CITIZENS LEAGUE REPORT

No. 59

Care of the Chronically Ill and Medically Indigent in Minneapolis

August 1956

59

Report on

CARE OF THE CHRONICALLY ILL MEDICALLY INDIGENT IN MINNEAPOLIS

By the

Health, Hospitals and Welfare Committee

August 1956

CITIZENS LEAGUE

of

MINNEAPOLIS AND HENNEPIN COUNTY

601 Syndicate Building

FE 8-0791

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OF MINNEAPOLIS AND HENNEPIN COUNTY

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Minneapolis 2

August 2, 1956

Minneapolis Board of Public Welfare
Hennepin County Welfare Board
Community Welfare Council of Minneapolis and Hennepin County

The Health, Hospitals and Welfare Committee of the Citizens League of Minneapolis and Hennepin County after studying the care of the chronically ill medically indigent in Minneapolis for over two years has completed an excellent and exhaustive report on this problem. The report is attached and despite its length, I urge you to read it. By so doing, you will find it spells out the full impact of our tremendous present and future need for facilities to care adequately for the chronically ill, and suggests steps necessary to provide that care.

In passing upon this report the League's Board of Directors asked the committee to review its conclusion as to the need for a new community agency, to see if the necessary leadership and coordination of action, research and education cannot be developed within existing agencies if additional financing and staff are provided. The directors asked that the committee review this recommendation with the Minneapolis Board of Public Welfare, the Hennepin County Welfare Board, and the Community Welfare Council.

The directors also asked the committee to review with the Board of Public Welfare prior to the League's taking a position the committee's recommendation as to the role of the Board of Public Welfare in relation to General Hospital. Meetings to cover these two points are being scheduled.

With these two exceptions the report as written was approved by the League's Board of Directors on August 1, 1956.

Your comments, questions and suggestions concerning the report are solicited.

Very truly yours,

Charles T. Silverson
President

CTS:cw

July 12, 1956

Report on

Care of the Chronically Ill Medically Indigent in Minneapolis

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IN BRIEF . . .

2,214 people were in chronic illness establishments in Minneapolis in 1954. 50% were supported entirely from public welfare funds, and another 7% were supported in part from public welfare funds.

The City and County governments paid out nearly $2,200,000 for care of indigent patients in nursing homes in 1955.

Although facilities for the care of chronically-ill medical indigents in Minneapolis are not publicly owned, government -- City, County, State and Federal -- exercises important influences on their establishment and operation:

- Half the patients are City and County welfare cases.
- The County Welfare Board sets the schedule of rates for welfare cases.
- The Federal and State governments participate in financing and supervision of County cases.
- The State Health Department licenses nursing homes to protect the health of persons needing care, and the City Health Department performs inspections for the State.

Evaluation of care presently being given in nursing homes indicates that:

There is a clear need for additional beds for the chronically ill and the aged. The State Health Department estimate for distribution of Hill-Burton funds indicates that as many as 1,775 new beds may be needed in Minneapolis.

Overall, the condition of present facilities and the care being provided in them is fair. Generally there has been a notable improvement

in facilities in recent years. Some homes are providing excellent care with good safety and sanitary conditions. Yet the following conditions exist in a number of homes, and indicate that the nursing home picture is far from satisfactory:

• Staffs are inadequate in numbers and insufficiently trained for, and adapted to, the job of handling the chronically ill.

• Buildings are old and cheerless. They do not meet minimum requirements of safety and have inadequate space for recreational and therapeutic activity and for separate utility rooms. Overcrowding exists. There are insufficient toilets and lavatories.

• Nursing home operators make little effort to get their patients on their feet. Efforts at rehabilitation are minimal.

• There is need for better liaison among the medical profession, welfare departments, families of patients and nursing home operators. Efforts are now being directed toward improving this situation.

• Important equipment for rehabilitation is lacking.

• Beds for private patients and young adults are especially lacking.

• The handling of drugs is becoming a problem in some nursing homes. Over-sedation may be used to render patients less bothersome.

