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THE JOURNAL OF Long-Term Care Administration

Long-Term Care
Facility Improvement—A Nationwide
Research Effort

Long-Term Care Program
Management—An Intersystem Approach

Nursing Home Administrator Roles:
An Overview



QUALITY
CARE:
MEASURE
OF THE
ADMINISTRATOR

COMMUNICATING
COORDINATING
TEACHING
STUDYING
PLANNING
ADVOCATING
MANAGING
LEADING
POLICY MAKING



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Faye G. Abdellah, R.N., Ed.D., L.L.D., F.A.A.N. and
Rita K. Chow, R.N., Ed.D., F.A.A.N.

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This article is adapted from the presentation at the First North American Symposium on Long-Term Care Administration held July 28 - 30, 1975, in Toronto, Ontario, Canada. Its content provides a basis for the development and implementation of a national strategy for long-term care in the areas of gerontology, mental retardation and developmental disabilities.

Long-Term Care Program Management — An Intersystem Approach

Jonathan M. Metsch, Dr. P.H.

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This paper discusses the manner in which a specific subset of systems concepts, the intersystem model and program management, are applicable to the planning and management of a comprehensive health care program in the long-term care institution.

Winter 1976

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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

Statement by the Assistant Secretary for Long-Term Care
LONG-TERM CARE FACILITY IMPROVEMENT STUDY

Introductory Report

July 1975

The quality of care being provided in the Nation's skilled nursing facilities is a matter of serious concern to a great many individuals, to the health professions, and to agencies of Government. The public registers their indignation and disapproval through the media, through their elected representatives, and through their own actions. This concern is being expressed in a number of ways. It is expressed by the disclosure of serious deficiencies through the media, by the filing of complaints, and by allegations of fraud. The concern of the public is not only the patients themselves but also the taxpayers whose dollars are expected 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 93-502, the Department of Health, Education, and Welfare organized a broad-based study of the quality of care in long-term care facilities. The study is being conducted in a number of ways. A survey of skilled nursing facilities that was conducted in 1974 and 1975 is being completed. The results of this survey will be made available to the public. 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 role and responsibilities of the Department and other agencies and organizations that have a legal or professional responsibility for the care and well-being of 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, the validation visits will be undertaken by the State health departments. The Department's 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, but 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 residents. The Department has placed strong emphasis on the training, certification, 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 widespread attention 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.

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

W. C. Cope, M.D.

LONG-TERM CARE
FACILITY IMPROVEMENT STUDY

Introductory Report

July 1975

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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.

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

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

²U.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.

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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 initiatives. 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 inter-

disciplinary 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 mini-

imum 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 con-

sists 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 sub-

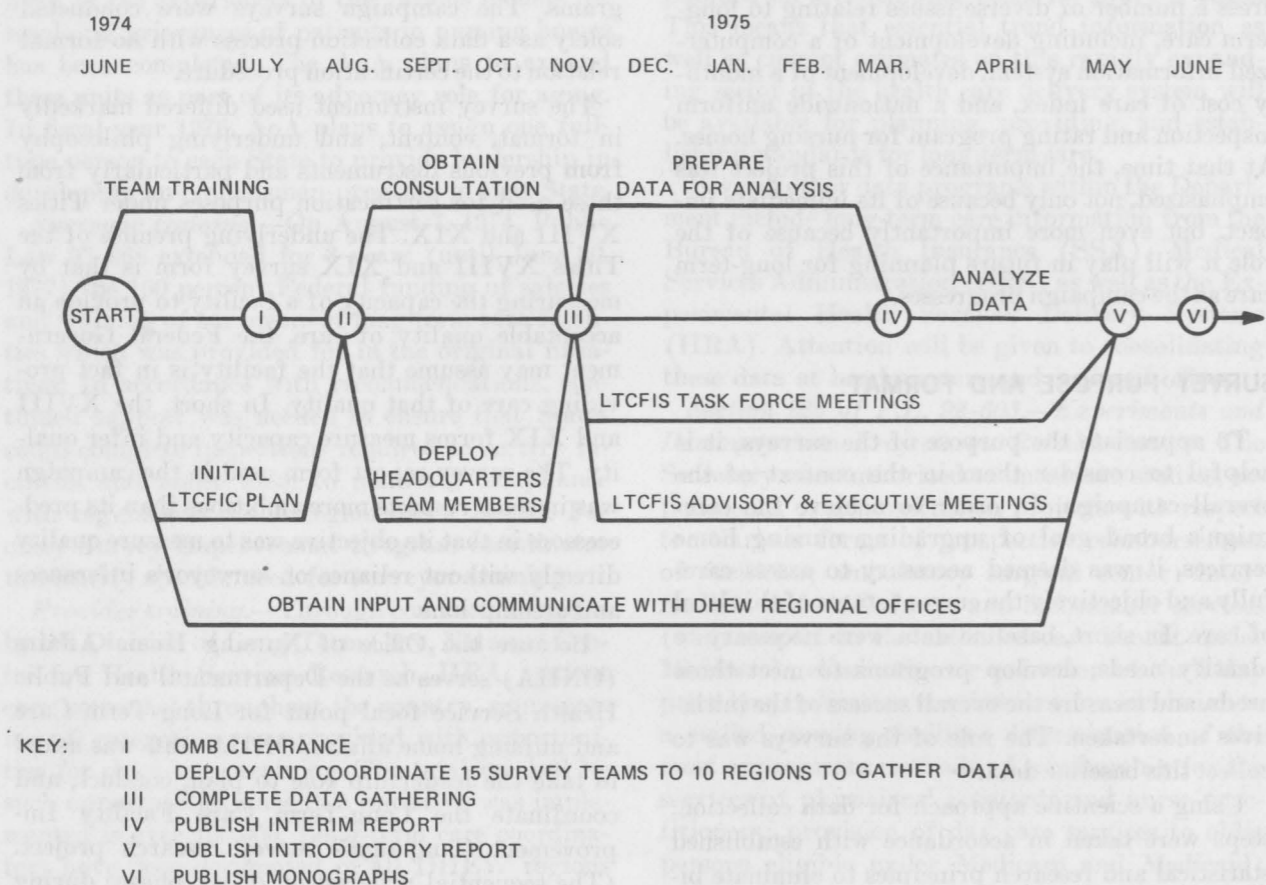


Figure 1

Implementation of LTCFIS Research Plan

jects, such as assessing health care needs in skilled nursing facilities.

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

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Regional Boundaries and Regional Offices

- | | |
|------------------------------|--------------------------------|
| REGION I: BOSTON, MASS. (20) | REGION VI: DALLAS, TEXAS (18) |
| II: NEW YORK, N.Y. (26) | VII: KANSAS CITY, MO. (11) |
| III: PHILADELPHIA, PA. (25) | VIII: DENVER, COLORADO (16) |
| IV: ATLANTA, GEORGIA (29) | IX: SAN FRANCISCO, CALIF. (53) |
| V: CHICAGO, ILLINOIS (70) | X: SEATTLE, WASHINGTON (20) |

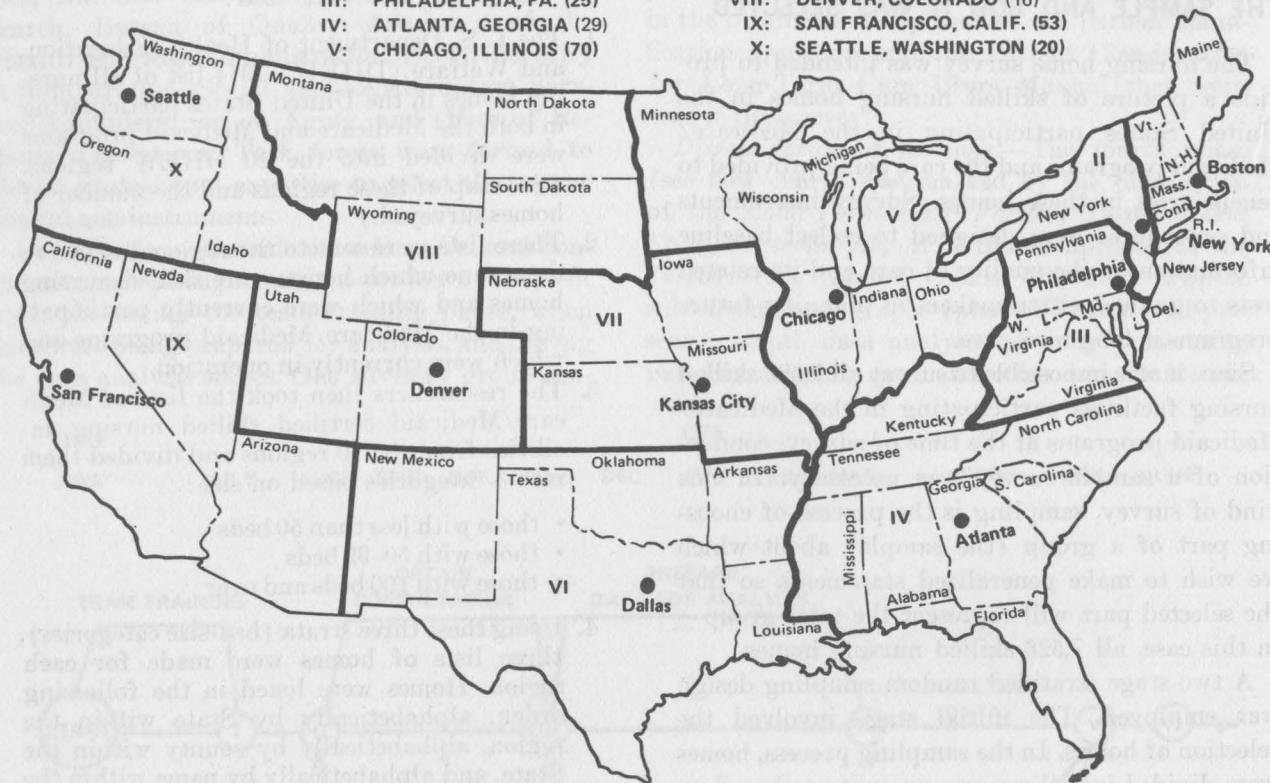


Figure 2

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.

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 $5,352 \pm 214$ 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 $5,352 \pm (2 \times 214)$ 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.

