUTION OF THOSE IN OTHER AGENCIES AND ORGANIZATIONS, THOSE IN ACADEMIC TEACHING AND RESEARCH, THOSE IN VOLUNTARY AND UNSALARIED SERVICE, AND THOSE WHO RECEIVE THAT CARE. [redacted] A START HAS BEEN MADE. [redacted] WE CAN DO MUCH BETTER FOR OUR ELDERLY. WE MUST OF COURSE PROTECT THEM FROM INSTITUTIONAL ABUSE, RECOGNIZING THAT SOME ARE WEAK AND DEPENDENT. - BUT WE CAN ALSO MAKE POSSIBLE A WIDE VARIETY OF SUPPORTING SERVICES AND LIVING ARRANGEMENTS, SO THAT THE INFIRMITIES OF ADVANCING AGE DO NOT BECOME A PRISON OF THE SPIRIT. THE ELDERLY WITH OUR HELP CAN HAVE ACCESS TO THE VARIETY AND FREEDOM WE ASK FOR OURSELVES.

LONG TERM CARE: WASHINGTON IS LISTENING, TOO

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LONG TERM CARE: WASHINGTON IS LISTENING, TOO

THE THEME OF THIS CONFERENCE -- "WE ARE LISTENING" -- COULD NOT HAVE BEEN BETTER CHOSEN. NOR COULD THIS GATHERING HAVE BEEN MORE APPROPRIATELY TIMED IN LIGHT OF THE ANNOUNCEMENT LAST FRIDAY THAT THE STATE OF IDAHO WILL BE ONE OF FIVE TO TEST A MODEL NURSING HOME PATIENT OMBUDSMAN PROJECT UNDER A HARD-WON FEDERAL CONTRACT.

I SAY HARD-WON BECAUSE IT WAS -- IN COMPETITION WITH MORE THAN A DOZEN STATES AND NATIONAL ORGANIZATIONS EAGER TO TRY OUT THEIR IDEAS ON OPENING UP NEW CHANNELS OF COMMUNICATIONS AMONG THE NURSING HOME PATIENT, THE NURSING HOME, AND THE GOVERNMENT AGENCIES RESPONSIBLE FOR SUPERVISING LONG TERM CARE FACILITIES.

I CONGRATULATE THE STATE PEOPLE RESPONSIBLE FOR DEVELOPING THE INNOVATIVE IDEAS WHICH RANKED THE PROJECT HIGH AMONG THE APPLICANTS. THE IDAHO PLAN IS PARTICULARLY IMAGINATIVE IN THE WAY IT WILL LINK AN ASSISTANT ATTORNEY GENERAL WITHIN THE DEPARTMENT OF SPECIAL SERVICES WITH REPRESENTATIVES OF OTHER STATE AGENCIES, NURSING HOME OPERATORS AND PATIENTS. AND THIS PROJECT IS TO BE FURTHER COMMENDED FOR ITS PLAN TO CALL ON LOCAL ORGANIZATIONS TO PROVIDE VOLUNTEER HELP. THIS IS THE KIND OF CITIZEN-INVOLVEMENT WITH LONG TERM CARE THAT WE HOPE WILL BE ENCOURAGED AS THE OMBUDSMAN IDEA CATCHES ON THROUGHOUT THE HEALTH CARE SYSTEM.

THREE OTHER STATES--PENNSYLVANIA, SOUTH CAROLINA AND WISCONSIN--AND THE NATIONAL COUNCIL OF SENIOR CITIZENS WHICH WILL WORK WITH THE STATE OF MICHIGAN, HAVE ALSO RECEIVED DEMONSTRATION CONTRACTS AND WILL BE TESTING OTHER KINDS OF LINKAGES AND COMMUNICATIONS CHANNELS.

WE HAVE HIGH HOPES FOR THESE FIVE TESTS AND WE ARE CONFIDENT THAT OUT OF THIS YEAR-LONG EXPERIMENT WILL EVOLVE A WORKABLE PLAN FOR CREATING A NATIONAL PROGRAM OF REAL VALUE TO THE PATIENT, THE INDUSTRY, AND THE GOVERNMENT.

I AM ALSO CONFIDENT THAT THE NURSING HOMES OF IDAHO WILL COOPERATE FULLY IN THIS EXPERIMENT IN "LISTENING" TO THEIR PATIENTS. AGAIN, THE THEME OF THIS CONFERENCE BESPEAKS YOUR OBVIOUS CONCERN FOR THE PATIENTS ENTRUSTED TO YOUR CARE.

"LISTENING," AS ANYONE WHO HAS EVER WORKED IN OR AROUND HEALTH CARE KNOWS ONLY TOO WELL, IS A TOO-SELDOM PRACTICED ART. INDEED, THERE CAN BE NO MORE SALIENT SYMPTOM OF WHAT MAY BE WRONG WITH ANY ASPECT OF ANY HEALTH CARE FACILITY THAN THE INABILITY--OR UNWILLINGNESS--OF THOSE WHO SERVE PATIENTS TO HEAR THOSE PATIENTS WHEN THEY CALL OUT FOR HUMAN CONCERN.

JUST AS THIS IS TRUE FOR HEALTH PROFESSIONALS AND ADMINISTRATORS, SO IS IT TRUE FOR THOSE IN GOVERNMENT CHARGED WITH OVERSEEING THE QUALITY AND SAFETY OF CARE PROVIDED TO AMERICAN CITIZENS. AND IT IS ESPECIALLY TRUE FOR THOSE AT ALL LEVELS OF GOVERNMENT WHO ARE CONCERNED WITH THE LONG-NEGLECTED AREA OF LONG TERM CARE.

THE PEOPLE WE ARE LISTENING TO IN WASHINGTON ARE THE VERY SAME PEOPLE YOU ARE TALKING ABOUT HERE TODAY--THE OLDER AMERICANS OF IDAHO AND THE OTHER 49 STATES, THE 21 MILLION OVER 65, AND MOST PARTICULARLY, THE MORE THAN ONE MILLION CONFINED TO LONG TERM CARE INSTITUTIONS.

THE PRESIDENT FIRST ARTICULATED HOW STRONGLY THEIR VOICES WERE BEING HEARD IN WASHINGTON NEARLY A YEAR AGO WHEN HE ANNOUNCED A COMPREHENSIVE ACTION PLAN ON LONG TERM CARE. HIS AIMS WERE SIMPLE AND DIRECT:

-- UPGRADE LONG TERM CARE FACILITIES;
-- UPGRADE THE WAYS GOVERNMENT AT ALL LEVELS MONITORS THESE FACILITIES;
-- UPGRADE CHANNELS OF COMMUNICATION BETWEEN THE PATIENT, HIS FAMILY, THE NURSING HOME AND GOVERNMENT AGENCIES CONCERNED WITH LONG TERM CARE;
-- UPGRADE THE CAPABILITY AND CONSCIOUSNESS OF LONG TERM CARE PERSONNEL;
-- AND, MOST IMPORTANTLY, UPGRADE OUR UNDERSTANDING OF LONG TERM CARE FACILITIES--LEARN WHAT THEY CAN AND CANNOT DO, AND CONSIDER WHAT ALTERNATIVE MODES AND LEVELS OF CARE MIGHT BE DEVELOPED TO ENSURE OUR OLDER CITIZENS THAT THAT RIGHT CARE, AT THE RIGHT TIME, AT THE RIGHT PLACE, AND AT THE RIGHT COST WILL BE THERE.

NOW THIS MAY SOUND LIKE A LOT OF UPGRADING--AND IT IS. AND IT HAS BEEN, AND IS GOING TO BE, AN UPGRADE BATTLE ALL THE WAY. NOT BECAUSE NO ONE IN THE NURSING HOME INDUSTRY OR IN THE GOVERNMENT OR AMONG THE PUBLIC HAS CARED IN THE PAST. BUT BECAUSE UNTIL VERY RECENTLY THERE HAVE NOT BEEN ENOUGH OF THESE ESSENTIAL ACTORS ON THE LONG TERM CARE STAGE TO CREATE AND MAINTAIN A SYSTEM OF THE QUALITY THAT OUR PEOPLE DEMAND.

IT WAS TO FULFILL THIS DEMAND THAT THE PRESIDENT ORDERED THE FEDERAL GOVERNMENT TO MOVE BOLDLY AND RAPIDLY ALONG SEVERAL INTEGRAL FRONTS. THE EFFECTIVENESS OF THAT ACTION IS ALREADY BEING FELT.

YOU ARE, OF COURSE, WELL AWARE OF THE MILESTONE WE HAVE JUST PASSED IN OUR EFFORTS TO UPGRADE STATE MEDICAID NURSING HOME INSPECTION PROGRAMS AND THROUGH THEM, NURSING HOMES THEMSELVES. HEW REPORTED TO THE PRESIDENT AND THE PUBLIC IN JULY THAT FULLY 88 PERCENT OF THE NATION'S 7,000 MEDICAID NURSING HOMES HAD PASSED RIGOROUS MUSTER AGAINST FEDERAL STANDARDS, WITH 24 PERCENT OF THESE MERITING FULL TWELVE-MONTH PROVIDER AGREEMENTS, INDICATING FULL CONFORMITY WITH THE MEDICAID STATUTE AND REGULATIONS. SLIGHTLY OVER 600 DID NOT MAKE THE GRADE--AND WERE EITHER DECERTIFIED BY THE STATES OR VOLUNTARILY WITHDREW FROM THE MEDICAID PROGRAM RATHER THAN ATTEMPT TO MEASURE UP.

YOU ARE ALSO AWARE THAT WE HAVE SEEN A MARKED IMPROVEMENT IN THE QUALITY OF STATE MEDICAID CERTIFICATION PROGRAMS SINCE LAST NOVEMBER WHEN WE FOUND NO FEWER THAN 39 STATES WITH MAJOR DEFICIENCIES. TODAY WE ARE REASONABLY CONFIDENT THAT EVERY STATE HAS A SOUND SURVEY AND CERTIFICATION PROGRAM--AND WE INTEND TO CONTINUE TO MONITOR THESE PROGRAMS TO ENSURE THAT THEY STAY THAT WAY.

THE OBVIOUS OBJECTIVE OF THIS PHASE OF THE NEW FEDERAL EFFORT WAS THREE-FOLD:

-- TO SERVE NOTICE ON THE STATES THAT FEDERAL STANDARDS ARE FOREVERMORE TO BE FOLLOWED TO THE LETTER AND SPIRIT;

-- TO SERVE NOTICE ON THE INDIVIDUAL NURSING HOME OPERATOR THAT ANY FEDERAL PORTION OF HIS PATIENT CARE DOLLAR IS GOING TO BE PAID ONLY IF THAT PATIENT IS RECEIVING THE QUALITY OF CARE HE OR SHE IS ENTITLED TO;

-- AND, MOST IMPORTANTLY, TO ASSURE THE INDIVIDUAL PATIENT THAT THE FULL BURDEN OF RESPONSIBILITY FOR THE QUALITY AND SAFETY OF HIS OR HER CARE IS NOW TO BE BORNE SQUARELY BY THE FEDERAL, STATE AND LOCAL GOVERNMENT AGENCIES SUPERVISING THAT CARE AND BY THE NURSING HOME PROVIDING THE SERVICES.

WE BELIEVE THESE PURPOSES HAVE BEEN MET. AND WE TRUST THEY WILL CONTINUE TO BE MET BECAUSE WE DO NOT INTEND TO LET THE BUCK STOP HERE. JULY 1 HAS COME AND GONE, BUT THE FEDERAL PRESENCE WILL LINGER ON IN THE ONGOING PROCESS OF KEEPING THE STATES, AND THROUGH THEM MEDICAID NURSING HOMES, UP TO THE LEVEL OF QUALITY CARE THAT THE FEDERAL DOLLAR IS INTENDED TO HELP PROVIDE.

SOME OF THE MOST IMPORTANT RESULTS OF THIS MASSIVE CERTIFICATION EFFORT ARE NOT SO IMMEDIATELY OBVIOUS IN THE STATISTICS ON HOW MANY HOMES IN HOW MANY STATES DID OR DID NOT MEET THE MARK. I REFER HERE TO THE GREAT MASS OF DATA THAT HAS BEEN ENGENDERED BY THIS NATIONWIDE EFFORT.

WE NOW HAVE, FOR THE FIRST TIME IN THE HISTORY OF GOVERNMENT CONCERN WITH LONG TERM CARE, THE MAKINGS OF A TRUE PICTURE OF THE LONG TERM CARE SYSTEM. WE KNOW WHAT'S RIGHT WITH IT--AND WE KNOW WHAT'S WRONG. WE CAN CATALOG DEFICIENCIES AND WE CAN DISCERN ANY PATTERNS WHICH MAY BE REFLECTED IN THEM. WE CAN COMPARE FACILITIES IN SINGLE STATES WITH THE NATIONAL PICTURE AND PERHAPS LEARN WHERE AND HOW IDIOSYNCRACIES IN STATE PROGRAMS AND LAWS MAY REFLECT ON THE QUALITY OF THEIR FACILITIES.

AND MOST IMPORTANTLY, WE CAN LOOK FORWARD TO DEVELOPING FROM THIS DATA IDEAS ON HOW GOVERNMENT REGULATIONS AND REIMBURSEMENT POLICIES MIGHT BETTER HELP THE LONG TERM CARE SYSTEM UPGRADE ITSELF.