• Many people who are in need of nursing home care are living in a less suitable place because of the shortage of adequate nursing home facilities.

• Many of the homes now serving as nursing homes, while they do meet minimum standards of sanitation and safety, are not suitable for effective nursing care.

These measures appear necessary to increase the number of chronic illness beds and improve the quality of care:

1. A new community agency should be formed in Minneapolis and Hennepin County to provide leadership and coordination in action, research and education on the problems of the chronically ill. *

2. The Minneapolis Board of Public Welfare should assume active responsibility in establishing chronic disease hospital beds in conjunction with existing facilities at Minneapolis General Hospital. Care must be taken, however, to avoid jeopardizing adequate financing of acute care at the hospital.*

3. Operators of proprietary nursing homes should act to expand facilities and improve care.

4. Charitable, fraternal, religious and congregate organizations are especially urged to establish homes for the aged and nursing homes.

5. Particular attention needs to be given to the establishment of chronic and rehabilitation facilities for young adults.

6. Discussions and plans for increasing low-cost housing should take into consideration the fact that some of the aged would not need to be in nursing homes if adequate low-cost housing were available.

7. Immediate action should be taken to tighten up the system of inspections and licensing of nursing homes in Minneapolis.

a. Until the Legislature meets again in 1957, the City Health Department should be encouraged to carry out the beginning it has made to enforce the State's minimum standards of nursing home maintenance and care under deputization by the State Board of Health.

b. The Hennepin County legislative delegation in the 1957 legislative session should act to give the City of Minneapolis the authority it needs to license nursing homes.

c. The State should be asked to reimburse the City for a cost which the State would otherwise have to incur by employment of its own inspectors.

*For Board of Directors' action on recommendations #1 and #2, see letter of transmittal.

d. A single combined City and State license should be issued.

e. The Health Department should have primary responsibility in the City Government for administering the inspection of nursing homes.

8. Organizations providing prepaid medical insurance should investigate the possibility of extending coverage to insurance for care in nursing homes and other chronic illness establishments.

9. Nursing home operators, inspection officials, physicians and all others concerned should take immediate action to eliminate abuses in drug-handling and prevent their recurrence.

I

BACKGROUND

Considerable publicity was given in 1952 to the belief that Minneapolis General Hospital was inadequate as an acute general hospital. Suggestions were made that the hospital should be expanded, abandoned or converted to one for care of chronically ill and convalescent persons.

Mayor Hoyer asked the Citizens League of Minneapolis and Hennepin County to study the adequacy of General Hospital. That study was undertaken. It showed need for more information on care of chronically ill and convalescent persons before a recommendation could be made on the use of the General Hospital structure.

Beyond the need for suggesting uses of General Hospital, the Health, Hospitals and Welfare Committee of the League found other reasons for study of the care of the chronically ill and convalescent. Chronically ill are found in large measure among the aged population. That group is increasing percentage-wise and in absolute numbers in Hennepin County each year. This is a national trend. The problem will require increasing public attention. More is being learned each year on how to restore the chronically ill and disabled to fuller activity and productive living. It is desirable that the community know what can be done by its governments to meet the responsibilities in these growing fields.

Finally, the chronically ill in Minneapolis by and large are cared for in nursing homes. Conditions in nursing homes have been called to public attention numerous times in recent years by press, grand juries, health and welfare agencies, and others. There is need for more facts on the operations and problems of nursing homes in Minneapolis.

II

SCOPE OF STUDY

The study undertakes to determine the adequacy of present facilities and care given, to measure possible requirements for the future, to suggest recommendations for action or point out areas where further research is needed.

The study covers care for persons involving all diseases or disabilities except four. Narcotic addiction and chronic alcoholism are excluded because special facilities are involved which do not lend themselves to inclusion in our more general study. Tuberculosis is not included because brief preliminary study indicated that facilities for diagnosis and treatment appear to be adequate for Minneapolis residents. Mental disease is not considered because it is a large problem of special nature that requires special study of its own. This subject did receive study by the Health, Hospitals and Welfare Committee in the original report on General Hospital and a 1955 report on expansion of the psychiatric service at the hospital. It is also recognized that there are patients now in state mental hospitals who might be discharged to communities if sufficient nursing home beds and foster care were available.