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 .04
No.....	5,352	81.2	
Total.....	6,591	100.0	
Unknown.....	1,301		

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 as-

certained, 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 Serv-

ice 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 SNFs 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:

- The research nature of the survey;
- the assurance that the survey was in no way related to certification surveys for participation in the Medicare/Medicaid program; and
- 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.

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", "mixed up," "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 im-

plementation 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.)

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

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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

¹Katz, 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.

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.

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.

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 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)

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 communicate 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 pur-

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

pose 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

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

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. Dysarthria 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.

PATIENT DIAGNOSES

Diagnosis is a common basis for defining patients' needs for care and in organizing patient

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

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 multivariate 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 hypertension. 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 ⁴	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

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

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.

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 appraises 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



Table 48.—Number and percent of SNFs in which the consultant appraises 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 appraises 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

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

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.

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 non-responsive 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 facility.

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 require-

ments 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.

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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 institution-ization 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 examina-

tion 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

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.—Patients¹ 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.

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.

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).

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

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-

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.

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

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 writ-

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

ten 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.

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

Table 64.—Number and percent of patients receiving drugs by drug category in rank order¹

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
Thyroid 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.

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.

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

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

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.

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-

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 conditions 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 phar-

maceutical 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

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

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 dietitian. 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.)

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 pre-

scribed 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).

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

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 hygienic 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.)

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,-

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

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.

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 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 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
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 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 admission.....	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 de-

scribed 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.

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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

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 con-

sumer 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 poli-

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

cies, 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.

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.

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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 con-

trol 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 _____
Nursing Home Id Number _____
Total SNF Residents in Home: _____ residents
Total SNF Residents in Sample: _____ residents

MFI Bed Size _____
Recode _____

LIST OF SNF RESIDENTS IN THE FACILITY

Sample designation	Name of SNF Resident*	Line No.	Sample designation	Name of SNF Resident*	Line No.
SW _____			SW _____		
TE _____			TE _____		
a	b	c	a	b	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 <u>1</u> TE <u>2</u> a	Name of SNF residents* b	Line No. c	Sample designation SW <u>1</u> TE <u>2</u> a	Name of SNF resident 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 <u>1, 2</u> TE <u>3</u> a	Name of SNF resident b	Line No. c	Sample designation SW <u>1, 2</u> TE <u>3</u> 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,

$$X' = \sum_{h=1}^3 \frac{m_{n'}}{m_h} \sum_{i=1}^{m_h} W_{1hi} X_{hi}$$

where:

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

W_{1hi} = 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.

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.

$m_{n'}$ = 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

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

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:

$$M' = \sum_{h=1}^3 \frac{m_{n'}}{m_h} \sum_{i=1}^{m_h} W_{1hi} X_{hi}$$

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:

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

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

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_{2hi} = 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.

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

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

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

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

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 h^{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

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

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	1	1	0	1	0	0	0
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.



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).

Diagnostic category

ICDA Code

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 pre-

paring 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.

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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 evidenced 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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APPENDIX F

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(1) 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 intermediate 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 State 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

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 accredited 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 be-

comes 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. 315-327, as amended, 79 Stat. 331 (42 U.S.C. 1302, 1395f, 1395k, 1395i, 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 satis-

factorily 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,

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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

35774

RULES AND REGULATIONS

Title 20—Employees' Benefits
CHAPTER III—SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, 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 physician 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

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 sickle 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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*Presbyterian
Long term care*

FACT SHEET

Long-Term Care Facility Improvement Study INTRODUCTORY REPORT

BACKGROUND

On June 21, 1974, the Department of Health, Education, and Welfare announced a campaign to improve long-term patient care in nursing homes. One of the projects in this campaign was a survey of skilled nursing facilities. The survey asked three basic questions: Who are the patients? How are nursing homes managed? How good is patient care?

THE SURVEY

Designed cooperatively by several government organizations and consultants from leading universities, the survey was conducted by teams of specially trained experts. Each team consisted of a physician, a nurse, an administrator, a nutritionist, a pharmacist, a physical therapist, a fire safety engineer, and a social worker.

To insure statistical reliability, the nursing homes surveyed were chosen proportionally from ten regional lists. Homes and patients in them were selected by random sampling techniques. All visits were unannounced.

The survey covered 288 homes -- enough to provide a reliable sample of all skilled nursing facilities. The survey data were processed according to approved statistical techniques. The result is a valid, comprehensive picture of long-term nursing home care.

THE FINDINGS

A complete report of the survey findings (Long-Term Care Facility Improvement Study: Introductory Report) contains three broad sections: PATIENT CHARACTERISTICS, FACILITY MANAGEMENT, and PATIENT CARE. Another section presents recommendations for NEEDED ACTION.

PATIENT CHARACTERISTICS

WHO ARE THE PATIENTS?

They are old: the median age is 82, and 50% are over 80. 73% are women; 90% are Caucasian. 87% are single (mostly widowed). 52% completed grade school; 16% graduated from high school; 4% finished college.

They are retired, or have never worked (95%). 60% were formerly skilled, semi-skilled, or clerical workers; farmers; or housewives. 8% were in professional or managerial positions. At present, 68% have less than \$3,000 annual income from all sources, and 22% have no income at all.

IN WHAT DAILY ACTIVITIES DO PATIENTS NEED HELP?

They cannot bathe without difficulty: 60% need some help, and 33% more cannot bathe themselves at all. 72% require help in dressing. 34% need some help in

**U.S. DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE**

Public Health Service
Office of Nursing Home Affairs

Single copies of the full document, **Long-Term Care Facility Improvement Study: Introductory Report**, may be obtained from the *Office of Nursing Home Affairs, 5600 Fishers Lane, Room 17B07, Rockville, Md. 20852.*

eating, and 16% must be fed by others. 45% must be helped in using the toilet; 29% cannot use it at all. 50% experience some degree of incontinence -- from occasional to total. 87% are not fully ambulatory; 9% suffer pressure sores because of reduced ability to move in bed.

WHAT OTHER IMPAIRMENTS HAVE THEY?

Impaired vision is suffered by 68%; 3% more are legally blind. 33% have at least some hearing loss. 32% have some degree of speech impairment. 92% are missing some or all natural teeth, and 38% lack compensating restorations or dentures. 54% show some confusion as to time, place, or their own identity (27% occasionally and 27% continuously). 41% display inappropriate behavior -- typically wandering or disruptiveness.

WHAT ARE THEIR MEDICAL CONDITIONS?

Patients' commonest primary and secondary diagnoses when admitted to skilled nursing facilities are: heart disease, 38%; chronic brain disease, 29%; generalized arteriosclerosis and hypertension, 23%; diseases of the musculo-skeletal system, 20%; stroke, 18%; fractures, 16%; neurological disease, 15%.

FACILITY MANAGEMENT

HOW ARE POLICIES MADE AND IMPLEMENTED?

In 16% of the facilities, the governing bodies (responsible for overall policy) meet less frequently than their by-laws require, and 50% keep inadequate minutes

or none at all. 29% of facility administrators are not so-designated in writing by their governing bodies.

Administrative policies are made and revised as needed in 80% of cases. Physicians and nurses contribute to patient care policy planning 98% of the time, but other specialists are consulted less often: pharmacists, 64% of the time; dietitians, 55%; therapists, 43%.

WHAT ARE STAFF EMPLOYMENT PRACTICES?

Written job descriptions are not provided to prospective employees in 26% of cases. 35% of facilities do not require pre-employment health examinations. 22% do not verify the registration or license numbers of professional staff upon hiring them, and 20% do not re-check these numbers periodically. 32% do not maintain employee health records.

HOW DO FACILITIES UPGRADE STAFF SKILLS?

Staff development programs are completely lacking in 20% of facilities. Where they do exist, these programs are often incomplete: 22% of the facilities do not provide an orientation program; 22% do not offer skills training; 37% do not provide an ongoing education program; and 66% have no leadership training program for supervisory personnel. Staff members do not apply the training they receive 26% of the time.

HOW DO FACILITIES MANAGE THEIR FINANCES?

The survey was unable to determine this, partly because there is no uniformity of accounting procedures.

HOW WELL ARE FIRE CODES MET?

At least one fire safety deficiency was found in 96% of all facilities (though in 69%, there are fewer than 10 deficiencies). The points most commonly found deficient are: properly illuminated exit signs, 52%; weekly testing of alarm system, 49%; enforcement of smoking regulations, 37%; fire protection of hazardous areas, 33%; electrical monitoring of main sprinkler valve, 31%.

PATIENT CARE

WHAT PHYSICIAN SERVICES ARE PROVIDED?

Of the patients who have been in a nursing home less than four months, 90% are reviewed by a physician at least every 30 days. For long-term patients, the proportion reviewed monthly by a physician drops to 75%. Of the physicians who review their cases monthly, 90% actually see their patients and 80% examine the overall care plans.

HOW RELIABLE ARE PHARMACEUTICAL SERVICES?

Pharmacists are not able to work directly from a physician's written drug order 76% of the time. 28% of the time, physicians do not confirm their drug orders in writing within a two-day period.

Drugs are administered only by licensed personnel 93% of the time. Pharmacists make at least monthly reviews of patients' overall drug profiles in 68% of cases. 69% of facilities do not have separate rooms for drug storage. Controlled drugs are properly inventoried in 79% of all facilities.

HOW ARE PATIENTS' NUTRITIONAL NEEDS MET?

Most facilities have the services of a dietician (part-time, in 90% of all cases). Dietitians spend anywhere from half a day to 20 days at a facility each month. Dietetic service supervisors are also retained: 60% part-time. In 29% of facilities, too few nutrition staff are on duty in any 12-hour period to permit preparation of meals immediately prior to serving. 60% of all patients' overall care plans lack dietary information.

More than 14 hours between major meals is allowed by 20% of facilities. 28% do not offer an appropriate snack at bedtime. 73% of patients who reject half or more of a meal are not offered an appropriate substitute. 19% of patients who need help in feeding themselves do not receive it promptly at each meal. 34% who need mechanical devices to help them eat do not receive them.

WHAT EFFORTS AT REHABILITATION ARE MADE?

Of the patients who need physical therapy 31% receive it; 11% of those needing occupational therapy get it; and 11% who could benefit from speech therapy get it.

Skilled physical therapists are retained by 72% of all facilities. 40% retain occupational therapists, and 32% have speech therapists. Of facilities offering physical therapy, 56% have it at least daily and 29% offer it 2 or 3 times a week. For 33% of patients undergoing therapy, there is no written therapy plan. And 84% of patient records do not contain baseline data for use in determining therapy needs.