THIS KIND OF INFORMATION -- AND THESE KINDS OF IDEAS -- WILL PROVIDE A MAJOR SEGMENT OF THE INPUT WE NEED FOR THE STUDY OF LONG TERM CARE WE NOW HAVE UNDERWAY IN WASHINGTON. OUT OF THIS STUDY, WHICH WE EXPECT TO COMPLETE BY THE END OF NEXT YEAR, WILL COME ANOTHER FIRST FOR FEDERAL CONCERN WITH LONG TERM CARE: THE DEVELOPMENT OF A TRULY COMPREHENSIVE FEDERAL PHILOSOPHY TOWARD THE DAY-TO-DAY HEALTH AND HEALTH-RELATED NEEDS OF OLDER AMERICANS, A PHILOSOPHY FOUNDED IN AN ENLIGHTENED ATTITUDE TOWARD AGING AND GROUNDED IN INNOVATIVE APPLICATIONS OF THE FULL SPAN OF RESOURCES

AVAILABLE TO US FROM THE ORGANIZATIONAL, SOCIAL, BEHAVIORIAL AND BIO-MEDICAL SCIENCES. I NEED NOT DWELL HERE ON THE NEED FOR SUCH A BREAKTHROUGH IN WASHINGTON. WE ARE SUFFERING TODAY FROM THE ABSENCE OF SUCH A POLICY OVER THE PAST SEVERAL DECADES WHEN TOO FEW IN WASHINGTON WERE LISTENING, AND NOT ENOUGH WAS BEING DONE TO HELP MEET THE REAL NEEDS OF OUR LONG TERM CARE POPULATION.

THIS BEING OUR CONTEXT, THE WORK BEING DONE NOW REPRESENTS A HISTORIC OPPORTUNITY TO HELP FASHION THE FUTURE SHAPE OF LONG TERM CARE IN AMERICA.

WE ARE FOCUSING OUR STUDIES ALONG THREE PRIMARY LINES WHERE TOO LITTLE -- AND IN SOME CASES NOTHING AT ALL -- IS KNOWN ABOUT EITHER LONG TERM CARE OR THE POTENTIAL IMPACT THAT GOVERNMENTAL POLICY AND REIMBURSEMENT PROCEDURES MAY HAVE ON THAT CARE.

THE FIRST OF THESE FOCAL POINTS INVOLVES POTENTIAL ALTERNATIVES TO INSTITUTIONAL CARE OF THE ELDERLY AND CHRONICALLY ILL AND INCLUDES EVALUATION OF THEIR EXPECTED IMPACT OF THE HUMAN NEEDS OF THE PATIENT, ON BED NEEDS, AND ON COSTS.

THE SECOND CONCERNS THE QUALITY OF ALL MODES OF LONG TERM CARE. HERE, WE ARE HOPING TO DEVELOP WORKABLE METHODS OF QUANTIFYING INDICATORS THAT WILL TELL US QUICKLY AND SURELY WHICH FACTORS HAVE WHAT EFFECT ON THE QUALITY OF PATIENT SERVICES.

THE THIRD INVOLVES DATA COLLECTION AND ANALYSIS, WITH PARTICULAR STRESS ON DEVELOPING INNOVATIVE WAYS TO ENABLE HEALTH PROFESSIONALS, THE INDUSTRY, AND GOVERNMENT TO READILY MONITOR PROGRESS AND INDENTIFY PROBLEM AREAS.

GROUNDWORK FOR THE STUDY IS BEING DONE BOTH WITHIN AND WITHOUT THE FEDERAL GOVERNMENT. IN THE STUDY, AS IN ALL OTHER ASPECTS OF THE LONG TERM CARE PROGRAM, WE ARE WORKING CLOSELY WITH ALL FEDERAL OFFICES AND AGENCIES WITH RESPONSIBILITY FOR OR INTEREST IN THE PROBLEMS OF THE AGING RANGING FROM THE ADMINISTRATION ON AGING TO THE VETERANS ADMINISTRATION AND THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT.

I CANNOT STRESS TOO MUCH THAT THE DEVELOPMENT OF THIS PROJECT WILL NOT TAKE PLACE IN A FEDERAL ECHO CHAMBER. WE ARE TAKING GREAT PAINS TO ENSURE THAT THE VOICES OF EXPERIENCE AND EXPERTISE FROM ALL POSSIBLE POINTS ARE LISTENED TO IN THE COURSE OF OUR WORK.

AMONG THE MOST ARTICULATE VOICES SHOULD BE THOSE OF THE LONG TERM CARE INDUSTRY ITSELF -- THE VOICES OF NATIONAL AND STATE ASSOCIATIONS, AND THE VOICES OF INDIVIDUAL FACILITY OPERATORS. WE WANT TO HEAR WHAT YOU HAVE TO SAY AND WE ARE NOW DEVELOPING THE CAPABILITY WITHIN MY OFFICE TO ENSURE THAT YOU WILL HAVE OUR EAR.

TO FACILITATE YOUR COMMUNICATION WITH US, AND TO ACTIVELY SOLICIT YOUR IDEAS, I HAVE ASSIGNED MY ASSISTANT FOR HEALTH POLICY, PAUL B. SIMMONS, TO WORK WITH NATIONAL AND STATE NURSING HOME ASSOCIATIONS AND WITH OTHER GROUPS INVOLVED IN LONG TERM CARE. I URGE YOU TO GET IN TOUCH WITH HIM AT ANY TIME. HE WILL BE RESPONSIBLE FOR OPENING -- AND KEEPING OPEN -- DIRECT LINES INTO THE FEDERAL GOVERNMENT FOR ANYONE WITH ANYTHING TO SAY ABOUT LONG TERM CARE.

IN CLOSING I WANT TO TOUCH BRIEFLY ON THE PROGRESS WE HAVE BEEN MAKING ALONG SEVERAL OTHER FRONTS OF THE FEDERAL LONG TERM CARE PROGRAM.

YOU WILL SOON BE SEEING THE FIRST PUBLICATION OF FEDERAL MEDICAID STANDARDS FOR INTERMEDIATE CARE FACILITIES. WE EXPECT THESE WILL BE READY FOR COMMENT BY LATE SUMMER AND TO BE READY FOR IMPLEMENTATION IN THE FALL.

WE ALSO EXPECT TO FINISH UP SOON ON THE DEVELOPMENT OF JOINT MEDICARE-MEDICAID NURSING HOME STANDARDS WHICH WILL COORDINATE AND SIMPLIFY VIRTUALLY ALL COMPLEMENTARY ASPECTS OF THESE PROGRAMS.

OUR TRAINING PROGRAMS ARE ALSO RUNNING AT HIGH MOMENTUM. WE HAVE NOW REACHED MORE THAN 700 OF THE 1100 STATE MEDICAID NURSING HOME INSPECTORS IN THE FIELD WITH UNIVERSITY-BASED TRAINING COURSES. WE HOPE TO REACH THE REMAINING 400 BEFORE THE END OF THE YEAR. AND WE FURTHER HOPE THAT THE CONGRESS WILL ACT ON THE PRESIDENT'S PROPOSAL THAT THE FEDERAL GOVERNMENT ASSUME THE FULL COSTS OF STATE MEDICAID NURSING HOME INSPECTION PROGRAMS. SUCH A MOVE WOULD ENCOURAGE THE STATES TO EXPAND AND UPGRADE THEIR ENFORCEMENT CAPABILITIES.

AND FINALLY, OUR TRAINING PROGRAMS FOR NURSING HOME PERSONNEL ARE ALSO MOVING ALONG RAPIDLY. WE EXPECT TO REACH UPWARDS OF 20,000 ADMINISTRATORS, PHYSICIANS, NURSES AND ACTIVITIES DIRECTORS DURING EACH OF THE FIRST TWO FULL YEARS OF THIS EFFORT. AND FOR THE LONG RUN, WE ARE WORKING NOW ON DEVELOPING WHOLLY NEW METHODS OF BRINGING CRITICALLY NEEDED TRAINING DIRECTLY TO THE 500,000 PEOPLE WORKING IN THE LONG TERM CARE FACILITY SETTING. THROUGHOUT THE DEVELOPMENTAL

AND TRAINING ASPECTS OF THIS PROGRAM, WE ARE RELYING HEAVILY ON THE EXPERTISE OF FOUR MAJOR GROUPS UNDER CONTRACT WITH US: THE AMERICAN NURSING HOME ASSOCIATION; THE ASSOCIATION OF UNIVERSITY PROGRAMS IN HOSPITAL ADMINISTRATION; THE AMERICAN MEDICAL ASSOCIATION; AND THE AMERICAN NURSES' ASSOCIATION.

SINCE WE ARE TALKING HERE TODAY ABOUT THE SPECIAL HEALTH PROBLEMS OF OLDER AMERICANS, AND WHAT ALL OF US CAN DO TO HELP RESOLVE THEM, IT SEEMS A PROPOS TO LEAVE YOU WITH A THOUGHT ASCRIBED TO AMBROSE BIERCE, A ONE-TIME OLDER AMERICAN WHOSE OWN SPECIAL PROBLEM SEEMS TO HAVE BEEN A CHRONIC BAD MOOD.

"RESPONSIBILITY," HE SAID, "IS A DETACHABLE BURDEN EASILY SHIFTED FROM ONE'S OWN SHOULDERS TO THOSE OF GOD, FATE, FORTUNE, LUCK -- OR ONE'S NEIGHBOR."

I JUDGE FROM THE TONE AND THRUST OF THIS CONFERENCE THAT NO ONE IN THIS ROOM NEED BE REMINDED OF HIS OR HER SHARE OF RESPONSIBILITY FOR THE FUTURE OF LONG TERM CARE IN IDAHO. AND I SENSE FROM THE SPIRIT OF RESPONSIBILITY IMPLICIT IN YOUR AGENDA THIS WEEK THAT IF THERE IS ANY SHIFTING OF THAT BURDEN, IT WILL BE TO PLACE EVEN MORE OF IT UPON YOUR OWN SHOULDERS.

TEXT OF REMARKS BY UNDER SECRETARY
JOHN G. VENEMAN
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
BEFORE THE
AMERICAN NURSING HOME ASSOCIATION
ANAHEIM, CALIFORNIA
NOVEMBER 5, 1971

Two years ago, it was my privilege to address your Annual Convention in Houston, and I have not forgotten in those two years that many of the members of your Association, the proprietary nursing home industry, provide most of the institutional care of the aging in America.

Privately owned homes care for nearly 67 percent of all the aging receiving institutional care. This is a solemn responsibility, and I know that you bear it with a great sense of honor and pride. I also know that you share the anguish of your fellow Americans at the tragic nursing home fire at Honesdales, Pennsylvania this month. A fire that resulted in the death of 15 aged and helpless Americans.

It would be easy to find in this home a ready scapegoat for the problems that beset the nursing home industry, and certainly there are lessons to be learned from this and similar recent tragedies. But I am not going to indulge in

scapegoating today. That would be too easy. It would also be all too wrong.

The fact is, there is blame enough to go around for everyone in the nursing home fires and other incidents that have made headlines in the past. The problem is not to find the scapegoats, it is to reform the system that produces the scapegoats.

Solutions do not lie in hand-wringing declarations, or pious finger-pointing. Solutions lie in acting to right the wrongs of the present system for administering, regulating and enforcing standards of safety and patient care. Those solutions have to be realistic. They cannot be based upon the flimsy paper of publicity releases and panic solutions.

As you know, President Nixon has announced his firm intention of assuring that our aging receive good care in safe institutions. His speech in New Hampshire on August 6th was not just words. Nor was it just a call to action. It <u>was</u> action.

In that speech the President issued eight action directives and charged the Department of Health, Education, and Welfare with carrying them out, and we are carrying them out. Last week, I reported in public testimony before Senator Moss's

Subcommittee on Long Term Care of the Aging what HEW is doing to implement those eight directives.

One big problem that we had already begun to act on is the indifferent performance of many states in enforcing Medicaid standards. The record is not a good one.

Last May, the General Accounting Office looked into the Medicaid enforcement effort of 90 homes in three states: Michigan, New York and Oklahoma. That study found deficiencies in over half of these homes, and discovered that 44 of them failed even to meet fire safety standards. That should tell us one thing. The clock may already be ticking toward the next tragic nursing home fire. HEW is acting to stay the hands of that clock. Last week, final fire and safety regulations for Medicare were published. These new regulations require extended care facilities and hospitals to comply with the Life Safety Code. This will make Medicare fire safety standards the same as Medicaid's.

HEW conducted its own enforcement survey recently. Among the 15 States surveyed, Medicaid standards were not even being used to certify homes.

Contrary to law, State Licensure Standards were being used to certify homes. Your Association has

repeatedly pointed out that there is no uniformity among state licensure standards. So one of the first things we have to do is to bring about uniformity.

This month, a special HEW survey team launched a crash effort to find out how well each State is enforcing Medicaid rules. This team has already gone into 34 States, and it will visit the remaining 16 by November 15th.

Quite frankly, we aren't expecting to find any miraculous improvements since the recent spot surveys, but we expect to find out where the problems are, what the problems are, and what we at the Federal level can do to solve them.

The Administration and enforcement of Medicaid safety and patient care regulations is still a state responsibility, as the law requires. However, an increasing Federal presence among state regulatory agencies is clearly needed. That's why the President has asked Congress to appropriate funds to finance an additional 150 Federal positions for nursing home enforcement. When these funds become available, most of those 150 persons will be assigned to work directly with the States, out of HEW's regional offices.

I suppose you could characterize this as looking over the States' shoulders, and I suppose you would

be right. But the law gives us this responsibility and we will soon have the additional personnel needed to fully discharge it.

We know, and you know, that monitoring the enforcement efforts of the States isn't going to produce instant miracles. The actual enforcement of Medicaid standards has to be done by the States themselves. That's why the President is going to ask Congress to authorize the Federal Government to pick up the full cost of state nursing home inspection programs, and also why the President has directed that an additional 2,000 state nursing home inspectors be trained at Federal expense over the next 18 months. HEW has already begun that training. Over half of these 2,000 state inspectors will be trained within a year, and all 2,000 will be trained within 18 months.

Something else your Association has called for is the training of more personnel serving the aged in facilities. We fully agree with you. The President has called for 'short-term' training courses for 20,000 health personnel now serving the aging in institutions, and we intend to see to it that these people get that training within the next 18 months. These, as you know, are solutions that will bear fruit in the future. But meanwhile,

there is today, and one of the biggest 'today' problems to be faced is money.