Essentially, the study confines itself to problems within the City of Minneapolis, because problems within Hennepin County outside Minneapolis are under study by another sub committee. However, this sub committee found that the principal agency responsible for the medically indigent in nursing homes in Minneapolis is the County Welfare Board, through its duty to provide medical care for old age assistance patients. This fact impels recognition that effectively dealing with the problem of the medically indigent chronically ill in Minneapolis at the local level requires important action through the County Welfare Board. Thus, though the sub committee did confine most of its data to facilities within the boundaries of the City of Minneapolis, it recognized that this is an arbitrary choice, and that the county is probably a better geographical area. However, the sub committee does not feel that limiting to Minneapolis is serious, since the great majority of chronic illness facilities are within the City itself.

III

DEFINITIONS

The sub committee used the following definitions.

(1) Categorical aids - the public assistance grants provided under the Federal Social Security Act, and include these types, or categories, of aid; old age assistance, aid to the blind, aid to dependent children and aid to the permanently and totally disabled.

(2) Chronic illness - illness or disability which is either permanent or recurrent or which requires a long period of supervision or care, as distinguished from acute illnesses which are short, self-limiting in nature, and leave no permanent effects. The National Conference on Chronic Disease has attempted to clarify the meaning of the term "chronic disease" by pointing out various characteristics of this group of diseases. According to this, a chronic disease (a) may require long periods of supervision; (b) may require special rehabilitation services; (c) may cause alterations in the structure or functions of thebody; (d) may result in permanent impairment; (e) may be a residual disability following acute disease.

In using this definition of chronic illness we recognize that it has practical limitations in considering facilities for the chronically ill. This is because different categories of chronic illness require different types of institutional facilities for proper care. For example, some chronically ill people can get adequate care at home, with or without housekeepers and visiting nurse service, some need the nursing care of a nursing home, and some need the more specialized and intensive care given in a chronic disease hospital.

Thus for purposes of this study, where one of the aims is the determination of the number of beds needed, it would be important to differentiate chronically ill patients according to the intensity and type of care required.

At the present time, however, while there appears to be growing recognition of these differences, there has been little effort to distinguish the chronically ill on the basis of type of institution needed. (The Wilder report of Ramsey County is an exception). For this reason, therefore, we have had to lump all chronically ill persons together in our definition and statistics, and have attempted to differentiate type of institutional facility needed by reference to general formulae that have been developed, rather than through actual counting of the present load of chronically ill.

(3) Convalescent - the process of recovering from illness, or the period of recovery.

(4) Medical care - includes all health services and institutional care as well as professional services. Institutional care covers, for example, diagnostic procedures, x-rays and drugs. Professional services include, besides

physicians' services, such services as those provided by nurses and physiotherapists.

(5) Medically indigent person - one who lacks adequate economic resources to pay for medical care. He may or may not have adequate resources to purchase the other necessities of life, such as food, shelter and clothing. Standards of adequacy are established by government and voluntary social service agencies. We have examined those set up by (1) Hennepin County Welfare Board, (2) Minneapolis General Hospital, (3) the Health Division and Division of Public Relief of the City Board of Public Welfare, and (4) the Community Welfare Council, whose standards are the basis for most community chest agencies. All these are similar in principle. They are used as guides not as rigid rules. Hence, the committee felt little would be contributed by a minute analysis of their variations.

IV

WHO ARE THE CHRONICALLY ILL?

In order to understand the problem of providing institutional care for the medically indigent, chronically ill of Minneapolis, it is important to know something about them. How many people are chronically ill? How old are they? What diseases do they have? What medical care to they get? How much does local government pay for their care? These are only a few of the questions that occur.