HOW ARE SOCIAL AND PSYCHOLOGICAL NEEDS MET?

The proportion of facilities employing staff for social work is 49% (26% full-time). 62% of the time, patients' psychosocial needs are evaluated as part of the admitting process. In those facilities with social work staff, 70% of patients have written plans for psychosocial care. Family counseling is carried on 66% of the time.

In 72% of all facilities, social activities programs are conducted by qualified staff (working part-time in 28% of cases). About 50% of medical records note patients' needs for activities and their responses to them. 75% of all facilities have space available for activities, and 71% have equipment available.

NEEDED ACTION

Several clear needs for action emerge from the survey findings. These needs include:

A total review of the survey/certification process.

Nationwide training and certification of all state surveyors.

A complete analysis of the entire fiscal approach to reimbursement for services provided.

Alternatives to institutional care, such as home health care and day care.



Department of
Health, Education, and Welfare
Washington, D.C. 20201

LONG TERM
CARE

Sarah -

Date:

Per request. If you have questions

The attached may be of interest to you. please call:

Trena Schuelby
WH. 57450

Room 5448 North
330 Independence Avenue, S.W.
Telephone: (202) 245-7450

Frank E. Samuel, Jr.
Deputy Assistant Secretary
for Legislation (Health)



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

*Sent to OMB for clearance 11/20/75
not cleared as of 12/5*

The Honorable Al Ullman
Chairman, Committee on
Ways and Means
House of Representatives
Washington, D.C. 20515

DRAFT OF PROPOSED REPORT

Dear Mr. Chairman:

This is in response to your request of February 19, 1975, for a report on H.R. 2268 and your request of October 29, 1975, for a report on H.R. 9607, identical bills "To amend title XVIII of the Social Security Act to establish a program of long-term care services within the Medicare program, to provide for the creation of community long-term care centers and State long-term care agencies as part of a new administrative structure for the organization and delivery of long-term care services, to provide a significant role for persons eligible for long-term care benefits in the administration of the program, and for other purposes."

We are greatly concerned about the serious problem of financing and providing access to adequate long-term care for the elderly and disabled. However, we are opposed to enactment of the bills because Medicare is not the appropriate vehicle for financing long-term care.

The bills would establish under Medicare a voluntary program of long-term care benefits for aged and disabled individuals. This program would be financed from premiums paid by those who enroll in the program and Federal and State general revenue funds. The bills would also provide for establishment of community long-term care centers throughout the country, and State long-term care agencies to coordinate and arrange for the organization and delivery of long-term care services.

Long-term care necessarily includes a high proportion of social services and income support. The Medicare health insurance mechanism, which is designed to provide protection against unexpected costs of short-term acute illness, is not easily adaptable to these long-term and less medically oriented types of care and support. Moreover, many of the types of benefits proposed in the bills are similar to those services currently included in Medicaid and the social services programs (titles XIX and XX of the Social Security Act). The additional cost of adding these long-term care benefits to Medicare would be \$5 to \$10 billion in the first year.



In addition to our general objections to the bills, we are particularly troubled by one of their specific provisions. Under the bills, a person's social security cash benefits would be reduced by two-thirds beginning with the seventh consecutive month he receives institutional services as an inpatient, or foster home care for which payment is provided under the proposed new long-term care services program, apparently because he would not need as much in the way of social security benefits. This reduction in cash benefits would go contrary to the basic purpose of the social security program--to replace, in part, earnings from work that are lost when a worker retires in old age, becomes disabled, or dies. The amount of a person's benefits is not based on his or her individual need at a given time or under given circumstances, but is, instead, based on the average monthly earnings the person had in work covered under the social security program. The enactment of a provision that would reduce a person's monthly social security benefit because his living costs are being met through other means would, we believe, set an undesirable precedent for relating social security benefits to individual need or personal circumstances.

We therefore recommend that the bills not be favorably considered.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Secretary



FOR RELEASE ONLY UPON DELIVERY
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT
OF
PETER FRANKLIN
SPECIAL ASSISTANT TO THE SECRETARY
BEFORE THE
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
SELECT COMMITTEE ON AGING
U.S. HOUSE OF REPRESENTATIVES

WEDNESDAY, NOVEMBER 19, 1975



MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to appear before you today to review with you the Department's efforts in an important part of our health care system--home health care and related services for the elderly.

As you know, the Federal government will invest over \$17 billion for the financing and direct provision of hospital and medical services for the aged in 1976. During FY 1975, Medicare payments for services to the elderly amounted to \$13.9 billion; and the Federal share for the elderly under the Medicaid program was \$2.4 billion. These FY 1975 figures do not include expenditures by the Department for other health services for the elderly rendered by Community Health Centers, Community Mental Health Centers, Health Maintenance Organizations, Vocational Rehabilitation and Developmentally Disabled programs, or the National Health Service Corps. And these FY 1975 figures do not include expenditures for research and development programs directly related to the health and well-being of the elderly. For example, the proposed budget for the National Institute on Aging of the National Institutes of Health is over \$16.2 million for FY 1976.

The Subcommittee has requested that we focus our remarks today on three specific areas of interest: home health services for the elderly, health clinics for the elderly, and multi-purpose centers for the elderly. After I review the first two topics with you, Dr. Arthur Fleming, Commissioner of the Administration on Aging, will discuss the multi-purpose centers.

Home Health Care

The Department of Health, Education, and Welfare encourages the development of an access to home health services through the efforts of several programs. These several programs have attempted to be catalysts for community development of effective home health care mechanisms. The health financing activities have sought to provide financial access to Federal beneficiaries in need of services that can be provided by home health agencies. The human resource programs have encouraged the integration of home health services with other services for the ill, elderly, and poor.

Additionally, the Office of Nursing Home Affairs chairs an Interagency Task Force on home health services. This Task Force includes representation from the Public Health Service, the Social Security Administration, the Social and Rehabilitation Service, the Administration on Aging and the

Office of the Secretary. It is through this group that the Office of Nursing Home Affairs coordinates all the Department's home health services activities.

The Task Force was specifically asked to develop a plan that would provide for increased Federal participation in both the utilization and reimbursement of home health services for Medicare and Medicaid recipients, and to show ways that would be available to develop, expand, and improve home health services. Since January, Interagency efforts have produced tangible results, all of which respond to recommendations by the GAO.

For example:

- The staff has reviewed State Medicaid programs, and we will, for the first time, know what population is being served and what kinds of services are in fact provided and covered by reimbursements. This analysis will clearly define the extent of the current programs.
- Proposed new home health regulations, which I will discuss later, have been published this year.
- SSA staff has carried out a careful study of Medicare guidelines and fiscal intermediary practices and is now preparing a report that will provide a background to Interagency discussions for revision of these guidelines where needed.

Today, when our nation's medical care system is producing an unprecedented escalation of cost, there is a great need to foster use of more economical approaches to the delivery of health care to American people, and especially to our older population. Home health care is one such approach. Properly run home health care programs have demonstrated an ability to expand the capacity of a delivery system by providing needed care while conserving some forms of scarce and costly resources, both institutional and professional. The appropriate use of home health care services can also have a restraining influence on overall medical care costs. It is also possible, however, that use of home health services may add more services to the medical care system and increase costs. At this point, it is not possible to draw firm conclusions from the evidence on the cost effectiveness of home health services.

Home health services cannot and should not be looked upon as a replacement for medical care that must be delivered in an institutional setting. Rather, home health care should be viewed as a component of a comprehensive health care delivery system--an alternative for treatment and medical support for those who do not need institutional care. Obviously, there are

times when institutional care is essential, just as there are times when home health care is more appropriate. Ideally, the aim should be a balanced system, enabling patients to continue participation in home and community life as long as possible, and the availability of an institutional care setting when that is necessary or desirable. We are unable to say, however, to what extent this type of system is now available to Americans or to estimate its costs and benefits.

For the past four years, the Department has been undergoing an extensive review of the broad spectrum of long-term care, with a view to developing a comprehensive approach to provision of adequate long-term care services for persons of all ages. Home health service is an integral part of this review.

Mr. Chairman, in the hearing before your Subcommittee and the Senate Subcommittee on Long-Term Care on October 28, Departmental witnesses testified on HEW's programs which are designed to develop home health services as a more effective resource for health care delivery.



I would like to review briefly the Department's involvement with home health care, through the Public Health Service, the Social Security Administration, and the Social and Rehabilitation Service.

Public Health Service

Since 1796, health professionals have been deeply involved in overseeing both the program organization and development of medical services in the home, and in supervising quality control to ensure appropriate and effective patient care. For the past two decades, the Public Health Service has supported the concept of home care as that phase of comprehensive medical care that provides medical, nursing, social and other services as well as ancillary services to the patient who requires intermittent care in the home.

Even after enactment of Medicare and Medicaid to finance home health services to the aged and the poor, the Public Health Service continued efforts to promote, develop and expand home health services through organizing workshops and conferences, stimulating non-governmental involvement in sponsorship, by distribution of literature, development of technical assistance materials and data, and by conducting and funding research and development projects.

In January of this year the Secretary reaffirmed the Public Health Service as the lead agency for coordinating and monitoring the implementation of the Department's short-term home health care improvement efforts. This responsibility has been assigned to the Office of Nursing Home Affairs.

We recognize that home health services, when prescribed by a physician and when properly monitored, offer an effective alternative to long-term care for some patients. Nevertheless, we do not believe that it is either necessary or desirable for the Federal government to undertake a new narrow categorical grant program for home health agencies such as that authorized in recent legislation. There already are over 2,000 certified home health agencies participating under Medicare and Medicaid programs. These Medicaid and Medicare services have expended rapidly in recent years and will continue to do so due to several proposed changes which I will be explaining later in my testimony. Moreover, reimbursement from these programs will be available to finance services by new home health agencies to program beneficiaries.

Medicare

Home health services for the aged and disabled are an important component of the coverage provided under the Medicare program, which is administered by the Social Security

Administration. Under Medicare, home health benefits were designed primarily to meet specific, medically-related, home care needs of patients who do not require the round-the-clock care or supervision by a registered nurse that is available in hospitals and skilled nursing facilities. Such patients nevertheless suffer from conditions of such severity that they are confined to their homes under the care of a physician and are in need of either skilled nursing care on an intermittent basis, or physical therapy or speech pathology.