As you have pointed out, a tougher enforcement effort means that nursing homes will have to spend more money to improve their facilities. We have a uniform fire safety code now. That code calls for things like firewalls, sprinkler systems and flame-resistant materials. To make that code enforceable, a way must be found to finance the cost of these capital improvements.

I know you are concerned about this, and you have suggested a solution.

We in HEW are aware of your proposal to have the Federal Government offer low-cost guaranteed loans of up to $50,000 to nursing homes that need to make capital improvements in order to meet standards.

I wish I could have come here today with the news that your proposal has been favorably received, but I can't. But I can tell you this -- your proposal is being actively considered, and although this news may not make your pulse quicken, I hope that it conveys to you that we understand your problem, and that we too appreciate the need to help you find a solution to your fiscal problem.

But meanwhile, while you are awaiting decisions, there are several misconceptions about the Administration's initiatives in the nursing home field that I want to try to clear up.

One misconception is that the crackdown is going to mean wholesale withdrawal of Federal certification. Another misconception - quite the opposite - is that the President's firm language is just so many words.

First, let me assure you on this second point; Anyone who assumes that we aren't going to withdraw funds from institutions that won't meet standards is attaching a false and dangerous interpretation to the President's remarks. The President has told it like it is, "We are not going to pay for substandard subhuman care for our aging."

Now as to the first misconception, that we plan a wholesale purge of institutions that don't measure up in every way. That's wrong too. It would serve no purpose to force the wholesale withdrawal of Federal funds to facilities that are visibly trying to measure up, but we intend to develop a monitoring and enforcement system that will apply selective pressure. Selective pressure does not mean withdrawing certification from every institution that fails to meet every minor rule. It does mean that inspectors

will be around to visit and to spot deficiencies, and to come back again, perhaps unannounced, to see with their own eyes whether a facility has made visible progress toward correcting those deficiencies.

Right now, a handful of states have a fair eyeball enforcement program. The President's intention is to ensure that every state gets that kind of enforcement machinery.

Another kind of misconception has also sprung up since the President said he would cut off Federal funds to substandard homes. There are some who simply don't believe that's going to happen. Where would they put the patients if homes are forced to close their doors for lack of funds? So goes reasoning.

As far as Medicare patients are concerned, that's no problem. Any Medicare patient currently housed in a facility that loses its Medicare certification remains in that home until the issue is resolved, or until their condition no longer requires them to remain in that institution.

The States, however, do possess the authority to close down any facility that they have decertified for Medicaid. In the past, states have been understandably reluctant to take that action, fearing that they would create real hardships among patients displac

by the closing of a facility. And indeed, credible enforcement cannot be achieved by the threat of incredible actions.

No one would put up with having aging patients thrown into the streets. That would only punish the victims. It would be like blowing up the bridge to relieve the traffic jam, but we in HEW are taking steps to make the incredible threat a credible possibility.

We are keeping close track of how many beds are available in certain Federal hospitals, such as those operated by the Public Health Service. This is being done with the view of making empty beds available for the prompt use of Medicaid patients who would be displaced by the impending closing of an institution that a state had decertified for reimbursement.

We will also work closely with state certification agencies to pinpoint other facilities that can be used to house and care for these patients, and we are prepared to take whatever action is needed to ensure that no aging patient suffers hardship because an institution faces Medicaid decertification. We hope that further closings will not occur, but if they do, we will see to it that facilities are standing by to handle the patient population involved.

Some of what I've said to you today may sound like tough talk. Maybe it is, but it is also honest talk. Frankly, I don't think that anything I've said is very far opposed to what your organization stands for.

I've read your President's recent speeches, and I've read that part of your Association's constitution that says; "The object of this Association shall be to improve the standards of service and Administration of member nursing homes, to secure and merit public and official recognition and approval of the work of nursing homes..." That's a good statement, and I know you plan to live up to it. Any other course of action would be disastrous, not only for our aging, who depend upon you, but also for the nursing home industry itself. Because unless the American people see continued and visible progress in upgrading the institutions for our aging, there will be calls for tougher and tougher legislation.

You don't need me to tell you that fires in nursing homes move us closer to that possibility. I hope and trust that your Association takes an aggressive stand in self-policing. It's worth a ton of legislation.

I see some signs that you plan to move on the self-regulation route. The fact that your President, David Mosher, wrote President Nixon to express your Association's support of his initiatives is refreshing. We in HEW are also happy that you are keeping your lines of communication open with us.

Last month, your representatives sat down with some of our people and held a good brass-tacks discussion about the Administration's nursing home initiatives. That's another good sign. Our communications with you will continue to improve rapidly.

As you know, Dr. Merlin K. DuVal, Assistant Secretary for Health and Scientific Affairs is the man charged with success of failure of our hursing home initiatives. But he won't be alone in this responsibility.

Secretary Richardson has named one of the Nation's top experts in nursing homes to assist Dr. DuVal. Her name is Mrs. Marie Callender.

She served recently as Assistant Professor of the Department of Clinical Medicine and Health Care at the University of Connecticut School of Medicine. Few people know their way around the nursing home field any better than Mrs. Callender. So your discussions with her are sure to be - shall we say -- 'meaningful.'

In any case, my present feeling is that your Association -- and you as individuals -- are not far away from what the President, the Congress and HEW want to see happen soon in the nursing home field. That's a good feeling, and with your concurrence, that's the message I plan to take back with me when I return to Washington.

Thank you.

# # #

REMARKS FOR THE UNDER SECRETARY
DEDICATION OF THE METROPOLITAN HOSPITAL FOR EXTENDED CARE
Washington, D.C.
November 19, 1970

At a time when we are all searching for new ways to solve our health care problems, and when health promises to be a significant political issue in future campaigns, I am very happy to be able to represent the Administration in dedicating this extended care center.

The extended care facility has taken its place, during recent years, as an important component in the continuum of medical care. The opening of each new instituiuion, such as this one, ~~stregthens~~ strengthens the ~~tion~~ implication of comprehensive community health planning and meets a clearly established health need.

But amid such great expectations, there has developed in recent months a liturgy of criticism of facilities such as this. There are many members of the medical community who sincerely believe that we are on the road to the total depersonalization of medical care, toward a state of affairs in which patients and physicians alike will be reduced to numbers, ~~to be~~ processed through computers, with virtually no regard for the personal interactions that are at the heart of the practice of medicine.

One Congressman has gone so far as to refer to nursing homes as "human junkyards" and a Washington Post article last week speculated

The American system of care is passing through a difficult period, a period of change, of re-evaluations, of innovation, and frankly of a crisis of confidence. If we view this period as a time to dig in and hold onto things as they are, we will face an overwhelming demand for uprooting of the whole national system of health care.

If, on the other hand, we accept the need for change and take advantage of the opportunities for orderly evolution based on the great strengths that are to be found in the pluralistic American health enterprise, then I think we will move into an era of unmatched excellence in health care.

A critical ingredient of a scheme such as this is the involvement of all segments of the society. It is essential that the innovative business skills that characterize the American free enterprise system be brought to bear upon the health care delivery system.

And this is another of the criteria for effective care which this extended care facility satisfies. In this sense, it is truly a model for the nation and we intend to encourage the development of other models along the same lines.

All of the components of an effective comprehensive health strategy have a difficult task ahead of them and that is to combat the cynicism of the American people when it comes to the quality of health

upon the use of potent tranquilizers in nursing homes as effective "chemical strait-jackets" for the aging.

Recognizing the distinction between nursing homes and extended care facilities, I can only say that I do not share such apprehensions. ~~Plans~~ Your plans for this facility emphasize the pleasant atmosphere and careful attention that patients will receive. And so, I think, on the contrary that as health care for individuals becomes more continuous, as the emphasis moves toward health maintenance and away from acute care, that physicians will develop a rapport with their patients much more conducive to the best of health care. And that is what the doctor-patient relationship is all about.

Last year, the Federal Government spent $500 million on Medicare reimbursements to extended care facilities. Obviously, we hold responsibility for insuring that the care ~~that~~ our Medicare beneficiaries receive is high quality, comprehensive care at the lowest possible cost. And that is why I am so happy, and the Administration is so willing, to encourage the establishment of facilities such as this one which offer patients just such care as this.

"Overuse of high cost acute facilities is one of our most crucial health care problems. There is a growing need for lower cost alternatives, including extended care facilities." These are the words of former Secretary Finch, and they characterize the attitude of the entire Administration.

care they are able to obtain.

A recent Harris survey gives evidence of ~~this~~ such widespread discontent.

Conducted in over 1500 households around the country, the survey came up with some significant findings, and some startling ones, in spite of the fact that we, in government, ~~had~~ have long been aware of a deep-seated resentment and concern among the American people.

— 63 per cent of the people questioned felt that doctors try to jam so many patients into office hours that they don't give enough time and attention to anyone.

— 62 per cent of the people agree that, since Medicare and Medicaid have come in, doctors have jumped their fees to take advantage of it.

53 per cent of the people questioned felt that, if doctors paid more attention to preventive medicine, their patients could avoid a lot of illness.

These, and other significant findings all tend to reinforce a feeling we in the government have had for a long time . . .that there does exist this "crisis in confidence" as regards medical care and the medical profession.

Of course, we feel that we have some responsibility for dealing with this trend, but I must emphasize that we cannot do it alone. Doctors will have to look closely at these statistics and even more closely at their own habits and procedures.

Medical schools will have to weigh the benefits of their research programs against the long-term benefits to the public of larger teaching programs. We face very critical manpower shortages, and yet many of our medical schools continue to pursue irrelevant research objectives at the expense of turning out more doctors.

I am happy to see that this facility will be dealing with this problem of manpower by offering teaching and training programs, especially to the under employed.

I suppose the point of all this is that we must work together if we are to confront and conquer the very severe problems of costs, manpower and resources. We will have to explore a variety of routes toward the same goal. . .that is to enable every person in the United States to benefit equally in the tremendous national investment in health and health care.

The Metropolitan Hospital for Extended Care will offer the people of the District of Columbia low cost care, ideally located, and

in pleasant surroundings. It will offer doctors in this area the opportunity of reaching their patients at least once, if not twice a day, and they will be able to work in modern, convenient facilities with ample support staff.

We in the government are committed to the development of this facility and others like it. We believe it is truly an essential ingredient in whatever health scheme we should settle upon to solve the nation's health problems.

And I know that everyone involved in the planning and providing of health care within the Administration joins me in thanking you for helping us through the establishment of the Metropolitan Hospital for Extended Care.

PARTIAL TEXT OF REMARKS BY
UNDER SECRETARY JOHN G. VENEMAN
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
BEFORE THE
GOVERNOR'S CONFERENCE ON COMMUNITY HEALTH SERVICES
OKLAHOMA CITY, OKLAHOMA
THURSDAY, MARCH 12, 1970

I am pleased to be here tonight, to bring greetings from Secretary Finch, and to represent the Department of Health, Education, and Welfare at this important conference.

I would like to thank Governor Bartlett for asking me to address this distinguished group and for calling attention to the health problems we face.

Oklahoma has an active and effective State Health Planning Agency, reaching about 60 percent of the State's population. I see from your brochure that recent "quality of life" studies ranked Oklahoma 17th among the 50 States in achievement of health goals, and I know your Planning Agency is outlining priorities and choices for achieving even better health for all citizens of your State. Their comprehensive approach... covering all areas of physical, mental and environmental health...with the commitment and dedication exemplified by groups like yours, can meet the growing challenge of effective health care in Oklahoma. The situation is not so encouraging in other parts of the country.

parts of the system are private and largely autonomous organizations. It is an industry which lacks to a large degree competition, which is almost completely lacking in organizational relationships and community-wide linkages, and which is unable to organize itself to meet an increasing demand for services. The question for the governmental authorities... Federal, State and local...therefore is, how can we develop a comprehensive system of health care delivery without massive Federal intervention and regulation?

Last July Secretary Finch warned that "what is ultimately at stake is the pluralistic, independent, voluntary nature of our health care system" and that "We will lose it to pressures for monolithic, government-dominated medical care unless we can make that system work for everyone in this Nation."

Let me outline some of the problems we face in accomplishing this goal.

The escalation of health care costs is perhaps our most publicized problem for the immediate future.

In 1955, total expenditures for health services were just over $17 billion. By 1965, they had risen to over $37 billion. The latest estimates for 1969 show that health care is now a $60 billion enterprise. By 1975, estimates indicate that we will be spending between $90 and $100 billion on health services.

In spite of the great increase in expenditures for health, the indicators of health status show us as lagging behind other nations. In world ranking, we have slipped to fifteenth in infant mortality and 22nd in life expectancy for men.

The implementation of Medicare and Medicaid have multiplied the stresses and strains on this fragile system. The great increases in numbers of patients demanding and receiving health care, as well as the rise in the proportion of total funds for health provided from public sources, have not been accompanied by a rise in equitable utilization of health care resources for all members of society.

First, there are vast shortages of resources. For example, under the current conditions, we are short about 50,000 physicians, and a recent study shows that modernization of our decaying hospital facilities would cost at least $6 billion.

Second, we are not only short on resources, they are also poorly distributed. For example, in one area of Harlem, there were 50 physicians to serve 25,000 people 25 years ago; today, there are 5 physicians for 50,000.

What these problems represent is an area of social welfare in which, more than in any other, we have derived limited results from vast amounts of money and an abundance of facilities. The problem is clearly not one of availability of funds.

The stake of the Federal Government in this area is reflected in the fact that it is currently purchasing more than 25 percent of the output of the health care system, while State and local governments are purchasing another 12 percent for a total of 37 percent. The three levels of government combined now purchase more than half of the hospital care in this Nation.