A number of studies have been made in recent years providing data on the chronically ill in Minneapolis. They have had different emphases, depending upon the purpose of the study. The latest and possibly the most comprehensive survey was made in 1954 by the Minnesota Department of Health as part of a coordinated nationwide survey conducted by the Commission on Chronic Illness (CCI). The commission is an independent agency founded by the American Hospital Association, American Medical Association, American Public Health Association, and the American Public Welfare Association, for the purpose of studying problems of chronic disease, illness and disability.* Though the survey was a state-wide study, the State Health Department kindly agreed to tabulate data relating only to Minneapolis for the purposes of this study.

The CCI survey was titled, "Survey of Persons in Establishments which provide Nursing and Personal Care." It embraced all persons in such establishments, regardless of financial status. However, as will be noted, more than half the patients are public assistance cases, so that conclusions on the total group can probably be interpreted as applicable also to the indigent sub-group.

Here are just a few of the more interesting and important facts about the chronic illness problem in Minneapolis in 1954 as revealed by the survey:

Information about chronically ill in Minneapolis 1954

General

Persons in establishments: Men - 675 Women - 1,536 Total - 2,214

* Went out of business June 16, 1956. Council of Medical Services of AMA assumed responsibility of the publication of the News Letter on February 1, 1956

Socio-economic characteristics

Median Age:	Men - 78 yrs	Women - 78 yrs	Total - 78 yr.
Number over 65:	2,141 or 97%		
Widowed:	61%		
Those from Hennepin County:	81%		

Source of funds:

Percent of persons supported entirely from public welfare funds: 50%
Percent supported in whole or in part from public welfare funds: 57%

Charge for care (median): $148.00 per month

Condition of Patients

Most frequently mentioned diagnoses:	No.	% of total patients
Senility	466	21
Circulatory, excluding heart	367	17
Heart Disease	341	15
Hemiplegia	256	12
Arthritis & rheumatism	226	10

Bed status:

Out of bed except to sleep or rest	1,272	58
In bed part of time	421	19
In bed most of time	307	14
In bed all of the time	212	9
Unknown	2	
Total	2,214	100

Walking status:

Alone or with cane or crutch	1,420	64
With walker, wheelchair, etc.	182	8
Only with attendant's help	202	9
Does not walk or get about	403	18
Unknown	7	-
Total	2,214	99

Mental condition:

Always clear	1,236	56
Confused part of time	629	28
Confused most of time	344	16
Unknown	5	-
Total	2,214	100

Continence:	No.	% of total patients
Continent	1,618	73
Incontinent, feces only	39	2
Incontinent, urine only	143	6
Incontinent, both	401	18
Unknown	14	1
Total	2,214	100

Care of patients

Length of stay (median)	20 months	
Services received (sample)		
Help in feeding	514	23
Help in dressing	851	39
Help in and out of bed to chair	574	26
Time elapsed since last physician's visit (median)	10 months	
Requiring special diet		23%

The aged are the main problem

Probably the most impressive fact in these figures is that the people in the establishments surveyed were predominantly the aged; the median age was 78 years and 97% of the people were over 65 years of age.

V

IN WHAT TYPES OF ESTABLISHMENT DO THE CHRONICALLY ILL RECEIVE CARE?

The chronically ill are cared for in a variety of establishments. The variety reflects the skill and intensity of care needed, the financial status of the ill person, and the profit or non-profit nature of the establishment.

Description

1. General hospitals

These are intended to provide facilities for the care of the acutely ill. However, it is estimated that about 10% - 20% of general hospital beds in Minnesota are used for long-term cases. Also, at least five of the general hospitals in Minneapolis provide a physical therapy service. Physical therapy is an important service in the care of the chronically ill. The five hospitals are Fairview, Northwestern, St. Barnabas, Swedish and Minneapolis General. The University of Minnesota Hospitals also has a department of physical medicine and rehabilitation.

All the privately-owned hospitals are non-profit associations.