As of July 9, 1975, there were 2,123 home health agencies participating in the Medicare program. In order to participate, these agencies must meet prescribed standards relating to qualifications of personnel providing services and to maintenance of appropriate records and other conditions deemed necessary to protect the health and safety of beneficiaries. For fiscal year 1972, home health expenditures amounted to \$59 million. Home health benefit payments increased to \$110 million for fiscal year 1974 and are estimated to reach \$185 million in FY 1977.

The Social Security Amendments enacted in 1972 contain several provisions which may significantly affect the structure of Medicare home health benefits in the future.

Under Section 222 of the Social Security Amendments (P.L. 92-603), the Department is funding research and demonstration projects using, when medically appropriate, certain day care and homemaker services as alternative options to institutionalization in hospitals and skilled nursing facilities. Through these experiments we hope to determine whether such coverage would provide quality and effectively lower long-range costs by reducing the demand for higher cost institutional care. We also hope to ascertain the costs of providing various types and groupings of alternative services and to evaluate alternative eligibility regulations.

The 1972 Amendments should also improve overall administration of home health benefits in that we are authorized to establish in advance specific minimum numbers of home health visits, under Part A, which a patient would be presumed to require following hospitalization. On July 9, 1975, the implementing regulations were promulgated for a 30-day public comment period (later extended) and drew a large number of responses. I would like to re-emphasize that the limits set forth in these regulations are only guaranteed minimums and that other services and additional periods of coverage may be approved and reimbursed. Implementation of this authority should reduce uncertainty on the part

of physicians and patients as to whether or not home health care services would be covered, thereby encouraging prompt discharge from institutional care to the home care setting.

Another significant new regulation was proposed in the June 9 Federal Register which would greatly expand the ability of home health agencies to provide a large range of services by allowing such agencies to contract with a proprietary provider of home health services.

A further change in the rules governing proprietary home health care providers has been included as part of the Administration's proposed "Social Security Amendments of 1975," transmitted to the Congress as draft legislation. Section 302 of this proposal would repeal the requirement that proprietary agencies be licensed under State law and subject them to the same licensure requirements as public and private nonprofit agencies. In this way we hope to increase the number of participating home health agencies and make home health services more accessible.

A number of bills have been introduced in the House which would expand the scope of the Medicare home health benefit. Most, such as H.R. 4772, introduced by Representative Koch, seek to encourage the use of home health services by making these services available to patients who require less intensive treatment and by providing an expanded number of home health visits

and services to beneficiaries. We share the concerns of the sponsors of this and similar legislation that the costs of hospital and other institutional services are high and could be reduced in part by the substitution of appropriate high quality home health services. We would caution, however, that such substitutions can be effective only if they are professionally controlled to prevent misutilization.

Nevertheless, we are opposed to such legislation because there is inadequate justification for making such changes at this time.

We are hopeful that the results of the experiments now underway under Section 222 will provide a basis for identifying additional, more definitive research which will provide a sound basis for any proposed changes in the present home health benefit package.

Medicaid

As you know, Title XIX, known as Medicaid, is administered by the Medical Services Administration of the Social and Rehabilitation Services. It provides Federal matching payments for State expenditures for health care for the poor. States participating in the program must generally provide payment for specified types of medical assistance to recipients of cash assistance--poor persons aged 65 and over, low-income blind and disabled individuals and poor families with dependent children. In addition, States may extend their programs to cover the medically needy--those persons who have incomes above the cash assistance eligibility levels but whose income is insufficient to pay for medical care.

The Medicaid program devotes over \$5 billion, or 38 percent of its expenditures, to the area of long-term care. Almost all of these funds are for institutional care. Over one million Medicaid recipients spent some time this year in a nursing home, mental or tuberculosis hospital as a long-term care patient.

As I stated before, we recognize that hospital and nursing home care are essential elements of a continuum of care; however, so too are suitable alternatives, such as a viable home care program, for Medicaid patients who can be maintained in their own homes.

Although home health services are mandatory under Medicaid, it has been recognized for some time that clarification of existing home health regulations was necessary in order that the service be adequately implemented by the States as a mechanism of non-institutional care.

On August 21, the Department published proposed regulations which clarified mandatory and optional home health services and recipient eligibility. The proposed regulations also would expand the number of qualified providers capable of delivering home health services. Although the 30-day comment period was scheduled to close September 20, that date was extended to October 7 because of the quantity and quality of comments received. We have received well over 1,000 comments and we are presently analyzing them in order to prepare final regulations.

Dr. Keith Weikel, Commissioner of the Medicaid program, discussed the proposed regulations in detail before your Subcommittee on October 28. However, I would like to state again that the intent of the regulations to implement the law and permit the use of home health care where such care is appropriate and determined by a physician to be necessary. Moreover, the regulations clarify and define services that were mandated by Congress.

In summary, the proposed regulations:

- (1) Clarify which home health services are required and which are optional with States. The States must provide nursing services (RN or LPN as appropriate), home health aide services, and medical supplies, equipment and appliances suitable for home use. They may, at their option, provide physical, occupational, or speech therapy. Any service, whether required or optional, must first be found necessary by the patient's physician and must be included in a written plan of care developed by the

physician and home health agency personnel, and reviewed by him as the patient's condition requires. This revision will assure that all States will reimburse a basic package, and at the same time encourage expansion of coverage of other optional services.

- (2) Clarify which recipients are eligible. Some States have limited home health care to those who need "skilled" care or those either leaving or about to enter institutions. No such limitation appears either in statute or regulation, and it should not, since many persons need some home care to maintain or recover their health in order to avoid institutionalization. They should receive home care before they reach the crisis point of institutionalization.

The revised regulation clearly repeats the statutory requirement that all "categorically needy" persons age 21 or over must receive home health services when determined necessary by the physician (the categorically needy are generally those eligible for cash payments under SSI or AFDC). The revision also clarifies that certain groups chosen by the State to be eligible for nursing home care must also be eligible for home health services, and that the State may provide home care to all Medicaid eligibles if it wishes to do so. This clarification expands the population eligible for coverage.

(3) Expand the types of agencies which may participate under Medicaid, in addition to those certified under Medicare. Under the proposed expansion, agencies offering the single service of either nursing or home health aide services as well as proprietary agencies may be certified for Medicaid if they meet certain prescribed Federal standards. These changes are intended to make home health services more available to Medicaid recipients and thus in future years decrease the need for institutional services under Medicaid. The proposed standards for such agencies parallel those for the Medicare program wherever possible.

The objection to single-service agencies is that they may provide only fragmented care for patients who need multiple services. We do not think this concern is valid, since in all cases a registered nurse must make an initial home evaluation visit and must supervise the care given by home health aides. This will provide coordination of care and guard against fragmentation of services. Allowing single-service agencies of this type to participate will overcome the current lack of care for recipients who need only one service provided in a community and who live in neighborhoods where multi-service agencies do not exist.

We realize that there is potential for abuse of the program by both proprietary and non-proprietary providers of home health care services, just as there is potential for fraud and abuse by proprietary and non-proprietary providers of all types of services. As you know, the Commissioner of the Medical Services Administration has made the fraud and abuse surveillance effort one of his highest priorities. It is the Department's intention, to include home health within this effort.

We believe the proposed regulatory changes will be instrumental in expanding access to home health care for Medicaid recipients. However, as we stated on October 28, the regulations are not final. We are in the process of reviewing the many comments received.

On November 17, the Department held a major meeting with members of proprietary and non-proprietary home health service agencies, consumer groups and staff from State program and licensing agencies to discuss the proposed changes in Medicaid regulations. The major issues were removal of the restrictions on provision of home health services by proprietary agencies, the feasibility of strong State and Federal monitoring of providers and inclusion of provider offering only a single service.

A number of valuable concepts and ideas were offered which the Department will take into consideration in developing final regulations.

Another provision of H.R. 4772, introduced by Representative Koch, would make home health services available to all Medicaid recipients, both medically and categorically needy, without regard to the recipient's entitlement to skilled nursing services. At present, home health services are required to be provided to all categorically needy individuals 21 years of age or over, to all categorically needy individuals under 21 years of age if the State provides skilled nursing facility services for such individuals and to all corresponding groups of medically needy individuals for whom skilled nursing services are provided.

As noted earlier, the proposed regulations would clarify the entitlement of the categorically needy to home health services, without regard to their need for skilled care. However, we oppose mandating the expansion of these services to individuals other than those currently entitled.

There are other objectionable provisions in H.R. 4772. For example, rent payments under the Medicaid program. The Department will submit a report on the bill shortly.

Mr. Chairman, I would like to discuss briefly health clinics for the elderly and then proceed with Dr. Fleming's presentation on multi-purpose centers.

Outpatient Clinics for the Elderly

Your letter of invitation to participate in this hearing also mentioned the need for "outpatient clinics designed specifically to meet the medical needs of the elderly." While we are aware that the elderly need care on an outpatient basis, we would be opposed to establishment of clinics whose sole purpose would be to treat the elderly.

The Department believes that health care for the elderly should be provided through existing health care delivery systems serving the general population. It has been the Department's philosophy to avoid segregating the aged from the mainstream of society, but instead to integrate their involvement with all age groups. We believe one of the most detrimental attitudes that can be expressed by society is to treat the aged separately, thereby creating a new minority segment of our population. However, we recognize the fact that aged people do have problems peculiar to their age group. We are concerned that those who provide treatment to older people are fully oriented to the nature and scope of their problems and that they are prepared to treat them with the most effective methods known.



The aged have more health care needs than any other population group within our society. This Administration, as have past Administrations, recognizes this need and seeks, therefore, to provide the aged an adequate number of entry points into the health care system so that they readily may secure adequate primary care services. If, as with other population groups, there are needs which must be handled by a medical specialist, then the primary care physician would refer the person to the appropriate medical specialty. To establish separate clinics to treat all the medical needs of the older patients, generally, would be wasteful and duplicative. The Department is continuing to follow the policies and approaches which have been developed since the passage of Medicare which are: (1) to provide financial resources to assist the elderly in purchasing their own medical care; (2) to allow the elderly citizen freedom of choice in choosing a physician; and to promote and preserve the physician-patient relationship. To have the Federal government as a general policy promote and establish out-patient clinics for the elderly through new categorical program authorities would not contribute to the welfare of the aged nor would it make effective use of the health service delivery capacity which now exists.

Mr. Chairman, I would like to turn to Dr. Flemming for a discussion of multi-purpose centers for the elderly and then we would be pleased to answer any questions the Committee has.