These figures indicate that the use of its purchasing power is probably the government's primary source of leverage to initiate changes in the organization and delivery of health care.

How are we to use this leverage? To what extent should it be used to change present patterns in an essentially private system... and to preserve that system?

Let me talk about some of the initiatives the government has already taken...and then mention the long range picture.

Some of these initiatives do deal with the financing of health services. I happen to feel that these are the most immediate changes we can make. The Health Cost Effectiveness Amendments of 1969, and the preliminary recommendations of the Medicaid Task

Force, for example, are intended to improve the effectiveness of health care financing mechanisms.

They reflect the feeling of the Administration that it is now time to make some fundamental changes in the law which governs Medicare and Medicaid reimbursement. We need an incentive system of institutional reimbursement and we need changes in the law that will help control the increases in the amount that the Medicare program will recognize in the charges of individual practitioners.

In the case of hospitals and other institutional providers, reimbursement is now on a retroactive basis. Consequently, facilities do not have strong economic reasons for trying to improve the efficiency of their operation.

I think we should move as quickly as possible in the direction of prospective rather than retroactive reimbursement. With rates set in advance, a provider would be challenged to stay within the limits of the known reimbursement and would share in savings that come from economies achieved through effective management.

Furthermore, our programs would no longer have only a passive role in responding to costs incurred by providers. They would have an active role in influencing in advance the amounts which will be made available for institutional health care.

I would not want to minimize the difficulty that would accompany the introduction of this prospective approach to reimbursement. Implementation will take time, but I believe that the benefits merit such an effort.

We have also recommended that the law should be changed so as to limit further the rate at which increases in physicians fees would be recognized by Medicare.

Realistically, charges under the current program and the fees recognized by carriers reflect whatever physicians choose to charge the public generally...in a market where growing demand is pressing increasingly on the limited supply of health personnel.

We are also proposing for the Medicaid program modifications in the rate of Federal participation with incentives for the use of long term institutional care. Unfortunately, statistics show that a significant factor in skyrocketing costs can be traced to the practice of needlessly retaining patients in costly hospital beds simply because the government is around to pay the bills. We have all heard it said that you cannot legislate morality, but limitations on the length of stay for which there will be full Federal participation and a system of "utilization review" would go a long way toward curbing the practice.

We will not reach our objectives through solutions which deal solely with financial problems. Our efforts must represent a

strategy for solution to all aspects of the total health problem. With this in mind, the Administration has introduced revisions in other health programs which would improve the organization and delivery of health care. We would encourage the development of ambulatory care programs. The proposed Health Services Improvement Act of 1970 focuses sharply on improving the efficiency and effectiveness of our health systems and targets the efforts of the Comprehensive Health Planning and Services program, the Regional Medical Programs and the efforts in health services research and development toward these ends. We are linking the reimbursement policies under Medicare and Medicaid to mesh with these programs.

We will be moving in the direction of improvement of the organization of health services at the community level. Our responsibility will be to assist in the development of new social institutions at the community level which will draw together the health resources, the providers of health care, and the consumers into a community trusteeship for health. The need for such an institution was recognized five years ago by the National Commission on Community Health Services chaired by a distinguished former Secretary of HEW, Marion Folsom. The time has come to initiate these measures in each community in the Nation and the Administration stands ready to assist such community efforts.

We have proposed redirections in the Hill-Burton construction program. When the program was launched 23 years ago, the United States had less than 60 percent of the hospital beds it needed. Today, despite the rapid growth of the population, we have about 90 percent of the acute hospital beds we need.

We will move to reorder our priorities under Hill-Burton away from inpatient care toward outpatient care...and from sickness to preventing sickness. We propose a program of bloc grants to encourage the states to expand such facilities as outpatient clinics, neighborhood health centers, skilled nursing homes and extended care facilities. We believe that these measures would provide a better balanced health structure and would enable more people to get more care at less cost.

It is obvious that prevention is cheaper in the long run, both to the individual and to society in general.

That is when we have such high hopes for our [redacted] programs for rubella vaccination and our campaign against hunger and malnutrition. The difficult situation we face in the area of hunger was emphasized by the convening of the White House Conference on Hunger held in December. We are presently conducting a national nutrition survey system as well as support for community nutrition programs.

In addition, we are giving a great deal of attention to the first few years of life and to the health needs of mothers and children. We hope to expand such programs as family planning, maternal and child health services, day care and other prevention service.

Support will also be provided for specific activities which improve the quality and productivity of health services, including the utilization of new types of health manpower such as returning medics from the Armed Services.

All of these efforts look forward to a time when ability to pay for medical care will no longer be an important barrier to receipt of care. This situation will be brought about largely through the extension of health insurance, whether required by government or provided through government or in part subsidized by government. Just about everyone is going to be under a health insurance plan, public or private, covering a major part of individual health costs... including low income people who will one day participate in the same systems that cover the rest of the population. This situation could create more severe strains on the delivery of care.

With this in mind, it is important to recognize that many of the solutions to the problems will be found only in changes within the private health industry and with their cooperation. The Federal Government clearly needs to safeguard the public interest in administer-

ing the public programs. We must consider interface between the public and private sectors, and the methods of influencing the private sector to look at their policies which may impede improvements.

Private employers and consumers need to reevaluate their health insurance policies to provide incentives to the use of lower cost alternative modes of care.

It is this kind of organizational "put together" that will make the difference not only in the cost but in the organization of delivery of better health care...and not just to Medicare and Medicaid recipients, but to all of our citizens. We at HEW are giving the highest priority to the exercise of the discretion and leverage that we have in our various programs to enhance and make more rational the organization and delivery of medical care.

As Secretary Finch has pointed out, "what is at stake is the pluralistic, independent, voluntary nature of our health care system." We must move now to assure a leadership role for government and to avoid any move toward the direct Federal assumption of responsibility for the Nation's health system.

I hope you will work with us toward these ends and to make good health a reality throughout the country. Your influence in these areas can be considerable.

ADDENDUM TO SPEECH:

I am delighted to publically commend Oklahomans, the Oklahoma Health Science Foundation, and Dr. James Dennis for the innovative health program which has become known as the Oklahoma Health Center -- the "Oklahoma Plan."

This program promises to put into actual practice a concept which many of us in the health field still dream about. It combines the considerable resources of academic medicine, practicing medicine, voluntary agencies, and public health agencies into a single operating health continuum.

In the present space age, the word "spinoff" has become routine. So, I would mention that the spinoff from the "Oklahoma Plan" will be felt outside of Oklahoma. The experiences gained in this program will most surely guide and benefit the entire Nation.

And certainly the program at the University of Oklahoma School of Health to train health planning personnel for 13 states will have a national impact.

ADDENDUM TO SPEECH:

Subject: Oklahoma's Unusually Successful Effort in Raising Immunization Levels Against Rubella

In a cooperative team effort combining resources from both public and private agencies, a statewide "Rubella Sunday" was conducted on February 1, 1970. Joining the Oklahoma state and local health departments in this massive campaign were the State Medical Association, Oklahoma Nurses Association, Pharmaceutical Association, Osteopathic Association and Oklahoma Jaycees. 255,000 doses of rubella vaccine were administered reaching 51% of the total susceptible population in the age group 1 through 11. Oklahoma is one of the first states in the nation to conduct such a community-wide campaign.

THE OUTLOOK ON NURSING HOMES

It is with some humility that I approach a topic as broad as "The Outlook on Nursing Homes." For not only are you, of the Virginia Nursing Home Association involved in the immediate, personal job of caring for patients in nursing homes, but also as Virginians you are too close to Washington to harbor illusions about the wisdom or grandeur of Federal power. You can gaze across the Potomac and witness the legislative jungle through which a program must pass in Congress to become law, and you can observe the difficulty in translating an administrative policy conceived in the HEW North building into a reality in Arlington County. So you know that those of us who serve the Federal Government today do not come equipped with all the answers - ready to dispense the balm of great personal wisdom to heal all wounds afflicting a troubled society.

I come before you today then not to offer ready-made prescriptions or rock-hard certainties, but to describe to you some of the problems we see and the answers we have devised. And I want to enlist your aid in helping us find and realize solutions to the problems facing those who need or are receiving nursing home care.

The Federal Government has become increasingly involved in nursing home care over the last twenty years, particularly since the enactment of the Medicare and Medicaid programs in 1965. In 1970 the Federal Government spent over $2 billion in support of nursing home patients, while State and local government spent another $700 million.

THE DIFFICULTY WITH SUCH MASSIVE INVOLVEMENT IS IN ASSURING THAT DESIRED AND DESIRABLE IMPACT IS ACHIEVED. WITH RESPECT TO CONTINUITY OF CARE BETWEEN HOSPITAL AND ENTENDED CARE FACILITY, I BELIEVE THE FEDERAL ROLE HAS BEEN USEFUL AND IMPORTANT. THE PRESIDENT'S 8-POINT PLAN FOR ACTION TO IMPROVE NURSING HOMES, ANNOUNCED LAST AUGUST IN NEW HAMPSHIRE, IS DESIGNED TO STRENGTHEN AND IMPROVE THAT ROLE. THE IMPLEMENTATION OF THAT PLAN HAS ABSORBED MOST OF MY TIME SINCE I ASSUMED MY NURSING HOME RESPONSIBILITIES LAST DECEMBER - MORE OF MY TIME THAN I HAD IMAGINED, I MIGHT ADD - AND I WOULD LIKE TO DESCRIBE FOR YOU SOME OF THESE EFFORTS. BUT I WOULD ALSO LIKE TO DESCRIBE FOR YOU THE PROBLEMS AT THE OPPOSITE END OF THE SPECTRUM - CONTINUITY BETWEEN INSTITUTIONAL CARE AND THE HOME. I BELIEVE THAT THE FEDERAL ROLE HAS BEEN LESS CONSTRUCTIVE IN THAT AREA, WHICH REPRESENTS TOMORROW'S CHALLENGES. AND THESE CHALLENGES FACE US ALREADY IN WAYS I SHALL DESCRIBE.

THE EXTENDED CARE FACILITY PROGRAM UNDER MEDICARE WAS DESIGNED TO COVER THE EXTENSION OF CARE FOR A PATIENT WHO NO LONGER REQUIRES THE FULL MEDICAL RESOURCES OF A HOSPITAL, BUT STILL NEEDS RELATIVELY INTENSIVE MEDICAL SERVICES. THE SKILLED NURSING HOME PROGRAM UNDER MEDICAID, ALTHOUGH THE PHILOSOPHIC INTENT WAS SOMEWHAT DIFFERENT, ADOPTED VERY SIMILAR STANDARDS. ACUTE ILLNESS, IN WHICH THE PATIENT IS EXPECTED EVENTUALLY RECOVER, IS THE BASIC MODEL FOR WHICH THIS SYSTEM IS DESIGNED, AND THE EMPHASIS HAS BEEN ON MEDICAL RATHER THEN SOCIAL AND PERSONAL SERVICES. THIS APPROACH HAS LED TO VERY REAL PROBLEMS WHEN APPLIED TO PATIENTS WITH CHRONIC ILLNESS, WHO MAKE UP A LARGE PROPORTION OF THE ELDERLY NURSING HOME POPULATION - I SHALL DISCUSS THESE PROBLEMS LATER.

THE PRESIDENT'S PLAN FOR NURSING HOMES ACCEPTED THE RESPONSIBILITY TO ASSURE THAT NURSING HOMES DELIVER CARE AT LEAST AT THE LEVELS OF FEDERAL STANDARDS AND REGULATIONS. A MAJOR GOAL OF THE PLAN IS TO IMPROVE FEDERAL ENFORCEMENT OF NURSING HOME STANDARDS. AS YOU KNOW, THE TERM "NURSING HOME" IS APPLIED TO A WIDE RANGE OF FACILITIES, FROM THOSE PROVIDING PRIMARILY CUSTODIAL CARE TO THOSE DELIVERING HIGHLY SKILLED POST-HOSPITAL AND REHABILITATIVE SERVICES. THESE DIFFERENT TYPES OF FACILITIES ARE ACCREDITED THROUGH DIFFERENT MECHANISMS, AND FEDERAL LEVERAGE IN ENFORCING STANDARDS VARIES WIDELY. MEDICARE CERTIFICATION OF EXTENDED CARE FACILITIES IS A FEDERAL PROGRAM MEDIATED THROUGH STATE AGENCIES. MEDICAID IS A FEDERAL-STATE PROGRAM, FINANCED AND ADMINISTERED THROUGH BOTH FEDERAL AND STATE FUNDS AND ACTIVITIES. INTERMEDIATE CARE FACILITIES UNTIL RECENTLY WERE REQUIRED TO MEET ONLY STATE LICENSING REQUIREMENTS TO RECEIVE FEDERAL FUNDS. THESE DIFFERENCES HAVE COMPLICATED THE ENFORCEMENT OF STANDARDS. IF H.R. 1 AS CURRENTLY AMENDED BY THE SENATE FINANCE COMMITTEE IS PASSED, THEM SOME OF THESE DIFFERENCES WILL BE MINIMIZED AND MORE UNIFORM STANDARDS AND CERTIFICATION PROCEDURES WILL BE ADOPTED FOR MEDICARE AND MEDICAID. IN ANTICIPATION OF THESE CHANGES, A COMMON SET OF STANDARDS FOR BOTH PROGRAMS IS BEING DEVELOPED UNDER THE AUSPICES OF MY OFFICE. BUT THE STATE AGENCY WILL RETAIN ITS INSPECTION ROLE. AND THE FEDERAL GOVERNMENT, WHICH IS RESPONSIBLE FOR THE QUALITY OF CARE WHICH IT FINANCES, MUST AID IN ENHANCING THE CAPABILITY OF THE STATE AGENCIES TO REGULATE AND IMPROVE THE QUALITY OF NURSING HOME CARE. TO IMPROVE ENFORCEMENT OF NURSING HOME STANDARDS, THE PRESIDENT'S PLAN PLEDGED THE FOLLOWING STEPS:

1. Consolidation of responsibility for nursing home affairs

Nursing home activities have been scattered among several branches of the Department of HEW, including the Social Security Administration, the Social and Rehabilitation Service, and the Health Service and Mental Health Administration. The President ordered that all Federal enforcement responsibility be consolidated in a single office, and Dr. Merlin K. DuVal, the Assistant Secretary of Health and Scientific Affairs, was designated as the responsible official. Dr. DuVal appointed me to work with him on these activities and to function as a full-time coordinator of nursing home activities.