2. Chronic disease hospitals.

A chronic disease hospital has the primary purpose of providing medical treatment for the cure or rehabilitation of persons with chronic illness. Such patients usually require a relatively long period of hospitalization. Because of their special treatment requirements, a segregated unit for their care is desirable. Chronic hospitals are not intended to provide care for tuberculosis patients, mental patients or persons needing primarily nursing or domiciliary care. When the CCI study was made, Franklin and Parkview hospitals were classified as chronic disease hospitals for licensing purposes. These have since been reclassified to nursing homes. At the present time the only chronic disease hospital in Minneapolis is the Variety Heart Hospital on the University Campus which limits its admissions to cardiac cases.

3. Specialized facilities.

According to the survey of rehabilitation facilities in Hennepin County entitled, "Resources for the Handicapped", (Community Welfare Council) completed in May 1952, there were 55 institutions, special departments or agencies in Hennepin County active in the fields of physical restoration, vocation rehabilitation, employment, etc.

4. Nursing homes.

These are homes licensed by the state to provide nursing care for three or more aged or infirm persons at one time. "Nursing care" means care required

by a person because of prolonged mental or physical illness or defect or during recovery from injury or disease. It includes any or all of the procedures commonly employed in caring for the sick.

Nursing homes must have a registered nurse or a licensed practical nurse in charge of the nursing service. If there are 20 or more beds, the nurse must be employed full time.

Maternity patients, disturbed mental patients, or persons having or suspected of having a disease endangering the health of others may not be admitted or retained in a nursing home.

Most homes for the aged are considered nursing homes for licensing purposes, although they are sometimes distinguished from nursing homes because their emphasis is on the aged person rather than the ill person. Thus, generally they do not accept people for admission known to be ill at the time, but most of them maintain infirmaries for those becoming ill after admission and so are licensed as nursing homes.

All but a few nursing homes are operated for profit with about an equal division between individual and corporate ownership. All the homes for the aged are non-profit associations, in many cases with church affiliations.

5. Boarding care homes.

These are homes licensed by the state to provide personal or custodial care for three or more aged or infirm persons. "Personal or custodial care" means care incident to old age or infirmity required by a person who because of advancing age or infirmity is not able to care for himself properly.

These homes are not required to have a nurse on the staff, but must have a responsible person immediately available to the residents at all times. A "resident" is cared for in a boarding care home, as distinguished from the "patient" cared for in the nursing home.

6. Hotels, boarding and lodging houses.

It is believed that many persons now residing in hotels, boarding and lodging homes need nursing care.

7. Private homes

Chronically ill and disabled persons are cared for in their own or other private homes. Sometimes full-time care is not needed. Relatives are an important source of care in these cases. Where relatives are not available, bedside nursing programs conducted by the Visiting Nurse Service, and Homemaker and Housekeeping Services of the Family and Children's Service agency are helpful.

8. Homes with one or two persons needing care

At the present time, homes with one or two persons requiring chronic or convalescent care are excluded from licensure. It is known that many of these homes exist and that many of the persons in them require intensive nursing care which they are not receiving at the present time.

Present use of various types of establishment

The Commission on Chronic Illness survey in 1954 provided data on the general distribution of chronically ill patients in Minneapolis institutions exclusive of those found in general hospitals.

	No. of homes	No. of beds	No. of patients	Percentage occupancy
Proprietary nursing care homes	38	963	934	97.0
Non-proprietary nursing care homes	2	115	120	104.3
Chronic disease hospitals	2	223	210	94.2
Primarily domiciliary care homes for the aged	12	986	950	96.3
Total	54	2,287	2,214	96.8%

The above tabulation indicates that the preponderance of the chronically ill in chronic illness establishments in Minneapolis currently are cared for in nursing homes as defined by state regulation (that is, including homes for the aged as nursing homes).

Trend in number of nursing homes and homes for the aged.

There has been a substantial increase in the past 10 years in the number of nursing homes and homes for the aged, and the beds available, as indicated by the following data on Minneapolis homes licensed by the State Health Department:

	1945	1955	Increase
Homes			
Nursing homes	28	49	21
Homes for the aged	9	10	1
Total	37	59	22
Beds			
Nursing homes	820	1,444	624
Homes for the aged	593	898	305
Total	1,413	2,342	929

Study of present care focused on nursing homes

To summarize the chronically ill in Minneapolis are found in general hospitals, nursing homes, boarding care homes, unlicensed homes, hotels and

boarding and lodging houses and private homes.