MEMORANDUM

file - long term care
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : Sarah Massengale
Special Assistant to the President

DATE: OCT 29 1975

FROM : Director, Division of Policy Development
Office of Nursing Home Affairs

SUBJECT: Re: Provider/Consumer Meeting of October 14

As we discussed a few days ago, I am enclosing a copy of the paper Dr. Carl Adams presented at our Provider/Consumer Symposium on Patient Assessment. The full agenda is also enclosed to give you an idea of how the subject was handled from the Federal Government, provider and consumer points of view. Dr. Abdellah's notes are also attached.

Dr. Adams' paper is evidence of how the industry is giving full support to this concept. It deals with how his chain of nursing homes is using patient assessment as a management tool toward improving patient care. Dr. Abdellah, in her remarks, stressed ONHA's and HEW's concern that patient assessment also become a viable tool in the survey and certification process. The ongoing cooperative project in Region IV brings these two interests together.

We are planning to edit all papers from the October symposium and make it a part of the monograph we are preparing now on Patient Assessment as it pertains to the Nursing Home Improvement Survey. We will be happy to send you the completed document as soon as it is available.

Claire Ryder
Claire F. Ryder, M.D., M.P.H.

Enclosure

OFFICE OF NURSING HOME AFFAIRS
PUBLIC HEALTH SERVICE
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

A G E N D A

SYMPOSIUM ON PATIENT ASSESSMENT:
AN ESSENTIAL FACTOR IN IMPROVING QUALITY OF CARE

Tuesday, October 14, 1975
1:00 PM to 4:00 PM
Snow Room, HEW North

- 1:00 - Welcome and Introductory Remarks
Peter Franklin, M.Ed., M.B.A.
Special Assistant to the Secretary

Moderator - Claire F. Ryder, M.D., M.P.H.
- 1:15 - Faye G. Abdellah, Ed.D., LL.D.
"Patient Assessment: Vantage Point Federal Role"
- 1:45 - Joan Quinn, R.N., M.S.N.
"Patient Assessment: Vantage Point Researcher"
- 2:15 - Carl E. Adams, M.D.
"Patient Assessment: Vantage Point Provider"
- 2:45 - Coffee Break
- 3:00 - Iris Schneider, M.A.
"Patient Assessment: Vantage Point Consumer"
- 3:30 - Questions and Answers
- 4:00 - Adjournment

* * * * *

Secretary David Mathews hopes to join us at some point during the program as his schedule permits.



"PATIENT ASSESSMENT AND THE PROVIDER"

October, 1975

Carl E. Adams, M.D.
Chairman, Medical Advisory Committee
American Health Care Association
Washington, D.C.

Chairman of the Board
National Health Corporation
Murfreesboro, Tennessee



PATIENT ASSESSMENT AND THE PROVIDER

Patient assessment, as used, is the summarization of the patient's identifying and population characteristics (social demography); the diagnoses and/or conditions; the functioning status as to physical, mental and psychosocial; the medical care, health care and social care needs; the services rendered, the treatments given and the outcomes.

The idea of patient assessment is not new. For many years patient assessments have been done in one way or another, perhaps for as long as there have been patients and Health Care or Medical Care Practitioners. The use of a broad base of information and uniformity is new in long-term care patient assessment.

The items to be discussed are methodology or the process of doing the patient assessment, its use in the quality assurance program and its use as an aid in management. It becomes apparent that quality assurance and good management are practically synonymous and that the one follows the other.

METHODOLOGY

The patient assessment is done on admission, continued stay, with change of level of care, discharge or death.

The essential tools for doing patient assessment are:

1. A dictionary of definitions of terms, descriptors and identifiers used
(The Denson - Jones User's Manual)
2. An abstract form
(There are many different forms in process of development.)
3. A procedure manual with instructions for completing the specific abstract form

It is important that the person or persons completing the abstract and responsible for its correctness and accuracy be knowledgeable in its use. This

personnel may include the physician advisor or medical director, the director of nurses, charge nurse, coordinator, or other persons knowledgeable and capable in its use. The in-house social worker is a possible resource person.

The abstract form is in duplicate. The original is retained by the facility and placed in the patient's medical record. The duplicate (NCR copy) is sent for data processing. The time consumed in completing the initial abstracts is about 15 minutes. Subsequent abstracts require 3-4 minutes each.

The abstract is completed in a uniform manner at the indicated time. On arrival at the data processing point the completed abstract is audited, edited and a detail listing of the abstract material is printed out in code form. The detail listing is the data base for all future printouts.

The printouts from the detail listing include, but are not limited to the patient assessment, profiles, and other profiles as special groups of patients, special types of care, facility and practitioner profiles. The facility summary, other summaries including special groups as company (corporate), area, state, regional, national, and a condensed summary of comparative statistics of critical items are available. Level of care summaries, as skilled and intermediate, may be done. These printouts constitute the tools gained from patient assessment for use as aids in evaluating patient care and management efficiency.

QUALITY ASSURANCE

This is the foundation for the justification of patient assessment.

Quality assurance includes in its envelope the assurance that:

1. The patient needs the care, that is, medical necessity exists
2. The care needed is being given
3. The care is being given in the most appropriate setting as regards quality and cost.

The use of the patient assessment facilitates the review of the patient in the entirety and aids in the evaluation of the patient in many ways.

Staff

The Coordinator has use of the assessments and profiles when doing admission certification or preparing for utilization review. A review of the patient's status can be more readily evaluated and decisions made with more uniformity as to the need for recertification or review.

The Physician has an aid for use in reviewing the patient's problems, conditions, status and the services, treatments and medications. Changes in the patient's condition are noted; the drug review and profile helps to monitor the medications.

The Director of Nurses has available a complete set of profiles of all of the patients in the facility for use in checking or discussing any patient or group of patients. These profiles are updated monthly. Changes in a patient's condition may be noted and attention given. The profiles do not replace making rounds and visiting patients, but they do help in identifying needs and areas of concern. Indications may be noted for the moving of patients to areas with different staffing or for implementing involvement of the patient in particular programs of activity or rehabilitation.

The Patient Care Plan is more complete and comprehensive as a result of having the patient assessment and patient profile for a point of reference. Also the nursing assessment history blends with the patient profile and the patient care plan.

All of the department heads and the staff may use the profiles and summaries in a manner similar to what has been described, with adaptation to their individual or special needs.

Improvement of efficiency and functioning of the staff is noted with implementation of the patient assessment program. There is an improvement in the attitude and objectivity of the staff. A meaning comes into the charting and the efforts of the

staff. Accuracy and completeness come to have a new meaning as it is recognized that the information is being seen and used by others. The staff personnel become better aware of each patient's condition and treatments. The completion of the abstracts and the patient profile printouts on all patients in a uniform and orderly manner gives a better base for comparison and evaluation. Social service, activities, rehabilitation and dietary departments can each find their work made easier and more comprehensive. The medical records area is greatly improved.

The patient assessment is oriented toward identifying the conditions and problems confronting the patient and the treatments being given.

The improvement in charting, recording and accurate coding make the diagnostic index and the cross-referencing possible and more meaningful.

The coding of accidents and incidents, the recording of decubiti and the origin of their occurrence, as well as the progress of the condition, the uniform definition of restraints and the incidence of use all bring the items into focus and give a basis for comparison that evaluations may be arrived at for recognition of achievement or that attention may be given to correction of problems.

The facility summary calls attention to the use of different services and the percentage participation of the patients in relation to the incidence of problems or conditions.

Further identification is made by noting the diagnostic summary and the individual patient profile or assessment which can be readily identified for study and/or evaluation. Frequency and type of social visitations are noted. Patients' psychosocial problems or needs are recognized. Drugs as to types or kinds and numbers of medications are identified. The time saved in retrieving information is material.

Utilization Review

There is increased organized information available for use in the different components of evaluation as in:

Concurrent Review

1. Admission Certification has the diagnosis, needs and conditions of the patient identified on the completed abstract form. This form is replaced in the medical record by the patient profile printout. The admission assessment and profile may become a permanent part of the medical record for documentary evidence and remains as a constant for future reference. Also a copy of the assessment may be sent to the state agency for verification of the reasons for the need for admission.

2. Continued Stay Review

The profile may be used to evaluate the need for recertification and to evaluate the services, treatments and medications in relation to the diagnosis, problems and conditions. Any change in the patient's condition since admission or last review is noted, as are changes in treatments. The required level of care is compared to the source of payment for evaluation of the propriety of the care and the need for continued stay.

3. Discharge Planning

- a) The patient may be followed in sequential manner as to problems, conditions and required services, treatments and medications.
- b) The coordinator, social worker, director of nurses, physician and Utilization Review Committee are better able to evaluate and make decisions with the use of the patient profile.
- c) The information is available to all in a uniform manner.

The patient profile saves a great deal of time by virtue of it not being necessary to gather and write information on forms, as the information is already in an organized arrangement on the profile.

The profile indicates many things including diagnosis, problems, conditions, treatments, medications, as well as the frequency of physician visits and the incidence of consultations. Outcomes and discharge destination are noted, in addition to admission source, age and length of stay.

Medical Audit (Medical Care Evaluation Studies)

The profiles of groups of patients as to diagnosis, problems, or conditions, services rendered, treatments given or medications, length of stay, age, required level of care, source of payment, etc., all lend themselves for use in evaluating the care given to the patients.

From the facility summary can be noted the percentages of different problems and treatments as tube feeding, multiple injections, the participation in physical therapy and the outcomes are noted as related to frequency of treatments and indications for giving the therapy. Frequency and types of social visitations are noted. Patients' psychosocial problems or needs are recognized. Medications as to number and kinds are identified. Drug review indicates frequency of errors, reactions, interactions, allergies, toxicities, etc.

Physician visits as to frequency and type are identified and with the physician's code number the physician profile can be developed.

Medical care evaluation and studies have the bulk of the source material collected, assimilated, organized and tabulated for use in doing evaluations and studies or for making decisions. Problems are identified and the mechanics are provided for gathering the data needed for the study regarding the quality of the basic care of all of the patients; groups of patients by diagnosis, procedures, services, treatments or medications. Educational needs may be recognized and correct programs implemented.

