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LONG-TERM CARE FACILITY IMPROVEMENT STUDY

Introductory Report

July 1975

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Office of Nursing Home Affairs

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Statement by the Assistant Secretary for Health

The quality of care being provided in the Nation's skilled nursing facilities is quite properly a matter of serious concern to a great many individuals, to the health professions, and to agencies of Government that both regulate these facilities and channel vast amounts of public moneys to pay for their services. That concern, obviously, is heightened by disclosures of seriously deficient care, by sometimes tragic evidence of inadequate fire and safety protection, and by allegations of fraud the victims of which are not only the patients themselves but also the taxpayers whose dollars are supposed to be providing high quality care in safe, comfortable, and properly managed facilities.

In response to a Presidential initiative and to the will of the Congress as expressed in Public Law 92–603, the Department of Health, Education, and Welfare is engaged in a broad campaign aimed at improving the performance of long-term care facilities. This report presents the results of a key element in the campaign, namely a survey of skilled nursing facilities that was conducted to obtain a clearer picture of the care actually being provided, the health status of patients and residents, and the physical environment and managerial setting as they affect both the quality and the cost of skilled nursing care.

While the primary purpose of the survey was data collection, a purpose that has, I believe, been fully met, the longer range and more significant goal involves identifying the need for change in the roles and responsibilities of the Department and other agencies and organizations that have a legal or professional responsibility for the services and care rendered in the Nation's skilled nursing facilities.

The preparation and distribution of this statistical report and recommendations does not mark the end of the efforts underway. Validation surveys will continue through 1975 and will in fact be increased. Like the initial survey reported here, these validation site visits will be unannounced. In addition, a departmental management information system is being designed so that information obtained either through surveys or through periodic certification inspections can quickly identify those facilities that are not in compliance with existing regulations.

Obviously, the States carry the primary burden of monitoring the performance of skilled nursing facilities, thus the State surveyor has a critical and continuing responsibility to evaluate not merely the physical surroundings and facilities of nursing homes but also the health status of the people residing in them. For this reason the Department has placed strong emphasis on the training, credentialing, and licensing of State surveyors and on the training of providers and health personnel at all levels. In addition, the nursing home ombudsman demonstrations that the Department has funded, and the results of which are now being evaluated, appear to offer nursing home residents a much-needed voice in the care and services being provided them.

I hope that this report will receive wide circulation both because the information it contains offers a uniquely perceptive view of the health of persons residing in skilled nursing facilities, and more important because it can provide the basis for constructive cooperation among all of us who are seeking the best possible life for present and future residents of skilled nursing facilities.

THEODORE COOPER, M.D.

We are grateful for the extraordinary contributions of the many dedicated individuals who made this Long-Term Care Facility Improvement Survey possible. This collaboratively prepared report is the result of Federal key staff listed here and in appendix B.

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Foreword

"Nursing home care is a field with a brief past and an important future. We have come a long way in a short time." [1]

One forward step was accomplished when the President signed Public Law 92–603 to establish a common definition of care and mandate a single set of nursing home standards for health, safety, environment, and staffs in skilled nursing homes. These Federal standards were issued January 1974.

On June 21, 1974, the Department announced the special long-term care improvement campaign, consisting of four projects.

The first was a visit to a sample of skilled nursing homes across the Nation by teams from the Department's 10 regional offices and headquarters. The purpose was to identify the needs and determine where the Department's emphasis should be to improve the quality of care and provide a safe environment in nursing homes.

A second element of the campaign involved setting up a Long-Term Care Management Information System with a rapid response capability. The system must be capable of responding to the steady demand for quick information about surveys, certification status, Life Safety Code inspections and other matters. This system will link up the data-gathering apparatus at headquarters, regional, and State offices.

A third project will be to establish a monthly cost of care index for long-term care. The plan is to arrive at a national index and 10 regional indices—and one for Skilled and another for Intermediate facilities. The indices will gauge administration, nursing, food, and costs and will help to guide Federal and State reimbursement policies.

Another project in this campaign will be to develop uniform inspections and uniform ratings for nursing homes.

Part of this plan will be to develop a uniform scorecard for grading nursing home care. An "A" would then mean the same thing in any State in the country.

This report is limited to the presentation of the findings of the Long-Term Care Facility Improvement Study. The findings are different from those of other studies particularly because for the first time a patient assessment form specifically designed for long-term care facilities was used on a national basis.[2] Most existing survey forms currently used to survey nursing homes are designed for short term, acute care facilities such as hospitals. Further, since the main purpose of the survey was fact finding no effort was made to utilize the survey findings for certification purposes. Only skilled nursing facilities were included in the survey.

The staff of the National Center for Health Statistics provided continuing consultation and assistance in selecting the sample and in designing the sampling procedures. These are described in detail in the report.

The Federal regulations governing Skilled Nursing Facilities published in the January 17 and October 3, 1974, regulations were used as a basis for comparing the survey findings. These Federal regulations represent minimum standards and appear in appendix F.

It was not the intention of the survey to substantiate the common allegations made about lack of care in nursing homes. The survey process did not permit the collection of data and information, for example, about patients left sitting in chairs for extended periods of time nor the extent of use of various types of physical restraints and locked rooms for patient control. No assumptions or

[1] Remarks by Under Secretary Frank C. Carlucci, Department of Health, Education, and Welfare, before the Meeting of State Surveyors, St. Petersburg, Fla., June 21, 1974.

[2] U.S. Department of Health, Education, and Welfare, Health Administration. *Patient Classification for Long-Term Care: Users Manual.* DHEW Pub. No. (HRA) 74–3107. (Washington, D.C.: U.S. Government Printing Office, December 1973).

judgments can be made about the physical and mental abuse of patients. A realistic picture of patient's needs for care associated with their pathophysiologic and psychosocial conditions and the related practice and service requirements to satisfy these needs was sought.

In many cases, the social and economic needs of older people can be met much better through programs that permit self-sufficiency for older people in their own homes. It is important to make it possible for older people to keep functioning in their own homes. We have not yet begun to realize the full possibilities—human and economic—of expanding home health services. Long-term care should be based on what the individual needs, and not be limited to institutional care.

We are truly grateful to the large number of persons who contributed to this survey research project, especially the Department's Office of Nursing Home Affairs staff and the Regional Directors of the Offices of Long-Term Care Standards Enforcement. (See appendix E.)

FAYE G. ABDELLAH,
Assistant Surgeon General
U.S. Public Health Service.

Contents

Historical Overview of DHEW's Efforts in Long-Term Care

In 1965, Congress passed Public Law 89–97 and established Medicare and Medicaid under Titles XVIII and XIX of the Social Security Act to help meet the health care needs of the over 65, and the poor. One of the benefits provided coverage of care rendered by a certified nursing home. Certification was obtained by demonstrating compliance with Federal regulations directed toward assuring an acceptable quality of care. Since the mid-sixties, the regulations have gone through an evolutionary process—from ensuring safety to a greater focus on the need for achieving an optimum quality of life and care—keeping in mind the need to provide the technical assistance to States to support their efforts to upgrade nursing homes. In 1972, the Congress approved creation of unified standards and regulations governing skilled nursing facilities under Titles XVIII and XIX.

The Nursing Home Improvement Program, resulting from President Nixon's August 1971 message and subsequent administration interest and directives, has intensified and broadened activities already underway and initiated new activities where needed. Response to these priorities has focused on improving the quality of care and life through innovation, experimentation, evaluation, and technical assistance.

One of the initiatives was to provide a Departmental focal point for standards enforcement and facility improvement, and further development and coordination of long-term care policy in the Department. These responsibilities were assigned to the Office of Nursing Home Affairs (ONHA), Public Health Service. Additional responsibilities assigned to this Office have been expanded to include aging in the Public Health Service and Home Health Services. The staff of ONHA coordinates long-term care program aspects of agencies throughout the Department. In the same way that ONHA's original responsibilities have expanded, so have the other initiatives been modified to respond to continuing needs in the area of long-term care. A brief review of the accomplishments are in the subsequent paragraphs.

Development of uniform standards for skilled nursing facilities (*SNFs*).—In January 1974, uniform Federal regulations governing participation of skilled nursing facilities in Titles XVIII and XIX were published, and interpretive guidelines for professional and consumer groups as well as instructional guidelines and forms for surveyors were developed. The process by which these are developed seeks to assure that standards are reasonable, yet adhere to sound professional practice. The regulations provide a streamlined efficient mechanism for inspecting and certifying nursing homes receiving Federal funds and places special emphasis on the health and safety of patients.

On October 3, 1974, additional standards were published in final form after having been published as Notice of Proposed Rulemaking on May 1 for comment. Requirements for medical direction, 7-day registered nurse coverage, discharge planning and patients' rights were established. These four standards have been long awaited to enhance the quality of care and life that ONHA and the Department had made a commitment to improve.

In January 1974, the regulations governing *Intermediate Care Facilities* (ICF) were also published, creating in response to congressional legislation, a new level of care to be provided under the Medicaid program.

Working with DHEW, the Department of Housing and Urban Development established a *guaranteed loan program* called for by Public Law 93–204. Provisions of the program, published in the FEDERAL REGISTER of August 12, 1974, will assist facility administrators to purchase and install fire safety equipment which would enable them to meet the Life Safety Code (LSC) requirements of the SNF and ICF regulations.

The Life Safety Code Survey training sessions were held for State and regional office personnel. Approximately 230 State people attended these sessions which were geared to improving interpretation and documentation requirements and survey techniques. In addition, a contract has been entered into with an outside consultant for the development of an audiovisual training program which can be used by State survey personnel to improve their understanding and application of LSC requirements.

Ombudsman demonstration.—The seven nursing home ombudsman demonstration projects which were initiated following the initiatives were transferred from the Public Health Service to the Administration on Aging (AoA) in 1973. An assessment of the experiences of the various models for resolving grievances of patients in nursing homes has been completed. The AoA plans to expand these units as part of its advocacy role for aging. In fiscal year 1976, AoA plans to assign one full-time person to each State to provide leadership in developing an ombudsman program in that State.

Surveyor training.—On August 7, 1974, Public Law 93–368 extended for 3 years (until June 30, 1977) the 100 percent Federal funding of salaries and training of surveyors of long-term care facilities which was provided for in the original intiatives. In accordance with recommendations, continued support was needed to ensure that States could complete inspections required to certify facilities and assist them to maintain compliance with regulations. Each region has a Health Facility Survey Improvement Program coordinator to identify specific need for surveyor training.

Provider training.—Through contracts awarded by the Division of Long-Term Care, National Center for Health Services Research, HRA, patient care personnel throughout the country, representing all categories, were provided with opportunities for short-term training. The total reached by such opportunities since this initiative was implemented is over 100,000. Long-term care coordinators have been designated in all DHEW regions and nine regions have identified a "center of excellence" within their jurisdiction, a long-term care facility where onsite training can be given to interdisciplinary teams from other facilities. Materials from earlier contracts have been produced for distribution.

Research and development and data collection.—Through contracts and grants, studies are being conducted by the DHEW in the areas of (1) quality of care; (2) assessment of alternatives to institutional care; and (3) data collection. ONHA coordinates these efforts throughout the Department to avoid duplication.

During 1974, the nationwide sample survey of nursing homes, their residents, and staff, was completed by the National Center for Health Statistics. Data (including cost data) based on a subsample (nearly 300 of the 2,112 homes included in the survey) has been published. Surveys are planned on a continuing basis for every 2 years. This means that essential trend information as well as current estimates on this rapidly expanding sector of the health care delivery system will be available for planning, providing, and establishing standards for long-term care.

Several other data programs within the Department include long-term care information from the Bureau of Health Insurance (SSA), Medical Services Administration (SRS) as well as the Experimental Health Services Delivery Systems (HRA). Attention will be given to consolidating these data at headquarters and regional offices.

Section 222 of P.L. 92–603.—Experiments and Demonstration Projects on Reimbursement. The Secretary was authorized to undertake studies, experiments, or demonstration projects with respect to: Various forms of prospective reimbursement of facilities; ambulatory surgical center; intermediate and skilled care and homemaker services (with respect to the extended care benefit under Medicare); elimination or reduction of the 3-day prior hospitalization requirement for admission to a skilled nursing facility; determination of the most appropriate methods of reimbursing for the services of physicians' assistants and nurse practitioners; provision of day care services to older persons eligible under Medicare and Medicaid; and, possible means of making the services of clinical psychologists more generally available under Medicare.

CHAPTER 2

Survey Methodology

On June 21, 1974, Under Secretary Frank C. Carlucci announced the Long-Term Care Facility Improvement Campaign, an accelerated project directed toward upgrading the quality of care provided in the Nation's nursing homes. A multifaceted effort, the campaign will ultimately address a number of diverse issues relating to long-term care, including development of a computerized information system, development of a monthly cost of care index, and a nationwide uniform inspection and rating program for nursing homes. At that time, the importance of this project was emphasized, not only because of its immediate impact, but even more importantly because of the role it will play in future planning for long-term care as the campaign progresses.

SURVEY PURPOSE AND FORMAT

To appreciate the purpose of the surveys, it is helpful to consider them in the context of the overall campaign. In order to achieve the campaign's broad goal of upgrading nursing home services, it was deemed necessary to assess carefully and objectively the current status of this level of care. In short, baseline data were necessary to identify needs, develop programs to meet those needs, and measure the overall success of the initiatives undertaken. The role of the surveys was to collect this baseline data.

Using a scientific approach for data collection, steps were taken in accordance with established statistical and research principles to eliminate biases which might otherwise destroy the integrity of the surveys. For example, all visits were unannounced to assure that a true profile of the home's normal operations was obtained; homes to be surveyed were selected randomly on a regional basis and with no prior knowledge concerning those facilities ultimately selected. Originally, the total figure of 304 visits was selected as the minimum number acceptable if the data collected were to be regarded as nationally representative.

It is essential that the purpose of the campaign surveys be carefully distinguished from surveys conducted for the purpose of certifying homes for participation in the Medicare and Medicaid programs. The campaign surveys were conducted solely as a data collection process with no formal relation to the certification procedure.

The survey instrument used differed markedly in format, content, and underlying philosophy from previous instruments and particularly from those used for certification purposes under Titles XVIII and XIX. The underlying premise of the Titles XVIII and XIX survey form is that by measuring the capacity of a facility to provide an acceptable quality of care, the Federal Government may assume that the facility is in fact providing care of that quality. In short, the XVIII and XIX forms measure capacity and infer quality. The survey report form used in the campaign was in some respects more ambitious than its predecessors in that its objective was to measure quality directly without reliance on surveyor's inferences and assumptions.

Because the Office of Nursing Home Affairs (ONHA) serves as the Departmental and Public Health Service focal point for Long-Term Care and nursing home affairs, ONHA staff was asked to take the leadership role to plan, conduct, and coordinate the Long-Term Care Facility Improvement Campaign's survey research project. (The sequential progression of six phases during 1974 and 1975 are shown on the flow chart—figure 1.)

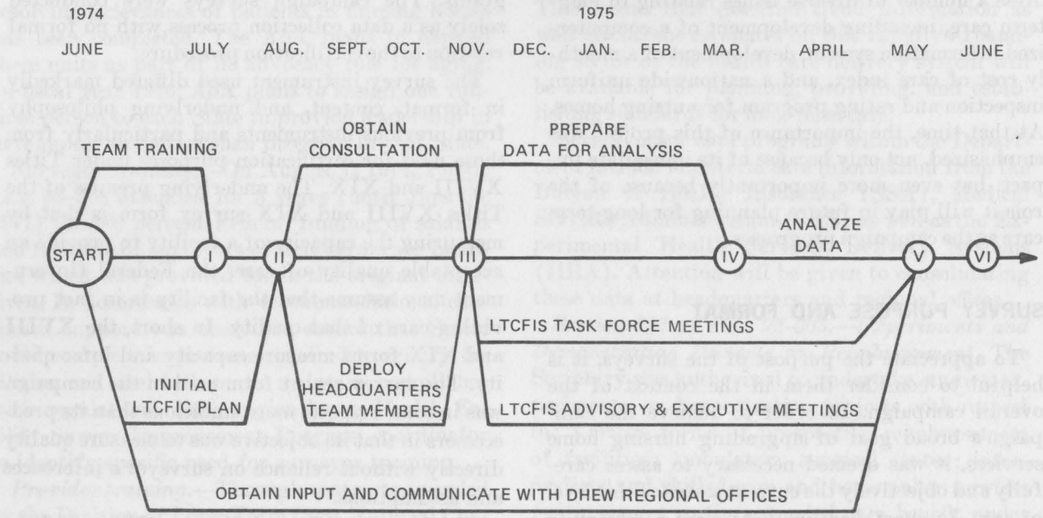
RESEARCH PLAN

The initial campaign plan was made with an ad hoc executive committee of representatives from various segments of the Federal health sector who

served in an advisory capacity. These representatives included health professionals from such components as the National Center for Health Statistics, National Center for Health Services Research, Bureau of Quality Assurance of the Health Services Administration, Social Security Administration, Social and Rehabilitation Service, Administration on Aging, and Office of Regional Operations. Task forces were formed to obtain professional expertise to select the survey format and instruments.

Consultation.—Outside as well as Federal consultants were brought into the project at frequent intervals during the team training phase, when data were being prepared for analysis, and during the data analysis stages. One advisory group consists of representatives from Michigan State University, Harvard University, Johns Hopkins University, Syracuse University, and others (see appendix B). These key individuals had assisted in the original development of the patient classification approach and the Patient Classification for Long-Term Care Users Manual that were used in this survey.

Dissemination of findings.—The fourth phase (see flow chart) was marked by the publication of the *Long-Term Care Facility Improvement Study: Interim Report.* After completion of the *Introductory Report* (phase V), there will be subsequent monographs (phase VI) that will present in-depth data analyses of drug prescribing patterns, nursing care, and other important subjects, such as assessing health care needs in skilled nursing facilities.



KEY:
- I OMB CLEARANCE
- II DEPLOY AND COORDINATE 15 SURVEY TEAMS TO 10 REGIONS TO GATHER DATA
- III COMPLETE DATA GATHERING
- IV PUBLISH INTERIM REPORT
- V PUBLISH INTRODUCTORY REPORT
- VI PUBLISH MONOGRAPHS

Figure 1
Implementation of LTCFIS Research Plan

THE SAMPLE AND HOW IT WAS SELECTED

The nursing home survey was intended to provide a picture of skilled nursing homes in the United States participating in the Medicare/Medicaid programs and the care being provided to beneficiaries in these homes. Survey instruments and procedures were designed to collect baseline information on the quality of care and its related costs to guide decision-makers in planning future programs in long-term care.

Since it was impossible to survey all 7,526 skilled nursing facilities participating in the Medicare/Medicaid programs at the time of survey, conduction of a sample survey was necessary. In this kind of survey, sampling is the process of choosing part of a group (the sample) about which we wish to make generalized statements so that the selected part will represent the total group—in this case, all 7,526 skilled nursing homes.

A two-stage stratified random sampling design was employed. The initial stage involved the selection of homes. In the sampling process, homes were divided into three groups or strata based on their size. In the second stage, a sample of patients was drawn from the homes in the sample. The random selection procedures gave an equal chance for every skilled nursing home participating in the Medicare/Medicaid programs to be selected in the sample. In turn, every Medicare/Medicaid patient in these homes also had an equal chance of being selected.

The particular sampling process used resulted in the selection of 288 homes. (Figure 2—Map.) From this sample, it is possible to make generalized statements about the 7,526 skilled nursing homes. The specific procedures for selecting both the home and patient samples are described in detail below. In general, the samples were designed to make reliable national estimates.

Selection of Nursing Homes

Since the study was designed to obtain a national picture of all types of skilled nursing homes participating in the Medicare/Medicaid program, it was necessary to ensure that all regions of the country and all sizes of institutions were represented in the sample. To achieve this objective, the following procedures were used:

1. The U.S. Department of Health, Education, and Welfare (DHEW) 1974 list of all nursing homes in the United States participating in both the Medicare and Medicaid programs were divided into the 10 DHEW regions. (See map of these regions and the number of homes surveyed.)
2. These lists were sent to the regional offices to determine which homes were skilled nursing homes and which were currently participating in the Medicare/Medicaid programs and which were currently in operation.
3. The researchers then took the lists of Medicare/Medicaid certified skilled nursing facilities from the 10 regions and divided them into 3 categories based on size:
   - those with less than 50 beds
   - those with 50–99 beds
   - those with 100 beds and over
4. Using these three strata (bed-size categories), three lists of homes were made for each region. Homes were listed in the following order: alphabetically by State within the region, alphabetically by county within the State, and alphabetically by name within the county.
5. To ensure that certain nursing homes were not overburdened with DHEW surveys, those homes used by the Department's National Center for Health Statistics Nursing Home Survey conducted in 1973 were removed from the lists. Since the National Center for Health Statistics plans to include in its 1975 survey facilities with 500 or more beds, homes of this size were eliminated. There were 32 of these homes at the time of the survey.
6. Homes were then selected from each of the 30 lists by using the following random start procedures:
   - The first home was randomly selected from the list. Thus, each nursing home had the same probability of being selected as any other home.
   - Using the home selected in the first step as the starting point every 30th home on the list was selected if it were on the list whose bed-size category was less than 50; every 25th home was selected if it were on the list whose bed-size category was between 50–99; and every 10th home was

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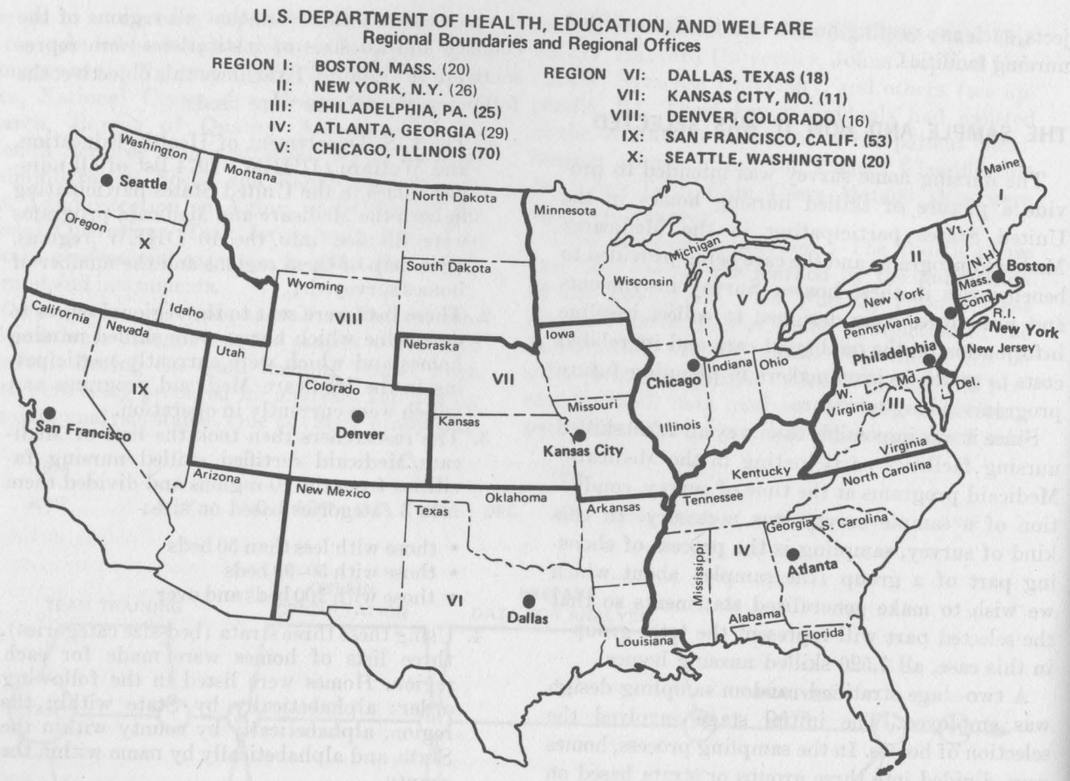

Figure 2

Regional Distribution of 288 Facilities Surveyed

selected if it were on the list whose bed-size category was 100 beds or more.

These procedures were used to ensure that homes selected in the sample in these three bed-size categories were represented in the same proportion as they are among all 7,526 skilled nursing homes.

These procedures resulted in the selection of 354 homes. Because of time, staff, and money constraints the 354 homes were reduced to 304 homes. Random selection procedures were again applied to each of 354 homes to eliminate 50 homes. In spite of all of the precautions taken to ensure that this sampling would be as accurate as possible, it was found when going into the field that 16 homes were either no longer participating in the Medicare/Medicaid program or did not have patients that could be included for study. This reduced the sample to 288 homes.

Selection of Residents

One of the aims of the survey was to determine the status of nursing home residents. Since it was not feasible to obtain detailed information about all of the residents in the homes selected for study, it was necessary to institute procedures for selecting a sample of residents. Designers of the study felt that because of time constraints it would not be feasible to obtain reliable information on any more than 15 patients in a home. The following procedures were used to obtain the sample patients. When arriving at a home, surveyors obtained a roster of current residents who were being reimbursed through the Medicare/Medicaid programs. Random start selection procedures of the same type as described in the sixth step of the nursing home sampling procedures were then used to select the sample Medicare/Medicaid residents.

The number of residents to be surveyed varied depending on the size of the home. The number ranged from all Medicare/Medicaid patients who were available at the time of the survey in homes of 15 residents or less to 1 out of every 35 for homes having up to 500 residents. (See appendix A for the forms and instructions used in selecting the sample patients.)

RELIABILITY OF THE ESTIMATES

In interpreting the findings from this survey, the reader should keep in mind that this was a sample survey, and that the sample was designed to make national estimates. Since all 7,526 skilled nursing homes were not surveyed, it is only possible to present information or to make the national estimates based on the 288 homes in the sample. In other words, the 288 homes have to represent all 7,526 homes. The estimates made from a sample survey will of course not be quite the same as if a complete census had been done. Statisticians refer to the difference between the estimate which is made on the basis of a sample and that which would be obtained from a complete census as the "standard error of the estimate". The relative standard error of an estimate is obtained through a mathematical procedure in which the standard error of an estimate is divided by the estimate itself and is then expressed as a percent of an estimate. The chances are about 68 out of 100 that an estimate from the sample would differ from the complete census by less than the standard error. The chances are about 95 out of 100 that the difference would be less than twice the standard error and about 99 out of 100 that it would be less than 2½ times as large. The following table 1 illustrates this estimation procedure and what it means in interpreting the data in this report.

Table 1.—Number of facilities classified according to whether pharmacist provides written comments concerning review to the medical director

Written comments provided to medical director	Count	Percent	Relative standard error
Yes	1,239	18.8	0.18
No	5,352	81.2	.04
Total	6,591	100.0	
Unknown	1,301		

The relative standard error in table 1 may be interpreted as follows: The sample estimated is that in 5,352 or 81.2 percent of all homes the pharmacist did not provide written comments to the medical director. A relative standard error of 0.04 is equivalent to 214 homes or 3.2 percent. Hence, the chances are about 2 out of 3 that in the total population, the number of homes in which the pharmacist did not provide comments to the medical director lay between 5,352 ± 214 homes, or equivalently 81.2 ± 3.2 percent. Similarly, the chances are 19 out of 20 that the number of homes in the total population where the pharmacist did not provide written comment is 5,352± (2×214) or a range of 4,934–5,770. A comparable range in percent of all homes is 74.8–87.6 percent.

As in *all* sampling surveys, certain difficulties were encountered in the execution of the sampling plan. For example as mentioned previously, 9 of the 16 homes were not surveyed either because they were closed or were no longer participating in the Medicare/Medicaid programs when the surveyors went into the field. In other cases, Medicare/Medicaid patients were not available for interviews. To overcome these and other difficulties. estimation procedures were introduced into the data during the analysis stage. Essentially, the estimating procedures used corrected for "nonresponse". They included correcting for missing data when: (a) Homes in the sampling frame were not surveyed; (b) when Medicare/Medicaid patients were not available; (c) when particular forms were missing; and (d) when individual questionnaire items were incomplete. The technical details of the estimation procedures are explained in appendix A along with the formulas employed.

METHODS AND PROCEDURES

The Study Team

Fifteen study teams of DHEW employees were used to collect the survey data. Each team was composed of a physician, nurse, administrator, nutritionist, pharmacist, physical therapist, fire safety engineer, and a social worker. Each of the 10 DHEW regions supplied 1 team, the remaining 5 teams were staffed from Public Health Service Headquarters. Fifteen additional health professionals were also selected from headquarters to serve as replacements in case of absences of members of the regular teams.

Selection of Team Members

Public Health Service Headquarters and the 10 DHEW regional offices asked for volunteers from the 8 disciplines outlined above to serve as surveyors. The credentials of the volunteers were presented to the study directors. The qualifications of potential surveyors were then individually reviewed to determine whether they met special criteria established by the researchers.

Priority in selection of team members were given to candidates having the following qualifications:

- Health status and physical stamina that permit a rigorous travel schedule.
- Work experience in nursing home standards formulation, survey and certification procedures and standards enforcement.
- Recent clinical or work experience in a health field closely related to or associated with the nursing home fields of practice.
- Personal qualification—demonstrated high standards of performance, and an ability to work well with others, an objective attitude, and sound judgment.

Special criteria were established for each discipline. For example, the criteria for physicians were as follows:

Educational Background:

- Graduation from an accredited medical school.
- Residency training in geriatrics, internal medicine, or family practice preferred.

Knowledge and Experience:

- Knowledge of medical audit and utilization review.
- Recent clinical experience in geriatrics, chronic illness, or rehabilitation preferred but not mandatory.

As a further example, nurses were selected on the basis of their educational background and experience, such as:

- Current license to practice in a State as a registered nurse.
- Advanced education or experience in administration, supervision, geriatrics, or rehabilitation.

Knowledge and Experience:

- Experience in nursing service administration, supervision, or ward management, and
- Experience in geriatrics and rehabilitation nursing.

Orientation and Training of Team Members

After the manpower requirements for the national sample survey of nursing homes were ascertained, 1- to 3-day intensive training programs were conducted for the campaign survey. The survey purpose, format, and survey research methodology were made explicit through comprehensive lectures and discussions.

The orientation emphasized that the campaign's broad goal was to upgrade nursing home services, so it was deemed necessary to assess carefully and objectively the current status and level of nursing home care. It was conveyed that baseline data were to be obtained to identify needs, develop programs to meet those needs, and measure the overall success of the initiatives undertaken.

It was emphasized that as a data collection tool the survey process must be utilized in a scientifically valid manner. For this reason, steps were taken in accordance with established statistical and research principles to eliminate biases which might otherwise destroy the integrity of surveys. All visits were unannounced to obtain a profile of the home's normal operations. For this reason only, a strictly limited number of people in the Nation knew the identity of a home to be surveyed until the day of the visit. Homes to be surveyed were selected randomly on a regional basis to attain the number acceptable for nationally representative data.

It was essential that the purpose of the campaign surveys be carefully distinguished from surveys conducted for the purpose of certifying homes for participation in the Medicare and Medicaid programs. That is, the campaign surveys were to be conducted solely as a data collection process with no formal relation to the certification procedure under Titles XVIII and XIX.

The central tool of the surveyor was considered to be his or her professional training and experience, since the questions on the various forms were drawn from the basic tenets of the several disciplines represented on the teams. In the final analysis the surveyor's common sense, courtesy, professional expertise, and initiative were considered invaluable contributions.

Emphasis in this health care survey of a randomly selected national sample of nursing homes was placed upon assessment of the quality of care (health, nutritional, and psychosocial) in relation to costs as they affect the provider, consumer, Federal Government, and the evaluation of safety and environmental factors. A patient classification assessment tool, for example, was used to determine if patients were properly placed in the facility.

During the training sessions, extensive instruction was provided to the surveyors on their own duties and responsibilities during the survey period. Each discipline was given special instructions in order to complete their portion(s) of the survey forms. Content of the survey instruments were discussed item by item to ensure that there was comparable understanding of all survey items. In addition, considerable time was spent in the training sessions in the discussion of the survey research methodology, including such topics as survey sampling and survey techniques.

SURVEY INSTRUMENTS

Content of the Instruments

In general, the forms were designed to measure the cost and quality of care rendered to include the physical, nutritional, rehabilitative, and mental health status of the recipients of care.

Four basic instruments were used to collect data about the home:

1. Identifying form—included basic characteristics of the home such as bed size.
2. Financial form—used to assess the costs of providing care.
3. Fire safety form—measures the conformance of facilities with established safety and fire standards.
4. Facility specific form—consists of the sections on management, patient care policies, nursing, rehabilitation, pharmaceutical, nutrition and dietetics, and psychosocial factors.

Two basic forms were used to collect data about the patient:

1. *Patient assessment form.*—This instrument describes the individual patient at the time of the survey. Data are provided about a patient's status from several perspectives: his physical function, his impairments, his medical risk status, and his sociodemographic status.
2. *Patient specific form.*—This form describes the care being provided to the patient and includes: patient care policies, medical care including diagnosis, nursing care, rehabilitation, pharmaceutical, nutrition and dietetics, and psychosocial aspects of care.

How Survey Instruments Were Developed

Patient assessment form.—The patient assessment form is the outgrowth of a series of workshops sponsored by the U.S. Public Health Service in the years 1965–69. During these workshops researchers and those delivering and monitoring care attempted to develop a uniform system of patient assessment by combining data systems in operation at the time. It became evident, however, that the problem was more complex than a mere interdigitation of terminology because of differences among the systems in scope, structure, type of scale or measurement, and methods of application. It became apparent that a research approach was necessary. A collaborative effort was then undertaken by four research groups to develop a patient assessment system, based on their own and others' experience, that would be useful for a variety of purposes and that could be recommended for general use in the long-term care field. The four research groups included: Case Western Reserve University Medical School; Harvard University's Center for Community Health and Medical Care; Johns Hopkins University, School of Hygiene and Public Health, and Syracuse University Research Corp. Developmental activities of the four groups have included conceptualization and construction of the patient assessment form used in this survey. Prior to use in this survey, the instrument had been field tested for feasibility, reliability, and usefulness and proved to be a successful instrument.

Other instruments.—To evaluate the services of skilled nursing facilities (SNFs), it was necessary to identify basic measurable elements common to all facilities. After considerable deliberation it soon became clear that the requirements contained in the conditions of participation for SNFs in the Medicare and Medicaid programs could serve as a nucleus for developing survey questions since these requirements represent basic standards of service. In this respect only, the survey questions bear resemblance to the survey and certification process for SNF's from which it was divorced. Other questions on generally accepted service and practice standards were incorporated and an initial set of survey questions were developed. After undergoing field tests and at least four different reviews by qualified Federal personnel in each field of practice, a final set of questions were developed, approved, and used for the survey.

SURVEY PROCEDURES

Since the survey was intended to provide information about the normal operations of sampled

homes, the survey team arrived unannounced. The administrator on the team usually acted as the team leader. On arrival at the home, he introduced himself and asked to speak to the home's administrator. (If the administrator was not at the home, he asked to speak to the person in charge.) The purpose of the survey was explained and a letter of introduction from the Under Secretary of DHEW was presented. In describing the survey, both the team leader and the letter of introduction stressed: (a) The research nature of the survey; (b) the assurance that the survey was in no way related to certification surveys for participation in the Medicare/Medicaid program; and (c) the assurance that all data were confidential and that homes and patients in the homes would be identified by number only.

At the conclusion of this introductory session, the team leader then obtained the list of Medicare and Medicaid patients. Using the forms and procedures given to him, he randomly selected the sample patients.

Individual team members then proceeded to obtain the information for their portion of the survey instruments. These data were collected by direct observation of the operation of the facility, discussions with facility staff, review of records, etc.

Upon completion of the data collection over a period of 8–16 hours (1–2 days) the team reassembled. The facility administrator and the staff were asked for their suggestions and recommendations for DHEW programs which would meet their needs. These recommendations were recorded. Before leaving the nursing home, the team leader checked to determine if all team members had fully completed their forms.

CHAPTER 3

Summary of Findings and Implications

The population characteristics of 283,915 patients in skilled nursing facilities are changing—predominantly still an elderly population but one in which the proportion of residents under 65 years of age is 22 percent (62,886). These individuals are primarily those who are mentally retarded or developmentally disabled. The increased attention being given to the latter requires study of the special needs of these individuals and their appropriate placement.

The usual occupations in which the patient is engaged or was engaged for the major part of his employment were skilled, semiskilled, and unskilled work. About 8 percent had been engaged in professional, technical, or managerial activities.

Information on family income of skilled nursing facility patients indicates the extent of their limited financial resources. It was found that 67.3 percent had less than $3,000 family income or no income at all.

The survey did not include intermediate care facilities (ICFs) where a larger number of mentally retarded and developmentally disabled are found. This year's March 18 deadline requiring the survey/certification of the intermediate care facilities has highlighted the importance of addressing the needs for controlled health and safety supervision of shelter and residential facilities. The Department is exploring the need to undertake a survey of ICFs.

Health Care Needs of Patients and Residents

The high degree of dependency of patients on the nursing staff for activities of daily living raises important questions for consideration. It was found, for example, that 93.9 percent (263,551) required assistance with bathing. About 72 percent (202,000) required the services of another person when dressing. Those who required assistance in order to eat amounted to 50.1 percent. Slightly more than two-thirds (68 percent or 193,137) needed assistance with their toileting.

Approximately half of all patients were incontinent of either urine (54.7 percent) or feces (50.1 percent). Over 5 percent had either an indwelling urinary catheter or an external device or ostomy for bladder drainage.

The long-term patient with limited mobility is prone to have pressure sores. A relatively low percent (9.2) of patients in this study was found to have bedsores, which is surprising in view of the large percent of incontinent patients.

As to their orientation and state of awareness, over half of the patients studied had difficulty in their awareness of their situation in respect to time, place, and self-identification. One out of every seven of the patients was not aware of the environment or was comatose.

The majority of patients, i.e., 70.4 percent, had sight impairments, including 2.6 percent that were blind and 50.7 percent who wore corrective lenses. Hearing and speech impairments were found in 32.9 and 32 percent, respectively.

An age differential became evident in the diagnostic profile. Two out of 3 of those under 65 had neurological diseases; 1 in 4, mental retardation; and 1 in 5 had a neurosis or psychosis. For 2 out of 3 patients 65 and over, the primary diagnoses were cardiovascular and cerebrovascular disease, senility, and accidents.

In ascertaining the dental health status of 210,411 patients, it was found that only 8.1 percent had no missing teeth. Edentulousness with dentures accounted for 46.8 percent of the patients studied. Seven percent had some teeth missing, but a restoration compensated for the loss. The remaining 38.1 percent of the patients required teeth replaced, including full dentures, but had none.

Nutritional Needs

The nutritional requirements of the aged are the same as for other adults, although they need more proteins and fewer carbohydrates. Also, the fact that almost half were edentulous and had dentures and over a third required teeth to be replaced but had no dentures, indicates that food preparation should be selected from basic food groups due to possible chewing difficulty. All too often the edentulous patient is given gruel instead of a nutritionally balanced diet.

About 4 of 10 patient care plans showed pertinent information about diet and dietetic problems. Menus were planned in writing for 89.3 percent of the patients in the sample. There were 51,666 patients who refused more than half of the meal served them. Only 27 percent (1,530) were offered appropriate substitutes. Approximately 1 out of 5 facilities had a more than 14-hour span between a substantial evening meal and breakfast. There was no documented evidence in 28 percent of the facilities that bedtime nourishments were routinely offered to patients to the extent medically possible.

Pharmaceutical Services

Survey pharmacists found that most skilled nursing facilities are well on their way toward achieving the capacity to render pharmaceutical services in accordance with accepted professional practices. Every effort should be made to incorporate a drug ordering system in the facility whereby the pharmacist works directly from a physician's order form. Further, it is important that the attending physician countersign all verbal orders within a maximum of 48 hours. Research is also needed that would objectively identify the nature, extent, and frequency of clinically significant drug therapy problems in long-term care facilities. There is a need to promote the development of pharmaceutical service committees in skilled nursing facilities. The issue of appropriate reimbursement of the pharmacist needs to be studied.

This is such an important complex area that the Office of Nursing Home Affairs is undertaking an indepth analysis of drugs ordered for patients classified as cathartics, analgesics, and antipyretics, and tranquilizers. This separate analysis will be reported in a later monograph.

Physician Services

A determination of physician involvement as measured by a review of the patient's total program of care during a visit of at least every 30 days was most difficult to assess. The records for 4 out of 5 patients did show a physician's signature at least every 30 days in 4 months prior to the survey. The proportion was higher, i.e., 9 out of 10, for those in the facility less than 4 months. About 9 out of 10 patients are seen by their physician during a visit to the institution, and in 1 in 5 cases, the physician sees the patient, but does not review the care plan. In 3 to 4 percent of patients studied, the physician reviews the care plan, but does not see the patient.

Survey physicians reported patients' records as "incomplete", "mixedup," "not signed". This raises a question about the validity of using a record review as a source of information on nursing home patients. The over-reliance on the recording of primary and secondary diagnoses often did not reflect the reason for continued care. Attending physicians under-reported many impairments such as loss of sight, hearing, amputations, etc., as well as senility or chronic brain syndrome. An important finding was that one-third of the diagnoses recorded *subsequent* to admission may be directly linked to the quality of care provided in the nursing home, e.g. decubitus ulcers, genito-urinary and respiratory infections, and fractures. Laboratory services were inadequately used by physicians. Over-medication may be attributed to the physician not discontinuing orders no longer needed.

An important implication of the findings is that quality assessment by physicians requires careful examination of the patients, including laboratory tests and should not be limited to record review.

Survey physicians found that some long-stay patients no longer were in need of skilled nursing care. This should have been identified by periodic medical review. There is a dire need for greater physician involvement and for assessment tools that confirm that services needed are provided.

Rehabilitative Services

These services included physical therapy, occupational therapy, and speech therapy. The survey findings showed that many patients in skilled nursing facilities needed specialized rehabilitative services that they were not receiving, e.g., 47.9 percent needed physical therapy, 35 percent needed occupational therapy, and 13 percent needed speech therapy. State surveyors need to become more cognizant of the need for these services and health personnel, particularly physicians and nurses need to be acutely aware of the importance of ordering and seeing that they are provided. An underlying issue is the slow and inadequate reimbursement of rehabilitative services while in others abuse of the program was apparent.

Other Health Professional Involvement

Reference is made frequently to the high turnover of health personnel, particularly RNs, LPNs, and aides in nursing homes. Yet what provision is made for retirement plans, fringe benefits comparable to hospitals, and opportunities for inservice and continuing education? The need for technical assistance for all levels of personnel is paramount, particularly training tools such as self-instructional multi-media training modules.

Administrative and Fiscal Management

In evaluating the administrative management of skilled nursing facilities the survey team looked to see how well the management function was being performed in relation to the governing body, the nursing home administrator, personnel management, and outside resources.

It was found that the governing body frequently does not discharge its obligations in an effective manner. Policies, usually in policy manuals, were often not implemented. Patient care policies were found to lack the input from health care professionals other than physicians and nurses. There was a lack of coordination between personnel management practices and personnel resources. A critical finding was the lack of opportunities for career development and continuing education. Outside resources were often not utilized and the findings and recommendations of consultants not followed.

The fact that governing bodies of a large number of SNFs do not carry out their duties and responsibilities effectively inhibits the delivery of high quality of care. It is recommended that a study be made to determine the body of knowledge and preparation needed by administrators of nursing homes. There are implications that State nursing home licensure programs are licensing individuals who are ineffective administrators. It is recommended that a review of nursing home administrator licensure procedures be undertaken to determine what statutory or regulatory changes are needed to assure that only fully qualified individuals are licensed.

Evaluation of the fiscal management aspect of the survey was directed at finding data to base national estimates of the cost of care in a skilled nursing facility so that such data could be related to a cost-of-care index. The lack of uniform cost accounting procedures presented the major difficulty in obtaining valid and reliable fiscal data. Under Public Law 92–603, section 249 such procedures will be mandated by July 1976. It is recommended that research be undertaken to determine the relationship of the costs of nursing care to the services provided and thus identify the differences between SNF care and ICF care. Further, cost hypotheses need to be tested concerning the type of control and ownership of nursing homes, the size and the major source of cost reimbursement.

Health and Safety of the Environment

Specifically in this area surveyors looked to see how well SNFs met the requirements of the 1967 Life Safety Code published by the National Fire Protection Association and a statutory requirement of Medicare and Medicaid regulations. Each facility was evaluated as a whole in addition to reviewing each standard, thus the design features of a facility were taken into account. It was found that few facilities met all Life Safety Code requirements, that is, 6.1 percent. Sixty-six percent had 1–9 requirements that were not met. Most important, many of these requirements could be met with little or no additional expense, e.g., illumination of exit signs. One-fourth of the facilities were of fire resistive construction and one-fourth of protected wood frame construction. The remaining facilities were primarily of protected noncombustible construction, protected ordinary construction, or ordinary construction.

State surveyors need to become qualified in fire safety regulations to make valid judgments par-

ticularly with respect to recommending waivers. Nursing home administrators also need this information.

In addition, regional validation surveys need to be increased to assure that State fire authorities are accurately assessing compliance with the Life Safety Code.

Social Services

In assessing the importance of psychosocial services to assist in maintaining patient physical, social, and mental health, it was found that SNF patients, as a whole, represent patients, whose needs tax facilities for the highest level of staff skill and understanding.

Many of these patients suffer from complex physical and emotional problems. The factor of longevity combined with diminution of actual physical capabilities is often a source of deep frustration and patient embarrassment.

Findings indicate that in a number of facilities, efforts were made to provide daily activity at each patient's appropriate level of functioning irrespective of physical condition. However, in the greater number of facilities, there was very limited understanding of the importance of psychosocial services. The goal of enriching the daily environment of residents was frequently cited in the policies but rarely implemented. Recording of the patient's social and emotional status, interests, and adjustments was either incomplete, or if documented, was rarely readily available for staff use.

Data indicate that most of the facilities surveyed were in the process of developing required patient care plans. However, achievement of a regular review of patient status, evaluation of the kinds of care being given, and documentation by way of progress notes in the patient record was in an initial stage in most facilities. Relatively few facilities had the trained rehabilitative or social services staff with skills needed to achieve these goals for the total patient population.

As the importance of the psychosocial dimensions of patient care are recognized, the corresponding level and quality of such care in SNFs must be raised. The social and emotional needs of the patient must receive equal attention with that given to physical and medical aspects.

State and local agencies need to identify ways in which their personnel can receive the necessary social work, occupational therapy, and therapeutic recreation leadership to monitor discharge planning, transfer arrangements, develop programs in facilities, to identify problems, and develop therapeutic problems. The Department is exploring the need to revise Federal regulations to emphasize implementation of policies and sound programs, and provide staff for technical assistance.

The necessity for further research concerning psychosocial treatment methodologies, such as reality-orientation techniques is evidenced by the findings.

Training

Survey findings identified and reinforced the need for continuing and accelerated training activities for all disciplines and levels of provider personnel, both on a single-discipline and on a multi-discipline basis in order to meet the needs of the elderly. The implicit scope of need was found to require the concerted efforts of the Federal Government, States, professional, and provider organizations, health educators, and consumers.

Each of the study teams in the eight disciplines concerned with health care delivery noted an absence of orientation of personnel in rehabilitative concepts and psychosocial needs of elderly patients in the facilities they studied. An additional concern of all disciplines included that of the psychosocial impact on the patient resulting from translocation from home or hospital and the subsequent institutionalization in a long-term care facility. The need for increased personnel capabilities for effectively dealing with resultant patient behaviors was also evident.

Implications of the findings include the need for research and the subsequent identification of multiple sources of public and private funding in order to spread the financial burden of training equitably. Combined nationwide resources are required from all concerned in order to respond to the multitude of continuing provider training needs that have been identified.

NEEDED ACTION

1. *A total review of the survey/certification process.* Present survey items reflect the regulations which, in turn, are based on a hospital model and should be redesigned to assess patient care in long-term care facilities. There must be a shift from the facility's capability to provide services to the patients and residents to assessing the services actually being provided to them.

The survey findings document that paper compliance alone provides insufficient evidence to show that quality care is being provided to patients in a safe environment. A high percent of skilled nursing homes showed that the governing bodies of those institutions did not adopt their own policies, rules, and regulations nor did they implement them. Recommendations of utilization review committees were not acted upon by one out of five facilities. Further, recommendations *not* acted upon by governing bodies of facilities included those of pharmaceutical committees (42 percent), patient care policies (27 percent), and infection control (44 percent).

It is difficult to assess the quality of medical care that patients are receiving on the basis of record review alone. The survey documents this finding. For example, a patient may have a diagnosis, a physician visit at least every 30 days, a monthly review of his care and still show evidences of poor quality medical care. Whether this is due to an erroneous diagnosis or an overlooked problem, or signing of patients' records 6 months in advance warrants further study.

The Office of Nursing Home Affairs (ONHA) with the Bureau of Quality Assurance of the Health Services Administration, Social Security Administration, and Social and Rehabilitation Service is undertaking a complete review of the total survey/certification process. The Department of Health, Education, and Welfare, region IV, is now training State surveyors and nursing home providers to use a patient assessment approach both as a management tool and as an evaluation tool. The Department is exploring ways in which a patient assessment approach can be used in the survey/certification process.

2. *Nationwide training, credentialing, certification, and licensure of all State surveyors* must be achieved as rapidly as possible. A valid and reliable method of survey assessment and quality control, as an integral part of the survey/certification process depends on the judgments of the trained surveyors. The Bureau of Quality Assurance working with the Office of Nursing Home Affairs is addressing these problems.

3. *A complete analysis of the entire fiscal approach of reimbursement of facilities for services* provided including uniform cost accounting procedures, rate setting, provider/ownership arrangements, rentals, and so forth. Well-conceived experiments by States need to be encouraged. Exploration is also needed of reimbursement approaches based on provider's ability to maintain patients and residents mobile and behaviorally motivated. The Department has several efforts underway which focus on these problems.

4. *Alternatives to institutional care* such as home health care and day care must be given the highest priority. Steps need to be taken immediately to explore ways in which such alternatives can be utilized and such services increased. The Department is supporting several demonstration experiments under section 222 (Public Law 92–603) to determine alternative approaches to institutional care and costs of services provided under different combinations of home health care, day care, and intermediate care.

The milestone legislation Public Law 93–641, "National Health Planning and Resources Development Act of 1974," is being studied very carefully by the Department particularly with reference to alternatives to institutional care.

The survey report provides documentation to show that deterioration of patients' conditions can be linked directly to institutionalization and prolonged bed rest. This was true for 2 out of 5 patients under 65 years of age and for 1 out of 3 patients over 65. Further, one-third of the diagnoses recorded subsequent to admission can be linked directly to the quality of care provided in the nursing home. Physical and emotional rehabilitation or maintaining patients at a given level is stated as a goal in policies of nursing homes but seldom achieved.

5. *Training of health personnel at all levels* must be intensified and continued on a national basis. Physicians, nurses, and other health personnel need to be attracted to long-term care facilities. Training, career mobility, and other fringe benefits need to be considered. States and providers must assume the major responsibilities for these efforts.

In summary, the findings of the Department's Long-Term Care Survey have provided a baseline for a program for action through a working part-

nership of the surveyors, the providers, consumers, and associations working together with the Federal and State governments. Thus this report provides a basis for the development and implementation of a national strategy for long-term care for older Americans, the mentally retarded, and developmentally disabled who require quality care in a safe environment.

CHAPTER 4

Characteristics of Facilities and Patients

The central focus of the national survey of skilled nursing facilities was the patient. It is recognized that the long-term care patients differs from patients in acute care settings in terms of their physical, functional, and psychosocial conditions and needs. To acquire a thorough knowledge of the requirements for upgrading care in long-term facilities basic information on the characteristics of the patients served was essential. A profile of patients could provide an understanding of the factors affecting the needs and demands for care. It could serve as a basis for decisions on ways to effect change and improvements in the delivery of patient care services and a continuing meaningful Federal role in long-term care.

Number of Facilities

National estimates, as of July 1974, of the number of nursing homes, defined as facilities which provide some level of nursing care, participating in the Medicare (Title XVIII) and Medicaid (Title XIX) programs was 16,526 (*1*). About 7,526 homes or 45 percent were certified as skilled nursing facilities (SNFs) for patients who require skilled nursing and rehabilitation services on a daily basis to help them achieve their optimal level of functioning. Among the 7,526 SNFs, 3,945 or 52 percent had multiple certification as Medicare and Medicaid providers. Of 3,581 SNFs certified as single providers, 90 percent were Medicaid facilities only.

More than half of all participating homes, about 9,000 or 54 percent are intermediate care facilities (ICFs) participating in the Medicaid program They provide health related care and services to individuals who do not require the degree of care and treatment that a hospital or SNF is designed to provide but who do require care above the level of room and board.

The distribution of homes participating in Medicare and Medicaid programs follows. ICFs were not included in the survey.

Skilled nursing facilities	7,526
Medicare only	(301)
Medicaid only	(3,280)
Both Medicare and Medicaid	(3,945)
Intermediate care facilities	9,000
Total	16,526

Facilities in the Study

The sample survey of skilled nursing facilities resulted in a national sample for study purposes of 6,591 facilities participating in the Medicare and Medicaid programs, about 87.6 percent of all participating facilities. By bed size, the sample homes comprised close to 20 percent with less than 50 beds and approximately 40 percent of homes in each stratum 50–99 beds and 100 beds or more as shown in table 2.

The stratification of the sample homes by type of control or ownership is shown in table 3. As noted, close to 73 percent of SNFs in the survey are proprietary homes and 27 percent are under voluntary nonprofit, government, and religious auspices. This stratification reflects the national picture of ownership of nursing homes when all type of nonprofit homes are grouped together, In the 1973–74 sample survey of nursing homes of the National Center for Health Statistics, provisional data revealed that 73 percent of nursing homes in the Nation were operated under proprietary auspices and 27 percent under nonprofit auspices (*2*). The sample size probably does not per-

Table 2.—Number and percent of skilled nursing facilities in the national sample survey by bed size

Bed size	Number	Percent
Total	6,591	100.0
Less than 50 beds	1,239	18.8
50 to 99 beds	2,675	40.6
100 beds or over	2,677	40.6

Table 3.—Number and percent of skilled nursing facilities in the national sample survey by type of control

Type of control	Number	Percent
Total	6,591	100.0
Proprietary	4,803	72.9
Voluntary nonprofit	711	10.8
Government	465	7.0
Religious	612	9.3

mit valid estimates of those homes classified as nonprofit because of their small number in the sample. As a matter of interest, it appears from the crude data that proprietary owners may tend to have fewer small homes than nonprofit owners. The data suggest that about one-third of voluntary nonprofit, government and religious homes in the survey had 50 beds or less while one-sixth of proprietary homes were under 50 beds.

Number of Patients

In the 1973–74 National Center for Health Statistics survey of nursing homes, there were 1,098,500 residents in the Nation's 16,100 homes (*3*). Data available at the time of survey indicate that 29 percent of all nursing home patients receive skilled nursing care financed by Medicaid and 4 percent receive such care financed by Medicare. An estimate on this basis would yield a patient population of 351,520 beneficiaries in skilled nursing facilities.

It is difficult to estimate the number of Medicare and Medicaid beneficiaries who are patients in skilled nursing facilities. The reporting system and patterns in certification and termination of skilled nursing beds and facilities in the Medicare and Medicaid programs, termination of program benefits, disallowance of reimbursement claims, as well as, resident turnover or admissions and discharges preclude the ready availability of mutually exclusive and definitive data.

In July 1974 there were approximately 30 million beneficiaries enrolled in the Medicare and Medicaid programs who qualified as potential patients in the 7,526 participating skilled nursing facilities. The national sample of Medicare and Medicaid beneficiaries surveyed in the 6,591 facilities reported in this survey resulted in a population of 283,914 patients. Information on the demographic and economic characteristics of these patients and their educational and employment experience is presented below.

DEMOGRAPHIC CHARACTERISTICS

The most outstanding demographic characteristics of the patients surveyed in the 6,591 skilled nursing facilities described a survey population which in general is not unlike that of nursing home residents as revealed in previous studies (*4*) They present the classic profile of nursing home patients who are very aged, predominately female, unmarried, and almost exclusively white.

Age

Today, the primary focus of the skilled nursing facility is still the care of the elderly, although as a long-term care facility the SNF is a setting for the care of individuals with a wide array of chronic diseases and disabling conditions irrespective of age. It is known that the population with developmental disabilities in nursing homes includes the mentally retarded, persons afflicted with congenital heart disease, chronic renal disease, multiple sclerosis, and other related conditions of relatively younger patients.

Approximately 78 percent of all patients in SNF's were 65 years of age and over; they totaled 221,029. Almost 50 percent were 80 years of age or older. Patients in the eighth decade of life were the largest proportion of all ages. An additional 11 percent were 90 years of age and over. For all patients under age 65, the proportion was 22 percent and the total number 62,886. (See table 4.)

Table 4.—Number and percent distribution of patients in skilled nursing facilities by age

Age group(s)	Number	Percent
Total	283,915	100.0
Under 20	4,838	1.7
20 to 64	58,048	20.4
65 to 69	15,139	5.3
70 to 74	28,384	10.0
75 to 79	35,954	12.7
80 to 84	52,984	18.7
85 to 89	56,769	20.0
90 and over	31,799	11.2

Sex

Women outnumbered men in the skilled nursing facilities by more than 2 to 1. Only 27.1 percent of the nursing home patients were male, compared with 72.9 percent female. The predominance of the female patient is clearly shown within each racial classification as well. (See table 5.)

Race

Slightly less than 10 percent of the patients included in the SNF survey represented minority groups. Included were the black, Spanish American, Asian American, and other racial groups. The largest population of the nonwhite patients were of the black race, 7 percent. Spanish Americans comprised 1.6 percent and Asian Americans 0.3 percent. The distribution of male and female patients by race is shown in tables 6 and 7.

Previous studies of nursing home residents have tended to show a low utilization rate by other than

Table 5.—Number and percent of patients by sex and race

Race(s)	Both sexes total [1]		Male total		Female total	
	Number	Percent	Number	Percent	Number	Percent
All races	283,912	100.0	76,845	27.1	207,067	73.0
White	256,827	90.5	66,691	23.5	190,136	67.0
Negro/black	19,952	7.0	7,417	2.6	12,535	4.4
Spanish American	4,419	1.6	1,899	.7	2,520	.9
Asian American	940	.3	120	.0	820	.3
Other	1,774	.6	718	.3	1,056	.4

[1] Uniform procedures were used in computations; there may be a minor difference between the sum total figure and the total obtained when the subtotals are added together.

Table 6.—Number and percent of male patients by race

Race(s)	Male patients	
	Number	Percent
All races	76,845	100.0
White	66,691	86.8
Negro/black	7,417	9.6
Spanish American	1,899	2.5
Asian American	120	.2
Other	718	.9

Table 7.—Number and percent of female patients by race

Race(s)	Female patients	
	Number	Percent
All races	207,067	100.0
White	190,136	91.8
Negro/black	12,535	6.1
Spanish American	2,520	1.2
Asian American	820	.4
Other	1,056	.5

the white population (*5*). If the racial distribution of SNF patients is related to their distribution in the total population, there is a disparity in the utilization rates between the white and nonwhite races. From a cursory look at the data it appears that the proportions are 0.14 and 0.10 percent respectively (*6*). This does not take into account differences in morbidity, mortality and longevity of the two groups. These factors have not been compared for this report.

It has also been noted that the nonwhite population receive more health-related care outside the institution or in the home than the white (*7*). This has led to the postulation by some that the inability to pay for care and the availability of care at home or elsewhere may be factors influencing the inequality in the utilization of nursing homes by minorities and their lower proportion in comparison to their numbers in the skilled nursing facilities.

Marital Status

The marital status of patients clearly depicts the higher survival rate for women in our society. Less than one out of every eight patients was

married at the time of survey. The greatest number did not have spouses. Most individuals (60.6 percent) were widowed. A few persons had terminated their marriages through separation or divorce. A sizable number (18.7 percent) of individuals had never married (see table 8) and of these the higher proportion were also women.

Table 8.—Number and percent of patients by marital status

Marital status	Both sexes total		Male total [1]		Female total	
	Number	Percent	Number	Percent	Number	Percent
Total all groups	283,914	100.0	76,890	27.1	207,024	72.9
Married	37,754	13.3	18,184	6.4	19,570	6.9
Widowed	171,812	60.6	26,007	9.2	145,804	51.4
Separated	5,567	2.0	2,200	.8	3,367	1.2
Divorced	15,520	5.4	6,602	2.3	8,918	3.1
Single	53,261	18.7	23,896	8.4	29,365	10.3

[1] Uniform procedures were used in computations; there may be a minor difference between the sum total figure and the total obtained when the subtotals are added together.

EDUCATIONAL AND ECONOMIC CHARACTERISTICS

The education and employment experiences of the beneficiary population of skilled nursing facilities participating in the Medicare and Medicaid programs as well as their level of income provides insight into the sociological factors affecting the utilization and the role of these facilities within the health care system.

Educational Attainment

Data on the educational attainment of patients may well reflect their age, the social structure at the time of their youth, the values placed on education, and their educational opportunities. About 30 percent of all patients had less than 8 years of schooling. An additional 22.1 percent had completed 8 years. Less than 9 percent of all patients had ever attended college. (See table 9.)

Occupation

The educational levels of patients are in turn reflected in their occupational patterns. Few professional workers are represented among skilled nursing home patients. Their usual occupations (*8*), defined as the occupation in which the patient is engaged or was engaged for the major part of his employment career, were in skilled, semi-skilled and unskilled services. As shown in table 10, almost one-third of all patients were employed as farmers, skilled service or clerical workers with an additional one-fifth employed as unskilled laborers. Homemakers accounted for slightly more than one-fourth of all occupations. Nearly one-seventh of patients had never been employed.

Table 9.—Last year of schooling completed by patients in skilled nursing facilities

Years of schooling completed	Patients	
	Number	Percent
Total	283,915	100.0
Less than 8	84,559	29.9
8	62,781	22.1
1 or more years high school	37,882	13.3
High school diploma	36,488	12.8
High school (trade) diploma	8,173	2.9
One or more college	10,359	3.6
Baccalaureate degree	11,257	4.0
Advanced college degree	3,499	1.2
No schooling	28,917	10.2

Table 10.—Usual occupation of patients in skilled nursing facilities

Occupation	Patients	
	Number	Percent
All	283,915	100.0
Clerical, sales, craftsmen, foremen, etc.	91,204	32.0
Housewives	78,110	27.5
Unskilled laborers	54,381	19.2
Never employed	37,931	13.4
Professional, technical, managerial	21,493	7.6
Members of Armed Forces	796	.3

Very few patients in skilled nursing homes were in the labor force. While close to 70 percent were participants at some time, 64 percent were retired. The fact that over 95 percent of patients were not employed and were not seeking employment is shown in table 11.

Family Income

Information on the family income of patients was also sought. Income is the sum of the dollar amounts of money received by all members of the family annually as wages or salary, net self-employment income, or other income from pensions, investments, public welfare, or assistance as defined for the 1970 census. Family refers to two or more people related by blood, marriage, or adoption, living together in the same household.

Table 11.—Current employment status of patients in skilled nursing facilities

Employment status	Patients number	Percent
Total	283,916	100.0
Retired	183,190	64.5
Never employed	87,292	30.8
Currently unemployed	11,413	4.0
Currently employed	1,668	.6
Sick leave	353	.1

The characteristically associated levels of educational attainment, employment, and family income is not wholly applicable to SNF patients, because of their age; retired, unemployed, or never employed status; and the various factors influencing their family and economic situations which were not studied. However, it appears that patient and family financial resources are very limited. As presented in table 12, over 68 percent of all family income was less than $3,000 a year. An additional 22 percent of families had no income. This indicates that 90 percent were below poverty level.

Table 12.—Number and percent of patients by sex and family income

Family income totals	Both sexes		Male sex		Female sex	
	Number	Percent	Number	Percent	Number	Percent
All incomes	283,917	100.0	78,186	27.6	205,731	72.4
$15,000 or more	2,025	.7	1,437	.5	588	.2
$10,000 to $14,999	1,132	.4	254	.1	878	.3
$7,000 to $9,999	1,754	.6	522	.2	1,232	.4
$5,000 to $6,999	4,962	1.7	2,009	.7	2,953	1.0
$3,000 to $4,999	15,107	5.4	6,141	2.2	8,966	3.2
Less than $3,000	194,949	68.7	46,417	16.4	148,532	52.3
No income	63,988	22.5	21,406	7.5	42,582	15.0

It is not surprising that proportionately males tended to have slightly higher levels of family income than females. This is particularly so for income in the highest bracket, $15,000 and over. However, distribution of income at all levels for both sexes was similar in that the majority had less than $3,000 family income with a substantial number receiving no income at all. (See tables 13 and 14.)

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Table 13.—Number and percent of male patients by family income

Family income totals	By male sex	
	Number	Percent
All incomes	78,186	100.0
$15,000 or more	1,437	1.8
$10,000 to $14,999	254	.3
$7,000 to $9,999	522	.7
$5,000 to $6,999	2,009	2.6
$3,000 to $4,999	6,141	7.8
Less than $3,000	46,417	59.4
No income	21,406	27.4

Table 14.—Number and percent of female patients by family income

Family income totals	By female sex	
	Number	Percent
All incomes	205,731	100.0
$15,000 or more	588	.3
$10,000 to $14,999	878	.4
$7,000 to $9,999	1,232	.6
$5,000 to $6,999	2,953	1.4
$3,000 to $4,999	8,966	4.4
Less than $3,000	148,532	72.2
No income	42,582	20.7

References

1. U.S. Department of Health, Education and Welfare, Public Health Service, Office of Nursing Home Affairs. *Chart Booklet 1974 Regulations for Skilled Nursing Facilities and Intermediate Care Facilities.* November 1974, p. 2.
2. U.S. Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics. "1973–74 Nursing Home Survey," *Monthly Vital Statistics Report,* Vol. 23, No. 6, Supplement. September 5, 1974, p. 2.
3. Ibid., p. 2.
4. National Center for Health Statistics. Measures of Chronic Illness Among Residents of Nursing and Personal Care Homes. June–August 1969, *Vital and Health Statistics,* U.S. Series 12, No. 24 (HRA) 74–1709 (Washington: Government Printing Office, May 1974), pp. 5–8.
5. Ibid., pp. 6–7.
6. U.S. Department of Commerce, Bureau of the Census. *Statistical Abstract of the United States 1974.* 95th Annual Edition. (Washington, D.C.: U.S. Government Printing Office, 1974), p. 26.
7. National Center for Health Statistics: Home Care for Persons 55 Years and Over: United States, July 1966–June 1968. *Vital and Health Statistics,* Series 10, No. 73. DHEW Pub. No. (HSM) 72–1062. Washington, D.C.: U.S. Government Printing Office, July 1972.
8. U.S. Department of Health, Education, and Welfare, Health Resources Administration. *Patient Classification for Long-Term Care: Users Manual.* DHEW Pub. No. (HRA) 74–3107. (Washington, D.C.: U.S. Government Printing Office, December 1973), p. 30.

CHAPTER 5

Health Status

The Nation's skilled nursing facility (SNF) population of all ages has a variety of pathophysiologic conditions and problems commonly described as accidental or developmental disabilities, chronic illnesses, and diseases of the aging. These conditions are usually associated with some type of extent of impairment in the biological, behavioral, and physiological capacities and performance of individuals that are interrelated and interact with social and psychological changes including changes in mental health. For the predominantly aged population, there are varying degrees of deterioration in all capacities that are cumulative. Each patient's condition was assessed as part of the survey to determine his/her needs for care and the potential demand for services commensurate with these needs.

ACTIVITIES OF DAILY LIVING

A readily available and objective method to determine the patient's requirements for basic care and dependency on the nursing home staff is to assess the varying degrees of ability he/she has in coping with the activities of daily living (ADL).[1] Evaluation of the patient's usual performance in bathing, dressing, eating, toileting, and mobility, as well as the patient's bladder and bowel function; orientation as to time, place, and persons; communication of needs; and behavior are included in this report. These activities serve as measures of the patient's biological and psychosocial functioning in terms of his/her capacity to function alone or require assistance of another person, mechanical aids or devices.

Viewed in their totality, these activities give the nursing home staff a picture of the functional status of the patient that enables them to plan a realistic program relative to the patient's needs for care.

The easily recognized components of nursing care in a skilled nursing facility are concerned with the bathing, dressing, feeding, and toileting of patients. They include assisting patients with walking and transferring to wheelchairs or to carry out prescribed special therapies. The administration of drugs, care of catheters, bladder irrigations and dressings of wounds are nursing functions. The responsibility of the nursing service to deal with pain and comfort, provide emotional and psychological support, identify adverse reactions to medications and treatments or altered patient status and patterns of behavior are less obvious. Many other functions and activities that contribute to quality care could be described.

In the absence of other in-house health professionals, the management, provision and continuity of total care in skilled nursing facilities becomes primarily the responsibility of the nursing service. The components of care may be assessed, directed, and supervised by professionals other than nurses. Their execution is most often delegated to the nursing service, and care is carried out by the least prepared members of the health team, the aides. A heavy load of responsibility for patient care coordination and management is borne by the nursing service administrator.

The varied and multiple functions and responsibilities assumed and carried out by the nursing service in SNFs is reflected in the reports on each of the other services. The dimensions of nursing care will be described in a separate monograph. A few aspects are highlighted in this report since they are well defined areas of nursing responsibility.

[1] Katz, S., and others, "Studies of Illness in the Aged, The Index of ADL: A Standardized Measure of Biological and Psychosocial Function". *Journal of American Medical Association.* 185: 914, 1963.

Bathing

About 93.9 percent of all patients or 263,551 required assistance, either partial (60.2 percent) or complete assistance (32.7 percent) with their bath. The latter group of 92,702 patients did not participate to any extent as shown in table 15.

Table 15.—Bathing ability of patients

Bathing ability	Patients	
	Number	Percent
Total	283, 912	100. 0
Bathes aided by person	123, 815	43. 6
Bathes aided by person and device	47, 034	16. 6
Is bathed	92, 702	32. 7
Bathes without help	18, 871	6. 6
Bathes self with aid of device	1, 490	. 5

Dressing

As measured in this survey, dressing is the complex behavior of putting on, fastening, and taking off all items of clothing, braces, and artificial limbs that are worn daily by the patient. Getting and replacing these items from closets and drawers is considered part of dressing. Approximately 72 percent of patients or more than 202,000 required the services of another individual when dressing. About 17 percent dressed themselves unaided by another. The remaining patients, about 12 percent, were not dressed. These relationships are shown in table 16.

Eating

Eating concerns the process of getting food from a plate or receptacle into the mouth without regard to social niceties. The process requires coordination, tactile sense, and manipulative skill in handling utensils. Patients were almost evenly divided between those who required assistance of some kind in order to eat (50.1 percent) and those who were able to eat unaided (48.3 percent). About 2,500 patient were fed parenterally (0.9 percent) and the eating ability of the remaining few was unknown (0.7 percent) as shown in table 17.