2. Enlargement of Federal staff for enforcement of nursing home standards.

The Social and Rehabilitation Service, which administers the Medicaid program, has been assigned 142 additional positions to carry out its increased responsibilities. One hundred ten of these positions were allocated to the Regional office of HEW. The Social Security Administration received thirty-four additional positions to increase their audits of nursing home operations. The National Center for Health Services Research and Development received seven new positions for efforts to improve nursing home data systems and to develop data in special fields relevant to nursing home care.

3. Federal support of 100% of the cost of State Medicaid Inspections.

We recognize that an increased level of enforcement activity involves additional costs to the States. Medicare inspection costs have always been fully paid for by the Federal government, but under the Medicaid program States have paid 25 to 50 percent of these costs. Secretary Richardson submitted to Congress in October, 1971,

AN AMENDMENT TO H.R. 1, AUTHORIZING THE FEDERAL GOVERNMENT TO ASSUME 100 PERCENT OF INSPECTION COSTS UNDER MEDICAID; THIS STEP WILL PLACE BOTH PROGRAMS ON AN EQUAL FOOTING AND LESSEN THE FINANCIAL BURDEN TO THE STATES.

4. Training State nursing home inspectors.

NURSING HOME SURVEYORS HAVE BEEN TRAINED IN SURVEY AND COUNSELLING TECHNIQUES UNDER A PROGRAM SPONSORED BY THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION SINCE MARCH, 1970. THESE FOUR-WEEK COURSES HAVE BEEN PRESENTED IN UNIVERSITY CENTERS IN NEW HAMPSHIRE, LOUISIANA, AND CALIFORNIA. IN HIS AUGUST SPEECH, THE PRESIDENT PLEDGED AN EXPANSION OF THIS PROGRAM SO THAT 2,000 SURVEYORS WOULD BE TRAINED IN THE ENSUING EIGHTEEN MONTH PERIOD. AS A RESULT OF THE PRESIDENT'S ORDER , THE PROGRAM HAS BEEN ACCELERATED SO THAT MORE THAN 700 SURVEYORS WILL HAVE BEEN TRAINED BY JULY 1. CONTRACT NEGOTIATIONS ARE IN PROCESS TO ESTABLISH THREE ADDITIONAL UNIVERSITY CENTERS. IN ADDITION, A STUDY WAS PERFORMED BY MACRO, SYSTEMS, INC., TO EVALUATE THE EFFECTIVENESS OF THE TRAINING COURSES, AND THESE HAVE NOW BEEN MODIFIED TO REFLECT THE RESULTS OF THAT STUDY.

THESE EFFORTS TO ACHIEVE COMPLIANCE WITH FEDERAL STANDARDS AND REGULATIONS ARE NOT DESIGNED TO ELIMINATE FACILITIES AND THUS TO DEPRIVE PATIENTS OF NEEDED NURSING HOME CARE. WE ARE WORKING RATHER TO COORDINATE FEDERAL AND STATE PROGRAMS AND STATE AGENCIES TO SHARE THEIR RESOURCES AND EXPERTISE SO THAT SUBSTANDARD FACILITIES CAN BE UPGRADED. THE FEDERAL PROGRAM TO TRAIN NURSING HOME SURVEYORS, FOR EXAMPLE, EMPHASIZES THE DEVELOPMENT OF SKILLS TO AID NURSING HOME ADMINISTRATORS IN MAKING NEEDED IMPROVEMENTS. FEDERAL FINANCIAL ASSISTANCE IS AVAILABLE FOR NURSING HOME MODERNIZATION AND NEW CONSTRUCTION FROM THE FEDERAL HOUSING

ADMINISTRATION AND SUCH PROGRAMS AS HILL BURTON. THE STANDARDS THEMSELVES ARE BEING REVISED AND STRENGTHENED. WE ARE DEVELOPING PROGRAMS TO IMPROVE NURSING HOMES DIRECTLY-I SHALL DESCRIBE THEM IN A FEW MOMENTS.

BUT AS THE PRESIDENT WARNED LAST AUGUST," ... LET THERE BE NO MISTAKING THE FACT THAT WHEN FACILITIES FAIL TO MEET REASONABLE STANDARDS, WE WILL NOT HESITATE TO CUT OFF THEIR MEDICARE AND MEDICAID FUNDS." BETWEEN AUGUST 6, 1971, AND FEBRUARY 11, 1972, 13 EXTENDED CARE FACILITIES WERE DECERTIFIED FOR MEDICARE PARTICIPATION. ON NOVEMBER 30, 1971, THIRTY-NINE STATES WERE DECLARED OUT OF COMPLIANCE WITH TITLE 19-MEDICAID--CERTIFICATION PROCEDURES. BY FEBRUARY 1, 1972, IN RESPONSE TO SECRETARY RICHARDSON'S DEADLINE, ALL BUT ONE OF THOSE STATES HAD MADE THE IMPROVEMENTS REQUIRED FOR COMPLIANCE. BY JULY 1, 1972, ALL TITLE 19 FACILITIES IN ALL STATES ARE TO HAVE BEEN INSPECTED AND CERTIFIED THROUGH THE CORRECT PROCEDURES. THE FEDERAL GOVERNMENT IS PLEDGED TO MEET ITS RESPONSIBILITY TO ASSURE THAT FEDERAL DOLLARS DO NOT FINANCE SUBSTANDARD CARE.

IN ADDITION TO IMPROVED ENFORCEMENT OF NURSING HOME STANDARDS, TWO OTHER POINTS IN THE PRESIDENT'S PLAN INITIATED MORE DIRECT STEPS TO IMPROVE NURSING HOME CARE. THE PRESIDENT DIRECTED THE DEPARTMENT OF HEW "TO INSTITUTE A NEW PROGRAM OF SHORT-TERM COURSES FOR PHYSICIANS, NURSES, DIETICIANS, SOCIAL WORKERS AND OTHERS WHO ARE REGULARLY INVOLVED IN FURNISHING SERVICES TO NURSING HOME PATIENTS." HEW HAS SUPPORTED SUCH TRAINING FOR SEVERAL YEARS, AND HAS DEVELOPED CLOSE WORKING RELATIONSHIPS WITH PROFESSIONAL ASSOCIATIONS AND WITH TRAINING CENTERS. IN RESPONSE TO THE PRESIDENTS' DIRECTIVE, SUCH PROGRAMS HAVE BEEN EXPANDED UNDER THE LEADERSHIP OF THE COMMUNITY HEALTH SERVICE, HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION, AND IT IS ANTICIPATED THAT APPROXIMATELY 20,000 PERSONS

WILL BE TRAINED IN FISCAL YEAR 1972 AT A COST OF $2.5 MILLION. TRAINING PROGRAMS WILL FOCUS INITIALLY ON FOUR MANPOWER AREAS SELECTED BECAUSE OF THEIR DIRECT DAY-TO-DAY RELATIONS WITH NURSING HOME PATIENTS: NURSING HOME ADMINISTRATORS, PHYSICIANS, NURSES, AND PATIENT ACTIVITIES DIRECTORS. MANY OF THESE TRAINING PROGRAMS WILL BE OPERATED UNDER CONTRACTS WITH PROFESSIONAL GROUPS. APPROACHES TO MENTAL HEALTH PROBLEMS OF NURSING HOME PATIENTS WILL BE DEVELOPED BY NATIONAL INSTITUTE OF MENTAL HEALTH STAFF WORKING WITH THE GERONTOLOGICAL SOCIETY. OTHER TRAINING MECHANISMS WILL ALSO BE EXPLORED, SUCH AS PROGRAMS SPONSORED BY STATE HEALTH DEPARTMENTS AND STATE AGENCIES. THESE PROGRAMS WILL BE DIRECTED TOWARD MAKING NURSING HOME STAFF-BOTH PROFESSIONAL AND ALLIED HEALTH-MORE SENSITIVE AND EXPERT IN THE SPECIAL PROBLEMS OF CARE FOR GERIATRIC PATIENTS AND THE CHRONICALLY ILL. THEY ARE INTENDED TO BE THE BEGINNING OF A SYSTEM FOR NATIONWIDE, CONTINUOUS TRAINING FOR NURSING HOME PERSONNEL WHICH WILL BECOME STANDARD PRACTICE IN THE NURSING HOME INDUSTRY OF THE FUTURE.

AS THE SEVENTH POINT IN HIS PLAN, THE PRESIDENT DIRECTED THE DEPARTMENT OF HEW "TO ASSIST THE STATES IN ESTABLISHING INVESTIGATIVE UNITS WHICH WILL RESPOND IN A RESPONSIBLE AND CONSTRUCTIVE WAY TO COMPLAINTS MADE BY OR ON BEHALF OF INDIVIDUAL PATIENTS." SINCE I ASSUMED MY NURSING HOME RESPONSIBILITIES, I HAVE RECEIVED MANY LETTERS FROM NURSING HOME PATIENTS-TOUCHING IN THEIR APPEAL FOR CARE OFFERING SIMPLE DIGNITY AND RIGHTS OF PRIVACY, HARROWING SOMETIMES IN THEIR DESCRIPTIONS OF PHYSICAL OR PSYCHOLOGICAL ABUSE. THESE PATIENTS ARE OFTEN HELPLESS IN THEIR DEPENDENCE ON THE INSTITUTION IN WHICH THEY LIVE. THEY DESERVE A FAIR HEARING, AND AN ADVOCATE WHEN THEY ARE POWERLESS. THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION HAS DEVELOPED FIVE MODELS FOR OMBUDSMAN

UNITS TO FILL THIS ROLE, PLACED AT VARIOUS LEVELS WITHIN THE STATES AND DEMONSTRATING DIFFERENT MECHANISMS FOR ACTION. CONTRACT PROPOSALS TO TEST THESE MODELS ARE BEING SOLICITED, AND $600,000 HAS BEEN BUDGETED FOR FISCAY YEAR 1972 FOR THIS ACTIVITY.

IT WILL TAKE TIME TO TEST AND DEVELOP SUCH AN OMBUDSMAN SYSTEM, TIME INAPPROPRIATE TO THE URGENCY OF THE PROBLEM. SO AN INTERIM OMBUDSMAN MECHANISM HAS BEEN ESTABLISHED WITH THE 855 SOCIAL SECURITY ADMINISTRATION DISTRICT OFFICES DESIGNATED TO RECEIVE AND INVESTIGATE COMPLAINTS. THIS MECHANISM IS CURRENTLY IN EFFECT, AND HAS RECEIVED OVER A THOUSAND RESPONSES.

FOR THESE NURSING HOME INITIATIVES, A SUPPLEMENTAL APPROPRIATION OF $9,572,000 HAS BEEN REQUESTED FOR FISCAL YEAR, 1972. WE FEEL THAT BY MEANS OF THESE PROGRAMS A SIGNIFICANT IMPROVEMENT IN NURSING HOME CARE CAN BE ACHIEVED IN A RELATIVELY SHORT PERIOD OF TIME.

I WOULD LIKE TO EXAMINE NURSING HOMES NOW IN A DIFFERENT PERSPECTIVE. I HAVE MENTIONED THAT MEDICARE FINANCES NURSING HOME CARE AS AN EXTENSION OF HOSPITAL CARE - THE PRIOR HOSPITALIZATION REQUIREMENT AND THE TIME LIMITATIONS PER SPELL OF ILLNESS ARE MANIFESTATIONS OF THIS PRINCIPLE. MEDICAID REQUIREMENTS FOR SKILLED NURSING HOMES, WHILE THEY ARE NOT BASED ON THE SAME CONCEPT OF EXTENDED CARE TEND TO EMPHASIZE AND PROVIDE COVERAGE FOR MEDICAL SERVICES AS OPPOSED TO SOCIAL AND PERSONAL CARE.

THE ELDERLY OF COURSE SUFFER FROM ACUTE DISEASE, BUT THEY ARE MUCH MORE SUBJECT THAN YOUNGER PEOPLE TO THE DEPENDENCY OF CHRONIC ILLNESS. THE TERM "SPELL OF ILLNESS" MAKES LITTLE SENSE WHEN APPLIED TO A DISEASE PROCESS WHICH WILL NEVER BE CURED. MOREOVER, ALTHOUGH THE CHRONICALLY - ILL PATIENT MAY BENEFIT FROM INTENSIVE MEDICAL SERVICES, HE IS MORE LIKELY TO REQIRE LESS INTENSIVE BUT CONTINUOUS MEDICAL CARE IN COMBINATION WITH SOCIAL AND PERSONAL SERVICES TO HELP HIM LIVE WITH HIS CHRONIC DISABILITY. SO THE HEALTH FACILITY WHICH CAN BEST SERVE HIM MAY BE VERY DIFFERENT FROM THE EXTENDED CARE FACILITY WHICH IS IDEALLY SUITED TO A PATIENT RECUPERATING FROM A MYOCARDIAL INFARCTION OR A BROKEN HIP. OR HE MIGHT NOT REQUIRE INSTITUTIONAL CARE AT ALL - HE MIGHT BE PERFECTLY ABLE TO LIVE IN HIS OWN HOME WITH THE AID OF HOMEMAKING AND HOME HEALTH SERVICES.