Profiles are developed for the:

1. Consumer
 - a. Patient - (individual)
 - b. Population group, as the types and kinds of patients of a given facility, community, area, state, etc.
2. Provider
 - a. Physician - as to types or kinds of patients, practices regarding admission or care, treatments and other characteristics as regards quality of care and cost.
 - b. Other practitioners - as physical therapists, dietitians, social service workers, activity directors, etc.
 - c. Institutional - types and kinds of patients, services offered, and amount of participation in, treatments given and outcomes.
3. Modalities of Care
 - a. Drug services
 - b. Rehabilitative departments
 - c. Nursing care
 - d. Dietary departments
 - e. Medical records
 - f. Others

The committees, such as the pharmaceutical services, infection and medical records all find the material and information useful in evaluation and decision making. Research becomes a feasible and effective method as new innovative programs and ideas can be tried and evaluated.

The items mentioned in the foregoing are but a few of the many that may be identified with a few minutes of effort, study and evaluation.

Through the documentation in permanent form as a part of the medical record patient assessment lends itself to being capable of being monitored as to accuracy and validity by either in-house or external methods. The assessments, profiles and summaries include the information necessary for PSRO and can be modified to adapt to the changing needs.

The collected material provides a data base for use in the development of norms, standards and criteria and gives information for evaluation of differences in individual localities and regions.

MANAGEMENT

Management finds many uses for the patient assessment and its profiles and summaries.

The Administrator has available a current printout of the patient profiles, the other profiles, and the summaries. The patient profiles are a source for ready reference concerning the different medical, health and social aspects of the patient. It becomes easy to keep in touch with the welfare and condition of the patients. It is no longer necessary to go to the nurses station or the director of nurses, etc. for each bit of information. The profiles and summaries offer information as to the types and kinds of patients, their ages, number and kinds of problems, frequency and kinds of diagnoses, the services, treatments and medications. This information offers a method for monitoring the required level of care, the payment source, the discharge planning and its adequacy. Better information is available as to why certain patients remain in the facility. Discussions with families and others can be carried on with more clarity and depth of understanding.

By doing patient assessment at the time of admission proper level of care determinations may be made, compliance requirements may be met and unnecessary admissions may be avoided.

The Administrator and the Staff can use the profiles and summaries in interdepartmental meetings for evaluation and determination of adequacy of staffing.

The percentage patient participation in the different programs of activities, rehabilitation and training give an index as to the adequacy of the staff, available equipment and allocated floor space. Study of the problems or impairments indicate the need or lack of need for personnel in the respective areas.

A study of the incidents and accidents gives an alert as to hazards, type of care, medication problems, as tranquilizers, smoking or flammable agents, or laxness in supervision of patient activities. At the same time excellence of care may be noted for example, by seeing a smaller number of accidents.

Performance Evaluation

This becomes a practical matter of using critical items and looking at numbers and percentages in a realistic manner. The participation of the patients, the treatments given, the services rendered and the outcomes are seen by management in relation to hours of labor per patient day and the allocation of the labor as to areas or departments. Nursing stations may be compared to one another. Characteristic patterns of personnel behavior will develop.

The Governing or Corporate body find the assessments, profiles and summaries of value in evaluating the patient care and the efficiency and adequacy of the operation.

Comparisons may be made between different facilities in the same corporate structure or in other groups.

Cost Determinations

The services provided, the types and kinds of patients cared for and the outcomes are seen in a more accurate and valid relation in comparison to cost.

Health Service Areas have information available as to needs, supply of types of personnel and physical facilities and numbers of patients receiving or needing care and their diagnosis, problems, treatments, etc. The population area from which

the patients come may be identified through use of the zip code number. There is available information for use in determining need for and the present available services.

Health Care Insurors (Proprietary and Non-Proprietary)

Health care insurors are provided a method of evaluation of patients in long-term care facilities, as to age, diagnosis, conditions, length of stay, procedures, treatments, medications and outcomes as to risk and cost. Sources of payment as self-pay, government programs and private insurance coverage, etc., and the relative percentages of each are identified.

This information has previously been available for Medicare Skilled Patients; however, no valid information has been available for Medicaid Skilled, Medicaid Intermediate Care, private pay or those covered under the various health care plans other than Blue Cross.

Public Relations

The information is available to properly inform the public, the consumer groups and families or friends of patients.

Statements in the media and those made by critical agencies may be properly handled and when true the acknowledgement can be made and information given as to what is being done to remedy, improve or correct the situation.

In summary patient assessment is a valuable, if not indispensable, tool for use in any program of quality assurance. The information gathered is essential regardless of the method used. It is important to continue to concentrate on important and critical items and to discard the unimportant items as they are found to be unnecessary. Patient assessment, utilization review and self-assessment are critical and necessary components in the totality of giving better patient care.

Many peer review groups, state and national survey agencies find considerable help in evaluating the area of patient care through the use of the assessments, profiles and summaries.

The utilization review and indeed the entire facility and its performance can be monitored by the PSRO, the state agency and HEW through the use of the assessment information.

Management has a bottom line opportunity to use patient assessment for quality assurance and managerial improvement as to proper allocation of labor and costs with accurate and valid information as to the adequacy of each. Just as financial statements show the results of financial management, the patient assessment gives the information for the evaluation of the patient care and effectiveness of the management system.

The patient assessments, profiles and summaries provide an opportunity for dialogue of a constructive nature between the provider, consumer, government and intermediaries.

List of Illustrations

- # 1 -- Abstract Form
- # 2 -- Abstract Detail (Detail Listing)
- # 3 -- Patient Profile
- # 4 -- Facility Summary (Extracts)
(2 pages)
- # 5 -- Diagnosis Summary (Extract)
- # 6 -- Condensed Summary (Critical Items)



I BASIC DATA

MEDICAL RECORD #	PHYSICIAN CODE	ABSTRACT TYPE & DATE	SEX & BIRTH DATE	AGE	RAC	M	L	ZIP	REL A-I	E U	QCC WORK I-O	PAYMENT SOURCES	TRANSF DEST	L P C S
21	18001	3 8/31/75	2 2/05/81	94	1	2	2	37130	1		2	1 07	5 1107	2 4
42*	18001	1 8/09/75	1 6/18/81	94	1	2	3	37130	1	1	5 3	01	1 1996	2 5
42	18001	3 8/31/75	1 6/18/81	94	1	2	3	37130	1	1	5 3	01	1 1996	2 5
86	18003	3 8/31/75	2 11/14/06	68	1	2	1	37130	1		3 6	01	1 1996	2 3
245	18001	3 8/31/75	2 8/28/90	85	1	2	3	37130	1	1	2 1	07	1 1996	2 4

II DIAGNOSIS AND MAJOR COMPLAINT

MEDICAL RECORD #	PRIM LOS DIAG	DX A LOS	DX B	DX C	DX D	VITAL TPRS	HGT	INCID & LOS	DEATH CAUSE	PHY-VISIT TYPE FREQ	L C	PMT SRC	DAYS NSF
21	820.2 999	713.0 999				41111		2		1 6	2	07	3180
42*	09.9 30	437.9 30	309.9			11111		2			2	01	
42	09.9 30	437.9 30	309.9			11111		2		1 6	2	01	22
86	344.2	F707.0				11111		2		1 5	2	01	2202
245	820. 999	342. 999				11111		1		1 6	2	07	1347

III PROBLEM IDENTIFICATION

MEDICAL RECORD #	MOBILITY NHELP	B C B	SENSES-- IMP.	EXPRS LOSS	MEN FEELS	BEH	HABIT I A C	CONFR T A B	EXP	SOCIAL S M F P	ACTIVIT A R C R	DEATH CAUSE	L C	PMT SRC	DAYS NSF
21	247 68	1 1	36	1	1	2	5 5 2	2 2 2	1	2 5 3 4	3 3 4 1		2	07	3180
42*	4 5678	1 1	16	7	2	1	5 5 3		1				2	01	
42	4 5678	1 1	16	7	2	1	5 5 3	2 2 2	1	5 6 6 6	4 4 4 4		2	01	22
86	2467 0	5 3	6	1	1	1	5 4 4	3 2 2	1	3 6 4 1	3 3 4 3		2	01	2202
245	4 2678	3 3	2	6	1	3	5 5 4	3 3 3	1	1 6 3 4	2 3 3 2		2	07	1347

-IV EVALUATION POTENTIAL-- -V REHAB. SERVICE-- -VI CONSULTATIONS-- -VII PHYSICIAN VISITS--

MEDICAL RECORD #	PROJECT TYP LOS	REHAB PUT C	TYPES	FREQ	RESULT	TYPES	FREQ	TYPE	FREQ	DEATH CAUSE	L C	PMT SRC	DAYS NSF
21	3 999	3 2						1	6		2	07	3180
42*	1 999	3 2									2	01	
42	3 999	3 2						1	6		2	01	22
86	3 999	2 2	4	2	2			1	5		2	01	2202
245	3 999	3 2						1	6		2	07	1347

VIII SPECIAL TREATMENTS & SERVICE

MEDICAL RECORD #	SPECIAL TREATMENT	SERVICES LAB X/RAY TESTS	MEDICATIONS	DEATH CAUSE	L C	PMT SRC	DAYS NSF
21			15 06 20 10		2	07	3180
42*			15 20 01 03 18		2	01	
42	02	950	15 20 01 03 18		2	01	22
86					2	01	2202
245			05 01 20 18 10		2	07	1347

ILLUSTRATION # 2 (Detail Listing)



PHYSICIAN CODE- 25001 DATE OF BIRTH 9/19/90 AGE- 84 SEX-F RACE-WHITE
 PROVIDER NBR. - 7440147 ADMISSION DATE 12/03/74 ADMISSION SOURCE-NURS. HOME
 MEDICAL RECORD- 358 DISCHARGE DATE / / TRANSFER DESTIN.-
 ADM. DIAG. 820. - FRACTURE OF NECK OF FEMUR

OCCUPATION -HOUSE WF MARITAL STATUS-WIDOWED
 WORK STATUS-NEVER WK RELIGION-PROTESTANT
 EDUCATION -GRAN.SCH ZIP CODE- 37211
 LIVING ARNG-INSTITUTION