Table 16.—Dressing ability of patients

Dressing ability	Patients	
	Number	Percent
Total	283, 913	100. 0
Dresses aided by person	125, 605	44. 2
Dresses aided by person and device	4, 760	1. 7
Is dressed	72, 206	25. 4
Dresses without help	46, 044	16. 2
Dresses with aid of device	1, 034	. 4
Is not dressed	34, 264	12. 1

Table 17.—Eating ability of patients

Eating ability	Patients	
	Number	Percent
Total	283, 913	100. 0
Feeds self aided by person	93, 267	32. 8
Eats aided by person and device	3, 006	1. 1
Is spoon fed	46, 160	16. 2
Is fed parenterally	2, 533	. 9
Feeds self without help	133, 377	47. 0
Feeds self aided by device	3, 635	1. 3
Unknown	1, 935	. 7

Toileting

Toileting is the act of getting to and from the toilet room for bowel and bladder functions, transferring on and off the toilet, cleansing self after elimination and, arranging clothes. Slightly more than two-thirds (68 percent) of all patients, a total of 193,137 needed assistance with their toileting. The toilet room was not used by 82,968 patients (29.2 percent). (See table 18.)

The four measures of self-function in patient's activities of daily living, bathing, dressing, eat-

Table 18.—Toileting ability of patients

Toileting ability	Patients	
	Number	Percent
Total	283, 915	100. 0
Uses toilet without help	73, 061	25. 7
Uses toilet aided by device	17, 717	6. 3
Uses toilet aided by person	73, 155	25. 8
Uses toilet aided by person and device	37, 014	13. 0
Does not use toilet room	82, 968	29. 2

ing, and toileting reveals that at least half of all patients are dependent upon the skilled nursing home staff for assistance in carrying out one or more activity. Patients, as a whole, were least able to function independently and required assistance in bathing followed by dressing, toileting, and eating. A small proportion of patients were self-functioning by virtue of the use of special aids. The performance of bathing, dressing, eating, and toileting require complex organized neurological and locomotor responses. Dependence of patients in more than one activity or a combination of activities is usual and suggested by the data. These relationships will be explored and described in a future report.

Mobility

The mobility status of patients involving walking, wheeling, stair climbing, or functional ability to move about physically has not been analyzed for this report. The number of chairfast and bedfast patients and the transferring of patients between the bed, chair, and wheelchair is being examined. It is interesting to note that 13.2 percent of patients or 37,437 were fully ambulatory and able to leave the facility and walk outdoors at will. The reasons for institutionalization of these patients is immediately questioned. While alternatives to skilled nursing home care are suggested, they need to be ruled out by analysis of these patients' care plans and examination of the services being received.

Bladder and Bowel Function

The physiologic process of elimination from the bladder and bowel is referred to as continence. Incontinence is the involuntary loss of urine and/or feces. The process of elimination may take place through an external opening resulting from a surgical procedure (ostomy) such as a colostomy or a device such as a catheter may be used in the process. The function was assessed in terms of control without regard to influencing factors as constipation and medications. In cases where patients had surgical openings or external or internal devices were used, need for assistance with care was determined.

Approximately 40 percent of patients manifested no problem with bladder sphincter control (table 19). The remaining patients, however, had bladder control difficulties. The majority (54.7 percent) were incontinent of urine at least occasionally. About 5.7 percent of patients had either an indwelling catheter, an external device or an ostomy to compensate for their biological bladder dysfunction.

About half of all patients had difficulty with bowel sphincter control at least occasionally. Less than 1 percent had had surgical intervention to correct previous pathological conditions (table 20).

The status of patients' bladder and bowel functions poses another area of considerable dependence on the nursing home staff for assistance and care. More patients had full control of bowel function than bladder. Half may be dependent at some time for care in one functional area. The data indicate that at least 10 percent of patients may be

Table 19.—Bladder function of patients

Bladder function	Patients	
	Number	Percent
Total	283, 914	100. 0
No problem	112, 492	39. 6
Incontinent of urine	155, 392	54. 7
External device	912	.3
(a) Self-care	46	0
(b) Not self-care	866	.3
Indwelling catheter	14, 701	5. 2
(a) Self-care	755	.3
(b) Not self-care	13, 946	4. 9
Ostomy	417	.2
(a) Self-care	45	0
(b) Not self-care	372	.2

Table 20.—Bowel function of patients

Bowel function	Patients	
	Number	Percent
Total	283, 913	100. 0
No problem	139, 467	49. 1
Incontinent of feces	142, 188	50. 1
Ostomy	2, 258	.8
(a) Self-care	367	.1
(b) Not self-care	1, 891	.7

dependent in both functions. When patients had surgical openings of devices, they most often did not care for themselves. This fact raises the question of patients' potential for rehabilitation, another responsibility of the nursing home staff.

Orientation and Behavior

The effects of developmental disabilities, of chronic illness, and aging on mental functions are complex, difficult to measure, and have wide variation among individuals. The awareness of an individual within his environment can range from oriented to disoriented. Oriented means the patient is aware of who he is, where he is and what time, day, month, or year it is. Disoriented means the patient is unaware of time, place, and his identity. Disorientation may be in one of more spheres as time only or time and place and the patient may have alternating periods of awareness—unawareness or intermittent disorientation. As a practical matter clinical intuition and impressions are traditionally used as a basis of screening for mental functions and impairment. Answers were sought to simple questions about orientation of the skilled nursing facility patient for time, place, and person spheres.

The answers to these simple questions indicated that over half of all patients had some degree of difficulty in their awareness of the existing situation with reference to time, place and identity of self. One-seventh of patients had no awareness of their environment at any time or were comatose. (See table 21.)

Another concern in long-term care is the behavioral capacities of patients and whether their patterns of behavior are appropriate to the nursing home environment as distinguished from their personality characteristics. In appropriate behavior on this basis is described as passive, disruptive, and other acts detrimental to life, comfort and property. Patient behavior was assessed from staff reports, recordings, and observation of patients' actions of this nature.

For 58.4 percent of patients behavior was suitable to the environment although 41.1 percent of patients exhibited behavioral problems. Patients manifesting inappropriate behavior for the most part equally divided between those who were passive, those disruptive and those with other detrimental behavior as shown in table 22.

It appears from the profile of the orientation and behavior patterns of patients in the skilled nursing facilities that a sizeable proportion present major management problems both in terms of providing a safe environment and in rendering care. The inappropriate behavior and disorientation which ranged from 41.1 to 54.2 percent of patients requires nursing expertise of the highest order. What has been termed nursing psychiatry is believed by some to probably constitute the most important vehicle of patient management in care of the long-term care patient. Bathing, dressing, and feeding of the disoriented patient can challenge all the conventional techniques and skill known to nurses. It may be just as difficult to elicit a response and stimulate participation in care from the passive patient so that he will utilize his full potential for carrying out his activities of daily living.

Table 21.—Patient's orientation as to time, place, and person—spheres

Orientation state(s)	Patients	
	Number	Percent
Total	283, 914	100. 0
Oriented	130, 130	45. 8
Disoriented	153, 784	54. 2
(a) Some spheres, some time	(60, 544)	(21. 3)
(b) Some spheres, all the time	(33, 508)	(11. 8)
(c) All spheres, some time	(15, 915)	(5. 6)
(d) All spheres, all the time	(41, 292)	(14. 5)
(e) Comatose	(2, 525)	(1. 0)

Communication of Needs

Another consideration in the care of the long-term patient is the ability to make known by any means his needs for physical, mental, and social

Table 22.—Patients classified according to appropriate behavior

Behavior classified	Patients	
	Number	Percent
Total	283, 914	100. 0
1. Appropriate	165, 847	58. 4
2. Inappropriate	116, 578	41. 1
(a) Wanders; passive	(38, 627)	(13. 6)
(b) Aggressive; disruptive	(42, 006)	(14. 8)
(c) Inappropriate—other	(35, 945)	(12. 7)
3. Comatose	1, 489	0. 5

comfort. In its broadest sense, communication can be regarded as a system of significant symbols which permit ordered human interaction. If a patient can communicate he can transmit his needs effectively through the use of language and thus his needs can be understood. This patient has an advantage over the patient who must communicate nonverbally by substituting gestures, pointing or using written means for spoken and understood words.

Most patients (74.5 percent) in the survey communicated verbally and an additional 6.9 percent communicated on a nonverbal level. However, in respect to the attention that is necessary for the patient with whom contact relationships and response must be established, a sizeable number 52,745 patients or 18.6 percent did not communicate verbally or nonverbally. (See table 23.)

The lack of ability of patients to communicate illustrates yet another dimension of long-term care. Additional information on patients' speaking ability is described in the following section.

CONDITION OF THE SKIN

The long-term care patient with limitations on mobility is particularly susceptible to decubitus ulcers or bedsores. Prevention as well as therapeutic measures are nursing functions. The basic causes of bedsores are a blocking of blood flow to the affected area and lack of normal movement. A combination of external etiological factors of pressure, temperature, and moisture plus multiple internal debilitating and nutritional associated factors influence the formation of ulcers. Pressure, however, is considered the fundamental causative agent. The obvious external causative factors are one that nurses can conceivably control. The prevention and care of bedsores requires technical skill and attention to the causative factors and the application of the full talents of nurses.

Table 23.—Patients' ability to comunicate needs

Communication state(s)	Patients	
	Number	Percent
Total	283, 913	100. 0
Verbally	211, 491	74. 5
Nonverbally	19, 677	6. 9
Does not communicate	52, 745	18. 6

Considering their diagnoses, functional status, and dependency, a relatively low number of patients in skilled nursing facilities had bedsores, 26,037 or 9.2 percent, and of these the majority had but one site. This fact speaks well for the nursing services. (See table 24.)

It is well to remember that every patient who is bedridden for an extended period of time, is a possible candidate for a decubitus ulcer or pressure sore. Because elderly patients are more prone to skin breakdown due to decline in circulation and a tendency toward dry skin, extra care of the skin and preventive measures are indicated. These include protection of the patient against pressure and the maintenance of proper body alignment.

Patients with certain diseases and/or conditions require particular attention and these patients include those with: Diabetes, arteriosclerosis, patients with neurologic damage, e.g., paraplegia and those deprived of sensory feedback, e.g., the blind. Patients with limited movement, e.g., wheelchair patients as well as those who are bedfast, should be observed most carefully.

It is significant to note that 75.6 percent of all patients with decubitus ulcers (20,086 of 26,554) did not walk. And of equal interest is the fact that only 1,113 of the remaining 6,468 patients did walk without any assistance. The assistance of other persons or devices or both were needed by the 5,355 other patients. (See table 25.)

Table 24.—Number and percent of decubitus ulcers among patient population and site frequency among those patients with decubitus ulcers

Patient population	Number	Percent
Total, all patients	283, 907	100. 0
Ulcer-free patients	257, 870	90. 8
Patients with decubitus ulcers	26, 037	9. 2
One site only	(16, 770)	(5. 9)
Two sites	(4, 709)	(1. 7)
Three or more sites	(4, 558)	(1. 6)

Table 25.—Walking status of patients with decubitus ulcers

Degrees of walking ability	Patients	
	Number	Percent
Total, all	26, 554	100. 0
Does not walk	20, 086	75. 6
Walks with help/person	2, 451	9. 2
Walks with help person/device	1, 693	6. 4
Walks with help/device	1, 211	4. 6
Walks without help	1, 113	4. 2

Approximately 7 of every 10 patients (18,271 of 26,812) with a decubitus ulcer also had an associated difficulty with joint motion of the upper body, e.g., shoulder, elbow, wrist, etc. Limited movement was most frequently cited (59.6 percent). (See table 26.)

Approximately 85 out of every 100 patients (22,882 of 26,773) with a decubitus ulcer also had an associated difficulty with joint motion of the lower body, e.g., hip, knee, ankle, etc. Limited movement was most frequently cited (45.7 percent). (See table 27.)

Approximately 3 out of every 10 patients with an ulcer (8,093 of 26,614) also had a fracture or dislocation. The majority of fractures or 70.3 percent of them (5,690) were fractures of the hip. (See table 28.)

Fewer than 10 percent of all patients with decubitus ulcers (2,424 of 26,498) were self sufficient in their ability to transfer without the assistance of another person. (See table 29.)

Table 26.—Number and percent of difficulties of joint motion, upper body, among patients with decubitus ulcers

Difficulties, joint motion upper body	Number	Percent
Total	18, 271	100. 0
Limited movement	10, 884	59. 6
Immobility	1, 180	6. 5
Instability	757	4. 1
Combinations (of above)	5, 450	29. 8

Table 27.—Number and percent of difficulties of joint motion lower body among patients with decubitus ulcers

Difficulties, joint motion lower body	Number	Percent
Total	22, 882	100. 0
Limited movement	10, 456	45. 7
Immobility	2, 026	8. 9
Instability	883	3. 8
Combinations (of above)	9, 517	41. 6

Table 28.—Number and percent of fractures or dislocations among patients with decubitus ulcers

Fractures or dislocations	Number	Percent
Total	8, 093	100. 0
Hip fracture, right or left	5, 543	68. 5
Hip fracture, right and left	147	1. 8
Fracture or dislocation, not hip	2, 403	29. 7

Table 29.—Transfer status among patients with decubitus ulcers

Method of transfer	Number	Percent
Total	26, 498	100. 0
Transfer without any help	2, 036	7. 7
Transfer with help of device	388	1. 5
Transfer with aid of person	9, 651	36. 3
Is transferred	9, 322	35. 2
Transferred with device and person	2, 457	9. 3
Bedfast	2, 643	10. 0

Diagnoses of patients with decubitus ulcers.—Approximately 15 percent (3,931) of all patients with decubitus ulcers (26,765) were diagnosed as being diabetic. The presence of anemia was found in 6.3 percent (1,677) of patients with decubitus ulcers. Alcoholism and drug were rarely present among these patients. The data show alcoholism for 454 or 1.7 percent of 26,613 patients and drug abuse in 217 or 0.8 percent of 26,746 patients.

Decubitus ulcer sites.—It has been established that prolonged concentration of body weight on a small area of soft tissue over a bony prominence, e.g., the heel is the leading cause of decubitus ulcer formation. Table 30 gives the number and distribution of the various sites of decubitus ulcers among the patient population. It will be noted that the sacrum, hip, heel, and spine were the four most prevalent sites of decubitus ulcers. A larger proportion of patients having ulcers in these sites as compared to other parts of the body did not walk, transfer out of bed or use the wheelchair.

Treatment and care of decubitus ulcers.—Prevention of the decubitus ulcers is most important. Care is often difficult, painful for the patient and

Table 30.—Distribution, number and percent of decubitus ulcer sites among patients who do not walk, who are not transferred, and who are not wheeled

Various sites of decubitus ulcers	Various mobility/immobility attributes					
	Does not walk		Is not transferred		Is not wheeled	
	Number	Percent	Number	Percent	Number	Percent
All Sites	29, 726	100. 0	5, 080	100. 0	11, 737	100. 0
Sacrum coccyx	11, 008	37. 0	1, 210	23. 8	3, 714	31. 6
Shoulder blade	1, 366	4. 6	325	6. 3	433	3. 7
Elbow	780	2. 6	207	4. 1	301	2. 6
Heel	3, 572	12. 0	544	10. 7	1, 364	11. 6
Foot (other heel)	2, 946	10. 0	593	11. 7	1, 364	11. 6
Knee	889	3. 0	184	3. 6	1, 008	8. 6
Hip	5, 808	19. 5	1, 457	28. 7	215	1. 8
Spine (upper)	859	2. 9	184	3. 6	2, 871	24. 5
Ribs (chest)	479	1. 6	0	0	252	2. 2
Other	2, 019	6. 8	376	7. 4	215	1. 8

challenges the skill of the medical and nursing staff. Decubitus ulcers can present complications that require additional nursing care to prevent further ulceration and damage to the skin and underlying tissue. One sign of progressing deterioration of ulcers is the presence of exudate—serous fluid or pus. Table 31 shows the number of patients that had exudative ulcers and the frequency of treatment given to these patients. For 56.4 percent of patients with draining ulcers, treatment was given twice a day or more often.

The data of decubitus ulcers present a classic picture of one aspect of nursing care in the skilled nursing facility. It emphasizes the particular attention that the long-term patient demands. Patients must be examined frequently and observed for any abnormal signs or changes in their physical status and functioning. The techniques of care embrace all of the nursing judgment and skill required for the short-term patient. In addition, it must incorporate a fuller measure of prevention, health maintenance, and restorative care in terms of particular disease states, disabilities, and functional status, and patient care needs.

IMPAIRMENTS IN SENSORY PERCEPTION

Characteristically, long-term care patients have many impairments. Those impairments related to sensory perception may be: congenital, associated with developmental disabilities, the sequelae of disease or accidents, or constitute deterioration in function due to the aging process. The sensory perception of the patients in the skilled nursing facilities was assessed by descriptors without reference to their etiology. The descriptors constitute a scale of severity of impairment without judgment about the contribution of the impairment to the overall disability of the patient.

Sight.—Sight is the act, faculty, or process of perceiving objects through the eye. For the purpose of classification of patients, impairments in sight range from "no impairment" to being "legally blind." The majority of skilled nursing facility patients (70.4 percent of 200,005) were assessed as having sight impairment. Of these 2.6 percent (7,441) were legally blind; 50.7 percent (149,682) wore corrective lenses/glasses; and 15.1 percent (42,882) were not users of eyeglasses. (See table 32.)

Hearing.—Hearing is the act, faculty, or process of perceiving sound through the ear. For the purpose of classification of patients, impairment ranges from "no impairment" to "does not hear." Hearing was assessed in terms of the patient's response to normally audible and shouting voice sound waves. To understand the findings, it should be explained that for the aging, hearing changes include a gradual loss of high frequency sounds and distortion of environmental sounds, for example traffic in the street or dripping faucets. Loss of high frequency sound impairs speech discrimination. Shouting which is a high frequency sound is distorted. The person with a high frequency loss needs to be addressed clearly and slowly in a lower pitched voice, rather than by shouting. Hearing aids which amplify sound do not help the person with high frequency sound loss.

No impairment in hearing was found for 67.1 percent of patients (190,407). At the other extreme, a relatively small number of patients did not hear, 1.2 percent or 3,364 patients. The largest number of patients with impairments responded to a loud voice, not shouting. These 60,286 patients were 21.2 percent of total patients in the survey and 64.5 percent of those with hearing impairments. Very few patients identified as having hearing losses wore hearing aids, 4.6 percent of 12,907 patients. (See table 33.)

Speech.—Numerous defects and disorders produce speech that is indistinct, unpleasant or not understandable. Among the defects are articulatory defects, stuttering, voice problems, conditions associated with impaired hearing, organic disorders and retarded speech development. For the purpose of classifying patients, speech impairments ranged from "no impairment" to "does not speak." Some terms used in the classification are defined for clarification. Aphasia is a defect or loss of the power of expression by speech. Dysarthric means imperfect articulation in speech.

Each of the speech impairments, stuttering, dysarthria, aphasia, jargon, and no speech were identified with no single defect occurring in more than 8.8 percent of patients. Normal speech was most frequent for 68 percent of patients. (See table 34.)

Among the patients surveyed, visual impairments occurred with greatest frequency or 70.4 percent followed by hearing and speech impairments which were of almost equal frequency, hearing in 32.9 percent of patients and speech in 32 percent.

Table 31.—Number and percent of patients with exudative ulcers and the frequency of treatment of the ulcers

Frequency of treatment	Patients	
	Number	Percent
Total	8,061	100.0
Once a day or less	2,764	34.4
Twice a day	3,083	38.2
More than twice a day	1,470	18.2
None	744	9.2

Table 32.—Classification of patients according to visual perception

Visual state(s)	Patients	
	Number	Percent
All	283,912	100.0
No impairment	83,907	29.6
Impairment one eye (with glasses)	3,787	1.3
Impairment both eyes (with glasses)	145,895	51.4
Impairment one eye (no glasses)	3,010	1.1
Impairment both eyes (no glasses)	39,872	14.0
Legally blind	7,441	2.6

Table 33.—Classification of patients according to hearing acuity

Hearing state(s)	Patients	
	Number	Percent
All	283,913	100.0
No impairment	190,407	67.1
Impairment one or both ears	89,212	31.4
(a) Hears loud voice no shouting	(60,286)	(21.2)
(b) Hears normal and loud voice with hearing aid	(9,543)	(3.4)
(c) Hears only shouting no hearing aid	(16,019)	(5.6)
(d) Hears only shouting with hearing aid	(3,364)	(1.2)
Does not hear	4,294	1.5

Table 34.—Classification of patients according to speaking ability

Speaking state(s)	Patients	
	Number	Percent
All	283,913	100.0
Normal speech	192,957	68.0
Stuttering (not dysarthria)	7,423	2.6
Dysarthria (with intelligible speech)	25,002	8.8
Aphasic (conveys thoughts)	9,485	3.3
Speaks (makes no sense)	24,317	8.6
Does not speak	24,729	8.7

PATIENT DIAGNOSES

Diagnosis is a common basis for defining patients' needs for care and in organizing patient care services. In long-term care, diagnosis alone is not meaningful. The patient's functional status and limitations must be related to his clinical status. The chronically ill present great variability in stages and severity of illness. In addition, the aged characteristically have more than one chronic condition, disease, or disability. Patient care requirements must be measured in terms of the aggregate of physical, functional, and psychosocial needs at given points in time.

The physician traditionally refers to the needs of patients in terms of diagnostic categories. The diagnoses of the patients in the survey are presented below. They illustrate the multivaried medical conditions that must be considered in planning long-term care. Further correlations between patients' functional status and diagnoses could expand on definitive care requirements.

The review of records both on admission and subsequent to admission made possible identification of the traditional medical descriptors of patients:

1. The primary diagnoses judged to be the reason for admission to the facility (table 35).
2. The aggregate of diagnoses identified on admission to the facility (table 36).
3. The diagnoses identified subsequent to admission (table 37).

In these three tables there are significant differences demonstrated in comparison of age groups (i.e., those under 65 and those 65 and over) and of admission and postadmission diagnoses.

In table 35 it is clear that the primary diagnoses for nearly two-thirds of those under 65 years of age is pathology of the nervous system, i.e., neurological disease, mental retardation, neuroses and psychoses, stroke, and chronic brain disease. On the other hand, for the same proportion of patients over the age of 65, the diagnoses judged to be the primary reason for institutionalization are heart disease, chronic brain disease (including senility), stroke, fractures and generalized arteriosclerosis and hyptertension. As would be expected, those under 65 enter the nursing home for developmental disabilities and their sequelae; those 65 and over for the disorders and accidents common to the aging process.

Table 36 provides a broader perspective of the diagnostic profile of patients admitted to nursing homes since it shows all diagnoses recorded on admission. Again, an age differential is clearly evident. Of those under 65, two out of five have an

Table 35.—Primary diagnoses recorded on admission by diagnostic group and by age

Diagnoses	All ages		Under 65		65 and over	
	Number	Percent	Number	Percent	Number	Percent
Total	283,300	100.0	50,400	100.0	232,900	100.0
Heart disease	44,300	15.6	2,500	5.0	41,900	18.0
Chronic brain disease	39,200	13.8	3,700	7.3	35,500	15.2
Stroke	30,300	10.7	3,900	7.7	26,400	11.3
Fractures	24,800	8.8	1,700	3.4	23,100	9.9
Neurological disease	19,000	6.7	9,600	19.0	9,500	4.1
Generalized arteriosclerosis and hypertension	17,300	6.1	1,300	2.6	16,000	6.9
Neuroses and psychoses	15,200	5.4	5,700	11.3	9,500	4.1
Diabetes	14,300	5.0	1,700	3.4	12,600	5.4
Diseases of musculoskeletal system	13,400	4.7	2,000	4.0	11,300	4.9
Mental retardation	9,300	3.3	9,000	17.9	400	.2
Neoplasms	8,400	3.0	1,800	3.6	6,600	2.8
Diseases of respiratory system	6,600	2.3	800	1.6	5,700	2.4
Diseases of digestive system	6,500	2.3	600	1.1	6,000	2.6
Diseases of genito-urinary system	3,700	1.3	500	1.0	3,200	1.3
Diseases of eye and ear	3,300	1.2	600	1.1	2,700	1.2
Other	27,700	9.8	5,000	10.0	22,700	9.7

Table 36.—All diagnoses recorded on admission by diagnostic group and by age

Diagnoses	All ages		Under 65		65 and over	
	Number	Percent[1]	Number	Percent[2]	Number	Percent[3]
Heart disease	108,200	38.1	7,800	15.2	100,400	43 1
Chronic brain disease	83,000	29.2	6,900	13.5	76,100	32.7
Generalized arteriosclerosis and hypertension	64,800	22.8	6,800	13.3	57,900	24.9
Diseases of musculoskeletal system	55,800	19.7	6,100	11.9	49,700	21.4
Stroke	51,300	18.1	6,900	13.5	44,400	19.1
Fractures	46,200	16.3	4,400	8.6	41,800	18.0
Neurological disease	43,800	15.4	21,500	42.0	22,300	9.6
Diabetes	40,700	14.3	6,100	11.9	34,600	14.9
Neuroses and psychoses	34,100	12.0	10,500	20.5	23,600	10.1
Diseases of digestive system	30,700	10.8	4,000	7.8	26,700	11.5
Diseases of genito-urinary system	29,600	10.3	5,500	10.7	24,100	10.4
Diseases of eye and ear	28,400	10.0	5,900	11.5	22,500	9.7
Diseases of respiratory system	21,400	7.5	3,400	6.6	18,000	7.7
Neoplasms	15,800	5.6	3,300	6.4	12,500	5.4
Mental retardation	14,900	5.2	13,700	26.8	1,200	(4)
Other [5]	52,700	18.6	11,600	22.7	41,100	17.7

[1] Percentages are based on a total of 283,900 patients.
[2] Percentages are based on a total of 51,200 patients.
[3] Percentages are based on a total of 232,700 patients.
[4] Less than 0.1 percent.
[5] Includes major surgery, endocrine disease (other than diabetes mellitus), anemias, nutritional disease, and decubitus ulcers and other skin disorders.

Note.—Percentages add up to more than 100 because of multiple diagnoses recorded on admission for same patients.

identified neurological disease, one in four is mentally retarded, and one in five has a neurosis or psychosis. For those 65 and over, over two in five have heart disease; nearly one in three have chronic brain disease; one in four have generalized arteriosclerosis or hypertension; and one in five have stroke or a disease of musculoskeletal system, i.e., arthritis.

Finally, the diseases or disorders diagnosed following admission also demonstrate differing patterns for the two age groups. See table 37. For those under 65, nearly two out of five of the diagnoses recorded are diseases of the respiratory, gastrointestinal, or genito-urinary systems or decubitus ulcers, in other words, mainly infectious diseases or disorders generally related to institutionalization and prolonged bed rest. For those over 65, of the diagnoses recorded subsequent to admission, one in three was for these conditions. Fractures occurred slightly more frequently in the

65 and over (7.3 percent) than in those under 65 (5.2 percent). Postadmission diagnoses of diseases that are more related to the aging process than to institutionalization occurred more frequently in the 65 and over. One in four diagnoses in this age group was for diseases of the eye and ear, musculoskeletal or cardiovascular systems. In those under 65, only one in six diagnoses was for these conditions.

These differing characteristics are summarized in table 38, which shows the comparative rank order of both primary and all diagnoses made on admission and of diagnoses made postadmission for these two age groups.

In summary, the following were the significant findings relating to medical needs for care and services as indicated by diagnoses:

1. The primary diagnoses on admission for two out of three patients under 65 years of age were pathology of the nervous system, primarily developmental disabilities and their sequelae.
2. For two out of three patients 65 and over, the primary diagnoses were of cardiovascular and cerebrovascular disease, senility, and accidents.
3. For those under 65, the diagnoses recorded postadmission are those infectious diseases or disorders generally related to institutionalization and prolonged bed rest in two out of five cases. In those 65 and over, this proportion was one in three.

Table 37.—Most prevalent diagnostic groups (recorded postadmission) by age

Diagnoses	Age Group						
	All Ages		Cumulative Total (percent)	Under 65		65 and Over	
	Number [1]	Percent		Number [2]	Percent	Number [3]	Percent
Diseases of genito-urinary system	11,500	11.8	11.8	1,700	7.4	9,700	13.1
Decubitus ulcers and other skin conditions	9,500	9.8	21.6	2,600	11.3	6,900	9.3
Diseases of eye and ear	9,500	9.8	31.4	1,600	6.9	7,900	10.6
Diseases of musculoskeletal system	7,200	7.4	38.8	900	3.9	6,300	8.5
Diseases of respiratory system	7,100	7.3	46.1	2,700	11.7	4,300	5.8
Heart disease	7,100	7.3	53.4	1,100	4.8	6,000	8.1
Fractures	6,700	6.9	60.3	1,200	5.2	5,400	7.3
Diseases of digestive system	6,600	6.8	67.1	2,000	8.7	4,600	6.2

[1] Total postadmission diagnoses equals 97,400.
[2] Total postadmission diagnoses among the under 65-age group equals 23,100.
[3] Total postadmission diagnoses among 65 and over age group equals 74,300.

Note—Not all patients had a postadmission diagnosis and there were multiple diagnoses for some patients.

Table 38.—Rank order of most common diagnostic groups by time of recording and age group

Rank order	Primary diagnoses on admission		All diagnoses on admission		All diagnoses postadmission	
	Under 65	65 and over	Under 65	65 and over	Under 65	65 and over
1	Neurological disease	Heart disease	Neurological disease	Heart disease	Diseases of respiratory system.	Diseases of genito-urinary system.
2	Mental retardation	Chronic brain disease	Mental retardation	Chronic brain disease	Decubitus ulcers and other skin diseases.	Diseases of eye and ear.
3	Neuroses and psychoses	Stroke	Neuroses and psychoses	General arteriosclerosis and hypertension.	Diseases of digestive system.	Decubitus ulcers and other skin diseases.
4	Stroke	Fractures	Heart disease	Diseases of musculoskeletal system.	Diseases of genito-urinary system.	Diseases of musculoskeletal system.
5	Chronic brain disease	General arteriosclerosis and hypertension.	Chronic brain disease	Stroke	Diseases of eye and ear.	Heart disease.
6	Heart disease	Diabetes	Stroke	Fractures	Fractures	Fractures.
7	Diseases of musculoskeletal system.	Diseases of musculoskeletal system.	General arteriosclerosis and hypertension.	Diabetes	Heart disease.	Diseases of digestive system.
8	Neoplasms	Neuroses and psychoses	Diseases of musculoskeletal system.	Diseases of digestive system.	Diseases of musculoskeletal system.	Diseases of respiratory system.
9	Diabetes	Neurological disease	Diabetes	Diseases of genito-urinary system.		
10	Fractures	Neoplasms	Diseases of eye and ear	Neuroses and psychoses.		

DENTITION

That good dental health is an essential component of good general health is by now a truism. What needs to be emphasized, however, is that while maintaining a sound dentition preserves the masticatory function and all that implies with respect to nutrition, it also adds immeasurably to one's appearance, ability to speak, and sense of well-being.

Despite this, the universality of dental disease and its generally nonfatal character tends to foster complacency concerning its prevention and treatment. Yet dental diseases are not self-healing; most are irreversible and become more severe without treatment. It is in this context that the dental health problems of the long-term patient must be weighed.

Survey methods.—There were no dentists on the survey teams nor were patients routinely examined to determine dental health status. Instead, team physicians attempted to determine whether patients selected in the survey had significant unmet dental health problems. This was done by review of medical records and by interviewing facility personnel. Additional information was obtained when the physicians saw and talked with the patients.

Notwithstanding the limitations of this procedure for determining the dental health status of the patients—particularly the lack of attention to soft tissue problems which are prevalent among adults and impact significantly with respect to treatment needs—it did provide a gross measure of tooth loss among the surveyed population. It also indicated the extent to which this loss had been compensated for by restorations and prosthetic appliances.

Findings.—Among the 210,411 patients represented in the report, only 8.1 percent had no missing teeth. (See table 39.) An additional 7 percent had some missing teeth, but a restoration compensated for the loss. Edentulousness with dentures accounted for an additional 46.8 percent of the patients. The remaining 38.1 percent of the patients required tooth replacements, including full dentures, but had none.

Though some prostheses had been provided for 53.8 percent of the patients, the extent to which these needed repair or replacement—a not uncommon service requirement—was not determined. Similarly, neither the extent to which patients with teeth required extractions because of dental caries or periodontal disease nor the need for oral hygiene services, a particularly common need among the ill and aged, was documented. Thus, these data undoubtedly underestimate the prevalence and severity of dental problems among the surveyed population and, therefore, any conclusions drawn from them with respect to dental service needs should take this into account.

Table 39.—Patients status of dentition

Dentition status	Patient	
	Number	Percent
Total	210,411	100.0
No teeth missing	16,958	8.1
Some missing	53,310	25.4
(a) Compensated	14,593	7.0
(b) Not compensated	38,717	18.4
Edentulous	140,143	66.5
(a) With plates	98,761	46.8
(b) Without plates	41,382	19.7

CHAPTER 6

The Patient Care Setting

The physical environment, administration, and fiscal management of all health care institutions including skilled nursing facilities (SNF) are the basic support for all services offered. The size of the facility, its configuration, administrative, and fiscal policies and how they are implemented determine the extent of services offered, the resources employed in rendering services, their quality, and the efficacy of services (*1*).

This section of the report will describe the health and safety environment of SNFs and management and fiscal practices based on data available at the time of survey.

ADMINISTRATIVE AND FISCAL MANAGEMENT

The major concern in evaluating the administrative management of SNFs in the survey was how well the management function was being performed. The issues are divided into discussion of: The governing body, the nursing home administrator, personnel management, and outside resources.

The Governing Body

Federal regulations require that every nursing home must have an identifiable authority having full legal and moral responsibility for all aspects of facility operations. This authority might be called the "governing body," "board of directors," "board of trustees," "owners," or other appropriate designation. The individual or group, regardless of the formal name, has responsibilities and duties with which it is charged and of which it cannot be relieved by delegation. The degree to which these responsibilities and duties are conscientiously fulfilled, have a direct relationship to the effectiveness of the facility's performance. Representing minimum standards and as a basis for comparison, the governing body must perform such duties as (*2*):

a. Adoption of bylaws, patient care policies, administrative policies and rules and regulations which govern and direct the operation of the facility. These policies and rules and regulations must be reviewed and revised as necessary;
b. appointment of a competent, licensed administrator with full responsibility for operating the nursing home in accordance with policies established by the board;
c. conducting meetings periodically and for specific purposes to take care of ongoing policy and operational matters of the nursing home. Governing body members must attend these meetings. Minutes of the meetings must be kept as they are legal records of decisions made. Such decisions must be transmitted to those having direct operational responsibility; and
d. provision of assurance that the nursing home is operated in compliance with applicable Federal, State, and local laws.

If a facility does not have an identifiable governing body or if the governing body does not function effectively, many of the activities carried out in the facility diminish, especially the quality of patient care. In 96.9 percent (6,389) of the facilities a governing body or a designated person functioning in the same capacity with full legal authority and responsibility for the operation of the facility was identified. Although most homes have a governing body, the frequency of meetings prescribed by the adopted bylaws was not complied with in 16 percent (1,057) of the facilities.

The minutes of the governing body should show actions taken in formally adopting bylaws and policies, including patient care policies, subsequent revisions made, action taken on recommendations made by various facility committees that require governing body consideration, and the appointment of the administrator. In 50.4 percent (3,320)

of the facilities, the recorded minutes of the governing body meetings were considered complete and/or adequate. The larger the home the greater the likelihood of finding the minutes complete. The difference between the small and large facility in having adequate minutes is 20 percent. In other facilities the minutes did not reflect the details of the matters discussed and did not provide adequate information on the decisions made. Frequently the content of the minutes reflected corporate financial matters to the exclusion of those matters directly affecting the quality of patient care.

Apparently in many nursing homes, either the governing body did not hold meetings in accordance with the frequency stated in its own bylaws or did not record the substance of such meetings. This inattention to its bylaws and to operational matters indicates that frequently, governing bodies do not fully meet their obligations and responsibilities. Additionally, the governing bodies of a large number of facilities, apparently did not understand the necessity for keeping minutes that were complete enough to reflect the details of matters discussed at meetings and decisions made.

Nursing Home Administrator

The administrator is fully responsible for the day-to-day operation of the nursing home and is accountable to the governing body alone. Appointed by the governing body, the administrator is delegated in writing the responsibility for operating the home in accordance with policies, rules, regulations, and operating procedures adopted by the governing body (*3*).

The governing body should appoint an administrator who is currently licensed by the State and qualified by education and experience to effectively manage the facility. The administrator is normally charged with defining the objectives of the facility and transmitting them to the professional staff and other employees so that they know what is expected of them. The administrator has responsibility for effectively coordinating staff efforts to assure the delivery of high quality patient care. Employment of an adequate number of qualified personnel by the facility and maintenance of appropriate personnel records for each employee are fundamental.

The administrator evaluates and implements recommendations from the facility's committees, and maintains liaison with the governing body, medical staff, and other professional and supervisory staff (*4*). A qualified alternate employee to serve as administrator should be designated in writing. The administrator usually establishes the overall atmosphere of the home. Interest in patients receiving quality care will also be reflected by the staff. The opposite will usually prevail if the administrator has other interests.

It was found in the survey that 29.2 percent (1,926) of the administrators had not been so designated in writing by the governing body. In 96.7 percent (6,372) of the facilities, however, there were administrators, whether designated in writing or not who were responsible for the overall management of the facility.

Administrative policies were in writing in 93.8 percent (6,179) of the facilities. In 19.5 percent (1,284) of these facilities, however, these policies had not been adopted by the governing body and in 29.1 percent (1,915) of facilities, the policies had not been implemented. Further, 19.5 percent (1,284) of the facilities failed to revise these policies to meet changing requirements.

Findings related to administrative policies indicated that similar conditions would exist relative to the adoption and implementation of rules and regulations for the health care of patients. This was found to be the case. In 93.2 percent (6,142) of the facilities, rules and regulations pertaining to the health care of patients were established, but in 19.7 percent (1,297) of the facilities, the administrator did not enforce these rules and regulations; and in 19.5 percent (1,287) of the facilities, there was no documentation that the governing body had adopted the rules and regulations for the health care of patients. In 95.1 percent (6,267) of the facilities, patient care policies are in writing but in 22.3 percent (1,471) of the facilities policies have not been adopted by the governing body and in 39.3 percent (2,593) of the facilities, the policies have not been implemented. (Tables 40, 41, and 42.)

In many facilities, when the administrator is absent, it appears there may be uncertainty as to who has the authority to act in that capacity. It was found that in 34.5 percent (2,274) of the facilities the administrator had not designated such a person in writing. In order to maintain continuity of management of the facility during the absence of the appointed administrator, another qualified employee should be authorized to assume the duties of the administrator. The appointment should be in writing to ensure that the authority of the administrator has been properly delegated to a specific person.

Table 40.—Number and percent of SNFs which have adopted rules and regulations pertaining to the health care of patients

Bed size	Facilities	Total	Health care rules and regulations	
			Yes	No
Total	Number	6,591	6,142	449
	Percent	100.0	93.2	6.8
1 to 49	Number	1,242	1,167	75
	Percent	100.0	94.0	6.0
50 to 99	Number	2,682	2,453	228
	Percent	100.0	91.5	8.5
100 and over	Number	2,668	2,522	146
	Percent	100.0	94.5	5.5

Table 41.—Number and percent of SNFs in which the administrator enforces rules and regulations pertaining to the level of health care provided

Bed size	Facilities	Total	Enforced health care rules and regulations	
			Yes	No
Total	Number	6,591	5,294	1,297
	Percent	100.0	80.3	19.7
1 to 49	Number	1,245	988	257
	Percent	100.0	79.4	20.6
50 to 99	Number	2,689	2,161	528
	Percent	100.0	80.3	19.7
100 and over	Number	2,657	2,145	512
	Percent	100.0	80.7	19.3

Table 42.—Number and percent of SNFs in which the governing body has adopted rules and regulations for the general operation of the facility

Bed size	Facilities	Total	Rules and regulations	
			Yes	No
Total	Number	6,591	5,303	1,287
	Percent	100.0	80.5	19.5
1 to 49	Number	1,239	1,127	111
	Percent	100.0	91.0	9.0
50 to 99	Number	2,675	1,968	707
	Percent	100.0	73.6	26.4
100 and over	Number	2,677	2,208	470
	Percent	100.0	82.5	17.5

Patient Care Policies

In order to meet all needs of the patients, the patient care policies of the facility should be developed with the advice of representatives of all health care disciplines. In at least 98 percent of facilities with written patient care policies, nurses and physicians participated in their development. This same high degree of participation by other health professionals, however, was not found. For instance, participation by pharmacists occurred in 64.1 percent (4,226); by dietitians in 54.9 percent (3,617); and by a physical or occupational therapist in 43 percent (2,836) of the facilities.

Of major importance are the services included in a facility's patient care policies. Nearly all facilities have policies covering admission of patients and nursing services. A number of facilities did not have policies in the following areas: Dental services, 917 facilities or 13.9 percent; restorative services, 898 facilities or 13.6 percent; categories of patients accepted, 1,007 facilities or 15.3 percent; categories of patients not accepted, 1,290 facilities or 19.6 percent; and for social services, 1,077 facilities or 16.3 percent. It is apparent that most facilities have patient care policies, administrative policies, and rules and regulations pertaining to the health care of patients. A disturbing aspect of the findings, however, is the tendency towards "paper compliance" as evidenced by the high percentage of facilities in which the governing body did not adopt their own policies and rules and regulations, or if adopted, policies were not fully implemented by the administrator.

The facility establishes committees as necessary to develop policies and procedures dealing with utilization review, pharmaceutical services, patient care, infection control and other services of areas deemed appropriate. Committees meet on a regular basis to review, discuss, and revise policies as necessary. Minutes of meetings are recorded and contain recommendations which are submitted to the administrator for appropriate action (*5*).

Action to implement recommendations of facility committees is important in order for the facility to maintain the delivery of high quality care. It is the duty and responsibility of the administrator to consider and act on recommendations submitted by committees. He must, of course, refer to the governing body for consideration, those recommendations requiring major policy decisions. It appears that administrators in many facilities do not re-

spond to the recommendations of the facility's committees. Recommendations of the utilization review committee were not acted upon by the administrator in 18.7 percent (1,229) of the facilities. The pharmaceutical committee recommendations were not acted upon in 42.2 percent (2,782) of facilities, the patient care policy committee recommendations in 27.1 percent (1,787) of facilities, and the infection control committee recommendations in 44.3 percent (2,922) of the facilities.

Personnel Management

Nursing home management has the responsibility for providing the best possible care to all patients and to employ a staff trained and qualified to perform their duties. (*6*). Clearly, the quality of health care in a facility can be no better than the quality of personnel the facility employs (*7*).

The process for employment of qualified personnel begins with the application. This important tool should provide basic information about the background, skills, education, license or registration number, working experience, and other related essential information (*8*). The facility should verify the information contained in the application form and, above all, the license or registration number of the prospective employee to be sure it is valid and current (*9*). Additionally, verification of required licenses of current employees must be made at time of each renewal.

A preemployment health examination for prospective employees is necessary to determine if they are of sufficient good health to discharge their duties, are free from communicable diseases, and are physically and mentally fit for the position. A personnel record should be maintained for each employee. These records deserve careful attention as they should contain the application, references, performance evaluations, status of health, position employed in, insurance, salary, inservice education, and similar information which provides a profile of the individual (*10*).

In order to maintain an adequate staff to meet the needs of the facility, the administrator must anticipate the staffing needs. The factors to be considered include the diversity of tasks to be performed, the need for replacements due to turnover, the requirements for certain levels and kind of staff performance, the services offered to patients, the various types of specific functions performed by the facility, the number of patients in the facility, and the requirements of State licensing regulations and Federal qualifications standards (*11*).

The survey found that nearly all facilities maintain a personnel record for each of its employees. The content of the record did not, however, provide evidence that management was as selective as it should have been as to whom they hired, especially in respect to the employees' health and qualifications. While 96.2 percent (6,341) of the facilities required an application for employment, 35.3 percent (2,324) did not maintain evidence of a preemployment health examination; 26.2 percent (1,724) did not provide a position description; 32.2 percent (2,123) did not have a current health record; and 23.5 percent (1,548) did not include the employees' current license or registration number in their personnel record. Omission of these important items and data from employee personnel records raises a major question as to the administrators' real concern for employing staff having appropriate qualifications and providing high quality service.

As for professional personnel requiring a license, it was found that one-sixth of the facilities did not verify the license or registration number of the applicant at the time of employment, and one of five facilities did not recheck annually, or biannually, as appropriate, to verify the current status of the license. In both instances, the smaller facilities had the highest percentage of negative responses. (Tables 43 and 44.)

The administrator should take an active part in the development of the staff through well planned and constructed inservice educational activities directly related to the work performed by the staff in performing their duties (*12*).

Nearly one-fifth (1,313) of the facilities did not conduct an ongoing staff development program. As for subject matter, 21.9 percent (1,379) of the facilities did not provide an orientation program; skills training was not carried on in 22 percent (1,452) of the facilities; staff was not provided an opportunity to participate in an ongoing education program in 37.1 percent (2,445) of the facilities; and of major importance, the supervisory staff was not provided with leadership/supervisory training in nearly two-thirds (4,015) of the facilities.

Not only were specific types of inservice educational programs often absent, 20.2 percent (1,334) of the facilities did not maintain staff development records containing the names of attendees and the subject matter covered. Also, there was

Table 43.—Number and percent of SNFs that verify the licensure and registration of staff at time of employment by bed size

Bed size	Facilities	Total	Verify licensure and registration	
			Yes	No
Total	Number	6,591	5,492	1,098
	Percent	100.0	83.3	16.7
1 to 49	Number	1,245	952	293
	Percent	100.0	76.4	23.6
50 to 99	Number	2,689	2,197	492
	Percent	100.0	81.7	18.3
100 and over	Number	2,657	2,344	313
	Percent	100.0	88.2	11.8

Table 44.—Number and percent of SNFs that annually verify current status of licensure or registration of staff by bed size

Bed size	Facilities	Total	Verify licensure or registration	
			Yes	No
Total	Number	6,591	5,288	1,303
	Percent	100.0	80.2	19.8
1 to 49	Number	1,242	837	405
	Percent	100.0	67.4	32.6
50 to 99	Number	2,683	2,192	491
	Percent	100.0	81.7	18.3
100 and over	Number	2,666	2,259	407
	Percent	100.0	84.7	15.3

no evidence in over one-fourth of the facilities to indicate that the staff applied what was learned (table 45).

Use of Outside Resources for Consultative Services

If the facility does not employ a qualified person(s) to render a specific required or offered service, the facility must contract with an outside resource, a person or agency that renders direct service to patients, or acts as a consultant. The services most frequently furnished in this manner are physical, occupational, and speech therapies; consultation for dietary, social, and pharmaceutical services and medical records administration.

Data indicate that there was a wide variation in homes having written agreements with outside resources to provide services not otherwise available in the facility. In almost all cases, the larger the facility the more likelihood there was of finding such an agreement (table 46).

Once an agreement is negotiated, there must be evidence that the services of the consultant are provided. When acting as a consultant, the outside resource must furnish regular reports to the

Table 45.—Number and percent of SNFs in which there is evidence that staff utilizes training

Facilities	Total	Utilize training	
		Yes	No
Number	6,591	4,856	1,735
Percent	100.0	73.7	26.3

Table 46.—Percentage of SNFs having agreements with outside resources for services by size of facility

Services	All	Bed size		
		1–49	50–99	100 and over
Physical therapy	51.0	29.3	52.8	59.4
Speech therapy	32.9	14.6	33.7	40.7
Occupational therapy	22.7	11.8	20.6	30.0
Pharmacy	79.1	57.8	85.5	82.4
Dietary	68.9	53.0	68.6	76.8
Social service	38.9	21.3	37.4	48.4
Medical records	63.4	38.0	67.3	71.4
Other	61.7	48.3	60.9	68.6

administrator containing recommendations, plans for their implementation and continuing assessment of the services provided. These reports are used by the administrator to followup on recommendations made and to evaluate the performance of the services for which consultation was provided. It is through these reports, as well as other contacts, that communication between the consultant and administrator is maintained and services improved.

Review of consultants' activities indicates that such reports are either not made or are incomplete. The data indicate that in 42.5 percent (2,802) of the facilities, the reports do not apprise the administrator of a continuing assessment of the services provided. In 38.4 percent (2,534) of the facilities, the reports do not include recommendations of the consultants, and in 45.4 percent (2,994) of the facilities, these reports do not contain plans for implementing recommendations if any were made (tables 47, 48, and 49).

Table 47.—Number and percent of SNFs in which the consultant apprises the administrator through written reports of continuing assessment of the service provided

Facilities	Total	Reports of services provided	
		Yes	No
Number	6,591	3,789	2,802
Percent	100.0	57.5	42.5

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Table 48.—Number and percent of SNFs in which the consultant apprises the administrator through written reports of his recommendations

Facilities	Total	Reports of recommendations	
		Yes	No
Number	6,591	4,057	2,534
Percent	100.0	61.6	38.4

Table 49.—Number and percent of SNFs in which the consultant apprises the administrator through written reports of plans for implementation of his recommendations

Facility	Total	Reports of plans for recommendations	
		Yes	No
Number	6,591	3,597	2,994
Percent	100.0	54.6	45.4

Summary of Findings*

- The governing body frequently does not discharge its obligations in a consistently effective manner.
- The administrator's overall direction for the operation of the facility is not always consonant with his professional status and responsibilities.
- Policies of the facility are in most instances documented but often not implemented.
- Patient care policies often lack input from health care professionals other than physicians and nurses.
- Personnel management practices do not appear to contribute to personnel resources that enhance the quality of patient care rendered.
- Management does not consistently provide the opportunity for or encourage staff to develop new skills and update existing ones.
- Outside resources are often not utilized, and when they are, management frequently fails to act upon their findings and recommendations.

Conclusions and Implications

1. There is considerable evidence that the governing bodies of a large number of facilities do not properly carry out their duties and responsibilities in an effective manner, thus inhibiting the delivery of high quality care. The education, backgrounds, interests, and motives of members of governing bodies of nursing facilities are varied and it is quite possible that many are not fully aware of their responsibilities. Clearly, these individuals need direction in how they can best perform their duties and responsibilities more effectively and ensure that the nursing home they operate will provide care of high quality.

Additionally, it would be helpful to develop and issue concrete examples, applicable to each type of facility sponsorship, of the kinds of matters properly requiring governing body action, as well as model minutes and mechanism and procedures for transmitting their decisions to the administrator and staff of the facility. This could be similar to the kinds of assistance, such as seminars and manuals, provided by and through the American Hospital Association to hospital trustees.

2. The nursing home administrator is not consistently "managing" to contribute to care of high quality. Patients in these facilities are probably not receiving the quality of services to which they are entitled.

3. As indicated, a large number of facilities do not have written agreements with outside resources for the provision of health care services and consultation. The data do not indicate the proportion of these facilities which in fact furnished needed health services to their patients and obtained consultation despite the absence of agreements. The failure of the facility, however, to formalize the responsibilities of those practitioners and consultants by written agreements leads to a lack of clarity in defining their role and responsibility in providing services. Furthermore, because of uncertainty, the full scope of services required by many patients may not be provided. Ultimately, the lack of written agreements adversely affects facility performance and the quality of care provided and facilities should be consistent in obtaining agreements with outside resources.

4. There are clear implications that State nursing home licensure programs are licensing individuals who are ineffective administrators. A review of nursing home administrator licensure procedures should be explored to determine what statutory or regulatory changes are needed to ensure that only fully qualified and capable individuals are licensed as nursing home administrators. Further, consideration should be given to require the suspension or revocation of the license of an administrator whose facility is found to have a pattern of serious deficiencies in successive certification surveys.

* Federal regulations are used as a minimum standard and as a basis for comparison.

FISCAL MANAGEMENT

The goals of the financial information aspect of the survey were: (1) To obtain data upon which to base national estimates of the cost of care in a skilled nursing facility (SNF) certified under the Medicare program, the Medicaid program, or both; (2) to test the applicability of this survey method for setting up a monthly cost-of-care index on a national and regional basis; and (3) to explore the possibility of identifying relationships between the cost data reported and data reported on facilities, administrators, and patient characteristics.

Unfortunately, the cost data obtained were not of the caliber sufficient to allow these goals to be fulfilled. The fact that survey visits were unannounced aided the objectivity of the data collected for the other assessment measures, but the unavailability of the cost data at the time of the visit led to sizable nonresponses for many financial information survey items. The cost data were often not on hand in the facility but retained in an accountant's office or in the corporate headquarters of a nursing home chain. Because the Office of Nursing Home Affairs promised the SNFs that their identity would be held in strict confidence, it was not possible to follow up on the nonresponses.

Another problem was the use of many different accounting systems. Under these circumstances, the surveyors assessing cost factors were instructed to record data from Medicare on State Medicaid Cost Reports whenever possible and to use the facility's financial statements only when the program cost reports were not available.

Although data analyses could not be made as anticipated, inferences and implications can be drawn from the very fact that obtaining financial information was so difficult:

1. The unannounced survey method is inappropriate for obtaining cost data as data were not readily available and the confidentiality requirement precluded following up on nonresponsive financial information data sources.
2. Efforts should be made toward achieving a national uniform system of accounts for nursing homes. Nursing home accounting systems do not appear to be able to maintain monthly statements because of accruals. There appears to be a need for a continuing panel to assist in developing a uniform system.
3. Future surveys taking 1 and 2 into consideration should be conducted to obtain data for a cost-of-care index.
4. More research should be done on the relationship of the costs of nursing home care to the quality of services provided so that the differences between SNF care and ICF care can be determined.
5. Future surveys should be undertaken to estimate the cost of improving each facility so that it meets the standards of the Medicare and Medicaid programs for which it is certified.

Rigorous cost hypotheses concerning the type of control and ownership of nursing homes, the size, the major source of cost reimbursement and other factors that influence the financial variables need to be tested. Application here of the statistical method of regression analysis may be useful so that the researcher can examine the influence of each important factor on a dependent variable. Particular attention could be given to the influence on total expense per patient per day of: (1) Different proportions of Medicare and Medicaid patients (or beds) to total patients (or beds) in an institution; (2) the type of control of the skilled nursing facility; and (3) the payroll expenses, especially employee wages. For example, a regression analysis of the differences between private pay patients' charges and the Medicare or Medicaid patients' costs might be fruitful.

HEALTH AND SAFETY OF THE ENVIRONMENT

Both Congress and the Department recognize the need for providing a nursing home environment which adequately protects patients against health and fire hazards. The requirements mandated by Congress in the Medicare and Medicaid law are those contained in the institutional occupancy section of the 1967 Life Safety Code. The code is a publication of the National Fire Protection Association and its requirements are intended to provide a reasonable degree of safety against not only fire but also its by-products, i.e., smoke, heat, and toxic fumes.

The Life Safety Code requirements generally address the following areas: Fire and smoke containment, safe and orderly evacuation of patients, and limiting the potential fuel for fire. In all cases, these requirements must be met. However, what specific individual requirements a facility must meet to be in compliance with these general objectives are in great part determined by the facili-

ty's construction type. In other words, buildings that have a lesser resistance to fire will have more stringent requirements than those that have a greater resistance to fire. Therefore, it is essential that a building be evaluated as a whole rather than evaluating one requirement at a time. Additionally, the code recognizes that while the ideal is to be sought, it is more often than not unattainable. Accordingly, it provides for exemptions to code requirements where the State fire authority can document that correction of a deficiency would not enhance patient safety and would cause undue hardship on the provider. For example, the code requires that patient room doors be not less than 40 inches in width. If the doors in question are 35 inches in width the fire authority could waive the requirement.

In any event, the requirements must be considered together with the design features of a facility, including furniture arrangements, in order to make a decision as to whether or not a particular facility provides adequate protection against fire hazards. For this reason, it is not possible to judge whether a facility provides adequate safeguards against fire hazards solely on the basis of the number of requirements not met.

The recently revised Fire Safety Survey Report Form developed by the Federal Government and presently used by State surveyors to inspect long-term care facilities was selected as one of the Long-Term Care Facility Improvement Campaign instruments with minor modifications. The objective of this part of the survey was to ascertain the number and type of fire safety requirements that were met or not met. There was no investigation as to whether the State fire authority had excused the provider from meeting the requirement, nor whether the provider had plans to, or was in the process of meeting the requirements. Consequently, no conclusions are drawn concerning the number of facilities that are or are not in compliance with code requirements. The data obtained were analyzed to determine program implications.

The Fire Safety Survey Report Form consists of 61 requirements against which a facility is surveyed, not less than once annually, by the State fire authority. The analysis of the fire safety data when projected to the total number of long-term care facilities indicated that few facilities actually met all of the Life Safety Code requirements. Table 50A shows the breakdown for the 6,591 facilities (100 percent) that have 0 to 36 requirements that were not met. It is to be noted that a substantial majority of facilities 4,813 (73 percent) had fewer than 10 requirements that were not met. The distribution of deficiencies among these facilities (0–9 deficiencies) is shown in table 50B. It is to be noted that 293 facilities (6 percent) had no deficiencies with an additional 476 others or (9.9 percent) with but a single deficiency. There were certain requirements that were more frequently found to be "not met" than others. (See table 51.) Many of the requirements shown in table 51 can be met with little or no additional expense. Examples include: Illumination of exit signs, weekly testing of fire alarm systems, posting of smoking regulations, electrical monitoring of sprinkler control valves, and the posting of evacuation plans. These are indicated in table 52.

The data also revealed that there were eight construction types among the 6,591 facilities. The number by type in descending order of frequency is as follows:

Type	*Number*	*Percent*
All types	6, 591	100. 0
Fire resistive	1, 740	26. 4
Protected wood frame	1, 668	25. 3
Protected noncombustible	866	13. 1
Protected ordinary	634	9. 6
Ordinary	619	9. 4
Mixed types	568	8. 6
Wood frame	320	4. 9
Noncombustible	176	2. 7

Among the eight construction types, over one-fourth (26.4 percent) were of fire-resistive construction. This is the type of construction which is most resistive to fire and it does not require an automatic sprinkler system. Protected wood frame construction, on the other hand, is more susceptible to fire and the Life Safety Code requires that facilities of this type of construction have automatic sprinkler systems. The Life Safety Code contains definitions for the various construction types (*13*).

Table 50A.—Number and percent of skilled nursing facilities and range in number of deficiencies

Number of deficiencies	Number of facilities	Percent of facilities
Total, 0 to 36	6, 591	100. 0
0 to 9	4, 813	73. 0
10 to 19	1, 341	20. 3
20 to 29	388	5. 9
30 to 36	49	.8

Table 50B.—Number and percent of skilled nursing facilities in the deficiency range between 0–9

Deficiency range 0–9	Number of facilities	Percent of facilities
Total, 0–9	4, 813 [1]	100. 0
0	293	6. 1
1	476	9. 9
2	550	11. 4
3	411	8. 6
4	521	10. 8
5	631	13. 1
6	647	13. 5
7	628	13. 0
8	255	5. 3
9	399	8. 3

[1] The total 4,813 is correct for the 0–9 group of facilities. A difference of 2 (4,811 rather than 4,813) will be found when the subgroup totals are added together due to having the subgroup totals calculated separately.

Table 51.—Number and percent of skilled nursing facilities not meeting Life Safety Code requirements by order of magnitude

Survey code no.	Requirement	Facilities	
		Number	Percent
4–8	Proper illumination of exit signs	3, 433	52. 1
6–1	Weekly testing of fire alarm system	3, 210	48. 7
6–14	Adoption, implementation, and posting of smoking regulations	2, 454	37. 2
6–4	Fire protection of hazardous areas	2, 161	32. 8
5–10	Electrical monitoring of main sprinkler control valve	2, 058	31. 2
6–12	Flame retardant draperies and curtains	1, 940	29. 4
6–5	Maintenance of air conditioning and ventilating equipment	1, 925	29. 2
2–10	Doors to hazardous areas are not to be held open automatically	1, 759	26. 7
5–8	Maintenance, testing, and inspection of automatic sprinkler system	1, 663	25. 2
2–1	Compliance with construction requirement	1, 491	22. 6
5–7	Automatic sprinkler protection	1, 451	22. 0
2–2	Proper separation of corridor walls from sleeping rooms	1, 445	21. 9
5–9	Electrical interconnection of sprinkler system with fire alarm system	1, 402	21. 3
4–7	Proper notice on stairwell doors	1, 280	19. 4
6–9	Evacuation plan is posted in prominent locations	1, 275	19. 3
2–3	Proper door to patient rooms and treatment room	1, 264	19. 2
7–1	Nonflammable medical gas systems	1, 067	16. 2

Conclusions and Implications

In deciding whether or not an individual facility complies with the Life Safety Code requirements, State surveyors must exercise a great deal of professional judgment. The number, type, and the interrelation of deficiencies are considered. Thus a judgment must be made on a case-by-case basis.

Data obtained in the study indicate that:

1. State surveyors need to be better qualified to assess fire safety requirements that are not met;

Table 52.—Number and percent of skilled nursing facilities meeting Life Safety Code requirements by order of magnitude

Survey code No.	Requirement	Facilities	
		Number	Percent
4–5	Proper windows in patient rooms	6, 418	97. 4
4–6	Proper doors in fire and smoke partitions	6, 408	97. 2
4–2	Door width	6, 378	96. 8
4–1	Travel distance to exits	6, 362	96. 5
3–8	Horizontal exits	6, 360	96. 5
6–6	Absence of space heaters	6, 339	96. 2
3–1	Stairs and smokeproof towers meet required classification	6, 248	94. 8
3–10	Room egress	6, 201	94. 1
3–6	Accessibility to exits	6, 142	93. 2
5–4	Automatic emergency lighting	6, 104	92. 6
5–11	Manually operated fire alarm system	6, 096	92. 5
6–2	Portable fire extinguishers	6, 086	92. 3
6–8	Fire protection plan is in effect and available	6, 062	92. 0
6–3	Proper maintenance of fire extinguishers	6, 050	91. 8
3–7	Capacity of exits	6, 033	91. 5
4–3	Proper locks on patient room doors	5, 985	90. 8
3–9	Corridors are of required width	5, 841	88. 6
5–3	Proper emergency lighting	5, 836	88. 5
5–5	Interior finish of walls and ceilings meet required classification	5, 815	88. 2
6–13	Noncombustible wastebaskets	5, 801	88. 0
6–11	Furnishings and decorations do not obstruct exits	5, 747	87. 2
3–5	Proper number and type of exits	5, 552	84. 2
5–1	Proper illumination of exit and directional signs	5, 551	84. 2
6–10	Fire drills	5, 546	84. 1

2. Nursing home administrators need to be knowledgeable about fire safety requirements; and
3. The Office of Long Term Care Standards Enforcement in the DHEW regional offices need to increase regional validation surveys to assure that State fire authorities are accurately assessing Life Safety Code compliance.

References

1. U.S. Department of Health, Education, and Welfare. Public Health Service. *Nursing Homes Environmental Health Factors.* PHS Pub. No. 1009 (Washington, D.C.: U.S. Government Printing Office, February 1967), p. iii.
2. General Services Administration. Office of the Federal Register. *Code of Federal Regulations, Title 20, Employee's Benefits,* Chapter III Social Security Administration, Department of Health, Education, and Welfare 405.1120 Conditions of Participation Governing Body and Management, Washington, D.C.: U.S. Government Printing Office, Apr. 1, 1974, p. 521.
3. Springer, Eric W., *et al.* "The Administrator." *Nursing Home Law Manual.* (Pittsburgh: Aspen Systems Corporation, 1972), p. 12.
4. Ibid, pp. 1–22.
5. U.S. Department of Health, Education, and Welfare, Bureau of Quality Assurance, Interpretive Guidelines and Survey Procedures for the Application of the Conditions of Participation for Skilled Nursing Facilities. Nov. 6, 1974, pp. 86 and 100.

6. Mathieu, Robert P. *Hospital and Nursing Home Management.* (Philadelphia: W. B. Saunders Co., 1971), p. 5.
7. McQuillan, Florence L. *Fundamentals of Nursing Home Administration.* (Philadelphia: W. B. Saunders Co., 1974), p. 77.
8. U.S. Department of Health, Education, and Welfare, Bureau of Quality Assurance, op. cit., p. 4.
9. Rogers, Wesley, Wiley. *General Administration in the Nursing Home.* (Boston: Caliners Publishing Co., Inc., 1972), p. 20.
10. McQuillan, Florence L., op. cit., p. 70.
11. Rogers, op. cit., p. 17.
12. McQuillan, Florence L., op. cit., p. 70.
13. National Fire Protection Association. *Code for Safety to Life from Fire in Buildings and Structures.* NFPA No. 101–1967. Boston: National Fire Protection Association, 1967. 209 pp.

CHAPTER 7

Patient Care Services

For the long-term care patient, the goals of care are to manage disease states; correct, restore, or maintain biological functions; and support the psychosocial needs that arise as a consequence of chronic illness, the aging process or institutionalization. The components of care are monitoring and maintaining vital functions, curative care, rehabilitation, prevention, and guidance in psychosocial problems. The services through which care is provided strive to assist the patient to become maximally independent in functioning, in carrying out their own programs of required therapy and in attaining or maintaining their optimal level of health and well-being.

Providing patient care in terms of the individual's physical, functional and psychosocial needs requires an overall assessment of the patient's condition and the needs for care and the development of a patient care plan by the total professional staff specifying the services to be given and the goals to be accomplished. Evaluating the results of care and the patient's response is equally as important for obtaining indications of the adequacy of care given and additional requirements. In the survey, services provided in skilled nursing facilities to the beneficiaries of the Medicare and Medicaid programs were examined as they related to the service requirements of these patients.

The survey did not include an inventory of numbers and kinds of personnel employed by the skilled nursing facilities. Some data and information are included relative to staffing patterns for specialized services and arrangements for consultative and supervisory services. The 1973–74 Nursing Home Survey conducted by the National Center for Health Statistics contains data on the number and type of full-time equivalent employees providing care (*1*). Nursing staff are categorized by level of education and training and other personnel are classified by professional and nonprofessional status.

The discussion of each service generally includes a description of measurement criteria, discussion of findings in the specific area of inquiry, conclusions reached, and implications of the findings. Priorities for action are detailed in the introductory chapter on summary findings, implications, and recommendations.

PHYSICIAN SERVICES

The medical care and management of the long-term care patient presents a particular challenge to the physician. The pathology and symptomatology presented by the chronically ill and aged and their unique response to prescribed treatment demand keen discernment and an individualized medical care plan. Perhaps no other group requires a higher level of performance of the art and application of the science of medicine.

Traditionally, nursing homes have not had a full-time house staff and daily medical supervision by the private attending physicians is often absent. The attending physician has primary professional and legal responsibility for the medical assessment and management of his patients in skilled nursing facilities. This includes establishing a diagnosis, prescribing treatments, diet, medications, and rehabilitative therapies and providing supervision and followup of those patients under his care.

It was recognized from the beginning that the data gathered about physician care, although allowing significant statements about the type and timing of health care delivery, would not be sufficient to evaluate the "quality" of physician services in the settings surveyed. It is quite difficult to assess the quality of medical care that patients are receiving on the basis of a questionnaire survey. This problem resides in the nature of the medical care process. A patient may have a diagnosis, a

record that shows a physician visits at least every month, a review of this care every 30 days, etc., and still receive poor quality medical care. Whether this is due to an erroneous diagnosis or an overlooked problem, or signing patients' records 6 months in advance needs further study. Thus, an assessment of the quality of care delivered is related to the state of the art of evaluating quality of care, the nature of the survey, and information provided. Reliance only on a patient's records provides only a partial picture of the patient's condition and services provided.

While other team members were usually able to discuss their specialty areas with the appropriate facility representative, physicians or medical directors were seldom available to team physicians. Therefore, team physicians relied on the following: (1) The facility's written policies and procedures; (2) the medical records of the selected patients; and (3) interviews with pertinent persons from the facility staff. The medical record perusal was limited to the current chart, except where review of old records was necessary to determine admission information for long-stay patients. Selected patients were seen or examined as deemed necessary. Many items such as discharge summaries, supplemental information on admission, progress notes, or records of histories taken and physical examinations done were not in the record at all, or if recorded, were inadequate, late, incomplete, or unsigned by the physician. The patient who had been in the nursing home for years was apt only to have very recent records, and initial old records were not available for review.

Admission Data

Information on medical findings, diagnoses, functional status, and response to previous treatment and care, as well as orders to initiate care are essential for appropriate immediate care of patients following admission. Efforts were made by the physicians on the survey teams to determine the availability of such information supplied by the attending physician on patients admitted from the community. Discharge summaries and orders received from transferring facilities were also sought by team physicians.

Comparison of patients in terms of the transfer location reveals some interesting differences. For example, a discharge summary was received from the transferring institution in nearly 75 percent of the cases; and in nearly 90 percent of these cases, this discharge summary was received in advance of, or at the time of, admission. In addition, for two-thirds of the patients where the discharge summary was not received or was judged by the surveyor to be inadequate, additional information had been received within 48 hours of admission. One in seven patients had no discharge summary, or additional information; or it was impossible to determine that basic information had been submitted to the nursing home in time to allow for appropriate immediate care following admission. Notations by the survey physicians indicated that in many instances the information was supplied later than 48 hours as required by regulations and a few days to a few weeks elapsed before the admitting nursing home had information as to medical findings, diagnoses, or immediate orders for many patients.

On the other hand, in terms of patients transferred from the community, the physician examined 56 percent of them within 48 hours yet he provided medical findings for only 31 percent of the patients, diagnoses for 41 percent, and immediate orders for almost 42 percent. These percentages also reflect that in nearly 50 percent of the records, information of this nature was impossible to determine. Of greatest concern was the fact that many patients' charts on admission revealed no evidence that the patient had the benefit of a physician's examination or medical assessment. For those transferred from the community, 30.9 percent fell into this category. For those transferred from another institution, the percentage who had neither a discharge summary nor additional information provided within 48 hours of admission was about half of that, or 16.7 percent.

Continuing Care

Continuing physician care following admission was another concern of the survey physicians. As a minimum standard and basis of comparison, the Federal regulations require that the attending physician carry out a review of the patient's total program of care during a visit at least once every 30 days. After the first 90 days, for the patient requiring skilled nursing, not rehabilitation, an alternate schedule may be justified by the physician up to every 60 days. In the immediate 4 months preceding the survey, the attending physician had carried out visits every 30 days for nearly 4 out of 5 patients. Table 53 shows that the length of stay in the institution affects only slightly the proportion of patients whose physicians review and revise their plan of care except for the early months (up to 4 months) of institutionalization where a schedule of visits every 30 days is applied in 9 out of 10 patients. Three out of four longer-stay patients had their program of care reviewed by their physician every 30 days.