THESE PATIENTS WITH CHRONIC ILLNESSES - WHICH INCLUDE A DISPROPORTIONATE SHARE OF THE ELDERLY - AND THOSE SUFFERING THE INCREASED DEPENDENCY OF OLD AGE ITSELF-DEMONSTRATE THE WEAKNESSES OF LONG TERM CARE AS SUPPORTED BY THE FEDERAL GOVERNMENT.

FIRST, MEDICARE AND MEDICAID TEND TO BE MORE CONCERNED IN TERM OF STANDARDS AND COVERAGE WITH THE MEDICAL COMPONENT OF NURSING HOME CARE. THIS HAS BEEN TRUE FOR BOTH STATUTORY AND HISTORICAL REASONS BASED ON THEIR ORIGIN AS HEALTH INSURANCE PROGRAMS. I DO NOT THINK IT IS HELPFUL TO SEPARATE THE PHYSICAL, EMOTIONAL, SOCIAL, AND ENVIRONMENTAL COMPONENTS OF CARE, PARTICULARLY FOR THE ELDERLY. THESE ARE IMPERMANENT SEPARATIONS OF INTEREST, EMPHASIS, ORGANIZATION AND PREFERENCE; THEY REST MORE UPON TRADITION AND ARBITARY BOUNDARIES THEN THE APPLICATION OF KNOWLEDGE TO LONG TERM CARE.

SECOND THE PRESENT HEALTH FINANCING SYSTEM OFFERS MORE COMPLETE COVERAGE FOR PATIENTS INSIDE INSTITUTIONS THAN FOR THOSE WHO REMAIN OUTSIDE. SO OUR FINANCING STRUCTURE TENDS TO PUSH THE ELDERLY INTO NURSING HOMES, SOMETIMES PREMATURELY. SOCIETY PAYS A PRICE FOR THIS. INSTITUTIONAL CARE IS MORE COSTLY THEN HOME HEALTH CARE. MORE IMPORTANT, THERE IS INCREASING EVIDENCE THAT THE DISPLACEMENT, LOSS OF STATUS, AND ISOLATION CAUSED BY INSTITUTIONALIZATION MAY EXACERBATE IF NOT PRECIPITATE ACTUAL PHYSIOLOGIC DISEASE. THE TRANSFER OF A PERSON FROM HIS HOME TO AN INSTITUTION MAY MAKE HIM MORE ILL AND MORE DEPENDENT.

IF A NURSING HOME IS NOT THE MOST APPROPRIATE PLACE FOR A PERSON'S PARTICULAR NEEDS, THEN HE SHOULD NOT BE REQUIRED TO GO THERE. IF IT IS PERSONAL CARE RATHER THEN HEALTH CARE THAT IS REQUIRED, THEN THAT SHOULD BE AVAILABLE. IF IT IS APPROPRIATE HOUSING RATHER THEN INSTITUTIONAL CARE THAT IS NEEDED, THEN THE EMPHASIS SHOULD BE ON HOUSING. THE ELDERLY SHOULD HAVE MORE OPTIONS AVAILABLE.

THESE SEEM TO ME BASIC AND VALID CRITICISMS OF OUR PRESENT SYSTEM - THE SEPARATION BETWEEN MEDICAL AND PERSONAL CARE AND THE FAILURE TO PROVIDE ADEQUATE ALTERNATIVES TO INSTITUTIONAL CARE. AND IN THESE AREAS, FEDERAL PROGRAMS HAVE HAD AN UNFORTUNATE IF UNINTENDED IMPACT. THESE ISSUES CANNOT BE POSTPONED. ON DECEMBER 28, 1971, PRESIDENT NIXON SIGNED INTO LAW PUBLIC LAW 92-223, WHICH AUTHORIZES THE TRANSFER OF INTERMEDIATE CARE FACILITIES INTO THE MEDICAID PROGRAM. AN INTERMEDICATE CARE FACILITY PROVIDES HEALTH RELATED SERVICES FOR PATIENTS WHO DO NOT REQUIRE CARE IN SKILLED NURSING HOMES, BUT NEED INSTITUTIONAL CARE BEYOND

ROOM AND BOARD. AS YOU KNOW, ICF'S WERE PREVIOUSLY FINANCED BY PUBLIC ASSISTANCE PROGRAMS FOR THE AGED, THE BLIND, AND THE DISABLED, AND WERE SUBJECT ONLY TO STATE LICENSING. TRANSFER OF FINANCING TO THE MEDICAID PROGRAM MEANS NOT ONLY THAT A LARGER GROUP OF PEOPLE - INCLUDING THE "MEDICALLY NEEDY" - MAY POTENTIALLY BE ELIGIBLE FOR BENEFITS, BUT ALSO THAT THE FEDERAL GOVERNMENT IS EMPOWERED TO SET PHYSICAL AND SAFETY STANDARDS AND DEFINE THE CARE AND SERVICES THAT MUST BE PROVIDED. THE MEDICAL SERVICES ADMINISTRATION OF THE SOCIAL AND REHABILITATION SERVICES AND MY OFFICE OF NURSING HOME AFFAIRS ARE CURRENTLY EXAMINING SUCH ISSUES AS WHO SHOULD BE IN THESE FACILITIES, WHAT SERVICES MUST THEY PROVIDE, AND WHAT SHOULD BE THE LEVEL OF BENEFITS IN ATTEMPTING TO DEVELOP STANDARDS FOR INTERMEDIATE CARE FACILITIES. SO THESE FACILITIES ARE FORCING A RE-EXAMINATION OF COVERAGE ISSUES, AND THE BALANCES OF MEDICAL AND PERSONAL SERVICES WITHIN INSTITUTIONS. THE "PROBLEMS TO COME" ARE HERE ALREADY.

I WOULD LIKE TO MENTION ONE MORE PROBLEM THAT HAS DEMANDED ATTENTION, AND THAT IS THE PLANNING PROCESS ITSELF. AN IMPORTANT REASON FOR THE INSUFFICIENT AND SOMETIMES INAPPROPRIATE IMPACT OF FEDERAL PROGRAMS FOR LONG TERM CARE HAS BEEN THE LACK OF PLANNING AND COORDINATION BETWEEN FEDERAL, STATE, AND LOCAL PROGRAMS. PLANNING FOR LONG TERM CARE SHOULD MOVE FROM IDENTIFICATION OF AN ISSUE OR PROBLEM TO ITS SOLUTION, WITH IDENTIFIABLE GOALS GUIDING THE PROCESS. MOVEMENT TOWARD A GOAL SHOULD NOT BE INTERRUPTED BY CHANGES IN ADMINISTRATION. WHAT IS TRULY IMPORTANT TODAY SHOULD NOT BE CAST ASIDE TOMORROW. NEW PROGRAMS SHOULD NOT BE APPENDAGES TO SATISFY THE INTERESTS OF A FEW, NOR SHOULD THEY BE ADDED AS PACIFIERS TO THE MANY. PROGRAMS DEVELOPED THROUGH A RATIONAL PLANNING PROCESS SHOULD THEN BE ADMINISTERED THROUGH AN EFFECTIVE AND COORDINATED MECHANISMS.

THE ESTABLISHMENT OF THE OFFICE OF NURSING HOME AFFAIRS WITHIN HEW WAS A STEP TOWARD IMPROVING COORDINATION. THE EIGHTH POINT OF THE PRESIDENT'S PLAN IS A MANDATE FOR A TASK FORCE ON LONG TERM CARE. THIS TASK FORCE WILL RE-EXAMINE ISSUES AND SET NEW GOALS, DEVELOP A NATIONWIDE DATA SYSTEM NECESSARY FOR POLICY FORMULATION, AND RECOMMEND AN ORGANIZATION FOR LONG TERM CARE WITHIN HEW AND FEDERAL STATE AND LOCAL PROGRAMS WHICH CAN ACHIEVE ITS GOALS MOST EFFECTIVELY.

A NATIONAL POLICY COURSE FOR THE CHRONICALLY ILL AND FOR THE ELDERLY SHOULD BE SET. IT SHOULD BE SET BY GOVERNMENT, WITH THE FULL AND CREATIVE CONTRIBUTION OF THOSE IN OTHER AGENCIES AND ORGANIZATIONS, THOSE IN ACADEMIC TEACHING AND RESEARCH, THOSE IN VOLUNTARY AND UNSALARIED SERVICE, AND THOSE WHO RECEIVE THAT CARE.

WE CAN DO MUCH BETTER FOR OUR ELDERLY. WE MUST OF COURSE PROTECT THEM FROM INSTITUTIONAL ABUSE, RECOGNIZING THAT SOME ARE WEAK AND DEPENDENT. BUT WE CAN ALSO MAKE POSSIBLE A WIDE VARIETY OF SUPPORTING SERVICES AND LIVING ARRANGEMENTS, SO THAT THE INFIRMITIES OF ADVANCING AGE DO NOT BECOME A PRISON OF THE SPIRIT. THE ELDERLY WITH OUR HELP CAN HAVE ACCESS TO THE VARIETY AND FREEDOM WE ASK FOR OURSELVES.

THE OUTLOOK ON NURSING HOMES

MRS. MARIE.CALLENDER
SPECIAL ASSISTANT FOR NURSING HOME AFFAIRS
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE*

*TO BE PRESENTED AT THE ANNUAL SPRING CONVENTION OF THE COLORADO ASSOCIATED NURSING HOMES, INC., ON TUESDAY, MAY 16, L972.

THE OUTLOOK ON NURSING HOMES

IT IS WITH SOME HUMILITY THAT I APPROACH A TOPIC AS BROAD AS "~~THE OUTLOOK ON NURSING HOMES.~~ A Challenge from the White House" FOR NOT ONLY ARE YOU, OF THE COLORADO ASSOCIATED NURSING HOMES INVOLVED IN THE IMMEDIATE, PERSONAL JOB OF CARING FOR PATIENTS IN NURSING HOMES, BUT ALSO AS COLORADANS YOU ARE DISTANT ENOUGH FROM WASHINGTON TO UNDERSTAND THE DIFFICULTY IN TRANSLATING AN ADMINISTRATIVE POLICY CONCEIVED IN THE HEW NORTH BUILDING INTO A REALITY IN DENVER. SO YOU KNOW THAT THOSE OF US WHO SERVE THE FEDERAL GOVERNMENT TODAY DO NOT COME EQUIPPED WITH ALL THE ANSWERS - READY TO DISPENSE THE BALM OF GREAT PERSONAL WISDOM TO HEAL ALL WOUNDS AFFLICTING A TROUBLED SOCIETY.

I COME BEFORE YOU TODAY THEN NOT TO OFFER READY-MADE PRESCRIPTIONS OR ROCK-HARD CERTAINTIES, BUT TO DESCRIBE TO YOU SOME OF THE PROBLEMS WE SEE AND THE ANSWERS WE HAVE DEVISED. AND I WANT TO ENLIST YOUR AID IN HELPING US FIND AND REALIZE additional SOLUTIONS TO THE PROBLEMS FACING THOSE WHO NEED OR ARE RECEIVING NURSING HOME CARE.

THE FEDERAL GOVERNMENT HAS BECOME INCREASINGLY INVOLVED IN NURSING HOME CARE OVER THE LAST ~~TWENTY~~ YEARS, PARTICULARLY SINCE THE ENACTMENT OF THE MEDICARE AND MEDICAID PROGRAMS IN 1965. IN 1970 THE FEDERAL GOVERNMENT SPENT OVER $2 BILLION IN SUPPORT OF NURSING HOME PATIENTS, WHILE STATE AND LOCAL GOVERNMENT SPENT ANOTHER $700 MILLION.

THE DIFFICULTY WITH SUCH MASSIVE INVOLVEMENT IS IN ASSURING THAT DESIRED AND DESIRABLE IMPACT IS ACHIEVED. WITH RESPECT TO CONTINUITY OF CARE BETWEEN HOSPITAL AND ENTENDED CARE FACILITY, I BELIEVE THE FEDERAL ROLE HAS BEEN USEFUL AND IMPORTANT. THE PRESIDENT'S 8-POINT PLAN FOR ACTION TO IMPROVE NURSING HOMES, ANNOUNCED LAST AUGUST IN NEW HAMPSHIRE, IS DESIGNED TO STRENGTHEN AND IMPROVE THAT ROLE. THE IMPLEMENTATION OF THAT PLAN HAS ABSORBED MOST OF MY TIME SINCE I ASSUMED MY NURSING HOME RESPONSIBILITIES LAST DECEMBER - MORE OF MY TIME THAN I HAD IMAGINED, I MIGHT ADD - AND I WOULD LIKE TO DESCRIBE FOR YOU SOME OF THESE EFFORTS. BUT I WOULD ALSO LIKE TO DESCRIBE FOR YOU THE PROBLEMS AT THE OPPOSITE END OF THE SPECTRUM - CONTINUITY BETWEEN INSTITUTIONAL CARE AND THE HOME. I BELIEVE THAT THE FEDERAL ROLE HAS BEEN LESS CONSTRUCTIVE IN THAT AREA, WHICH REPRESENTS TOMORROW'S CHALLENGES. AND THESE CHALLENGES FACE US ALREADY IN WAYS I SHALL DESCRIBE.

In part the challenges stem from the fact that

THE EXTENDED CARE FACILITY PROGRAM UNDER MEDICARE WAS DESIGNED TO COVER THE EXTENSION OF CARE FOR A PATIENT WHO NO LONGER REQUIRES THE FULL MEDICAL RESOURCES OF A HOSPITAL, BUT STILL NEEDS RELATIVELY INTENSIVE MEDICAL SERVICES. THE SKILLED NURSING HOME PROGRAM UNDER MEDICAID, ALTHOUGH THE PHILOSOPHIC INTENT WAS SOMEWHAT DIFFERENT, ADOPTED VERY SIMILAR STANDARDS. ACUTE ILLNESS, IN WHICH THE PATIENT IS EXPECTED EVENTUALLY RECOVER, IS THE BASIC MODEL FOR WHICH THIS SYSTEM IS DESIGNED, AND THE EMPHASIS HAS BEEN ON MEDICAL RATHER THEN SOCIAL AND PERSONAL SERVICES. THIS APPROACH HAS LED TO VERY REAL PROBLEMS WHEN APPLIED TO PATIENTS WITH CHRONIC ILLNESS, WHO MAKE UP A LARGE PROPORTION OF THE ELDERLY NURSING HOME POPULATION - I SHALL DISCUSS THESE PROBLEMS LATER.