Since the bulk of the care is provided by nursing homes, however, this study gives major emphasis to nursing homes -- the care they are now providing and may provide in the near future.

VI

WHAT IS GOVERNMENT'S RESPONSIBILITY IN MINNEAPOLIS FOR THE CARE OF THE CHRONICALLY ILL?

Government has responsibility for the chronically ill in Minneapolis in two respects: (1) Under its responsibility for the well-being of the indigent and medically indigent, it is obligated to see that they get proper medical care when needed, (2) Under its general responsibility for the health and welfare of all the people, non-indigent as well as indigent, it regulates and inspects institutions for the chronically ill to see that they meet minimum standards as to sanitation and safety of the buildings and the "health, treatment, comfort, safety and well-being of the persons accomodated for care."

Responsibility for medically indigent patients

The City of Minneapolis and the County of Hennepin are responsible for providing care for the medically indigent. Included in such care is the provision of medical services, such as those required by the chronically ill.

The city's responsibility stems from its responsibility for providing poor relief. It administers its poor relief program through the Division of Public Relief of the Board of Public Welfare. Acutely ill relief cases are cared for at General Hospital, another division of the Board of Public Welfare.

The Hennepin County Welfare Board administers the "categorical aids" throughout Hennepin County including Minneapolis. In addition, it handles child welfare services.

A person eligible for old age assistance is not eligible for direct relief unless the O.A.A. grant is not sufficient to meet his needs, in which case the City Relief Division provides supplementary assistance up to its minimum standard. Pending determination of eligibility for O.A.A., however, the City does give relief.

Following are data on the average number of persons on the Minneapolis relief roles who were in nursing homes during the years 1950-1955, inclusive, and the cost of their care paid by the Relief Division.

Year	Monthly average of cases	Total cost	Average monthly cost per patient to Relief Div.
1950 (Mar-Dec)	60	$ 81,479	$136
1951	69	119,838	145
1952	75	137,608	153
1953	77	137,445	150
1954	81	148,512	153
1955*	88	136,011	128

* See footnote next page.

The Relief Division also had a group of men at Mission Farm Hospital receiving nursing home care. The hospital cares for alcoholics and federal transients in addition to bona fide Minneapolis nursing home cases on the relief rolls. From 1950 to 1955 there were an estimated 65 - 75 men in the hospital for nursing home care at all times. The rate is now a flat $60 per month. The average yearly cost for 1951 - 1955 was $36,810.

The cost of relief cases is financed out of the City's property tax.

Following are data on the average monthly number of Hennepin County Welfare Board patients in nursing homes in 1954 and 1955 and the total yearly cost:

Year	Monthly average of cases	Total cost
1954	1225	$1,830,127
1955	1300	2,039,097

Some of the above cases are at Mission Farm Hospital.

The federal, state and county governments share in financing O.A.A. cases. In 1955 the estimated sharing of nursing homes cases was federal -- 27%, state -- 39%, County -- 34%. Beginning this year the county's percentage share will increase, since payments over $55 to O. A. A. cases will be shared 45 -55% between the state and county instead of 50 -50%.

The county's share comes out of the property tax, In 1955 it was estimated at $693,000 or about 1.50 mills.

From March 1950 - December 1953, over 97% of the Welfare Board's admissions to nursing homes were from Minneapolis residents, indicating that for practical purposes we can consider the Welfare Board's problem in nursing homes to be one of handling Minneapolis patients as distinguished from patients of the rest of the county.

The relative importance of relief and O.A.A. patients in the patients load of nursing homes in Minneapolis is shown by the following figures from the CCI's 1954 survey:**

* Increase in number of patients reflects new Aid to Disabled patients program to whom the Relief Division makes payments supplementing basic payments made by County Welfare Board.