Table 54 shows a composite answer to the question of whether a physician visited the institution to review the care plan and at the same time ac-

Table 53.—Review of the total program of care by the attending physician during a visit at least every 30 days (in the 4 months immediately preceding survey) by length of stay

Length of stay	Program of care reviewed					
	Total		Yes		No	
	Number	Percent	Number	Percent	Number	Percent
Total	283,400	100.0	221,700	78.2	61,700	21.8
Less than 4 mo	45,600	100.0	41,200	90.4	4,400	9.6
4 to 12 mo	46,200	100.0	34,400	74.5	11,800	25.5
1 to 3 yr	74,400	100.0	58,600	78.8	15,800	21.2
More than 3 yr	61,500	100.0	45,000	73.2	16,500	26.8
Unspecified	55,700	100.0	42,500	76.3	13,200	23.7

Table 54.—Review of the total program of care by the attending physician during a visit at least every 30 days (in the 4 months immediately preceding survey) by length of stay and by whether the physician saw the patient at the time of each visit

Length of stay	Physician saw patient	Program of care reviewed					
		Total		Yes		No	
		Number	Percent	Number	Percent	Number	Percent
Grand total	Total	283,306	100.0	221,646	78.2	61,660	21.8
	Yes	259,126	91.5	212,863	75.1	46,263	16.4
	No	24,180	8.5	8,783	3.1	15,397	5.4
Less than 4 mo	Total	45,543	100.0	41,172	90.4	4,371	9.6
	Yes	42,856	94.1	40,397	88.7	2,459	5.4
	No	2,687	5.9	775	1.7	1,912	4.2
4 to 12 mo	Total	46,131	100.0	34,356	74.5	11,775	25.5
	Yes	43,350	94.0	33,394	72.4	9,956	21.6
	No	2,781	6.0	962	2.1	1,819	3.9
1 to 3 yr	Total	74,366	100.0	58,624	78.8	15,742	21.2
	Yes	69,485	93.4	56,510	76.0	12,975	17.4
	No	4,881	6.6	2,114	2.8	2,767	3.8
Over 3 yr	Total	61,525	100.0	44,998	73.1	16,527	26.9
	Yes	54,835	89.1	42,499	69.0	12,336	20.1
	No	6,690	10.9	2,499	4.1	4,191	6.8
Unspecified	Total	55,741	100.0	42,496	76.3	13,245	23.7
	Yes	48,600	87.2	40,063	71.9	8,537	15.3
	No	7,141	12.8	2,433	4.4	4,708	8.4

tually saw the patient. It also shows only a slight diminution of the percentage of patients actually seen by the physician as the length of stay increases from 94.1 percent for those in the institution less than 4 months, to 89.1 percent for those there over 3 years. A more definite trend downward from 88.7 percent to 69 percent can be seen as the length of stay increases when both questions are applied, i.e., review of the care plan and patient seen by physician. It also appears that after the first 4 months of institutionalization, the physician sees the patient but does not review the care plan in about one out of five cases, whereas the reverse of this, where the care plan is reviewed but the patient is not seen occurs in only 3 to 4 percent of cases depending on the length of stay. Again of greatest concern are the patients who have the advantage of neither of these physician services. This percentage is about the same for all patients about 4 percent except for those in the institution over 3 years where it is nearly 7 percent.

Summary of Findings

The following summary of findings presents the major indicators of the extent of physician involvement and medical care in skilled nursing facilities:

1. A discharge summary was received for three out of four patients admitted from an institution, of which two-thirds were received in advance of or at least at the time of admission.

2. For two out of three patients whose discharge summaries were not received or were inadequate, additional information was received by the institution within 48 hours after admission. Of the total, for one patient in seven, evidence of any discharge summary or additional information could not be found in the record.

3. In terms of patients transferred from out of institutional settings, over one-half were not examined by the attending physician within 48 hours of admission, only 3 in 10 had recorded medical findings, and 4 in 10 immediate physician's orders for care.

4. In the immediate 4 months preceding the survey, the records showed that attending physicians had made visits every 30 days to review the plan of care for four out of five patients. This proportion was higher—9 out of 10—for those in the facility less than 4 months, but remained fairly stable at three out of four for those institutionalized longer.

5. About 9 out of 10 patients were actually seen by their physician during a visit to the institution and in one in five cases, the physician saw the patient but did not review the care plan. In only 3 to 4 percent of patients, the physician reviewed the care plan but did not actually see the patient.

Conclusions and Implications

1. One needs to question the validity of using a record review as a source of information on nursing home patients. Physicians reported records as "incomplete", "mixed up", "not signed". For long-stay patients, the only record available was of recent origin, the rest of the record was stored elsewhere.

2. The reliance of the survey on the recording of primary and secondary diagnoses on admission is influenced by several factors. Examples of these are:

a. For reimbursement purposes (Medicare) primary diagnosis must be tied in with reason for hospitalization, whether or not it is the reason for nursing home care.
b. Many physicians did not identify primary and secondary diagnoses as such, merely listing several diagnoses, of equal importance, which may actually be the situation.
c. Whichever diagnoses were identified on admission may not be the reason for continued care.

3. There was underreporting of many impairments such as amputations, loss of sight, or of hearing, etc., for several reasons:

a. The diagnosis (etiology) was listed rather than sequelae, e.g., glaucoma—but not impaired vision.
b. The impairment was longstanding and although appearing in the record of physicians' examinations, was not identified as a diagnosis, or condition on admission, e.g., amputation of leg following gangrene.
c. Impairments were not recognized because of lack of accurate testing on admission or during the course of care, e.g., no vision and hearing tests were conducted to determine if impairment was present.

4. Other diagnoses were not recorded by the attending physician at the time of admission, possibly because he was unaware of the condition. This is most apparent in those transferred directly from the community, where the appropriate diagnostic work-up had not been done.

5. One diagnostic category, senility or chronic brain syndrome, may be underrecorded on admission because of the fear the attending physician has of "labeling" a patient and subsequently risking his classification as "custodial." Further, since the attending physician may see the patient only briefly and intermittently, and seldom does a complete physical examination to determine patient status, he may not recognize the development of this condition subsequent to admission.

6. One-third of the diagnoses recorded *subsequent to admission* may be directly linked to the quality of care provided in the nursing home, e.g., decubitus ulcers, genito-urinary and respiratory infections, and fractures. Others, such as arthritis, may be the result of immobilization but also might represent an acute flare-up of a longstanding condition. Some diagnoses, such as blindness, deafness, probably represent worsening conditions, unreported on admission and be discovered during the course of care. Finally, it should be noted that accidental injury is not totally or even well represented by recorded diagnoses of fractures and dislocations. Many injuries were of minor character and never recorded, and when recorded in progress notes, were not presented as diagnoses and thus were not recorded in the survey.

7. Generally, it was evident that laboratory services were inadequately used, either in terms of reaching an accurate diagnosis, or in monitoring the care given.

8. In terms of overmedication, it appears that in some instances it is due to failure on the part of the physician to discontinue orders no longer needed. In other cases, however, there was no clinical evidence of the need for potentially dangerous drugs.

9. Because the attending physician often failed to do a physical examination, or provide medical findings and orders for the patient on admission directly from the community, one might ask if the 3-day prior hospitalization required to qualify for Medicare extended care benefits is in addition an opportunity to provide a complete work-up necessary for adequate continuing care.

10. In terms of the survey itself, the physicians were quick to point out that assessment of quality of care through record review alone was inadequate. This suggests that quality assessment by physicians would require more careful examination of the patients, including laboratory tests where needed. It was recognized, however, that this would be both costly and time consuming, would require the use of physicians active in clinical practice and licensed in the States where the nursing homes were to be surveyed, not to mention the added and almost impossible burden of obtaining patient consent and attending physician approval on an "unannounced" visit.

11. The future role and involvement of the medical director should be vital in programs of correction of the observed areas of poor quality—poor medical records, inadequate laboratory testing, failure to see and/or examine the patient, inappropriate or overmedication, etc. The medical director (required by January 1, 1976 unless waiver is given to the nursing home) would review the policies of the nursing home and revise them as needed. Acting as liaison between the administrator and attending physicians, he would work toward the improvement of quality of medical care for all patients. It is expected that the medical director in most nursing homes would be part time, but it was possible for our survey physicians in less than 2 days to uncover conditions, mostly by record review and discussion without staff, that, if remedied, would greatly improve the quality of care rendered in the institution.

12. Review of the records, and observation, revealed that some of the patients, usually long-stay, were no longer in need of skilled nursing care. In other words, they were not eligible for continuing reimbursement under Medicaid. Periodic medical review should have identified such patients no longer needing skilled nursing care and if custodial beds were not available in the facility, appropriate referral to and placement in other community resources should have been carried out.

13. Although for four out of five patients, the attending physician had made monthly visits to the facility, these often were reported to be perfunctory and did not include a careful assessment of the patient's medical care needs. Some patients never saw the physician at all, particularly long-stay patients. Thus, in too many cases, the attending physician spent less and less time on those who might indeed have needed his services more.

14. It was unfortunate that a dentist could not have been a member of the team, but as in several areas, physical therapists covered occupational therapy, social workers covered recreational activities, the physician had to cover this part of the

assessment. Even though only a gross estimate of need was possible, dental health seemed to be the largest problem existing among the younger patients, i.e., those primarily with developmental disabilities who had been transferred from another institution to the nursing home. Since the other institution was most frequently a State facility for the mentally retarded, one can hypothesize that dental care was poor or nonexistent in that institution.

REHABILITATIVE SERVICES

A large number of long-term care patients have been disabled by chronic illness or injury and require specialized rehabilitative services and long periods of care and supervision. The objectives of such services include restoring patients to their highest possible levels of physical, psychological, and social functions; to prevent deformities; to retard the rate of deterioration in progressively degenerating conditions; and to teach patients to function effectively and independently within their limitations. Such services include tests, measurements and various therapeutic modalities and procedures directed at improving such functions as eating, toileting, dressing, sitting, turning, standing, walking, wheeling, transferring, and the use of prosthetic devices. They are also concerned with verbal and nonverbal communication, the redirection of interests, and motivating, encouraging, and keeping patients physically, mentally and socially active. The three principal rehabilitative services considered in this survey were physical, occupational, and speech therapy.

This portion of the survey was accomplished by qualified physical therapists who evaluated the physical, occupational, and speech therapy services provided by the facilities, in collaboration with the other members of the multidiscipline survey team. The therapists assessed patient's needs for service, and examined the organizational structure, physical facilities, coordination of services, and other conditions under which the services were rendered. They also reviewed factors related to quality of services, and completed selected sections of the patient assessment portion of the survey. This report contains the significant findings of the rehabilitative services aspects of this survey effort.

Specialized Rehabilitative Services

The majority of patients in SNFs receiving specialized rehabilitative services were receiving physical therapy; 40,949 patients or about 14 percent of the patient population. Less than 4 percent received occupational therapy and about 1 percent received speech therapy (table 55).

The therapist surveyors judgment of the need for physical therapy, occupational therapy, and speech therapy was based on a review of the patient's diagnosis, observed functional status, medical records, and discussion with staff, patients and other survey team members. The following estimates of need were made: Among the total patient population of 283,912, 47.9 percent needed physical therapy, 35 percent needed occupational therapy, and 13 percent needed speech therapy. (See table 56.)

A patient's estimated need for specialized rehabilitative services is compared with the estimated number receiving each of these services, that is, physical therapy, occupational therapy and speech therapy in table 57. It is to be noted that a patient may have more than one specialized rehabilitative service need. In relation to need, physical therapy was more often provided than the other two therapies. Almost 90 percent of patients in need of occupational therapy and an equal proportion in need of speech therapy were not receiving the service. About 70 percent of patients needing physical therapy were not receiving it.

Table 55.—Patients receiving specialized rehabilitative services in skilled nursing facilities

Specialized rehabilitative services	Patients	
	Number	Percent
Total	283,913	100.0
Physical therapy	40,949	14.4
Occupational therapy	10,818	3.8
Speech therapy	3,988	1.4

Table 56.—Estimated need for specialized rehabilitative services among patients in skilled nursing facilities (SNFs)

Specialized rehabilitative services	Total patients		Estimated need	
	Number	Percent	Number	Percent
Physical therapy	283,912	100.0	133,438	47.0
Occupational therapy	283,912	100.0	99,369	35.0
Speech therapy	283,912	100.0	36,908	13.0

Table 57.—Patients [1] identified as needing specialized rehabilitative services and the estimated number and percent receiving and not receiving these services

Specialized rehabilitative services	Estimated need		Receiving service		Not receiving service	
	Number	Percent	Number	Percent	Number	Percent
Physical therapy	133,438	100.0	40,949	30.7	92,489	69.3
Occupational therapy	99,369	100.0	10,818	10.9	88,551	89.1
Speech therapy	36,908	100.0	3,988	10.8	32,920	89.2

[1] Note a patient may have more than one specialized rehabilitative service need.

Utilization of Specialized Rehabilitative Services

Nursing homes were utilizing physical therapists more frequently than other rehabilitative specialists. It was estimated that 72.2 percent of skilled nursing facilities in the nation employed or contracted with physical therapists to provide services. Approximately 40 percent of SNFs provided the services of speech therapists and about 32 percent had arrangements to provide occupational therapy (table 58).

Table 58.—Number and percent of SNFs employing or contracting for specialized rehabilitative services

Specialized rehabilitative services	Facilities	
	Number	Percent
Total	6,591	100.0
Physical therapy	4,757	72.2
Occupational therapy	2,640	40.1
Speech therapy	2,094	31.8

Skilled nursing facilities of 100 beds or more on the average were more likely to provide physical therapy, speech therapy, and/or occupational therapy. These services were somewhat less likely to be available in homes having between 50 and 90 beds and least likely to be available in facilities with fewer than 50 beds (table 59).

Frequency of Treatments

Data on the frequency with which patients received physical therapy was available for 37,368 of the 40,949 patients receiving this service. Estimated frequencies of treatment reveal that 55.8 percent of these patients receiving physical therapy received these services at least once a day. An additional 29 percent received these treatments two or three times each week. The remaining patients either received them on a weekly or less frequent basis (6.7 percent) or the frequency of their treatment was not determined or not available (8.1 percent) (table 60). Estimates regarding the frequency of speech therapy and occupational therapy could not be determined from the available data.

Table 60.—Frequency of physical therapy treatments

Frequency of treatment(s)	Patients	
	Number	Percent
Total	37,368	100.0
(1) At least once a day	20,864	55.8
(2) Two or three times a week	10,980	29.4
(3) Once a week or less	2,509	6.7
(4) Frequency not available or not determined	3,015	8.1

Characteristics of the Services

It is important in providing rehabilitative services that the plan for therapy be written and be coordinated with the patient's total plan of care. Information on patients' plans of care were available for 39,360 of the 40,949 patients receiving physical therapy. For slightly more than half of these patients receiving physical therapy services (55.8 percent), written plans of care were coordi-

Table 59.—Number and percent of SNFs providing rehabilitative personnel specializing in physical therapy, speech therapy, and occupational therapy by bed size of facility

Bed size strata	Total		Facilities providing services					
			Physical therapy		Speech therapy		Occupational therapy	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All strata	6,591	100.0	4,757	100.0	2,640	100.0	2,094	100.0
0 to 49 beds	1,239	18.8	694	14.6	362	13.7	289	13.8
50 to 99 beds	2,675	40.6	1,949	41.0	860	32.6	679	32.4
100 or more beds	2,677	40.6	2,114	44.4	1,418	53.7	1,126	53.8

nated with the patients' total plan of care. The nursing staff participated in the rehabilitative programs of about 58 percent of the patients receiving physical therapy services. These figures suggest that coordinating the patient's specialized rehabilitative service plan of care with the total plan of care may influence whether the nursing service participates in the patient's rehabilitative program (table 61). This type of data unfortunately was not available for either occupational therapy or speech therapy.

Table 61.—Characteristics of the physical therapy service provided patients

Characteristics of service	Patients		
	Total number	Frequency of finding	
		Number	Percent
Treatments according to written plan	39, 360	26, 397	67. 1
Therapy plan identifies objectives	39, 360	23, 335	59. 3
Plan identifies procedures and modalities	39, 360	27, 379	69. 6
Written plan coordinated with total plan of care	39, 360	21, 975	55. 8
Nursing staff participates in rehabilitation program	39, 360	22, 702	57. 7

Only a small number of patients, 45,009 or about 16 percent of patients in skilled nursing facilities had baseline data from initial rehabilitation tests and measurements recorded in their medical records when such tests were applicable. About 11 percent of patients (or 31,553) had joint motion measurements and/or strength tests and measurements recorded when such tests were applicable.

The surveyors were asked to determine whether selected factors related to the quality of services were being met. These indicators were: (1) Person providing specialized rehabilitative service met the Medicare/Medicaid Qualification Requirements; (2) the organization plans for achieving the objectives of the service were written; and (3) written service procedures for the discipline were available.

At least 8 of every 10 providers of specialized rehabilitative services met the Medicare/Medicaid Qualification Requirements. About half of the facilities had written organizational plans for achieving objectives of the various specialized rehabilitative services. Except for speech therapy at least half of all facilities had written service procedures. (See table 62.)

Space and Equipment

The most desirable arrangement is to have the facility provide a specific space with sufficient equipment for patients needing specialized rehabilitative services. These provisions are often lacking. Accommodations for physical therapy were found most often. (See table 63.) Sixty-five percent of SNFs had a specific space for physical therapy services while a slightly smaller proportion, 57 percent, had sufficient equipment.

Surveyors looked at equipment to determine whether: (1) Equipment used for therapy was safe and structurally sound; (2) accepted electrical safety principles were met; and (3) preventive maintenance was being carried out.

The continued safety of the specialized rehabilitation services equipment is of concern because many of the facilities providing services did not have written policies for preventive maintenance for their specialized rehabilitation equipment. The number and proportion of facilities lacking written policies for preventive maintenance is as follows: Physical therapy—3,737 facilities or 56.7 percent; occupational therapy—2,039 facilities or 30.9 percent; and speech therapy—1,566 facilities or 23.8 percent.

Without preventive maintenance policies, deterioration of this equipment is more likely to go unobserved, subjecting patients and staff to unnecessary hazards.

Table 63.—Space and equipment available to provide specialized rehabilitative services in SNFs

Rehabilitative services	Facilities			
	Specific Space		Sufficient Equipment	
	Number	Percent	Number	Percent
Physical therapy	4, 284	65. 0	3, 758	57. 0
Occupational therapy	1, 826	27. 7	1, 343	20. 4
Speech therapy	889	13. 5	713	10. 8

Table 62.—Quality indicators related to specialized rehabilitative services provided in SNFs

Selected factors	Facilities meeting factors related to services					
	Physical Therapy		Occupational Therapy		Speech Therapy	
	Number	Percent	Number	Percent	Number	Percent
Discipline met medicare qualification requirements	4, 311	91. 3	1, 739	83. 0	2, 340	89. 1
Written organizational plans for achieving objectives of service	2, 776	58. 8	1, 154	55. 1	1, 336	50. 9
Written service procedures	2, 573	54. 5	1, 086	51. 9	1, 085	41. 3

Summary of Findings

The survey substantiates that there are many patients in skilled nursing facilities who need specialized rehabilitative services that are not receiving them.

The survey further substantiates that there is a significant lack of other critical elements in the specialized rehabilitation services of facilities:

1. Many facilities are not observing the principles of electrical safety, particularly with occupational therapy and speech therapy equipment.
2. Preventive maintenance policies and procedure for rehabilitative equipment are absent in many facilities.
3. Many rehabilitative plans of care do not include treatment objectives.
4. There is a lack of documentation of baseline data from initial rehabilitative tests and measurements in patients' medical records.
5. Many specialized rehabilitation plans of care are not being coordinated with patient's total plans of care.
6. Frequently, nursing personnel do not participate in patient's rehabilitative programs.

Conclusions and Implications

1. Since January 17, 1974, Federal regulations for Medicare and Medicaid patients require that participating facilities not admit nor retain patients in need of specialized rehabilitative services unless they are provided, either directly or under arrangements with outside resources. Federal and State agencies responsible for surveying and certifying skilled nursing facilities need to take appropriate action to make certain that surveyors carefully assess facilities: admission policies, the services they provide, and their patients' needs to assure that facilities comply with this regulation.

2. The need exists for surveyors to become more cognizant of the reasons for these requirements in specialized rehabilitative services, and when necessary, to assist facilities to meet them. This implies: (a) A need for better trained surveyors; (b) an increased utilization of specialized rehabilitative personnel to survey skilled nursing facilities; and (c) provision for consultation to the facilities and to other disciplines who are required to survey specialized rehabilitation services.

3. It is urgent that attention be given to the financial reimbursement aspects of these services. Slow and inadequate reimbursement appears to affect the delivery of appropriate services in many instances while in other situations fiscal abuse of the program appears to be occurring.

PHARMACEUTICAL SERVICES

Pharmaceutical services are an essential and integral component of the total spectrum of services provided to patients in skilled nursing facilities. Of the various therapies (physical, occupational, speech, etc.), chemotherapy has become a principal element in the restoration of the patient to optimal physiological and psychological body function.

The delivery of quality chemotherapeutic or pharmaceutical services in the institutional setting requires the combined talents of three professions: Medicine, pharmacy, and nursing. The goal that these three disciplines strive to attain is to assure that the right drug is prescribed for the patient's condition; that the prescribed drug is administered to the right patient, in the right dose and dosage interval; that the drug achieves its desired effect; and that it does so without resulting in significant adverse effects.

The attainment of this goal is dependent on a number of functions, each of which have many facets. These functions may be classified as follows:

1. Drug prescribing;
2. Drug ordering (from the pharmacy by nursing personnel);
3. Drug dispensing;
4. Drug distributing;
5. Drug administering and recording;
6. Drug monitoring;
7. Drug storing and inventorying;
8. Supervising pharmaceutical services;
9. Coordinating pharmaceutical services; and
10. Drug counseling.

The principal facets of each of these functions will be examined in an effort to determine to what extent the attainment of the above goal is being

achieved in skilled nursing facilities in this country. It should be noted that these functions are a measure of the capacity of a facility to attain the stated goal. The actual attainment of that goal is dependent upon the diligence and professionalism with which each professional carries out his or her responsibility.

Drug Prescribing

Although determining whether the right drug is prescribed for the patient's condition is a critical element in providing quality pharmaceutical services, this survey did not attempt to assess this particular function of the service. Since peer review is a more appropriate mechanism, the survey did, however, measure physicians' prescribing patterns by therapeutic categories. The categories from which drugs are most frequently prescribed are shown in table 64.

There are a number of speculations that can be made from this data, but no definitive conclusions can be made from these gross statistics. Analysis of the individual drugs prescribed in each of these categories by individual patient will reveal more interesting information from which more definitive conclusions about drug prescribing may be made. This analysis may alter the figures shown since some drugs can be classified in more than a single category. For example, an analgesic with codeine may also be classified as a controlled substance. The detailed discussion of drugs will be in a forthcoming monograph.

Table 64.—Number and percent of patients receiving drugs by drug category in rank order [1]

Drug category	Patients		
	Number	Percent	Rank
Cathartics	1,839	53.3	1
Analgesics and antipyretics	1,645	47.7	2
Tranquilizers	1,549	44.8	3
Other	1,258	36.4	4
Diuretics	1,169	33.8	5
Vitamins	1,149	33.3	6
Sedatives and hypnotics	1,147	33.2	7
Cardiac drugs	1,000	28.9	8
Skin and mucous membranes	613	17.7	9
Antiinfectives	559	16.9	10
Antacids and absorbents	489	14.2	11
Antihistamine	479	13.8	12
Hypotensives	428	12.4	13
Eye, ear, nose, and throat	408	11.8	14
Spasmolytics	394	11.4	15
Insulin and antidiabetic agents	384	11.1	16
Controlled substances (Schedule II)	372	10.7	17
Electrolyte replacements	345	9.9	18
Vasodilating agents	298	8.6	19
Antidepressants	289	8.4	20
Anticonvulsants	257	7.4	21
Estrogens/androgens	121	3.5	22
Thryroid replacements and antithyroid agents	87	2.5	23
Adrenals	77	2.2	24
Anticoagulants	37	1.0	25

[1] Category reference: American Society of Hospital Pharmacists Formulary Service.

Drug Ordering

This aspect of the drug distribution system is of particular importance in that a significant number of medication errors are created at this point. It is believed by pharmacists that the interpretation and transposition of drug orders afford the greatest opportunity for medication errors. The most accepted manner of eliminating or reducing errors at this point is through the use of a physician's order form that provides the pharmacist the original physician's order or a direct copy thereof as his working document. The survey attempted to determine the degree to which drugs were ordered in this manner. The data reveal that the pharmacist receives the original or direct copy of the physician's order form 24.2 percent of the time.

Verbal orders present a particular problem relative to drug ordering in that the person receiving the verbal order may misinterpret it. With the myriad of drugs that are pronounced similarly, the opportunity for error is increased when orders are given verbally. With this realization, the original Medicare regulations required that the attending physician countersign these orders within 48 hours. The survey data show that physicians countersign verbal orders within 48 hours 71.5 percent of the time and that nurses receive and sign these verbal orders 96 percent of the time.

Although a significant number of pharmacists are dispensing from the original or direct copy of the physician's orders and a significant number of physicians are countersigning verbal orders within 48 hours, the possibility of medication errors occurring through the drug ordering process remains great.

Dispensing of Medications

The physician's order sheet is the legal document for dispensing drugs. The medication sheet, medication card, Kardex, and prescription label are controls in the correct administration of medications. The prescription label is the single most important documentation in the process of administering drugs. It should contain all information required for the correct administration of medication. The patient's individual prescription label contained each of the following items of information in close to 99 percent of the time: patient's name, prescribing physician's name, name of drug, strength of drug and the prescription number. Eighty-eight percent of the time the labels contained the date dispensed and dispensing instructions. Accessory and/or cautionary statements appeared on 72 percent of the labels and the quantity dispensed was a surprisingly high 63 percent. On the average, 87 percent of the labels included all of the information listed below (table 65).

The imperative nature of the information contained on a prescription label cannot be argued. Any diminution in label information results in the patients being placed at greater risk with respect to medication errors.

Pharmacists traditionally take great pride in the completeness of their labels. The findings of this survey substantiate this attitude. The survey did not attempt to define the professional interpretation of labeling ascribed to by each pharmacist; nor were State pharmacy laws and regulations taken into consideration. In many instances, State laws do not require the pharmacist to include on the label all of the items included in the survey.

Drug Distributing

For the skilled nursing facility, the physician's orders can be filled and drugs distributed from a community pharmacy, from a pharmacy in a hospital of which the SNF is a part or from a pharmacy within the SNF itself. The location of the source of supply of drugs can influence the effectiveness of pharmaceutical services. The proximity or remoteness of the pharmacy and pharmacist to the SNF largely determines the degree to which the pharmacist has access to the original physician's order and the degree to which orders are transmitted verbally. In turn, the location of the pharmacy may affect the amount of time the pharmacist has available and spends in the SNF for patient counseling, staff development, drug regimen review and policy development for SNF pharmaceutical services.

The primary source of drug supply for SNFs is the community pharmacy. Currently, almost 89 percent of the facilities are being served professionally by community pharmacists. The remaining 11 percent are being supplied by hospital pharmacies and pharmacy units located within the SNFs.

While the survey finding for the numbers of community pharmacies were of a significant nature, the data for the other sources were not individually significant.

Table 65.—Information contained on patient's individual prescription labels

Information	Prescription label	
	Number	Percent
Name of patient	6,367	96.6
Date dispensed	5,804	88.1
Prescribing physician's name	6,213	94.3
Name of drug	6,418	97.4
Strength of drug	6,330	96.0
Quantity dispensed	4,133	62.7
Dispensing instructions	5,793	87.9
Accessory or cautionary statement	4,754	72.1
Prescription number	6,091	92.4

Administering and Recording

The administration of drugs is another potential major source of medication errors in the skilled nursing facility. Medication errors have been reported in the literature to occur at a rate of from 15 to 50 percent (*2*) (*3*).

A medication error is said to occur when a medication is administered to the wrong patient, the wrong drug or dosage strength is administered, the wrong dosage form is administered or medications are administered at the wrong time. Proper drug administration is essential to protect the health and safety of the patient. Prompt and accurate recording of the administration of drugs is an essential element of drug administration. The survey attempted to identify who administers medication and the degree to which proper recording takes place.

Except in a small percentage of the facilities surveyed, registered or licensed practical nurses administer drugs to patients and to a great extent drugs are recorded as having been administered. The data show that licensed nursing personnel administer the medications 92.5 percent of the time while unlicensed personnel administer drugs 7.5 percent of the time in the SNF. The nurse makes a written record of each dose administered to a patient 93.3 percent of the time. Written records included the documentation of nonprescription medication administered 91.4 percent of the time. Past experiences in the certification proc-

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ess raises the question of the validity of the data that shows that only a small number of unlicensed personnel are administering drugs. On January 13, 1975, the Department, through its Office of Nursing Home Affairs, issued a policy statement to assure that unlicensed personnel who administer drugs receive training in drug administration.

A significant number of facilities do not govern the administration of drugs with a stop order policy. The administration of drugs not specifically limited as to the time and number of doses should be controlled by established written stop order policies. The data showed that an automatic stop order policy was in effect at 77.2 percent of the SNFs. Of those SNFs with a stop order policy, 54.1 percent had the approval of the Pharmaceutical Services Committee. A major effort is needed for the implementation of automatic stop order policies or other control methods when drugs are not specifically limited as to time or number of doses.

Drug Monitoring

The appropriate use of pharmaceuticals in long-term care facilities has been a matter of concern for a number of years. The original Medicare regulations required that the physician and nurse review orders for the patient at least monthly to determine whether or not the drug therapy of the patient was appropriate for the diagnoses and whether or not adverse drug reactions and drug interreactions were occurring. It became common practice for the physician's orders to be consolidated or "recapped" into a single sheet of the physician's order form and for the physician and nurse to review the orders at monthly intervals. On February 19, 1974, new regulations for skilled nursing facilities became effective which required the pharmacist to review the drug regimen of each patient in the SNF at least monthly and to report any irregularities to the medical director and administrator. The national survey of nursing homes attempted to identify problems in drug therapy and to obtain data on the new role of the pharmacist in monitoring the drug regimen of SNF patients.

The pharmacist's role, his proficiency and communication patterns in monitoring the drug therapy of SNF patients are still being developed. Pharmacists are willing to review drug regimens but are experiencing some problems in developing appropriate methodologies and effective reporting relationships. Patient drug profiles are often used to assist pharmacists in monitoring the drug therapy. These patient drug profile records were reported to be maintained by about 65 percent of the pharmacists. Eighty-six percent of the drug profile records were located at places other than the SNF, presumably in pharmacies. The patient drug profile records often do not contain information (i.e., drug sensitivities, chronic diseases) which would help the pharmacist in monitoring drug therapy. Information contained on the SNFs' drug profile records is shown in table 66.

About 68 percent of the pharmacists reported that they reviewed the drug regimen at least monthly. Forty-six percent of those reviewing the drug regimen, reported that they provide written comments concerning the review to the registered nurse; 45 percent to the administrator; 27 percent to the attending physician; and 19 percent to the medical director. Only 21 percent of the pharmacists reported that they participated in the development of patient medication therapy plans. If the drug regimen review is to be effective in improving overall drug therapy in long-term care facilities, the methods and procedures used will need to be improved.

Storage and Inventorying

The security of medications at all points of its movements from manufacture to the patient must be assured. In the institutional setting it is important that the drug storage be secure to prevent unauthorized use and that periodic inventories of drugs are performed to determine if unauthorized use is occurring. This is of particular importance with respect to drugs listed as being subject to the

Table 66.—Number and percent of SNFs by type of information contained on the drug profile record

Information	Facilities	
	Number	Percent
Name of patient	6,131	93.0
Age	2,579	39.1
Drug sensitivities	4,254	64.5
Chronic diseases	2,091	31.7
Date prescription filled	5,834	88.5
Prescription number	5,397	81.9
Name of drug	6,115	92.8
Directions	4,867	73.9
Date to be refilled	2,037	31.5
Name of prescriber	5,868	89.0

Comprehensive Drug Abuse Prevention and Control Act of 1970. Another important aspect in the storing of drugs is the assurance that the integrity of thermolabile and photosensitive drugs is maintained, and that drugs are stored in an orderly fashion thereby precluding confusion and error in preparing drugs for administration. In view of the enormous dollar volume of drugs and the presence of significant amounts of controlled substances in the nursing homes, it becomes necessary to constantly maintain the security of these products (4). The legal aspects of controlled drugs, mandate complete records of receipt and dispositions. Proper drug storage and inventory increases the efficiency of the pharmaceutical service and aids in reducing medication errors.

In 31 percent of the facilities there is a separate drug storage room. This room is separate and distinct from the drug medication room usually found in conjunction with the nurses station wherein medications are "set up," "measured," or "poured" prior to administration.

Survey data revealed that over 86 percent of all facilities utilize the individual patient prescription system, while the remaining 14 percent is made up of floor stock systems and variations of the unit dose system.

There appears to be a certain laxness in inventorying controlled drugs in skilled nursing facilities, particularly in maintaining records for verification of receipt and disposition of controlled substances as required by the condition's of participation for SNFs. The fact that 21 percent of facilities do not maintain proper disposition records of controlled drugs, indicates weakness in this area. Separate records are maintained for controlled drugs in 79 percent of the facilities surveyed. Over 95 percent of these controlled drug records contained each of the following items of information: Patient's name, name of drug, strength of drug, date administered and balance remaining. The time and dose administered were present 91 percent and 93 percent respectively.

On the other hand, there seems to be a misuse of professional nursing time in inventorying controlled drugs at each shift change. The inordinate amount of time devoted to controlled drug counts by nursing personnel at shift change may deprive the patients of many hours of professional nursing service. Eighty percent of the facilities utilize the services of two nurses to inventory controlled drugs at each shift change.

Supervising Pharmaceutical Services

The activities of the pharmacist in the long-term care facility can be categorized into three functions: (1) Dispensing or supplying drugs to the facility; (2) monitoring the patients' drug therapy; and (3) supervising the overall pharmaceutical service. Although these functions are often carried out by the same individual, it is not uncommon to find two or more pharmacists providing services, each with some degree of specialization. For example, each of the pharmacists in a pharmacy may dispense drugs to the SNF; a single individual may review the drug regimen; while yet another may provide overall supervision of the pharmaceutical service. Supervision is a key element since all of the various activities related to drug use, distribution, and control must be properly coordinated for effective pharmaceutical services.

While the survey did not assess the extent of the pharmacists' activities in each functional area, some data were obtained which helped to evaluate the extent of the pharmacists' activities in monitoring the patients' drug therapy and in supervising the pharmaceutical services. Although most of this data are discussed elsewhere in the report, a brief summary of the kinds of pharmaceutical service activities that SNFs are rendered by pharmacists follows in table 67.

In view of the many activities which were reported as being performed by the pharmacists, the small number of hours spent in providing pharmacy services, questions about the overall effectiveness of pharmacy supervision and of the pharmaceutical services can be raised. If the pharmacist is expected to provide more services than he can do in the time he spends in the facility, the overall quality of pharmaceutical services is apt to be diminished. The amount of time per week

Table 67.—Kinds of pharmaceutical service activities rendered by pharmacists to skilled nursing facilities

Pharmaceutical service activities	Facilities	
	Number	Percent
Prepare a written report for the Pharmaceutical Service Committee	3,041	46.1
Maintain a drug profile	4,298	65.2
Review the drug regimen of patients at least monthly	4,496	68.2
Conduct inservice training sessions with personnel	4,482	68.0
Responsible for medications throughout the SNF	5,337	81.0
Periodically check drugs and biologicals for deterioration	5,791	87.9

that a pharmacist provides pharmaceutical services in skilled nursing facilities was determined by the survey as follows in table 68.

Coordinating Pharmaceutical Services

An extremely critical element in the provisions of quality pharmaceutical services in the skilled nursing facility, and one that has in the past had little attention, is the coordination of the activities of pharmacy, nursing and medical personnel. Because each of these disciplines performs an essential role in the provisions of this service, it is imperative that each is aware of the others' activities and how their respective activities are combined into an efficient and effective whole. Achievement of this coordination may be accomplished in many ways. Inservice training is one mechanism. Informal discussions between these disciplines is another. The formal mechanism for accomplishing this coordination is through the development and operation of a pharmaceutical services committee whose task it is to oversee the entire service and to develop and implement comprehensive policy for it.

The requirement for a pharmaceutical services committee for skilled nursing facilities is relatively new (February 19, 1974). The survey data reveal that within 9 months in 69.4 percent of facilities, (4,575 out of a universe of 6,591) a pharmaceutical services committee had been established. These committees are still in the process of development and have yet to fully implement their charge of coordinating and overseeing pharmaceutical services. Of the 4,575 facilities which had established pharmaceutical services committees, the data show that 80 percent were meeting at least quarterly, that 72.2 percent were documenting their activities, findings, and recommendations, and that 66.5 percent were receiving the pharmacists' written report to guide their activities and recommendations.

Table 68.—Hours per week that skilled nursing facilities are provided pharmaceutical services by a pharmacist(s)

Hours per week services provided	Facilities	
	Number	Percent
Less than 5 hr.	4,362	66.2
5 to 10 hr.	1,201	18.2
10 to 20 hr.	729	11.1
More than 20 hr.	299	4.5

Drug Counseling

Another important function in the provision of quality pharmaceutical service is that of drug counseling. This entails the provision of drug information to patients and to the nursing staff. The principle activity within drug counseling has to do with staff development. The current regulations contain a standard on staff development that requires that an ongoing educational program for the development and improvement of the skills of all the facility's personnel be planned and conducted. This requirement includes inservice training the pharmacist could develop for nursing service and other appropriate personnel with respect to drug ordering, storage, distribution, administration, and monitoring.

The survey sought information on the pharmacist's involvement in inservice training sessions. A significant number of pharmacists from the community pharmacy sector, 63.6 percent, conducted inservice training programs; of the pharmacists from a pharmacy within the facility, 66.9 percent conducted training; and of the hospital pharmacists serving SNFs, 82.4 percent conducted training sessions.

Summary of Findings

Considering all the functions and levels of performance that constitute quality pharmaceutical services that have been examined in this report, it is fair to conclude that most skilled nursing facilities are well on their way toward achieving the capacity to render pharmaceutical services in accordance with accepted professional practices.

The review of the patients' drug regimen by the pharmacist holds great promise for improving the monitoring of the patients' chemotherapy, but this challenge will require diligent applications of the pharmacist's knowledge, and the cooperation of and coordination with the nursing and medical profession in order for this review to benefit the patient. To assist pharmacists in this task, the Department has already sponsored a successful training program now nearing its completion which will enhance their skills in reviewing drug regimens and in interacting with nursing and medical personnel in this regard.

The development and effective operation of a pharmaceutical services committee also hold considerable promise for the improvement of pharmaceutical services in skilled nursing facilities. But this coordinative mechanism must be nurtured and supported by its professional disciplines in the years ahead in order for it to fully realize its potential for improving patient care.

The supervision of pharmaceutical services likewise holds considerable promise for effecting an efficient and high quality service, but the data show that this element of the service must also be improved in order for the pharmacist to assist medical and nursing personnel in enhancing the quality of care rendered to skilled nursing facility patients.

Conclusions and Implications

1. Assiduous attention to strict drug ordering procedures is required to prevent errors in drug ordering. Wherever feasible, the pharmacist should be working from the original physician's order or a direct copy thereof. Intensive efforts should be made to incorporate a drug ordering system in the SNF whereby the pharmacist works from a physician's order form. Also, increased efforts should be made to assure that the attending physician countersigns all verbal orders within a maximum of 48 hours. A study might be designed and conducted to determine the effectiveness of various mechanisms, their availability, cost, and the degree to which they reduce error rates.

2. The State surveyors need to be encouraged to utilize more fully the information contained in the SNF interpretative guidelines on pharmaceutical services and to further the greater implementation of standards for these services. Providers of long-term care need to be aware of the importance of controlled substances and the storing and inventorying of drugs. State agency pharmacy consultants should work more closely with community pharmacists to spread this information. Studies might be conducted to determine the amount of time spent by nursing personnel in counting controlled drugs at each shift change and, surveillance should be increased to assure that only trained personnel administer medication.

3. A research program should be undertaken to identify objectively the nature, extent, and frequency of clinically significant drug therapy problems in long-term care facilities so that the pharmacist would be better equipped to know where to concentrate his time in reviewing drug regimens.

4. There is a need to promote the development of pharmaceutical service committees in skilled nursing facilities to a greater extent and more importantly, to encourage and assist them to actually achieve their coordinative task. Emphasis should be placed by State agency surveyors on the implementation of the requirement for establishing a pharmaceutical services committee and in determining that the pharmaceutical services committee is actively discharging its responsibilities. Technical assistance should be provided in order to aid these committees in performing their responsibilities.

5. The amount of time the pharmacist spends in the SNF may be due to the inability of the pharmacist to receive adequate reimbursement for his services. The issue of appropriate reimbursement should be studied and some steps taken to correct the inequities in reimbursement, if it is proved to be the problem.

NUTRITION AND DIETETIC SERVICES

The basic nutritional requirements for the aged are essentially the same as for other adults. However, the need for calories is not as great as activity is decreased and the basal metabolic rate is lower. Generally, nutritional needs of the elderly can be met by following the basic four food plan each day. The groups are milk and milk products, meat and fish, breads and cereals, and fruits and vegetables. If the diet is adequate, vitamin and mineral supplements are seldom necessary.

To prevent inadequate fluid intake, many older persons need to be reminded to drink sufficient fluids. One of the biggest dietary problems is to assure sufficient roughage to maintain natural regular elimination.

Food preparation methods should allow for slower digestive processes and poorer chewing ability. The presence and fit of dentures may affect the choice of foods.

A substantial proportion of individuals 60 years of age and older consume less food than needed to meet nutrient standards for their age, sex, and weight—especially calcium, vitamins A and C (*5*).

The long-term care patient's care plan, therefore, must include nutrition goals to meet identified needs. To carry out therapeutic diets prescribed by the physician, a hygienic dietetic service, managed by a qualified dietetic service super-

visor(s) with an adequate number of supportive staff is required. Proper equipment, ample storage and space for food preparation and service, are necessary for efficient work and personnel satisfaction.

Good food in pleasant surroundings in the company of others, adds to the enjoyment of eating. Modification of established eating habits may be necessary to maintain or improve the nutritional status of some patients. Since food habits are established early in life, assisting a patient to change long-standing eating patterns can be accomplished only by exercising great tact and skill. A proper climate for eating makes any indicated change in eating habits more likely.

Supervision of Staff and Related Factors

Approximately 4 of every 10 facilities surveyed had a full time qualified dietetic service supervisor (table 69).

Table 69.—Number and percent of facilities employing a full-time qualified dietetic service supervisor

Full-time qualified dietetic service supervisor	Number	Percent
Total all	6,591	100.0
Employed	2,644	40.1
Not employed	3,947	59.9

Appropriate management and supervisory functions were performed more frequently in facilities with a full time qualified dietetic service supervisor than in facilities without such a full time qualified supervisor. These relationships are shown in table 70.

Ninety percent of skilled nursing facilities (SNFs) received some consultation or supervision of their dietetic service from a qualified dietitian. The amount of time spent by the dietitian in the facility varied widely from less than one-half day per month to full time, i.e., 35 or more hours per week. Some States require at least weekly visits with the number of hours per week based upon the size of the facility.

Information provided by the nutritionist team member indicated that the quality of dietetic service provided by the facility was directly related to the amount of time spent by the dietition. It is not surprising, considering the limited amount of time many dietitians provide, that they are more likely to provide assistance with policy development and inservice education for dietetic service employees than to provide the more time consuming responsibilities of continuing liaison with medical and nursing staffs and counseling of patients. Data on 89.6 percent (5,909) of the facilities in table 71 illustrate the type of service provided by the dietitian.

Table 71.—Type of services provided by the dietitian in 5,909 SNFs

Services identified	Facilities	
	Number	Percent
Total all	5,909	100.0
Continuing liaison with medical and nursing staffs	3,182	53.9
Patient counseling	3,306	55.9
Assistance in development of dietetic policies	4,352	73.7
Assistance with inservice education	4,877	82.5

Dietetic Personnel

The survey findings indicated that 28.96 percent of facilities had insufficient dietetic personnel on duty over a 12-hour period. There was a significant relationship between sufficient dietetic personnel and proper spacing of meals; preparation of food by methods to conserve nutritive value, flavor, and appearance; food service in a form to meet individual needs and the routine offering of bedtime nourishments. (Tables 72 and 73.)

Table 70.—Management and supervisory functions performed by dietetic service supervisors

Management and supervisory functions	Total facilities		In facilities employing full time qualified supervisor		In facilities not employing a full time qualified supervisor	
	Number	Percent	Number	Percent	Number	Percent
Total all	6,591	100.0	2,644	100.0	3,947	100.0
Orientation, work assignments, food handling, techniques, personnel	5,378	81.6	2,470	93.4	2,908	73.7
Menu planning, recommending supplies for purchase, record maintenance	4,309	65.4	2,290	86.6	2,019	51.2
Participation in regularly scheduled conferences	3,584	54.4	1,898	71.8	1,686	42.7

Documentation

Approximately 4 out of 10 patient care plans showed pertinent information about diet, goals, and action steps to resolve dietetic problems. However, there was infrequent evidence of intervention by the dietitian to help resolve dietetic problems of individual patients. For example, malnutrition exacerbates and delays healing of decubitus ulcers. Nevertheless, only 5.5 percent (1,449) of the patients with decubitus ulcers had dietary progress notes or problem statements written by the dietitian contained in their medical records. In only 7.6 percent of the medical records belonging to patients on therapeutic diets were there entries made by the facility's dietitian to indicate the patients response. Progress notes or problem statements indicating individual response to prescribed diets were found on 77.5 percent of patients' records.

Menus and Nutritional Adequacy

Menus were planned in writing for 89.3 percent of the patients in the sample. There was a positive correlation between the patient's menu being planned in writing and the nutritional adequacy of his or her meals; also, between the written menu and the accuracy in preparing and serving the meal as ordered (table 74).

A current therapeutic diet manual approved by the dietitian available to attending physicians, nursing and dietetic personnel was not available in only 23 percent of the facilities (1,530). There were 51,666 patients who refused more than half of the meal served to them. Only 27 percent of

Table 72.—Dietary characteristics of SNFs with insufficient dietetic personnel on duty over a 12-hr period

Dietary characteristics	Number of facilities	Characteristics noted		Characteristics not noted	
		Number	Percent	Number	Percent
Span between evening meal and breakfast 14 hr or less	1,909	1,240	65.0	669	35.0
Foods prepared by methods that conserve flavor and appearance	1,909	1,242	65.1	667	34.9
Foods served in a form to meet individual needs	1,909	1,486	77.8	423	22.2
Bedtime nourishments routinely offered to all patients (not contraindicated)	1,909	1,017	53.3	892	46.7

Table 73.—Dietary characteristics of SNFs with sufficient dietetic personnel on duty over a 12-hr period

Dietary characteristics	Number of facilities	Characteristics noted		Characteristics not noted	
		Number	Percent	Number	Percent
Span between evening meal and breakfast 14 hr or less	4,682	3,940	84.2	742	15.8
Foods prepared by methods that conserve flavor and appearance	4,682	4,152	88.7	530	11.3
Foods served in a form to meet individual needs	4,682	4,177	89.2	505	10.8
Bedtime nourishments routinely offered to all patients (not contraindicated)	4,682	3,694	78.9	988	21.1

Table 74.—Patients menus planned in writing and not in writing related to other characteristics

Food planning, other characteristics	Patient menus					
	Total patients		In writing		Not in writing	
	Number	Percent	Number	Percent	Number	Percent
Meal plans	283,911	100.0	253,485	89.3	30,426	10.7
Meals as planned	283,911	100.0	253,874	100.0	30,037	100.0
Nutritionally adequate	259,030	91.2	243,699	96.0	15,331	51.1
Nutritionally inadequate	24,881	8.8	10,175	4.0	14,706	48.9
Meals prepared and served	283,911	100.0	253,485	90.2	30,426	100.0
As ordered	240,578	84.7	228,743	9.8	11,835	38.9
Not as ordered	43,333	15.3	24,742	57.1	18,591	61.1

them or 14,035 were offered appropriate substitutes. One can surmise, therefore, that it is the exception rather than the rule for providers to make this offer.

Frequency of Meals

At least three meals or their equivalent should be served daily with not more than a 14-hour span between a substantial evening meal and breakfast. Patients experience discomfort resulting from an overlong span between the last substantial meal of one day and breakfast of the next day.

Approximately one out of five facilities had an overlong span between these two meals (i.e., more than 14 hours). There was no documented evidence in 28.5 percent of the facilities (1,880 of 6,591) that bedtime nourishments were routinely offered to patients to the extent medically possible. Bedtime nourishments also help elderly patients, who have variable appetites at mealtime, to prevent hunger sensations in the night (tables 72 and 73).

Other Nutritional Care Issues

Data show that 19,224 patients or 18.8 percent of 102,436 patients needing help in eating were not given prompt assistance upon receipt of their trays. The number of patients needing self-help eating devices was 32,609. Surveyors found such devices in use by only 21, 485 or 65.9 percent of these patients (table 75).

Frequently, patients are admitted to skilled nursing facilities from hospitals. In the interest of continuity of care, pertinent information for immediate care of the patient should be transmitted by the hospital to the skilled nursing facility. Just over half of the patients (54 percent) who had been transferred to their facilities from hospitals had any transfer information containing pertinent diet information.

Nursing service personnel should be aware of the nutritional needs and observe the food and fluid intake of patients. There must be an established procedure to inform the dietetic service of diet orders and patient's dietetic problems. In the survey, however, reports from nursing service were received by the dietetic service for only 56.2 percent of those patients having dietetic problems (table 76).

Sanitation and Safety

The survey indicated that 94.2 percent of facilities disposed of waste properly and 84.3 percent had written reports of sanitation inspections by State or local authorities on file. In somewhat fewer facilities, i.e., 76.7 percent dietetic employees were practicing hygenic food handling techniques. In almost three out of four facilities or 75.5 percent, surveyors answered yes to the question "Is food stored, prepared, distributed, and served under sanitary conditions?" (Table 77.)

Table 75.—Number and percent of patients receiving assistance with eating when indicated

Type of assistance required	Patients requiring assistance					
	Total		Receiving assistance		Not receiving assistance	
	Number	Percent	Number	Percent	Number	Percent
Total, all	135,045	100.0	104,697	77.5	30,348	22.5
Assistance in eating needed	102,436	100.0	83,212	81.2	19,224	18.8
Self-help eating devices indicated	32,609	100.0	21,485	65.9	11,124	34.1

Table 76.—Communication of information concerning dietetic needs of patients to the dietetic service

Kind of patient information	Patient information					
	Total		Communicated		Not communicated	
	Number	Percent	Number	Percent	Number	Percent
Total, all	360,178	100.0	197,720	54.9	162,458	45.1
Transfer information contained pertinent dietetic inputs	217,993	100.0	117,817	54.0	100,176	46.0
Nursing service reports patient's problems to dietetic service	142,185	100.0	79,903	56.2	62,282	43.8

Facilities, Space and Equipment

There were positive correlations between proper dietetic preparation equipment and the following: Foods served at proper temperatures; the practice of food preparation methods that conserve nutritive value, flavor, and appearance; and sanitary conditions in food storage, preparation, distribution, and service (table 78). There was a finding of inadequate work space in dietetic areas in one out of every four facilities.

Conclusions and Implications

Standards enforcement.—Enforcement of compliance with existing Federal regulations would result in significant improvement in the dietetic services in SNFs. The Department is exploring the need for the following changes in Federal regulations:

- A range of the minimum number of hours per week for the dietitian to spend in the facility based on bed capacity or the number of patients in the facility. This would help ensure sufficient time for dietitians to aid full-time staff members in identifying and resolving nutrition problems of individual patients. At this time, such problems frequently are overlooked by the skilled nursing facility's staff.
- A range of acceptable labor time per meal served for all supportive dietetic personnel. This would help providers and surveyors to assess whether there are sufficient supportive personnel scheduled over a period of 12 or more hours each day to carry out the functions of the dietetic service properly.

Utilization of information.—Dietetic personnel need to utilize data from routine weighing of patients and other available measures as a part of a system for regular assessment of food intake and nutritional health; monitor returned food from patients and offering replacements that constitute "similar nutritive value"; and assure that all menus, especially those for special diets, are planned in advance and records kept of the menus actually served. Also needed are more effective transfer agreements to improve continuity of care through the flow of pertinent information about the patient's dietetic problems and needs.

Studies or special projects.—Reports of studies and projects published in journals or other media available to nursing home personnel can have a beneficial influence on the nutritional care of pa-

Table 77.—SNFs meeting certain sanitation and safety factors related to food and food service

Sanitary and safety factors	Total		Meeting		Not meeting	
	Number	Percent	Number	Percent	Number	Percent
Total, all	6,591	100.0		82.6		17.4
Proper waste disposal	6,591	100.0	6,208	94.2	383	5.8
Filed written inspection reports—State or local	6,591	100.0	5,554	84.3	1,037	15.7
Employee hygienic food handling	6,591	100.0	5,054	76.7	1,537	23.3
Sanitary conditions regarding food storage, preparation, service, etc.	6,591	100.0	4,973	75.5	1,618	24.5

Table 78.—Assessment of certain SNF factors in food preparation and service in relation to the equipment in use

Food preparation and service	Total		Proper equipment present		Proper equipment not present	
	Number	Percent	Number	Percent	Number	Percent
Total, all	6,591	100.0	5,706	86.6	885	13.4
Foods served:						
Proper temperature	5,417	100.0	4,549	84.0	868	16.0
Not at proper temperature	1,174	100.0	521	44.4	653	55.6
Preparation methods:						
Conserve value, food, etc	5,386	100.0	4,560	84.7	826	15.3
Do not conserve value, etc	1,205	100.0	517	42.9	688	57.1
Sanitary conditions, food storage, service, etc.:						
Present	4,973	100.0	4,215	84.8	758	15.2
Not present	1,618	100.0	836	51.7	782	48.3

tients. Several studies and projects suggested by the findings of this report are as follows:

- *Performance/Cost.*—Study relating to nutritional care assessment of patients to the frequency of visits by dietitian and amount of time spent in the facility.
- *Personnel turnover.*—Study to determine effective and feasible measures to reduce dietetic service personnel turnover.
- *Assessment tool.*—Development and testing of a nutritional assessment tool which SNF personnel and State surveyors can use.
- *Cultural/Ethnic preferences.*—Project to identify and determine ways to satisfy cultural food preferences when patients of an ethnic group represent a small minority of patients in the facility.
- *Time study.*—Project to demonstrate time required for the dietitian to perform all professional dietetic responsibilities including counseling a significant number of patients and/or their families.
- *Nutritional status.*—Study of nutritional status of patients and identification of conditions contributing to nutritional problems of this population.

SOCIAL SERVICES AND ACTIVITIES PROGRAMS

The quality of life in long-term care institutions has become the concern of many groups, including health professionals, private citizens, community groups, legislatures, and patients themselves. One of the critical issues of care in skilled nursing facilities is the maximum preservation of each person's lifestyle within the care setting. To implement this concept it is necessary that each individual's lifestyle and psychosocial needs be known by all care personnel, especially nursing, so that the patient can be encouraged and supported in the direction of personal and social autonomy. Major roles in identifying these needs and implementing efforts to change the environment belong to social workers, occupational therapists, therapeutic recreators, and nurses by reasons of training, skill, and commitment. Consequently, how well social, emotional, economic, and daily activities needs of patients were being addressed in skilled nursing facilities was assessed.

Social Work Programs

The social workers serving on the survey teams determined after reviewing personnel records whether there was a social work program being implemented in each facility. Such a program would include the services of either a full or part time social worker (qualified by at least a Bachelor's degree) on the staff, or a designated staff member suited by training and experience to perform social service functions, or, in the absence of a qualified staff person, an effective arrangement with an individual or with a public or private agency to provide consultation from a qualified social worker. The team social workers checked job descriptions, qualifications, contracts, records of amount and times of consultation, and services performed before deciding that a social work program was or was not in effect for a particular facility.

Staff resources for social work programs.—Based on findings, 3,241 (49.2 percent) of long-term care facilities have staff for social work programs. As those reviewing the findings had hypothesized in advance, the bed size of the facility affected staffing patterns. Table 79 shows that social work programs are found more frequently in facilities of larger bed size. Approximately 1,732 (26.3 percent) of facilities had full time social work staff.

Utilization of social work resources.—The presence of staff to perform social service functions does not always mean that these staff members are engaged in activities with or on behalf of the patients that make the most appropriate use of their skills. Four functions considered to be important in ensuring that patients' psychosocial needs receive staff attention were evaluated. In about two-thirds of the facilities where staff was available, they were involved to the maximum, as table 80 shows. This reflects a staff comment frequently encountered in facilities. "There is no real time to do anything properly."

Recording of psychosocial data on patients' charts.—Less than one-half of patients in long-term care facilities have psychosocial data recorded on their charts (136,765 or less versus 283,913). Documentation of referrals of social problems to other agencies is particularly minimal, a total of 29,907, and of this small total over 90 percent are recorded in facilities having social work program staff. Table 81 illustrates that two-thirds or more of such recording is done in facilities with social work staff.

Table 79.—Number of SNFs with full and part time social work program staff by bed size

Bed size	Number	Percent by size
Total all sizes	3,241	49.2
Under 50 beds	487	38.9
50 to 99 beds	1,151	43.0
100 beds and over	1,603	60.2

Table 80.—Utilization of social work staff in selected activities

Major social work responsibilities and contributions	Facilities utilizing social work staff	
	Number	Percent
Total facilities with social work staff	3,241	100.0
Participation in patient's admission process to determine psychosocial care needs and treatment approach	2,010	62.0
Participation in development of patient's care plan and its ongoing evaluation	2,277	70.3
Work with both family and patient concerning continuity of family and community ties	2,239	69.1
Participation in staff development programs	2,140	66.0

Flow of psychosocial information.—There is a discrepancy between the minimal recording of social data and the frequency of written facility policies facilitating the admission, discharge, or transfer of patients. For instance, 94.9 percent (269,489) of patients were in facilities having written transfer agreements with local hospitals at the time of the survey. However, surveyor reviews of records coming from these hospitals showed excellent data relating to medical and health status, but for only 36.5 percent (98,321) of the patients was there social and emotional information which might assist the admitting facility to make the initial and long-term adjustment of the patient happier. Table 82 gives the number of patients who are in long-term care facilities with written policies indicating interest in facilitating the continuity of care and the flow of information, and who have psychosocial data included on their records.

Table 82.—Number of patients in facilities with policies affecting continuity of information, by documentation of psychosocial data

Kinds of documentation of psychosocial data	Facility has transfer agreements with local hospitals		Facility has written discharge planning program	
	Number	Percent	Number	Percent
Patients' records include social and emotional information transferred from referring source	98,321	36.5	80,425	40.4
Medical record indicates social and emotional needs	131,310	48.7	108,592	54.4
Medical record indicates social service findings	123,998	46.0	99,300	49.8
Medical record indicates referrals of social problems to other agencies	29,103	10.8	83,535	41.9
Medical record indicates actions taken to meet patient's social and emotional needs	93,306	36.5	21,337	10.8 [1]
Patient records document how patient is protected against physical or mental abuse	104,995	39.0	83,205	41.8

[1] The standard error in calculation was 29 percent.

Patient's perception of care received.—Many patients are not able, because of degree of illness or disorientation, to report to an interviewer whether they believe they are receiving the care they require. During the study, 27.1 percent of patients (77,025) were unable to respond. However, 63.1 percent of patients (179,134) indicated they were receiving the care required, and 9.8 percent (27,755) responded negatively. The study determined for each facility whether or not various policies and programs deemed desirable to support social functioning and to create a warm, humane environment were being implemented. Data on patients reported as believing they were receiving the care they required were reviewed to see what relationships might exist between their responses and such facility policies. These data are shown in table 83.

Table 81.—Patients in skilled nursing facilities having psychosocial data recorded

Kinds of psychosocial data recorded	In facilities with social work program staff		In facilities without social work program staff	
	Number	Percent	Number	Percent
Patients' records contain social and emotional information from referring source	70,086	67.9	33,143	32.1
Medical records indicate social and emotional needs	98,911	72.3	37,854	27.7
Medical records indicate social service findings	100,010	78.6	27,180	21.4
Medical records indicate referral of social problems are made to other agencies	27,305	91.3	2,602	8.7
Medical records indicate actions taken to meet patients' social and emotional needs	82,439	79.8	20,863	20.2
Patients' records document that the facility protects against physical and mental abuse	72,534	67.3	35,529	32.7

Table 83.—Number of patients stating they felt they received the care they required, by SNF programs and policies

Characteristics of facility programs and policies	Patient response	
	Number	Percent
Policies allowing patients to manage their own financial affairs	71,357	70.0
Program involving continuity of care, beginning with preadmission evaluation and continuing throughout the period the patient is in the facility	95,947	68.5
Programs to welcome and orient the patient as a new resident of the nursing home community	145,818	66.9
Written policies stating how referrals are made for patients needing financial and other assistance	86,627	66.7
Policies encouraging visits by patients prior to admision	99,568	65.8
Program where staff understands the need for an adjustment period for both patients and relatives	149,109	65.3
Policies defining limits for use of physical and chemical restraints for patients	112,001	64.9
Policy to give patients or representatives a periodic accounting if patient does not manage own finances	103,022	62.5
Written policies that referring agencies must participate in the psychological preparation of the patient and family for the nursing home experience prior to patient's arrival	35,842	60.4

Activities Programs

In determining whether a facility had effective activities direction, the surveyors looked at the qualifications of both the person responsible for coordinating patient activities and the resources for consultation available. A qualified activities coordinator can be an occupational therapist, occupational therapy assistant, therapeutic "recreator", a qualified social worker, or a person who has completed an approved course and has had 2 years experience in patient activities. If the person responsible did not meet these qualifications, then consultation from an occupational therapist, social worker, or therapeutic "recreator" was considered necessary.

Staff resources for activities direction.—Activities direction by either qualified coordinators or consultants was found in 71.9 percent of facilities (4,473); 44 percent (2,903) have staff coordinators; and 27.9 percent (1,840) use consultants. Table 84 shows staffing patterns by bed size of facility.

Table 84.—Staffing patterns for activities programs by bed size

Bed size	Activities direction resources			
	Qualified coordinator		Qualified consultant	
	Number	Percent	Number	Percent
Total all sizes	2,903	44.0	1,840	27.9
Under 50 beds	294	24.2	296	23.8
50 to 99 beds	1,284	47.4	825	30.7
100 beds and over	1,325	49.7	719	27.0

Recording of activities data on patient's charts.—Although more patients were in homes with activities coordinators than in facilities using consultants (137,400 versus 55,410) there is no striking difference in the percentage of patients on whose charts activities data are recorded, except for the actual patient participation in activities recorded on the medical record. Recording was more apt to be done by the staff person than the consultant, as shown in table 85.

Space and equipment available.—Areas of space available (without interfering with meals or other activities) for a variety of group and/or independent patient activities, as well as equipment to supply patient needs and interests as indicated, were surveyed during the study. As illustrated in table 86, a high percentage of facilities were found to have activity areas available. In fact, more facilities had activity areas than had qualified direction for any activities which might be initiated (70.9 percent). However, in many instances, facilities appear to have qualified staff but not adequate space for activity programs. It was noted that only 65.4 percent of facilities (4,311) had space for private interviewing. Privacy is an important consideration in maintaining individuality for residents of long-term care facilities.

Summary of Findings

The findings and conclusions have been based on statistical data from the psychosocial sections of the survey instrument. The data were obtained by review of individual facility policies, procedures, and contracts; patient care plans and medical records; interviews with staff and patients; and professional observation. The patterns which have emerged from these analyses while subject to further validation from subsequent or other surveys, have been sufficiently consistent to have implications for Federal program direction and

Table 85.—Patients having activities data recorded

Kinds of activities data recorded	In facilities with activities coordinator		In facilities with activities consultant	
	Number	Percent	Number	Percent
Patients activities needs and interests on medical record	65,535	51.0	31,620	50.8
Actual participation in activities on medical record	60,381	52.3	43,815	37.9
Response to activities on medical record	40,982	48.1	27,223	54.6

Table 86.—Space and equipment available in SNFs for activities programs

Space and equipment	All facilities having space		Facilities with qualified coordinator		Facilities with qualified consultant	
	Number	Percent	Number	Percent	Number	Percent
Totals	6,591	100.0	2,903	100.0	1,840	100.0
Space:						
Noisy recreation	5,355	81.2	2,466	84.9	1,419	77.1
Large spectator	5,347	81.1	2,462	84.8	1,526	82.9
Outdoor activities	5,226	79.3	2,276	78.4	1,496	81.3
Personal activities	5,116	77.6	2,247	77.4	1,480	80.4
Storage	4,933	74.8	2,271	78.2	1,636	88.9
Preparation	4,521	68.6	2,105	72.5	1,399	76.0
Office	4,521	68.6	2,065	71.1	1,271	69.0
Private interview	4,311	65.4	1,938	66.7	1,267	68.9
Work-type setting	3,865	58.6	1,862	64.1	1,081	58.8
Equipment: Equipment available for meeting patients, interests	4,651	70.6	2,105	72.5	1,418	77.0

standard setting. Significant areas of patient needs have been identified; gaps in service described; failure to use best current knowledge observed; and questions for further study raised.

A great number of these patients in skilled nursing facilities suffer from emotional as well as complex physical problems. They are members of a group whose needs would be difficult to fully identify and meet completely. One reason is because many of the patients in the sample could not be interviewed because of combined physical/emotional deterioration.

Psychosocial services.—A number of excellent facilities were surveyed, where staff expertise combined with warmth and concern to provide individualized patient care—covering both physical health and social/emotional needs. In such facilities efforts were made to provide daily activity at each patient's appropriate level of functioning irrespective of physical condition.

However, in the greater number of facilities, there was very limited understanding of the importance of psychosocial services to assist in maintaining patient physical, social, and mental health. In these facilities staff/patient and patient/patient interaction was minimal. Many patients were found sitting in rows in the facility lobby and halls, not communicating, and waiting for the next meal 1 or 2 hours ahead of time. The activities or social programs were directed primarily toward the active resident.

The administrator and/or director of nursing set the climate and working tone in most of the homes, affecting significantly the level and quality of patient care. A number of facilities were described as carrying over a hospital orientation and atmosphere in the operation of the home. The goal of enriching the daily environment of residents was frequently cited in the policies, but rarely implemented. Facilities in both urban and rural areas used volunteers or were interested in recruiting them. The volunteer program was most often part of the responsibilities of the activities coordinator and was used to enhance limited staff resources and increase the variety of activities offered in this program area. Recruitment, program organization, and supervision of volunteers was recognized as time-consuming, but was also seen as one method of interpreting the facility to the wider community. Facilities in predominantly rural areas have special problems in arranging for training opportunities for their staff, in being informed about training resources available, and in keeping up-to-date in knowledge. In the majority of facilities surveyed, recording of the patient's personal history, social and emotional status, interests, and adjustment, is either nonexistent in significant particulars, or if documented is rarely in one location so that staff in daily contact with the patient have ready access to such information.

Patient needs for services.—The survey findings on patient characteristics pointed out that many patients were withdrawn and noncommunicative. (See section on patient characteristics.) Only 13.3 percent (37,754) of the patients have living spouses; 78 percent of the patients surveyed were 65 years of age or older, with one-third aged 75–84; another third over 85 years of which a hardy 4.8 percent were over the century mark. The factor of longevity, and the large number of patients in the upper age groups pose immediate problems and

questions in terms of levels of care offered in relation to patient care needed. Studies have shown that for many adults over 65 there is actual diminution of physical capabilities, including a greater risk of sensory and language impairment through vascular and neurological diseases. For example, it is estimated that at least 88 percent of individuals over 65 have some degree of hearing loss (*6*). This disability is often a source of deep frustration and embarrassment to many patients, and occurs at the very time that the patient recognizes his need for assistance in self-care, and when his self-esteem may be low because of emotional stress.

Review of patient records indicated that a progressive decline occurs in many patients' mental and physical functioning after admission. Physical and emotional rehabilitation or maintaining patients at a given level is stated as a goal in policies. Relatively few facilities surveyed had qualified rehabilitative or social services staff needed to achieve these goals for the SNF patients. Surveyors noted that in a large number of facilities, patients' dependency attitudes were reinforced continuously by the manner in which staff addressed them by first name and often as though speaking to a child. This prevalent attitude contrasts sharply with survey data which shows that two-thirds of the patients (66.1 percent or 187,920) whose "usual living arrangements" could be identified had maintained themselves in the community within the previous 24 months. A more detailed breakdown of community residence underscores again the importance for staff to be aware of the need to strengthen and maintain the capacity of patients to make decisions and retain their dignity. About 35.3 percent of patients (or 39,148) who had lived in a private residence, lived alone; 88.5 percent (or 5,173) of those who lived in rooms, lived alone.

As a whole it must be concluded that in a high proportion of the facilities surveyed, there are many patients with high levels of emotional and life-adjustment problems; chronic difficulties in their interpersonal relations, isolated or noncommunicative, unwilling or unable to accept the facility environment, exhibiting either unacceptable behavior and/or withdrawal and depression.

Staffing.—While 49.1 percent of the facilities surveyed were reported as having social services program staff, in only 26.3 percent were they employed full time. For the part-time staff the time devoted to direct patient services was very limited, except for crisis situations. Hours of work reported for such staff ranged from 6–14 hours per week. Staff members were most likely to be involved in seeking financial reimbursement for patient care, other environmental manipulation, or in responding to a problem situation in regard to patient behavioral symptoms which upset the routine, or involved relatives.

The time spent by social service consultants in given facilities was generally reported as being very limited. A number of these consultants had contracts with from 6–17 facilities in a given geographic area, a pattern which is seen in other disciplines as well. Services performed were primarily in providing inservice training as requested, assisting with program direction or care consultation, and in some instances, providing supervision for a student or the activities staff. While many came in on a regular basis, there were a number of instances where the consultant was on "call," with services to be offered unspecified. In terms of disciplines represented, consultants included social workers with master's degrees in social work, sociologists, psychologists, and County Department of Public Welfare Assistance staff.

Psychosocial needs of patients were frequently translated into patient activities and recreation. Most facilities had coordinators or aides acting in that capacity who were helpful and usually responsive in terms of patient needs. However, both because of inadequate skills and limited numbers of activities staff, the greatest portion of program time was devoted to working with alert, mobile patients, rather than "problem" or room-bound patients.

Survey data indicate that most of the facilities surveyed were in the process of developing required patient care plans which set forth individual patient needs, interests, and goals. However, achievement of a regular review of patient status, evaluation of the nature of the care being given, and documentation by way of progress notes in the patient record was in a beginning stage in most facilities. The implied need to use patient-care conferences—a team approach—to assist in the process of providing individualized patient care was in evidence primarily only in those facilities with good patient care and administrative direction and were implemented by trained nursing and psychosocial staff.

Conclusions and Implications

1. There must be recognition of, and implementation at the Federal, State and local levels, of the importance of the psychosocial dimensions of patient care if the level and quality of such care in skilled nursing facilities are to be raised. The social and emotional needs of the patient must receive equal attention with that given to the physical and medical aspects. There are great variations among States in technical resources and capacity to assist facilities in utilizing and providing for psychosocial needs of patients. State and local agencies need social work, occupational therapy, and therapeutic recreation leadership (consultants) in addition to nursing to monitor programing in facilities, identify problems and develop corrective action programs (consultation, staffing changes, training peer review, and standard interpretation). Surveyors reported instances where social service staff had been discharged by a facility when such staff were no longer mandated under Federal regulations. Where States required social work consultants to be available when there were no social workers on staff, a number of examples were cited of consultant contracts undated and so general that there was no specification of the time to be given, or the nature of the services to be provided.