THE PRESIDENT'S PLAN FOR NURSING HOMES ACCEPTED THE RESPONSIBILITY TO ASSURE THAT NURSING HOMES DELIVER CARE AT LEAST AT THE LEVELS OF FEDERAL STANDARDS AND REGULATIONS. A MAJOR GOAL OF THE PLAN IS TO IMPROVE FEDERAL ENFORCEMENT OF NURSING HOME STANDARDS. AS YOU KNOW, THE TERM "NURSING HOME" IS APPLIED TO A WIDE RANGE OF FACILITIES, FROM THOSE PROVIDING PRIMARILY CUSTODIAL CARE TO THOSE DELIVERING HIGHLY SKILLED POST-HOSPITAL AND REHABILITATIVE SERVICES. THESE DIFFERENT TYPES OF FACILITIES ARE ACCREDITED THROUGH DIFFERENT MECHANISMS, AND FEDERAL LEVERAGE IN ENFORCING STANDARDS VARIES WIDELY. MEDICARE CERTIFICATION OF EXTENDED CARE FACILITIES IS A FEDERAL PROGRAM MEDIATED THROUGH STATE AGENCIES. MEDICAID IS A FEDERAL-STATE PROGRAM, FINANCED AND ADMINISTERED THROUGH BOTH FEDERAL AND STATE FUNDS AND ACTIVITIES. INTERMEDIATE CARE FACILITIES UNTIL RECENTLY WERE REQUIRED TO MEET ONLY STATE LICENSING REQUIREMENTS TO RECEIVE FEDERAL FUNDS. THESE DIFFERENCES HAVE COMPLICATED THE ENFORCEMENT OF STANDARDS. IF H.R. 1 AS CURRENTLY AMENDED BY THE SENATE FINANCE COMMITTEE IS PASSED, THEM SOME OF THESE DIFFERENCES WILL BE MINIMIZED AND MORE UNIFORM STANDARDS AND CERTIFICATION PROCEDURES WILL BE ADOPTED FOR MEDICARE AND MEDICAID. IN ANTICIPATION OF THESE CHANGES, A COMMON SET OF STANDARDS FOR BOTH PROGRAMS IS BEING DEVELOPED UNDER THE AUSPICES OF MY OFFICE. BUT THE STATE AGENCY WILL RETAIN ITS INSPECTION ROLE. AND THE FEDERAL GOVERNMENT, WHICH IS RESPONSIBLE FOR THE QUALITY OF CARE WHICH IT FINANCES, MUST AID IN ENHANCING THE CAPABILITY OF THE STATE AGENCIES TO REGULATE AND IMPROVE THE QUALITY OF NURSING HOME CARE. TO IMPROVE ENFORCEMENT OF NURSING HOME STANDARDS, THE PRESIDENT'S PLAN PLEDGED THE FOLLOWING STEPS:

1. CONSOLIDATION OF RESPONSIBILITY FOR NURSING HOME AFFAIRS

NURSING HOME ACTIVITIES HAVE BEEN SCATTERED AMONG SEVERAL BRANCHES OF THE DEPARTMENT OF HEW, INCLUDING THE SOCIAL SECURITY ADMINISTRATION, THE SOCIAL AND REHABILITATION SERVICE, AND THE HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION. THE PRESIDENT ORDERED THAT ALL FEDERAL ENFORCEMENT RESPONSIBILITY BE CONSOLIDATED IN A SINGLE OFFICE, ~~AND~~ DR. MERLIN K. DUVAL, THE ASSISTANT SECRETARY OF HEALTH AND SCIENTIFIC AFFAIRS, WAS DESIGNATED AS THE RESPONSIBLE OFFICIAL. DR. DUVAL in turn DELEGATED TO ME THESE RESPONSIBILITIES AND THE FUNCTION OF FULL-TIME COORDINATOR OF NURSING HOME ACTIVITIES.

2. ENLARGEMENT OF FEDERAL STAFF FOR ENFORCEMENT OF NURSING HOME STANDARDS.

THE SOCIAL AND REHABILITATION SERVICE, WHICH ADMINISTERS THE MEDICAID PROGRAM, HAS BEEN ASSIGNED 142 ADDITIONAL POSITIONS TO CARRY OUT ITS INCREASED RESPONSIBILITIES. ONE HUNDRED TEN OF THESE POSITIONS WERE ALLOCATED TO THE REGIONAL OFFICE OF HEW. THE ASSISTANT SECRETARY COMPTROLLER RECEIVED THIRTY-FOUR ADDITIONAL POSITIONS TO INCREASE THEIR AUDITS OF NURSING HOME OPERATIONS. THE NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT RECEIVED SEVEN NEW POSITIONS FOR EFFORTS TO IMPROVE NURSING HOME DATA SYSTEMS AND TO DEVELOP DATA IN SPECIAL FIELDS RELEVANT TO NURSING HOME CARE. these positions will strengthen our assistant to State Agencies.

3. FEDERAL SUPPORT OF 100% OF THE COST OF STATE MEDICAID ~~INSPECTIONS~~ activities.

WE RECOGNIZE THAT AN INCREASED LEVEL OF ~~ENFORCEMENT~~ ACTIVITIY INVOLVES ADDITIONAL COSTS TO THE STATES. STATE MEDICARE ~~INSPECTION~~ COSTS HAVE ALWAYS BEEN FULLY PAID FOR BY THE FEDERAL GOVERNMENT, BUT UNDER THE MEDICAID PROGRAM STATES HAVE PAID 25 TO 50 PERCENT OF THESE COSTS. SECRETARY RICHARDSON SUBMITTED TO CONGRESS IN OCTOBER, 1971,

AN AMENDMENT TO H.R. 1. AUTHORIZING THE FEDERAL GOVERNMENT TO ASSUME 100 PERCENT OF ~~INSPECTION~~ nursing home COSTS UNDER MEDICAID; THIS STEP WILL PLACE BOTH PROGRAMS ON AN EQUAL FOOTING AND LESSEN THE FINANCIAL BURDEN TO THE STATES.

4. TRAINING STATE NURSING HOME INSPECTORS.

NURSING HOME SURVEYORS HAVE BEEN TRAINED IN SURVEY AND COUNSELLING TECHNIQUES UNDER A PROGRAM SPONSORED BY THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION SINCE MARCH, 1970. THESE FOUR-WEEK COURSES HAVE BEEN PRESENTED IN UNIVERSITY CENTERS IN NEW HAMPSHIRE, LOUISIANA, AND CALIFORNIA. IN HIS AUGUST SPEECH, THE PRESIDENT PLEDGED AN EXPANSION OF THIS PROGRAM SO THAT 2,000 SURVEYORS COULD BE TRAINED IN THE ENSUING EIGHTEEN MONTH PERIOD. AS A RESULT OF THE PRESIDENT'S ORDER, THE PROGRAM HAS BEEN ACCELERATED SO THAT MORE THAN 700 SURVEYORS WILL HAVE BEEN TRAINED BY JULY 1. CONTRACT NEGOTIATIONS ARE IN PROCESS TO ESTABLISH THREE ADDITIONAL UNIVERSITY CENTERS. IN ADDITION, A STUDY WAS PERFORMED, TO EVALUATE THE EFFECTIVENESS OF THE TRAINING COURSES, AND THESE HAVE NOW BEEN MODIFIED TO REFLECT THE RESULTS OF THAT STUDY.

THESE EFFORTS TO ACHIEVE COMPLIANCE WITH FEDERAL STANDARDS AND REGULATIONS ARE NOT DESIGNED TO ELIMINATE FACILITIES AND THUS TO DEPRIVE PATIENTS OF NEEDED NURSING HOME CARE. WE ARE WORKING RATHER TO COORDINATE FEDERAL AND STATE PROGRAMS AND STATE AGENCIES, TO SHARE THEIR RESOURCES AND EXPERTISE SO THAT more substantial assistant and consultation can be offered. ~~SUBSTANDARD FACILITIES CAN BE UPGRADED~~. THE FEDERAL PROGRAM TO TRAIN NURSING HOME SURVEYORS, FOR EXAMPLE, EMPHASIZES THE DEVELOPMENT OF SKILLS TO AID NURSING HOME ADMINISTRATORS and personnel IN MAKING NEEDED ~~IMPROVEMENTS~~ changes. In addition FEDERAL FINANCIAL ASSISTANCE IS AVAILABLE FOR NURSING HOME MODERNIZATION AND NEW CONSTRUCTION FROM THE FEDERAL HOUSING

ADMINISTRATION AND ~~SUCH PROGRAMS AS~~ the HILL BURTON Program. THE STANDARDS ~~THEMSELVES~~ ARE BEING REVISED AND STRENGTHENED. WE ARE DEVELOPING PROGRAMS TO IMPROVE NURSING HOMES DIRECTLY- ~~I SHALL DESCRIBE THEM IN A FEW MOMENTS~~.

BUT AS THE PRESIDENT WARNED LAST AUGUST," ... LET THERE BE NO MISTAKING THE FACT THAT WHEN FACILITIES FAIL TO MEET REASONABLE STANDARDS, WE WILL NOT HESITATE TO CUT OFF THEIR MEDICARE AND MEDICAID FUNDS." BETWEEN AUGUST 6, 1971, AND FEBRUARY 11, 1972, ~~13 EXTENDED CARE~~ FACILITIES WERE DECERTIFIED FOR MEDICARE ~~PARTICIPATION~~. ON NOVEMBER 30, 1971, THIRTY-NINE STATES WERE DECLARED OUT OF COMPLIANCE WITH TITLE 19-MEDICAID--CERTIFICATION PROCEDURES. BY FEBRUARY 1, 1972, IN RESPONSE TO SECRETARY RICHARDSON'S DEADLINE, ALL BUT ONE OF THOSE STATES HAD MADE THE IMPROVEMENTS REQUIRED FOR COMPLIANCE. BY this coming JULY 1, 1972, ALL TITLE 19 FACILITIES IN ALL STATES ARE TO HAVE BEEN ~~INSPECTED~~ surveyed AND CERTIFIED ~~THROUGH THE CORRECT PROCEDURES~~ against Title 19 standards. THE FEDERAL GOVERNMENT IS PLEDGED TO MEET ITS RESPONSIBILITY TO ASSURE THAT FEDERAL DOLLARS DO NOT FINANCE SUBSTANDARD CARE. and that the elderly of this country have assurance that these standards are met.

IN ADDITION TO IMPROVED ENFORCEMENT OF NURSING HOME STANDARDS, TWO OTHER POINTS IN THE PRESIDENT'S PLAN INITIATED MORE DIRECT STEPS TO IMPROVE NURSING HOME CARE. THE PRESIDENT DIRECTED THE DEPARTMENT OF HEW "TO INSTITUTE A NEW PROGRAM OF SHORT-TERM COURSES FOR PHYSICIANS, NURSES, DIETICIANS, SOCIAL WORKERS AND OTHERS WHO ARE REGULARLY INVOLVED IN FURNISHING SERVICES TO NURSING HOME PATIENTS." HEW HAS SUPPORTED SUCH TRAINING FOR SEVERAL YEARS, AND HAS DEVELOPED CLOSE WORKING RELATIONSHIPS WITH PROFESSIONAL ASSOCIATIONS AND WITH TRAINING CENTERS. IN RESPONSE TO THE PRESIDENTS' DIRECTIVE, SUCH PROGRAMS HAVE BEEN EXPANDED, ~~UNDER THE LEADERSHIP OF THE COMMUNITY HEALTH SERVICE, HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION, AND~~ IT IS ANTICIPATED THAT APPROXIMATELY 20,000 PERSONS

WILL BE offered TRAINED IN FISCAL YEAR 1972 AT A COST OF $2.5 MILLION. TRAINING PROGRAMS WILL FOCUS INITIALLY ON FOUR MANPOWER AREAS SELECTED BECAUSE OF THEIR DIRECT DAY-TO-DAY RELATIONS WITH NURSING HOME PATIENTS: NURSING HOME ADMINISTRATORS, PHYSICIANS, NURSES, AND PATIENT ACTIVITIES DIRECTORS. MANY OF THESE TRAINING PROGRAMS WILL BE OPERATED UNDER CONTRACTS WITH PROFESSIONAL GROUPS. APPROACHES TO MENTAL HEALTH PROBLEMS OF NURSING HOME PATIENTS WILL BE DEVELOPED BY NATIONAL INSTITUTE OF MENTAL HEALTH STAFF WORKING WITH THE GERONTOLOGICAL SOCIETY. OTHER TRAINING MECHANISMS WILL ALSO BE EXPLORED, SUCH AS PROGRAMS SPONSORED BY STATE HEALTH DEPARTMENTS AND STATE AGENCIES. THESE PROGRAMS WILL BE DIRECTED TOWARD MAKING helping you NURSING HOME STAFF-BOTH PROFESSIONAL AND ALLIED HEALTH-MORE SENSITIVE AND EXPERT IN THE SPECIAL PROBLEMS OF CARE FOR GERIATRIC PATIENTS AND THE CHRONICALLY ILL. THEY ARE INTENDED TO BE THE BEGINNING OF A SYSTEM FOR NATIONWIDE, CONTINUOUS TRAINING FOR NURSING HOME PERSONNEL, ~~WHICH WILL BECOME STANDARD PRACTICE IN THE NURSING HOME INDUSTRY OF THE FUTURE~~.