	ADMISSION	04/30/75	05/31/75	06/30/75		ADMISSION	04/30/75	05/31/75	06/30/75
LEVEL OF CARE	ICF	ICF	ICF	ICF	REHAB TYPE	NONE	P.T.	P.T.	P.T.
SOURCE PYMNT	MED.ICF	MED.ICF	MED.ICF	MED.ICF					
PRIMARY DX	820.	820.	820.	820.					
FRACTURE OF NECK OF FEMUR									
OTHER DX	998.5	998.5	998.5	998.5					
	599.0	599.0	599.0	599.0	REHAB FREQUENCY	NONE	DAILY	DAILY	DAILY
	795.	795.	795.	795.					
INC. ACCID.	NO	NO	NO	NO					
SELF CARE	NO	NO	NO	NO					
MOBIL - HELP	BEDFAST				REHAB RESULTS		MOD IMPV	MOD IMPV	MOD IMPV
	EAT-FEED								
	BATHING	BATHING	BATHING	BATHING					
		TOILET	TOILET	TOILET					
		TRANSFER	TRANSFER	TRANSFER					
BLADDER	CATH/NHO	CONT.	OC.INC.	OC.INC.	CONSULT TYPE				
BOWEL	OC.INC.	CONT.	OC.INC.	OC.INC.					
SENSES - IMP.									
		HEARING							
	SWALLOW				PHYSICIAN VISIT	ROUTINE	ROUTINE	ROUTINE	
	MOVING	MOVING	MOVING	MOVING	FREQUENCY	EVERY 60	EVERY 60	EVERY 60	
SENSES - LOSS					SP. TREATMENTS	IRRIGATN		DEC.CARE	STER.DR.
						DEC.CARE			
EXP. FEELING	RESTLESS	UNCOMFT	CONTENT	CONTENT					
	UNCOMFT								
					LAB				OTHER
MENTAL STATE	OC/DISOR	OC/DISOR	CLEAR	CLEAR					
BEHAVIOR	FREQ/INA	OCC/INAP	APPROPR	APPROPRI					
HABITS TOB.	NONE	NEVER	NEVER	NEVER	X-RAY				
ALC.	NONE	NEVER	NEVER	NEVER					
COF.	NONE	NONE	NONE	NONE					
CONF. FAC. ST.									
TIME		AVERAGE	AVERAGE	AVERAGE	TESTS				
AREA		POOR	AVERAGE	AVERAGE					
BEHAVIOR		AVERAGE	AVERAGE	AVERAGE					
EXP. NEEDS	VERBALLY	VERBALLY	VERBALLY	VERBALLY	MEDICATIONS	CARDIAC	TRANQUZR	TRANQUZR	TRANQUZR
SOCIAL CONTACT						DIURETIC	CARDIAC	CARDIAC	CARDIAC
SPOUSE-CHD		MONTHLY	MONTHLY	MONTHLY			DIURETIC	DIURETIC	DIURETIC
MINISTER		NEVER	NEVER	NEVER			VIT/IRON	VIT/IRON	VIT/IRON
FRIENDS-OT.		NEVER	MONTHLY	MONTHLY					
MAIL-PHONE		NEVER	INFREQ	INFREQ					
ACTIVITIES		NONE	SLIGHT	SLIGHT					
RELIGION		NONE	SLIGHT	SLIGHT					
ARTS CRAFTS		NONE	NONE	NONE					
RESTORATIVE		NONE	MODERATE	MODERATE					
REHAB POTENTIAL	SLIGHT	SLIGHT	MODERATE	SLIGHT					
PROJ. L.O.S.	EXTENDED	EXTENDED	EXTENDED	EXTENDED	PATIENT STATUS	PAR.REHB	STATION.	STATION.	STATION.
TEMP.					DEATH DIAG				
PULSE.									
RESP.									
SYSTOLIC									
DIASTOLIC									
WT. INDEX									

ILLUSTRATION # 3 Patient Profile

COMBINED CARE ITEM	ADMISSIONS		LEVEL OF CARE		CONT. STAY		DISCHARGES		DEATHS	
	NUM.	%	NUM.	%	NUM.	%	NUM.	%	NUM.	%
-SEX-										
MALE	4	33			18	22	1	13	1	100
FEMALE	8	67			65	78	7	88		
TOTAL PATIENTS	12	100			83	100	8	100	1	100
-RACE AND ETHNIC ORIGIN-										
WHITE	11	92			75	90	7	88	1	100
BLACK	1	8			8	10	1	13		
MEXICAN										
PUERTO RICAN										
RED										
YELLOW										
OTHER										
-AGE DISTRIBUTION-										
UNDER 60					5	6				
60-64	1	8			4	5	2	25		
65-69					2	2				
70-74	3	25			8	10	2	25		
75-79	4	33			21	25	1	13		
80-84	2	17			17	20			1	100
85-89	1	8			20	24	2	25		
90-94	1	8			6	7	1	13		
95-99					1	1				
100 AND OVER										
AVERAGE AGE	77				78		75		83	
-MARITAL STATUS-										
SINGLE					4	5				
MARRIED	2	17			17	20	2	25	1	100
SEPARATED										
DIVORCED					2	2				
WIDOWED	10	83			60	72	6	75		
UNKNOWN										
-OCCUPATION CLASS-										
PROFESSIONAL	3	25			4	5				
WHITE COLLAR					7	8				
BLUE COLLAR	1	8			3	4	1	13		
LABORER	2	17			15	18	1	13	1	100
HOUSEWIFE	6	50			50	60	6	75		
OTHER					3	4				
UNKNOWN					1	1				
-WORK STATUS-										
WORKING FULL TIME	1	8			7	8	1	13		
WORKING PART TIME	1	8			1	1				
SICK LEAVE										
RETIRED WITH PENSION	3	25			9	11			1	100
RETIRED WITHGUT PENSION	2	17			21	25	2	25		
NEVER WORKED	5	42			48	58	4	50		
UNKNOWN					3	4	1	13		
-PRIMARY SOURCE OF PAYMENT-										
SELF PAY	6	50			25	30	3	38	1	100
BLUE CROSS										
MEDICARE	1	8			4	5				
MEDICAID SKILLED										
MEDICAID ICF	5	42			54	65	5	63		
VETERANS										
CHAMPUS										
WORKMENS COMPENSATION										
CHARITY										
OTHER										
NO PAYMENT										
-LEVEL OF CARE-										
SKILLED					4	5			1	100
ICF	12	100			79	95	8	100		
ICF - M.R.										
SPECIAL THERAPY										
PERSONAL/CUSTODIAL										
ROOM RESERVED										
HOME HEALTH SERVICE										
RESIDENTIAL										

ILLUSTRATION # 4 Facility Summary (2 pages)
Extracts to give examples of information available.



COMBINED CARE ITEM	ADMISSIONS		LEVEL OF CARE		CONT. STAY		DISCHARGES		DEATHS	
	NUM.	%	NUM.	%	NUM.	%	NUM.	%	NUM.	%
-TRANSFER DEST., DISCHARGES ONLY-										
HOSPITAL							3	38		
PSYCHIATRIC FACILITY										
HOME							4	50		
ORGANIZED HOME CARE										
FOSTER HOME										
NURSING HOME							1	13		
COUNTY HOME										
CUSTODIAL										
OTHER										
-NUMBER OF DIAGNOSES-										
ONE	4	33			20	24	2	25		
TWO	2	17			27	33	4	50	1	100
THREE	3	25			20	24	1	13		
FOUR	3	25			11	13	1	13		
FIVE AND ABOVE					5	6				
-INCIDENTS & ACCIDENTS-										
YES					4	5				
NONE	12	100			79	95	8	100	1	100
-MOBILITY STATUS WITH NO HELP-										
SELF CARE	1	8			2	2				
WHEELCHAIR					4	5				
BED-FAST										
EATING-FEEDING	9	75			73	88	7	88		
WALKING	1	8			15	18	1	13		
BATHING					5	6				
TOILETING					18	22	1	13		
TRANSFER					16	19				
-MOBILITY STATUS WITH HELP-										
SELF CARE										
WHEELCHAIR					9	11	1	13		
BED-FAST					1	1				
EATING-FEEDING	2	17			9	11	1	13	1	100
WALKING	10	83			45	54	5	63	1	100
BATHING	11	92			75	90	8	100	1	100
TOILETING	11	92			55	66	6	75	1	100
TRANSFER	8	67			55	66	8	100		
-DECUBITUS PROBLEM-										
HAD WHEN ADMITTED					1	1	1	13		
DEVELOPED DURING NSF STAY					2	2				
NO PROBLEM	12	100			80	96	7	88	1	100
-SPECIAL TREATMENTS-										
DECUBITUS CARE					1	1				
IV/TUBE FEEDING					4	5	1	13	1	100
TRACH. CARE										
SUCTIONING					1	1				
THER. DIET					1	1				
SPEC. OSTOMY CARE					1	1				
STERILE DRESSINGS					1	1				
RESTRAINTS										
DRUG REGULATION										
MULTIPLE INJECTIONS					3	4				
IRRIGATIONS	1	8			4	5				
O2 THERAPY					1	1				
FLU VACCINE										
NO SPECIAL TREATMENTS	11	92			73	88	7	88		
-MEDICATIONS-										
TRANQUILIZERS	6	50			44	53	5	63		
HYPNOTICS	2	17			26	31	2	25		
ANTIBIOTICS	4	33			13	16	1	13		
CHEMOTHERAPY										
VASODILATORS					20	24	1	13		
ANTI-HYPERTENSIVES					14	17				
CARDIAC DRUGS	7	58			27	33	3	38		
ANTICOGULANTS										
NARCOTICS					4	5				
PAIN RELIEVERS	6	50			43	52	4	50		
STEROIDS					8	10				
INSULIN	2	17			3	4	1	13		
ANTI-DIABETICS					3	4				
DURETICS	1	8			19	23	2	25		
VITAMINS	2	17			20	24	1	13		
2 MEDS SAME RX EFFECT					3	4				
HORMONES					7	8				
OTHER	7	58			38	46	2	25		
ERROR										
LAXATIVES	9	75			46	55	3	38		
NONE	1	8			2	2			1	100
-PATIENT STATUS-										
WELL										
MAXIMUM REHABILITATION					1	1				
PARTIAL REHABILITATION	2	17			12	14	1	13		
STATIONARY	7	58			61	73	6	75		
DETERIORATING	3	25			9	11	1	13		
EXPIRED WITH AUTOPSY										
EXPIRED WITHOUT AUTOPSY									1	100
CORONER										