2. The Department is exploring the need to revise Federal regulations to emphasize implementation of policies and programing, rather than emphasizing the presence of policies and one staff member or consultant in service areas. The data indicate many facilities have the appropriate policies and minimum staff required by regulation but have not implemented the policy or provided enough staff and consultant support to meet patient needs. Activities personnel are identified as working with the alert mobile patients. It was not possible from the data to determine whether or not these patients were alert and mobile because of their participation in activities. Leaving the question of whether other patients might have improved, if offered programing to meet their interests and needs.

3. Consultants in social work and activities need to be more aware of the importance of and interpretation of information on care plans and activities participation. The data indicate that consultants are not encouraging certain kinds of recording such as what was done to meet identified needs and activities participation. Both kinds of information are vital to evaluation and individualization of care.

Social work and activities personnel need to utilize appropriate helping techniques to meet psychosocial needs, and approaches for creating, supporting, and restoring the lifestyle of the resident in the direction of personal social autonomy.

4. Development of information is needed on resources and methods traditional and new for meeting the psychosocial and lifestyle needs of patients. Surveyors indicate that some techniques have been effective in meeting the needs of patients with specific problems. Reality orientation is one technique which has been documented and information about it developed under the President's initiative. Many other such techniques need to be documented for effectiveness and have information developed and disseminated about them.

5. Efforts must be made to get more adequate social information on patients coming from hospitals. The Department is exploring the need for hospitals participating in Medicare and Medicaid programs to be required to have social workers involved in discharge planning which includes consideration of SNF/ICF placement. Survey data show that 94.9 percent of survey patients were in facilities with current transfer agreements with hospitals. However, the review of patients' records coming from the hospital showed that 36.5 percent had information of social and emotional status transferred with them, even though the records contained excellent information on medical and health status. This points up the need for social work involvement in discharge planning on the part of the referring institution to prepare the patient and family for placement.

References

1. U.S. Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics. "1973–74 Nursing Home Survey," *Monthly Vital Statistics Report*, Vol. 23, No. 6, Supplement. September 5, 1974, pp. 6–9.
2. Cheung, Alan, Ron Kayne, and Margaret M. McCarran. A Prospective Study of Drug Preparation and Administration in Extended Care Facilities, Unpublished study. p. 67.
3. Crawley, Henry K., III, Fred M. Eckel, and Don C. McLead. "Comparison of a Traditional and Unit Dose Drug Distribution System in a Nursing Home," *Drug Intelligence and Clinical Pharmacy*, 5:166–171, June 1971.

4. Brady, Edward S. *et al*, "An Application of Clinical Pharmacy in Extended Care Facilities," *Drugs and the Elderly*, Los Angeles, Ethel Percy Andrews Gerontology Society, University of Southern California, 1973. pp. 65–69.
5. Preliminary Findings of the First Health and Nutrition Examination Survey, United States, 1971–72: Dietary Intake and Biochemical Findings, DHEW Publication No. (HRA) 74–1219–1, Washington, D.C., U.S. Government Printing Office.
6. Hull, Raymond H., "Presbycusis: An Epidemiological Approach." Paper presented at workshop on Geriatric Aural Rehabilitation held in Rockville, Md., February 25, 1975.

CHAPTER 8

Historical Development of Surveyor and Provider Training Programs

In 1916, a group of concerned physicians organized and conducted a survey of 2,000 hospitals to examine the existing hospital conditions. Response indicated that only 30 percent of these hospitals met the physicians' very minimal qualifying standards. From this discouraging and humble beginning, the Joint Commission on Accreditation of Hospitals (JCAH) was formed. State and local health facility licensure laws were developed and the present Medicare and Medicaid survey and certification procedures were established.

Following the enactment of Medicare legislation in 1965, conditions of participation by health facilities in the Medicare program were provisional upon their having met the comprehensive Federal health and safety certification standards. Since Federal certification standards were much more stringent than those for State licensure, many State agencies were unable to meet the added responsibilities brought on by Medicare and did not conduct inspections for licensure.

In order to comply with the arrangement, the States recognized the urgency to organize new units to perform the certification functions and to obtain qualified administrative and professional staffing. However, there was only a short 6 to 8-month period from the signing of the agreement by the State to the start of the hospital phase of the Medicare program on July 1, 1966.

Subsequent experience gained by the State agencies in surveying and certifying extended care facilities, home health agencies, and independent laboratories showed clearly that a national Federal Government sponsored program to train health facility surveyors to conduct surveys and to provide technical assistance to nursing homes to enable them to meet conditions of participation was essential. Early in 1967, the Division of Medical Care Administration (DMCA), U.S. Public Health Service, launched a comprehensive surveyor training program.

This new unit charged with the responsibility to perform those health related functions recognized that these responsibilities included the furnishing of health consultation to providers and the training of surveyors and other State personnel performing certification functions in order to effectively support Medicare activities. The Nursing Homes and Related Facilities Branch within DMCA was charged with the responsibility to develop and quickly implement such a program on a national scale.

Implementation in 1967 of the State-Public Health Service (PHS) Cooperative Nursing Home Improvement Program required long-range funding and commitment of personnel for success in improving surveys and nursing homes. In August 1967, the National Communicable Disease Center, Atlanta, Ga., contracted to develop and conduct a prototype surveyor training course that was expected to be utilized by various universities throughout the United States.

While this first formal effort to develop and conduct a comprehensive course to train surveyors was in many respects successful, it required considerable modification and new direction. Meanwhile, other aspects of the State-Public Health Service Cooperative Nursing Home Improvement Program continued.

In May 1968, the Nursing Home Branch sponsored the first conference of State Nursing Home Licensure Personnel which was held in Dallas, Tex. Recommendations were made on matters pertaining to the improvement of the quality of care in nursing homes and similar facilities. All aspects

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of the State-PHS Cooperative Nursing Home Improvement Program were reviewed and subsequently endorsed in their entirety by representatives from 47 States, Puerto Rico, and the District of Columbia.

Many of the recommendations made at the conference were implemented, including the formation and establishment of the National Association of Directors of State Health Facility licensure and certification programs. Of major importance was that the surveyor training program was endorsed and accepted by the States. This was needed to accelerate its development and implementation as a university-based training program and to ensure its success as the keystone to the overall nursing home improvement program.

On August 6, 1971, President Nixon announced the Eight-Point Improvement Program which was designed to significantly improve the quality of care provided in these homes. Since then, over 2,000 State and Federal survey and certification personnel have attended specialized university-based surveyor training courses in 10 regions, ranging from 1,809 participants in the basic course, 255 in the advanced course, and 255 in the supervisory course.

Improved performance of health facility surveyors employed by the States has been approached in three ways: (1) Establishing minimum qualifications for surveyors; (2) providing a uniform training program; and (3) developing an interim credentialing method for the certification of surveyors. In addition to the surveyor training program, plans are currently underway to identify and update necessary basic course modifications; to design a new advanced course to include substantive programmatic concerns and specialty needs; to conduct national and regional conferences for State survey agency directors, supervisors, and consultants. As an interim method of credentialing surveyors, a contract to validate an existing survey task inventory and produce an occupational analysis was let. From this occupational analysis, surveyor performance criteria and standards will be established and a skills and knowledge test for credentialing will be developed.

An optimal level of long-term health care is dependent not only upon the development and application of regulatory standards. The ability of the facilities to meet performance criteria needed to effectively support Medicare depends equally upon the ratio and availability of well-trained individuals and the application of health manpower resources to consumer needs. In order to meet these needs, the U.S. Public Health Service recognized that those duties include the furnishing of health consultation to providers.

Responsibility for directing Federal resources toward short-term training of personnel employed in long-term care facilities was initiated and continues in the Division of Long-Term Care (National Center for Health Services Research). Their goal has been to institute short-term training courses, sufficiently diversified geographically by discipline, and by types of training methods used, and assure an approach and measurable effect on the upgrading of the abilities of nursing home personnel in meeting patient care responsibilities, through improving the quality of care given the nursing home patient.

Since the 1970 proposal for a national training program and the inception of provider training activities with the administration's Eight-Point Nursing Home Initiatives of 1971 and the subsequent yearly appropriation by Congress of $1.8 million, there has been continued growth of training opportunities for professional and paraprofessional long-term health care personnel. As of December 1974, approximately 78,000 provider personnel within 12 health disciplines are reported as having received training. Of this number, 18,927 were trained as a result of contracts with national professional organizations; 14,470 as a result of State-based contracts; 4,013 as a result of the nationwide long-term care training system, and the remainder 40,944, as a result of regional office purchase orders.

In 1974, to further the Department of Health, Education, and Welfare's efforts toward upgrading the quality of care in nursing homes by improving the skills of those responsible for providing that care, 16 contracts for State and national training programs were awarded, totaling almost $1.3 million. These programs were designed to include: (1) The instruction of nurse aides employed in long-term care facilities in rural areas of four states; (2) the nationwide training of medical directors in skilled nursing facilities (to achieve compliance with legislative mandates, mandatory by December 1975); (3) nationwide seminars and workshops for dietitians and other food service personnel; and (4) a national training system for medical record consultants employed by long-term care facilities.

In 1973, six regional training centers were created to train multidisciplinary teams within each geographic area with the focus on combined on-the-job and didactic training. In 1974, each of these centers was provided continuation funds allowing for further innovative development and implementation of the training programs, including inservice training for nursing personnel in their own facilities and communities. This ongoing program has led to modifications which are responsive to varying regional and State needs. Also, in 1974, three additional centers were funded and two contracts that called for development of training aids and materials were completed, with both programs currently in production. Program development in 1974 also included the establishment of a long-term care media center which will serve as a central repository for the training and educational materials developed through contracts so that these materials will be more readily available to providers throughout the country.

Plans for a continuation of the training effort in 1975 call for activities to be centered in those general areas being brought to focus as a result of new skilled nursing facility and intermediate care facility regulations. These include training in rehabilitation skills for all levels of nursing personnel, as well as training for community pharmacists, dietary consultants, food supervisors, medical directors to skilled nursing facilities, medical record consultants, and social work designees. By making these training models and prototypes available for wide national use, it is hoped that impact will be made on the approximately 580,000 employees working in the Nation's nursing homes and long-term care facilities.

To date, there are no requirements for the training of nurse aides in or for nursing home employment. Identification of specific needs in this area and initiation of a training program will require the collaborative efforts of the Federal Government, States, surveyors, and providers in order to continue to strengthen the national long-term care education system in 1975.

The implementation and enforcement of Federal regulatory policy in an effort to meet consumer needs and to provide adequate patient care in long-term care facilities, is not only dependent upon the adequate training and cooperative interaction among surveyors and providers, but is also dependent upon reliable up-to-date knowledge of existing conditions and patterns of health care in nursing homes.

For the purpose of obtaining this information, survey and subsequent assessment mechanisms were developed. Designers of the survey were hopeful that the knowledge resulting from this survey and future surveys and information from the Long-Term Care Management Information System will serve as an evaluation guide to members of the long-term health care professions. It is also hoped that those concerned with efforts to improve long-term care by means of a positive, constructive program might glean from the data some meaningful information upon which improvements may be based.

However, the data should be directly related to improving the availability and accessibility of long-term health care, and the survey mechanism should also provide substantial assistance in assuring the eventual achievement of successful collaborative local, State, and Federal improvement efforts.

IMPLICATIONS FOR PROVIDER TRAINING

In a statement released August 6, 1971, the President outlined a "Plan of Action" to upgrade the quality of care in the Nation's nursing homes that included a new program of short-term training for personnel regularly involved in providing services to residents. He stated, "In too many cases, those who provide nursing home care—though they have been generally well prepared—have not been adequately trained to meet the special needs of the elderly. Our new program will help correct this deficiency." In the ensuing 3 years following the President's initiatives, a variety of training activities designed to upgrade the knowledge and skills of long-term care provider personnel were developed under a variety of auspices. The Department of Health, Education, and Welfare allocated a total of more than $6 million for this purpose, programed by the Public Health Service's Health Resources Administration (Division of Long-Term Care, Na-

tional Center for Health Services Research) and the Alcohol, Drug Abuse, and Mental Health Administration (Division of Manpower and Training Programs, National Institute of Mental Health). Training opportunities were provided for over 85,000 provider personnel in all categories during 1972, 1973, and 1974. Considering the fact that the potential trainee population totals over 1 million persons at any point, and allowing for the turnover rate of personnel which is estimated to range from 30 percent to over 100 percent annually in various categories, it is apparent that a strategy for programs of ongoing and continuing education are essential for improvement of services in the long-term care field.

The Long-Term Care Facility Improvement Study findings reinforced the need for continuing and stepped-up training activities for all disciplines and levels of provider personnel, both on a single discipline and on a multidiscipline basis. This need was especially apparent in the area of quality of life or psychosocial aspects of patient care. It is significant that the identification of training needs was an implicit goal of the study. Every study team and each disciplinary group, upon completion of the study, identified areas of needed training. The scope of need is such as to require the concerted efforts of the Federal government, States, professional and provider organizations, health educators, and consumers.

Training Issues

A variety of training issues are identified by this study including:

1. multidisciplinary/interdisciplinary concerns;
2. single discipline concerns;
3. need for resources and opportunities;
4. career development and upward mobility opportunities, especially for paraprofessional and support personnel;
5. alternatives for meeting continuing education needs.

As was noted in 1971 by the President, while most personnel in long-term care facilities have been adequately trained for their specific discipline, most have not received specialized training to meet the needs of the elderly, the predominant population in nursing homes and related long-term care facilities. The majority of elderly persons suffer from one or more chronic illnesses—the average for nursing home residents is four chronic conditions requiring attention of health professionals. The concept of an episode of acute illness coming to an eventual close is not relevant for long-term care; however, this is the concept for which most health care personnel have been educated. All eight of the study team disciplines concerned with health care delivery noted an absence of orientation of personnel toward long-term rehabilitation concepts and in-depth knowledge regarding psychosocial needs of patients in the facilities they studied. These concepts are common to all disciplines and are essential to providing quality care to residents. The 10 most common diagnostic groupings found among the patients studied all have rehabilitative and psychosocial implications for training needs of patient care personnel. It is particularly noteworthy that nearly two-thirds of the patients studied had diagnoses that related to the nervous system. These data should indicate the need for all personnel to be capable of effectively dealing with disordered behavior (chronic brain disease, senility, neurosis and psychosis.)[1]

An additional concept of concern to all disciplines providing care in the long-term care facility is that of psychological impact on the patient as a result of institutionalization. Translocation of a person from home or hospital to a long-term care facility brings with it a host of "losses" to the resident—loss of health, independence, status, family, and friends. All or any of these have a potential for precipitating disordered behavior and depression, factors that must be dealt with by all levels of personnel in the facility. Appropriately designed training programs can prepare staff to be aware of, alert and responsive to the need for psychosocial support that the long-term care facility can provide as a part of its service.

This report includes the findings of each of the eight disciplines represented on the study team. Patients in these facilities are probably not receiving the quality of services to which they are entitled. Many nursing home administrators need technical assistance and training in a number of areas such as the fundamentals of nursing home administration, personnel management practices, the development and maintenance of personnel records, the proper utilization of consultants and outside health care resources, the development and implementation of staff training and facility policies, and similar areas to ensure significant improvement in the management of nursing homes. In order to assure an appropriate curriculum, a study should be made to determine the body of knowledge and preparation needed by an administrator to effectively manage a nursing home so that it can deliver high quality patient care.

[1] The findings of other studies including those of intermediate care facilities estimate this figure to be closer to 80 percent.

Intensification of the long-term care provider training program is needed to reach as many pharmacists as possible to assist them in maintaining and improving their professional competence and to keep them informed of various program requirements. Training should be designed and conducted to improve the quality of pharmaceutical services and coordination with the nursing and medical personnel on appropriate aspects of drug storage, distribution, administration, and monitoring. Considerable support should be given to stimulating training programs which will enhance the skills of the pharmacist in monitoring the drug therapy of specific disease states and improve his ability to communicate effectively with prescribing physicians.

The dietitian's continuing education should include current concepts and practice of diet therapy for the geriatric patient; special patient needs because of physical disabilities or impairments; and appropriate learning experiences to help them identify and meet dietetic-related training needs of other SNF staff, improve liaison with medical and nursing staff, document problems and progress appropriately in patients' medical records, and indicate goals and action steps in patient care plans.

For both the dietitian and the dietetic service supervisor, training in management techniques is needed for time economy and to establish work priorities. There is a need to promote interagency efforts on State and local levels to strengthen a network of approved educational programs for dietetic service supervisors.

Administrators need training to understand nutritional needs of patients at this level of care in order to provide adequate staffing, equipment, and space for the dietetic services.

Cooks are often employed without prior training or experience in quantity food production. Comments in surveyors' summary statements frequently focused on problems of food preparation. "Even though only a few patients require sodium restriction, all food is prepared without salt. Food is prepared too far in advance and held for long periods in a steam table. Employees fail to practice hygienic food handling techniques." Training courses for cooks in vocational schools as well as on the job training should be encouraged.

Since 1972 basic orientation courses have been offered for social workers and activities personnel groups under the President's nursing home initiatives but training has not been of a career development, in-depth technique training, or program development nature. Uniform training curricula and methodologies must be developed. In addition, teachers must be recruited and trained to disseminate the information especially into rural areas.

Some training needs are unique to the role that each discipline plays as a part of the health team; others will relate to the role the discipline plays in concert with other team members. For example, nutrition consultants, food service supervisors, and dietary aides need specific training in the unique nutritional needs of the institutionalized elderly, the impact that inactivity and illness have on appetite, nutritional needs, and spacing of feedings. In addition, however, knowledge of potentially hazardous food-drug interaction is essential for adequate planning of dietary regimen and require collaboration and communication between dietary, nursing, pharmacy, and medical personnel.

The above points indicate both the need for discipline specific training as well as interdisciplinary training. Both these needs are addressed in Federally supported training activities conducted in fiscal year 1975 and planned for fiscal year 1976, but maximizing of this training at State and local levels must be planned for by providers in order to impact on service delivery in individual long-term care facilities.

The report of the social work study members provides another example of both discipline-specific and multidisciplinary training needs. The primary responsibility for ensuring that psychosocial and continuity of care needs of long-term care residents are met, rests with social service personnel. Although 49.1 percent of the facilities surveyed had social work staff, only 26.3 percent (1,732 facilities) employed them on a full-time basis. Since such social service staff are of prime importance in ensuring that psychosocial needs are receiving staff attention. The data indicate a need for training of other personnel to fill this gap and training of social work consultant to impart this knowledge and skill to the staff. Again, this is an area that has been addressed by the Public Health

Service training contracts and additional work is essential, especially at the facility level.

The essential point is that training needs and a variety of alternatives for accomplishing training exist. The Federal Government has supported demonstrations of various alternatives, and the initial development of training activities, but the accomplishment of an ongoing and continuing program of staff training requires the collaborative efforts of Federal and State government, provider organizations and facilities, and educational institutions.

Training Costs

A multiplicity of private and public funding resources are necessary in order to spread the financial burden over as great a number of persons as possible. Further research into the most effective and equitable methods of financial support of educational opportunities is indicated.

A major problem for the long-term care facilities is a high turnover rate of health care personnel. In those Federally supported training programs from which data are available, turnover seems to be directly affected by job satisfaction levels, and job satisfaction related to feelings of adequacy and competence—both factors of training and job preparation.

One factor requiring further study is the degree to which opportunities for upward career mobility, provided by training and education, are a factor in job satisfaction and reduced turnover rates. Data would indicate that continual orientation of new, inexperienced personnel is expensive for the provider and can substantially influence overall cost-of-care rates.

An hypothesis on which the initial Federal training strategy was based is that a vast amount of experience and resources are available in the Nation and the task effectively to link these resources to meet the training needs at hand. This hypothesis has proved to be true and a degree of success has been obtained in utilizing existing professional, provider, State and consumer organizations in initiating or strengthening training capability. This study has pointed out needs for additional or redirected training activities and nationwide combined resources are needed from all concerned and to respond in concert to the multitude of continuing provider training needs that have been identified.

Bibliography

Aging

1. Birdwhistell, R. L. *Kinesics and Context: Essays on Body Motion Communication.* Philadelphia, University of Pennsylvania Press, 1970, 95 pp.
2. Bromley, D. B., M.D. "Mental Aspects of Aging." *Triangle Sandoz Journal of Medical Science,* 12:175, 1973. No. 4, 1973.
3. Linn, Margaret W. and Lynn P. Carmichael. "Introducing Pre-Professionals to Gerontology." *Gerontology,* 14: 476–478, December 1974.
4. Michelmore, Peter. "A Model Geriatric Health Care System: Coordinated Endeavor of Patient Care and Physician Training." *Geriatrics,* 30:146–149, 152–154, February 1975.
5. Novick, Louis J. "Day Care Meets Geriatric Needs." *Journal of the American Hospital Association,* 47:22: 47–50, November 1973.
6. Phillips, Donald F. "Reality Orientation." *Journal of the American Hospital Association,* 47:13:46–49, July 1973.
7. U.S. Department of Health, Education, and Welfare. *Designs for Action for Older Americans: A Project Report on Group Volunteer Service.* Washington, D.C., The Department, February 1969.
8. U.S. Department of Health, Education, and Welfare. *Medicare: Health Insurance for the Aged, 1967, Section 4.1: Short-Stay Hospital Utilization.* Washington, D.C., The Department, 1975.
9. U.S. Department of Health, Education, and Welfare. *Older Americans and Community Colleges: An Overview.* Washington, D.C., The Department, June 1974.

Dental

1. U.S. Department of Health, Education, and Welfare. *Dental Care for the Chronically Ill and Aged. A Community Experiment.* Washington, D.C., The Department, 1961.
2. U.S. Department of Health, Education, and Welfare. *Edentulous Persons in the United States.* Washington, D.C., The Department, June 1974.
3. Waldman, H. Barry and Murray Stein. *Dental Program for the Chronically Ill and Aged in Cleveland, Ohio.* Cleveland, Highland View Hospital, 1967.
4. U.S. Department of Health, Education, and Welfare. *Portable Dentistry for the Homebound or Handicapped Patient.* Washington, D.C., The Department, January 1975.
5. U.S. Department of Health, Education, and Welfare. *Need for Dental Care Among Adults in the United States.* Series 11, No. 36. Washington, D.C., The Department, March 1970.
6. Waldman, H. Barry and Murray Stein. *For the Chronically Ill and Aged: A Plan for Total Dental Services.* Community Health Services Grant CH 37–18. Cleveland, Highland View Hospital, Department of Dentistry, April 30, 1967.

Fire Safety

1. American Nursing Home Association. *Fire Safety Manual for Nursing Homes,* Washington, D.C. American Nursing Home Association with the Department of Health, Education, and Welfare, Health Services and Mental Health Administration, Contract No. HSM 110–73–363, 1974.
2. U.S. Congress. House Committee on Government Operations. *Fire Safety Deficiencies in Nursing Homes.* House Report No. 93–1627, 93rd Congress, 2nd Session, December 18, 1974. Washington: Government Printing Office, 1974.
3. U.S. Department of Health, Education, and Welfare. *Many Medicare and Medicaid Nursing Homes Do Not Meet Federal Fire Safety Requirements.* Washington, D.C., The Department, March 1975.

Fiscal or Financial

1. Brazda, Jerome F. "A Tale of Two Cities, and Many Reimbursement Rates." *Modern Health Care,* 2:4:15–16, October 1974.
2. Franklin, Paula A. "The Disabled Widow." *Social Security Bulletin,* 38:1:20–27, January 1975.
3. Rice, Dorothy P. *Estimating the Cost of Illness.* U.S. Public Health Service Publication No. 947–6. Washington, D.C., The Department of Health, Education, and Welfare, May 1966.
4. Shapley, Deborah. "Computers in Medicine: Hospitals Cope with Costs, Quality Review." *Science,* 187:770–771, February 1975.
5. Skolnik, Alfred M. and Sophie R. Dales. "Social Welfare Expenditures, Fiscal Year 1974." *Social Security Bulletin,* 38:1:3–19, January 1975.
6. U.S. Department of Health, Education, and Welfare. *Comparison of Cost and Benefit Incidence of Government Medical Care Programs, Fiscal Years 1966 and*

1969. Staff Paper No. 18, PHS Publication No. (SSA) 75–11852, September 1974.

Health Education

1. Beaumont, Estelle and Loy Wiley, eds. "Innovations in Nursing." *Nursing '74*, 4:5:68–69, May 1974.
2. "Inservice Spending in Nebraska." *Modern Health Care*, 2:4:69–71, October 1974.
3. Kisley, Cathryn A. "Striking Bake at Stroke." *Journal of the American Hospital Association*, 47:22:64, 66, 68, 70, 72, November 1973.
4. Schoenrich, Edith H. "The Potential of Health Education in Health Services Delivery." *Health Services Reports*, 89:1:3–7, January–February 1974.

Medical Care and Role of the Director

1. American Medical Association, Council on Medical Service. *Guidelines for a Medical Director in a Long-Term Care Facility*. Chicago, The American Medical Association, January 1974.
2. American Nursing Home Association. "Training Program to Improve Delivery of Medical Services." *Modern Nursing Home*, 29:4:36, October 1972.
3. Boyd, R. and C. G. Oakes, eds. *Foundations of Practical Gerontology*. Columbia, University of South Carolina Press, 1973.
4. Bristow, Opal and Stickney, Carol. *Discharge Planning for Continuity of Care*. Richmond, Virginia Regional Medical Program, Inc., September 1974. 208 pp.
5. Donabedian, Avedis. "Evaluating the Quality of Medical Care." *Milbank Memorial Fund Quarterly*, 44:3:166–203, July 1966.
6. Downey, Gregg W. "American Medical Association Seminar Seeks Ways to Improve Medical Services in Nursing Homes." *Modern Nursing Home*, 29:6:17–19, December 1972.
7. Gladue, J. Raymond. "The Role of the Physician in the Nursing Home: Past, Present, and Future." *Journal of American Geriatrics Society*, 21:444–449, October 1973.
8. Goldman, Ralph. "Geriatrics as a Specialty—Problems and Prospects." *Gerontology*, 14:468–471, December 1974.
9. Howard, John B. and Kenneth E. Strong. "The Nursing Home Medical Director and Quality Care." *The Journal of Long-Term Care Administration*, 3:1:3–8, Winter, 1974–75.
10. Kavaler, Florence and Mrs. Perry G. Haber. "Delivery Models for Nursing Home Health Care Services: The New York City Experience." *Nursing Home*, 22:8:6–8, 33–34, August–September 1973.
11. Kleh, Jack. "Better Patient Care Role of Medical Director." *Journal of American College of Nursing Home Administrators*, 1:3:11–18, Spring 1973.
12. Lawson, Ian R. "Professional Standards Review Organization and Care of the Elderly." *Journal of American Medical Association*, 229:311–313, July 15, 1974.
13. Levey, Samuel, et al. "An Appraisal of Nursing Home Care." *Journal of Gerontology*, 28:2:222–228, 1973.

Nursing

1. Miller, Marian E. and Marvin L. Sachs. *About Bedsores: What You Need to Know to Help Prevent and Treat Them*. Philadelphia, J. B. Lippincott Company, 1974.
2. "Patient Rights, Nursing Responsibilities." *Journal of the American Hospital Assoication*, 47:102–104, 134, June 1973.
3. Schwab, Sister Marilyn. "Caring for the Aged." *American Journal of Nursing*, 73:2051–2052, December 1973. No. 12.
4. Verhonick, Phyllis J. "Clinical Studies in Nursing: Models, Methods, and Madness." *Nursing Research*, 21:6:490–493, November–December 1972.

Nursing Homes

1. Barney, Jane L. "Nursing Directors in Nursing Homes." *Nursing Outlook*, 22:7:436–440, July 1974.
2. Brook, Robert H. "Quality of Care Assessment: Policy Relevant Issues." *Policy Sciences*, 5:317–341, September 1974.
3. Burnside, I. M. "Loneliness in Old Age." *Mental Hygiene*, 55:391–397, 1971.
4. Burnside, I. M. ed. *Psychosocial Nursing Care of the Aged*. New York, McGraw-Hill, 1973.
5. Busse, E. and E. Pfeiffer, eds. *Functional Psychiatric Disorders in Old Age*. Boston, Little, Brown and Company, 1969.
6. Downey, Gregg W. "Must a Transfer Order Be a Death Sentence for SNF Patients?" *Modern Health Care*, 72:4:44–47, October 1974.
7. Etzioni, Amitai, Alfred J. Kahn, and Sheila B. Kamerman. *Public Management of Health and Home Care for the Aged and Disabled: "Alternatives to Nursing Homes."* A Position Paper. New York, Center for Policy Research, Columbia University, January 1975.
8. Farrell, John R. "PSROs and Internal Audit Review." *Hospital Progress*, 54:10:64–66, October 1973.
9. "Federal Regulations Force Changes in Nursing Home Care." *Hospital Practice*, 10:2:134–136, 138, February 1975.
10. Gold, Jacob G. and Saul M. Kaufman. "Development of Care of Elderly: Tracing the History of Institutional Facilities." *Gerontologist*, 10:4:262–274, Winter 1970.
11. Greenwald, Shayna R. and Margaret W. Linn. "Intercorrelation of Data on Nursing Homes." *Gerontologist*, 11:337–340, Winter 1971.
12. "Guess Who's Coming to the Nursing Home?" *Modern Health Care*, 2:1:40–43, July 1974.
13. Harvard Center for Community Health and Medical Care. *Summary of Proceedings, Third Invitational Conference on Nursing Home Care*. Boston, May 30, 1974.
14. Hefferin, Elizabeth A. and Ruth E. Hunter. "Nursing Observation and Care Planning for the Hospitalized Aged." *Gerontologist*, 15:57–60, February 1975.
15. Heidell, B. "Sensory Training Puts Patient in Touch." *Modern Nursing Home*, 28:39–43, 1972.

16. Johnson, Richard L. "Health Care Myths." *Hospital Progress*, 54:10:55–58, October 1973.
17. Joint Commission on Accreditation of Hospitals. *Accreditation, Manual for Long-Term Care Facilities*. Chicago, The Commission, 1975.
18. Kernodle, John R. "Toward a Brighter Future." *Health Services Reports*, 88:316–319, April 1973.
19. Levey, Samuel, *et al.* "Nursing Homes in Massachusetts: Industry in Transition." *American Journal of Public Health*, 65:1:66–71, January 1975.
20. Linn, Margaret W. "Predicting Quality of Patient Care in Nursing Homes." *Gerontologist*, 14:225–227, June 1974.
21. Mendelson, Mary Adelaide. *Tender Loving Greed*. New York, Alfred A. Knopf, 1974.
22. "Periodic Review Rx: Personal Touch, Flexibility. Persistence." *Hospital Practice*, 10:2:145–146, 149, 153, February 1975.
23. Reader, George G. "Types of Geriatric Instiutions." *Gerontologist*, 13:3:290–294, Autumn 1973.
24. Shanas, Ethel. "Factors Affecting Care of the Patient: Clients, Government Policy, Role of the Family and Social Attitudes." *Journal of the American Geriatrics Society*, 21:9:394–397, September 1973.
25. Sherwood, Sylvia and Claire S. Feldman. "The Use of Easily Obtained Pre-coded Data in Screening Applicants to a Long-Term Care Facility." *Gerontologist*, 10:3:182–189, Autumn 1970.
26. Stotsky, B. A. *The Elderly Patient*. New York, Grune and Stratton, 1968.
27. U.S. Department of Health, Education, and Welfare. *Nursing Home Care*. Washington, D.C., The Department, 1973.
28. U.S. Department of Health, Education, and Welfare. "Skilled Nursing Facilities: Standards for Certification and Participation in Medicare and Medicaid Programs." In *Federal Register*, 39:12, Part II. Washington, D.C., The Department, January 17, 1974.

Pharmacy

1. Brands, Alvira Bernice. "Factors Influencing Geriatric Nursing Practice in the Drug Therapy Regimen of Aged Patients in Selected Nursing Homes." Unpublished D.N.Sc. dissertation, The Catholic University of America, 1975.
2. DiPalma, Joseph R. "Drug Therapy Today: Enzymes Used as Drugs." *RN*, 35:1:53–58, January 1972.
3. DiPalma, Joseph R. "Drug Therapy Today: Precautions with the Anticoagulants." *RN*, 34:10, 57, 60, 62, 64, October 1971.
4. "Drugs of Abuse." *Drug Enforcement*, 2:2–41, Spring 1975, No. 2.
5. Hood, Jerry C., Max Lemberger, and Ronald B. Stewart. "Promoting Appropriate Therapy in a Long-Term Care Facility." *Journal of the American Pharmaceutical Association*, NS15:1:32–34, 37, January 1975.
6. Hutchinson, Richard A. "Adverse Drug Reactions—A Review." *Hospital Topics*, 48:9:69–74, September 1970.
7. Kidder, Samuel W. "Pharmaceutical Services in Skilled Nursing Facilities—the Intent of the Regulations." *Journal of the American Pharmaceutical Association*, NS15:1:14–15, January 1975.
8. Koch-Weser, Jan and Edward M. Sellers. "Drug Interactions with Coumarin Anticoagulants (First of Two Parts)." *The New England Journal of Medicine*, 285:10:547–558, September 1971.
9. Koch-Weser, Jan and Edward M. Sellers. "Drug Interactions with Coumarin Anticoagulants (Second of Two Parts)." *The New England Journal of Medicine*, 285:10:547–558, September 1971.
10. Korsan-Bengsten, Kristoffer. "Long-term Anticoagulant Therapy for Coronary Artery Disease." *Geriatrics*, 26:8:92–95, 98–99, August 1971.
11. McKenzie, Michael N., *et al.* "The Pharmacist's Involvement-Monitoring Patient Drug Therapy." *Journal of the American Pharmaceutical Association*, NS15:1:16–20, January 1975.
12. Owren, P. A. "Recent Advances in the Control of Anticoagulant Therapy." *Geriatrics*, 26:8:74, 79–81, 84–89, August 1971.
13. Rodman, Morton J. "Drug Therapy Today: Drugs for Treating Anxiety," *RN*, 36:9:57, 59–60, 63–64, 68, September 1973.

Social Services

1. Forman, Allan. "The Nursing Home Ombudsman Demonstration Program:" *Health Services Reports*, 89:2:128–133, March–April 1974.
2. Mell, Labe B. "Cost Containment—The Result of Social Services." *The Journal of Long-Term Care Administration*, 2:4:4–10, Fall 1974.
3. Putman, Phyllis A. "Nurse Awareness and Psychosocial Function in the Aged." *Gerontologist*, 13:163–166, 1973.
4. *The Psychosocial Needs of the Aged: Selected Papers*. Gerontology Center, University of Southern California, Los Angeles, 1973.
5. U.S. Department of Health, Education, and Welfare. *A Social Work Guide for Long-Term Care Facilities*. Washington, D.C., The Department, 1974.

Instructions for Selecting a Sample of Residents for the Long-Term Care Facility Improvement Campaign

The National Center for Health Statistics' staff devised the method and wrote the instructions for selecting a sample of approximately 40 residents per facility for the Long-Term Care Facility Improvement Campaign. As required, the sampling instructions can be redesigned to reflect the number of residents which can be examined during a team visit.

A new form—the Resident Control Record—was included as part of the packet of questionnaires for each facility visit and received Office of Management and Budget clearance. It was essential to the statistical weighting of the sample that the resident control record is included in the packet of completed questionnaires. The sampling instructions were emphasized during the training sessions.

HOW TO COMPLETE THE RESIDENT CONTROL RECORD AND SELECT THE SAMPLE OF RESIDENTS

Purpose

The resident control record has only one purpose: to list all SNF residents (both Title XVIII and Title XIX) of the facility for the purpose of selecting a sample to collect survey data. A resident is defined as an individual domiciled in the facility for the purpose of receiving specialty care. A resident is *not* a discharged patient.

Selecting the Sample

1. Enter the name of the nursing home, its identification number, and the MFI bed size recode on the lines provided at the top of the resident control record. (A copy of this form is on the next page.)

2. List all SNF residents (both Title XVIII and Title XIX) on the form, one resident per line. (See above definition of "resident".) Be careful not to skip any lines when you are preparing the list. Any manner of recording residents in the list is acceptable (i.e., names, facility's resident identification number, etc.) as long as the manner allows identification of the residents selected for the sample.

3. The total SNF residents in the facility equals the line number of the last resident entered on the resident control record. Enter this number on the line provided at the top of the resident control record.

4. Use table 1 to determine the correct sample designation. Select the interval in the column headed "Total SNF residents in the home" which corresponds to the total number of SNF residents entered on the resident control record. The sample designation, "Start with" (SW), "Take every" (TE), can be found in table 1 by reading across the row to the appropriate SW and TE columns. Enter the SW and TE numbers from table 1 in the appropriate lines in column "a" of the resident control record. Once you have recorded the sample, you can verify its overall accuracy by checking the column on table 1 headed "Range for sample of SNF residents". The total number of residents in the sample should fall within the range listed in this column.

Example.—Assume that you recorded 74 SNF residents on the resident control record. Seventy-four falls in the interval between 61–90 in the first column of table 1. Reading across the table,

RESIDENT CONTROL RECORD

Page _____ of _____ Pages

Nursing Home Name _____ MFI Bed Size _____

Nursing Home Id Number _____ Recode

Total SNF Residents in Home: _____ residents

Total SNF Residents in Sample: _____ residents

LIST OF SNF RESIDENTS IN THE FACILITY

Sample designation SW ____ TE ____ a	Name of SNF Resident* b	Line No. c	Sample designation SW ____ TE ____ a	Name of SNF Resident* b	Line No. c
		01			51
		02			52
		03			53
		04			54
		05			55
		06			56
		07			57
		08			58
		09			59
		10			60
		11			61
		12			62
		13			63
		14			64
		15			65
		16			66
		17			67
		18			68
		19			69
		20			70
		21			71
		22			72
		23			73
		24			74
		25			75
		26			76
		27			77
		28			78
		29			79
		30			80
		31			81
		32			82
		33			83
		34			84
		35			85
		36			86
		37			87
		38			88
		39			89
		40			90
		41			91
		42			92
		43			93
		44			94
		45			95
		46			96
		47			97
		48			98
		49			99
		50			100

* Initials, facility identification number, or any other type of identifier can be used in the list as long as the residents chosen for the sample can be identified so that their records can be examined.

LIST OF SNF RESIDENTS IN THE FACILITY

Sample designation SW 1 TE 2 a	Name of SNF residents* b	Line No. c	Sample designation SW 1 TE 2 a	Name of SNF b
	Adams	01		
	App	02		
	Andrews	03		
	Art	04		
	Baker	05		
	Bett	06		
	Bibe	07		
	Bic	08		
	Bitten	09		
	Bauer	10		
	Cobb	11		
	Colby	12		
		13		
		14		
		15		

ILLUSTRATION 1: *Partial View of Resident Control Record*

the SW would be 1, the TE would be 2, and the number of sample residents will fall somewhere between 31–45.

5. The sampling procedure is as follows: start with the number of the line designated as SW and circle the line number in column "c" of that person as the individual first selected for the sample. Next, count down from that line the number of lines designated in the TE instruction, circle the line number in column "c" and so on until you have gone through the entire list of residents of the home.

Example.—When the SW number is 1 and TE number is 2, you would start with resident number 01. Circle that resident's line number and count down 2 lines to line 03, circle line 03, and count down 2 more lines to line number 05, circle line number 05 and so on until you have gone through the entire list of residents of the home. The resident line numbers that you have circled are the persons who will be included in the sample. See illustration 1 for an example of the resident control record when SW is 1 and TE is 2.

6. Count the total number of sample residents (i.e., the line numbers circled in column "c") and enter this on the appropriate line at the top of the resident control record.

7. It is very important to do this sampling carefully and correctly as this will affect the variation in the national estimates.

Table 1.—Sample designations for obtaining a sample of SNF residents in nursing homes

Total SNF residents in home	Start with	Take every	Range for sample of SNF residents
1–45	1	Take all	1–45
46–60	1, 2	3	31–40
61–90	1	2	31–45
91–120	3	3	30–40
121–160	3	4	30–40
161–200	4	5	32–40
201–240	3	6	34–40
241–280	1	7	35–40
281–320	8	8	35–40
321–360	2	9	36–40
361–400	3	10	36–40
401–440	9	11	36–40
441–480	10	12	36–40
481–520	7	13	37–40
521–560	9	14	37–40
561–600	2	15	38–40
601–640	1	16	38–40
641–680	1	17	38–40
681–720	7	18	38–40
721–760	10	19	38–40
761–800	14	20	38–40
801–840	11	21	38–40
841–880	7	22	38–40
881–920	2	23	39–40
921–960	9	24	39–40
961–1000	4	25	39–40
1001–1040	5	26	39–40
1041–1080	10	27	39–40
1081–1120	13	28	39–40
1121–1160	25	29	38–40
1161–1200	9	30	39–40
1201–1240	29	31	38–40
1241–1280	17	32	39–40
1281–1320	13	33	39–40
1321–1360	24	34	39–40
1361–1400	14	35	39–40
1401–1440	26	36	39–40
1441–1480	34	37	39–40
1481–1520	32	38	39–40
1521–1560	14	39	39–40
1561–1600	36	40	39–40
1601–1640	8	41	39–40

LIST OF SNF RESIDENTS IN THE FACILITY

Sample designation SW 1, 2 TE 3 a	Name of SNF resident b	Line No. c	Sample designation SW 1, 2 TE 3 a	Name of SNF resident b	Line No. c
	Adams	01		Williams	51
	App	02		Vincent	52
	Andrews	03		Yost	53
	Art	04		Zemil	54
	Baker	05			55
	Bett	06			56
	Bic	07			57
	Bitten	08			58
	Cobb	09			59
	Coby	10			60
	Consent	11			61
	Core	12			62
	Corr	13			63
	Cott	14			64
	Dee	15			65
	Dint	16			66
	Dor	17			67
	Farr	18			68
	Finch	19			69
	Fizz	20			70
	Flair	21			71
	Gale	22			72
	Gamel	23			73
	Gore	24			74
	Hill	25			75
	Hope	26			76
	Horn	27			77
	Jackson	28			78
	Jones	29			79
	June	30			80
	Kain	31			81
	Keets	32			82
	King	33			83
	Kole	34			84
	Lambert	35			85
	Long	36			86
	Lost	37			87
	McKay	38			88
	Mang	39			89
	Melton	40			90
	Moore	41			91
	Nickel	42			92
	Norman	43			93
	Raft	44			94
	Rick	45			95
	Rust	46			96
	Sills	47			97
	Smith	48			98
	Tackel	49			99
	Tucker	50			100

ILLUSTRATION 2: *Example of Step 1 for Selecting a Resident Sample When SW Is 1, 2 and TE Is 3.*

LIST OF SNF RESIDENTS IN THE FACILITY

Sample designation SW 1, 2 TE 3 a	Name of SNF resident b	Line No. c	Sample designation SW 1, 2 TE 3 a	Name of SNF resident b	Line No. c
	Adams	01		Williams	51
	App	02		Vincent	52
	Andrews	03		Yost	53
	Art	04		Zemil	54
	Baker	05			55
	Bett	06			56
	Bic	07			57
	Bitten	08			58
	Cobb	09			59
	Coby	10			60
	Consent	11			61
	Core	12			62
	Corr	13			63
	Cott	14			64
	Dee	15			65
	Dint	16			66
	Dor	17			67
	Farr	18			68
	Finch	19			69
	Fizz	20			70
	Flair	21			71
	Gale	22			72
	Gamel	23			73
	Gore	24			74
	Hill	25			75
	Hope	26			76
	Horn	27			77
	Jackson	28			78
	Jones	29			79
	June	30			80
	Kain	31			81
	Keets	32			82
	King	33			83
	Kole	34			84
	Lambert	35			85
	Long	36			86
	Lost	37			87
	McKay	38			88
	Mang	39			89
	Melton	40			90
	Moore	41			91
	Nickel	42			92
	Norman	43			93
	Raft	44			94
	Rick	45			95
	Rust	46			96
	Sills	47			97
	Smith	48			98
	Tackel	49			99
	Tucker	50			100

ILLUSTRATION 3: *Example of the Completed Sample Selection (i.e., Step 2 Is Completed) When SW Is 1, 2 and TE Is 3.*

Regardless of the number of SNF residents, the sample selection is done in exactly the same way, with only the SW and TE numbers changing. However, the sampling of residents for facilities which have 46–60 SNF residents represent a "special case" in that it is done in the same way but in two steps.

Example.—Assume that you recorded 54 SNF residents on the residents control record. Fifty-four falls in the interval of 46–60 in the column head "Total SNF residents" in table 1. Reading across table 1, the SW numbers are 1 *and* 2, the TE number is 3 and number of sample residents will fall somewhere between 31–40. Since there are two SW numbers, the sampling is done in two steps. In step 1, you start with 1 and take every 3. Thus, you would start with resident 01, circle his line number, take every third resident thereafter and circle their line numbers (i.e., circle line numbers 04, 07, 10, 13, 16, * * * 43, 46, 49, 52). See illustration 2 for the example of step 1.

In step 2, you would return to the beginning of the list, start with resident 02, circle his line number and take every third resident thereafter and circle their line numbers (i.e., circle line numbers 05, 08, 11, 17, * * * 44, 47, 50, 53). As noted above, the number of sample residents will fall somewhere between 31–40. If you count the number of circled lines in illustration 3, the precise number of sample residents is 36.

8. After the sample is selected, *remember to include the resident control record in the packet with all the other questionnaires.* Its inclusion is extremely important because the information on the resident control record is essential to the statistical weighting of the sample so that the data will represent information on *all* SNF residents in the Nation.

When More Form(s) Are Needed

The resident control record has room for listing 100 residents if more lines are needed, use another resident control record and renumber the lines beginning with 101. If a 3rd record is needed, renumber starting with 201, and so on until all SNF resident's names have been recorded.

The nursing home name, identification number, MFI bed size recode, total SNF residents in the home and in the sample, the SW and TE numbers should be completed on the additional form(s), the same as on the first form. Recording this information is essential, because it will be impossible to identify the facility without it. The TE number will run past the first to the second form, past the second form to the third, and so on. For example, when the TE number is 10 and the last resident number sampled was 93, seven lines will be counted on page 1 and three lines on page 2, and the 103d resident selected for the sample.

Selecting the Subsample for the Densen Patient Classification Instrument

The subsampling procedure is as follows: start with the first SNF resident selected in the sample (i.e., the first resident whose line number is circled). Put a second circle around that resident's line number and count down 10 *sample* residents (10 circled resident line numbers), put a second circle around that resident's line number and so on until you have gone through the entire *sample* of residents (circled line numbers only). The sample resident line numbers that you have put a second circle on are the persons who will be in the subsample for the Densen Patient Classification Instrument. The number of residents in this subsample will never be less than one or more than five. The number of residents will usually be three or four.

Estimation and Variance Specifications for the Long-Term Care Facility Improvement Campaign

The following section specifies the estimation and variance specifications for the Long-Term Care Facility Improvement Campaign as developed by the National Center for Health Statistics. The following instructions for calculation of the variance estimates require information on the region, State, county, and city of the facility to be maintained on the data tape.

ESTIMATION AND VARIANCE SPECIFICATIONS FOR 1974 ONHA SURVEY

Home Type Estimates

The estimator recommended for use in the ONHA survey is an inflation estimator. Specifically,

$$X'=\sum_{h=1}^{3}\frac{m_{h'}}{\dot{m}_h}\sum_{i=1}^{\dot{m}_h}W_{1_{hi}}X_{hi}$$

where:

X_{hi}=measure of characteristic for the i^{th} home in the h^{th} stratum.

$W_{1_{hi}}$=The first stage weight of the i^{th} home in the h^{th} stratum.

NOTE:—The weights W_{1hi} are given in table 1 of this document.

$\dot{m}_h$ =number of in-scope sample homes responding in the h^{th} stratum, where a home is in scope if it is a skilled nursing home.

m_h'=number of sample homes clarified as being in-scope at survey time in the h^{th} stratum.

m_h =number of sample homes selected from the h^{th} stratum.

The estimator X' is the estimator of an aggregate. The estimator for proportions, ratios, etc., are computed as follows.

For a ratio statistic of the form $R=X/Z$, the estimate of X would be X' shown above and for Z use the estimator

$$Z'=\sum_{h=1}^{3}\frac{m'_h}{\dot{m}_h}\sum_{i=1}^{\dot{m}_h}W_{1_{hi}}Z_{hi}$$

where:

Z_{hi}=the measure of characteristic for the i^{th} home in the h^{th} stratum.

Then the estimated ratio is $R'=X'/Z'$.

For a proportion of homes having a particular characteristic, the numerator would be X' as computed above with

$$X_{hi}=\begin{cases}1 \text{ if the } i^{th} \text{ home in the } h^{th} \text{ stratum has the characteristic.}\\ 0 \text{ otherwise.}\end{cases}$$

The denominator would be computed as follows:

$$M'=\sum_{h=,1}^{3}\frac{m_h'}{\dot{m}_h}\sum_{i=1}^{\dot{m}_h}W_{1_{hi}}X_{hi}$$

where

$$X_{hi}=\begin{cases}1 \text{ if the } i^{th} \text{ home in the } h^{th} \text{ stratum is in-scope.}\\ 0 \text{ otherwise}\end{cases}$$

Then $P'=X'/M'$.

Resident Type Estimates

The estimator recommended for use is again an inflation estimator.

That is:

$$X''=\sum_{h=1}^{3}\frac{m_h'}{\dot{m}_h}\sum_{i=1}^{\dot{m}_h}W_{1_{hi}}\left(\frac{N_{hi}}{N_{hi}W_{2_{hi}}}\right)\cdot\left(\frac{N_{hi}W_{2_{hi}}}{\dot{n}_{hi}}\right)$$

$$\sum_{j=1}^{\dot{n}_{hi}}X_{hij}=\sum_{h=1}^{3}\frac{m_h'}{\dot{m}_h}\sum_{i=1}^{m_h'}\sum_{j=1}^{\dot{n}_{hi}}W_{1_{hi}}\frac{N_{hi}}{\dot{n}_{hi}}X_{hij}$$

where:

X_{hij}=the measure of characteristic for the j^{th} in-scope sample resident in the i^{th} home of the h^{th} stratum. (An in-scope resident is a resident receiving skilled nursing care under the Medicare or Medicaid programs.)

$W_{2_{hi}}$=the second stage weight for in-scope sample residents in the i^{th} home of the h^{th} stratum.

n_{hi}=number of in-scope sample residents from the i^{th} home of the h^{th} stratum.

$\dot{n}_{hi}$=number of responding in-scope sample residents from the i^{th} home in the h^{th} stratum.

N_{hi}=total number of in-scope residents in the i^{th} home of the h^{th} stratum.

The estimator X'' is the estimator for an aggregate. Similar estimates for proportions, ratios, etc., are computed as follows:

For a proportion, the numerator would be X'' as computed above with:

$$X_{hi}=\begin{cases}1 \text{ if the } j^{th} \text{ in-scope resident of the } i^{th} \text{ home in the } h^{th} \text{ stratum has the characteristic.}\\ 0 \text{ otherwise.}\end{cases}$$

The denominator would be computed by the formula

$$N''=\sum_{h=1}^{3}\frac{m'_h}{\dot{m}_h}\sum_{i=1}^{\dot{m}_h}W_{1_{hi}}\frac{N_{hi}}{\dot{n}_{hi}}\sum_{j=1}^{\dot{n}_{hi}}X_{hij}$$

where

$$X_{hij}=\begin{cases}1 \text{ for residents who are in-scope and in the } i^{th} \text{ home of the } h^{th} \text{ stratum}\\ 0 \text{ otherwise}\end{cases}$$

For a ratio statistic of the form $R=X/Z$, the estimate X would again be X'', and for Z use

$$Z''=\sum_{h=1}^{3}\frac{m'_h}{\dot{m}_h}\sum_{i=1}^{\dot{m}_h}W_{1_{hi}}\frac{N_{hi}}{\dot{n}_{hi}}\sum_{j=1}^{\dot{n}_{hi}}Z_{hij}$$

where

Z_{hij}=the measure of characteristic for the j^{th} sample resident of the i^{th} home in the h^{th} stratum.

Then the estimated ratio is $R''=X''/Z$.

Variance Estimate

The variance estimation procedure to be used is the balanced half-sample replication procedure. There will be eight balanced half-sample replicates whose composition is shown in table 2. For the procedure, two pseudo PSU's must be formed in each of the three bed-size stratum. The bed size stratum is indicated by the bed size recode, which is 1, 2, or 3. Within each stratum arrange the homes by region, alphabetical by State within region, alphabetical by county within State, alphabetical by city within county, and alphabetical by name within city. The pseudo PSU A will contain the first listed home in the stratum and every second home after that, i.e., the first, third, fifth, and so on. The pseudo PSU B in the stratum will contain the remaining homes, i.e., the second, fourth, sixth, and so on.

To construct a variance estimate for resident type estimates, first compute an estimate of the form X_k'' from the k^{th} half-sample. This estimate is like X'' computed from the whole sample (see resident type estimates), except that all records should be weighted by 2 before summing. Then, given an estimate X_k'' from each replication, the variance of X'' is estimated by

$$S_{X''}=\tfrac{1}{8}\sum_{k=1}^{8}(X_k''-X'')^2.$$

The variance for home type estimates is computed in the same way as the variance for resident type estimates except X_k' *is like* X' for home type estimates with all records being weighted by 2 before summing.

These procedures should also be used for estimating the variance of rates, percentages, and so on, as well as aggregates.

Table 2.—ONHA survey replicate indicators

Stratum	Pseudo PSU	Replicate indicators							
1	A	1	1	1	0	1	0	0	0
	B	0	0	0	1	0	1	1	1
2	A	0	1	1	1	0	1	0	0
	B	1	0	0	0	1	0	1	1
3	A	0	0	1	1	1	0	1	0
	B	1	1	0	0	0	1	0	1

Example: The first half sample replicate contains PSU A from stratum 1, PSU B from stratum 2, and PSU B from stratum 3.

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Preparation of the Data for Analysis

DIAGNOSTIC CATEGORIES

Team physicians transcribed the actual diagnoses to the survey form as they appeared on patients' charts, identifying primary and secondary diagnoses on admission and other diagnoses postadmission. To assure consistent coding the corresponding ICDA designation was assigned to all diagnoses on returned questionnaires by a group of three physicians, who mutually clarified non-specific diagnoses and agreed on the diagnostic groups used in the reported tables. The diagnostic categories used with appropriate ICDA Code are shown below.

Diagnostic category	*ICDA Code*
1. Heart Disease	Chronic rheumatic (393–398). Hypertensive (402, 404). Ischemic (410–414). Other forms (420–429).
2. Chronic brain disease	Mental disorders not specified as psychotic associated with physical condition (309). Other disease of brain (347). Generalized ischemic cerebrovascular disease (437). Senility without mention of psychosis (794).
3. Stroke	Cerebrovascular disease (except generalized ischemic) (430–436, 438).
4. Fractures	Fractures (800–829). Dislocations without fracture (830–839).
5. Neurological disease	Late effects of acute poliomyelitis (044). Syphilis of central nervous system (094). Inflammatory disease of central nervous system (320–324). Hereditary and familial disease of nervous system (330–333). Other diseases of central nervous system (340–349). Disease of nerves and peripheral ganglia (350–358). Congenital anomalies of brain and spinal cord (740–743). Down's disease (759).
6. Generalized arteriosclerosis and hypertension.	Hypertensive disease (400–401). Disease of arteries, arterioles and capillaries (440–448). Diseases of veins and lymphatics and other diseases of circulatory system (450–458).
7. Neuroses and psychoses	Psychoses (290–299). Neuroses, personality disorders and other nonpsychotic mental disorders (300–309).
8. Diabetes	Diabetes Mellitus (250).
9. Diseases of musculoskeletal system.	Diseases of musculoskeletal system and connective tissue (710–738).
10. Mental retardation	Mental retardation (310–315).
11. Neoplasms	Neoplasms—all sites (140–239).
12. Diseases of respiratory system.	Pulmonary embolism and infarction (450). Acute respiratory disease except influenza (460–466). Influenza (470–474). Pneumonia (480–486). Bronchitis, emphysema and asthma (490–493). Other diseases of respiratory system (510–519). Symptoms referable to respiratory system (783).
13. Diseases of digestive system	Disease of esophagus, stomach and duodenum (530–537). Hernia of abdominal cavity (550–553). Other diseases of intestine and peritoneum (560–569). Disease of liver, gall bladder, and pancreas (570–577). Symptoms referable to upper GI tract (784). Symptoms referable to abdomen and lower GI tract (785).
14. Diseases of genitourinary system.	Diseases of genitourinary system (580–629). Symptoms referable to genitourinary system (786). Uremia (792).
15. Diseases of eye and ear	Other diseases and conditions of eye (370–379). Diseases of ear and mastoid process (380–389). Combined blindness and deafness (special code).
16. Other	Other category includes: Disease of thyroid gland (240–246). Disease of other endocrine glands excluding diabetes mellitus (250–258). Avitaminosis and other nutritional deficiencies (260–269). Congenital disorders of amino acid metabolism (270–279). Disease of the blood and blood-forming organs (280–289). Infections of skin and subcutaneous tissue (680–686). Other inflammatory conditions of skin and subcutaneous tissue (690–698). Chronic ulcer of skin (707).

General Instructions for Members of the Survey Team

A SUMMARY

1. The random selection and the survey team is to concern itself only with SNF patients in the Title XVIII and Title XIX programs. *No ICF patients. No private patients.*

2. If facility has no SNF XVIII/XIX patients do all of the survey except the patient specific criteria sections and the patient assessment worksheets.

3. You are to survey for the current status of the facility and its SNF patients. Review records of the randomly selected patients *only*.

4. This is a fact-finding survey, *not* a certification or licensure survey. Be tactful.

5. All report forms and other information is confidential. Do not lose any forms or instructions or other material provided. Keep the material secure at all times.

6. Definitions appearing in the FEDERAL REGISTER of Jan. 17, 1974 are to be used for this survey.

7. Identification Procedures—use code numbers *only* for all forms. Names of: Facility, patients, personnel, city, State or any other information is *not* to be entered on the forms with the exception of the patient selection form. Your forms are already coded. After patients have been selected use only the number opposite the patient's name appearing on the patient selection form, on the patient specific criteria form and patient assessment worksheet.

Instructions for Physician Member of Team

The physician member of the survey team will be responsible for the overall patient assessment activity and in that regard will:

1. *Coordinate* the survey activities of the other professional specialists in conducting the patient specific criteria sections of the survey and in preparing the work sheets. This condition responsibility will require implementation of activities which will enable the members of the team to review each of the selected patient's medical record and to conduct necessary interviews and observations.

2. Act as a consultant to the team members to assist in finalizing judgments concerning the medical condition of a patient.

3. Review the medical record and assist in conducting interviews and observation of the randomly selected patients.

4. *Survey patient care policies* of the survey.

5. Survey the medical unit of the survey.

6. For each randomly selected patient, prepare that portion of the patient assessment worksheet which pertains to the current primary diagnosis (or if not available, the primary admitting diagnosis) and each current secondary diagnosis. In addition, record the drugs currently prescribed for the patient which fall within the categories listed.

7. Review for accuracy and completeness the patient assessment report.

Registered Nurse Responsibilities

1. Conduct nursing facility survey using the nursing facility specific criteria forms.

2. Conduct survey of records of patients in the sample using the nursing patient specific criteria forms.

3. Conduct observation/interview of patients in the sample using the nursing patient specific criteria forms.

4. Conduct assessment of selected patients in sample using patient assessment worksheet.

Rehabilitative Responsibilities

1. Conduct rehabilitative facility survey using the rehabilitative facility specific criteria forms.

2. Conduct survey of records of patients in the sample using the rehabilitative patient specific criteria forms.

3. Conduct observation/interview of patients in the sample using the rehabilitative patient specific criteria forms.

Pharmacist Responsibilities

1. Conduct the pharmaceutical facility specific criteria survey.

2. Conduct the pharmaceutical patient specific criteria survey on the patients in the sample.

Dietitian Responsibilities

1. Conduct nutrition and dietetics facility survey using the nutrition and dietetics facility specific criteria forms.

2. Conduct survey of records of patients in the sample using the nutrition and dietetics patient specific criteria forms.

3. Conduct observation/interview of patients in the sample using the nutrition and dietetics patient specific criteria forms.

Social Worker Responsibilities

1. Conduct psychosocial facility survey using the psychosocial facility specific criteria forms.

2. Conduct survey of records of patients in the sample using the psychosocial patient specific criteria forms.

3. Conduct observation/interview of patients in the sample using the psychosocial patient specific criteria forms.

Fire Safety Engineer Responsibilities

1. Conduct life safety code survey.

2. Assist other surveyors as necessary.

Administrative Surveyor Responsibilities

As team leader for the survey:

1. Responsible for the overall survey effort.

2. Entry and exit conference.

3. Survey schedule for survey.

4. Management section of quality of care survey form.

5. Financial information survey.

6. Control over all survey forms and security of confidentiality.

7. Collecting, assembling, and reviewing for accuracy and completion (all forms).

8. Select patients for record review, observation and interview.

9. Complete the LTCFI survey identification sheet for each facility.

Acknowledgments

The Office of Nursing Home Affairs gratefully acknowledges the splendid cooperation and the significant contribution of all persons who directly or indirectly participated in the Long-Term Care Facility Survey and the preparation of this report. Without their breadth of experience and expertise in a wide number of health fields and in long-term care, this study would have been impossible. We have attempted to list the names of those who participated directly to whom we are indebted for assistance. This brief list does not reveal their extensive academic credentials.

At this time we also wish to express our sincere appreciation to all programs and agencies and the many individuals who indirectly supported the survey in other countless ways. The interest and enthusiasm envidenced by all who participated directly and indirectly in the survey and in the preparation of this introductory report indicate that steady progress will continue to be made in improving long-term care in the Nation.

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Social Security Amendments of 1972 Public Law 92-603

SUMMARY OF SECTIONS AFFECTING LONG-TERM CARE FACILITIES

Sections 246 and 247 Institutional Standards: Skilled Nursing Facilities

These H.R. 1 sections establish a common definition of care and a single set of health, safety, environmental, and staffing standards for institutions (redesignated Skilled Nursing Facilities under section 278) formerly identified as Extended Care Facilities under Medicare and Skilled Nursing Homes under Medicaid.

Section 246.—Requires, effective July 1, 1973, uniform standards for the participation of skilled nursing facilities under both Medicare and Medicaid. It incorporates the present Medicare requirements and adds certain additional requirements: a skilled nursing facility must: (a) Supply complete information to the Secretary as to facility ownership; (b) cooperate in a program of independent medical evaluation and audit of patients; (c) adhere to the Life Safety Code; (d) make all information required to be filed with the Secretary available to Federal and State employees for administration of Title XVIII and XIX; and (e) meet the institutional planning requirements of section 234 (effective April 1, 1973) under Medicare.

Section 247.—Establishes, effective January 1, 1973, a common definition of care requirement for services provided in skilled nursing facilities. The Medicare definition of covered extended care services is broadened and the section makes the same definition applicable for skilled nursing services under Medicaid. Skilled nursing facility services are defined as those services provided directly by or requiring the supervision of skilled nursing personnel or skilled rehabilitation services which the patient needs on a daily basis and which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis.

Sections 265, 267, and 277 Professional Services: Skilled Nursing Facilities

These H.R. 1 sections change the requirements for certain professional services as conditions of participation for skilled nursing facilities. Authorizes States to provide specialized consultation services.

Section 265.—Specifies that provision of medical social services will not be required as a condition of participation for skilled nursing facilities under Medicare. Amends section 1861(j). Effective upon enactment.

Section 267.—Provides that to the extent that law or regulation requires the presence of a registered nurse for more than 40 hours a week the Secretary may grant a waiver of such requirement if: (1) The facility is located in a rural area and supply of skilled nursing facility services in such area is insufficient to meet needs of patients residing therein; (2) the facility has one full-time RN who is regularly on duty 40 hours a week; (3) the facility is caring only for patients whom physicians have certified can go without RN services for a 48-hour period; and (4) if the facility has patients for whom physicians have indicated a need for daily skilled nursing services, the facility has made arrangements for an RN or physician to spend time at the facility as needed to provide services on uncovered days. Amends section 1861(j). Effective upon enactment.

Section 277.—Permits State agencies to provide specialized consultant services for Medicare patients in SNF's, upon request by the SNF. Amends section 1864(a). Effective upon enactment.

Sections 239 (Part), 249A, 249B, 299L Certification Functions: Skilled Nursing and Intermediate Care Facilities

These H.R. 1 sections broaden the authority of the Secretary to certify skilled nursing facilities for participation in Medicare and Medicaid, and prescribe related functions for State health agencies.

Section 239.—Effective January 1973, this section specifies the same State Health Agency (or other appropriate medical agency) shall be responsible for certifying facilities for participation in Medicare and Medicaid.

Section 249A.—Authorizes the Secretary to certify for participation in Title XIX those facilities which he certifies under Title XVIII. Makes uniform the term of agreements. Under Section 246, the Secretary is also given authority to waive Life Safety Code requirements under Title XVIII and XIX.

Section 249B.—From October 1, 1972 to July 1, 1974 authorizes 100 percent reimbursement for costs incurred in surveying skilled nursing facilities and intermediate care facilities under Medicaid.

Section 299L.—Authorizes the Secretary to certify, under Medicaid, intermediate care facilities and skilled nursing facilities located on Indian reservations.

Section 269 Qualifications of Health Personnel: Skilled Nursing Facilities

Permits States to waive permanently licensure requirements for persons who served as nursing home administrators for the 3-year period prior to the establishment of the State's licensing program. Amends section 1908(d). Effective upon enactment.

Sections 207 (part), 228, 237, 238, 239 (part), 246 (part), 248, and 298 Medical Audit and Utilization Review: Skilled Nursing and Intermediate Care Facilities

These H.R. 1 sections require a common program of independent professional evaluation of all patients in skilled nursing facilities and intermediate care facilities, identify certain State responsibilities for utilization review, and provide for other requirements concerning medical certifications and utilization controls.

Section 207 (part).—Adds a new section 1903(g) to provide for a reduction in Federal matching for institutional services for Medicaid eligibles after a specified number of days unless the State agency makes a satisfactory showing that it has in effect an effective system of utilization controls, meeting requirements set forth in this section; and to require the Secretary to validate a State's utilization control procedures by sample on-site surveys (as referenced to by sections 238, 239, 246).

Section 228.—Requires advance coverage approval of length of stays in skilled nursing facilities and for the need of home health agency services based upon diagnosis, plan of treatment, and other requirements of eligibility. Effective date July 1, 1973.

Section 237.—Amends new section 1903(l) to require participating hospitals and skilled nursing facilities to have Title XIX cases reviewed by the same utilization review (UR) committee that reviews Title XVIII cases, or one that meets Title XVIII standards; and permits the Secretary to waive this requirement if the State demonstrates it has a superior alternative (as required in section 207).

Section 238.—Amends 1814(a)(7) and 1861(k)(4) by adding to the utilization review requirement, "including any finding made in the course of a sample or other review of admissions to the institution". (as referenced to by sections 207, 239, 246).

Section 239 (part).—Amends section 1902(a)(9) to require the State Health Agency, or equivalent to establish a plan for advising the single State agency with respect to conduct of utilization, medical, and independent professional review.

Section 246 (part).—Part of this section requires skilled nursing facilities under both Medicare and Medicaid to institute a common program of independent professional evaluation and audit of all patients in the skilled nursing facility. Effective date July 1, 1973.

Section 248.—Authorizes extension of the 14-day transfer requirement for skilled nursing facility medicare benefits to 28 days if appropriate bed space is not available in the geographical area, in which a patient resides, or longer than 28 days if the patient's condition is not appropriate for immediate provision of skilled nursing services. Effective upon enactment.

Section 298.—Technical amendment to Public Law 92-223 under section 1902(a)(31)(A) to eliminating the phrase "which provides more than a minimum level of health care services."

Section 246 (part), 249A (part), 249C, 299A, 299D Disclosure Requirements: Skilled Nursing and Intermediate Care Facilities

These H.R. 1 sections require disclosure of various types of information by the Secretary to appropriate State agencies, by the Secretary and State agencies to the public, and by providers to the Secretary and State agencies.

Section 246 (part).—Amends section 1861(j). Effective July 1, 1973, requires all skilled nursing facilities participating in Title XVIII to disclose to the Secretary or his delegate full and complete information as to ownership and to report any changes in ownership. It also requires that all information obtained under this section be made available to Federal and State employees for purposes consistent with effective administration of the Medicare and Medicaid programs.

Section 249A (part).—Requires the Secretary to notify the Sate agency administering the Medicaid program, of his approval or disapproval of any institution which applies for certification as a skilled nursing facility under Title XVIII. This provision is effective with respect to agreements filed under section 1866, on, or after enactment but accepted by the Secretary on or after enactment.

Section 249C.—Requires the Secretary to make available to State agencies administering Title XIX and to the public, certain information obtained by him regarding the performance of carriers, intermediaries, State agencies, and providers of services under Medicaid and Medicare. This requirement is effective with respect to reports completed after the third calendar month following enactment (February 1973).

Section 299A.—Effective January 1, 1973, requires any intermediate care facility participating in Title XIX to disclose to the State licensing agency full and complete information as to the ownership of such facility and to report any changes of ownership.

Section 299D.—Effective before May 1, 1973, requires the Secretary and the appropriate State agency to make available to the public, within 90 days following completion of each survey, the pertinent findings of surveys of any health care facility, laboratory, clinic, agency, or organization.

Sections 228, 249, and 299 Reimbursement Requirements: Skilled Nursing and Intermediate Care Facilities

These H.R. 1 sections add additional requirements relating to reimbursement levels for skilled nursing homes and intermediate care facilities.

Section 228.—For purposes of making payment for services, the Secretary is authorized to establish, by diagnosis or medical condition, minimum periods of time after hospitalization during which a patient would be presumed eligible under Medicare for skilled nursing facility and home health care benefits. The attending physicians will certify prior to or on admission to SNF or home health services that the condition is one designated in the regulations and furnish a plan of treatment. Certification and patient stays are to be reviewed and the provisions may be suspended for the physician involved if there is abuse of the advance approval procedure. The section specifically restricts the retroactive application of regulations pertinent to these provisions. The effective date is January 1, 1973.

Section 249.—Requires the States to develop methods of reimbursing SNF's and ICF's on a basis reasonably related to cost, and to implement these methods under Medicaid after approval by the Secretary, by July 1, 1976. Reimbursement methods found acceptable by the Secretary for Medicaid would be adapted for the purpose of Medicare reimbursement. The Secretary may adjust the rates upward (not to exceed 10 percent) for requirements under Medicare not otherwise taken into account in computation of Medicaid rates. Percentage adjustments may be made on a geographic basis of classes of facilities rather than on an institution-by-institution basis.