AS THE SEVENTH POINT IN HIS PLAN, THE PRESIDENT DIRECTED THE DEPARTMENT OF HEW "TO ASSIST THE STATES IN ESTABLISHING INVESTIGATIVE UNITS WHICH WILL RESPOND IN A RESPONSIBLE AND CONSTRUCTIVE WAY TO COMPLAINTS MADE BY OR ON BEHALF OF INDIVIDUAL PATIENTS." SINCE I ASSUMED MY NURSING HOME RESPONSIBILITIES, I HAVE RECEIVED MANY LETTERS FROM NURSING HOME PATIENTS-TOUCHING IN THEIR APPEAL FOR CARE OFFERING SIMPLE DIGNITY AND RIGHTS OF PRIVACY, HARROWING SOMETIMES IN THEIR DESCRIPTIONS OF PHYSICAL OR PSYCHOLOGICAL ABUSE. THESE PATIENTS ARE OFTEN HELPLESS IN THEIR DEPENDENCE ON THE INSTITUTION IN WHICH THEY LIVE. THEY DESERVE A FAIR HEARING, AND AN ADVOCATE WHEN THEY ARE POWERLESS. THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION HAS DEVELOPED FIVE MODELS FOR OMBUDSMAN

UNITS TO FILL THIS ROLE, PLACED AT VARIOUS LEVELS WITHIN THE STATES AND DEMONSTRATING DIFFERENT MECHANISMS FOR ACTION. CONTRACT PROPOSALS TO TEST THESE MODELS ARE BEING SOLICITED, AND $600,000 HAS BEEN BUDGETED FOR FISCAY YEAR 1972 FOR THIS ACTIVITY.

IT WILL TAKE TIME TO TEST AND DEVELOP SUCH AN OMBUDSMAN SYSTEM, TIME INAPPROPRIATE TO THE URGENCY OF THE PROBLEM. SO AN INTERIM OMBUDSMAN MECHANISM HAS BEEN ESTABLISHED WITH THE 855 SOCIAL SECURITY ADMINISTRATION DISTRICT OFFICES DESIGNATED TO RECEIVE AND INVESTIGATE COMPLAINTS. THIS MECHANISM IS CURRENTLY IN EFFECT, AND HAS RECEIVED OVER A THOUSAND RESPONSES.

FOR THESE NURSING HOME INITIATIVES, A SUPPLEMENTAL APPROPRIATION OF $9,572,000 HAS BEEN REQUESTED FOR FISCAL YEAR, 1972. WE FEEL THAT BY MEANS OF THESE PROGRAMS A SIGNIFICANT IMPROVEMENT IN NURSING HOME CARE CAN BE ACHIEVED IN A RELATIVELY SHORT PERIOD OF TIME.

I WOULD LIKE TO EXAMINE NURSING HOMES NOW IN A DIFFERENT PERSPECTIVE. I HAVE MENTIONED THAT MEDICARE FINANCES NURSING HOME CARE AS AN EXTENSION OF HOSPITAL CARE - THE PRIOR HOSPITALIZATION REQUIREMENT AND THE TIME LIMITATIONS PER SPELL OF ILLNESS ARE MANIFESTATIONS OF THIS PRINCIPLE. MEDICAID REQUIREMENTS FOR SKILLED NURSING HOMES, WHILE THEY ARE NOT BASED ON THE SAME CONCEPT OF EXTENDED CARE TEND TO EMPHASIZE AND PROVIDE COVERAGE FOR MEDICAL SERVICES AS OPPOSED TO SOCIAL AND PERSONAL CARE.

THE ELDERLY OF COURSE SUFFER FROM ACUTE DISEASE, BUT THEY ARE MUCH MORE SUBJECT THAN YOUNGER PEOPLE TO THE DEPENDENCY OF CHRONIC ILLNESS. THE TERM "SPELL OF ILLNESS" MAKES LITTLE SENSE WHEN APPLIED TO A DISEASE PROCESS WHICH WILL NEVER BE CURED. MOREOVER, ALTHOUGH THE CHRONICALLY - ILL PATIENT MAY BENEFIT FROM INTENSIVE MEDICAL SERVICES, HE IS MORE LIKELY TO REQIRE LESS INTENSIVE BUT CONTINUOUS MEDICAL CARE IN COMBINATION WITH SOCIAL AND PERSONAL SERVICES TO HELP HIM LIVE WITH HIS CHRONIC DISABILITY. SO THE HEALTH FACILITY WHICH CAN BEST SERVE HIM MAY BE VERY DIFFERENT FROM THE EXTENDED CARE FACILITY WHICH IS IDEALLY SUITED TO A PATIENT RECUPERATING FROM A MYOCARDIAL INFARCTION OR A BROKEN HIP. OR HE MIGHT NOT REQUIRE INSTITUTIONAL CARE AT ALL - HE MIGHT BE PERFECTLY ABLE TO LIVE IN HIS OWN HOME WITH THE AID OF HOMEMAKING AND HOME HEALTH SERVICES.

THESE PATIENTS WITH CHRONIC ILLNESSES - WHICH INCLUDE A DISPROPORTIONATE SHARE OF THE ELDERLY - AND THOSE SUFFERING THE INCREASED DEPENDENCY OF OLD AGE ITSELF-DEMONSTRATE THE WEAKNESSES OF LONG TERM CARE AS SUPPORTED BY THE FEDERAL GOVERNMENT.

FIRST, MEDICARE AND MEDICAID TEND TO BE MORE CONCERNED IN TERM OF STANDARDS AND COVERAGE WITH THE MEDICAL COMPONENT OF NURSING HOME CARE. THIS HAS BEEN TRUE FOR BOTH STATUTORY AND HISTORICAL REASONS BASED ON THEIR ORIGIN AS HEALTH INSURANCE PROGRAMS. I DO NOT THINK IT IS HELPFUL TO SEPARATE THE PHYSICAL, EMOTIONAL, SOCIAL, AND ENVIRONMENTAL COMPONENTS OF CARE, PARTICULARLY FOR THE ELDERLY. THESE ARE IMPERMANENT SEPARATIONS OF INTEREST, EMPHASIS, ORGANIZATION AND PREFERENCE; THEY REST MORE UPON TRADITION AND ARBITARY BOUNDARIES THEN THE APPLICATION OF KNOWLEDGE TO LONG TERM CARE.

SECOND THE PRESENT HEALTH FINANCING SYSTEM OFFERS MORE COMPLETE COVERAGE FOR PATIENTS INSIDE INSTITUTIONS THAN FOR THOSE WHO REMAIN OUTSIDE. SO OUR FINANCING STRUCTURE TENDS TO PUSH THE ELDERLY INTO NURSING HOMES, SOMETIMES PREMATURELY. SOCIETY PAYS A PRICE FOR THIS. INSTITUTIONAL CARE IS MORE COSTLY THEN HOME HEALTH CARE. MORE IMPORTANT, THERE IS INCREASING EVIDENCE THAT THE DISPLACEMENT, LOSS OF STATUS, AND ISOLATION CAUSED BY INSTITUTIONALIZATION MAY EXACERBATE IF NOT PRECIPITATE ACTUAL PHYSIOLOGIC DISEASE. THE TRANSFER OF A PERSON FROM HIS HOME TO AN INSTITUTION MAY MAKE HIM MORE ILL AND MORE DEPENDENT.

IF A NURSING HOME IS NOT THE MOST APPROPRIATE PLACE FOR A PERSON'S PARTICULAR NEEDS, THEN HE SHOULD NOT BE REQUIRED TO GO THERE. IF IT IS PERSONAL CARE RATHER THEN HEALTH CARE THAT IS REQUIRED, THEN THAT SHOULD BE AVAILABLE. IF IT IS APPROPRIATE HOUSING RATHER THEN INSTITUTIONAL CARE THAT IS NEEDED, THEN THE EMPHASIS SHOULD BE ON HOUSING. THE ELDERLY SHOULD HAVE MORE OPTIONS AVAILABLE.

THESE SEEM TO ME BASIC AND VALID CRITICISMS OF OUR PRESENT SYSTEM - THE SEPARATION BETWEEN MEDICAL AND PERSONAL CARE AND THE FAILURE TO PROVIDE ADEQUATE ALTERNATIVES TO INSTITUTIONAL CARE. AND IN THESE AREAS, FEDERAL PROGRAMS HAVE HAD AN UNFORTUNATE IF UNINTENDED IMPACT. THESE ISSUES CANNOT BE POSTPONED. ON DECEMBER 28, 1971, PRESIDENT NIXON SIGNED INTO LAW PUBLIC LAW 92-223, WHICH AUTHORIZES THE TRANSFER OF INTERMEDIATE CARE FACILITIES INTO THE MEDICAID PROGRAM. AN INTERMEDICATE CARE FACILITY PROVIDES HEALTH RELATED SERVICES FOR PATIENTS WHO DO NOT REQUIRE CARE IN SKILLED NURSING HOMES, BUT NEED INSTITUTIONAL CARE BEYOND

ROOM AND BOARD. AS YOU KNOW, ICF'S WERE PREVIOUSLY FINANCED BY PUBLIC ASSISTANCE PROGRAMS FOR THE AGED, THE BLIND, AND THE DISABLED, AND WERE SUBJECT ONLY TO STATE LICENSING. TRANSFER OF FINANCING TO THE MEDICAID PROGRAM MEANS NOT ONLY THAT A LARGER GROUP OF PEOPLE - INCLUDING THE "MEDICALLY NEEDY" - MAY POTENTIALLY BE ELIGIBLE FOR BENEFITS, BUT ALSO THAT THE FEDERAL GOVERNMENT IS EMPOWERED TO SET PHYSICAL AND SAFETY STANDARDS AND DEFINE THE CARE AND SERVICES THAT MUST BE PROVIDED. THE MEDICAL SERVICES ADMINISTRATION OF THE SOCIAL AND REHABILITATION SERVICES AND MY OFFICE OF NURSING HOME AFFAIRS ARE CURRENTLY EXAMINING SUCH ISSUES AS WHO SHOULD BE IN THESE FACILITIES, WHAT SERVICES MUST THEY PROVIDE, AND WHAT SHOULD BE THE LEVEL OF BENEFITS IN ATTEMPTING TO DEVELOP STANDARDS FOR INTERMEDIATE CARE FACILITIES. SO THESE FACILITIES ARE FORCING A RE-EXAMINATION OF COVERAGE ISSUES, AND THE BALANCES OF MEDICAL AND PERSONAL SERVICES WITHIN INSTITUTIONS. THE "PROBLEMS TO COME" ARE HERE ALREADY.

I WOULD LIKE TO MENTION ONE MORE PROBLEM THAT HAS DEMANDED ATTENTION, AND THAT IS THE PLANNING PROCESS ITSELF. AN IMPORTANT REASON FOR THE INSUFFICIENT AND SOMETIMES INAPPROPRIATE IMPACT OF FEDERAL PROGRAMS FOR LONG TERM CARE HAS BEEN THE LACK OF PLANNING AND COORDINATION BETWEEN FEDERAL, STATE, AND LOCAL PROGRAMS. PLANNING FOR LONG TERM CARE SHOULD MOVE FROM IDENTIFICATION OF AN ISSUE OR PROBLEM TO ITS SOLUTION, WITH IDENTIFIABLE GOALS GUIDING THE PROCESS. MOVEMENT TOWARD A GOAL SHOULD NOT BE INTERRUPTED BY CHANGES IN ADMINISTRATION. WHAT IS TRULY IMPORTANT TODAY SHOULD NOT BE CAST ASIDE TOMORROW. NEW PROGRAMS SHOULD NOT BE APPENDAGES TO SATISFY THE INTERESTS OF A FEW, NOR SHOULD THEY BE ADDED AS PACIFIERS TO THE MANY. PROGRAMS DEVELOPED THROUGH A RATIONAL PLANNING PROCESS SHOULD THEN BE ADMINISTERED THROUGH AN EFFECTIVE AND COORDINATED MECHANISMS.

THE ESTABLISHMENT OF THE OFFICE OF NURSING HOME AFFAIRS WITHIN HEW WAS A STEP TOWARD IMPROVING COORDINATION. THE EIGHTH POINT OF THE PRESIDENT'S PLAN IS A MANDATE FOR A TASK FORCE ON LONG TERM CARE. THIS TASK FORCE WILL RE-EXAMINE ISSUES AND SET NEW GOALS, DEVELOP A NATIONWIDE DATA SYSTEM NECESSARY FOR POLICY FORMULATION, AND RECOMMEND AN ORGANIZATION FOR LONG TERM CARE WITHIN HEW AND FEDERAL STATE AND LOCAL PROGRAMS WHICH CAN ACHIEVE ITS GOALS MOST EFFECTIVELY.

A NATIONAL POLICY COURSE FOR THE CHRONICALLY ILL AND FOR THE ELDERLY SHOULD BE SET. IT SHOULD BE SET BY GOVERNMENT, WITH THE FULL AND CREATIVE CONTRIBUTION OF THOSE IN OTHER AGENCIES AND ORGANIZATIONS, THOSE IN ACADEMIC TEACHING AND RESEARCH, THOSE IN VOLUNTARY AND UNSALARIED SERVICE, AND THOSE WHO RECEIVE THAT CARE.

WE CAN DO MUCH BETTER FOR OUR ELDERLY. WE MUST OF COURSE PROTECT THEM FROM INSTITUTIONAL ABUSE, RECOGNIZING THAT SOME ARE WEAK AND DEPENDENT. BUT WE CAN ALSO MAKE POSSIBLE A WIDE VARIETY OF SUPPORTING SERVICES AND LIVING ARRANGEMENTS, SO THAT THE INFIRMITIES OF ADVANCING AGE DO NOT BECOME A PRISON OF THE SPIRIT. THE ELDERLY WITH OUR HELP CAN HAVE ACCESS TO THE VARIETY AND FREEDOM WE ASK FOR OURSELVES.