118255

LONG TERM CARE PROGRAM
SKILLED CARE DISCHARGED ALIVE

DIAGNOSES REPORT

TN# 7440147

APR-JUN 1975

PAGE 16

PRIM DIAG	SECONDARY DIAGNOSES				MEDICAL RECORD #	AGE	LOS	I	STAT	-PROBLEM IDENTIF-										LC PRIM VA PAYMT LR SOURCE E									
	DX A	DX B	DX C	DX D						D	M	E	B	I	B	B	S	M	P		U	A	A	O	L	O	E	E	L
713 82.1					411	83	37	1	4	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	14		02 07 18	1 SELF
82.5					418	71	25	1	3	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	14		07 10	1 SELF
162 162.1 492.	MALIGNANT NEOPLASH OF TRACHEA, BRONCHUS & LUNG				440	58	6	5	5	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	1		02 10 12	01 02 05 09 18	1 SELF
401 401. 438.0	ESSENTIAL BENIGN HYPERTENSION				424	81	20	4	3	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	14	05	02 07 06 03	1 M/CARE
427 427.0 412.9 Y10.0 919.1	SYMPTOMATIC HEART DISEASE				447	79	17	5	5	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1		10 12	02 06 07 18	1 M/CARE
438 438.	OTHER & ILL-DEFINED CEREBROVASCULAR DISEASE				435	72	12	1	4	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	14		05 07 02 14 18	1 M/CARE

118193

LONG TERM CARE PROGRAM
SKILLED CARE DISCHARGED ALIVE

TN# 7440147

83-BFDS 32-SK 51-INT

APR-JUN 1975

PG 16

COUNT	HR#	MOBILITY	EATING FEEDING	BATHING	TOILET	BLADDER	BOWEL	SPECL SENSES	MENTAL	PSYCHO SOCIAL	LOS	PAYMENT SOURCE	LEVEL CARE	TRANSFER DEST.	
1	435	1		1	1						12	MEDICARE	SKILLED	HOME	
	411	1		1	1					1	37	SELF PAY	SKILLED	HOME	
	418	1		1	1					1	25	SELF PAY	SKILLED	HOME	
	424	1		1	1					1	20	MEDICARE	SKILLED	NURS HM	
3															
1	447	1	1	1						1	17	MEDICARE	SKILLED	HOSPITAL	
1	440	1	1	1	1					1	6	SELF PAY	SKILLED	HOSPITAL	
6	TOT PATIENTS														
TOT PAYS & %		#	%	#	%	#	%	#	%	#	%	#	%	#	%
PROBLEM TYPE		6	100	2	33	6	100	5	83					5	83
PROBLEM GROUP		NONE		ONE		TWO		THREE		FOUR		FIVE		SIX	
TOT PAYS & %								1	17	4	67	1	17		

ILLUSTRATION # 5 Diagnosis Summary (Discharged Alive
Done on Admission, Continued Stay, Discharged Alive, and Death

CRITICAL ITEMS REPORT

JUNE, 1975

PG. 1

PROVIDER NO. - 7440147

	FACILITY			COMPANY			STATE			REGIONAL			NATIONAL		
	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb
BED CAPACITY			83			2438			1439			2468			2541
Avg. Daily Census			80			2310			1418			2341			2413
% Occupancy			96			95			99			95			95
# ADMISSIONS	5	22	27	96	150	246	32	126	158	96	154	250	96	158	251
# DISCHARGES	3	10	13	52	144	196	14	113	127	52	141	193	52	144	195
# DEATHS		3	3	30	23	53	7	19	26	30	22	52	30	23	53
TOTAL PATIENTS	11	86	97	758	1788	2546	85	1432	1517	760	1768	2528	760	1843	2603
AVERAGE AGE	73	80	79	78	77	77	75	78	76	78	77	77	78	77	77
% SEX - Male	36	20	22	30	30	30	24	30	30	30	30	30	30	30	30
Female	64	80	78	70	70	70	76	70	70	70	70	70	70	70	70
RACE - White	91	92	92	91	92	91	92	92	92	91	92	91	91	92	91
Black	9	8	8	9	8	8	7	7	7	9	8	8	9	8	8
Other				1			1			1			1		
PRIMARY SOURCE OF PAYMENT															
Self	36	28	29	13	28	24	15	31	30	13	28	24	13	28	23
Medicare	55	2	8	32	3	11	56	2	5	32	3	12	32	3	11
Medicaid Skilled				47	2	15	9	1	1	47	2	15	47	2	15
Medicaid ICF	9	69	62	3	63	45	15	61	58	3	63	45	3	63	46
All Other	1	1	1	4	4	4	3	4	4	4	4	4	4	4	4
REQUIRED LEVEL OF CARE															
Skilled	100		11	100		30	100		6	100		30	100		29
ICF		99	88		91	64		92	87		91	64		91	65
Personal/Custodial					1			1			1			1	
All Other		1	1		8	6		7	7		8	6		8	6
ADMISSION SOURCE															
Hospital	100	59	67	82	61	69	93	64	72	82	61	69	82	61	69
Home		23	19		13	21		5	25		13	21		13	17
Nursing Home		18	15		3	17		3	8		3	17		3	12
All Other					2	2		0	1		2	0		2	2
TRANSFER DESTINATION (Discharge Only)															
Hospital	67		15	56	46	48	50	45	46	56	45	48	56	46	48
Home		33	80		19	35		31	37		19	35		19	31
Nursing Home			20		23	16		18	17		23	16		23	18
All Other					2	3		3	1		2	3		2	3

CRITICAL ITEMS REPORT

JUNE, 1975

PG. 2

PROVIDER NO. - 7440147

	FACILITY			COMPANY			STATE			REGIONAL			NATIONAL		
	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb
INCIDENTS & ACCIDENTS	1	1	2	3	3	3	1	2	2	2	3	3	2	3	3
SELF CARE	2	2	4	15	12	12	2	12	11	4	14	11	4	15	12
ADL															
Help with walking or wheelchair	63	59	58	61	55	87	49	57	56	61	53	56	61	55	56
Bedfast	36	2	6	16	7	10	35	10	12	16	9	11	16	9	11
Help with eating	45	10	14	36	21	26	48	24	25	36	21	26	36	21	26
CATHETER															
On admission		2	2		12	5		7	18		5	6		12	5
During stay	27	9	11	9	5	6	20	5	6	9	5	7	9	5	6
INCONTINENCE															
Bladder		17	15		22	17		18	13		17	17		22	17
Bowel	9	17	16	31	20	23	35	20	21	31	15	23	31	20	24
SOCIAL CONTACTS															
Spouse (none)	9	16	15	24	29	27	19	27	27	24	28	27	24	28	27
Minister (none)	27	56	53	12	16	15	19	18	18	12	16	15	12	15	14
Friends (none)	7	6	5	7	7	8	6	7	5	7	7	7	5	7	7
Mail & phone (none)	18	23	23	13	17	16	21	17	18	13	18	16	13	17	16
ACTIVITY PARTICIPATION															
Activities (none)	55	17	22	33	23	26	38	24	25	33	23	26	33	23	26
Arts & crafts (none)	64	28	32	50	44	46	55	49	49	50	45	47	50	45	47
Religion (none)	27	16	18	31	21	24	36	21	22	31	21	24	31	22	24
RESTORATIVE (none)	45	16	20	30	32	31	34	29	30	30	31	31	30	31	31
REHABILITATION															
Physical therapy	36	14	16	16	10	11	38	14	15	16	12	13	16	11	12
Speech therapy					1			2			1			1	
Occupational therapy	9	30	28		3	2		1	1		1	1		3	2
PHYSICIAN VISITS															
at least q30d	91	15	24	88	30	46	79	23	26	88	33	48	88	30	47
at least q60d	9	84	75	1	61	43	12	68	65	1	57	41	1	59	42
Infrequently	1	1	9	8	8	8	4	7	7		7	8	9	8	8

CRITICAL ITEMS REPORT

JUNE, 1975

PG. 3

PROVIDER NO. - 7440147

	FACILITY			COMPANY			STATE			REGIONAL			NATIONAL		
	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb
LABORATORY	36	8	11	20	10	13	19	8	10	20	10	13	20	10	13
X-RAY	16	2	4	2	4	3	8	5	5	2	4	3	2	4	3
SPECIAL TEST				2	1	4	2	2	2	2	1	2	2	1	2
SPECIAL TREATMENTS															
Special Skin Care	9	5	5	10	4	6	28	5	7	10	5	6	10	5	6
IV/tube feeding	36	1	5	7	1	3	33	1	3	7	1	3	7	1	3
Trach care	9		1			4			1			1			1
Suction	18		2	4	1	2	12	26	27	4	25	28	4	25	28
Therapeutic Diet	9	9	8	34	25	28	35	26	27	34	25	28	34	25	28
Sterile ostomy care	9		1			1			1			1			1
Sterile Dressing	9	1	2	8	2	4	11	2	3	8	2	4	8	2	4
Restraints				10	4	6	7	5	5	10	6	7	10	5	7
Drug Regulations				5	5	5	16	6	7	5	5	5	5	5	5
Multiple Injections	55	6	11	5	3	4	16	3	4	5	3	4	5	3	4
Irrigations	27	12	13	15	7	10	26	8	9	15	7	10	15	7	10
O2	18		2			1			1			1			1
Flu Vaccine						1			1			1			1
None	36	78	73	39	61	54	15	59	57	39	59	53	39	60	53
DECUBITUS PROBLEM															
On adm.	9	2	3	4	1	2	13	1	2	4	1	2	4	1	2
During stay	9	2	3	1	1	1	2	1	1	1	1	1	1	1	1
No problem	82	95	94	95	96	97	85	97	97	95	98	97	95	98	97
MEDICATIONS															
Tranquillizer	64	58	59	60	57	58	54	57	57	60	59	59	60	58	58
Hypnotics	36	24	26	35	26	28	34	28	23	35	24	27	35	25	28
Antibiotics	27	10	12	17	13	14	28	13	14	17	13	14	17	13	14
Narcotics	27	3	6	10	3	5	20	3	4	10	3	5	10	3	5
Insulin	3	3	6	4	4	4	7	4	4	6	4	4	6	4	4
2 med with same Rx effect	1	1	14	6	9	7	7	7	7	14	7	9	14	7	9
Error						1			1			1			1
None	1	1	1	3	3	3	2	3	3	1	3	2	1	3	3

CRITICAL ITEMS REPORT

JUNE, 1975

PG. 4

PROVIDER NO. - 7440147

	FACILITY			COMPANY			STATE			REGIONAL			NATIONAL		
	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb	Sk	ICF	Comb
VITAL SIGNS PROBLEM															
TPR	27	17	19	22	12	19	29	17	18	22	17	19	22	18	19
B/P	37	30	30	31	35	34	39	32	32	31					