Section 299.—Provides that for Federal matching purposes under Medicaid, until January 1, 1975, a State may not reduce non-Federal expenditures for patients receiving intermediate care services in public institutions for the mentally retarded below the average amount expended for such services in these institutions in the four quarters immediately preceding the quarter in which the State elects to provide such services under Title XIX.

Sections 292 and 297
Coverage Requirements:
Intermediate Care Facilities

These H.R. 1 sections clarify coverage for ICF services under Medicaid and provide technical amendments to Public Law 29–223.

Section 292.—Allows Federal matching for intermediate care in States which, on January 1, 1972, did not have a Medicaid program in operation. Exempts transfer of ICF's from Title XI to Title XIX in these instances until the State has a Title XIX program in effect. Effective date: October 30, 1972.

Section 297.—Provides coverage for intermediate care furnished in mental and tuberculosis institutions to individuals age 65 or older. Effective date: January 1973.

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PART III

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service

Social Security Administration

■

SKILLED NURSING FACILITIES

Standards for Certification and Participation in Medicare and Medicaid Programs

No. 12—Pt. III——1

Title 20—Employees' Benefits

CHAPTER III—SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

[Regs. 5, further amended]

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Skilled Nursing Facilities

On July 12, 1973, there was published in the FEDERAL REGISTER (38 FR 18620) a notice of proposed rulemaking which set forth proposed amendments to regulations relating to the conditions of participation for skilled nursing facilities, the certification procedures for providers and suppliers of services, the provider and supplier appeals processes, and implementation of provisions of the Social Security Amendments of 1972 (Pub. L. 92-603) affecting the foregoing.

Interested parties were given the opportunity to submit within 30 days data, views, or arguments on the proposed amendments. The comment period was extended by the Secretary for an additional 30 days to September 13, 1973, and notice of this extension appeared in the FEDERAL REGISTER of August 14, 1973.

Comments were received from many sources (including representatives of national, State and local organizations) concerned with skilled nursing services and with the qualifications and duties of health care personnel rendering services under Medicare. All of the comments received on the proposed regulations have been carefully considered.

The most substantive comments received recommended the inclusion of requirements for: (1) A medical director or organized medical staff for skilled nursing facilities; (2) 7-day registered nurse services; (3) a discharge planning program; and (4) a "bill of rights" for patients in such facilities. Since these items were not included in the proposed regulations as published, and are of considerable impact, they are not included in these final regulations. However, they will be published with notice of proposed rulemaking at a later date to afford ample opportunity for comments. Furthermore, under another notice of proposed rulemaking, to be published at a later date, additional changes in the utilization review standards will be issued.

A number of the comments recommended that: (1) Patient care policies be available to the public; (2) the frequency of physician visits be clearly defined; (3) all nursing service staff receive training in rehabilitative nursing; (4) the definition of qualifications of certain health specialists be clarified; (5) there should be a requirement for daily rounds by the charge nurse; and (6) the director of nursing services participates at least annually in continuing education. These comments were accepted and the regulations clarified accordingly.

The following changes have been made to reflect other comments that were received:

(1) The director of nursing services may not serve as a charge nurse in a facility with an average daily total occupancy of 60 or more. This requirement had been an average daily occupancy of 50 or more. This brings the requirement in line with most other Federal and State standards.

(2) In the case of patients needing laboratory and radiological services in a facility not providing such services, the requirement was added that the facility assist the patient in arranging for transportation to the provider of such services. This addition reflects a similar requirement for dental services; as with the dental services provision, transportation of patients for laboratory and radiological services is not covered under Medicare.

(3) The paragraph concerning approved drugs and biologicals which lack substantial evidence of effectiveness for all indications has been deleted. Department-wide regulations on this subject, applicable to all providers and suppliers participating in Federal programs, will be published in the near future. In the meantime, current regulations and policies relating to drugs and biologicals remain in effect.

(4) Those provisions concerning the term of a provider agreement were revised to extend the term of agreement to 60 days after the date specified for the correction of deficiencies to enable the State agency to survey and process their recommendation to the Secretary before the agreement expires.

(5) The definition of a social worker has been revised to include a graduate of a school of social work approved or accedited by the Council on Social Work Education. This will permit a social worker with either a master's or baccalaureate degree in social work to serve as a qualified consultant.

(6) The definitions of qualified professionals in § 405.1101 frequently make reference to the standards of various national professional organizations. The Department has examined the current standards of those organizations and is adopting them. The Secretary will examine future changes in the standards of these organizations and determine whether such changes should be reflected in regulations.

(7) Several provisions of existing regulations which were not included in the proposed regulations as published on July 12, 1973, have now been reinstated after reviewing comments that their deletion could have an adverse effect on patient care. These were: Time requirements for physical examination of the patient at admission; the attending physician must arrange for the medical care of the patient in his absence; duties assigned food service employees outside the dietetic service cannot interfere with their dietetic work assignments; and space, supplies, and equipment must be provided for a patient activities program.

(8) A provision was added to require the retention of the medical records of minors until 3 years after the patient becomes of age under State law. The regulations had been silent on this point. State laws typically provide opportunity for an individual to personally enforce rights accruing during their minority once majority is reached. While this change may require retention of records for a considerable length of time, protection for both the minor patient and the facility is provided, should litigation occur.

The following summarizes those substantive comments that were not accepted.

(1) The suggestion that the time for consultation for the dietitian or pharmacist consultant be specified either in hours or number of visits weekly was not accepted because a rigidly accepted number of hours or visits is no assurance of quality of the service provided. The regulations are, to the extent possible, performance standards, and rely upon the professional judgment of the surveyor in determining whether quality service inherent in the standard has been achieved.

(2) Concern was expressed about the requirement that a facility assume financial responsibility when arranging with an outside resource to provide therapy and certain other services. It was suggested that the patient be billed directly by the person(s) furnishing the services. The provision was retained because these services are part of extended care services under Part A and billing for other services under Part A is done by the facility. Furthermore, the Part A payment mechanism provides safeguards against overutilization and exorbitant fees, and focusing responsibility on the facility enables the surveyor to readily review the circumstances under which the services are offered.

(3) Request was made that during the appeals process, benefits should continue to be paid to a facility that had been terminated from participation in the program. This request was rejected because facilities are terminated from program participation when the health and safety of patients can no longer be assured and only after the facility has been given notice of the nature of its deficiencies and been given ample time to make the necessary improvements. When this decision has been made, it is not possible to justify continuing payment to a facility beyond the 30-days benefits provided in the statute for those beneficiaries admitted to the facility prior to the effective date of termination.

(4) Request was also made that Medicaid provide hearings for all facilities that had been terminated or where agreements had not been renewed. This appeals process will be determined by State practices consonant with Medicaid being a State-administered program.

(5) Numerous comments were received from social workers, consumer groups and organizations, protesting the optional provision of social services by skilled nursing facilities. This change is the result of amendments found in section 265 of Pub. L. 92-603, the Social Security Amendments of 1972; hence, no action could be taken to reinstate this as a mandatory requirement without further legislative action.

(6) The suggestion that there be a specific ratio of nursing staff to patients was not accepted because the variation from facility to facility in the composition of its nursing staff, physical layout, patient needs and the services necessary to meet those needs precludes setting such a figure. A minimum ratio could result in all facilities striving only to reach that minimum and could result in other facilities hiring unneeded staff to satisfy an arbitrary ratio figure. However, as a means of closely monitoring the adequacy of staffing in skilled nursing facilities, Medicare has adopted a provision that now appears in title XIX regulations thereby further achieving uniformity between the two programs. This provision calls for the facility to submit quarterly staffing reports to the State agency, and this is reflected in these amendments in Subpart K, § 405.1121 (b).

(7) Several suggestions were made that there was insufficient provision for protection of the patient's rights. The regulations do specifically provide that the facility must have rules on the protection of the personal and property rights of patients; and that patient care policies include provisions to protect these rights. Additionally, discriminatory treatment in skilled nursing facilities would be barred by the continued requirement that the facilities must be in compliance with title VI of the Civil Rights Act of 1964. However, as previously indicated, a "bill of rights" for patients will be published under the notice of proposed rulemaking procedures.

Some criticism of the revised format of the conditions of participation was expressed. The skilled nursing facility regulations are designed as performance standards; greater specificity would diminish their applicability to all facilities. Additionally, State agency surveyors have recently undergone extensive training to enhance their understanding of the program and the survey process. These performance-oriented requirements will provide these surveyors criteria on which to base their assessment of an individual facility's performance. Further, certification requirements for all providers and suppliers of services (hospitals, skilled nursing facilities, home health agencies, providers of outpatient physical therapy services, independent laboratories, and portable X-ray services) are now centralized in the new Subpart T.

In the definition found in § 405.1101 (a)(2), administrator of skilled nursing facility, the length of supervisory management experience required was revised from one year to three years to assure adequate experience to direct administrative activities in such health facilities. This technical change reflects current title XIX requirements for administrators and thereby further achieves conformance between the two programs.

The amendments as announced under the notice of proposed rulemaking (38 FR 18620) are adopted, with the noted changes. In addition, some parts of the regulations were redrafted for clarification purposes, in line with the comments received.

(Secs. 1102, 1814, 1832, 1833, 1861, 1863, 1865, 1866, 1871, 49 Stat. 647, as amended, 79 Stat. 294, as amended, 79 Stat. 313–327, as amended, 79 Stat. 331 (42 U.S.C. 1302, 1395f, 1395k, 1395l, 1395x, 1395z, 1395bb, 1395cc, 1395hh))

Effective date. These amendments shall be effective February 19, 1974.

(Catalog of Federal Domestic Assistance Program No. 13.800, Health Insurance for the Aged and Disabled-Hospital Insurance)

Dated: December 19, 1973.

J. B. CARDWELL,
Commissioner of Social Security.

Approved: December 27, 1973.

CASPAR W. WEINBERGER,
Secretary of Health, Education, and Welfare.

Regulation No. 5 of the Social Security Administration, as amended (20 CFR Part 405), are further amended as set forth below:

Subpart F—Agreements, Elections, Contracts, Nominations, and Notices

1. The heading for Subpart F is revised to read as set forth above.

§ 405.601, 405.602 [Amended]

2. In §§ 405.601 and 405.602, the words "extended care facility" are revised to read "skilled nursing facility."

3. A new § 405.604 is added to read as follows:

§ 405.604 Term agreements with skilled nursing facilities.

Effective with respect to provider agreements accepted for filing on or after October 30, 1972, an agreement with a skilled nursing facility shall be for a specified term and such term shall be determined by the Secretary in the following manner:

(a)(1) The term of an agreement may be for a period of 12 full calendar months where the facility is in full compliance with the standards contained in Subpart K of this part.

(2) Where the facility is not in full compliance with standards contained in Subpart K of this part the term of an agreement may:

(i) Be restricted to a term that ends no later than the 60th day following the end of the time period specified for the correction of deficiencies in a written plan which the Secretary has approved: *Provided,* That such term shall not exceed 12 full calendar months; or

(ii) Provide a conditional term of 12 full months, subject to an automatic cancellation clause that the agreement will terminate at the close of a predetermined date which shall be no later than the 60th day following the end of the time period specified for the correction of deficiencies: *Provided,* That such date will occur within such 12-month term, unless the Secretary determines that all required corrections have been satisfactorily completed or that the facility has made substantial effort and progress in correcting such deficiencies and has resubmitted in writing a plan of correction acceptable to the Secretary.

(b)(1) Where the Secretary determines that the health and safety of program beneficiaries will not be jeopardized thereby, the term of an agreement may be extended for a period of 2 full calendar months, if the Secretary finds that such extension is necessary to:

(i) Prevent irreparable harm to such facility; or

(ii) Prevent hardship to the program beneficiaries being furnished items and services by such facility; or

(2) If the Secretary finds it impracticable within such term to determine whether such facility is complying with the provisions of the Act and regulations issued thereunder.

(c)(1) Except as provided in paragraph (b) of this section, the term of an agreement may not be extended and such agreement shall terminate at the close of the last day of its specified term and will not be automatically renewable from term to term.

(2) The nonrenewal of an agreement under the conditions described in this section is not a termination of the agreement by the Secretary pursuant to the provisions discussed in § 405.614. A determination by the Secretary not to accept such facility for participation following the end of such term shall be an initial determination relating to the facility's qualifications as a provider of services for the period immediately following such term and the facility shall be entitled to a hearing with respect to such determination. (See Subpart O of this part.)

(3) Where the Secretary determines that he will not accept an agreement with a skilled nursing facility for the period immediately following the end of the term of such facility's existing agreement, the Secretary shall give notice of such determination to the facility at least 30 days and to the public at least 15 days before the end of such term. Each notice by the Secretary shall state the reasons for such determination, the effective date for the termination of the existing agreement, and the applicability of such termination as it relates to the services of the facility.

(d) Notwithstanding the preceding provisions of this section, an agreement filed by an extended care facility (now defined as a skilled nursing facility) which was accepted by the Secretary prior to October 30, 1972, and which was in effect on such date, shall be for a specified term ending at the close of December 31, 1973.

4. Section 405.605 is revised to read as follows:

§ 405.605 Provider of services; scope of term.

As used in section 1866 of the Act and this Part 405, the term "provider of services" (or "provider") refers only to a hospital, a skilled nursing facility, or a home health agency (see Subparts J,

K, and L of this part) and, for the limited purposes of furnishing outpatient physical therapy or speech pathology services a clinic, rehabilitation agency, or public health agency (see Subpart Q of this part).

5. Section 405.606 is amended by revising paragraph (b), and adding a new paragraph (c) to read as follows:

§ 405.606 Acceptance of provider as a participant.

* * * * *

(b) If the provider wishes to participate in the program, both copies of the agreement shall be signed by an authorized official of the organization and filed with the Secretary and, upon acceptance for filing by the Secretary, a copy of such agreement shall be returned to the provider with the Secretary's written notice of acceptance. Such notice shall indicate the date on which the agreement was signed by the authorized official of the provider and the date on which the agreement was accepted by the Secretary; specify the effective date of the agreement; and, in the case of an agreement filed by a skilled nursing facility, the term of such agreement as determined in accordance with the provisions of § 405.604.

(c) The participation of a hospital, skilled nursing facility, or home health agency which voluntarily files an agreement to participate in the health insurance program contemplates that such hospital, facility, or agency will accept program beneficiaries for care and treatment. If a participating hospital, facility, or agency has any restrictions on the types of services it will make available and/or the type of health conditions that it will accept, or has any other criteria relating to the acceptance of persons for care and treatment, it is expected that such restrictions or criteria, if made applicable to program beneficiaries, will be applied in the same manner in which they are applied to all other persons seeking care and treatment by such hospital, facility, or agency. A provider's admission policies and practices that are inconsistent with the provider agreement objectives set forth in this paragraph (c) may be the basis for termination of participation by the Secretary pursuant to § 405.614(a)(1).

6. Paragraph (a) of § 405.613 is revised to read as follows:

§ 405.613 Termination by provider of services.

(a) A provider may terminate a section 1866 agreement (and in the case of a skilled nursing facility, prior to the end of the specified term of such agreement—see § 405.604) by filing with the Secretary a written notice of its intention to terminate such agreement. The notice of intent to terminate shall state the date for the termination of the agreement (the date must be the first day of a month). The Secretary may accept the termination date stated in the notice or he may set a different date. If the notice of termination does not specify the date for the termination of the agreement, the date shall be set by the Secretary. However, if the termination date is set by the Secretary, such date shall not be more than 6 months from the date the notice is filed. In addition to giving notice to the Secretary, the provider also gives at least 15 days notice to the public by publishing in one or more local newspapers a statement of the date of termination of the provider agreement with the Secretary. The notice also shall inform the public of the applicability of termination (see § 405.615) as it relates to services of the provider.

* * * * *

7. Paragraph (a) of § 405.614 is revised to read as follows:

§ 405.614 Termination by the Secretary.

(a) *Cause for termination.* The Secretary may terminate an agreement (and in the case of a skilled nursing facility, prior to the end of the specified term of such agreement—see § 405.604) if the Secretary determines that the provider of services:

(1) Is not complying substantially with the provisions of title XVIII and this Part 405, or with the provisions of the agreement entered into pursuant to § 405.606; or

(2) No longer meets the appropriate conditions of participation necessary to qualify as a hospital (see Subpart J of this part), skilled nursing facility (see Subpart K of this part), home health agency (see Subpart L of this part), or a rehabilitation agency, clinic, or public health agency as a provider of outpatient physical therapy or speech pathology services (see Subpart Q of this part), as the case may be; or

(3) Fails to furnish information as the Secretary finds to be necessary for a determination as to whether payments are due or were due under this Part 405 and the amounts thereof; or

(4) Refuses to permit examination of its fiscal or other records by, or on behalf of, the Secretary as may be necessary for verification of information furnished as a basis for payment under the health insurance benefits program.

* * * * *

8. Paragraph (a) of § 405.615 is revised to read as follows:

§ 405.615 Applicability of termination.

A termination of an agreement under the conditions described in §§ 405.604, 405.613, or 405.614 shall be applicable:

(a) In the case of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services), or posthospital extended care services furnished to any individual after the effective date of such termination, except that payment may be made for up to 30 days with respect to such services furnished to any beneficiary who was admitted to the hospital or skilled nursing facility prior to the effective date of the termination.

* * * * *

9. Section 405.616 is amended to read as follows:

§ 405.616 Reinstatement of provider as participant after termination.

(a) Subject to the provisions of paragraph (b) of this section, where an agreement between a provider of services and the Secretary is terminated by the Secretary under the conditions described in §§ 405.604 and 405.614, such institution or agency shall not file another agreement to participate in the health insurance benefits program unless the Secretary finds that the reason for the termination of the prior agreement has been removed and that there is reasonable assurance that it will not recur.

(b) Where an agreement between a provider of services and the Secretary is terminated under conditions described in § 405.604, § 405.613, or § 405.614, such institution or agency shall not file another agreement to participate in the health insurance benefits program unless the Secretary finds that such institution or agency has fulfilled (or has made arrangements satisfactory to the Secretary to fulfill) all of the statutory and regulatory responsibilities of its prior agreement with the Secretary.

* * * * *

10. Section 405.685 is amended by adding a paragraph (d) to read as follows:

§ 405.685 Agreements with States pursuant to section 1864; general.

The Secretary shall enter into an agreement with any State which is able and willing to do so, under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by the Secretary:

* * * * *

(d) To review statements obtained from each skilled nursing facility setting forth (from payroll records) the average numbers and types of personnel (in full-time equivalents) on each tour of duty during at least 1 week of each quarter, such week to be selected by the survey agency and to occur irregularly in each quarter of a year.

Subpart K—Conditions of Participation; Skilled Nursing Facilities

11. Subpart K is amended by deleting §§ 405.1101 through 405.1110. These sections are superseded by new Subpart T. Subpart K is further amended by revising the heading as set forth above, adding a new § 405.1101 and §§ 405.1120 through 405.1137 to read as follows:

Sec.

Sec.

§ 405.1101 Definitions.

As used in this subpart, the following definitions apply:

(a) *Administrator of skilled nursing facility.* A person who:

(1) Is licensed as required by State law; or

(2) If the State does not have a Medicaid program, and has no licensure requirement, is a high school graduate (or equivalent), has completed courses in administration or management approved by the appropriate State agency, and has 3 years of supervisory management experience in a skilled nursing facility or related health program; or

(3) If the administrator of a hospital in which there is a hospital-based distinct-part skilled nursing facility, in a State that does not license skilled nursing facility administrators, meets the requirements of § 405.1021(f).

(b) *Approved drugs and biologicals.* Only such drugs and biologicals as are:

(1) In the case of Medicare:

(i) Included (or approved for inclusion) in the United States Pharmacopoeia, National Formulary, or United States Homeopathic Pharmacopoeia; or

(ii) Included (or approved for inclusion) in AMA Drug Evaluations or Accepted Dental Therapeutics, except for any drugs and biologicals unfavorably evaluated therein; or

(iii) Not included (nor approved for inclusion) in the compendia listed in paragraphs (b)(1)(i) and (b)(1)(ii) of this section, may be considered approved if such drugs:

(A) Were furnished to the patient during his prior hospitalization, and

(B) Were approved for use during a prior hospitalization by the hospital's pharmacy and drug therapeutics committee (or equivalent), and

(C) Are required for the continuing treatment of the patient in the facility.

(2) In the case of Medicaid, those drugs approved by the State Title XIX agency.

(c) *Charge nurse.* A person who is:

(1) Licensed by the State in which practicing as a:

(i) Registered nurse; or

(ii) Practical (vocational) nurse who:

(A) Is a graduate of a State-approved school of practical (vocational) nursing; or

(B) Has 2 years of appropriate experience following licensure by waiver as a practical (vocational) nurse, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, or on a State licensure examination which the Secretary finds at least equivalent to the proficiency examination, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualifications as a practical (vocational) nurse after December 31, 1977; and

(2) Is experienced in nursing service administration and supervision and, in areas such as rehabilitative or geriatric nursing, or acquires such preparation through formal staff development programs.

In the case of skilled nursing facility services in an institution for the mentally retarded or in an institution for those with mental diseases, or a distinct part thereof, a person licensed in another category of health care discipline who has special training in the care of such patients may serve as charge nurse provided that such person is licensed in such category by the State following completion of a course of training which included at least the number of classroom and practice hours in all the nursing subjects included in the program of a State-approved school of practical (vocational) nursing, as evidenced by a report on comparison of the courses in the respective curricula to the State agency by the agency(ies) of the State responsible for the licensure of such personnel. (An institution primarily engaged in the care of the mentally retarded or in the treatment of mental diseases cannot qualify as a participating skilled nursing facility under Medicare.)

(d) *Controlled drugs.* Drugs listed as being subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970 (Pub. L. 91–513) as set forth in 21 CFR Part 308.

(e) *Dietetic service supervisor.* A person who:

(1) Is a qualified dietitian; or

(2) Is a graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved by the American Dietetic Association; or

(3) Is a graduate of a State-approved course that provided 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian; or

(4) Has training and experience in food service supervision and management in a military service equivalent in content to the program in paragraph (e)(2) or (e)(3) of this section.

(f) *Dietitian (qualified consultant).* A person who:

(1) Is eligible for registration by the American Dietetic Association under its requirements in effect on the publication of this provision.

(2) Has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management, has 1 year of supervisory experience in the dietetic service of a health care institution, and participates annually in continuing dietetic education.

(g) *Director of nursing services.* A registered nurse who is licensed by the State in which practicing, and has 1 year of additional education or experience in nursing service administration, as well as additional education or experience in such areas as rehabilitative or geriatric nursing, and participates annually in continuing nursing education.

(h) *Drug administration.* An act in which a single dose of a prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper patient, and promptly recording the time and dose given.

(i) *Drug dispensing.* An act entailing the interpretation of an order for a drug or biological and, pursuant to that order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological for a patient or for a service unit of the facility.

(j) *Existing buildings.* For purposes of ANSI Standard No. A117.1 and minimum patient room size (see § 405.1134 (c) and (e)) in skilled nursing facilities or parts thereof whose construction plans are approved and stamped by the appropriate State agency responsible therefore before the date these regulations become effective.

(k) *Licensed nursing personnel.* Registered nurses or practical (vocational) nurses licensed by the State in which practicing.

(l) *Medical record practitioner (qualified consultant).* A person who:

(1) Is eligible for certification as a registered record administrator (RRA), or an accredited record technician (ART), by the American Medical Record Association under its requirements in effect on the publication of this provision; or

(2) Is a graduate of a school of medical record science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Medical Record Association.

(m) *Occupational therapist (qualified consultant).* A person who:

(1) Is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association; or

(2) Is eligible for certification by the American Occupational Therapy Association under its requirements in effect on the publication of this provision; or

(3) Has 2 years of appropriate experience as an occupational therapist, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualifications as an occupational therapist after December 31, 1977.

(n) *Occupational therapy assistant.* A person who:

(1) Is eligible for certification as a certified occupational therapy assistant (COTA) by the American Occupational Therapy Association under its requirements in effect on the publication of this provision; or

(2) Has 2 years of appropriate experience as an occupational therapy assistant, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determination of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapy assistant after December 31, 1977.

(o) *Patient activities coordinator (qualified consultant).* A person who:

(1) Is a qualified therapeutic recreation specialist; or

(2) Has 2 years of experience in a social or recreational program within the last 5 years, 1 year of which was full-time in a patient activities program in a health care setting; or

(3) Is a qualified occupational therapist or occupational therapy assistant.

(p) *Pharmacist.* A person who:

(1) Is licensed as a pharmacist by the State in which practicing, and

(2) Has training or experience in the specialized functions of institutional pharmacy, such as residencies in hospital pharmacy, seminars on institutional pharmacy, and related training programs.

(q) *Physical therapist (qualified consultant):* A person who is licensed as a physical therapist by the State in which practicing, and

(1) Has graduated from a physical therapy curriculum approved by the American Physical Therapy Association, or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or

(2) Prior to January 1, 1966, was admitted to membership by the American Physical Therapy Association, or was admitted to registration by the American Registry of Physical Therapists, or has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or

(3) Has 2 years of appropriate experience as a physical therapist, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or

(4) Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or

(5) If trained outside the United States, was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, meets the requirements for membership in a member organization of the World Confederation for Physical Therapy, has 1 year of experience under the supervision of an active member of the American Physical Therapy Association, and has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

(r) *Physical therapist assistant.* A person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing, and

(1) Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or

(2) Has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapist assistant after December 31, 1977.

(s) *Social worker (qualified consultant).* A person who is licensed, if applicable, by the State in which practicing, is a graduate of a school of social work accredited or approved by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.

(t) *Speech pathologist or audiologist (qualified consultant).* A person who is licensed, if applicable, by the State in which practicing, and

(1) Is eligible for a certificate of clinical competence in the appropriate area (speech pathology or audiology) granted by the American Speech and Hearing Association under its requirements in effect on the publication of this provision; or

(2) Meets the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification.

(u) *Supervision.* Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence, with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Unless otherwise stated in regulations, the supervisor must be on the premises if the person does not meet assistant-level qualifications specified in these definitions.

(v) *Therapeutic recreation specialist (qualified consultant).* A person who is licensed or registered, if applicable, by the State in which practicing, and is eligible for registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society (Branch of National Recreation and Park Association) under its requirements in effect on publication of this provision.

§ 405.1120 Condition of participation—compliance with Federal, State, and local laws.

The skilled nursing facility is in compliance with applicable Federal, State, and local laws and regulations.

(a) *Standard: Licensure.* The facility, in any State in which State or applicable local law provides for licensing of facilities of this nature:

(1) Is licensed pursuant to such law; or

(2) If not subject to licensure, is approved by the agency of the State or locality responsible for licensing skilled nursing facilities as meeting fully the standards established for such licensing, and

(3) Except that a facility which formerly met fully such licensure requirements, but is currently determined not to meet fully all such requirements, may be recognized for a period specified by the State standard-setting authority.

(b) *Standard: Licensure or registration of personnel.* Staff of the facility are licensed or registered in accordance with applicable laws.

(c) *Standard: Conformity with other Federal, State, and local laws.* The facility is in conformity with all Federal, State, and local laws relating to fire and safety, sanitation, communicable and reportable diseases, postmortem procedures, and other relevant health and safety requirements.

§ 405.1121 Condition of participation—governing body and management.

The skilled nursing facility has an effective governing body, or designated persons so functioning, with full legal authority and responsibility for the operation of the facility. The governing body adopts and enforces rules and regulations relative to health care and safety of patients, to the protection of their personal and property rights, and to the general operation of the facility. The governing body develops a written institutional plan that reflects the operating budget and capital expenditures plan.

(a) *Standard: Disclosure of ownership.* The facility supplies full and complete information to the survey agency as to the identity (1) of each person who has any direct or indirect ownership interest of 10 per centum or more in such skilled nursing facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such skilled nursing facility or any of the property or assets of such skilled nursing facility, (2) in case a skilled nursing facility is organized as a corporation, of each officer and director of the corporation, and (3) in case a skilled nursing facility is organized as a partnership, of each partner; and promptly reports any changes which would affect the current accuracy of the information so required to be supplied.

(b) *Standard: Staffing patterns.* The facility furnishes to the State survey agency information from payroll records setting forth the average numbers and types of personnel (in full-time equivalents) on each tour of duty during at least 1 week of each quarter. Such week will be selected by the survey agency.

(c) *Standard: Bylaws.* The governing body adopts effective patient care policies and administrative policies and bylaws governing the operation of the facility, in accordance with legal requirements. Such policies and bylaws are in writing, dated, and made available to all members of the governing body which

ensures that they are operational, and reviews and revises them as necessary.

(d) *Standard: Independent medical evaluation (medical review).* The governing body adopts policies to ensure that the facility cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including, at least annually, medical evaluation of each patient's need for skilled nursing facility care).

(e) *Standard: Administrator.* The governing body appoints a qualified administrator who is responsible for the overall management of the facility, enforces the rules and regulations relative to the level of health care and safety of patients, and to the protection of their personal and property rights, and plans, organizes, and directs those responsibilities delegated to him by the governing body. Through meetings and periodic reports, the administrator maintains ongoing liaison among the governing body, medical and nursing staffs, and other professional and supervisory staff of the facility, and studies and acts upon recommendations made by the utilization review and other committees. In the absence of the administrator, an employee is authorized, in writing, to act on his behalf.

(f) *Standard: Institutional planning.* The institutional plan:

(1) Provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget, an item-by-item identification of the components of each type of anticipated expenditure or income),

(2) Provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in paragraph (1) of this section is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items,

(3) Provides for review and updating at least annually, and

(4) Is prepared, under the direction of the governing body of the institution, by a committee consisting of representatives of the governing body, the administrative staff, and the organized medical staff (if any) of the institution.

(g) *Standard: Personnel policies and procedures.* The governing body, through the administrator, is responsible for implementing and maintaining written personnel policies and procedures that support sound patient care and personnel practices. Personnel records are current and available for each employee and contain sufficient information to support placement in the position to which assigned. Written policies for control of communicable disease are in effect to ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work, and that a safe and sanitary environment for patients and personnel exists and incidents and accidents to patients and personnel are reviewed to identify health and safety hazards. Employees are provided, or referred for, periodic health examinations, to ensure freedom from communicable disease.

(h) *Standard: Staff development.* An ongoing educational program is planned and conducted for the development and improvement of skills of all the facility's personnel, including training related to problems and needs of the aged, ill, and disabled. Each employee receives appropriate orientation to the facility and its policies, and to his position and duties. Inservice training includes at least prevention and control of infections, fire prevention and safety, accident prevention, confidentiality of patient information, and preservation of patient dignity, including protection of his privacy and personal and property rights. Records are maintained which indicate the content of, and attendance at, such staff development programs.

(i) *Standard: Use of outside resources.* If the facility does not employ a qualified professional person to render a specific service to be provided by the facility, there are arrangements for such a service through a written agreement with an outside resource—a person or agency that will render direct service to patients or act as a consultant. The responsibilities, functions, and objectives, and the terms of agreement, including financial arrangements and charges, of each such outside resource are delineated in writing and signed by an authorized representative of the facility and the person or the agency providing the service. The agreement specifies that the facility retains professional and administrative responsibility for the services rendered. The financial arrangements provide that the outside resource bill the facility for covered services (either Part A or B for Medicare beneficiaries) rendered directly to the patient, and that receipt of payment from the program(s) to the facility for the services discharges the liability of the beneficiary or any other person to pay for the services. The outside resource, when acting as a consultant, apprises the administrator of recommendations, plans for implementation, and continuing assessment through dated, signed reports, which are retained by the administrator for follow-up action and evaluation of performance. (See requirement under each service—§§ 405.1125 through 405.1132.)

(j) *Standard: Notification of changes in patient status.* The facility has appropriate written policies and procedures relating to notification of the patient's attending physician and other responsible persons in the event of an accident involving the patient, or other significant change in the patient's physical, mental, or emotional status, or patient charges, billings, and related administrative matters. Except in a medical emergency, a patient is not transferred or discharged, nor is treatment altered radically, without consultation with the patient or, if he is incompetent, without prior notification of next of kin or sponsor.

§ 405.1122 Condition of participation—patient care policies.

The skilled nursing facility has written policies to govern the continuing skilled nursing care and related medical or other services provided.

(a) *Standard: Development and review of patient care policies.* The facility has policies, which are developed with the advice of (and with provision for review of such policies from time to time, but at least annually, by) a group of professional personnel including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical or other services it provides. The policies, which are available to admitting physicians, sponsoring agencies, patients, and the public, reflect awareness of, and provision for, meeting the total medical and psychosocial needs of patients, including admission, transfer, and discharge planning; and the range of services available to patients, including frequency of physician visits by each category of patients admitted. These policies also include provisions to protect patients' personal and property rights. Medical records and minutes of staff and committee meetings reflect that patient care is being rendered in accordance with the written patient care policies, and that utilization review committee recommendations regarding the policies are reviewed and necessary steps taken to ensure compliance.

(b) *Standard: Execution of patient care policies.* The facility has a physician, a registered nurse, or a medical staff, designated in writing, to be responsible for the execution of such policies. If the responsibility for day-to-day execution of patient care policies has been delegated to a registered nurse, the facility makes available an advisory physician from whom she receives medical guidance.

§ 405.1123 Condition of participation—physician services.

Patients in need of skilled nursing or rehabilitative care are admitted to the facility only upon the recommendation of, and remain under the care of, a physician. To the extent feasible, each patient or his sponsor designates a personal physician.

(a) *Standard: Medical findings and physicians' orders at time of admission.* There is made available to the facility, prior to or at the time of admission, patient information which includes current medical findings, diagnoses, and

orders from a physician for immediate care of the patient. Information about the rehabilitation potential of the patient and a summary of prior treatment are made available to the facility at the time of admission or within 48 hours thereafter.

(b) *Standard: Patient supervision by physician.* The facility has a policy that the health care of every patient must be under the supervision of a physician who, based on a medical evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of total patient care. Each attending physician is required to make arrangements for the medical care of his patients in his absence. The medical evlauation of the patient is based on a physical examination done within 48 hours of admission unless such examination was performed within 5 days prior to admission. The patient is seen by his attending physician at least once every 30 days for the first 90 days following admission. The patient's total program of care (including medications and treatments) is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days, and revised as necessary. A progress note is written and signed by the physician at the time of each visit, and he signs all his orders. Subsequent to the 90th day following admission, an alternate schedule for physician visits may be adopted where the attending physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at 30-day intervals. This alternate schedule does not apply for patients who require specialized rehabilitative services, in which case the review must be in accordance with § 405.1126(b). At no time may the alternate schedule exceed 60 days between visits. If the physician decides upon an alternate schedule of visits of more than 30 days for a patient, (1) in the case of a Medicaid benefits recipient, the facility notifies the State Medicaid agency of the change in schedule, including justification, and (2) the utilization review committee or the medical review team (see § 405.1121(d)) promptly reevaluates the patient's need for monthly physician visits as well as his continued need for skilled nursing facility services (see § 405.1137(d)). If the utilization review committee or the medical review team does not concur in the schedule of visits at intervals of more than 30 days, the alternate schedule is not acceptable.

(c) *Standard: Availability of physicians for emergency patient care.* The facility has written procedures, available at each nurses station, that provide for having a physician available to furnish necessary medical care in case of emergency.

§ 405.1124 Condition of participation—nursing services.

The skilled nursing facility provides 24-hour service by licensed nurses, including the services of a registered nurse at least during the day tour of duty 5 days a week. There is an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing needs of all patients.

(a) *Standard: Director of nursing services.* The director of nursing services is a qualified registered nurse employed full-time who has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff, and serves only one facility in this capacity. If the director of nursing services has other institutional responsibilities, a qualified registered nurse serves as her assistant so that there is the equivalent of a full-time director of nursing services on duty. The director of nursing services is responsible for the development and maintenance of nursing service objectives, standards of nursing practice, nursing policy and procedure manuals, written job descriptions for each level of nursing personnel, scheduling of daily rounds to see all patients, methods for coordination of nursing services with other patient services, for recommending the number and levels of nursing personnel to be employed, and nursing staff development (see § 405.1121(h)).

(b) *Standard: Charge nurse.* A registered nurse, or a qualified licensed practical (vocational) nurse, is designated as charge nurse by the director of nursing services for each tour of duty, and is responsible for supervision of the total nursing activities in the facility during each tour of duty. The director of nursing services does not serve as charge nurse in a facility with an average daily total occupancy of 60 or more patients. The charge nurse delegates responsibility to nursing personnel for the direct nursing care of specific patients during each tour of duty, on the basis of staff qualifications, size and physical layout of the facility, characteristics of the patient load, and the emotional, social, and nursing care needs of patients.

(c) *Standard: Twenty-four-hour nursing service.* The facility provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in § 405.1122(a) on patient care policies. The policies ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing care as needed; receives proper care to prevent decubitus ulcers and deformities, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection; and encouraged, assisted, and trained in self-care and group activities. Nursing personnel, including at least one registered nurse on the day tour of duty 5 days a week, licensed practical (vocational) nurses, nurse aides, orderlies, and ward clerks, are assigned duties consistent with their education and experience, and based on the characteristics of the patient load and the kinds of nursing skills needed to provide care to the patients. Weekly time schedules are maintained and indicate the number and classification of nursing personnel, including relief personnel, who worked on each unit for each tour of duty.

(d) *Standard: Patient care plan.* In coordination with the other patient care services to be provided, a written patient care plan for each patient is developed and maintained by the nursing service consonant with the attending physician's plan of medical care, and is implemented upon admission. The plan indicates care to be given and goals to be accomplished and which professional service is responsible for each element of care. The patient care plan is reviewed, evaluated, and updated as necessary by all professional personnel involved in the care of the patient.

(e) *Standard: Rehabilitative nursing care.* Nursing personnel are trained in rehabilitative nursing, and the facility has an active program of rehabilitative nursing care which is an integral part of nursing service and is directed toward assisting each patient to achieve and maintain an optimal level of self-care and independence. Rehabilitative nursing care services are performed daily for those patients who require such service, and are recorded routinely.

(f) *Standard: Supervision of patient nutrition.* Nursing personnel are aware of the nutritional needs and food and fluid intake of patients and assist promptly where necessary in the feeding of patients. A procedure is established to inform the dietetic service of physicians' diet orders and of patients' dietetic problems. Food and fluid intake of patients is observed, and deviations from normal are recorded and reported to the charge nurse and the physician.

(g) *Standard: Administration of drugs.* Drugs are administered in compliance with State and local laws. Procedures are established by the pharmaceutical services committee (see § 405.1127(d)) to ensure that drugs are checked against physicians' orders, that the patient is identified prior to administration of a drug, and that each patient has an individual medication record and that the dose of drug administered to that patient is properly recorded therein by the person who administers the drug. Drugs and biologicals are administered as soon as possible after doses are prepared, and are administered by the same person who prepared the doses for administration, except under single unit dose package distribution systems. (See § 405.1101(h).)

(h) *Standard: Conformance with physicians' drug orders.* Drugs are administered in accordance with written orders of the attending physician. Drugs not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies. Physicians' verbal orders for drugs are given only to a licensed nurse, pharmacist, or physician and are immediately recorded and signed by the person receiving the order. (Verbal orders for Schedule II drugs are permitted only in the case of a bona fide emergency situation.) Such orders are countersigned by the attending physician within 48 hours. The attending physician is notified of an automatic stop order prior to the last dose so that he may decide if the administration of the drug or biological is to be continued or altered.

(i) *Standard: Storage of drugs and biologicals.* Procedures for storing and disposing of drugs and biologicals are established by the pharmaceutical services committee. In accordance with State and Federal laws, all drugs and biologicals, are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Separately locked, permanently affixed compartments are provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention & Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. An emergency medication kit approved by the pharmaceutical services committee is kept readily available.

§ 405.1125 Condition of participation—dietetic services.

The skilled nursing facility provides a hygienic dietetic service that meets the daily nutritional needs of patients, ensures that special dietary needs are met, and provides palatable and attractive meals. A facility that has a contract with an outside food management company may be found to be in compliance with this condition provided the facility and/or company meets the standards listed herein.

(a) *Standard: Staffing.* Overall supervisory responsibility for the dietetic service is assigned to a full-time qualified dietetic service supervisor. If the dietetic service supervisor is not a qualified dietitian he functions with frequent, regularly scheduled consultation from a person so qualified. (See § 405.1121(i).) In addition, the facility employs sufficient supportive personnel competent to carry out the functions of the dietetic service. Food service personnel are on duty daily over a period of 12 or more hours. If consultant dietetic services are used, the consultant's visits are at appropriate times, and of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the dietetic service, approval of all menus, and participation in development or revision of dietetic policies and procedures and in planning and conducting inservice education programs (see § 405.1121(h)).

(b) *Standard: Menus and nutritional adequacy.* Menus are planned and followed to meet nutritional needs of patients in accordance with physicians' orders and, to the extent medically possible, in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences.

(c) *Standard: Therapeutic diets.* Therapeutic diets are prescribed by the attending physician. Therapeutic menus are planned in writing, and prepared and served as ordered, with supervision or consultation from the dietitian and advice from the physician whenever necessary. A current therapeutic diet manual approved by the dietition is readily available to attending physicians and nursing and dietetic service personnel.

(d) *Standard: Frequency of meals.* At least three meals or their equivalent are served daily, at regular hours, with not more than a 14-hour span between substantial evening meal and breakfast. To the extent medically possible, bedtime nourishments are offered routinely to all patients.

(e) *Standard: Preparation and service of food.* Foods are prepared by methods that conserve nutritive value, flavor, and appearance, and are attractively served at the proper temperatures and in a form to meet individual needs. If a patient refuses food served, appropriate substitutes of similar nutritive value are offered.

(f) *Standard: Hygiene of staff.* Dietetic service personnel are free of communicable diseases and practice hygienic food-handling techniques. In the event food service employees are assigned duties outside the dietetic service, these duties do not interfere with the sanitation, safety, or time required for dietetic work assignments. (See § 405.1121(g).)

(g) *Standard: Sanitary conditions.* Food is procured from sources approved or considered satisfactory by Federal, State, or local authorities, and stored, prepared, distributed, and served under sanitary conditions. Waste is disposed of properly. Written reports of inspections by State and local health authorities are on file at the facility, with notation made of action taken by the facility to comply with any recommendations.

§ 405.1126 Condition of participation—specialized rehabilitative services.

In addition to rehabilitative nursing (§ 405.1124(e)), the skilled nursing facility provides, or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (i.e., physical therapy, speech pathology and audiology, and occupational therapy) as needed by patients to improve and maintain functioning. These services are provided upon the written order of the patient's attending physician. Safe and adequate space and equipment are available, commensurate with the services offered. If the facility does not offer such services directly, it does not admit nor retain patients in need of this care unless provision is made for such services under arrangement with qualified outside resources under which the facility assumes professional and financial responsibilities for the services rendered. (See § 405.1121(i).)

(a) *Standard: Organization and staffing.* Specialized rehabilitative services are provided, in accordance with accepted professional practices, by qualified therapists or by qualified assistants or other supportive personnel under the supervision of qualified therapists. Written administrative and patient care policies and procedures are developed for rehabilitative services by appropriate therapists and representatives of the medical, administrative, and nursing staffs.

(b) *Standard: Plan of care.* Rehabilitative services are provided under a written plan of care, initiated by the attending physician and developed in consultation with appropriate therapist(s) and the nursing service. Therapy is provided only upon written orders of the attending physician. A report of the patient's progress is communicated to the attending physician within 2 weeks of the initiation of specialized rehabilitative services. The patient's progress is thereafter reviewed regularly, and the plan of rehabilitative care is reevaluated as necessary, but at least every 30 days, by the physician and the therapist(s).

(c) *Standard: Documentation of services.* The physician's orders, the plan of rehabilitative care, services rendered, evaluations of progress, and other pertinent information are recorded in the patient's medical record, and are dated and signed by the physician ordering the service and the person who provided the service.

(d) *Standard: Qualifying to provide outpatient physical therapy services.* If the facility provides outpatient physical therapy services, it meets the applicable health and safety regulations pertaining to such services as are included in Subpart Q of this part. (See §§ 405.1719; 405.1720; 405.1722 (a) and (b) (1), (2), (3) (i), (4), (5), (6), (7), and (8); and 405.1725.)

§ 405.1127 Condition of participation—pharmaceutical services.

The skilled nursing facility provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility is responsible for providing such drugs and biologicals for its patients, insofar as they are covered under the programs, and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State, and local laws. (See § 405.1124 (g), (h), and (i).)

(a) *Standard: Supervision of services.* The pharmaceutical services are under the general supervision of a qualified pharmacist who is responsible to the administrative staff for developing, coordinating, and supervising all pharmaceutical services. The pharmacist (if not a full-time employee) devotes a sufficient number of hours, based upon the needs of the facility, during regularly scheduled visits to carry out these responsibilities. The pharmacist reviews the drug regimen of each patient at least monthly, and reports any irregularities to the medical director and administrator. The pharmacists submits a written report at least quarterly to the pharmaceutical services committee on the status of the facility's pharmaceutical service and staff performance.

(b) *Standard: Control and accountability.* The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility. Only approved drugs and

biologicals are used in the facility, and are dispensed in compliance with Federal and State laws. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation. The pharmacist determines that drug records are in order and that an account of all controlled drugs is maintained and reconciled.

(c) *Standard: Labeling of drugs and biologicals.* The labeling of drugs and biologicals is based on currently accepted professional principles, and includes the appropriate accessory and cautionary instructions, as well as the expiration date when applicable.

(d) *Standard: Pharmaceutical services committee.* A pharmaceutical services committee (or its equivalent) develops written policies and procedures for safe and effective drug therapy, distribution, control, and use. The committee is comprised of at least the pharmacist, the director of nursing services, the administrator, and one physician. The committee oversees pharmaceutical service in the facility, makes recommendations for improvement, and monitors the service to ensure its accuracy and adequacy. The committee meets at least quarterly and documents its activities, findings, and recommendations.

§ 405.1128 Condition of participation—laboratory and radiologic services.

The skilled nursing facility has provision for promptly obtaining required laboratory, X-ray, and other diagnostic services.

(a) *Standard: Provision for services.* If the facility provides its own laboratory and X-ray services, these meet the applicable conditions established for certification of hospitals that are contained in §§ 405.1028 and 405.1029, respectively. If the facility itself does not provide such services, arrangements are made for obtaining these services from a physician's office, a participating hospital or skilled nursing facility, or a portable X-ray supplier or independent laboratory which is approved to provide these services under the program. All such services are provided only on the orders of the attending physician, who is notified promptly of the findings. The facility assists the patient, if necessary, in arranging for transportation to and from the source of service. Signed and dated reports of a clinical laboratory, X-ray, and other diagnostic services are filed with the patient's medical record.

(b) *Standard: Blood and blood products.* Blood handling and storage facilities are safe, adequate, and properly supervised. If the facility provides for maintaining and transfusing blood and blood products, it meets the conditions established for certification of hospitals that are contained in § 405.1028(j). If the facility does not provide its own facilities but does provide transfusion services alone, it meets at least the requirements of § 405.1028(j)(1), (3), (4), (6), and (9).

§ 405.1129 Condition of participation—dental services.

The skilled nursing facility has satisfactory arrangements to assist patients to obtain routine and emergency dental care (See § 405.1121(i).) (The basic Hospital Insurance Program does not cover the services of a dentist in a skilled nursing facility in connection with the care, treatment, filling, removal, or replacement of teeth or structures supporting the teeth; and only certain oral surgery is included in the Supplemental Medical Insurance Program.)

(a) *Standard: Advisory dentist.* An advisory dentist participates in the staff development program for nursing and other appropriate personnel (see § 405.1121(h)), and recommends oral hygiene policies and practices for the care of patients.

(b) *Standard: Arrangements for outside services.* The facility has a cooperative agreement with a dental service, and maintains a list of dentists in the community for patients who do not have a private dentist. The facility assists the patient, if necessary, in arranging for transportation to and from the dentist's office.

§ 405.1130 Condition of participation—social services.

The skilled nursing facility has satisfactory arrangements for identifying the medically related social and emotional needs of the patient. It is not mandatory that the skilled nursing facility itself provide social services in order to participate in the program. If the facility does not provide social services, it has written procedures for referring patients in need of social services to appropriate social agencies. If social services are offered by the facility, they are provided under a clearly defined plan, by qualified persons, to assist each patient to adjust to the social and emotional aspects of his illness, treatment, and stay in the facility.

(a) *Standard: Social service functions.* The medically related social and emotional needs of the patient are identified and services provided to meet them, either by qualified staff of the facility, or by referral, based on established procedures, to appropriate social agencies. If financial assistance is indicated, arrangements are made promptly for referral to an appropriate agency. The patient and his family or responsible person are fully informed of the patient's personal and property rights.

(b) *Standard: Staffing.* If the facility offers social services, a member of the staff of the facility is designated as responsible for social services. If the designated person is not a qualified social worker, the facility has a written agreement with a qualified social worker or recognized social agency for consultation and assistance on a regularly scheduled basis. (See § 405.1121(i).) The social service also has sufficient supportive personnel to meet patient needs. Facilities are adequate for social service personnel, easily accessible to patients and medical and other staff, and ensure privacy for interviews.

(c) *Standard: Records and confidentiality of social data.* Records of pertinent social data about personal and family problems medically related to the patient's illness and care, and of action taken to meet his needs, are maintained in the patient's medical record. If social services are provided by an outside resource, a record is maintained of each referral to such resource. Policies and procedures are established for ensuring the confidentiality of all patients' social information.

§ 405.1131 Condition of participation—patient activities.

The skilled nursing facility provides for an activities program, appropriate to the needs and interests of each patient, to encourage self care, resumption of normal activities, and maintenance of an optimal level of psychosocial functioning.

(a) *Standard: Responsibility for patient activities.* A member of the facility's staff is designated as responsible for the patient activities program. If he is not a qualified patient activities coordinator, he functions with frequent, regularly scheduled consultation from a person so qualified. (See § 405.1121(i).)

(b) *Standard: Patient activities program.* Provision is made for an ongoing program of meaningful activities appropriate to the needs and interests of patients, designed to promote opportunities for engaging in normal pursuits, including religious activities of their choice, if any. Each patient's activities program is approved by the patient's attending physician as not in conflict with the treatment plan. The activities are designed to promote the physical, social, and mental well-being of the patients. The facility makes available adequate space and a variety of supplies and equipment to satisfy the individual interests of patients (see § 405.1134(g)).

§ 405.1132 Condition of participation—medical records.

The facility maintains clinical (medical) records on all patients in accordance with accepted professional standards and practices. The medical record service has sufficient staff, facilities, and equipment to provide medical records that are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

(a) *Standard: Staffing.* Overall supervisory responsibility for the medical record service is assigned to a full-time employee of the facility. The facility also employs sufficient supportive personnel competent to carry out the functions of the medical record service. If the medical record supervisor is not a qualified medical record practitioner, this person functions with consultation from a person so qualified. (See § 405.1121(i).)

(b) *Standard: Protection of medical record information.* The facility safeguards medical record information

against loss, destruction, or unauthorized use.

(c) *Standard: Content.* The medical record contains sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately. All medical records contain the following general categories of data: Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of treatment, and of the care and services provided; authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form), identification data and consent forms, medical and nursing history of patient, report of physical examination(s), diagnostic and therapeutic orders, observations and progress notes, reports of treatments and clinical findings, and discharge summary including final diagnosis and prognosis.

(d) *Standard: Physician documentation.* Only physicians enter or authenticate in medical records opinions that require medical judgment (in accordance with medical staff bylaws, rules, and regulations, if applicable). Each physician signs his entries into the medical record.

(e) *Standard: Completion of records and centralization of reports.* Current medical records and those of discharged patients are completed promptly. All clinical information pertaining to a patient's stay is centralized in the patient's medical record.

(f) *Standard: Retention and preservation.* Medical records are retained for a period of time not less than that determined by the respective State statute, the statute of limitations in the State, or 5 years from the date of discharge in the absence of a State statute, or, in the case of a minor, 3 years after the patient becomes of age under State law.

(g) *Standard: Indexes.* Patients' medical records are indexed according to name of patient and final diagnoses to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.

(h) *Standard: Location and facilities.* The facility maintains adequate facilities and equipment, conveniently located, to provide efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).

§ 405.1133 Condition of participation—transfer agreement.

The skilled nursing facility has in effect a transfer agreement with one or more hospitals approved for participation under the programs, which provides the basis for effective working arrangements under which inpatient hospital care or other hospital services are available promptly to the facility's patients when needed. (A facility that has been unable to establish a transfer agreement with the hospital(s) in the community or service area after documented attempts to do so is considered to have such an agreement in effect.)

(a) *Standard: Patient transfer.* A hospital and a skilled nursing facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that:

(1) Transfer of patients will be effected between the hospital and the skilled nursing facility, ensuring timely admission, whenever such transfer is medically appropriate as determined by the attending physician, and

(2) There will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions, and

(3) Security and accountability for patients' personal effects are provided on transfer.

Any skilled nursing facility which does not have such agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (a)(2) of this section, shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to ensuring skilled nursing facility services for persons in the community who are eligible for payments with respect to such services under the programs.

§ 405.1134 Condition of participation—Physical environment.

The skilled nursing facility is constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public.

(a) *Standard: Life safety from fire.* The skilled nursing facility meets such provisions of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) as are applicable to nursing homes; except that, in consideration of a recommendation by the State survey agency, the Secretary may waive, for such periods as deemed appropriate, specific provisions of such Code which, if rigidly applied, would result in unreasonable hardship upon a skilled nursing facility, but only if such waiver will not adversely affect the health and safety of the patients; and except that the provisions of such Code shall not apply in any State if the Secretary finds, in accordance with applicable provisions of section 1861(j)(13) of the Social Security Act, that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in skilled nursing facilities. Where waiver permits the participation of an existing facility of two or more stories which is not of at least 2-hour fire resistive construction, blind, nonambulatory, or physically handicapped patients are not housed above the street level floor unless the facility is of 1-hour protected noncombustible construction (as defined in National Fire Protection Association Standard No. 220), fully sprinklered 1-hour protected ordinary construction, or fully sprinklered 1-hour protected woodframe construction. Nonflammable medical gas systems, such as oxygen and nitrous oxide, installed in the facility comply with applicable provisions of National Fire Protection Association Standard No. 56B (Standard for the Use of Inhalation Therapy) 1968 and National Fire Protection Association Standard No. 56F (Nonflammable Medical Gas Systems) 1970.

(b) *Standard: Emergency power.* The facility provides an emergency source of electrical power necessary to protect the health and safety of patients in the event the normal electrical supply is interrupted. The emergency electrical power system must supply power adequate at least for lighting in all means of egress; equipment to maintain fire detection, alarm, and extinguishing systems; and life support systems. Where life support systems are used, emergency electrical service is provided by an emergency generator located on the premises.

(c) *Standard: Facilities for physically handicapped.* The facility is accessible to, and functional for, patients, personnel, and the public. All necessary accommodations are made to meet the needs of persons with semiambulatory disabilities, sight and hearing disabilities, disabilities of coordination, as well as other disabilities, in accordance with the American National Standards Institute (ANSI) Standard No. A117.1, American Standard Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped. The Secretary (or in the case of a facility participating as a skilled nursing facility under title XIX only, the survey agency—see § 249.33(a)(1)(i) of this title) may waive in existing buildings, for such periods as deemed appropriate, specific provisions of ANSI Standard No. A117.1 which, if rigidly enforced, would result in unreasonable hardship upon the facility, but only if such waiver will not adversely affect the health and safety of patients.

(d) *Standard: Nursing unit.* Each nursing unit has at least the following basic service areas: Nurses station, storage and preparation area(s) for drugs and biologicals, and utility and storage rooms that are adequate in size, conveniently located, and well lighted to facilitate staff functioning. The nurses station is equipped to register patients' calls through a communication system from patient areas, including patient rooms and toilet and bathing facilities.

(e) *Standard: Patient rooms and toilet facilities.* Patient rooms are designed and equipped for adequate nursing care and the comfort and privacy

of patients, and have no more than four beds, except in facilities primarily for the care of the mentally ill and/or retarded where there shall be no more than 12 beds per room. (An institution primarily engaged in the care of the mentally retarded or in the treatment of mental diseases cannot qualify as a participating skilled nursing facility under Medicare.) Single patient rooms measure at least 100 square feet, and multipatient rooms provide a minimum of 80 square feet per bed. The Secretary (or in the case of a facility participating as a skilled nursing facility under title XIX only, the survey agency—see § 249.33(a)(1)(i) of this title) may permit variations in individual cases where the facility demonstrates in writing that such variations are in accordance with the particular needs of the patients and will not adversely affect their health and safety. Each room is equipped with, or is conveniently located near, adequate toilet and bathing facilities. Each room has direct access to a corridor and outside exposure, with the floor at or above grade level.

(f) *Standard: Facilities for special care.* Provision is made for isolating patients as necessary in single rooms ventilated to the outside, with private toilet and handwashing facilities. Procedures in aseptic and isolation techniques are established in writing and followed by all personnel. Such areas are identified by appropriate precautionary signs.

(g) *Standard: Dining and patient activities rooms.* The facility provides one or more clean, orderly, and appropriately furnished rooms of adequate size designated for patient dining and for patient activities. These areas are well-lighted and well-ventilated. If a multipurpose room is used for dining and patient activities, there is sufficient space to accommodate all activities and prevent their intereference with each other.

(h) *Standard: Kitchen and dietetic service areas.* The facility has kitchen and dietetic service areas adequate to meet food service needs. These areas are properly ventilated, and arranged and equipped for sanitary refrigeration, storage, preparation, and serving of food as well as for dish and utensil cleaning and refuse storage and removal.

(i) *Standard: Maintenance of equipment, building, and grounds.* The facility establishes a written preventive maintenance program to ensure that equipment is operative and that the interior and exterior of the building are clean and orderly. All essential mechanical, electrical, and patient care equipment is maintained in safe operating condition.

(j) *Standard: Other environmental considerations.* The facility provides a functional, sanitary, and comfortable environment for patients, personnel, and the public. Provision is made for adequate and comfortable lighting levels in all areas, limitation of sounds at comfort levels, maintaining a comfortable room temperature, procedures to ensure water to all essential areas in the event of loss of normal water supply, and adequate ventilation through windows or mechanical means or a combination of both.

§ 405.1135 Condition of participation—infection control.

The skilled nursing facility establishes an infection control committee of representative professional staff with responsibility for overall infection control in the facility. All necessary housekeeping and maintenance services are provided to maintain a sanitary and comfortable environment and to help prevent the development and transmission of infection.

(a) *Standard: Infection control committee.* The infection control committee is composed of memers of the medical and nursing staffs, administration, and the dietetic, pharmacy, housekeeping, maintenance, and other services. The committee establishes policies and procedures for investigating, controlling, and preventing infections in the facility, and monitors staff performance to ensure that the policies and procedures are executed.

(b) *Standard: Aseptic and isolation techniques.* Written effective procedures in aseptic and isolation techniques are followed by all personnel. Procedures are reviewed and revised annually for effectiveness and improvement.

(c) *Standard: Housekeeping.* The facility employs sufficient housekeeping personnel and provides all necessary equipment to maintain a safe, clean, and orderly interior. A full-time employee is designated responsible for the services and for supervision and training of personnel. Nursing personnel are not assigned housekeeping duties. A facility that has a contract with an outside resource for housekeeping services may be found to be in compliance with this standard provided the facility and/or outside resource meets the requirements of the standard.

(d) *Standard: Linen.* The facility has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

(e) *Standard: Pest control.* The facility is maintained free from insects and rodents through operation of a pest control program.

§ 405.1136 Condition of participation—disaster preparedness.

The skilled nursing facility has a written plan, periodically rehearsed, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disasters.

(a) *Standard: Disaster plan.* The facility has an acceptable written plan in operation, with procedures to be followed in the event of fire, explosion, or other disaster. The plan is developed and maintained with the assistance of qualified fire, safety, and other appropriate experts, and includes procedures for prompt transfer of casualties and records, instructions regarding the location and use of alarm systems and signals and of fire-fighting equipment, information regarding methods of containing fire, procedures for notification of appropriate persons, and specifications of evacuation routes and procedures. (See § 405.1134(a).)

(b) *Standard: Staff training and drills.* All employees are trained, as part of their employment orientation, in all aspects of preparedness for any disaster. The disaster program includes orientation and ongoing training and drills for all personnel in all procedures so that each employee promptly and correctly carries out his specific role in case of a disaster. (See § 405.1121(h).)

§ 405.1137 Condition of participation—utilization review.

The skilled nursing facility carries out utilization review of the services provided in the facility at least to inpatients who are entitled to benefits under the program(s). Utilization review has as its overall objectives both the maintenance of high quality patient care and assurance of appropriate and efficient utilization of facility services. There are two elements to utilization review: medical care evaluation studies that identify and examine patterns of care provided in the facility, and review of extended duration cases which is concerned with efficiency, appropriateness, and cost effectiveness of care. If the Secretary determines that the utilization review procedures established pursuant to title XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this title that the procedures established pursuant to title XIX be utilized instead of the procedures required by this section.

(a) *Standard: Written plan of utilization review activity.* The facility has a written, currently applicable utilization review plan, approved by the governing body and the medical director or organized medical staff (if applicable), which includes at least the following: (1) procedures for medical care evaluation studies, and for dissemination and followup of study findings and committee recommendations; (2) definition of the period(s) of extended duration and procedures for review of individual cases of extended duration; (3) a method for identifying patients other than by name (e.g., medical record number); and (4) provision for maintaining written records of committee activities.

(b) *Standard: Composition and organization of utilization review committee.* The committee or group responsible for utilization review is composed of two or more physicians and, optionally, other professional personnel. All medical determinations are made by the physician members of the committee. No physician reviews any case in which he was professionally involved.

(c) *Standard: Medical care evaluation studies.* Medical care evaluation studies are performed to promote the most effective and appropriate use of available health facilities and services consistent with patient needs and professionally recognized standards of health care. Studies, which could include assessment of findings resulting from periodic medical review, emphasize identification and analysis of patterns of patient care and changes indicated to maintain consistent high quality of services. Each medical care evaluation study (whether medical or administrative in emphasis) identifies and analyzes factors related to the patient care rendered in the facility, and serves as the basis for recommendations for change beneficial to patients, staff, the facility, and the community. Studies, on a sample or other basis, include but need not be limited to, admissions, durations of stay, and professional services (including drugs and biologicals) furnished. At least one study is in progress at any given time.

(d) *Standard: Review of cases of extended duration.* Periodic review is made of each current inpatient skilled nursing facility beneficiary case of continuous extended duration, the length of which is defined in the utilization review plan, to determine whether further inpatient stay is necessary. Reviews may also be applied to patients not covered by the program, and/or to cases where duration of stay has not yet reached the definition(s) of extended duration. The plan may specify a different number of days for different diagnostic classes of cases, or may use the same number of days for all cases. In any event, the period(s) specified bears a reasonable relationship to current average length-of-stay statistics, and does not exceed 21 days from admission. An exception to this 21-day limit may be made where the specific diagnostic classes of cases have average lengths of stay exceeding 21 days, in which instances the plan specifices the extended duration period for each specific diagnostic class. In cases for which advance approval of payment has been made, the period(s) of extended duration may be defined as that period for which payment has been approved. After the initial review, reviews for medical necessity for further inpatient stay are made at least every 30 days for the first 90 days and at least every 90 days thereafter. A review is made and a final determination regarding the patient's further care is reached no later than 7 days following the time period specified as the period of extended duration in the utilization review plan.

(e) *Standard: Admission or further stay not medically necessary.* Final determination regarding the necessity for admission or for further stay, including stay beyond the period of extended duration, is limited to physician members of the committee, and may be made by the full physician complement, a subcommittee, or a single committee physician. When a single committee physician has decided that admission is not medically necessary or is inappropriate, or that further stay is no longer medically necessary, further concurrence is obtained as specified in the plan (to include at least a second committee physician) within the 7-day period. If committee members determine, from an extended duration review or a medical care evaluation study, that further stay is not medically necessary, the attending physician is consulted or given the opportunity for consultation, and notification is made in writing within 48 hours by the committee to the administration, the attending physician, and the patient or his representative.

(f) *Standard: Administrative responsibilities.* The administrative staff of the facility is kept directly and fully informed of committee activities to facilitate support and assistance. The administrator studies and acts upon recommendations made by the committee, coordinating such functions with appropriate staff members.

(g) *Standard: Utilization review records.* Written records of committee activities are maintained. Appropriate reports, signed by the committee chairman, are made regularly to the medical staff, administrative staff, governing body, and sponsors (if any). Minutes of each committee meeting are maintained and include at least:

(1) Name of committee,

(2) Date and duration of meeting,

(3) Names of committee members present and absent,

(4) Description of activities presently in progress to satisfy the requirements for medical care evaluation studies, including the subject and reason for study, dates of commencement and expected completion, summary of studies completed since the last meeting, conclusions, and followup on implementation of recommendations made from previous studies, and

(5) Summary of extended duration cases reviewed, including the number of cases, case identification numbers, admission and review dates, and decisions reached, including the basis for each determination and action taken for each case not approved for extended care.

Subpart O—Providers of Services, Independent Laboratories, and Suppliers of Portable X-ray Services; Determinations and Appeals Procedures

11. Section 405.1501 is revised to read as follows:

§ 405.1501 Providers of services, emergency service hospitals, independent laboratories, and suppliers of portable X-ray services; determinations and appeals procedures.

(a) The provisions contained in this Subpart O shall govern the procedure for making and reviewing determinations with respect to whether an institution, facility, agency, or clinic is a provider of services (i.e., a hospital, skilled nursing facility, home health agency, or for purposes of furnishing outpatient physical therapy or speech pathology services, a clinic, rehabilitation agency, or public health agency) within the meaning of title XVIII of the Social Security Act and Subparts J, K, L, or Q of this part, as appropriate; whether an institution is a hospital, as such term is included in section 1861(e) for purposes of sections 1814(d) and 1835(b) of the Act (see § 405.152(a)(1)), qualified to elect to claim payment for all emergency hospital services furnished in a calendar year (see § 405.658); the termination of the Secretary's agreement with a provider of services for cause (see §§ 405.604 and 405.614); whether an institution continues to remain in compliance with the qualifications for claiming emergency service reimbursement for a calendar year under the provisions of sections 1814(d) and 1835(b) of the Act; and whether an independent laboratory or supplier of portable X-ray services meets the appropriate conditions for coverage of its services (see Subparts M and N of this part).

(b) Any institution, facility, agency, or clinic dissatisfied with an initial determination (see § 405.1502) that it does not qualify as a provider of services may request a reconsideration of that determination (see § 405.1510). If dissatisfied with the reconsidered determination, or with an initial determination terminating the Secretary's agreement with it for cause, an institution, facility, agency, or clinic is entitled to a hearing thereon and, if dissatisfied with the Secretary's final decision after such hearing, to Appeals Council review and then judicial review of such decision (see § 405.1530 et seq.).

(c) Any independent laboratory or supplier of portable X-ray services which is dissatisfied with an initial determination (see § 405.1502) that its services do not meet the condition for coverage (see Subparts M and N of this Part 405) may request a reconsideration of that determination (§ 405.1510). If dissatisfied with the reconsidered determination or where a determination had been made that an independent laboratory's or portable X-ray supplier's services met the respective conditions for coverage, with an initial determination thereafter that its services no longer meet the respective conditions for coverage, a laboratory or portable X-ray supplier may request a hearing thereon (see § 405.1530), and if dissatisfied with the decision of the Administrative Law Judge may request Appeals Council review. A laboratory or portable X-ray supplier is not entitled to judicial review of the Secretary's final decision after such hearing and review.

(d) To be a participating provider of services, eligible for payment, a provider must be in compliance with title VI of the Civil Rights Act of 1964 and must enter into an agreement with the Secretary under section 1866 of the Social Security Act (see Subpart F of this Part 405). The provisions of this Subpart O do not govern in any respect the adjudication of issues related to the compliance of an institution or agency with title VI of the Civil Rights Act of 1964, or the implementing regulation (45 CFR Part 80) issued by the Secretary of Health, Education, and Welfare.

(e) Any institution which is dissatisfied with an initial determination (see § 405.1502) that it does not qualify to

elect to claim payment for all emergency hospital services furnished in a calendar year, may request a reconsideration of that determination (see § 405.1510). If dissatisfied with the reconsidered determination, or where the institution's election to claim payment for all such services furnished in a calendar year has been accepted for filing, with an initial determination thereafter of its failure to remain in compliance with the qualifications for claiming such payments for such calendar year, the institution is entitled to a hearing thereon and, if dissatisfied with the Secretary's final decision after such hearing, to Appeals Council review and then judicial review of such decision (see § 405.1530 et seq.).

§§ 405.1502, 405.1510, 405.1513, 405.1514, 405.1515, 405.1518, 405.1542 [Amended]

12. In §§ 405.1502, 405.1510, 405.1513, 405.1514, 405.1515, 405.1518, and 405.1542 (a), the word "Administration" is changed to "Secretary."

13. Paragraph (b) of § 405.1502 is amended by revising subparagraph (2) to read as follows:

§ 405.1502 Initial determinations.

The Secretary will make findings, setting forth the pertinent facts and conclusions, and an initial determination with respect to:

* * * * *

(b) * * *

(2) Whether an independent laboratory or supplier of portable X-ray services continues to meet the appropriate conditions for coverage of its services; and

* * * * *

14. Section 405.1503 is revised to read as follows:

§ 405.1503 Notice of initial determination.

Written notice of an initial determination (see § 405.1502) with respect to whether an institution, facility, agency, or clinic is or is not a provider; or with respect to whether an institution is or is not a hospital for purposes of the emergency service reimbursement provisions of sections 1814(d) and 1835(b) of the Act; or with respect to the termination of an agreement for cause; or with respect to whether an institution continues to remain in compliance with the qualifications for claiming emergency services reimbursement for a calendar year under the provisions of sections 1814(d) and 1835(b) of the Act; or with respect to whether an independent laboratory or supplier of portable X-ray services meets the appropriate conditions for coverage of its services (see Subparts M and N of this Part 405) will be mailed to the institution, facility, agency, clinic, laboratory, or portable X-ray supplier (see §§ 405.1510 and 405.1530).

15. Section 405.1505 is revised to read as follows:

§ 405.1505 Administrative actions which are not initial determinations.

(a) The finding that an institution, facility, agency, or clinic determined to be a provider has deficiencies with respect to one or more conditions of participation, or that an independent laboratory or supplier of portable X-ray services, determined to be in substantial compliance with the conditions, has deficiencies with respect to one or more conditions for coverage of services of independent laboratories or suppliers of portable X-ray services.

(b) The finding that an institution, facility, or agency does not meet the conditions for participation as set out in Subparts J, K, or L of this part, as appropriate, but only where such institution, facility, or agency is nevertheless approved as a provider of services on the basis of a special access certification.

(c) The finding that the services of a laboratory are covered under the health insurance program because the laboratory is not independent of a hospital for purposes of section 1861(s) (10) and (11) of the Act and the laboratory meets the health and safety standards prescribed for such laboratories.

(d) The finding that laboratory services are physician's services for the reason that the laboratory is being maintained primarily for the physician's patients, and such physician's services are covered under the supplementary medical insurance program.

(e) The refusal by the Secretary to accept for filing an agreement submitted by an institution, facility, agency, or clinic under the terms of section 1866 of the Social Security Act where such institution, facility, agency, or clinic:

(1) Is not in compliance with the provisions of title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.); or

(2) Has been adjudged insolvent or bankrupt under appropriate State or Federal law or with respect to which a court proceeding to make such a judgment is pending under such law.

(f) The finding that, pursuant to § 405.616, a provider may not file another agreement, where such provider's agreement has been terminated under the conditions described in §§ 405.604, 405.613, or 405.614.

(g) The finding that an institution is not a hospital for purposes of the emergency service reimbursement provisions of sections 1814(d) and 1835(b) of the Act, if such findings are not made in accordance with the provisions of §§ 405.1502(d) (1) or (2) and 405.1503.

(h) The refusal to accept for filing an election submitted by an institution to claim payment for all emergency hospital services furnished in a calendar year (see § 405.658), where such institution has previously charged an individual or other person for emergency hospital services furnished to the individual in such calendar year.

(i) The refusal to accept for filing an election submitted by an institution to claim payment for all emergency hospital services furnished in a calendar year where such election is submitted after the close of such calendar year (see § 405.658(c)).

(j) The finding that, pursuant to § 405.659, an institution is not eligible to file an election to claim emergency services reimbursement after such institution has been notified of its failure to continue to comply.

16. Paragraph (b) of § 405.1511 is revised to read as follows:

§ 405.1511 Time and place of filing request for reconsideration.

* * * * *

(b) The request for reconsideration must be filed within 6 months after the date of the mailing of the notice of the initial determination unless the time for filing is extended as provided in § 405.1518. The request is to be filed with the Secretary or with an employee of the Department of Health, Education, and Welfare authorized to accept such requests at a place other than such office. A request for reconsideration which has been timely filed with the State agency that performed the survey and certification function will be considered to have been filed with the Secretary.

17. Section 405.1519 is revised to read as follows:

§ 405.1519 Revision of initial or reconsidered determination.

Except in the case of a determination that an institution, facility, agency, or clinic qualifies as a provider of services, or that an institution qualifies to elect to claim payment for all emergency hospital services furnished in a calendar year, an initial or reconsidered determination which is otherwise final under § 405.1504 or § 405.1517 may be reopened by the Secretary upon his own motion within 12 months after the date of the notice of the initial determination (see § 405.1503). Notice of the reopening of a determination and any revision thereof shall be given to the institution, facility, agency, clinic, laboratory, or portable X-ray supplier which was a party to the determination (see § 405.1520).

18. Section 405.1531 is revised to read as follows:

§ 405.1531 Filing a request for a hearing; time and manner of filing.

The request for a hearing shall be made in writing, signed by a proper official of the institution, facility, agency, clinic, laboratory, or portable X-ray supplier concerned and filed at an office of the Department of Health, Education, and Welfare or with an Administrative Law Judge or the Appeals Council of the Bureau of Hearings and Appeals. The request must be filed within 6 months after the date on which written notice of an initial determination provided for in § 405.1502(b)(2), (c), or (d)(2), or a reconsidered or revised determination is mailed to the institution, facility, agency, clinic, laboratory, or portable X-ray supplier (see §§ 405.1503, 405.1516, and 405.1520), except where the time is extended for "good cause" (see § 405.1569).

19. Section 405.1532 is revised to read as follows:

§ 405.1532 Parties to the hearing.

The parties to the hearing shall be the institution, facility, agency, clinic, laboratory, or portable X-ray supplier which was a party to the prior determination (see §§ 405.1502(b)(2), (c), and (d)(2), 405.1514, and 405.1519) and the Bureau of Health Insurance as representing the Secretary. The Bureau of Health Insurance shall be represented at the hearing (see § 405.1543).

§§ 405.1537, 405.1545 [Amended]

20. In §§ 405.1537 and 405.1545, the words "Bureau of Health Insurance" are changed to "Secretary."

21. Paragraph (b) of § 405.1542 is revised to read as follows:

§ 405.1542 Hearing on new issues.

* * * * *

(b) On the application of either party, or on his own motion, in lieu of considering any new issue to the manner described in the preceding paragraph, the Administrative Law Judge may remand the case for consideration of the new issue and, where appropriate, a determination. Where necessary the Administrative Law Judge may direct that the case be returned to him for further proceedings. See also § 405.1560.

22. Section 405.1544 is revised to read as follows:

§ 405.1544 Subpoenas.

When reasonably necessary for the full presentation of a case, the Administrative Law Judge may upon his own motion, or upon the request of a party to the hearing, issue subpoenas for the attendance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents which are relevant and material to any matter in issue at the hearing. A party which desires the issuance of a subpoena shall, not less than 5 days prior to the time fixed for a hearing, file with the Administrative Law Judge a written request therefor, designating the witnesses or documents to be produced, and describing the address and location thereof with sufficient particularity to permit such witnesses or documents to be found. The request for a subpoena shall state the pertinent facts which the party expects to establish by such witnesses or documents and whether such facts could be established by other evidence without the use of a subpoena. A subpoena issued under the provisions of this section shall be issued in the name of the Secretary who shall pay the cost of the issuance and the fees and the mileage of any witnesses so subpoenaed, as provided in section 205(d) of the Act.

23. Section 405.1550 is revised to read as follows:

§ 405.1550 Waiver of right to appear and present evidence.

If the institution, facility, agency, clinic, laboratory, or portable X-ray supplier waives its right to appear before the Administrative Law Judge and present testimony, it shall not be necessary for the Administrative Law Judge to give notice of and conduct an oral hearing. A waiver of this right shall be made in writing and filed with the Administrative Law Judge. A waiver may be withdrawn by an institution, facility, agency, clinic, laboratory, or portable X-ray supplier, for good cause shown, at any time prior to the mailing of notice of the decision in the case. Even though an institution, facility, agency, clinic, laboratory, or portable X-ray supplier has filed a waiver of a hearing before an Administrative Law Judge, the Administrative Law Judge may nevertheless give notice of a time and place and conduct a hearing if he believes that testimony of the representatives of the institution, facility, agency, clinic, laboratory, or portable X-ray supplier or other persons is needed to clarify the facts in issue, or on a showing of good cause by the Bureau of Health Insurance as representing the Secretary of the need to present oral evidence. When such a waiver has been filed and no testimony received, the Administrative Law Judge shall make a record of the relevant written evidence, including applications, written statements, certificates, affidavits, reports, and other documents which were considered in connection with the initial, reconsidered, or revised determination (see §§ 405.1502, 405.1514, and 405.1519), and whatever additional relevant and material evidence was submitted by the parties for consideration by the Administrative Law Judge. Any additional evidence submitted by either party shall be furnished to the other party and that party shall be given a reasonable opportunity to submit further evidence in rebuttal. The parties may submit briefs or other written statements of evidence and/or proposed findings of fact or conclusions of law, copies of which shall be sent in accordance with § 405.1595. After the Administrative Law Judge sets the case for oral hearing and gives notice of the time and place set for the hearing, the request for hearing shall be dismissed in accordance with § 405.1552 where the institution, facility, agency, clinic, laboratory, or portable X-ray supplier fails to appear without good cause.

24. Section 405.1560 is revised to read as follows:

§ 405.1560 Remand by the Administrative Law Judge.

At the request of the Bureau of Health Insurance representing the Secretary and with the written or on-the-record concurrence of the other party to the hearing, the Administrative Law Judge may remand any case properly before him for a determination satisfactory to such other party. Such remand may be made at any time after the request for hearing and before mailing of the notice of decision.

25. Section 405.1563 is revised to read as follows:

§ 405.1563 Action by the Appeals Council on request for review.

The review or denial of the Administrative Law Judge's decision shall be conducted by a panel of at least two members of the Appeals Council designated by the Chairman or Deputy Chairman and one person from the U.S. Public Health Service designated by the Secretary. Except as provided in § 450.1568, the Appeals Council shall review the Administrative Law Judge's decision or dismissal where an institution, facility, agency, clinic, laboratory, or portable X-ray supplier, files a request for review. The Appeals Council may dismiss, deny, or grant a request for review filed by the Bureau of Health Insurance as representing the Secretary. If the review is granted, the Appeals Council may either modify, affirm, or reverse the Administrative Law Judge's decision. Notice of the action by the Appeals Council shall be mailed to the institution, facility, agency, clinic, laboratory, or portable X-ray supplier and the Bureau of Health Insurance.

§§ 405.1590, 405.1591 [Amended]

26. In §§ 405.1590 and 405.1591, the words "Social Security Administration" are changed to "Secretary."

27. Subparts J, L, M, and N are amended by deleting §§ 405.1001 through 405.1010, 405.1203 through 405.1208, 405.1301 through 405.1309, and 405.1401 through 405.1409. These deleted sections are superseded by new Subpart T.

Subpart T—Certification Procedure for Providers and Suppliers of Services

28. Subpart T is added to read as follows:

Sec.

AUTHORITY: Secs. 1102, 1814, 1861, 1865, 1866, 1871, 49 Stat. 647, as amended, 79 Stat. 249, as amended, 79 Stat. 313–327, as amended, 79 Stat. 331; 42 U.S.C. 1302, 1395 et seq.

§ 405.1901 The certification process.

(a) A prospective provider or supplier of services which meets the applicable statutory definitions contained in section 1861 (e), (f), (g), (j), (o), (p)(4), (s)(3) or (s)(10) of the Social Security Act and which is found to be in compliance with each of the conditions where applicable prescribed by the Secretary may agree to become a provider or supplier of services upon acceptance by the Secretary. Health and safety requirements prescribed by the Secretary are set forth in the conditions of participation for hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, clinics, and public health agencies (see Subparts J, K, L, and Q of this part), and in the conditions for coverage of independent laboratories and portable X-ray suppliers (see Subparts M and N of this part).

(b) Hospitals currently accredited by the Joint Commission on Accreditation of Hospitals or by the American Osteopathic Association are deemed to meet

all of the conditions of participation, except the requirements for utilization review as described in section 1861(e)(6) of the Act and any standard promulgated by the Secretary which is higher than the requirements for accreditation as specified in section 1861(e)(9) of the Act, and, in the case of tuberculosis and psychiatric hospitals, the additional staffing and medical records requirements considered necessary for the provision of intensive care. Notwithstanding that a hospital is accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association, it may be subject to a survey by State and/or Federal survey personnel. In such cases a copy of the latest JCAH or AOA survey report will be released to the Secretary (on a confidential basis) with the hospital's concurrence. If the hospital declines to authorize such release, it will lose its deemed status and will be subject to the regular State agency survey procedure. Such surveys will be conducted on a sample basis to validate the JCAH and AOA accreditation process or in response to substantial allegations or evidence of a condition adverse to the health and safety of patients in an accredited hospital. If such a survey reveals noncompliance with one or more of the conditions of participation established in or pursuant to title XVIII of the Act, the hospital must come into compliance with such condition(s).

(c) The Secretary may, at the request of a State, approve higher health and safety requirements for that State. Also, where a State or political subdivision imposes higher requirements as a condition for the purchase of health services under a State plan approved under titles I, XVI, or XIX of the Social Security Act, the Secretary is required to impose like requirements as a condition to the payment for services under title XVIII in such institutions or agencies in the State or subdivision.

(d) Attention is invited to the requirements of title VI of the Civil Rights Act of 1964 (78 Stat. 252; Pub. L. 88-352) which provides that no person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity receiving Federal financial assistance (section 601), and to the implementing regulations issued by the Secretary of Health, Education, and Welfare with the approval of the President (45 CFR Part 80).

§ 405.1902 Certification by State agency.

(a) Section 1864(a) of the Social Security Act provides that the services of State agencies, operating under agreements with the Secretary, will be used by the Secretary in determining whether providers or prospective providers meet the conditions of participation or suppliers meet the conditions for coverage. Pursuant to these agreements, State agencies will survey each provider and supplier and certify to the Secretary as to whether they are found to be in compliance with the conditions of participation and/or coverage.

(b) In the case of a skilled nursing facility completing the second of two successive agreements under title XIX provisions in effect prior to July 1, 1973, and having the same deficiency(ies) which occasioned the two agreements, the State survey agency will review the performance of such facility (which may be limited to a review of the documentation of record) in providing safe and adequate patient care and in progressing toward correction of such deficiency(ies). On the basis of its evaluation, the State survey agency will recommend to the Secretary that:

(1) No provider agreement may be executed with such facility; or

(2) A new provider agreement may be executed for a period related to the time required to correct such deficiency(ies) but not to exceed 6 months; or

(3) A new provider agreement may be executed for a period of 12 months but subject to a provision for automatic cancellation 60 days following the scheduled date for correction unless the State survey agency finds and notifies the Secretary that all required corrections have been satisfactorily completed.

(c) The certifications by the State agency represent recommendations to the Secretary. The Secretary, on the basis of such certifications by the State agency will determine whether a provider or supplier is eligible to participate in the Health Insurance for the Aged and Disabled Program. Notice of determination of eligibility or noneligibility will be sent to the provider or supplier.

§ 405.1903 Documentation of findings.

(a) The findings of the State agency with respect to each of the conditions of participation or conditions for coverage shall be adequately documented. Where the State agency certifies to the Secretary that a provider or supplier is not in compliance with the conditions, and therefore not eligible to participate in the program, such documentation includes, in addition to the description of the specific deficiencies which resulted in the agency's recommendation, a report of all consultation which has been undertaken in an effort to assist the provider or supplier to comply with the conditions, a report of the provider's or supplier's responses with respect to the consultation, and the State agency's assessment of the prospects for such improvements as to enable the provider or supplier to achieve compliance with the conditions within a reasonable period of time. (See § 405.1907.)

(b) If a provider or supplier is certified by the State agency as in compliance with the conditions or as meeting the requirements for special certification (see § 405.1910), with deficiencies not adversely affecting the health and safety of patients, the following information will be incorporated into the finding:

(1) A statement of the deficiencies which were found, and

(2) A description of further action which is required to remove the deficiencies, and

(3) A time-phased plan of correction developed by the provider and supplier and concurred with by the State agency, and

(4) A scheduled time for a resurvey of the institution or agency to be conducted by the State agency within 90 days following the completion of the survey.

(c) If, on the basis of the State certification, the Secretary determines that the provider or supplier is eligible to participate, the information described in paragraph (b) of this section will be incorporated into a notice of eligibility to the provider or supplier.

§ 405.1904 Periodic certification of compliance and approval.

(a) Initial certifications and recertifications by the State agency to the effect that a provider or supplier is in compliance with all the conditions of participation will be for a period of 12 months. (See paragraph (b) of this section for periods of certification applicable to skilled nursing facilities.) State agencies may visit or resurvey providers or suppliers more frequently where necessary to evaluate correction of deficiencies, ascertain continued compliance, or accommodate to periodic or cyclical survey programs. In addition, the State agency shall review information received through medical review conducted in skilled nursing facilities (see § 405.1121(d)). The State agency shall also review statements obtained from each facility setting forth (from payment records) the average numbers and types of personnel (in full-time equivalents) on each tour of duty during at least 1 week of each quarter, such week to be selected by the survey agency and to occur irregularly in each quarter of the year. The State agency shall evaluate such reports as may pertain to the health and safety requirements and, as necessary, take appropriate action to achieve compliance or certify to the Secretary that compliance has not been achieved. A State finding and certificaiton to the Secretary that a provider or supplier is no longer in compliance will supersede the State's previous certification.

(b) A certification of a skilled nursing facility shall be for a period of up to 12 months, subject to the provision that any agreement filed by a skilled nursing facility with the Secretary under section 1866 of the Social Security Act and accepted by him prior to October 30, 1972, shall be deemed to be for a specified period ending December 31, 1973. A certification for less than 12 months may be issued in appropriate situations, based on such factors as the nature of deficiencies which may exist and the degree of progress achieved in correcting prior deficiencies. An agreement with a skilled nursing facility may, at the option of the Secretary, also be subject to automatic cancellation based upon a failure to correct deficiencies. (See § 405.604.)

(See § 405.1908 where a standard is not met during the period of a certification.)

§ 405.1905 Certification of noncompliance.

(a) The State agency will certify that a provider or supplier is not or is no longer in compliance with the conditions of participation or conditions for coverage where the deficencies are of such character as to substantially limit the provider's or supplier's capacity to render adequate care or which adversely affect the health and safety of patients; or

(b) If it is determined by the Secretary that an institution or agency is not in compliance with the conditions of participation or conditions for coverage, or that an institution or agency is no longer in compliance and the participation agreement is terminated under the conditions described in § 405.614, the institution or agency has the right to request that the determination be reviewed.

§ 405.1906 Determining compliance.

The decision as to whether there is compliance with a particular condition of participation or condition for coverage will depend upon the manner and degree to which the provider or supplier satisfies the various standards within each condition. Evaluation of a provider's performance against these standards will enable the State survey agency to document the nature and extent of deficiencies, if any, with respect to a particular function, and to assess the need for improvement in relation to the prescribed conditions.

§ 405.1907 Providers or suppliers with deficiencies.

(a) If a provider or supplier is found to be deficient with respect to one or more of the standards in the conditions of participation or conditions for coverage, it may participate in or be covered under the Health Insurance for the Aged and Disabled Program only if the facility has submitted an acceptable plan of correction for achieving compliance within a reasonable period of time acceptable to the Secretary. The existing deficiencies noted either individually or in combination neither jeopardize the health and safety of patients nor are of such character as to seriously limit the provider's capacity to render adequate care. (See § 405.1908 for special requirements applicable to skilled nursing facilities.)

(b) If it is determined during a survey that a provider or supplier is not in compliance with one or more of the standards, it will be granted a reasonable time to achieve compliance. The amount of time will depend upon the nature of the deficiency and the State survey agency's judgment as to the capabilities of the facility to provide adequate and safe care. Ordinarily a provider or supplier will be expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies but the State survey agency may recommend that additional time be granted by the Secretary in individual situations, if in its judgment it is not reasonable to expect compliance within 60 days, e.g., a facility must obtain the approval of its governing body, or engage in competitive bidding.

§ 405.1908 Special requirements applicable to skilled nursing facilities with deficiencies.

(a) Where the facility is not in full compliance with the standards contained in Subpart K of this part, the period of certification shall:

(1) Be restricted to a period that is no later than the 60th day following the end of the time period specified for the correction of deficiencies in a written plan which the Secretary has approved: *Provided*, That such period shall not exceed 12 full calendar months, except as provided in § 405.604(b); or

(2) Provide a conditional period of 12 full months, subject to an automatic cancellation clause, the certification will expire at the close of a predetermined date which is no later than the 60th day following the end of the time period specified for the correction of deficiencies: *Provided*, That such date will occur within such 12-month period, unless the Secretary determines that all required corrections have been satisfactorily completed or that the facility has made substantial effort and progress in correcting such deficiencies and has resubmitted in writing a plan of correction acceptable to the Secretary.

(b) If the facility continues to be out of compliance with the same standard(s) at the end of the term of the agreement, a new agreement may not be accepted for filing (see

(c) When an agreement with a skilled nursing facility is not renewed at the end of its specified term (including the automatic cancellation of agreement), see § 405.604(c) for public notice and the right to request review.

(d) If the latest survey discloses that a skilled nursing facility that had standards out of compliance during the last survey is no longer in compliance with a standard that was previously met, a new period of certification may be approved only if, in the judgment of the Secretary, the new deficiency(ies) has occurred:

(1) Despite adequately documented intensive efforts or for reasons beyond its control, the skilled nursing facility was unable to maintain compliance, and

(2) Despite the deficiency the facility is making the best use of its resources to render adequate care.

(e) If a skilled nursing facility can document to the State's satisfaction that it achieved compliance with a previously unmet standard during the period of certification but for reasons beyond its control, e.g., loss of key staff member, was found out of compliance by the time of the next survey, this may be treated as a new deficiency instead of a carry-over deficiency unless in the judgment of the Secretary the facility did not make a good faith effort to maintain compliance with the standard.

§ 405.1909 Special requirements applicable to independent laboratories.

(a) The services of a qualified independent laboratory for which reimbursement may be made under the supplementary medical insurance program relate only to diagnostic tests performed in an independent laboratory as defined in § 405.1311(a). Diagnostic laboratory tests for purposes of section 1861(s)(10) and (11) of the Act and for purposes of this Subpart T shall include only those clinical and anatomical pathology diagnostic tests and procedures defined in § 405.1311(b). Diagnostic tests furnished by out-of-hospital physicians whose primary practice is directly attending patients and/or consultation as defined in § 405.1311(f), even though conducted partly through diagnostic procedures, are considered physicians' services rather than clinical laboratory services.

(b) A laboratory that requests an initial certification, or recertification by reason of a change in a director, but which meets all other requirements of Subpart M, except whose directory qualifies solely under the provisions of § 405.1312(b)(4), can be certified provided such laboratory requests approval based on such director's qualifications no later than 1 year following the effective date of these regulations.

(c) Independent laboratories previously found in compliance, but which have had their approval revoked in total or in a specialty or subspecialty because of unsatisfactory performance in proficiency testing, may subsequently be certified by the State agency and determined by the Secretary to be in compliance with the conditions where:

(1) After a 6-month period, an appraisal of the laboratory's performance in a proficiency testing program as defined in § 405.1311(c) reflects satisfactory test results on at least two sets of specimens, or

(2) After a 3-month period, the State agency's assessment of the laboratory's performance in examining proficiency test samples, analyzed during at least two State agency onsite visits, establishes the laboratory's competency.

(d) A laboratory which meets the requirements of § 405.1907 or paragraph (c) of this section may continue to be certified by the State agency and determined by the Secretary to be in compliance with these conditions where it (1) timely reports a change in ownership, location, directors, or supervisors, or (2) permits a State agency to conduct an onsite visit or survey at any time during the laboratory's regular hours of operations.

§ 405.1910 Special hospital certification.

(a) *General.* Where, by reason of factors such as isolated location or absence of sufficient facilities in an area, the failure to approve a hospital would seriously limit the access of beneficiaries to needed inpatient care, a hospital may, under special conditions and upon recommendation by the State agency, be

approved by the Secretary as a provider of services. Such approvals will be granted only when there are no deficiencies of such character and seriousness as to place health and safety of individuals in jeopardy. A hospital receiving this special approval shall furnish information showing the extent to which it is making the best use of its resources to improve its quality of care.

(b) *Minimum compliance requirements.* Each case will have to be decided on its individual merits, and while the degree and extent of compliance will vary, the institution must, as a minimum, meet all of the statutory conditions in section 1861(e)(1)–(8), in addition to meeting such other requirements as the Secretary finds necessary under section 1861(e)(9). (For further information relating to the exception in section 1861(e)(5) of the Act, see paragraph (c) of this section.)

(c) *Waiver of 24-hour registered nurse requirement.* For a period ending January 1, 1976, the Secretary is authorized to waive the requirement contained in section 1861(e)(5) that a hospital must provide 24-hour nursing service rendered or supervised by a registered nurse. Such a waiver may be granted for any 1-year period upon acceptance by the Secretary of findings adequately documented and certified by the State agency, that the following criteria are met:

(1) The hospital complies with all other requirements for special certification provided in this section.

(2) At least one registered nurse is employed full-time and sufficient other registered nurses are employed to assure that the day tour of duty is covered by a registered nurse 7 days a week.

(3) The hospital has in charge, on all tours of duty not covered by a registered nurse, a licensed practical (vocational) nurse who is a graduate of a State-approved school of practical (vocational) nursing or one who has passed a proficiency examination when such examinations are available and approved by the Secretary. Until such time as this examination is available, waivered licensed practical (vocational) nurses may serve as charge nurses.

(4) The hospital is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein and the failure to qualify as a participating hospital would seriously reduce the availability of such services to such individuals.

(5) The hospital has made and continues to make a good faith effort to comply with section 1861(e)(5), but such compliance is impeded by the lack of qualified nursing personnel in such area.

[FR Doc.74–1323 Filed 1–16–74;8:45 am]

Title 45—Public Welfare

CHAPTER II—SOCIAL AND REHABILITATION SERVICE (ASSISTANCE PROGRAMS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MEDICAL ASSISTANCE PROGRAM

Notice of proposed rulemaking to implement sections 239, 246 and 249A of Pub. L. 92–603 relating to the medical assistance program under title XIX of the Social Security Act, was published on July 12, 1973 in the FEDERAL REGISTER (38 FR 18616).

Interested parties were given the opportunity to submit comments on the proposed amendments within 30 days. The comment period was extended by the Secretary for an additional 30 days to September 13, 1973, and notice of this extension appeared in the FEDERAL REGISTER of August 14, 1973.

The comments received concerning Subpart K—Conditions of Participation; Skilled Nursing Facilities (38 FR 18621) as they apply to skilled nursing facilities under the Medicaid program were jointly reviewed with the Social Security Administration. The changes adopted will be reflected in the final regulations issued by the Social Security Administration in 20 CFR 405.1101 and 405.1120 through 405.1137.

The comments received concerning the Medicaid provisions under 45 CFR Parts 205, 249 and 250 reflected general and overall approval of the regulations as proposed. Some concern was expressed with respect to uniformity in skilled nursing facility certification language for both Medicaid and Medicare. The regulations have been amended to adopt insofar as possible identical certification language for both programs.

In addition, Medicaid provisions under 45 CFR Part 249 have been revised to delete existing Federal requirements under the definition of skilled nursing home services and the certification procedures for skilled nursing facilities have been reorganized with no significant changes to clarify the roles and responsibilities of the State survey agency and the title XIX agency in the certification of skilled nursing facilities and intermediate care facilities under the Medicaid program. The Medicaid provisions under 45 CFR Part 249 applicable to intermediate care facilities have also been modified to include a provision requiring that institutions for the mentally retarded submit a plan for achieving compliance with standards in § 249.13 which become effective three years from the effective date of the standards issued for intermediate care facilities under the Medicaid program.

PART 205—GENERAL ADMINISTRATION—PUBLIC ASSISTANCE PROGRAMS

Chapter II, Title 45, Code of Federal Regulations is amended as set forth below.

1. Section 205.190 is amended by revising the introductory words to paragraph (a) to read as set forth below, and by deleting the reference to medical assistance in paragraph (a)(2)(i), and the last sentence of paragraph (a)(2), and by revising paragraph (a)(2)(iii) (*a*) and (*b*):

§ 205.190 Standard-setting authority for institutions.

(a) *State plan requirements.* If a State plan under title I, X, XIV, or XVI, of the Social Security Act includes aid or assistance to individuals in institutions as defined in § 233.60(b) (1) and (2) of this chapter, the plan must:

(1) Provide for the designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(2) Provide that the State agency will keep on file and make available to the Social and Rehabilitation Service upon request:

(i) A listing of the types or kinds of institutions in which an individual may receive financial assistance;

(ii) A record naming the State authority(ies) responsible for establishing and maintaining standards for such types of institutions;

(iii) The standards to be utilized by such State authority(ies) for approval or licensing of institutions including, to the extent applicable, standards related to the following factors:

(*a*) Health (dietary standards and accident prevention);

(*b*) Humane treatment;

(*c*) Sanitation;

(*d*) Types of construction;

(*e*) Physical facilities, including space and accommodations per person;

(*f*) Fire and safety;

(*g*) Staffing, in number and qualifications, related to the purposes and scope of services of the institution;

(*h*) Resident records;

(*i*) Admission procedures;

(*j*) Administrative and fiscal records;

(*k*) The control by the individual, or his guardian or protective payee, of the individual's personal affairs.

* * * * *

PART 249—SERVICES AND PAYMENT IN MEDICAL ASSISTANCE PROGRAMS

2. Section 249.33 is revised to read as follows:

§ 249.33 Standards for payment for skilled nursing facility and intermediate care facility services.

(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must:

(1) Provide that the single State agency will, prior to execution of an agreement with any facility (including hospitals) for provision of skilled nursing facility services and making payments

under the plan obtain certification from:

(i) The agency designated pursuant to § 250.100(c) of this chapter that the facility meets the statutory definition contained in section 1861(j) of the Social Security Act and is in full compliance with the standards prescribed by the Secretary in the regulations promulgated thereunder, except that for purposes of § 405.1134(c) of this title, the agency may waive, or, for purposes of § 405.1134(e) of this title, the agency may permit, variations in the provisions therein for facilities participating only under title XIX, provided such waiver or variation is authorized under conditions promulgated by the Secretary; or

(ii) The Secretary, pursuant to section 1910 of the Act, that the facility has been determined to qualify as a skilled nursing facility under title XVIII of the Act; or

(iii) The Secretary, pursuant to section 1905 of the Act, in the case of a facility located in the State on an Indian reservation that it meets the statutory definition contained in section 1861(j) of the Social Security Act and in full compliance with the standards prescribed by the Secretary in the regulations promulgated thereunder.

(2) Provide that the single State agency will, prior to execution of an agreement with any facility (including hospitals and skilled nursing facilities) for provision of intermediate care facility services and making payments under the plan, obtain certification from the agency designated pursuant to § 250.100(c) of this chapter that the facility meets the definition set forth under § 249.10(b)(15) (proposed); except that in the case of an intermediate care facility determined to have deficiencies under the requirements for environment and sanitation (§ 249.12(a)(6)) or of the Life Safety Code (§ 249.12(a)(5)) it may be recognized for certification as an intermediate care facility in accordance with subparagraph (4)(iii) of this paragraph for a period not exceeding 2 years following the date of such determination provided that:

(i) The institution submits a written plan of correction acceptable to the survey agency which contains:

(A) The specific steps that it will take to meet all such requirements; and

(B) A timetable not exceeding 2 years from the date of the initial certification after publication of these regulations detailing the corrective steps to be taken and when correction of deficiencies will be accomplished;

(ii) The survey agency makes a finding that the facility potentially can meet such requirements through the corrective steps and they can be completed during the 2 year allowable period of time;

(iii) During the period allowed for corrections, the institution is in compliance with existing State fire safety and sanitation codes and regulations;

(iv) The institution is surveyed by qualified personnel at least semiannually until corrections are completed and the survey agency finds on the basis of such surveys that the institution has in fact made substantial effort and progress in its plan of correction as evidenced by supporting documentation, signed contracts and/or work orders, and a written justification of such findings is maintained on file; and

(v) At the completion of the period allowed for corrections, the intermediate care facility is in full compliance with the Life Safety Code (NFPA, 21st Edition 1967), and the requirements for environment and sanitation set forth under § 249.12(a)(6), except for any provisions waived in accordance with § 249.12.

(3) Provide that any intermediate care facility receiving payments under the plan must supply to the licensing agency of the State full and complete information, and promptly report any changes which would affect the current accuracy of such information, as to the identity:

(i) Of each person having (directly or indirectly) an ownership interest of 10 percent or more in such facility,

(ii) In case a facility is organized as a corporation, of each officer and director of the corporation, and

(iii) In case a facility is organized as a partnership, of each partner;

(4) Provide that certification by the survey agency designated pursuant to § 250.100(c) of this chapter will be subject to the following provisions and exclusions:

(i) For purposes of paragraph (a)(1)(i) of this section, the facility is in compliance with each condition of participation as determined by the manner and degree to which the facility satisfies the standards within each condition;

(ii) For purposes of paragraphs (a)(1)(i) and (a)(2) of this section, the facility is in full compliance with the standards or meets the following conditions for any standards not fully met:

(A) The deficiencies noted, individually or in combination neither jeopardize the health and safety of patients nor are of such character as to seriously limit the provider's capacity to render adequate care. A written justification of such findings is maintained on file by the survey agency; and

(B) The facility provides in writing a plan of correction acceptable to the survey agency;

(iii) In the case of facilities certified under the provisions of paragraph (a)(4)(ii)(A) and (B) of this section certification will be for:

(A) A period that is no later than the 60th day following the end of the time period specified for the correction of deficiencies in a written plan which the survey agency has approved provided that such period shall not exceed 12 full calendar months or

(B) A conditional term of 12 full months, subject to an automatic cancellation clause that the certification will expire at the close of a predetermined date which no later than the 60th day following the end of the time period specified for the correction of deficiencies: *Provided*, That such date will occur within such 12-month period, unless the survey agency finds that all required corrections have been satisfactorily completed, or unless the survey agency finds and notifies the State agency that the facility has made substantial progress in correcting such deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency. Except as provided in paragraph (a)(6) of this section, the period of a certification shall not exceed 12 calendar months.

(iv) No second certification under the condition specified in paragraph (a)(4)(ii) of this section may be executed if:

(A) The standard found deficient was in compliance during the previous certification period, except where the survey agency has made a determination based upon documented evidence that the facility despite intensive efforts or for reasons beyond its control was unable to maintain compliance and despite the deficiency(ies) the facility is making the best use of its resources to render adequate care; or

(B) The standards found deficient are the same as those which occasioned the prior certification, except:

(*1*) In a case where a facility can document to the State survey agency's satisfaction that it achieved compliance with a previously unmet standard during the period of certification but for reasons beyond its control and despite, in the judgment of the survey agency, a good faith effort to maintain compliance with the standard, was again out of compliance by the time of the next survey; or

(*2*) In the case of a skilled nursing facility completing the second of two successive agreements under provisions for certification in effect prior to July 1, 1973 and having the same deficiency(ies) which occasioned the two agreements, the survey agency will review the performance of such facility (which may be limited to a review of the documentation of record) in providing safe and adequate patient care and in progressing toward correction of such deficiency(ies). On the basis of its evaluation, the survey agency will advise the single State agency that:

(*i*) No provider agreement may be executed with such facility,

(*ii*) A new provider agreement may be executed for a period related to the time required to correct such deficiencies, but not to exceed six months; or

(*iii*) A new provider agreement may be executed for a period of twelve months but subject to a provision for automatic cancellation 60 days following the scheduled date for correction unless the survey agency finds and notifies the State agency that all required corrections have been satisfactorily completed. If the facility continues to be out of compliance with the same standard(s) at the end of the term of the agreement, a recertification may not be made.

(v) For purposes of this subparagraph (4), waivers granted pursuant to section 1902(a)(28) of the Act or § 249.12 are not considered deficiencies.

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(5) Provide that the survey agency designated pursuant to § 250.100(c) of this chapter will:

(i) Review information contained in medical review and independent professional review team inspections made pursuant to State plan provisions under section 1902(a)(26) and (31) of the Social Security Act;

(ii) Review statements obtained from each facility setting forth (from payroll records) the average numbers and types of personnel (in full-time equivalents) on each shift during at least 1 week of each quarter, such week to be selected by the survey agency and to occur irregularly in each quarter of the year;

(iii) Review and evaluate such reports as they reflect on health and safety requirements and as necessary take appropriate action to achieve compliance or withdraw certification; and

(iv) Perform, with qualified personnel, on-site inspections at least once during the term of a certification or more frequently if there is a question of compliance.

(6) Provide that execution of the single State agency provider agreement with a facility for payments under the plan shall be contingent upon certification in accordance with the provisions of paragraph (a)(1) and (2) of this section. The term of an agreement may not exceed a period of one year and the effective date of such agreement may not be earlier than the date of certification. Execution of a provider agreement shall be for the term and in accordance with the provisions of certification determined by the survey agency except that the single State agency for good cause based on adequate and documented evidence may elect to execute a provider agreement for a term less than the full period of certification or may elect not to execute a provider agreement or may cancel a provider agreement for participation by a facility certified under the State plan. Notwithstanding the provisions of this subparagraph the single State agency may extend such term for a period not exceeding two months where the survey agency has notified the single State agency in writing prior to the expiration of a provider agreement that the health and safety of the patients will not be jeopardized thereby, and that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services or that it is impracticable within such provider agreement period to determine whether such facility is complying with the provisions and requirements under the program.

(7) Provide that in the case of a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions, the single State agency will, prior to the execution of an agreement for the provision of intermediate care facility services, obtain a written agreement from the State or political subdivision responsible for the operation of such public institution that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to

(i) Services furnished to residents in such institutions (or distinct part thereof) and (ii) services for individuals released during the preceding four quarters as provided in § 249.10(c)(3), will not, because of payments made under the plan, be reduced below the average quarterly per capita amount expended for services to residents in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its approved plan;

(8) Provide during the period ending three years after the effective date of section 249.13 that in the case of an institution (or distinct part thereof) for the mentally retarded or persons with related conditions, the single State agency will:

(i) Prior to the execution of a provider agreement covering intermediate care facility services, where the institution is not in compliance with the standards specified in § 249.13, obtain a written plan of compliance which shall be submitted (including any amendments thereto) by the institution to the single State agency and approved by the Secretary, for achieving conformity with the standards specified in § 249.13. The plan of compliance shall:

(A) Detail the extent of the institution's current compliance with the standards prescribed in § 249.13, and the specific action steps required to achieve compliance with the standards specified in such section, including:

(*1*) The number, job titles, and qualifications of personnel currently employed by the facility and arrangements for recruiting and training additionally required personnel sufficient to assure that each resident participates in an effective program of active treatment;

(2) Any necessary structural changes and renovations to buildings and a schedule for their completion;

(3) The programs and services currently provided and any required reorganization or expansion thereof.

(B) Establish a timetable not exceeding 3 years from the effective date of § 249.13 for completion of all action steps necessary to achieve conformity with the standards specified in § 249.13;

(C) In the case of a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions, provide for approval of the plan of compliance by the State or political subdivision having jurisdiction over the operation of such public institution;

(D) Provide for semi-annual reports to be submitted to the single State agency by the institution documenting the actions taken and recording the progress made in implementing the plan of compliance;

(ii) Prior to the execution of a second (and each and any succeeding) provider agreement, obtain a written report from the survey agency (based on an on-site inspection) establishing that the facility is adhering to the timetable for completion of all necessary action steps referred to in paragraph (a)(8)(i) of this section.

(9) Provide that in the case of skilled nursing facilities certified under the provisions of title XVIII of the Social Security Act, the term of a provider agreement shall be subject to the same terms and conditions and coterminous with the period of approval of eligibility specified by the Secretary pursuant to that title, and upon notification that an agreement with a facility under title XVIII of the Act has been terminated or cancelled, the single State agency will take appropriate action to terminate the facility's participation under the plan. A facility whose agreement has been cancelled or otherwise terminated may not be issued another agreement until the reasons which cause the cancellation or termination have been removed and reasonable assurance provided the survey agency that they will not recur.

(10) Provide that facilities which do not qualify under this section are not recognized as skilled nursing facilities or intermediate care facilities for purposes of payment under title XIX of the Act.

(b) *Federal financial participation.* (1) Federal financial participation is available at 75 percentum in expenditures of the single State agency for compensation (or training) of its skilled professional medical personnel and staff directly supporting such personnel, which are necessary to carry out these regulations.

(2) Federal financial participation at applicable rates is also available for the single State agency to enter into a written contract (under the supervision of the Medical Assistance Unit) with the survey agency designated pursuant to § 250.100(c) of this chapter as necessary to carry out its responsibilities under these regulations. Such Federal financial participation is available only for those expenditures of the survey agency which are not attributable to the overall cost of meeting responsibilities under State law and regulations for establishing and maintaining standards but which are necessary and proper for carrying out these regulations.

PART 250—ADMINISTRATION OF MEDICAL ASSISTANCE PROGRAMS

3. A new § 250.100 is added to Part 250 as set forth below:

§ 250.100 Establishment and maintenance of State and Federal standards.

State plan requirements. A State plan for medical assistance under title XIX of the Social Security Act must:

(a) Provide for the designation of the State health agency or other appropriate State medical agency (whichever is utilized by the Secretary for purposes of title XVIII of the Act as specified in the first sentence of section 1864(a) of the Act) as the State authority responsible for establishing and maintaining health standards for private or public

institutions, excluding Christian Science sanatoria operated or listed and certified by the First Church of Christ Scientist, Boston, Massachusetts, in which recipients of medical assistance under the plan may receive care and services. The State plan must describe these standards and such standards must be kept on file and made available to the Social and Rehabilitation Service upon request;

(b) Provide for the designation of the single State agency or other appropriate State authority or authorities which shall be responsible for establishing and maintaining standards other than those relating to health for public and private institutions in which recipients of medical assistance under the plan may receive care or services. The State plan must describe these standards and such standards must be kept on file and made available to the Social and Rehabilitation Service upon request; and

(c) Provide that the agency referred to in paragraph (a) of this section or such other State agency as is responsible for licensing health institutions in the State will, in accordance with a written agreement (or other written formal arrangement) with the single State agency, determine whether institutions and agencies, excluding Christian Science sanatoria operated or listed and certified by the First Church of Christ Scientist, Boston, Massachusetts, meet the requirements for participation in the program as set forth elsewhere in this chapter; and that the staff of the agency making such determinations is the same staff responsible for such determinations for institutions or agencies participating under title XVIII. Written agreements (or other written formal arrangements) between the single State agency and the agency in the State responsible for licensing, for purposes of this paragraph, must specify and provide:

(1) That Federal standards and such forms, methods and procedures as may be designated by the Administrator of the Social and Rehabilitation Service will be used in determining provider eligibility and certification under the program;

(2) That copies of reports and inspections are completed by inspectors surveying the premises with notations indicating whether each requirement for which inspection is made is or is not satisfied, with documentation of deficiencies; and

(3) That all information and reports used in determining whether Federal requirements for participating facilities are being met are maintained on file by the survey agency for ready access by the Department of Health, Education, and Welfare, and the single State agency as may be necessary to meet other requirements under the plan and for purposes consistent with that agency's effective administration of the program.

4. Section 249.10 (of Part 249 is amended by revising paragraph (b)(4)(i) to read as follows:

§ 249.10 Amount, duration, and scope of medical assistance.

* * * * *

(b) *Federal financial participation.*

* * *

(4)(i) *Skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older.* "Skilled nursing facility services" means services ordered by and under the direction of a physician, which as a practical matter can only be provided on an inpatient basis in a skilled nursing facility (which term includes any institution located on an Indian reservation and certified by the Secretary as meeting the requirements of section 1861(j) of the Act), and which are:

(*a*) Provided by a facility or distinct part of a facility which has not been determined by an officially designated State standard-setting authority not to meet fully all requirements of the State for licensure as a nursing home except as provided in the next sentence. Payments to a nursing home which formerly met fully all such requirements but is currently determined not to meet them, may be recognized for a period specified by the State standard-setting authority, if during such period such home promptly takes all necessary steps to again meet such requirements; and

(*b*) Provided by a facility or distinct part of a facility which is certified for participation pursuant to § 249.33 as evidenced by an agreement executed in accordance with the provisions of § 249.33, between the single State agency and the facility for the provision of skilled nursing facility services and the making of payments under the plan; except that with respect to skilled nursing facility services furnished by a facility whose provider agreement has expired or has otherwise terminated, the State agency may continue to claim Federal financial participation in payments on behalf of eligible individuals for such services furnished by such institution during a period not to exceed 30 days starting with the date of expiration or other termination of its provider agreement, but only if such individuals were admitted to the facility before the date of expiration or other termination of its provider agreement, and if the State agency makes a showing satisfactory to the Secretary that it has made reasonable efforts to facilitate the orderly transfer of such individuals from such institution to another facility.

* * * * * *

(Sec. 1102, 49 Stat. 647 (42 U.S.C. 1302)).

Effective date. These regulations shall be effective February 19, 1974.

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: December 21, 1973.

JOHN A. SVAHN,
Acting Administrator, Social and Rehabilitation Service.

Approved: December 27, 1973.

CASPAR W. WEINBERGER,
Secretary of Health, Education, and Welfare.

[FR Doc.74-1325 Filed 1-16-74;8:45 am]

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PART II

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social Security Administration

■

SKILLED NURSING FACILITIES

Health Insurance for the Aged and Disabled; General Administration

Title 20—Employees' Benefits

CHAPTER III—SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATON, AND WELFARE

[Regs. 5]

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED (1965)

Skilled Nursing Facilities

On May 1, 1974, there was published in the FEDERAL REGISTER (39 FR 15230) a notice of proposed rulemaking which set forth proposed amendments to regulations relating to the conditions of participation for skilled nursing facilities. Included in the proposed amendments were several additional provisions to the Medicare-Medicaid common standards for skilled nursing facilities, which resulted from comments received with respect to the conditions of participation published as proposed rules on July 12, 1973 (38 FR 18620). Because of the substantive nature of these provisions, they were not included in the final regulations published on January 17, 1974 (39 FR 2238), but were published in proposed form on May 1. In addition to the proposed provisions resulting from those comments (a medical director, 7-day registered nurse services, discharge planning, and patients' rights), other provisions designed to clarify or expand upon existing regulations were included in the proposed rulemaking. Interested parties were given the opportunity to submit within 30 days data, views, and arguments on the proposed amendments.

Comments were received from many sources (including representatives of national, State, and local organizations) concerned with skilled nursing services, the quality of patient care, and the rights of these patients. All of the comments received, including earlier public comments and those reported from Senator Frank E. Moss' subcommittee hearings, have been carefully considered.

The following summarizes the changes made in consideration of comments received:

1. *Dietitian (qualified consultant), § 405.1101(f).*—The proposed revision corrected a typographical error in this definition, by adding "or" between clauses (1) and (2) to provide that a dietitian need meet only one of the alternatives in this definition. No adverse comments were received regarding this change. However, an additional change was made for purposes of clarity and consistency. This was to change the phrase "on the publication of this provision" to January 17, 1974, the date the final conditions of participation were published.

2. *Use of outside resources, § 405.1121(i).* This provision is addressed to the situation where a skilled nursing facility ordinarily furnishes a specific service to its patients through an outside resource. Considerable comment was received in opposition to the proposed amendment, which would except an independent laboratory from the requirement that the outside resource bill the facility for covered services rendered directly to the patient. Considering the strong protests, and that Medicaid has had administrative problems with the reimbursement procedure, any reference in § 405.1121(i) to billing procedures has been deleted. Its deletion, however, does not mean that, under Medicare, outside resources furnishing services to inpatients of a facility under an arrangement with the facility may bill the patient for services which constitute provider services. Furthermore, pursuant to section 1861(w) of the Social Security Act, such services furnished under an arrangement must be billed through the provider exclusively. Appropriate revisions to incorporate this principle will be transferred to the pertinent subparts of Regulations No. 5 at a later date.

3. *Patients' rights, § 405.1121(k).* On the basis of numerous comments received, including some 135 letters protesting the separation of married couples in skilled nursing facilities, the following substantive changes were made in the patients' rights provision in consideration of the viewpoints expressed, and the revised phrases are in italics:

(a) Policies and procedures regarding patients' rights are to be available *to the public*, as well as to patients, guardians, and others identified in the proposed regulations;

(b) *Written acknowledgement by the patient* that he has been fully informed of these rights is required;

(c) The patient is fully informed of his medical condition, *by a physician*, unless medically contraindicated (as documented *by a physican* in his medical record);

(d) Reasons for patient transfer or discharge are now delineated to include: *Medical, for the welfare of the patient or others, or for nonpayment for stay (except where prohibited by the program(s)), with such actions documented in the medical record;*

(e) The patient is encouraged to exercise his rights as a patient, *and as a citizen;*

(f) Delegation by the patient to the facility of the right to manage his funds now requires a *quarterly* accounting and specifies *that the delegation be in conformance with State laws;*

(g) Further limitations are placed on the use of restraints (that they be used only if authorized by a physician for a specified and limited period of time; that is, their use must be *necessary to protect the patient* from injury to himself or others);

(h) These regulations provide for the patient to *send* as well as receive mail unopened *unless medically contraindicated as documented by his physician in the medical record;*

(i) The patient retains and uses his personal clothing and possessions, *as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated and documented by his physician in his medical record;*

(j) A new provision has been added which provides that *if married, the patient is assured privacy for visits by his/her spouse, and if both are inpatients, they are permitted to share a room, unless medically contraindicated and documented by the attending physician in the medical record.*

This paragraph (k) also was clarified to reflect that the rights and responsibilities in paragraphs (k) (1) through (4) as they pertain to a patient found by his physician to be medically incapable *of understanding these rights* devolve to such patient's guardian, next of kin, etc.

4. *Seven-day registered nurse services, §§ 405.1124 and 405.1124(c).* As proposed, this revises the requirement for the employment of a registered nurse to at least the day tour of duty on 7 days a week. For purposes of classification, a cross reference to the waiver provision for this requirement was inserted after the condition of participation. Most comments regarding this provision were supportive and in addition suggested stronger requirements in line with some State requirements.

The requirement for a registered nurse on the day tour of duty is considered to be reasonable and necessary as a Federal standard and does not preclude higher State requirements.

Regarding waivers of this provision, some requests were received that waivers be considered for urban as well as rural skilled nursing facilities. However, section 267 of Pub. L. 92-603, the Social Security Amendments of 1972, provides that waiver of the 7-day registered nurse requirement applies to rural skilled nursing facilities. In addition, § 405.1911(a) regarding waivers was revised to parallel the waiver language for medical direction in skilled nursing facilities in that the facility must make good faith efforts to meet the 7-day registered nursing requirement.

5. *Administration of drugs, § 405.1124(g).* Several comments were received requesting that the phrase "in compliance with State and local laws" be added to this section. This comment was not accepted because it was felt that, in addition to meeting State and local laws as stipulated in § 405.1120, an appropriate Medicare-Medicaid requirement would be that drugs be administered only by physicians, licensed nursing personnel, or other staff who have completed a State-approved program in medication administration. These controls permit only qualified staff to administer medication, while making the best utilization of health manpower.

6. *Staffing for specialized rehabilitative services, § 405.1126(a).* The majority of comments received were in opposition to this proposal because it was interpreted to mean that nonqualified personnel could perform the professional activities of a therapist if under the supervision of a physician qualified in physical medicine. This was not the intent of the revision, however. The regulation has

been revised to clearly reflect that specialized rehabilitative services are provided in accordance with accepted professional practices by qualified therapists or qualified assistants, while other rehabilitative services must be under the supervision of a physician qualified in physical medicine in a facility that has an organized rehabilitative service.

7. *Handrails, § 405.1134(j).* The provision requiring corridors in skilled nursing facilities to be equipped with handrails on each side is adopted as proposed, few opposing comments having been received.

8. *Discharge planning, § 405.1137(h).* This new requirement was modified to reflect comments opposed to the time previously specified for determining each patient's need for discharge planning. This requirement was changed to read "within 7 days after the day of admission" as more suitable to the health care setting of a skilled nursing facility. Criticism indicated that the previous 72-hour time span was more suitable for a hospital setting.

The notice of proposed rulemaking included a provision that would require a skilled nursing facility to furnish a centralized, coordinated discharge planning program to ensure that each patient has a program of needed continuing care both during his stay and after discharge from the facility. The notice proposed that this section be incorporated in connection with utilization review, pursuant to the provisions of section 237(c) of the Social Security Amendments of 1972 (Pub. L. 92-603) which amend section 1861(k) of the Act by adding authority under which the Secretary may require the use in the Medicare program of utilization review procedures established pursuant to the Medicaid program, which he determines are superior in their effectiveness to the utilization review procedures in the Medicare program. The Secretary has determined that Medicaid program requirements for discharge planning published on this date in this edition of the FEDERAL REGISTER are superior, and accordingly this requirement for discharge planning is incorporated as a utilization review requirement of the Medicare program.

9. *Medical direction, proposed as § 405.1138.* This condition has been modified to include an organized medical staffied to include an organized medical staff, with a member of that staff serving as medical director. Additionally, provision has been added to permit hospital-based skilled nursing facilities to have a member of that staff to serve as medical director. Some concern was expressed that the medical director should not be responsible for surveillance of the environmental health status of the facility, and this comment was accepted. Opposition to the medical director's being responsible for delineation of responsibilities and clinical privileges of attending physicians was expressed; accordingly, the regulation was amended to include the delineation of attending physician responsibilities as part of the skilled nursing facility's bylaws, with approval required by the governing body. Also, a provision was added that medical direction can be provided through arrangement with a group of physicians, a local medical society, a hospital medical staff, or other similar arrangement. Due to concern expressed about a skilled nursing facility's possibly having difficulty in complying, the condition on medical direction now carries the proviso that the facility be allowed 12 full calendar months from effective date of these regulations to comply. The sentence that refers to employee health examinations will be retained as originally published in the FEDERAL REGISTER of January 17, 1974, in § 405.1121(g). Also, for the purpose of cohesion and clarity, the condition on medical direction now appears as § 405.1122. The condition formerly numbered § 405.1122, *Patient care policies,* is now a part of § 405.1121, Governing Body and Management, as standard (l).

Finally, a cross reference to § 405.1911 (b), which contains waiver provision for this requirement, was added to the condition on medical direction.

The amendments as announced under the proposed rule making (39 FR 15230) are adopted, with the noted changes. In addition, some parts of the regulations were redrafted for clarification purposes, in line with the comments received.

(Secs. 1102, 1861, 1871, 49 Stat. 647, as amended, 79 Stat. 313, as amended, 79 Stat. 331, (42 U.S.C. 1302, 1395x, 1395hh))

Effective date. These amendments shall be effective December 2, 1974.

(Catalog of Federal Domestic Assistance Program No. 13.800, Health Insurance for the Aged—Hospital Insurance)

Dated: September 20, 1974.

J. B. CARDWELL,
Commissioner of Social Security.

Approved: September 20, 1974.

FRANK CARLUCCI,
Acting Secretary of Health, Education, and Welfare.

Regulations No. 5 of the Social Security Administration, as amended (20 CFR Part 405), are further amended as set forth below:

1. Paragraph (f) of § 405.1101 is revised to read as follows:

§ 405.1101 Definitions.

As used in this subpart, the following definitions apply:

* * * * *

(f) *Dietitian (qualified consultant).* A person who:

(1) Is eligible for registration by the American Dietetic Association under its requirements in effect on January 17, 1974; or

(2) Has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management, has 1 year of supervisory experience in the dietetic service of a health care institution, and participates annually in continuing dietetic education.

* * * * *

2. Section 405.1121 is amended by revising paragraph (i), and adding a new paragraph (k). Section 405.1122 is redesignated as paragraph (l) of § 405.1121. As amended § 405.1121 (i), (k), and (l) reads as follows:

§ 405.1121 Condition of participation—governing body and management.

* * * * *

(i) *Standard: Use of outside resources.* If the facility does not employ a qualified professional person to render a specific service to be provided by the facility, it makes arrangements to have such a service provided by an outside resource—a person or agency that will render direct service to patients or act as a consultant to the facility. The responsibilities, functions, and objectives, and the terms of agreement, including financial arrangements and charges, of each such outside resource are delineated in writing and signed by an authorized representative of the facility and the person or agency providing the service. Agreements pertaining to services must specify that the facility assumes professional and administrative responsibility for the services rendered. The outside resource, when acting as a consultant, apprises the administrator of recommendations, plans for implementation, and continuing assessment through dated, signed reports, which are retained by the administrator for followup action and evaluation of performance. (See requirement under each service—§§ 405.1125 through 405.1132.)

* * * * *

(k) *Standard: Patients' rights.* The governing body of the facility establishes written policies regarding the rights and responsibilities of patients and, through the administrator, is responsible for development of, and adherence to, procedures implementing such policies. These policies and procedures are made available to patients, to any guardians, next of kin, sponsoring agency(ies), or representative payees selected pursuant to section 205 (j) of the Social Security Act, and Subpart Q of Part 404 of this chapter, and to the public. The staff of the facility is trained and involved in the implementation of these policies and procedures. These patients' rights policies and procedures ensure that, at least, each patient admitted to the facility:

(1) Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities;

(2) Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate;

(3) Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is

afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

(4) Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for nonpayment for his stay (except as prohibited by titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record;

(5) Is encouraged and assisted, throughout his period of stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

(6) May manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

(7) Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others;

(8) Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care institution, or as required by law or third-party payment contract;

(9) Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

(10) Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

(11) May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record);

(12) May meet with, and participate in activities of, social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record);

(13) May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record); and

(14) If married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).

All rights and responsibilities specified in paragraphs (k) (1) through (4) of this section—as they pertain to (a) a patient adjudicated incompetent in accordance with State law, (b) a patient who is found, by his physician, to be medically incapable of understanding these rights, or (c) a patient who exhibits a communication barrier—devolve to such patient's guardian, next of kin, sponsoring agency(ies), or representative payee (except when the facility itself is representative payee) selected pursuant to section 205(j) of the Social Security Act and Subpart Q of Part 404 of this chapter.

(l) *Standard: Patient care policies.* The skilled nursing facility has written patient care policies to govern the continuing skilled nursing care and related medical or other services provided.

(1) The facility has policies, which are developed by the medical director or the organized medical staff (see § 405.1122), with the advice of (and with provision for review of such policies from time to time, but at least annually, by) a group of professional personnel including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical or other services it provides. The policies, which are available to admitting physicians, sponsoring agencies, patients, and the public, reflect awareness of, and provision for, meeting the total medical and psychosocial needs of patients, including admission, transfer, and discharge planning; and the range of services available to patients, including frequency of physician visits by each category of patients admitted. These policies also include provisions to protect patients' personal and property rights. Medical records and minutes of staff and committee meetings reflect that patient care is being rendered in accordance with the written patient care policies, and that utilization review committee recommendations regarding the policies are reviewed and necessary steps taken to ensure compliance.

(2) The medical director or a registered nurse is designated, in writing, to be responsible for the execution of patient care policies. If the responsibility for day-to-day execution of patient care policies has been delegated to a registered nurse, the medical director serves as the advisory physician from whom she receives medical guidance. (See § 405.1122(b).)

3. A new § 405.1122 is added to read as follows:

§ 405.1122 Condition of participation—medical direction.

The facility retains, effective not later than 12 full calendar months from December 2, 1974, pursuant to a written agreement, a physician, licensed under State law to practice medicine or osteopathy, to serve as medical director on a part-time or full-time basis as is appropriate for the needs of the patients and the facility. If the facility has an organized medical staff, the medical director is designated by the medical staff with approval of the governing body. A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, a hospital medical staff, or through another similar arrangement. The medical director is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to patients and to maintain surveillance of the health status of employees. (See § 405.1911(b) regarding waiver of the requirement for a medical director.)

(a) *Standard: Coordination of medical care.* Medical direction and coordination of medical care in the facility are provided by a medical director. The medical director is responsible for the development of written bylaws, rules, and regulations which are approved by the governing body and include delineation of the responsibilities of attending physicians. Coordination of medical care includes liaison with attending physicians to ensure their writing orders promptly upon admission of a patient, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services.

(b) *Standard: Responsibilities to the facility.* The medical director is responsible for surveillance of the health status of the facility's employees. Incidents and accidents that occur on the premises are reviewed by the medical director to identify hazards to health and safety. The administrator is given appropriate information to help ensure a safe and sanitary environment for patients and personnel. The medical director is responsible for the execution of patient care policies in accordance with § 405.1121(l).

4. Section 405.1124 is amended by revising the material preceding paragraph (a) and also by revising paragraphs (c) and (g) to read as follows:

§ 405.1124 Condition of participation—nursing services.

The skilled nursing facility provides 24-hour service by licensed nurses, including the services of a registered nurse at least during the day tour of duty 7 days a week. There is an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing needs of all patients in the facility. (See § 405.1911(a) regarding waiver of the 7-day registered nurse requirement.)

* * * * *

(c) *Standard: Twenty-four-hour nursing service.* The facility provides 24-hour nursing services which are sufficient to meet total nursing needs and which are in accordance with the patient care policies developed as provided in § 405.1121(l). The policies are designed to ensure that each patient receives treatments, medications, and diet as prescribed, and rehabilitative nursing care as needed; receives proper care to prevent decubitus ulcers and deformities,

and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection, and encouraged, assisted, and trained in self-care and group activities. Nursing personnel, including at least one registered nurse on the day tour of duty 7 days a week, licensed practical (vocational) nurses, nurse aides, orderlies, and ward clerks, are assigned duties consistent with their education and experience and based on the characteristics of the patient load. Weekly time schedules are maintained and indicate the number and classifications of nursing personnel, including relief personnel, who worked on each unit for each tour of duty.

* * * * *

(g) *Standard: Administration of drugs.* Drugs and biologicals are administered only by physicians, licensed nursing personnel, or by other personnel who have completed a State-approved training program in medication administration. Procedures are established by the pharmaceutical services committee (see § 405.1127(d)) to ensure that drugs to be administered are checked against physicians' orders, that the patient is identified prior to administration of a drug, and that each patient has an individual medication record and that the dose of drug administered to that patient is properly recorded therein by the person who administered the drug. Drugs and biologicals are administered as soon as possible after doses are prepared, and are administered by the same person who prepared the doses for administration, except under single unit dose package distribution systems. (See § 405.1101(h).)

* * * * *

5. Section 405.1126 is amended by revising the material preceding paragraph (a) and also by revising paragraph (a) to read as follows:

§ 405.1126 Condition of participation—specialized rehabilitative services.

In addition to rehabilitative nursing (§ 405.1124(e), the skilled nursing facility provides, or arranges for, under written agreement, specialized rehabilitative services by qualified personnel (i.e., physical therapy, speech pathology and audiology, and occupational therapy) as needed by patients to improve and maintain functioning. These services are provided upon the written order of the patient's attending physician. Safe and adequate space and equipment are available, commensurate with the services offered. If the facility does not offer such services directly, it does not admit nor retain patients in need of this care unless provision is made for such services under arrangement with qualified outside resources under which the facility assumes professional responsibilities for the services rendered. (See § 450.1121(i).)

(a) *Standard: Organization and staffing.* Specialized rehabilitative services are provided, in accordance with accepted professional practices, by qualified therapists or by qualified assistants or other supportive personnel under the supervision of qualified therapists. Other rehabilitative services also may be provided, but must be in a facility where all rehabilitative services are provided through an organized rehabilitative service under the supervision of a physician qualified in physical medicine who determines the goals and limitations of these services and assigns duties appropriate to the training and experience of those providing such services. Written administrative and patient care policies and procedures are developed for rehabilitative services by appropriate therapists and representatives of the medical, administrative, and nursing staffs.

6. Paragraph (j) of § 405.1134 is revised to read as follows:

§ 405.1134 Condition of participation—physical environment.

* * * * *

(j) *Standard: Other environmental considerations.* The facility provides a functional, sanitary, and comfortable environment for patients, personnel, and the public. Provision is made for adequate and comfortable lighting levels in all areas, limitation of sounds at comfort levels, maintaining a comfortable room temperature, procedures to ensure water to all essential areas in the event of loss of normal water supply, and adequate ventilation through windows or mechanical means or a combination of both. Corridors are equipped with firmly secured handrails on each side.

7. Section 405.1137 is amended by adding a new paragraph (h) to read as follows:

§ 405.1137 Condition of participation—utilization review.

* * * * *

(h) *Standard: Discharge planning.* The facility maintains a centralized, coordinated program to ensure that each patient has a planned program of continuing care which meets his postdischarge needs.

(1) The facility has in operation an organized discharge planning program. The utilization review committee, in its evaluation of the current status of each extended duration case, has available to it the results of such discharge planning and information on alternative available community resources to which the patient may be referred.

(2) The administrator delegates responsibility for discharge planning, in writing, to one or more members of the facility's staff, with consultation, if necessary, or arranges for this service to be provided by a health, social, or welfare agency (see § 405.1121(i)).

(3) The facility maintains written discharge planning procedures which describe (i) how the discharge coordinator will function, and his authority and relationships with the facility's staff; (ii) the time period in which each patient's need for discharge planning is determined (preferably within 7 days after the day of admission); (iii) the maximum time period after which a reevaluation of each patient's discharge plan is made; (iv) local resources available to the facility, the patient, and the attending physician to assist in developing and implementing individual discharge plans; and (v) provsions for periodic review and reevaluation of the facility's discharge planning program.

(4) At the time of discharge, the facility provides those responsible for the patient's postdischarge care with an appropriate summary of information about the discharged patient to ensure the optimal continuity of care. The discharge summary includes at least current information relative to diagnoses, rehabilitation potential, a summary of the course of prior treatment, physician orders for the immediate care of the patient, and pertinent social information.

8. A new § 405.1911 is added to read as follows:

§ 405.1911 Special waivers applicable to skilled nursing facilities.

(a) *Waiver of 7-day registered nurse requirement.* To the extent that § 405.1124 requires any skilled nursing facility to engage the services of a registered nurse more than 40 hours a week, the Secretary may waive such requirement for such periods as he deems appropriate if, based upon documented findings of the State agency, he determines that:

(1) Such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individual patients therein,

(2) Such facility has at least one full-time registered nurse who is regularly on duty at such facility 40 hours a week, and

(3) Such facility (i) has only patients whose attending physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse for a 48-hour period, or (ii) has made arrangements for a registered nurse or a physician to spend such time at the facility as is determined necessary by the patient's attending physician to provide necessary services on days when the regular full-time registered nurse is not on duty.

(4) Such facility has made and continues to make a good faith effort to comply with the more than 40-hour registered nurse requirement, but such compliance is impeded by the unavailability of registered nurses in the area.

(b) *Waiver of medical director requirement.* To the extent that § 405.1122 requires any skilled nursing facility to engage the services of a medical director either part-time or full-time, the Secretary may waive such requirement for such periods as he deems appropriate if, based upon documented findings of the State agency, he determines that:

(1) Such facility is located in an area where the supply of physicians is not sufficient to permit compliance with this requirement without seriously reducing the availability of physician services within the area, and

(2) Such facility has made and continues to make a good faith effort to comply with § 405.1122, but such compliance is impeded by the unavailability of physicians in the area.

[FR Doc.74-22694 Filed 10-2-74;8:45 am]

Title 45—Public Welfare

CHAPTER II—SOCIAL AND REHABILITATION SERVICE (ASSISTANCE PROGRAMS) DEPARTMENT OF HEALTH, EDUCATON, AND WELFARE

PART 250—ADMINISTRATION OF MEDICAL ASSISTANCE PROGRAMS

Subpart A—General Administration

DISCHARGE PLANNING—SKILLED NURSING FACILITIES

Notice of proposed rulemaking was published May 1, 1974 (39 FR 15232), requiring that State plans for medical assistance under title XIX, Social Security Act (Medicaid) include in their utilization review programs a requirement for discharge planning for skilled nursing facility patients who are Medicaid recipients. A parallel requirement for the Medicare program was published at the same time.

The proposal specified that each patient's need for discharge planning must be determined within 72 hours of admission. Comments indicated that this time span was suitable for hospital care but not for care in a skilled nursing facility. Consequently, the final regulations have been modified to require this determination within 7 days after the day of admission. No other changes have been made.

As published on May 1, the proposed regulation would have amended another proposal published January 9, 1974 (39 FR 1500) which set forth a complete revision of 45 CFR 250.20, overall utilization review requirements for the Medicaid program. Since the final regulations resulting from the January 9 proposal are not yet ready for publication, the specific requirement for discharge planning with respect to skilled nursing facility patients is being published as an addition to existing utilization review requirements. It will be incorporated appropriately in the final regulations on the overall utilization review program.

Section 250.20 of Part 250, Chapter II, Title 45, Code of Federal Regulations, is amended as set forth below:

1. Wherever it appears, the phrase "skilled nursing home" is changed to "skilled nursing facility".

2. A new paragraph (a)(3) is added to read as follows:

§ 250.20 Utilization review of care and services.

(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must:

* * * * *

(3) Provide in the case of skilled nursing facilities, whether utilization review activities are performed pursuant to paragraph (a)(1) (i) or (ii) of this section, that the utilization review committee shall review each individual's discharge plan, which plan shall be developed in accordance with the provisions of this paragraph (a)(3) of this section. Such plan shall ensure that each individual has a planned program of post-facility continuing care which takes into account such individual's post discharge needs. (i) The facility shall maintain written discharge planning procedures which describe (*a*) which staff member of the facility or which outside health, social, or welfare agency will have operational responsibility for discharge planning; (*b*) the manner in, and methods by, which such staff member or agency will function, including its authority and its relationship with the facility's staff; (*c*) the time period in which each individual's need for discharge planning will be determined (which period may not be later than seven days after the day of admission); (*d*) the maximum time period after which a reevaluation of each individual's discharge plan will be made; (*e*) the local resources available to the facility, the individual, and the attending physician to assist in developing and implementing individual discharge plans and; (*f*) the provisions for periodic review and reevaluation of the facility's discharge planning program. (ii) At the time of the individual's discharge, the facility shall provide to those persons (if any) responsible for the individual's postdischarge care such information about the discharged individual as will ensure the optimal continuity of care, such as current information relative to diagnoses, prior treatment, rehabilitation potential, physician advice concerning immediate care, and pertinent social information.

* * * * *

(Sec. 1102, 49 Stat. 647 (42 U.S.C. 1302))

Effective date. These regulations shall be effective on December 2, 1974.

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program.)

Dated: August 26, 1974.

JAMES S. DWIGHT, JR.,
Administrator, Social and Rehabilitation Service.

Approved: September 23, 1974.

CASPER W. WEINBERGER,
Secretary of Health, Education, and Welfare.

[FR Doc.74-22695 Filed 10-2-74;8:45 am]

Glossary

Aide	A person who acts as an assistant.
Ambulatory	Term referring to the ability to move at will.
Analgesic	An agent that alleviates pain without causing loss of consciousness.
Anemia	Medical diagnosis of a condition in which the blood is deficient in red blood cells, in hemoglobin, or in total volume. Types of anemia include aplastic anemia, B–12 deficiency (pernicious) anemia, folic acid deficiency anemia, or sickel cell disease.
Antipyretic	An agent that reduces fever.
Aphasia	Defect or loss of the power of expression by speech.
Arteriosclerosis	A condition marked by loss of elasticity, thickening, and hardening of the arteries.
Baseline data	Data or information collected which is necessary to identify needs, develop programs and meet those needs, and to measure the overall success of the initiatives undertaken.
Bathing	Process of washing the body or body parts. It includes taking a sponge, shower, or tub bath and getting to or obtaining the bathing water or equipment.
Campaign survey(s)	Surveys of long term care facilities conducted solely as a data collection process with no formal relation to the certification procedure under Title XVIII and XIX.
Cathartic	A medicine that quickens and increases the evacuation from the bowels.
Chronic	Marked by long duration or frequent recurrence.
Clinical status	Measure of the stage and severity of illness.
Comatose	Pertaining to a state of profound unconsciousness from which the patient cannot be aroused, even by powerful stimulation.
Communication	A system of significant symbols which permit ordered human interaction.
Consultant	Qualified individual who provides professional advice or services.
Continence	Physiologic process of elimination from the bladder and bowel, if required.
Demographic characteristics	Profile of personal characteristics, including age, sex, marital status, and race.
Dentition status	Description of the number, kind, and arrangement of teeth in the jaw.
Decubitus ulcer	Break in the skin exposing deeper tissue caused by pressure on soft tissues while patient is lying down. Two other names which refer to the same condition are bedsores and pressure sores.
Diabetes	A deficiency condition marked by habitual discharge of an excessive quantity of urine; particularly diabetes mellitus.
Diagnosis	Common basis for defining patient needs for care and in organizing patient care services.
Dietitian	A person who has a baccalaureate degree and has completed a dietetic internship or coordinated undergraduate program approved by the American Dietetic Association, or who has the equivalent of such education and training.
Digestive	Pertaining to the process or act of converting food into materials fit to be absorbed and assimilated.

Discharge summary	Information from the transferring facility concerning medical findings, diagnoses, functional status, and response to previous treatment and care, as well as orders to initiate care of the patient.
Drug administration	An act in which a single dose of an identified drug, or combination of drugs, is given to a patient.
Dysarthic	Term referring to the imperfect articulation in speech.
Edentulous	Condition which occurs when all teeth are missing; toothlessness. If a person has a set of plates and does not use them, he is classified as edentulous.
Endocrine	Pertaining to internal secretions; applied to organs whose function is to secrete into the blood or lymph a substance that has a specific effect on another organ or part.
Facility personnel	Persons employed by the nursing home.
Facility specific form	Form which consists of the sections on management, patient care policies, nursing rehabilitation, pharmaceutical, nutrition and dietetics, and psychosocial behavior.
Financial form	Form used to assess the costs of providing care in the nursing home.
Fire door	A fire-resistive door assembly, including frame and hardware, which under standard test conditions, meets the fire protective requirements for the location in which it is to be used.
Fire partition	Floor-to-ceiling partition capable of retarding or stopping fire at a tested, specified rate.
Fire safety form	A printed form which measures the conformance of facilities with established safety and fire standards.
Flame retardant	Having or providing comparatively low flammability or flame-spread properties.
Fracture	A broken bone.
Functional status	Measure of the degree of ability to cope with the activities of daily living.
Geriatrics	A branch of medicine that deals with the problems and diseases of old age and aging people.
Governing body	An identifiable authority in every nursing home having full legal and moral responsibility for all aspects of facility operations. This authority might be called "governing body," "board of directors," "board of trustees," or other appropriate designation.
Health care facilities	Facilities defined in terms of State licensure requirements that are designed for individuals with health needs.
Hypertension	Medical diagnosis of a condition in which there exists an abnormally "high" blood pressure measurement.
Identifying form	A typed form used to collect data about the basic characteristics of the nursing home, such as bed size.
Incontinence	Involuntary loss of urine and/or feces.
Indwelling catheter	A hollow cylinder passed through the urethra into the bladder and retained there to keep the bladder drained of urine.
Licensed practical nurse (LPN)	A nurse who is a graduate of an approved school of practical nursing and/or is licensed by waiver to practice as a practical nurse. Also named licensed vocational nurse (LVN).
Life Safety Code	Publication of the National Fire Protection Association, which includes those requirements which are intended to provide a reasonable degree of safety against fire.
Long term care	Services for symptomatic treatment, maintenance, and rehabilitative services for patients of all age groups in various health care settings.
Intermediate care facility (ICF)	Facility certified by the Federal Government to provide an intermediate level of care. Facility providing health related care and services to individuals who do not require the degree of care and treatment that a hospital or SNF is designed to provide but who do require care above the level of room and board. ICFs were not included in the survey.
Long Term Care Facility Improvement Campaign (LTCFIC)	An accelerated project directed toward upgrading the quality of care provided in the Nation's nursing homes.
Medicaid	Health care coverage under Title XIX of the 1965 amendments to the Social Security Act (Public Law 89–97).

Medical director	The physician designated to help ensure the adequacy and appropriateness of the medical care provided to patients/residents.
Medical record	Clinical documentation of an individual's medical care.
Medical record administrator	A registered record administrator who has successfully passed an appropriate examination conducted by the American Medical Record Association, or who has the equivalent of such education or training.
Medicare	Health care coverage under Title XVIII of the 1965 amendments of the Social Security Act (Public Law 89-97).
Medication	Any substance or drug, that is taken orally, injected, inserted, or topically or otherwise administered to a patient.
Mental illness	A medical diagnosis of psychosis, anxiety, depression, or other psychiatric illness.
Neoplasm	Any new and abnormal growth such as a tumor.
Neurological disorders	Diseases of the central nervous system and peripheral nerves.
Nursing home(s)	Facilities which provide some level of nursing care, participating in the Medicare (Title XVIII and Medicaid (Title XIX) programs.
Nursing home administrator	Person who is fully responsible for the day-to-day operation of the nursing home.
Nursing service	Patient care services pertaining to the curative, restorative, and preventive aspects of nursing that are performed and/or supervised by a registered nurse pursuant to the medical care plan of the practitioner and the nursing care plan.
Nutritionist	A person who specializes in the science of nutrition.
Orientation pattern	Range or degree of awareness of an individual within his environment, as to location, identity and time of day, month or year.
Ostomy	Surgical procedure that establishes an external opening into such parts of the body as the ureter(s), colon, ileum, etc.
Pathophysiologic	Descriptive term which refers to a variety of conditions and problems commonly described as accidental or developmental disabilities, chronic illnesses, and diseases of the aging.
Patient assessment form	Form developed and used in this survey which contains questions to be answered which described the individual patient at the time of the survey. Data are provided about the patient's status from several perspectives: his physical functioning, impairments, medical risk status, and social demographic status.
Patient care policies	Policies adopted by the governing body of the facilities concerning the rules and regulations for the care of patients.
Patient care plan	A written program of care for the patient (a working tool) that is based on the assessment of individual needs, identifies the role of each service in meeting these needs, and the supportive measures each service will use to complement each other to accomplish the overall goal of care.
Patient population	Beneficiaries in skilled nursing facilities.
Patient specific form	Form developed and used in this survey which describes the care being provided to the patient at the time of the survey. Data are provided about patient care policies, medical care including diagnosis, nursing care, rehabilitation, pharmaceutical, nutrition and dietetics, and psychosocial aspects of care.
Patient classification assessment tool	Data collection tool used to determine if patients are properly placed in a facility.
Pharmacist	An apothecary or druggist.
Physical therapist	An individual who is licensed by the State and is a graduate of a program in physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, or who has the equivalent of such education and training.
Postadmission diagnosis	Medical description(s) of patient condition(s) identified after admission to facility.
Primary diagnosis	Medical description(s) of the main reason(s) for admission to the facility.
Proprietary homes	Privately owned nursing homes. This category does not include those homes which are under voluntary nonprofit, Government, and religious auspices.
Random selection procedure	Statistical procedure used to ensure that homes selected in the sample were represented in the same proportion as they are among the total number of skilled nursing facilities.

Region	A large territorial area that is delimited by the Department of Health, Education, and Welfare on the basis of geographic, economic, cultural, or a combination of the three categories.
Registered nurse (RN)	A nurse who is a graduate of an approved school of nursing and who is licensed to practice as a registered nurse.
Rehabilitative patient care	Equivalent to restorative patient care.
Resident	An individual domiciled in the intermediate care facility for the purpose of receiving specialty care.
Respiratory	Pertaining to the act or function of breathing.
Restorative nursing service	That aspect of nursing care oriented toward restoring an individual to his former capabilities.
Sample	A representative part of a group.
Skilled nursing facility (SNF)	Facility certified by the Federal Government to provide a skilled level of care. Facility or nursing home for patients who require skilled nursing and rehabilitation services on a daily basis to help them achieve their optimal level of functioning.
Social worker	An individual who is registered by the State, where applicable, has received at least the baccalaureate degree and has met the requirements of a 2-year curriculum in a school of social work that is accredited by the Council on Social Work Education, or who has the equivalent of such education and training.
Sociological factors	Profile of characteristics including educational level attained, occupation, income, and employment status.
Standard error of estimate	Statistical term which refers to the difference between the estimate which is made on the basis of a sample and that which would be obtained from a complete census.
Stratified random sampling design	Research procedure which ensures that every skilled nursing home participating in the Medicare/Medicaid program has an equal chance of being selected as a member of the survey sample.
Stratum	A statistical sampling of various populations.
Stroke	A sudden cerebrovascular accident.
Survey instrument(s)	Types of forms used to describe and record the characteristics of items being measured.
Study team	A leader and seven members who composed the 15 groups employed by DHEW who visited the selected sample of nursing homes to collect data.
Tranquilizer	An agent which acts on the emotional state, quieting or calming the patient without affecting clarity or consciousness.
Transfer agreement	A written arrangement to provide for reciprocal transfer of patients/residents between health care facilities.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

ROBERT VAN HOEK, M.D.

ACTING ADMINISTRATOR

HEALTH SERVICES ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

Tuesday, June 24, 1975

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

It is a pleasure to appear before you today to discuss the Department's implementation of Section 299I of the 1972 Social Security amendments. This provision made dialysis and transplant services available to virtually all patients suffering from End-Stage Renal Disease.

In October of 1972, Congress extended Medicare coverage for the cost of dialysis and transplantation to over 90 percent of the population through enactment of Section 299I of P.L. 92-603. By so doing, it sought to close the gap between the technologic advances that had occurred up to that time in the area of End-Stage Renal Disease treatment and the availability of this treatment to the general public.

The Congress authorized the Secretary of Health, Education, and Welfare to develop mechanisms to assure that ESRD care was both of high quality and cost effective.

The Secretary assigned overall responsibility for implementation of the ESRD program to the Social Security Administration while allocating responsibility for the health care aspects of the program to the Office of the Assistant Secretary for Health.

In order to make the Health Insurance benefits of the program available to patients as soon as possible, while, at the same time, allowing the Department to develop effective long-term mechanisms to assure quality and control costs, an interim ESRD program was established in June 1973.

The interim program provided reimbursement to eligible patients. At the same time it incorporated mechanisms to assure cost containment and minimize duplication and to require compliance with standards of quality in facilities receiving interim approval based on demonstrated need.

It seems clear that the interim program provided rapid and effective realization of some of the prime objectives of the legislation. Prior to enactment of the legislation, there were limited public funds available to patients to assist with the high cost of ESRD treatment. Therefore many patients went untreated for lack of funds. Now, however, ESRD treatment is available to virtually all of those who would benefit from it without regard to their financial status. The number of patients on maintenance dialysis has increased from approximately 11,000 in 1972 to approximately 20,000 at the present time. The number of transplants has also increased -- although not as dramatically because of lack of adequate donor organs for transplantation.

While in the initial months of the program there were some inevitable delays, reimbursement to facilities and physicians is now occurring in a timely fashion. At the same time, interim reimbursement mechanisms and the interim exception program seem to have contained the cost of services and to have controlled the unnecessary duplication of facilities.

Concurrent with implementation of the interim program the Department began to develop "long-term" ESRD program policies. In essence these policies were designed to assure that the program would: provide for the total health care needs associated with the treatment of End Stage Renal Disease, maintain - or if necessary create - the necessary availability and distribution of resources, assure quality through effective peer review, promote effective utilization of resources through the establishment of minimum utilization rates and contain the costs of covered services.

The "long term" ESRD regulations have been signed by the Secretary. The "long term" program will therefore, be established in the very near future. These regulations establish the conditions of participation that a facility must meet to receive Medicare reimbursement for the delivery of ESRD services. These proposed regulations detail the qualifications of the personnel in charge of ESRD services at the facility, the nature of the written operating policies and procedures of the facility, and its fire and safety requirements. They require

adequate documentation of the need for the ESRD services offered by the facility. As part of the documentation, the facility's utilization rates will be compared by the Department to Minimum Utilization Rates which are contained in the regulations for both dialysis and transplantation services.

A requirement for participation in the ESRD program is that each facility must belong to an ESRD Network. The designation of 29 ESRD network areas which cover the whole country is contained in the regulations. These networks have been designed primarily to assure that every facility is in a network which contains a sufficient number of ESRD facilities to guarantee every ESRD patient access to all the ESRD services he or she may potentially require. In addition networks are designed to allow effective peer review of the quality of ESRD care rendered to each ESRD patient. The network areas are generally compatible with both PSRO areas and with the Health Service Areas which have recently been proposed.

Each network will be required to establish both a Network Coordinating Council and a Medical Review Board.

The Network Coordinating Council will function to assure effective realization of the objectives of the ESRD program and to assist the Department in planning for the delivery of ESRD services. Its activities will be integrated with those of the Health Systems Agencies.

The Medical Review Board will carry out peer review of the care given to ESRD patients thereby assuring quality care. Its functions will be integrated with those of the PSROs.

To permit the Network Coordinating Council and the Medical Review Board to carry out their activities, the Department will supply information from the National ESRD Medical Information System. The regulations require every ESRD facility to submit data for inclusion in this system.

The Department appreciates the opportunity to outline our progress to date and future plans for this Subcommittee and will continue to make every effort in its administration of the ESRD program, to achieve the objectives outlined in the legislation. We would be happy to answer any questions.

FOR RELEASE ONLY UPON DELIVERY

STATEMENT BY
THOMAS M. TIERNEY
DIRECTOR OF THE BUREAU OF HEALTH INSURANCE
SOCIAL SECURITY ADMINISTRATION

SUBCOMMITTEE ON FEDERAL SPENDING PRACTICES,
EFFICIENCY, AND OPEN GOVERNMENT
COMMITTEE ON GOVERNMENT OPERATIONS
UNITED STATES SENATE

FRIDAY, JUNE 13, 1975

Statement of Thomas M. Tierney
Director of the Bureau of Health Insurance
Social Security Administration, DHEW
before the
Subcommittee on Federal Spending Practices,
Efficiency, and Open Government
Committee on Government Operations
United States Senate

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to discuss with you the administration of the Part B Medicare program, particularly with respect to the Subcommittee's interest in the problems in the State of Florida. These are problems which have been created in part by the unique characteristic of the Medicare beneficiary population and suppliers of health services in the State of Florida.

I am aware of the request of the Subcommittee to the General Accounting Office to make a review of the Florida situation. However, I have not yet received a copy of the GAO interim report and, therefore, may not be able to respond to any specific findings of the study in my meeting with you today.

As you know, in the administration of the Part B program the day-to-day operational work of the program is performed by carriers, such as Florida Blue Shield, which has administered the program in Florida since the beginning of the program in 1966. The carriers have the administrative responsibility for

receiving and reviewing claims for covered health services and making payments to the beneficiary or, in the case of assigned claims, to the supplier of the service. In its role of monitoring the administration of the Part B program, the Bureau of Health Insurance of the Social Security Administration maintains a comprehensive Contractor Inspection and Evaluation Program which is the responsibility of its regional representatives. This program consists of a continuing surveillance and assessment of the effectiveness of a contractor's operations.

In addition to the inspection and evaluation program, we have other measures to monitor the performance of carriers in three basic areas: cost, timeliness, and quality. Administrative cost and timeliness of workload processing are reported and analyzed on a periodic basis. A quality assurance program to determine the extent and type of errors in claims processing has recently been implemented. Through these measures, we try to identify problem areas and to work with the carrier to correct any deficiencies which may develop before considering transfer of jurisdiction or nonrenewal of the contract.

The administration of the program in Florida has long been of special concern to us as a number of problems manifested themselves.

A very large number of SMI enrollees reside in the State: some 1.1 million aged and 66 thousand disabled as of October 1, 1973.

Florida Blue Shield, as sole Medicare carrier in the State, has been handling a continually increasing claims load as the Medicare beneficiary group grows with more retirees moving into the State.

As an illustration of the claims workload processed by Florida Blue Shield during FY 1974, this carrier processed over 3.5 million claims--the fifth largest workload in the nation. This represented a 23 percent increase in claims workload over FY 1973. A 16 percent increase is projected in FY 1975 over 1974.

The problem of claims volume is further augmented by elderly vacationers, many of whom are in Florida for extended periods during the winter months.

Under the Medicare law, a beneficiary requiring a doctor's care in an area away from his home State must file for his benefits in the State where he receives care. This regulation places a heavy burden on the carrier in coping with the seasonal fluctuations which occur in Florida. Four counties in the State of Florida, for example, have over one million visitors each during the year. This produces a claims increase during the winter months experienced by few other Medicare carriers. The increasing workload and the seasonal nature of the claims submission to a single carrier have created problems in the State resulting in claims processing delays. As the pending

claims workload increased, beneficiary dissatisfaction grew until in July 1974, Florida Blue Shield reached a peak of 55,000 inquiries from beneficiaries awaiting reply.

In view of this situation, and the predicted future growth of Florida population, the Secretary concurred in our recommendation to transfer approximately 30 percent of the workload of Florida Blue Shield to a second carrier. Accordingly, on March 4, 1975, the decision was announced that effective July 1, 1975, responsibility for administering the Part B Medicare program in Dade and Monroe Counties of Southern Florida would be transferred from Florida Blue Shield to Group Health Incorporated (GHI) for services received on and after that date. It is estimated that Dade and Monroe Counties presently account for about 30 percent of the total Part B claims volume in Florida, and about 25 percent of the State's age 65 and over population. This area is probably the most complex and difficult area presently administered by Florida Blue Shield.

Group Health Incorporated, which currently administers the Part B Medicare program in Queens County, New York, will establish a claims processing operation within this jurisdiction.

In making the selection of Group Health Incorporated as the replacement carrier, the Bureau carefully reviewed both written and oral proposals from Equitable, Group Health Incorporated,

Metropolitan, Prudential, and Travelers, all of whom it was felt, from their past performance record, had the potential to assume the additional responsibility.

Group Health Incorporated was selected as the replacement carrier because of its highly favorable ranking on elements of past performance, unit cost, and ADP capabilities, as well as on the merits of the proposal submitted.

The preparations for transfer of jurisdiction have been proceeding smoothly to date and it is anticipated that Group Health Incorporated will be able to assume its responsibilities on July 1, 1975, as scheduled. Both carriers have been making every effort to assure the success of the transfer and have been cooperating to the fullest extent in exchanging data and meeting deadlines.

It is anticipated that by shifting this significant portion of the workload to Group Health Incorporated, Medicare beneficiaries will receive faster and more efficient service. We will, however, continue to watch the situation closely and be prepared to take whatever actions are necessary to improve service to the Medicare beneficiaries in Florida. Essentially, the provision of adequate service to the beneficiary is the principal objective of our administration of the Medicare program--not only in Florida but throughout the country.

FOR RELEASE ONLY UPON DELIVERY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

CASPAR W. WEINBERGER

SECRETARY OF HEALTH, EDUCATION, AND WELFARE

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

Thursday, June 12, 1975

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

It is both a pleasure and a privilege to appear before you today to discuss the efforts of the Department of Health, Education, and Welfare to implement specific cost control provisions of the 1972 Social Security Amendments. I will be glad to explain exactly what actions we have taken for each of those specific provisions; however, in order to understand those actions, we must first get a clear understanding of the entire medical cost area and its effects on the Federal budget.

As both the largest single purchaser of health care and a major contributor to the development of new medical technology, the Federal government has an important role to play in the health industry. It is responsible for administering programs passed by the Congress and must allocate limited Federal program dollars among competing social needs. Yet the ability of the Department of Health, Education, and Welfare to serve the public through its health care programs is being

seriously eroded every time the Consumer Price Index measures a higher hospital room rate or an increase in physician fees and every time an unnecessary service is rendered or some form of expensive but underutilized technology is introduced into a hospital. Moreover, the Federal health dollar cannot be stretched without limit, and increases in the Medicare and Medicaid programs must ultimately affect the resources we can commit to other equally critical social programs.

The health industry is one of the nation's largest and fastest growing, employing over four million people. It demands an ever-increasing portion of our national resources. As you can see from Figure 1, health expenditures were just slightly over $25 billion in 1960 and accounted for just over 5.0 percent of Gross National Product. By 1974, health expenditures had reached $104 billion, equivalent to 7.7 percent of GNP. With a continuation of current trends in GNP growth and the rapid increases in health spending, we project that they will exceed 8.3 percent of our total annual production by the end of this year.

The tremendous growth in our own Federal health financing programs has contributed significantly to this growth. As

shown in Figure 2, the Federal government accounted for 27 percent of total national health spending in 1974, up from 13 percent in 1966. The dramatic increase in the Federal share of national health spending has resulted in health becoming a major share of the Federal budget. Between 1966 and 1975, health spending increased from 4.4 percent to 11.2 percent of the Federal budget, one of the highest rates of increase in any major program area. Medicare and Medicaid have been growing at annual rates in excess of 15 percent. Expenditures for these programs have quadrupled in just eight years.

Figure 3 dramatically represents both the growth and changing composition of Federal health outlays in the last 10 years. Between 1966 and 1975 Federal health spending increased from $5.9 billion to $35 billion. Medicare and Medicaid expenditures now dominate the Federal health budget.

But all this added Federal spending did not buy as much as we would have hoped. The health industry suffers from chronic inflation, and the reimbursement methods used by Medicare and other third-party payors provide few incentives for either hospitals to control costs or for physicians to

limit fee increases. As you can see in Figure 4, both hospital and physician charges have exceeded the overall cost-of-living in every period except during the 1971-1974 Economic Stabilization Program. These medical price increases have had a profound effect on both public and private expenditures.

The hospital sector is the largest and most inflationary segment of the health industry. While the problem precedes Medicare and Medicaid, it increased significantly in intensity after 1966. As shown in Figure 4, hospital charges soared after the introduction of Medicare and Medicaid. Only during the Economic Stabilization Program did hospital charges rise at rates comparable to the increase in the general cost of living.

Between 1965 and 1974, expenditures for hospital care rose from $13.2 billion to $40.9 billion. Most of this increase in expenditures results from increases in costs per patient day. Over this 10-year period hospital costs per patient day increased at an annual rate of 12 percent. As Figure 5 indicates, approximately 52 percent of this increase can be attributed to increases in wages and prices while 48 percent resulted from increases in the number and kinds of services provided.

The environment fostered by extensive retrospective cost-based reimbursement has allowed these increases to occur with few constraints. Recent years have seen hospitals implement major new technologies that are very expensive. Yet there is little incentive for institutions to control costs, evaluate the cost-effectiveness of new services, or avoid duplicating underutilized equipment and services.

The Washington area is an interesting illustration. A local health planning agency had determined that all of the open heart surgery in this area could be performed by surgical teams in three hospitals. Yet, seven hospitals perform open heart surgery. Not only would cost savings result from concentrating the surgery in three hospitals, but quality would improve. Surgical teams that handle a low volume of patients typically have higher mortality rates.

Physicians, like hospitals, have been increasing their charges at rates in excess of the overall cost of living. As you can see from Figure 4, physician fees have increased at rates higher than the CPI in every period except for the 1971-1974 Economic Stabilization Program period.

Public and private expenditures for physician services have also increased at high rates in recent years. These increases result from a combination of rising prices for physician services, increases in population, and increases in the quantity and quality of physician services utilized per person. Between 1965 and 1974, total expenditures on physicians' services increased by $10.6 billion. As you can see from Figure 6, over 60 percent of this $10.6 billion increase was due to increases in the prices of physician services, 11 percent can be attributed to increases in population, and 28 percent was due to increases in quality and utilization of services per person.

The method of reimbursing physicians on the basis of customary and prevailing charges employed by Medicare and other third-party payors has contributed to rising physician fees, since a physician is paid on the basis of fees set by himself and his colleagues. Indeed, the legislative history of P.L. 92-603 demonstrates that Congress enacted the economic index provisions specifically with this problem in mind.

The magnitude of current health cost inflation can be seen even more clearly when we consider its effects on the Medicare and Medicaid programs. In the current fiscal year we

expect Medicare spending alone to jump by 22.5 percent or $2.6 billion over its level in the previous year. Over 50 cents of every new dollar spent on each Medicare beneficiary goes to pay for increases in medical prices. In total, Federal and State governments will spend in excess of $26 billion under Medicare and Medicaid this year, an increase of about $5.0 billion in a single year. In comparison, total spending for all other health programs administered by HEW will increase by only $900 million. Thus, while the Congress and the Administration are collectively seeking ways to limit the Federal budget, spending for Medicare and Medicaid continues to grow at rates that exceed the growth in both the GNP and tax revenues. It should not come as any surprise that New York City, which pays 25 percent of its Medicaid costs, is on the brink of bankruptcy.

The Administration supported the efforts of the Economic Stabilization Program and actively sought the continuation of a broad health cost control program. In the first 12 months following the expiration of the Economic Stabilization Program, the medical care component of the Consumer Price Index rose 36 percent faster (13.9 versus 10.2) than the prices for all goods and services in our economy.

Although one might expect a temporary bulge immediately following the expiration of the ESP controls, the rate of increase has not abated. The ESP controls expired over one year ago, but for the first four months of this calendar year, medical care prices have been increasing at an annual rate of 13.4 percent, more than twice the increase in the overall cost of living. Within the last month the Council on Wage and Price Stability singled out medical care as one of the worst remaining trouble spots in an otherwise improving inflation picture. I have said many times, and firmly believe, that the faulty design of Medicare and Medicaid is the principal culprit responsible for this super inflation in health care costs. The guaranteed government payment of health care costs in virtually any amount submitted by the provider, and with normal market factors absent in the health care area, inflation was bound to happen, and it did.

Unfortunately, our present situation with health care costs rising faster than the CPI is not unique to 1975. Similar trends were present in the late 1960s and early 1970s when the Congress and the Administration were discussing modifications in the Medicare and Medicaid programs. Out of these

discussions came a series of Amendments to Titles XVIII and XIX of the Social Security Act, designed to put somewhat of a brake on these uncontrollable increases in Federal spending for medical care. It is these provisions of P.L. 92-603 that we are discussing today.

I do not want to leave you with the erroneous impression that medical care price increases have been the only culprit responsible for these dramatic increases in Federal health spending. Over 30 percent of the increase in health expenditures over the last 10 years has been due to increased quality and utilization. There is, however, a growing body of data which indicates that some of this increase in utilization is unnecessary and can be eliminated through effective utilization review programs. For example, the Multnomah Foundation in Oregon experienced a permanent 1.1 day reduction in average length of stay through effective utilization review efforts. I see no reason why such results cannot be achieved at the national level through effective utilization review by hospital utilization review committees and Professional Standard Review Organizations (PSROs).

The four regulations which I will discuss today must be viewed in the context of this disheartening inflationary picture. Ironically, the economic pressures responsible for passage of these cost control provisions in 1972 are even stronger today, and their effects on the Federal budget are even more serious. These four regulations are the Department's efforts to implement the hospital cost limit provision of P.L. 92-603 (Section 223), the elimination of the inpatient routine nursing cost differential, the utilization review requirements of P.L. 92-603 (Sections 207 and 237), and the physician fee index provision of P.L. 92-603 (Section 224).

Hospital Cost Limits

Section 223 of P.L. 92-603 gave the Secretary of Health, Education, and Welfare authority to limit prospectively our reimbursement of provider costs where these are judged to be unreasonably high as a partial remedy for some of the previously discussed incentives for inefficiency that are inherent in retrospective cost reimbursement. This Committee's report on the bill suggested that the limits should initially be applied to costs which would generally not be expected to vary greatly with the quality of medical care among a group of similar providers and would, in the beginning, apply to relatively few providers. To meet these

objectives, the Department placed hospitals into 70 groupings to achieve comparability and applied the limits only to routine costs--i.e. room, board, and basic nursing. The costs of ancillary and special care services were not placed under limits.

The variables selected for this initial grouping were bed size, per capita income of the State in which the hospital was located, and whether or not the hospital was in a metropolitan area. Bed size was included to account for the higher costs typically present in larger institutions. The latter two variables represented, respectively, the general cost and wage pattern in the area and the effect of urban-rural cost differentials.

The limits were initially set at a fairly high level so that hospitals would have time to adjust to this new provision of the Medicare law and to allow for any lack of precision in the initial classification system. Specifically, we said that Medicare per diem payments would be limited to the 90th percentile of the distribution of routine per diem costs within each grouping plus 10 percent of the median. We estimated that only 4.5 percent of all hospitals would exceed the limits. It is important to point out that since these limits are set prospectively, all hospitals could potentially come in under the limits. To improve the equity

of the regulations, sole community providers were exempt from the limits, and exceptions were to be allowed for the costs of atypical services or of circumstances beyond the control of the hospital. I might add that hospitals with teaching programs tend to be grouped together.

Throughout this past year we have sought to develop objective criteria for evaluating requests for exceptions. To date, we have received only 13 exception requests plus an additional eight hospital that have sought exemptions on the grounds that they are sole community providers. Of these requests one was approved in total, five were given partial approval, and the remainder are either under consideration or have been returned for further development. All sole community provider exemption requests were approved.

We have now issued a new schedule of limits to be effective for cost reporting periods beginning on or after July 1, 1975. The hospital classification system has been modified slightly and reduced from 70 to 32 groupings. We have also lowered the group limits to the 80th percentile plus 10 percent of the median.

Two factors influenced this decision. First, each SMSA is now ranked on the basis of its own per capita income rather than State per capita income. This change, increasing

the equity of the system, was made because costs and incomes vary between urban areas in a State and use of State per capita income may have resulted in some areas being unfairly disadvantaged while other areas received a "free ride." Second, and perhaps more important, was an expectation that has been confirmed by the exception process. Review of cost reports in connection with the exception requests has indicated the existence of cost reporting areas where questionable accounting practices add to program costs. As a result, we believe it necessary to subject more cost reports to the intensive type of analysis which is required under the exception process.

We project that approximately 11 to 12 percent of all hospitals potentially could be affected by these limits--hopefully, fewer if those potentially over the limit respond by reducing their costs. The projected budgetary saving from this provision in FY 1976 is $60 million, about one-half of one percent of the projected Medicare hospital expenditures. Although a few hospitals will have large amounts of reimbursement questioned, most will be only slightly over the limits. In effect, the drop to the "80th percentile plus 10 percent of the median" really means the 90th percentile of the distribution.

The major criticism of the new schedule of limits is that the classification system does not directly take into account the scope of hospital services, teaching programs, or differences in patient mix. I would like to point out that, before publishing a schedule of limits based on this classification system, we analyzed many different variables and found that the available measures of patient mix and service complexity have little impact on routine costs per day. There are two reasons for this finding. First, the routine portion of costs is not likely to vary with the intensity of services required when more seriously ill patients are treated. Second, we found patient mix and service complexity variables to be highly correlated with bed size, making their inclusion redundant. Improving the method of grouping hospitals will remain an ongoing area for analysis within the Department.

Elimination of Nursing Differential

I would now like to discuss the termination of the 8-1/2 percent nursing differential that has been paid since 1969 to the 6700 hospitals participating in the Medicare program. This action has evoked much comment and criticism from the health industry.

The 8-1/2 percent nursing differential was implemented in 1969 because there was a general feeling that the Medicare reimbursement formula at that time did not adequately cover the costs of all hospital services furnished to Medicare beneficiaries. A study performed in 1966 had shown that elderly patients used more routine nursing services than those under 65. The 8-1/2 percent differential was then applied across the board to all hospitals, regardless of whether or not a particular hospital had actually demonstrated that a greater degree of nursing care was being furnished to aged patients. Since 1969 we have determined that changes in the Medicare law, changes in the way services are furnished, and changes in the way in which Medicare reimburses for routine services have occurred which make the concept of a cost differential for routine nursing services inappropriate. There are two additional reasons for the action we have taken:

(1) Public Law 92-603 has extended Medicare coverage to a significant number of disabled individuals under age 65 and those with end-stage renal disease. As this segment of the Medicare program increases in size, and the Medicare population becomes similar to the population as a whole with regard

to their requirements for skilled nursing, the differential can no longer be justified.

(2) Since 1969 there has been a marked increase in the number of special care beds (intensive care, coronary care, etc.), the higher costs of which are already reflected in medicare reimbursements. They provide more intensive care than that found in general routine care areas, and there has been a substantial shift of the seriously ill to these special care units, which largely substitute for the special services that previously were given in standard wards.

Thus, in an effort to refine further the Medicare cost reimbursement formula to reflect more accurately the actual direct and indirect costs incurred by hospitals in caring for Medicare beneficiaries and to bring some small reduction in costs to the ever rising Medicare budget, we decided to terminate the nursing differential. The budgetary savings in FY 1976 will be $20.0 million; however, in FY 1977, the first year in which the elimination of the differential will affect all hospitals, they are estimated at $130 million, or only 1.2 percent of Medicare reimbursement to hospitals and about one-third of one percent of total hospital budgets.

Utilization Review

The new regulations for utilization review were published in final form in the Federal Register on November 29, 1974. As you will recall, these regulations implement Sections 207 and 237 of Public Law 92-603, which made major changes in the nature of utilization review activities to eliminate confusion and duplication. Proposed regulations had been published in January 1974, and generated considerable public interest and comment. Shortly thereafter, I appointed an interagency committee to coordinate the development of the final regulations, to assure that Medicare and Medicaid provisions were identical wherever possible, and to guarantee that the final regulations were complementary to and supportive of the Professional Standards Review Organization (PSRO) program.

These new regulations, in our view, when combined with the evolving PSRO program, form a comprehensive mechanism for assuring that reimbursement will be made only for high quality care. They also will reduce expenditures for unneeded care by those programs as the previously cited experience in Oregon indicated. If these regulations are implemented in FY 1976, about $60 million in Medicare outlays would be saved--outlays that would otherwise go for unneeded, and potentially harmful, care.

These regulations have generated considerable concern on the part of hospitals and other providers. The Department has worked vigorously to provide technical assistance, guidelines, and support to individuals and institutions, as they move to implement the new requirements. Concern has been expressed that these regulations undermine local PSROs by shifting responsibility for medical decisions away from PSROs and back to fiscal intermediaries. Let me state unambiguously that this Administration is fully committed to the concept of peer review of medical care through the PSRO program as soon as possible. However, the PSRO program will not become fully operational nationwide for some time. In the interim, there remains a need for effective and efficient institutional peer review. These new UR regulations build upon and are fully congruent with the concepts of the PSRO review system.

The Department has recently developed explicit instructions to State agencies and intermediaries informing them that a qualified conditional PSRO takes precedence over utilization review requirements, and that a hospital's responsibilities for utilization review cease, when review responsibilities for that hospital have been assumed by a qualified PSRO. Of course, the PSRO may delegate the utilization review

functions back to the hospital, and is expected to do so where the hospital has proven competence to undertake the review function.

A number of sources have expressed concern with the capacity of smaller hospitals, particularly in rural areas, to comply with the utilization review requirements. It was largely in response to these concerns that I decided to postpone the effective date of the regulations from February 1, to July 1, 1975. Over the last several months, Department staff have met with large numbers of concerned physicians, administrators and State officials to provide guidance and technical assistance in complying with the regulation. The regulations as written contain considerable flexibility in the manner in which hospitals may organize their utilization review activities. Community-based review groups, established by medical societies or groups of hospitals, form one avaiable alternative particularly suited to the small hospital. In some States, Medicaid State agencies have requested waivers to permit the operation of an alternative, State-operated review system in isolated rural hospitals. We recognize, however, that despite these available options, there remain some additional concerns peculiar to small hospitals, which may require special attention.

First, the Medicaid statutory limitations on participation of individuals who are financially interested in any institution, employed by a long-term care facility, or directly responsible for patient care severely limits the availability of qualified physician and non-physician personnel to participate in review activities. The Department is working actively to develop guidelines for enforcing these limitations which provide some latitude in reviewer eligibility, while complying with the intent of the legislation. Secondly, some small hospitals may have difficulty in conducting the statutorily required review of each admission within the time frame specified in the regulations. Because the Department's primary concern is to improve the quality and appropriateness of care, we have taken a position which we feel will assist these isolated facilities to comply with the law. All hospitals participating in the program must be certified. However, through the special certification provisions in the regulations, small hospitals which are making good faith efforts to comply with the regulations can be certified for continued participation in Medicare and Medicaid. Similarly, we are

developing regulations and administrative mechanisms to assure that States with significant numbers of such specially certified hospitals are not in danger of being penalized by a reduction in Medicaid funds.

We feel that this approach adequately addresses the immediate problems of rural hospitals and will allow them to proceed with plans for implementation by July 1. However, we will maintain a close watch on this problem over the next year, with an eye toward further amending the regulations or seeking changes in the statute if it appears that such actions are necessary. Members of the Subcommittee can be assured that the Department's objective is to provide sufficient flexibility to rural hospitals to allow their continued participation in Medicare and Medicaid, while, at the same time, moving to improve their capability to deliver high quality care.

The American Medical Association has opposed the November 29 regulations on the grounds that they interfere with patient and physician rights. Judge Julius Hoffman recently issued a preliminary injunction, enjoining the Department from enforcing portions of these regulations. We have recommended appeal from this ruling and reaffirm the right of the Congress and the

Administration to provide mechanisms for determining what care shall be reimbursed under Medicare and Medicaid. We feel that physicians and other qualified medical personnel are best able to make such determinations and that, through utilization review committees and PSROs, their professional expertise can be brought to bear on these often difficult payment decisions.

Economic Index

I would now like to discuss the regulation that implements the physician fee index provision (Section 224) of P.L. 92-603. Congress enacted this provision to limit increases in physician fees that could not be justified on the basis of increased practice costs or increases in productivity. Fee increases that are justified because of higher office practice costs and increases in the productivity of physicians are fully allowed and recognized.

On April 14 of this year we published a Notice of Proposed Rulemaking implementing the economic index provision of the Medicare law. The final regulations will be published on Monday, June 16, 1975. This index will be operative in FY 1976. The economic index was not put into effect in fiscal years 1974 and 1975 since physician charge increases for those two years were limited by the Economic Stablization Program. That program's controls were considered to be at least as

stringent as those that would have been imposed by the economic index provision.

Before discussing the specific actions taken by the Department to implement the statute, I would like to point out that the budgetary implications of this regulation are quite small. In fact, the application of the economic index in FY 1976 will result in a budgetary saving of only $26 million, or about 8/10th of 1 percent of the total expected Medicare Part B physician expenditures of $3.2 billion.

The data used to calculate the economic index are national in nature but will be applied locally. Although the Senate Finance Committee Report suggested that a separate index for each locality be calculated, a national index is being used, at least initially, because the data required to construct local indices are not now available.

The index will be applied to every prevailing charge in each locality. It will also be applied on a cumulative basis with FY 1973 serving as the base year, as specified by Congress. In other words, increases in prevailing charges over the 1973 base year level cannot exceed the rate justified by the economic index calculated for that period. The

cumulative economic index figure for fiscal year 1976 will be 1.179. Thus, any individual prevailing charge that would increase by more than 17.9 percent over its 1973 base level will have its rate of increase limited to 17.9 percent. Prevailing charges that have increased by less than 17.9 percent will be unaffected, and any portion of the allowable increase not used will be carried forward to future years.

The economic index that has been constructed conforms to the legislative intent. The Senate Finance Committee Report suggested that the index consist of two components reflecting (1) increases in the expenses of physician practice (as indicated by IRS data), and (2) increases in general earnings levels (as indicated by Social Security data). The report suggested that these components be given the average weights shown in IRS data on self-employed physicians' gross incomes (40 percent office expenses, 60 percent net earnings). Because physicians are incorporating in increasing numbers, IRS data are no longer a good source of information about changes in physicians' office practice expenses; therefore, pertinent components of the Consumer Price Index, the Wholesale Price Index, Bureau of Labor Statistics wage indices, and data from Medical Economics have been used instead.

Also, it was felt that the use of BLS information on the average weekly earnings of workers is preferable to Social Security data because it is more current.

Recently, the rising cost of malpractice insurance has become a major concern. As you know medical malpractice costs differ widely by both physician specialty and locality. In addition, there are no reliable data on malpractice insurance costs at the local or national level. As a result, malpractice costs are only indirectly captured in the office practice expense component of the index. The Department is currently working to refine the index to account for medical malpractice costs directly and will implement such changes as soon as the appropriate data are developed.

Much controversy has surrounded the specific data used to construct the index. The Department utilized what it considered to be the best available data and methodology in developing the economic index figure. This does not preclude future refinement of the data and methodology. Efforts to refine the statistical bases of the economic index figure will continue and, as suggested by the Senate Finance Committee report which accompanied Public Law 92-603, any

additional data to refine the existing methodology which are obtained or received will be considered for use in determining the economic index for future fiscal years.

Conclusion

The emphasis of our discussion today has been on short-run and, unfortunately, piecemeal policies. But the problems in the health sector are deep-rooted. They require longer term and more comprehensive solutions.

Under present conditions, hospitals and physicians can often shift to Medicare beneficiaries or private paying patients those costs which the Medicare and Medicaid programs refuse to pay. Under the current retrospective cost based reimbursement system, hospitals have only very limited incentives to actively strive for improved efficiency. We must implement a reimbursement structure which sets budgets prospectively and applies to all payors, public and private. On the physician side, a program designed merely to limit increases in prevailing fees for Medicare patients cannot affect the system to any significant degree. To some extent, physicians have the ability to increase the quantity of services provided in order to achieve

self-established compensation levels. Therefore, an effective cost control program will have to limit not only unwarranted fee increases but also unnecessary utilization. Effective policies on the reimbursement side must be integrated with review mechanisms which monitor the appropriateness and quality of care being provided.

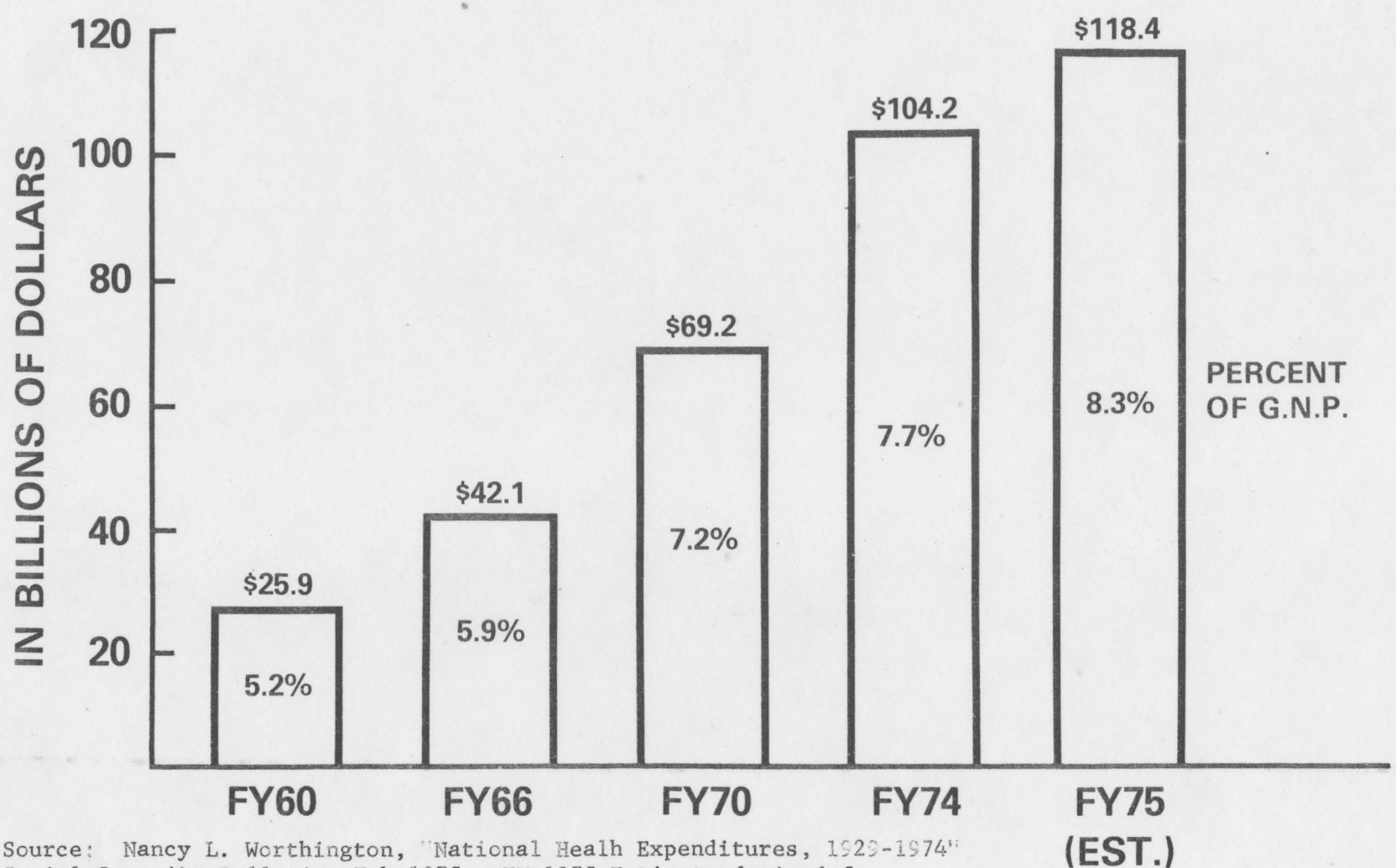
These four regulations, when fully operational, will save about a quarter billion dollars a year--not an inconsiderable amount even by Washington standards. Taken together, we believe that at the same time they will also improve the quality of care. But, I strongly feel that the only real way to end double-digit inflation in health care costs is through a broad based cost containment strategy similar to the kind envisioned in the Comprehensive Health Insurance Plan which was introduced in Congress last year. All we have now is a series of cost control provisions, limited to the Medicare and Medicaid programs, which do not permit us to take a broader look at health cost inflation or to deal with the totality of the problem through a single program.

Mr. Chairman, this concludes my prepared remarks. We will be pleased to answer any questions you or other Members of the Subcommittee may have.

FIGURE 1

NATIONAL HEALTH EXPENDITURES AND THEIR PERCENT OF G.N.P. - SELECTED FISCAL YEARS, FY 1960 - FY 1975

(IN BILLIONS OF DOLLARS)

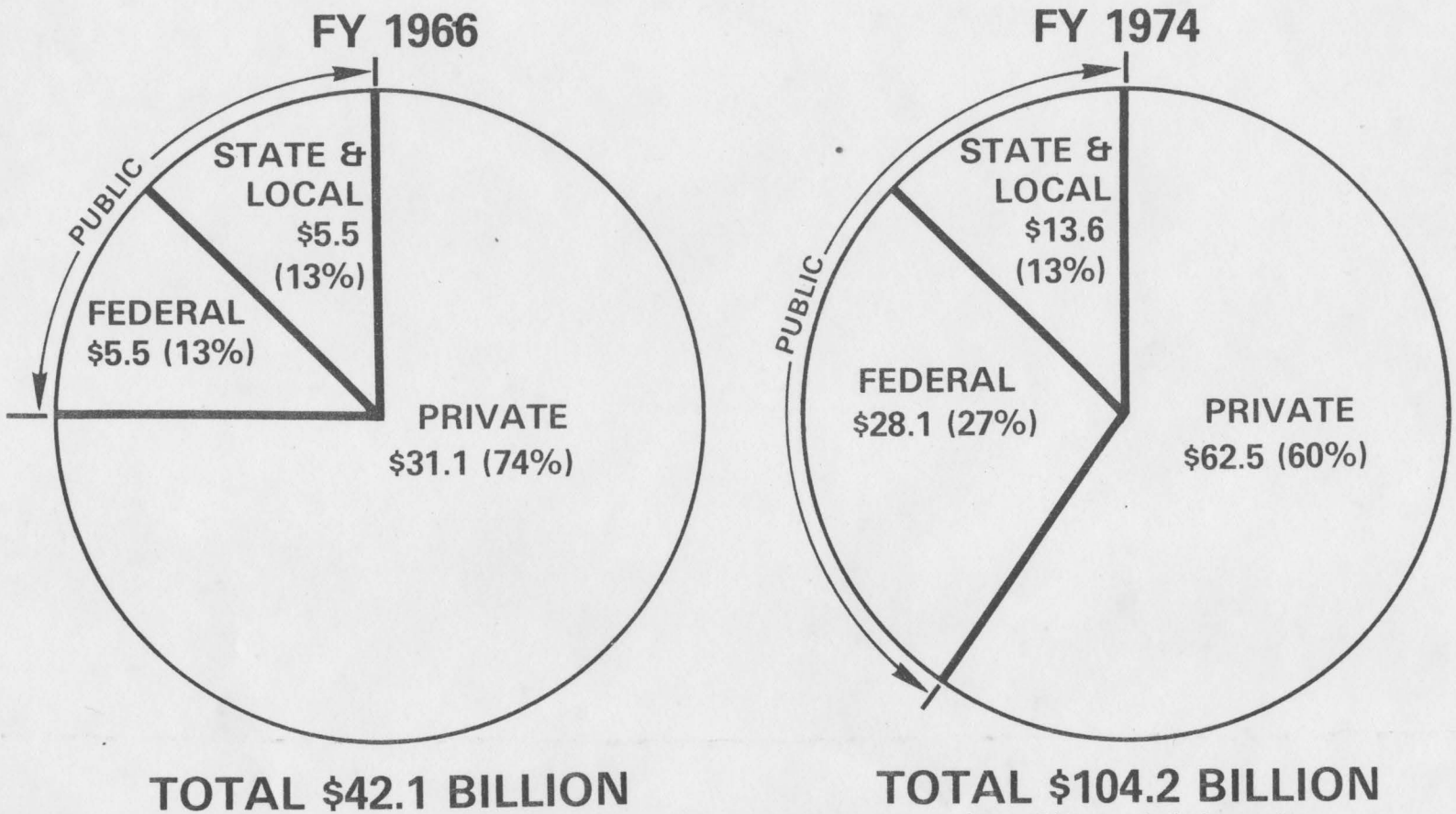


Source: Nancy L. Worthington, "National Healh Expenditures, 1929-1974" Social Security Bulletin, Feb 1975. FY 1975 Estimate derived from data furnished by Bureau of Economic Analysis, Dept of Commerce, and Office of Deputy Ass't Sec'y for Planning & Evaluation - Health, DHEW

FIGURE 2

DISTRIBUTION OF NATIONAL HEALTH EXPENDITURES

BY SOURCE OF FUNDS, FISCAL YEARS 1966 AND 1974

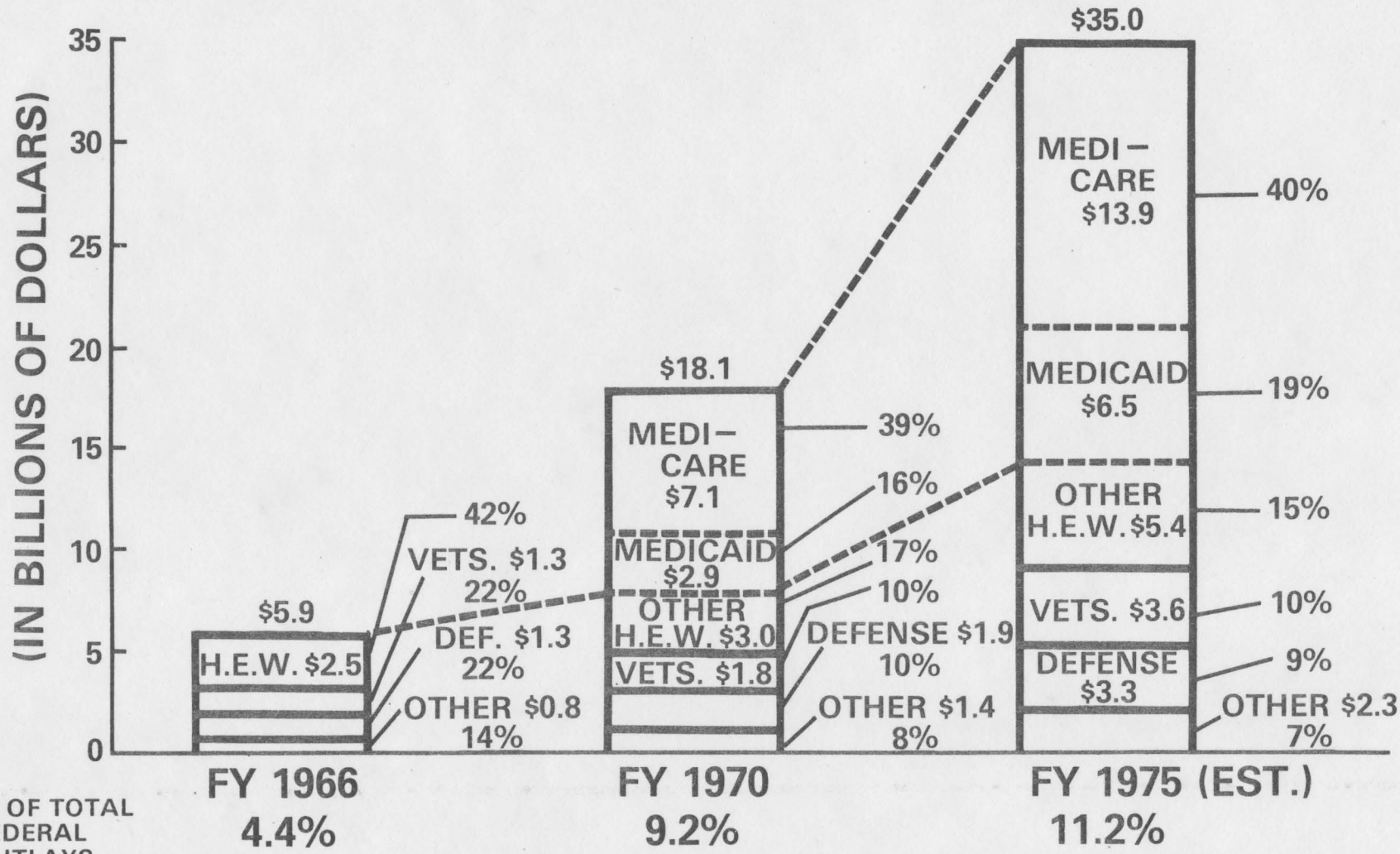


TOTAL $42.1 BILLION **TOTAL $104.2 BILLION**

Source: Nancy L. Worthington, "National Health Expenditures, 1929-1974" Social Security Bulletin, February 1975

FIGURE 3

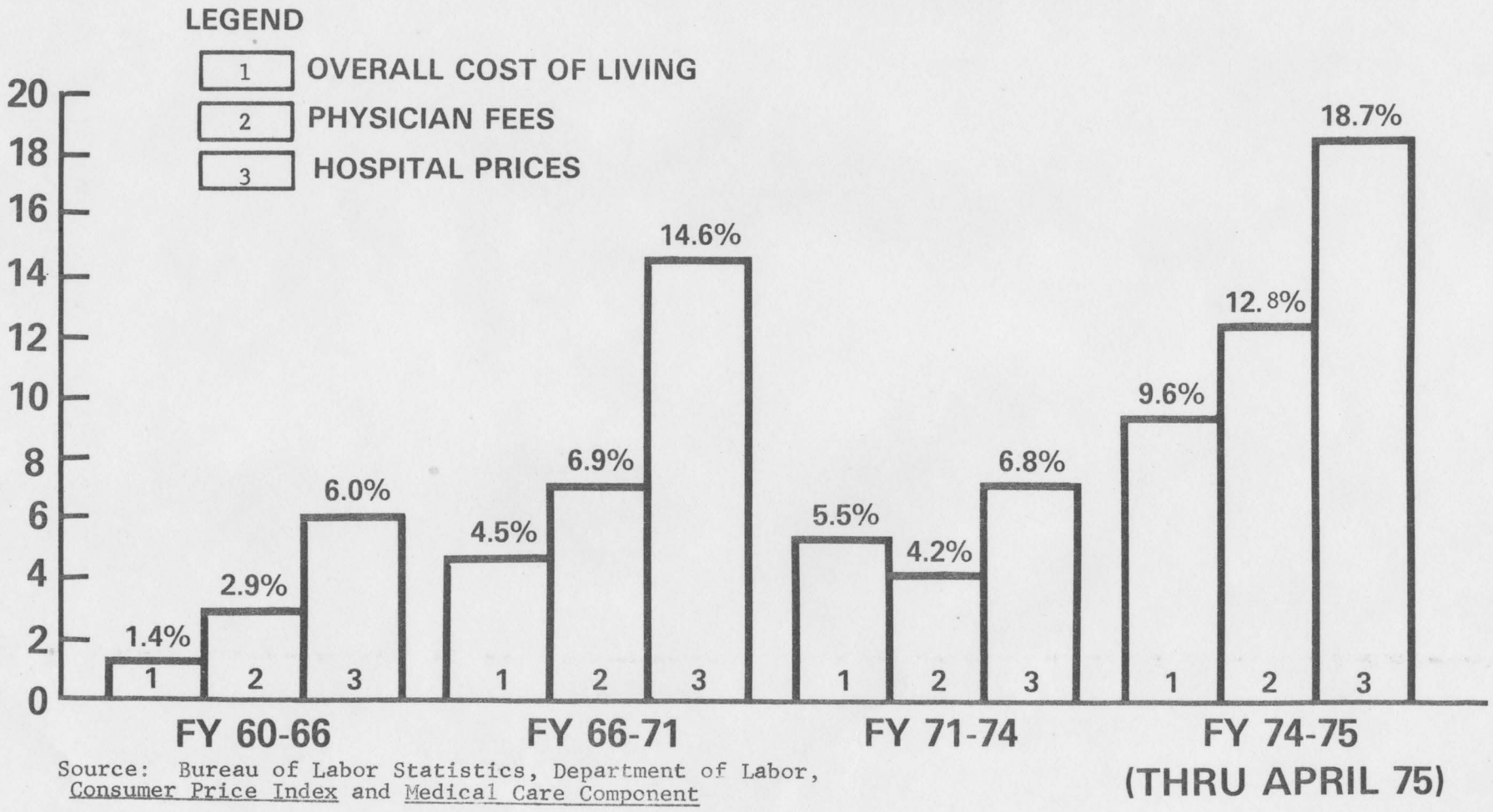
GROWTH IN FEDERAL HEALTH EXPENDITURES
FY 1966 - FY 1970 - FY 1975
(IN BILLIONS OF DOLLARS)



Source: Derived from various fiscal years Special Analyses, Federal Health Programs, Budget of the United States Government, Office of Management and Budget

FIGURE 4

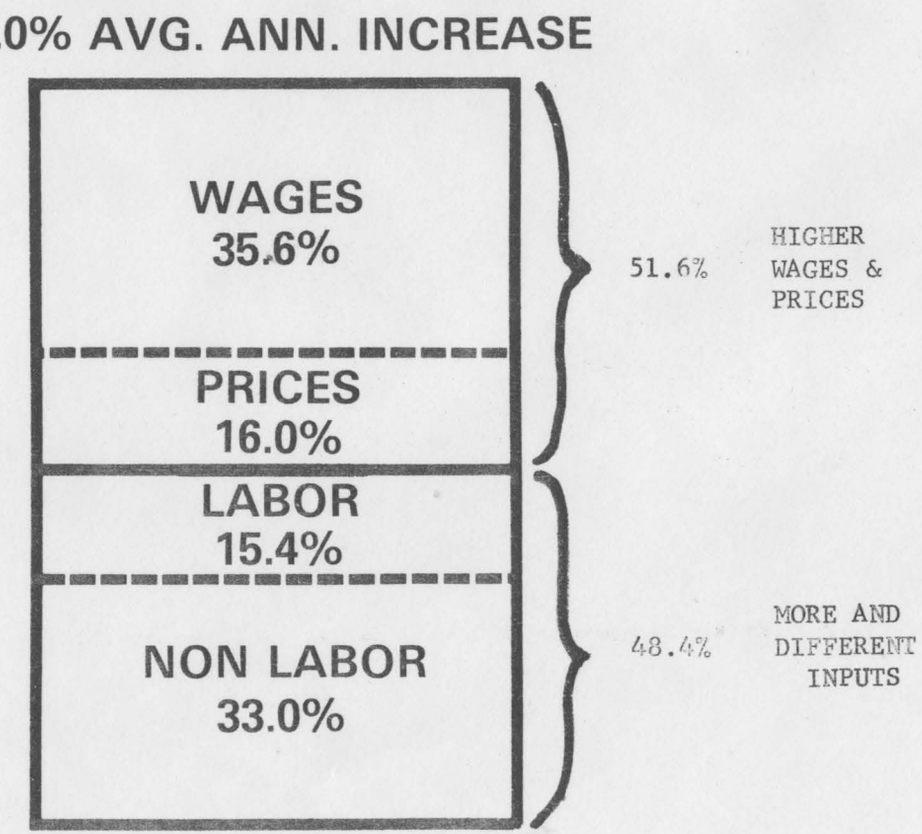
AVERAGE ANNUAL INCREASE IN CONSUMER PRICE INDEX ALL ITEMS - PHYSICIANS' FEES - SEMI PRIVATE HOSPITAL ROOMS - SELECTED PERIODS FY 1960-1975



Source: Bureau of Labor Statistics, Department of Labor, Consumer Price Index and Medical Care Component

FIGURE 5

FACTORS CONTRIBUTING TO AVERAGE ANNUAL INCREASES IN COST PER ADJUSTED PATIENT DAY IN U.S. COMMUNITY HOSPITALS FY 1965 - 1974

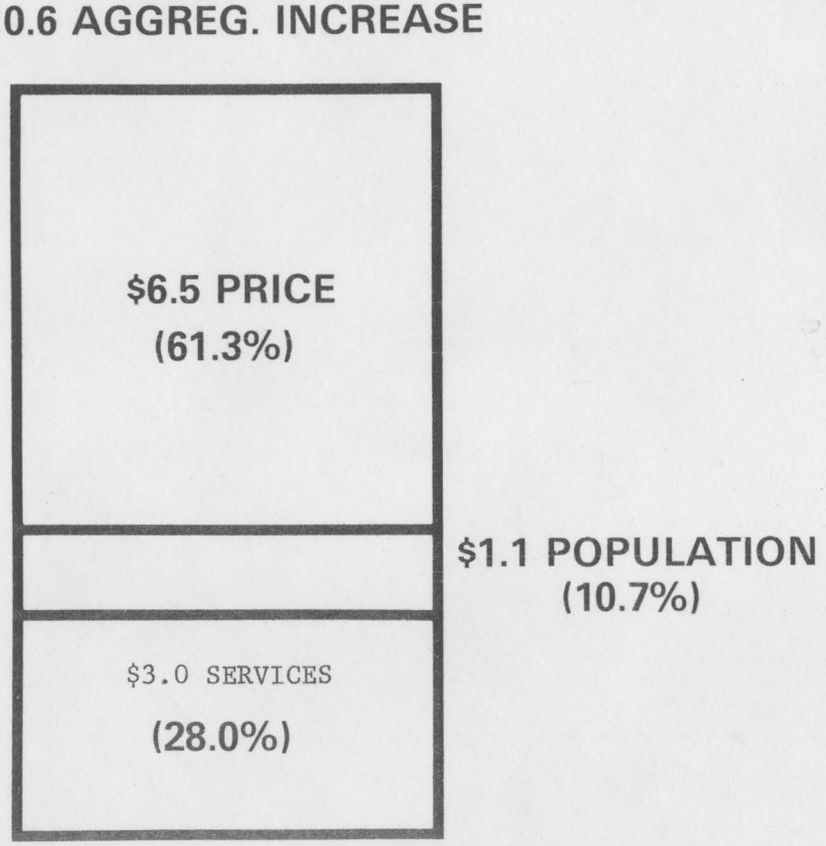


Source: Office of Research and Statistics, Social Security Administration, DHEW

FIGURE 6

FACTORS CONTRIBUTING TO INCREASES IN EXPENDITURES FOR PHYSICIANS SERVICES FY 1965 - 1974

(IN BILLIONS OF DOLLARS)



Source: Office of Research & Statistics, Social Security Administration, DHEW

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

JUN 6, 1975

Honorable Carl Albert
Speaker of the House of
Representatives
Washington, D. C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is a draft bill, "To amend the Social Security Act to eliminate trust fund financing for State capital expenditure review activities and expand the scope of mandatory outpatient services under State medical assistance programs."

Section 1 of the bill would terminate Federal Hospital Insurance Trust Fund financing of State activities under the program for review of proposed capital expenditures for health care facilities established by section 1122 of the Social Security Act. Federal financial assistance with respect to the State activities carried out under section 1122 is now available under the Public Health Service Act, as amended by the National Health Planning and Resources Development Act of 1974.

Section 2 would amend the Medicaid program to require that State plans approved under that program include coverage of outpatient care provided in freestanding ambulatory health care centers. This requirement would be in addition to the present requirement that State plans include coverage of outpatient hospital services. This amendment will improve the Medicaid program by increasing the availability to beneficiaries of less expensive alternatives to inpatient hospitalization. Enactment of this section would increase the cost of the Medicaid program by $20 million in fiscal year 1976. This increase is included in the President's 1976 Budget. The cost for a five-year period would be $137 million.

I urge speedy consideration and enactment of these amendments by the Congress.

The Office of Management and Budget has no objection to the submission of the enclosed draft legislation and advises that its enactment would be consistent with the objectives of the Administration.

Sincerely,

/s/ Caspar Weinberger

Secretary

Enclosure

A B I L L

To amend the Social Security Act to eliminate trust fund financing for State capital expenditure review activities and expand the scope of mandatory outpatient services under State medical assistance programs,

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

ELIMINATION OF TRUST FUND FINANCING FOR STATE CAPITAL EXPENDITURE REVIEW ACTIVITIES

Section 1. Section 1122(c) of the Social Security Act is repealed, effective with respect to functions performed after January 1, 1976, pursuant to agreements between the States and the Secretary of Health, Education, and Welfare entered into under section 1122 of that Act.

EXPANSION OF MANDATORY OUTPATIENT SERVICES UNDER STATE MEDICAL ASSISTANCE PROGRAMS

Sec. 2. (a)(1) Section 1905(a)(2) of the Social Security Act is amended by striking out "outpatient hospital services" and inserting "outpatient services whether provided in a hospital or in an ambulatory health care center" in lieu thereof.

(2) Section 1905 of that Act is further amended by inserting at the end thereof the following new subsection:

"(ℓ) The term 'ambulatory health care center' means a facility, other than a facility of a hospital, which--

"(1) is organized and operated to provide to ambulatory patients, through or under the supervision of physicians--

"(A) physician services (including consultation and referral services), diagnostic laboratory and radiologic services, and, where feasible, as determined under regulations prescribed by the Secretary, emergency medical services and the services of physicians' assistants and nurse clinicians; or

"(B) such specialized medical or surgical services as the Secretary may by regulation provide;

"(2) provides a substantial portion of its services, as determined under regulations prescribed by the Secretary, through its own staff and facilities;

"(3) in the case of a facility in a State or locality the laws of which provide for the licensing of such facilities, (A) is licensed pursuant to such

laws, or (B) is approved, by the State or local agency responsible for licensing such facilities, as meeting the standards for such licensing; and

"(4) meets such other requirements as the Secretary may by regulation prescribe."

(b) The amendments made by this section shall be effective with respect to payments under section 1903 for amounts expended during calendar quarters commencing after June 30, 1975.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Honorable Carl Albert
Speaker of the House of
Representatives
Washington, D. C. 20515

February 26, 1975

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is a draft bill "To amend the Social Security Act to improve and control the cost of the maternal and child health and crippled children's services program, and the program of grants to States for medical assistance programs".

The bill is part of the President's budget recommendations for bringing federal spending under control during fiscal years 1975 and 1976 and avoiding excessive growth of federal expenditures in the long run. As the President stated in his recent Budget Message: "Spending by all levels of government now makes up a third of our national output. Were the growth of domestic assistance programs to continue for the next two decades at the same rates as in the past 20 years, total government spending would grow to more than half of our national output. We cannot permit this to occur."

Section 2 of the bill would reduce the rate of federal financial participation in state expenditures under the maternal and child health and crippled children's services program from fifty percent to forty percent. It would also repeal the supplemental allotments currently authorized for some states under that program. Increased state financial participation in activities funded through the maternal and child health and crippled children's services appropriation will promote a careful review of the need for the funding of these programs through narrow categorical programs in the light of the availability of Medicaid financing for the same services. Federal and state funding for the Medicaid program will amount to over $14 billion in 1976.

Section 3 of the bill would eliminate federal matching for the provision of non-emergency dental services to adults under the Medicaid program. We believe these expenditures to be of a lower priority than other rapidly escalating

medical costs reimbursed from federal funds. Federal matching for children's preventive dental care, the most important phase of preventive dental care, would be continued for Medicaid eligible children under twenty-one.

Section 4 would lower the floor on the rate of federal participation in state Medicaid programs from fifty percent to forty percent. The average federal share would then be about fifty-one percent. The current formula, guaranteeing at least fifty percent matching, weighs the federal participation disproportionately in favor of the richer states. Only the thirteen highest income states would be affected by this change. The distribution of the remaining federal funds would be more closely related to the states' relative revenue producing capability as reflected by their average per capita income.

Enactment of this legislation is essential if the President's goal of controlling federal outlays in fiscal years 1975 and 1976 is to be met. It is estimated that enactment would result in savings of $210 million in 1975 and $770 million in 1976.

The Office of Management and Budget advises that enactment of this draft bill would be in accord with the program of the President.

Sincerely,

/s/ Caspar W. Weinberger

Secretary

Enclosure

A B I L L

To amend the Social Security Act to improve and control the cost of the maternal and child health and crippled children's services program, and the program of grants to States for medical assistance programs.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Maternal and Child Health and Crippled Children's Services and Medicaid Cost Control Amendments of 1975".

MODIFICATION OF FEDERAL FINANCIAL PARTICIPATION IN MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

Sec. 2. (a) Section 506(a) of the Social Security Act is amended by striking out "one-half" and inserting "forty per centum" in lieu thereof, effective with respect to payments under that section for amounts expended during quarters commencing after June 30, 1975.

(b) Section 516 of that Act is repealed, effective July 1, 1975.

SCOPE OF DENTAL SERVICES FOR WHICH FEDERAL MATCHING PAYMENTS WILL BE MADE UNDER STATE MEDICAL ASSISTANCE PROGRAMS

Sec. 3. (a) Paragraph (10) of subsection (a) of section 1905 of the Social Security Act is amended by

inserting "for individuals under the age of 21" immediately after "dental services".

(b) The matter after clause (17) in subsection (a) of such section is amended by--

(1) striking out "or" at the end of clause (A);

(2) striking out the period at the end of clause (B) and inserting "; or" in lieu thereof; and

(3) inserting after clause (B) the following new clause:

"(C) any such payment with respect to dental services for any individual who is 21 years of age or older, other than emergency dental services (as defined in regulations prescribed by the Secretary), and oral surgical services and treatment related thereto which legally may be performed by a doctor of medicine or osteopathy or of dentistry."

(c) Clause (I) of section 1902(a)(10) of such Act is amended by inserting ", (10)," immediately after "paragraph (4)".

(d) The amendments made by this section shall be effective with respect to payments under section 1903 of

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Honorable Carl Albert
Speaker of the House of
Representatives
Washington, D. C. 20515

FEB 26 1975

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is a draft bill "To amend the Social Security Act to improve and control the cost of the program of old-age, survivors, and disability insurance, the program of grants to States for aid to families with dependent children, and the program of health insurance for the aged and disabled."

The bill is part of the President's budget recommendations for bringing federal spending under control during fiscal years 1975 and 1976 and avoiding excessive growth of federal expenditures in the long run. As the President stated in his recent Budget Message: "Spending by all levels of government now makes up a third of our national output. Were the growth of domestic assistance programs to continue for the next two decades at the same rates as in the past 20 years, total government spending would grow to more than half of our national output. We cannot permit this to occur."

Section 2 of the bill would prohibit entitlement to retroactive OASDI benefits if future monthly benefits would be permanently reduced as a result. Under the present law, social security benefits may be paid retroactively, at the beneficiary's election, for up to twelve months prior to the month in which the application is filed, provided all conditions of entitlement are met. In many instances, an applicant who is entitled to retroactive benefits faces a choice of getting a large lump-sum payment to cover retroactive benefits and a permanently reduced monthly benefit in the future, or getting no lump-sum payment and a higher monthly benefit beginning with the month that an

application is filed. Many beneficiaries faced with this choice decide to take the large lump-sum payment. In some cases the lump-sum payment is quickly spent, and financial hardship results from the smaller continuing benefits on which the beneficiary has to rely for the rest of his life.

This proposal is based on a recommendation of the 1971 Advisory Council on Social Security. The Advisory Council, in making its recommendation, expressed concern about the fact that a high proportion of those applicants who are faced with the choice of a relatively large lump-sum retroactive benefit payment choose to take the lump-sum even though this means a permanent reduction in the monthly benefits they will get. The Council pointed out that such a result did not seem to be consistent with the objective of providing adequate benefit income for the aged.

In the aggregate, this proposal would not change the total lifetime benefits of people affected by it. Thus, over the long run the proposal would have a negligible effect on the costs of the program. However, expenditures in the next few years would be reduced because of the elimination of large one-time retroactive payments to certain beneficiaries.

Section 3 of the bill would remove the monthly measure of retirement, except in the year of retirement. Thus the retirement test would be changed from the present combined annual-monthly test to an annual test only.

Under present law, if a beneficiary under age seventy-two earns more than the annual exempt amount ($2,520 in 1975), $1 in benefits is withheld for each $2 of earnings above that amount. Regardless of his annual earnings, a beneficiary may receive full benefits for any month in which he neither earns wages in excess of the monthly test ($210 in 1975) nor renders substantial services in self-employment.

Under the proposal, the retirement test would be modified so that, except for the first year for which a beneficiary receives a cash benefit, benefits would be based solely on annual earnings.

Retaining the monthly test for the first year will permit a beneficiary to receive benefits for the months in which he is retired, regardless of his earnings in the preceding months of that year.

The proposed test would be a more valid and equitable measure of actual retirement than the present combination annual-monthly test. Individuals with substantial annual earnings after the year of retirement would no longer be entitled to benefits for months in which, for one reason or another, they did not have income from work. The proposal would eliminate the inequitable situation in which some individuals' benefits are withheld while the benefits of others who have the same total yearly earnings are not. It would also eliminate much public confusion and misunderstanding about the retirement earnings limitation as it relates to the monthly test and would produce some administrative savings.

Section 4 would alter the provisions of the AFDC program concerning the disregarding of earned income in determining benefit amounts. Current law requires that the first $30 plus one-third of the gross income an AFDC recipient earns in a month be disregarded in determining eligibility for assistance. In addition, costs for child care and other work expenses are deducted from income. Under the bill, the first $60 of earned income in the month, plus child care costs and one-third of the balance would be disregarded. The one-third reduction would occur after the $60 and child care expenses are disregarded.

Section 5 of the bill would amend the AFDC program to eliminate the option of the States to have federal financial participation in State expenditures for the provision of benefits determined on the basis of a percentage of the first $32 of the average State AFDC grant. Under the proposal federal financial participation in State expenditures for AFDC benefits would be determined for all States under the formula currently used to determine federal financial participation under the Medicaid program. This formula provides for increased matching rates for States with lower per capita incomes. It is currently used by all but twelve States under the AFDC program.

Sections 6, 7, and 8 of the bill would modify the cost-sharing structure of the Medicare program to provide the following: (1) a coinsurance requirement equal to ten percent of charges above the deductible amount on all part A covered services; (2) an annual deductible under part B of $60 for calendar year 1975, with increases thereafter in proportion to the percentage increase in cash benefits; (3) a cost-sharing liability limit in 1975 of $750 per spell of illness under part A, with increases thereafter in proportion to the percentage increase in cash benefits; and (4) a limit on part B liability per calendar year equal to the part A limit, beginning with calendar year 1976. The current inpatient hospital deductible provision would remain unchanged, as would the twenty percent coinsurance requirement now applicable to most part B services above the deductible.

Under the present provisions of part A, a beneficiary pays an initial deductible amount (currently $92) based on the national average cost of one day's stay in a hospital. The beneficiary pays nothing more toward his covered expenses until after he has been a patient in a hospital for at least sixty days or a patient in a skilled nursing facility for at least twenty days, after which he pays a per diem coinsurance related to the deductible amount.

The chief shortcoming of the present arrangement is that the beneficiary's cost-sharing burden occurs at the end of a long institutional stay when the beneficiary is least able to afford it. There is little built-in incentive to avoid overutilization during short hospital stays when it is most likely to occur. Moreover, the amount the beneficiary pays bears no direct relationship to the actual cost he incurs or to the services he receives in the course of inpatient or home health care. As a result, there are wide variations in utilization that reflect the availability of free services.

The proposed changes in coinsurance liability have the advantage of tying cost-sharing to actual charges and services used and of applying cost-sharing early enough during a hospital stay to discourage overutilization. The maximum-liability provision would assure heretofore unavailable

protection against costs associated with long-term intensive inpatient care.

The proposal for future increases in the part B deductible, which would allow the deductible to increase as OASDI benefits rise, would help to assure that beneficiary liability for medical expenses does not rise more than the percentage increase in the amount of social security benefits.

The present unlimited liability for part B cost-sharing would be replaced by a maximum annual liability--also related to increases in OASDI benefits--to provide protection against the potentially catastrophic costs of chronic conditions which, while not requiring institutionalization, may involve a high volume of outpatient services.

Section 9 would authorize the Secretary to establish percentage limits on the rate of increase in incurred costs recognized as reasonable in determining provider reimbursements under the Medicare program. This authority is necessary to protect the Medicare program from unreasonable increases in provider costs and should help to curb unnecessary or inefficient expansion of institutional services.

Section 10 would reduce the rate of federal financial participation in State expenditures for the provision of services and the training of State and local employees under the AFDC and adult assistance programs, the program of services to the aged, blind, and disabled, and the new consolidated services program. Under current law, expenditures by the States under plans approved under titles I, VI, X, XIV, and XVI, and part A of title IV for most services and for the training of State and local employees are matched at the rate of seventy-five percent. Expenditures for family planning services provided under part A of title IV are matched at the rate of ninety percent. The new title XX services program, which will be effective on October 1 of this year, currently provides for ninety percent matching for expenditures for family planning services and seventy-five percent matching for all other expenditures, including those for training. The bill would amend all of these programs

to establish a sixty-five percent matching rate for family planning services and all other services and training currently matched at the rate of seventy-five percent, beginning on July 1 of this year. Beginning on October 1, 1976, this matching rate would be reduced to fifty percent. The provisions of part A of title IV authorizing a ninety percent matching rate for services provided as part of the work incentive program would not be affected by the bill. We believe this new matching rate will make the rate of federal financial participation in expenditures for services and training more consistent with the rates of federal financial participation applicable to other expenditures under the State plan programs established by the Social Security Act.

Section 5 of the Social Services Amendments of 1974 amends titles I, X, XIV, and XVI, and part A of title IV of the Social Security Act, effective October 1 of this year, to require the Secretary to recognize the cost of short- and long-term institutional training as State and local training expenditures for which federal financial participation is available. Current law imposes no such requirement on the Secretary. The bill would preserve current law by repealing the amendments made by section 5 of the Social Services Amendments of 1974 and striking a similar requirement for the title XX services program that will go into effect on October 1 of this year.

Enactment of this legislation is essential if the President's goal of controlling federal outlays in fiscal years 1975 and 1976 is to be met. It is estimated that enactment would result in savings of $397 million in 1975 and $2,658 million in 1976.

We are advised by the Office of Management and Budget that enactment of this draft bill would be in accord with the program of the President.

Sincerely,

/s/ Caspar W. Weinberger

Secretary

Enclosure

A B I L L

To amend the Social Security Act to improve and control the cost of the program of old-age, survivors, and disability insurance, the program of grants to States for aid to families with dependent children, and the program of health insurance for the aged and disabled.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Social Security Cost Control Act of 1975".

ELIMINATION OF CERTAIN OPTIONAL PAYMENT PROCEDURES UNDER THE OASDI PROGRAM

Sec. 2. (a)(1) The first sentence of section 202(j)(1) of the Social Security Act is amended by striking out "An individual" and inserting "Subject to the limitations contained in paragraph (4), an individual" in lieu thereof.

(2) Section 202(j) of such Act is further amended by inserting at the end thereof the following new paragraph:

"(4)(A) Except as provided in subparagraph (B), no individual shall be entitled to benefits under subsections

(a), (b), (c), (e), or (f) for any month prior to the month in which he files an application for such benefits if the effect of such payment would be to reduce, pursuant to subsection (q), the monthly benefits to which such individual would otherwise be entitled.

"(B)(i) If the individual applying for retroactive benefits is applying for such benefits under subsection (a), and there are one or more other persons who would, except for subparagraph (A), be entitled for any month, on the basis of the wages and self-employment income of such individual and because of such individual's entitlement to such retroactive benefits, to retroactive benefits under subsection (b), (c), or (d) not subject to reduction under subsection (q), then subparagraph (A) shall not apply with respect to such month or any subsequent month.

"(ii) If the individual applying for retroactive benefits is a widow, widower, or surviving divorced wife who is under a disability (as defined in section 223(d)), and such individual would, except for subparagraph (A), be entitled to retroactive benefits as a disabled widow, widower, or surviving divorced wife for any month before he or she

attained the age of 60, then subparagraph (A) shall not apply with respect to such month or any subsequent month.

"(iii) If the individual applying for retroactive benefits has excess earnings (as defined in section 203(f)) in the year in which he files an application for such benefits which could, except for subparagraph (A), be charged to months in such year prior to the month of application, then subparagraph (A) shall not apply to so many of such months immediately preceding the month of application as are required to charge such excess earnings to the maximum extent possible."

(3) Section 226(h) of such Act is amended by inserting at the end thereof the following new paragraph:

"(4) For the purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual described in clause (iii) of subsection (b)(2)(A), the entitlement of such individual to widow's or widower's insurance benefits under section 202(e) or (f) by reason of a disability shall be deemed to be the entitlement to such benefits that would result if such entitlement were determined without regard to the provisions of section 202(j)(4)."

(b) The amendments made by this section shall be effective with respect to applications for benefits under title II of the Social Security Act filed after February 28, 1975.

REVISION OF THE RETIREMENT TEST
UNDER THE OASDI PROGRAM

Sec. 3. (a) Section 203(f)(1)(E) of the Social Security Act is amended to read as follows: "(E) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the exempt amount as determined under paragraph (8), but only if the month is in that taxable year in which occurs the first month that is both (i) a month for which the individual is entitled to benefits under subsection (a), (b), (c), (d), (e), (f), (g), or (h) of section 202 without regard to any previous entitlement under any other of such subsections, and (ii) a month in which the individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the exempt amount as determined under paragraph (8)."

(b) The amendment made by this section shall be effective with respect to benefits payable under title II of the Social Security Act for calendar months after February 1975.

ADJUSTMENT IN THE AMOUNT OF INCOME TO BE DISREGARDED IN DETERMINING NEED UNDER THE AFDC PROGRAM

Sec. 4. (a) Section 402(a)(7) of the Social Security Act is amended by striking out "as well as any expenses reasonably attributable to the earning of any such income".

(b) Section 402(a)(8)(A)(ii) of such Act is amended by striking out "the first $30 of the total of such earned income for such month plus one-third of the remainder of such income" and inserting in lieu thereof "the first $60 of the total of such earned income for such month plus an amount equal to any expenses (subject to such limitations as to amount or otherwise as the Secretary may prescribe) which are for the care of a dependent child and are reasonably attributable to the earning of any such income plus one-third of the remainder of such income".

(c) Section 402(a)(8)(D) of such Act is amended by striking out "was in excess of their need" and inserting in lieu thereof "was in excess of their need (after deducting from such income $60 plus an amount equal to any expenses, subject to such limitations as to amount or otherwise as the Secretary may prescribe, which are for the care of a dependent child and are reasonably attributable to the earning of any such income)".

(d) The amendments made by this section shall be effective with respect to payments under section 403 of the Social Security Act for amounts expended during calendar months after February 1975.

MODIFICATION OF RATE OF FEDERAL FINANCIAL PARTICIPATION IN STATE PROGRAMS OF AID TO NEEDY FAMILIES WITH CHILDREN AND AGED, BLIND, OR DISABLED INDIVIDUALS

Sec. 5. (a)(1) Section 3(a) of the Social Security Act is amended by striking out clauses (1) and (2) and inserting in lieu thereof the following:

"(1) in the case of any State, an amount equal to the Federal percentage (as defined in section 1101(a)(8)) of the total amount expended during such quarter as old-age assistance under the State plan;".

(2) Section 403(a) of that Act is amended by striking out clauses (1) and (2) and inserting in lieu thereof the following:

"(1) in the case of any State, an amount equal to the Federal percentage (as defined in section 1101(a)(8)) of the total amount expended during such quarter as aid to families with dependent children under the State plan; and".

(3) Section 1003(a) of that Act is amended by striking out clauses (1) and (2) and inserting in lieu thereof the following:

"(1) in the case of any State, an amount equal to the Federal percentage (as defined in section 1101(a)(8)) of the total amount expended during such quarter as aid to the blind under the State plan; and".

(4) Section 1403(a) of that Act is amended by striking out clauses (1) and (2) and inserting in lieu thereof the following:

"(1) in the case of any State, an amount equal to the Federal percentage (as defined in section 1101(a)(8)) of the total amount expended during such quarter as aid to the permanently and totally disabled under the State plan; and".

(5) Section 1603(a) of that Act is amended by striking out clauses (1) and (2) and inserting in lieu thereof the following:

"(1) in the case of any State, an amount equal to the Federal percentage (as defined in section 1101(a)(8)) of the total amount expended during such quarter as aid to the aged, blind, or disabled under the State plan;".

(6)(A) Section 1101(a)(8)(A) of that Act is amended to read as follows:

"(8)(A) The Federal percentage for any State is 100 percent less the State percentage; and the State percentage is that percentage which bears the same ratio to 45 percent as the square of the per capita income of the State bears to the square of the per capita income of the continental United States (including

Alaska) and Hawaii; except that (i) the Federal percentage shall in no case be less than 50 percent or more than 83 percent, and (ii) the Federal percentage for Puerto Rico, the Virgin Islands, and Guam is 50 percent."

(B) Section 1101(a)(8)(B) of that Act is amended by striking out everything after "such promulgation" and inserting a period in lieu thereof.

(C) Section 1101(a)(8) of that Act is further amended by striking out subparagraphs (C) and (D).

(7) Section 1118 of that Act is repealed.

(b) The amendments made by this section shall be effective with respect to payments under section 3, 403, 1003, 1403, or 1603 of the Social Security Act for amounts expended during calendar months after February 1975.

REFORM OF MEDICARE HOSPITAL INSURANCE DEDUCTIBLES AND COINSURANCE

Sec. 6. (a) Paragraph (1) of subsection (a) of section 1813 of the Social Security Act is amended to read as follows:

"(1) Except as provided in paragraph (4), the amount payable for inpatient hospital services furnished

an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges for such services imposed with respect to such individual for such services, and by a coinsurance amount equal to one-tenth of the charges imposed for such inpatient hospital services, other than--

"(A) charges subject to the inpatient hospital deductible, and

"(B) charges imposed for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined in regulations) furnished to such individual during such spell."

(b) Paragraph (3) of such subsection is amended to read as follows:

"(3) Except as provided in paragraph (4), the amount payable for post-hospital extended care services during any spell of illness and post-hospital home health services during the period after the beginning of one spell of illness and before the beginning of the next spell of illness shall be reduced by a coinsurance amount equal to one-tenth of the charges imposed for such services, other than charges

imposed for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined in regulations) furnished to such individual during such spell."

(c) Subsection (a) of such section is further amended by adding at the end thereof the following:

"(4)(A) The total amount of the reductions imposed under paragraphs (1) and (3) with respect to inpatient hospital services and post-hospital extended care services during a spell of illness and post-hospital home health services during the period after the beginning of that spell of illness and before the beginning of the next spell of illness shall not exceed $750 if such spell of illness begins in calendar year 1975, or the amount determined under subparagraph (B) if such spell of illness begins in calendar year 1976 or any year thereafter, and when such limit is reached no further reductions shall be imposed under paragraph (1) or (3).

"(B) The Secretary shall, during October of 1975, and of each year thereafter, determine and promulgate the limitation on reductions to be applied under subparagraph (A) with respect to spells of illness beginning in the succeeding calendar year. Such limitation shall be computed by increasing or decreasing $750 by the same percentage (rounded to the nearest one-tenth of one percent) by which the representative primary insurance amount exceeds or is less than $393.50. For the purpose of such computation the representative primary insurance amount shall be the primary insurance amount used to determine the amount payable under section 202 for January of the year succeeding the year in which such determination is made to an individual whose primary insurance amount (as determined under section 215(a)(1)(A)) is based on an average monthly wage of $750, taking into account all applicable laws and administrative determinations which have been enacted and promulgated, respectively, at the time of such computation, even if not yet effective. If the limitation derived from such computation is not a multiple of $10, it shall be reduced to the next lower multiple of $10.

"(5) In determining the reductions required under paragraphs (1) and (3), the customary charges of a provider for services furnished an individual, other than the services described in clause (B) of paragraph (1), shall be deemed to be the charges imposed for such services by such provider if such customary charges are greater than the charges imposed."

(d) Section 1861(y) of such Act is amended by striking out paragraph (3) and renumbering paragraph (4) as paragraph (3).

(e) The amendments made by this section shall be effective with respect to spells of illness, as defined in section 1861(a) of the Social Security Act, beginning after February 28, 1975.

REFORM OF MEDICARE SUPPLEMENTARY MEDICAL INSURANCE COINSURANCE

Sec. 7. (a) Section 1833(a) of the Social Security Act is amended to read as follows:

"Sec. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical

Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to--

"(1) in the case of services described in section 1832(a)(1), the reasonable charges for the services reduced by a coinsurance amount equal to 20 percent of such reasonable charges; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization reduced by a coinsurance amount equal to 20 percent of such reasonable cost if the organization undertakes to charge such individuals no more than the amount of any such reduction plus the amount of any reduction under subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician

in the field of radiology or pathology, the amounts paid shall equal the reasonable charges for such services reduced by a coinsurance amount equal to ten percent of the charges imposed for such services (or ten percent of the customary charges for such services if the customary charges for such services are greater than the charges imposed), (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, and (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), and

"(2) in the case of services described in section 1832(a)(2)--

"(A) the lesser of (i) the reasonable cost of such services, as determined under

section 1861(v), or (ii) the customary charges with respect to such services; or

"(B) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2); or

"(C) if such services are services to which the second sentence of section 1861(p) applies, the reasonable charges for such services, reduced, in the case of home health services, by a coinsurance amount equal to ten percent of the charges imposed for such services (or ten percent of the customary charges for such services if the customary charges for such services are greater than the charges imposed), and, in the case of other services, by a coinsurance amount equal to 20 percent of the amount otherwise payable."

(b) Section 1833(f)(1) of such Act is amended by striking out "the 20 percent coinsurance amount" and inserting "any coinsurance amount" in lieu thereof.

(c) Section 1833 of such Act is further amended by redesignating the second subsection (g) as subsection

(h) and by inserting at the end thereof the following new subsection:

"(i) The total amount of--

"(1) the reductions imposed under subsection (a)(1) (other than clause (C)),

"(2) the reductions imposed under subsection (a)(2) with respect to home health services, and

"(3) the amounts chargeable under section 1866(a)(2)(A)(ii),

with respect to expenses incurred by an individual in any calendar year shall not exceed an amount equal to the amount of the limitation on reductions imposed by section 1813(a)(4) with respect to spells of illness beginning in that calendar year, and when such limit is reached no further reductions shall be imposed under subsection (a) (other than clause (1)(C)) or under the first sentence of subsection (b) with respect to such expenses incurred by such individual in such year. The Secretary shall, during October of 1975 and of each year thereafter, determine and promulgate the limitation on reductions to be applied under paragraph (1) for the succeeding calendar year."

(d) Section 1866(a)(2)(A) is amended to read as follows:

"(2)(A)(i) A provider of services may charge such individual or other person the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1) or (a)(3) with respect to such items and services.

"(ii) A provider may charge such individual or other person the amount of any deduction imposed pursuant to section 1833(b) with respect to such items and services (but such amount may not exceed the amount customarily charged for such items and services by such provider); and may also, except as provided in paragraph (iii), charge such individual or other person an amount equal to 20 percent of the reasonable charges for such items and services for which payment is made under part B (but such amount may not exceed 20 percent of the amount customarily charged for such items and services by such provider), except that such charges may not be imposed to the extent that, pursuant to section 1833(i), payment under part B for such items and services is not reduced by a coinsurance amount.

"(iii) In the case of home health services described in section 1833(a)(2), a provider may charge such individual

or other person the amount of any coinsurance amount imposed pursuant to section 1833(a)(2) with respect to such services."

(e) The amendments made by this section shall be effective with respect to items and services provided after December 31, 1975, for which payment is made under title XVIII of the Social Security Act.

AUTOMATIC ADJUSTMENT OF MEDICARE SUPPLEMENTARY MEDICAL INSURANCE DEDUCTIBLE

Sec. 8. (a) The first sentence of subsection (b) of section 1833 of the Social Security Act is amended by striking out "a deductible of $60" and inserting "a deductible of $60 for calendar year 1975, and the amount determined under paragraph (2) of this subsection for calendar year 1976 and each year thereafter" in lieu thereof.

(b) Subsection (b) of such section is further amended by redesignating clauses (1) and (2) as clauses (A) and (B), respectively, by inserting "(1)" after "(b)", and by inserting at the end thereof the following new paragraph:

"(2) The Secretary shall, during November of 1975 and of each year thereafter, determine and promulgate the deductible to be applied under paragraph (1) of this subsection for the succeeding calendar year. Such deductible shall be computed by increasing or decreasing $60 by the same percentage (rounded to the nearest one-tenth of one

percent) by which the representative primary insurance amount exceeds or is less than $354.50. For the purpose of such computation the representative primary insurance amount shall be the primary insurance amount used to determine the amount payable under section 202 for January of the year succeeding the year in which such determination is made to an individual whose primary insurance amount (as determined under section 215(a)(1)(A)) is based on an average monthly wage of $750, taking into account all applicable laws and administrative determinations which have been enacted and promulgated, respectively, at the time of such computation, even if not yet effective. If the deductible derived from such computation is not a multiple of $1, it shall be reduced to the next lower multiple of $1."

AUTHORITY TO ESTABLISH LIMITS ON RATE OF INCREASE OF COSTS RECOGNIZED AS REASONABLE UNDER MEDICARE PROGRAM

Sec. 9. (a) The third sentence of section 1861(v)(1)(A) of the Social Security Act is amended by inserting "may provide for the establishment of limits on the rate of increase in the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of

items or services to be recognized as reasonable based on estimates of the rate increase in the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title," immediately after "established under this title,".

REDUCTION IN FEDERAL FINANCIAL PARTICIPATION IN STATE SERVICES AND TRAINING EXPENDITURES

Sec. 10. (a)(1) Sections 3(a)(4)(A), 1003(a)(3)(A), 1403(a)(3)(A), and 1603(a)(4)(A) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, Guam, and the Virgin Islands, and sections 403(a)(3)(A) and 603(a)(1)(A) of that Act are each amended by striking out "75 per centum" and inserting "65 per centum" in lieu thereof.

(2) Paragraph (4) of section 3(a) of the Social Services Amendments of 1974 and the amendment to the Social Security Act made by that paragraph are repealed.

(3) Section 403(e) of the Social Security Act is repealed.

(4) The amendments made by paragraphs (1) and (3) of this subsection shall be effective with respect to payments under section 3, 403, 603, 1003, 1403, and 1603 of the Social Security Act for amounts expended during calendar quarters commencing after June 30, 1975.

(b) Section 5 of the Social Services Amendments of 1974 and the amendments to the Social Security Act made by that section are repealed.

(c)(1) Paragraph (3) of section 3(a) of the Social Services Amendments of 1974 and the amendment to the Social Security Act made by that paragraph are repealed.

(2) Section 403(a)(3) of the Social Security Act is amended to read as follows:

"(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as are found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan--

"(A) 65 per centum of so much of such expenditures as are for the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision, and

"(B) one-half the remainder of such expenditures, except that no payment shall be made with respect to amounts expended in connection with the provision of any service described in section 2002(a)(1) of this Act other than services the provision of which is required by section 402(a)(19) to be included in the plan of the State; and"

(3) The amendment made by this subsection shall be effective with respect to payments under section 403 of the Social Security Act for amounts expended during calendar quarters commencing after September 30, 1975, except that the amendment shall not be effective with respect to the Commonwealth of Puerto Rico, the Virgin Islands, or Guam.

(d)(1) Section 2002(a)(1) of the Social Security Act, as amended by the Social Services Amendments of 1974, is amended by —

(A) striking out "90 per centum of the total expenditures during that quarter for the provision of family planning services and 75 per centum" and inserting "65 per centum" in lieu thereof; and

(B) striking out "(including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions)".

(2) The amendment made by this subsection shall be effective with respect to payments under section 2002 of the Social Security Act for expenditures during calendar quarters commencing after September 30, 1975.

(e)(1) Section 403(a)(3) of the Social Security Act, as in effect with respect to the fifty States and the District of Columbia, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) and (B) and inserting in lieu thereof the following:

"(3) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including expenditures for the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision,".

(2) The amendment made by this subsection shall be effective with respect to payments under section 403 of the Social Security

Act for amounts expended during calendar quarters commencing after September 30, 1976.

(f)(1) Section 2002(a)(1) of the Social Security Act, as amended by the Social Services Amendments of 1974 and subsection (d) of this section, is amended by striking out "65 per centum" and inserting "50 per centum" in lieu thereof.

(2) The amendment made by this subsection shall be effective with respect to payments under section 2002 of the Social Security Act for calendar quarters commencing after September 30, 1976.

(g)(1) Section 3(a)(4) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) through (C) and inserting in lieu thereof the following:

"(4) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including expenditures for--

"(A) services provided, in accordance with the next sentence, to applicants for or recipients of

assistance under the plan, and to individuals requesting such services who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of such assistance, and

"(B) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision."

(2) Section 3(a)(4) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by--

(A) striking out "subparagraphs (A) and (B)" in the matter before subparagraph (D) and inserting "subparagraph (A)" in lieu thereof; and

(B) striking out everything after "the State plan for vocational rehabilitation services so approved." in the matter after subparagraph (E).

(3) Section 3(a) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by striking out subparagraph (5).

(h)(1) Section 403(a)(3) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) and (B) and inserting in lieu thereof the following:

"(3) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including any expenditures for--

"(A) any of the services described in clauses (14) and (15) of section 402(a) which are provided to any child or relative who is receiving aid under the plan, or to any other individual, living in the same home as such relative and child, whose needs are taken into account in making the determination under clause (7) of such section, or to any child or relative who is applying for aid to families with dependent children or who, within such period or periods as the Secretary may prescribe, has been or is likely to become an applicant for or recipient of such aid, and

"(B) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision."

(2) Section 403(a)(3) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by striking out everything after "subparagraphs (C) and (D)." in the matter after subparagraph (D).

(i)(1) Section 1003(a)(3) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) through (C) and inserting in lieu thereof the following:

"(3) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including expenditures for--

"(A) services provided, in accordance with the next sentence, to applicants for or recipients of aid to the blind, and to individuals requesting such

services who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of such aid, and

"(B) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision."

(2) Section 1003(a)(3) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by--

"(A) striking out "subparagraphs (A) and (B)" in the matter before subparagraph (D) and inserting "subparagraph (A)" in lieu thereof; and

"(B) striking out everything after "the State plan for vocational rehabilitation services so approved." in the matter after subparagraph (E).

(3) Section 1003(a) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by striking out subparagraph (4).

(j)(1) Section 1403(a)(3) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, the

Virgin Islands, and Guam, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) through (C) and inserting in lieu thereof the following:

"(3) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including expenditures for--

"(A) services provided, in accordance with the next sentence, to applicants for or recipients of aid to the permanently and totally disabled, and to individuals requesting such services who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of such aid, and

"(B) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision."

(2) Section 1403(a)(3) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by--

(A) striking out "subparagraphs (A) and (B)" in the matter before subparagraph (D) and inserting "subparagraph (A)" in lieu thereof; and

(B) striking out everything after "the State plan for vocational rehabilitation services so approved." in the matter after subparagraph (E).

(3) Section 1403(a) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by striking out subparagraph (4).

(k)(1) Section 1603(a)(4) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) through (C) and inserting in lieu thereof the following:

"(4) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including expenditures for--

"(A) services provided, in accordance with the next sentence, to applicants for or recipients of aid or assistance under the plan, and to individuals

requesting such services who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of such aid or assistance, and

"(B) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision."

(2) Section 1603(a)(4) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by--

(A) striking out "subparagraphs (A) and (B)" in the matter before subparagraph (D) and inserting "subparagraph (A)" in lieu thereof; and

(B) striking out everything after "the State plan for vocational rehabilitation services so approved." in the matter after subparagraph (E).

(3) Section 1603(a) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by striking out subparagraph (5).

(ℓ) The amendments made by subsections (g) through (k) shall be effective with respect to payments under sections 3, 403, 1003, 1403, and 1603 of the Social Security Act for amounts expended during quarters commencing after September 30, 1976 .

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

February 26, 1975

Honorable Carl Albert
Speaker of the House of
Representatives
Washington, D. C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is a draft bill "To amend the Social Security Act to improve and control the cost of the program of old-age, survivors, and disability insurance, the program of grants to States for aid to families with dependent children, and the program of health insurance for the aged and disabled."

The bill is part of the President's budget recommendations for bringing federal spending under control during fiscal years 1975 and 1976 and avoiding excessive growth of federal expenditures in the long run. As the President stated in his recent Budget Message: "Spending by all levels of government now makes up a third of our national output. Were the growth of domestic assistance programs to continue for the next two decades at the same rates as in the past 20 years, total government spending would grow to more than half of our national output. We cannot permit this to occur."

Section 2 of the bill would prohibit entitlement to retroactive OASDI benefits if future monthly benefits would be permanently reduced as a result. Under the present law, social security benefits may be paid retroactively, at the beneficiary's election, for up to twelve months prior to the month in which the application is filed, provided all conditions of entitlement are met. In many instances, an applicant who is entitled to retroactive benefits faces a choice of getting a large lump-sum payment to cover retroactive benefits and a permanently reduced monthly benefit in the future, or getting no lump-sum payment and a higher monthly benefit beginning with the month that an

application is filed. Many beneficiaries faced with this choice decide to take the large lump-sum payment. In some cases the lump-sum payment is quickly spent, and financial hardship results from the smaller continuing benefits on which the beneficiary has to rely for the rest of his life.

This proposal is based on a recommendation of the 1971 Advisory Council on Social Security. The Advisory Council, in making its recommendation, expressed concern about the fact that a high proportion of those applicants who are faced with the choice of a relatively large lump-sum retroactive benefit payment choose to take the lump-sum even though this means a permanent reduction in the monthly benefits they will get. The Council pointed out that such a result did not seem to be consistent with the objective of providing adequate benefit income for the aged.

In the aggregate, this proposal would not change the total lifetime benefits of people affected by it. Thus, over the long run the proposal would have a negligible effect on the costs of the program. However, expenditures in the next few years would be reduced because of the elimination of large one-time retroactive payments to certain beneficiaries.

Section 3 of the bill would remove the monthly measure of retirement, except in the year of retirement. Thus the retirement test would be changed from the present combined annual-monthly test to an annual test only.

Under present law, if a beneficiary under age seventy-two earns more than the annual exempt amount ($2,520 in 1975), $1 in benefits is withheld for each $2 of earnings above that amount. Regardless of his annual earnings, a beneficiary may receive full benefits for any month in which he neither earns wages in excess of the monthly test ($210 in 1975) nor renders substantial services in self-employment.

Under the proposal, the retirement test would be modified so that, except for the first year for which a beneficiary receives a cash benefit, benefits would be based solely on annual earnings.

Retaining the monthly test for the first year will permit a beneficiary to receive benefits for the months in which he is retired, regardless of his earnings in the preceding months of that year.

The proposed test would be a more valid and equitable measure of actual retirement than the present combination annual-monthly test. Individuals with substantial annual earnings after the year of retirement would no longer be entitled to benefits for months in which, for one reason or another, they did not have income from work. The proposal would eliminate the inequitable situation in which some individuals' benefits are withheld while the benefits of others who have the same total yearly earnings are not. It would also eliminate much public confusion and misunderstanding about the retirement earnings limitation as it relates to the monthly test and would produce some administrative savings.

Section 4 would alter the provisions of the AFDC program concerning the disregarding of earned income in determining benefit amounts. Current law requires that the first $30 plus one-third of the gross income an AFDC recipient earns in a month be disregarded in determining eligibility for assistance. In addition, costs for child care and other work expenses are deducted from income. Under the bill, the first $60 of earned income in the month, plus child care costs and one-third of the balance would be disregarded. The one-third reduction would occur after the $60 and child care expenses are disregarded.

Section 5 of the bill would amend the AFDC program to eliminate the option of the States to have federal financial participation in State expenditures for the provision of benefits determined on the basis of a percentage of the first $32 of the average State AFDC grant. Under the proposal federal financial participation in State expenditures for AFDC benefits would be determined for all States under the formula currently used to determine federal financial participation under the Medicaid program. This formula provides for increased matching rates for States with lower per capita incomes. It is currently used by all but twelve States under the AFDC program.

Sections 6, 7, and 8 of the bill would modify the cost-sharing structure of the Medicare program to provide the following: (1) a coinsurance requirement equal to ten percent of charges above the deductible amount on all part A covered services; (2) an annual deductible under part B of $60 for calendar year 1975, with increases thereafter in proportion to the percentage increase in cash benefits; (3) a cost-sharing liability limit in 1975 of $750 per spell of illness under part A, with increases thereafter in proportion to the percentage increase in cash benefits; and (4) a limit on part B liability per calendar year equal to the part A limit, beginning with calendar year 1976. The current inpatient hospital deductible provision would remain unchanged, as would the twenty percent coinsurance requirement now applicable to most part B services above the deductible.

Under the present provisions of part A, a beneficiary pays an initial deductible amount (currently $92) based on the national average cost of one day's stay in a hospital. The beneficiary pays nothing more toward his covered expenses until after he has been a patient in a hospital for at least sixty days or a patient in a skilled nursing facility for at least twenty days, after which he pays a per diem coinsurance related to the deductible amount.

The chief shortcoming of the present arrangement is that the beneficiary's cost-sharing burden occurs at the end of a long institutional stay when the beneficiary is least able to afford it. There is little built-in incentive to avoid overutilization during short hospital stays when it is most likely to occur. Moreover, the amount the beneficiary pays bears no direct relationship to the actual cost he incurs or to the services he receives in the course of inpatient or home health care. As a result, there are wide variations in utilization that reflect the availability of free services.

The proposed changes in coinsurance liability have the advantage of tying cost-sharing to actual charges and services used and of applying cost-sharing early enough during a hospital stay to discourage overutilization. The maximum-liability provision would assure heretofore unavailable

protection against costs associated with long-term intensive inpatient care.

The proposal for future increases in the part B deductible, which would allow the deductible to increase as OASDI benefits rise, would help to assure that beneficiary liability for medical expenses does not rise more than the percentage increase in the amount of social security benefits.

The present unlimited liability for part B cost-sharing would be replaced by a maximum annual liability--also related to increases in OASDI benefits--to provide protection against the potentially catastrophic costs of chronic conditions which, while not requiring institutionalization, may involve a high volume of outpatient services.

Section 9 would authorize the Secretary to establish percentage limits on the rate of increase in incurred costs recognized as reasonable in determining provider reimbursements under the Medicare program. This authority is necessary to protect the Medicare program from unreasonable increases in provider costs and should help to curb unnecessary or inefficient expansion of institutional services.

Section 10 would reduce the rate of federal financial participation in State expenditures for the provision of services and the training of State and local employees under the AFDC and adult assistance programs, the program of services to the aged, blind, and disabled, and the new consolidated services program. Under current law, expenditures by the States under plans approved under titles I, VI, X, XIV, and XVI, and part A of title IV for most services and for the training of State and local employees are matched at the rate of seventy-five percent. Expenditures for family planning services provided under part A of title IV are matched at the rate of ninety percent. The new title XX services program, which will be effective on October 1 of this year, currently provides for ninety percent matching for expenditures for family planning services and seventy-five percent matching for all other expenditures, including those for training. The bill would amend all of these programs

to establish a sixty-five percent matching rate for family planning services and all other services and training currently matched at the rate of seventy-five percent, beginning on July 1 of this year. Beginning on October 1, 1976, this matching rate would be reduced to fifty percent. The provisions of part A of title IV authorizing a ninety percent matching rate for services provided as part of the work incentive program would not be affected by the bill. We believe this new matching rate will make the rate of federal financial participation in expenditures for services and training more consistent with the rates of federal financial participation applicable to other expenditures under the State plan programs established by the Social Security Act.

Section 5 of the Social Services Amendments of 1974 amends titles I, X, XIV, and XVI, and part A of title IV of the Social Security Act, effective October 1 of this year, to require the Secretary to recognize the cost of short- and long-term institutional training as State and local training expenditures for which federal financial participation is available. Current law imposes no such requirement on the Secretary. The bill would preserve current law by repealing the amendments made by section 5 of the Social Services Amendments of 1974 and striking a similar requirement for the title XX services program that will go into effect on October 1 of this year.

Enactment of this legislation is essential if the President's goal of controlling federal outlays in fiscal years 1975 and 1976 is to be met. It is estimated that enactment would result in savings of $397 million in 1975 and $2,658 million in 1976.

We are advised by the Office of Management and Budget that enactment of this draft bill would be in accord with the program of the President.

Sincerely,

/s/ Caspar W. Weinberger

Secretary

Enclosure

A B I L L

To amend the Social Security Act to improve and control the cost of the program of old-age, survivors, and disability insurance, the program of grants to States for aid to families with dependent children, and the program of health insurance for the aged and disabled.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Social Security Cost Control Act of 1975".

ELIMINATION OF CERTAIN OPTIONAL PAYMENT PROCEDURES UNDER THE OASDI PROGRAM

Sec. 2. (a)(1) The first sentence of section 202(j)(1) of the Social Security Act is amended by striking out "An individual" and inserting "Subject to the limitations contained in paragraph (4), an individual" in lieu thereof.

(2) Section 202(j) of such Act is further amended by inserting at the end thereof the following new paragraph:

"(4)(A) Except as provided in subparagraph (B), no individual shall be entitled to benefits under subsections

(a), (b), (c), (e), or (f) for any month prior to the month in which he files an application for such benefits if the effect of such payment would be to reduce, pursuant to subsection (q), the monthly benefits to which such individual would otherwise be entitled.

"(B)(i) If the individual applying for retroactive benefits is applying for such benefits under subsection (a), and there are one or more other persons who would, except for subparagraph (A), be entitled for any month, on the basis of the wages and self-employment income of such individual and because of such individual's entitlement to such retroactive benefits, to retroactive benefits under subsection (b), (c), or (d) not subject to reduction under subsection (q), then subparagraph (A) shall not apply with respect to such month or any subsequent month.

"(ii) If the individual applying for retroactive benefits is a widow, widower, or surviving divorced wife who is under a disability (as defined in section 223(d)), and such individual would, except for subparagraph (A), be entitled to retroactive benefits as a disabled widow, widower, or surviving divorced wife for any month before he or she

attained the age of 60, then subparagraph (A) shall not apply with respect to such month or any subsequent month.

"(iii) If the individual applying for retroactive benefits has excess earnings (as defined in section 203(f)) in the year in which he files an application for such benefits which could, except for subparagraph (A), be charged to months in such year prior to the month of application, then subparagraph (A) shall not apply to so many of such months immediately preceding the month of application as are required to charge such excess earnings to the maximum extent possible."

(3) Section 226(h) of such Act is amended by inserting at the end thereof the following new paragraph:

"(4) For the purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual described in clause (iii) of subsection (b)(2)(A), the entitlement of such individual to widow's or widower's insurance benefits under section 202(e) or (f) by reason of a disability shall be deemed to be the entitlement to such benefits that would result if such entitlement were determined without regard to the provisions of section 202(j)(4)."

(b) The amendments made by this section shall be effective with respect to applications for benefits under title II of the Social Security Act filed after February 28, 1975.

REVISION OF THE RETIREMENT TEST
UNDER THE OASDI PROGRAM

Sec. 3. (a) Section 203(f)(1)(E) of the Social Security Act is amended to read as follows: "(E) in which such individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the exempt amount as determined under paragraph (8), but only if the month is in that taxable year in which occurs the first month that is both (i) a month for which the individual is entitled to benefits under subsection (a), (b), (c), (d), (e), (f), (g), or (h) of section 202 without regard to any previous entitlement under any other of such subsections, and (ii) a month in which the individual did not engage in self-employment and did not render services for wages (determined as provided in paragraph (5) of this subsection) of more than the exempt amount as determined under paragraph (8)."

(b) The amendment made by this section shall be effective with respect to benefits payable under title II of the Social Security Act for calendar months after February 1975.

ADJUSTMENT IN THE AMOUNT OF INCOME TO BE DISREGARDED IN DETERMINING NEED UNDER THE AFDC PROGRAM

Sec. 4. (a) Section 402(a)(7) of the Social Security Act is amended by striking out "as well as any expenses reasonably attributable to the earning of any such income".

(b) Section 402(a)(8)(A)(ii) of such Act is amended by striking out "the first $30 of the total of such earned income for such month plus one-third of the remainder of such income" and inserting in lieu thereof "the first $60 of the total of such earned income for such month plus an amount equal to any expenses (subject to such limitations as to amount or otherwise as the Secretary may prescribe) which are for the care of a dependent child and are reasonably attributable to the earning of any such income plus one-third of the remainder of such income".

(c) Section 402(a)(8)(D) of such Act is amended by striking out "was in excess of their need" and inserting in lieu thereof "was in excess of their need (after deducting from such income $60 plus an amount equal to any expenses, subject to such limitations as to amount or otherwise as the Secretary may prescribe, which are for the care of a dependent child and are reasonably attributable to the earning of any such income)".

(d) The amendments made by this section shall be effective with respect to payments under section 403 of the Social Security Act for amounts expended during calendar months after February 1975.

MODIFICATION OF RATE OF FEDERAL FINANCIAL PARTICIPATION IN STATE PROGRAMS OF AID TO NEEDY FAMILIES WITH CHILDREN AND AGED, BLIND, OR DISABLED INDIVIDUALS

Sec. 5. (a)(1) Section 3(a) of the Social Security Act is amended by striking out clauses (1) and (2) and inserting in lieu thereof the following:

"(1) in the case of any State, an amount equal to the Federal percentage (as defined in section 1101(a)(8)) of the total amount expended during such quarter as old-age assistance under the State plan;".

(2) Section 403(a) of that Act is amended by striking out clauses (1) and (2) and inserting in lieu thereof the following:

"(1) in the case of any State, an amount equal to the Federal percentage (as defined in section 1101(a)(8)) of the total amount expended during such quarter as aid to families with dependent children under the State plan; and".

(3) Section 1003(a) of that Act is amended by striking out clauses (1) and (2) and inserting in lieu thereof the following:

"(1) in the case of any State, an amount equal to the Federal percentage (as defined in section 1101(a)(8)) of the total amount expended during such quarter as aid to the blind under the State plan; and".

(4) Section 1403(a) of that Act is amended by striking out clauses (1) and (2) and inserting in lieu thereof the following:

"(1) in the case of any State, an amount equal to the Federal percentage (as defined in section 1101(a)(8)) of the total amount expended during such quarter as aid to the permanently and totally disabled under the State plan; and".

(5) Section 1603(a) of that Act is amended by striking out clauses (1) and (2) and inserting in lieu thereof the following:

"(1) in the case of any State, an amount equal to the Federal percentage (as defined in section 1101(a)(8)) of the total amount expended during such quarter as aid to the aged, blind, or disabled under the State plan;".

(6)(A) Section 1101(a)(8)(A) of that Act is amended to read as follows:

"(8)(A) The Federal percentage for any State is 100 percent less the State percentage; and the State percentage is that percentage which bears the same ratio to 45 percent as the square of the per capita income of the State bears to the square of the per capita income of the continental United States (including

Alaska) and Hawaii; except that (i) the Federal percentage shall in no case be less than 50 percent or more than 83 percent, and (ii) the Federal percentage for Puerto Rico, the Virgin Islands, and Guam is 50 percent."

(B) Section 1101(a)(8)(B) of that Act is amended by striking out everything after "such promulgation" and inserting a period in lieu thereof.

(C) Section 1101(a)(8) of that Act is further amended by striking out subparagraphs (C) and (D).

(7) Section 1118 of that Act is repealed.

(b) The amendments made by this section shall be effective with respect to payments under section 3, 403, 1003, 1403, or 1603 of the Social Security Act for amounts expended during calendar months after February 1975.

REFORM OF MEDICARE HOSPITAL INSURANCE DEDUCTIBLES AND COINSURANCE

Sec. 6. (a) Paragraph (1) of subsection (a) of section 1813 of the Social Security Act is amended to read as follows:

"(1) Except as provided in paragraph (4), the amount payable for inpatient hospital services furnished

an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges for such services imposed with respect to such individual for such services, and by a coinsurance amount equal to one-tenth of the charges imposed for such inpatient hospital services, other than--

"(A) charges subject to the inpatient hospital deductible, and

"(B) charges imposed for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined in regulations) furnished to such individual during such spell."

(b) Paragraph (3) of such subsection is amended to read as follows:

"(3) Except as provided in paragraph (4), the amount payable for post-hospital extended care services during any spell of illness and post-hospital home health services during the period after the beginning of one spell of illness and before the beginning of the next spell of illness shall be reduced by a coinsurance amount equal to one-tenth of the charges imposed for such services, other than charges

imposed for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined in regulations) furnished to such individual during such spell."

(c) Subsection (a) of such section is further amended by adding at the end thereof the following:

"(4)(A) The total amount of the reductions imposed under paragraphs (1) and (3) with respect to inpatient hospital services and post-hospital extended care services during a spell of illness and post-hospital home health services during the period after the beginning of that spell of illness and before the beginning of the next spell of illness shall not exceed $750 if such spell of illness begins in calendar year 1975, or the amount determined under subparagraph (B) if such spell of illness begins in calendar year 1976 or any year thereafter, and when such limit is reached no further reductions shall be imposed under paragraph (1) or (3).

"(B) The Secretary shall, during October of 1975, and of each year thereafter, determine and promulgate the limitation on reductions to be applied under subparagraph (A) with respect to spells of illness beginning in the succeeding calendar year. Such limitation shall be computed by increasing or decreasing $750 by the same percentage (rounded to the nearest one-tenth of one percent) by which the representative primary insurance amount exceeds or is less than $393.50. For the purpose of such computation the representative primary insurance amount shall be the primary insurance amount used to determine the amount payable under section 202 for January of the year succeeding the year in which such determination is made to an individual whose primary insurance amount (as determined under section 215(a)(1)(A)) is based on an average monthly wage of $750, taking into account all applicable laws and administrative determinations which have been enacted and promulgated, respectively, at the time of such computation, even if not yet effective. If the limitation derived from such computation is not a multiple of $10, it shall be reduced to the next lower multiple of $10.

"(5) In determining the reductions required under paragraphs (1) and (3), the customary charges of a provider for services furnished an individual, other than the services described in clause (B) of paragraph (1), shall be deemed to be the charges imposed for such services by such provider if such customary charges are greater than the charges imposed."

(d) Section 1861(y) of such Act is amended by striking out paragraph (3) and renumbering paragraph (4) as paragraph (3).

(e) The amendments made by this section shall be effective with respect to spells of illness, as defined in section 1861(a) of the Social Security Act, beginning after February 28, 1975.

REFORM OF MEDICARE SUPPLEMENTARY MEDICAL INSURANCE COINSURANCE

Sec. 7. (a) Section 1833(a) of the Social Security Act is amended to read as follows:

"Sec. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical

Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to--

"(1) in the case of services described in section 1832(a)(1), the reasonable charges for the services reduced by a coinsurance amount equal to 20 percent of such reasonable charges; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization reduced by a coinsurance amount equal to 20 percent of such reasonable cost if the organization undertakes to charge such individuals no more than the amount of any such reduction plus the amount of any reduction under subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician

in the field of radiology or pathology, the amounts paid shall equal the reasonable charges for such services reduced by a coinsurance amount equal to ten percent of the charges imposed for such services (or ten percent of the customary charges for such services if the customary charges for such services are greater than the charges imposed), (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, and (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), and

"(2) in the case of services described in section 1832(a)(2)--

"(A) the lesser of (i) the reasonable cost of such services, as determined under

section 1861(v), or (ii) the customary charges with respect to such services; or

"(B) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2); or

"(C) if such services are services to which the second sentence of section 1861(p) applies, the reasonable charges for such services,

reduced, in the case of home health services, by a coinsurance amount equal to ten percent of the charges imposed for such services (or ten percent of the customary charges for such services if the customary charges for such services are greater than the charges imposed), and, in the case of other services, by a coinsurance amount equal to 20 percent of the amount otherwise payable."

(b) Section 1833(f)(1) of such Act is amended by striking out "the 20 percent coinsurance amount" and inserting "any coinsurance amount" in lieu thereof.

(c) Section 1833 of such Act is further amended by redesignating the second subsection (g) as subsection

(h) and by inserting at the end thereof the following new subsection:

"(i) The total amount of--

"(1) the reductions imposed under subsection (a)(1) (other than clause (C)),

"(2) the reductions imposed under subsection (a)(2) with respect to home health services, and

"(3) the amounts chargeable under section 1866(a)(2)(A)(ii),

with respect to expenses incurred by an individual in any calendar year shall not exceed an amount equal to the amount of the limitation on reductions imposed by section 1813(a)(4) with respect to spells of illness beginning in that calendar year, and when such limit is reached no further reductions shall be imposed under subsection (a) (other than clause (1)(C)) or under the first sentence of subsection (b) with respect to such expenses incurred by such individual in such year. The Secretary shall, during October of 1975 and of each year thereafter, determine and promulgate the limitation on reductions to be applied under paragraph (1) for the succeeding calendar year."

(d) Section 1866(a)(2)(A) is amended to read as follows:

"(2)(A)(i) A provider of services may charge such individual or other person the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1) or (a)(3) with respect to such items and services.

"(ii) A provider may charge such individual or other person the amount of any deduction imposed pursuant to section 1833(b) with respect to such items and services (but such amount may not exceed the amount customarily charged for such items and services by such provider); and may also, except as provided in paragraph (iii), charge such individual or other person an amount equal to 20 percent of the reasonable charges for such items and services for which payment is made under part B (but such amount may not exceed 20 percent of the amount customarily charged for such items and services by such provider), except that such charges may not be imposed to the extent that, pursuant to section 1833(i), payment under part B for such items and services is not reduced by a coinsurance amount.

"(iii) In the case of home health services described in section 1833(a)(2), a provider may charge such individual

or other person the amount of any coinsurance amount imposed pursuant to section 1833(a)(2) with respect to such services."

(e) The amendments made by this section shall be effective with respect to items and services provided after December 31, 1975, for which payment is made under title XVIII of the Social Security Act.

AUTOMATIC ADJUSTMENT OF MEDICARE SUPPLEMENTARY MEDICAL INSURANCE DEDUCTIBLE

Sec. 8. (a) The first sentence of subsection (b) of section 1833 of the Social Security Act is amended by striking out "a deductible of $60" and inserting "a deductible of $60 for calendar year 1975, and the amount determined under paragraph (2) of this subsection for calendar year 1976 and each year thereafter" in lieu thereof.

(b) Subsection (b) of such section is further amended by redesignating clauses (1) and (2) as clauses (A) and (B), respectively, by inserting "(1)" after "(b)", and by inserting at the end thereof the following new paragraph:

"(2) The Secretary shall, during November of 1975 and of each year thereafter, determine and promulgate the deductible to be applied under paragraph (1) of this subsection for the succeeding calendar year. Such deductible shall be computed by increasing or decreasing $60 by the same percentage (rounded to the nearest one-tenth of one

percent) by which the representative primary insurance amount exceeds or is less than $354.50. For the purpose of such computation the representative primary insurance amount shall be the primary insurance amount used to determine the amount payable under section 202 for January of the year succeeding the year in which such determination is made to an individual whose primary insurance amount (as determined under section 215(a)(1)(A)) is based on an average monthly wage of $750, taking into account all applicable laws and administrative determinations which have been enacted and promulgated, respectively, at the time of such computation, even if not yet effective. If the deductible derived from such computation is not a multiple of $1, it shall be reduced to the next lower multiple of $1."

AUTHORITY TO ESTABLISH LIMITS ON RATE OF INCREASE OF COSTS RECOGNIZED AS REASONABLE UNDER MEDICARE PROGRAM

Sec. 9. (a) The third sentence of section 1861(v)(1)(A) of the Social Security Act is amended by inserting "may provide for the establishment of limits on the rate of increase in the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of

items or services to be recognized as reasonable based on estimates of the rate increase in the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title," immediately after "established under this title,".

REDUCTION IN FEDERAL FINANCIAL PARTICIPATION IN STATE SERVICES AND TRAINING EXPENDITURES

Sec. 10. (a)(1) Sections 3(a)(4)(A), 1003(a)(3)(A), 1403(a)(3)(A), and 1603(a)(4)(A) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, Guam, and the Virgin Islands, and sections 403(a)(3)(A) and 603(a)(1)(A) of that Act are each amended by striking out "75 per centum" and inserting "65 per centum" in lieu thereof.

(2) Paragraph (4) of section 3(a) of the Social Services Amendments of 1974 and the amendment to the Social Security Act made by that paragraph are repealed.

(3) Section 403(e) of the Social Security Act is repealed.

(4) The amendments made by paragraphs (1) and (3) of this subsection shall be effective with respect to payments under section 3, 403, 603, 1003, 1403, and 1603 of the Social Security Act for amounts expended during calendar quarters commencing after June 30, 1975.

(b) Section 5 of the Social Services Amendments of 1974 and the amendments to the Social Security Act made by that section are repealed.

(c)(1) Paragraph (3) of section 3(a) of the Social Services Amendments of 1974 and the amendment to the Social Security Act made by that paragraph are repealed.

(2) Section 403(a)(3) of the Social Security Act is amended to read as follows:

"(3) in the case of any State, an amount equal to the sum of the following proportions of the total amounts expended during such quarter as are found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan--

"(A) 65 per centum of so much of such expenditures as are for the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision, and

"(B) one-half the remainder of such expenditures, except that no payment shall be made with respect to amounts expended in connection with the provision of any service described in section 2002(a)(1) of this Act other than services the provision of which is required by section 402(a)(19) to be included in the plan of the State; and"

(3) The amendment made by this subsection shall be effective with respect to payments under section 403 of the Social Security Act for amounts expended during calendar quarters commencing after September 30, 1975, except that the amendment shall not be effective with respect to the Commonwealth of Puerto Rico, the Virgin Islands, or Guam.

(d)(1) Section 2002(a)(1) of the Social Security Act, as amended by the Social Services Amendments of 1974, is amended by --

(A) striking out "90 per centum of the total expenditures during that quarter for the provision of family planning services and 75 per centum" and inserting "65 per centum" in lieu thereof; and

(B) striking out "(including both short- and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions)".

(2) The amendment made by this subsection shall be effective with respect to payments under section 2002 of the Social Security Act for expenditures during calendar quarters commencing after September 30, 1975.

(e)(1) Section 403(a)(3) of the Social Security Act, as in effect with respect to the fifty States and the District of Columbia, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) and (B) and inserting in lieu thereof the following:

"(3) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including expenditures for the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision,".

(2) The amendment made by this subsection shall be effective with respect to payments under section 403 of the Social Security

Act for amounts expended during calendar quarters commencing after September 30, 1976.

(f)(1) Section 2002(a)(1) of the Social Security Act, as amended by the Social Services Amendments of 1974 and subsection (d) of this section, is amended by striking out "65 per centum" and inserting "50 per centum" in lieu thereof.

(2) The amendment made by this subsection shall be effective with respect to payments under section 2002 of the Social Security Act for calendar quarters commencing after September 30, 1976.

(g)(1) Section 3(a)(4) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) through (C) and inserting in lieu thereof the following:

"(4) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including expenditures for--

"(A) services provided, in accordance with the next sentence, to applicants for or recipients of

assistance under the plan, and to individuals requesting such services who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of such assistance, and

"(B) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision."

(2) Section 3(a)(4) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by--

(A) striking out "subparagraphs (A) and (B)" in the matter before subparagraph (D) and inserting "subparagraph (A)" in lieu thereof; and

(B) striking out everything after "the State plan for vocational rehabilitation services so approved." in the matter after subparagraph (E).

(3) Section 3(a) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by striking out subparagraph (5).

(h)(1) Section 403(a)(3) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) and (B) and inserting in lieu thereof the following:

"(3) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including any expenditures for--

"(A) any of the services described in clauses (14) and (15) of section 402(a) which are provided to any child or relative who is receiving aid under the plan, or to any other individual, living in the same home as such relative and child, whose needs are taken into account in making the determination under clause (7) of such section, or to any child or relative who is applying for aid to families with dependent children or who, within such period or periods as the Secretary may prescribe, has been or is likely to become an applicant for or recipient of such aid, and

"(B) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision."

(2) Section 403(a)(3) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by striking out everything after "subparagraphs (C) and (D)." in the matter after subparagraph (D).

(i)(1) Section 1003(a)(3) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) through (C) and inserting in lieu thereof the following:

"(3) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including expenditures for--

"(A) services provided, in accordance with the next sentence, to applicants for or recipients of aid to the blind, and to individuals requesting such

services who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of such aid, and

"(B) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision."

(2) Section 1003(a)(3) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by--

"(A) striking out "subparagraphs (A) and (B)" in the matter before subparagraph (D) and inserting "subparagraph (A)" in lieu thereof; and

"(B) striking out everything after "the State plan for vocational rehabilitation services so approved." in the matter after subparagraph (E).

(3) Section 1003(a) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by striking out subparagraph (4).

(j)(1) Section 1403(a)(3) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, the

Virgin Islands, and Guam, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) through (C) and inserting in lieu thereof the following:

"(3) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including expenditures for--

"(A) services provided, in accordance with the next sentence, to applicants for or recipients of aid to the permanently and totally disabled, and to individuals requesting such services who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of such aid, and

"(B) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision."

(2) Section 1403(a)(3) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by--

(A) striking out "subparagraphs (A) and (B)" in the matter before subparagraph (D) and inserting "subparagraph (A)" in lieu thereof; and

(B) striking out everything after "the State plan for vocational rehabilitation services so approved." in the matter after subparagraph (E).

(3) Section 1403(a) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by striking out subparagraph (4).

(k)(1) Section 1603(a)(4) of the Social Security Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is amended by striking out the matter before subparagraph (A) and subparagraphs (A) through (C) and inserting in lieu thereof the following:

"(4) in the case of any State, an amount equal to 50 per centum of the total amounts expended during such quarter as found necessary by the Secretary of Health, Education, and Welfare for the proper and efficient administration of the State plan, including expenditures for--

"(A) services provided, in accordance with the next sentence, to applicants for or recipients of aid or assistance under the plan, and to individuals

requesting such services who, within such period or periods as the Secretary may prescribe, have been or are likely to become applicants for or recipients of such aid or assistance, and

"(B) the training of personnel employed or preparing for employment by the State agency or by the local agency administering the plan in the political subdivision."

(2) Section 1603(a)(4) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by--

(A) striking out "subparagraphs (A) and (B)" in the matter before subparagraph (D) and inserting "subparagraph (A)" in lieu thereof; and

(B) striking out everything after "the State plan for vocational rehabilitation services so approved." in the matter after subparagraph (E).

(3) Section 1603(a) of that Act, as in effect with respect to the Commonwealth of Puerto Rico, the Virgin Islands, and Guam, is further amended by striking out subparagraph (5).

(ℓ) The amendments made by subsections (g) through (k) shall be effective with respect to payments under sections 3, 403, 1003, 1403, and 1603 of the Social Security Act for amounts expended during quarters commencing after September 30, 1976 .

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

January 31, 1975

Honorable Carl Albert
Speaker of the House of
Representatives
Washington, D. C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is a draft bill, "To amend title XVIII of the Social Security Act to make technical changes in the method of determining the supplementary medical insurance premium."

The provisions of Public Law 93-233, which amended title II of the Social Security Act to advance the effective date of an automatic cost-of-living benefit increase from January of a calendar year to June of the previous year, had the unintended effect of permanently freezing the amount of the supplementary medical insurance (Medicare part B) premium at the July 1974 level.

Under title XVIII of the Social Security Act, I am required to promulgate, in December of each calendar year, the amount of the part B premium to be effective beginning July of the following calendar year. Any increase in the premium amount over the previous year is limited to the smaller of (1) the increase in the monthly actuarial rate for aged part B enrollees, based on estimated expenditures for the coming premium year, or (2) the percentage by which monthly cash benefits--more precisely, a primary insurance amount shown in the benefit table under title II--has increased between June 1 of the year in which the premium is promulgated and June 1 of the year in which the premium is effective. Under the law before enactment of Public Law 93-233, cash benefits were scheduled to be increased under the automatic provisions on January 1 of each calendar year in accordance with a prescribed formula for reflecting cost-of-living increases. The amount of the benefit increase was scheduled to be announced no later than November 1 of the calendar year

preceding the year in which the benefit increase would become effective. Thus, under prior law, the table of benefits which would be in effect for the following June was provided in the law at the time the part B premium was to be promulgated.

Under the law as amended by Public Law 93-233, benefit amounts that will be in effect for June 1 of the year following the year in which a part B premium increase is promulgated will not have been announced and will not be reflected in the benefit table at the time I am required to promulgate the part B premium; the part B premium promulgation must be made in December of a calendar year and the benefit increase that will be effective for June of the following year will not be announced until May of the following year. (Under Public Law 93-233, the promulgation of an automatic benefit increase is required to be made within 45 days after the end of the first calendar quarter of the year in which the increase would become effective.) Therefore, at the time I must promulgate the part B premium that will go into effect on the following July 1, the benefit rate scheduled in the law for June 1 of the following year will be the same as the benefit rate scheduled in the law for June 1 of the year in which the part B premium promulgation is made. The effect of this situation is to permanently freeze the amount of the part B monthly premium at $6.70--the rate for fiscal year 1975.

The intent of the provision in title XVIII is to limit increases in the part B premium to changes in the economic status (as reflected by social security cash benefits) of beneficiaries. There is no indication that the Congress intended that the amendment made in title II would permanently freeze the premium.

The bill would correct this situation by providing that the part B premium determination be made within 45 days after the end of the first calendar quarter of each year, but not before the amount of any cost-of-living increase in title II benefits for that year has been determined. Thus the premium promulgation would generally coincide with the announcement of any automatic cash benefit increase. In order to allow

individuals enrolled under part B to have adequate time to withdraw from the program before the new premium rate goes into effect, the bill would make the new rate effective on October 1 of that year. Should this recommended legislation not be enacted, the monthly rate of $6.70 which was promulgated last December will prevail throughout fiscal year 1976. This will reduce Federal revenues by $64 million and require an additional general revenue appropriation to the Federal Supplementary Medical Insurance Trust Fund.

I urge speedy consideration and enactment of this amendment by the Congress.

The Office of Management and Budget advises that enactment of this legislation would be in accord with the program of the President.

Sincerely,

/s/ Caspar W. Weinberger

Secretary

Enclosure

A B I L L

To amend title XVIII of the Social Security Act to make technical changes in the method of determining the supplementary medical insurance premium.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, That (a) section 1839(c)(1) of the Social Security Act is amended by--

(1) striking out "during December of 1972 and of each year thereafter" and inserting "within forty-five days after the close of the first quarter of each calendar year" in lieu thereof, and

(2) striking out "July 1 in the succeeding year" and inserting "October 1 of that year" in lieu thereof.

(b) Section 1839(c)(2) of that Act is amended by striking out "after June 1973".

(c) Section 1839(c)(3) of that Act is amended by striking out the first sentence and inserting in lieu thereof the following: "The Secretary shall, within forty-five days after the close of the first quarter of each calendar year and in accordance with the succeeding sentence of this paragraph, determine and promulgate the monthly premium applicable for

individuals enrolled under this part for the twelve-month period commencing October 1 of that year. If the first quarter of any calendar year is a cost-of-living computation quarter, as defined in section 215(i)(1)(B), the determination made in that year shall be made only after the resulting cost-of-living increase in benefits under title II has been published in the Federal Register pursuant to section 215(i)(2)(D)."

(d) Section 1839(c)(3)(B) of that Act is amended by--

(1) striking out "in the case of the determination made in December 1971, such rate promulgated under subsection (b)(2)" and inserting "in the case of the determination made in 1975, $6.70"; and

(2) inserting "preceding the year" after "June 1 of the year".

(e) Section 1839(c)(4) is amended by--

(1) striking out "during December of 1972 and of each year thereafter" and inserting "within forty-five days after the close of the first quarter of each calendar year" in lieu thereof; and

(2) striking out "July 1" and inserting "October 1" in lieu thereof.

(f) Section 1839 of that Act is further amended by--

(1) striking out subsections (a) and (b) and redesignating subsections (c), (d), (e), and (f) as subsections (a), (b), (c), and (d) respectively;

(2) striking out "subsection (d)" in subsection (a)(2), as redesignated by clause (1) of this subsection, and inserting "subsection (b)" in lieu thereof;

(3) striking out "subsection (b) or (c)" in subsection (b), as redesignated by clause (1) of this subsection, and inserting "subsection (a)" in lieu thereof; and

(4) striking out "subsection (c)" in subsection (d), as redesignated by clause (1) of this subsection, and inserting "subsection (a)" in lieu thereof.

Sec. 2. The amendments made by this Act shall be effective with respect to monthly premiums of individuals enrolled under part B of title XVIII of the Social Security Act for months after September 1975.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Honorable Carl Albert
Speaker of the House of
Representatives
Washington, D. C. 20515

JAN 30 1975

Dear Mr. Speaker:

Enclosed for the consideration of Congress is a draft bill "To amend the Older Americans Act of 1965 to extend authorizations of appropriations for two years, and for other purposes."

All appropriations authorizations in the Older Americans Act of 1965, with the exception of the authorizations for title VII, expire on June 30, 1975. Our draft bill would provide two-year extensions for most of the expiring authorizations, so that they would expire at the same time as the title VII authorizations. Specifically, it would authorize to be appropriated for each of the fiscal years 1976 and 1977--

$200,000 for the National Information and Resource Clearing House for the Aging,

$91,000,000 for title III area planning, social service, and State planning activities,

$5,000,000 for model projects, and

$7,000,000 for part B, title IV, research and development projects.

The draft bill would allow title V, which provides for grants for the acquisition, alteration, renovation, and initial staffing of multipurpose senior centers, and section 309, which provides for grants for transportation projects, to expire. Since title V and section 309 have never been funded, their funding in fiscal year 1976 would amount to a new program initiative. Allowing title V and

section 309 to expire would be in accord with the President's stated goal of holding the line on new government spending.

Moreover, the Department of Housing and Urban Development has extensive experience and technical competency in the acquisition and renovation of buildings. HUD has authority under the recently enacted Housing and Community Development Act of 1974 to make grants to local communities, which they may use to support construction and renovation of multipurpose senior centers. Continuation of the Department of Health, Education, and Welfare authority under part A, title V, would therefore be duplicative.

The Department of Transportation, under the Urban Mass Transit Act of 1964 and the Federal-Aid Highway Act of 1973, makes grants for the purpose of providing transportation to the elderly and the handicapped. The section 309 authority in the Older Americans Act is duplicative.

The draft bill would allow parts A and C of title IV to expire, since the Administration has never requested funding for these parts.

In addition, the draft bill would give statutory preference in title III programs, as is now given in title VII programs, to low-income, minority, and limited English-speaking individuals. This will serve to emphasize the Administration's policy of directing limited funds to those who need them most.

The draft bill also makes changes of a technical nature to the Older Americans Act.

We urge prompt and favorable consideration of this bill by Congress.

We are advised by the Office of Management and Budget that enactment of this draft bill would be in accord with the program of the President.

Sincerely,

/s/ Caspar W. Weinberger

Secretary

Enclosure

A B I L L

To amend the Older Americans Act of 1965 to extend authorizations of appropriations for two years, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Older Americans Act Amendments of 1975".

Sec. 2. Extension of the National Information and Resource Clearing House for the Aging authorization. Subsection 204(c) of the Act is amended by inserting "; and for the fiscal year ending June 30, 1976, and the following fiscal year, $200,000" after "necessary".

Sec. 3. Extension of area planning and social services program. Subsection 303(a) of the Act is amended by (A) striking out "and" following "June 30, 1974,", and (B) inserting "and $91,000,000 for the fiscal year ending June 30, 1976, and the following fiscal year," after "1975,".

Sec. 4. Preference for services for low-income, racial minority, or limited English-speaking individuals. Clause 304(c)(2) is amended by inserting ", with preference to be given to social services for, and, to the maximum extent feasible, provided by organizations operated by, individuals who are of low income, who are members of a racial minority (including Native Americans), or who are not reasonably fluent in the English language, so as to assure that the volume of services to those individuals are at least in proportion to their numbers within the area" after "plan".

Sec. 5. Extension of model projects authorization. Subsection 308(b) of the Act is amended by inserting "; and $5,000,000 for the fiscal year ending June 30, 1976, and the following fiscal year" after "1975".

Sec. 6. Extension of research authorization. Section 431 of the Act is amended by inserting "; and $7,000,000 for part B of this title for the fiscal year ending June 30, 1976, and the following fiscal year" after "1975".

Sec. 7. Preference for nutrition services for low-income, racial minority, or limited English-speaking individuals. Clause 705(a)(4) of the Act is amended to read as follows:

"(4) provide that preference shall be given in awarding grants or contracts under this title to projects primarily serving, and, to the maximum extent feasible, operated by, individuals who are of low income, who are members of a racial minority (including Native Americans), or who are not reasonably fluent in the English language, so as to assure that the volume of services to those individuals are at least in proportion to their numbers in the State.".

Sec. 8. Extension of time for submitting recommendations. Subsections 205(g) and 205(h) are amended by striking out, in each subsection, "eighteen months after enactment of this Act", and inserting instead "January 1, 1976".

Sec. 9. Technical amendments. (a) The second sentence of subsection 201(a) of the Act is amended to read "The Administration shall be the principal agency for carrying out this Act.".

(b) Section 202 of the Act is amended--

(1) by modifying the heading to read: "FUNCTIONS OF ADMINISTRATION ON AGING",

(2) in clause (8), by striking out the last "and", and

(3) in clause (14), by inserting "in Employment" after "Discrimination".

(c) Subclause 304(a)(2)(B) of the Act is amended by deleting the first comma.

(d) Subsection 305(e) of the Act is amended by striking out, in the last sentence, "Commissioners'" and inserting instead "Commissioner's".

(e) Subsection 307(a) of the Act is amended by striking out the last sentence.

(f) Subclause 308(a)(1)(B) of the Act is amended by striking out "construction of" and inserting instead "of constructing".

(g) Subsection 432(b) of the Act is amended by striking out "part" and inserting instead "title".

(h) The heading of section 703 of the Act is amended to read: "ALLOTMENT OF FUNDS".

(i) Section 705 of the Act is amended--

(1) in clause (a)(2), by striking out "sets", and inserting instead "set", and

(2) in subsection (c), by inserting, in the last sentence, a comma between "failure" and "or".

(j) Section 706 of the Act is amended--

(1) in clause (a)(5), by inserting a comma between "religious requirements" and "or", and

(2) in clause (a)(8), by inserting a comma between "the program" and "and".