** Franklin and Parkview "hospitals" have been included under proprietary nursing homes.

Source of funds	Number of beds: In proprietary homes	In non-proprietary home	In primarily domiciliary care home	Total
Single source:				
Patient	261	55	534	850
Public welfare	734	54	327	1,115
Other agency	4	-	11	15
Multiple sources:				
Public welfare in combination with:				
Patient	82	2	54	138
Other agency	2	1	3	6
Patient and other agency	-	-	2	2
Unknown	61	8	19	88
Total	1,144	120	950	2,214

Thus, of the 2,126 patients on whom payment data were available, 1115 or 52% were financed entirely by welfare funds, and 1,259 or 57% were financed by welfare funds in whole or in part.

The Hennepin County Welfare Board sets up the pattern for welfare payments to nursing homes, although on April 1, 1956, the State Welfare Department is to promulgate a new rate schedule to be followed by all county welfare boards. The present schedule was adopted in 1953 by the Board after consulation among representatives of the social service staff, the nursing home operators and the Hennepin County Medical Society. Under the schedule the case workers determine the amount to be paid for each patient, based upon the type of home and general care given therein and the special category of care required of the patient. The City Division of Public Relief, with less than one-tenth the number of patients under the County Welfare Board, follows the schedule and procedure set out by the County.

Summary

1. Our county and city governments have a large stake in the operation of nursing homes in Minneapolis. This is in terms of absolute numbers of patients and amount of costs, and also in terms of the relative proportion of total patients and financing the cost of care of nursing homes.

2. Of the two local governments, the county has by far the larger share, with over 90% of the welfare patients in the homes.

3. All but a relatively small percentage of County Welfare patients are Minneapolis residents.

4. The state and federal governments share in governmental responsibility for medically indigent patients in the nursing homes. Sharing in the financing carries with it responsibility and authority to oversee the way the money is spent.

Responsibility for adequate standards in institutions for the chronically ill.

1. State licensing and regulation

Minnesota became one of the first states to license establishments providing chronic or convalescent care for aged and infirm persons when in 1941 the Legislature enacted a law empowering the State Board of Health to license hospitals and related institutions.

Before a license is issued, the State Health Department must have first found on inspection that the home complies with state law and departmental regulations. Approval by the State Fire Marshal of the fire protection status of an institution is also a prerequisite for a license.

After issuance of a license, the Health Department makes periodic inspections to determine whether the institution continues to meet regulations adopted by the State Board of Health. The regulations "establish minimum standards as to the construction, equipment, maintenance, and operation of the institutions insofar as they relate to sanitation and safety of the buildings and to the health, treatment, comfort, safety, and well-being of the persons accomodated for care."

In March 1956, there was a total of 600 licensed institutions in Minnesota. During 1955 there were more than 300 potential nursing and boarding care homes where field visits and conferences were held to advise regarding requirements as to physical facilities and operation.

The State Health Department, however, has only two licensing inspectors in the field, which makes it impossible to visit every licensed institution annually. During 1955, for example, only 368 of the 600 licensed institutions were visited. In order to provide for a more adequate coverage for the Minneapolis homes, the State Board of Health appointed the Minneapolis Commissioner of Health as its deputy for inspectional services in nursing and boarding care homes in Minneapolis beginning on January 1, 1956.

2. City licensing and regulation

City ordinances contain many regulations for the construction and operation of nursing homes. These cover building safety, fire prevention and sanitation. In 1951, however, the State Legislature passed a law (Chapter 711) which granted the nursing homes the right to operate in cities over 500,000 population as long as they were approved by the State Health Department and the State Fire Marshal. This right was granted until July 1, 1953, but in the 1953 legislature the law was amended to remove the time limit (Chapter 466).

The sweeping effect of the 1951 law was overlooked for some time because attention was centered on a specific provision permitting the use of a ground or basement floor for patients and employees, provided that the room was more than one-half above ground level. However, as a result of an objection by a nursing home license applicant, the Attorney General in 1954 ruled that the 1951 and 1953 laws definitely did divest the City of power to license nursing homes.

In the 1955 legislature an effort was made to restore the licensing power to the city, and there were counter-efforts to keep its control limited, and even to further restrict the State Health Department's control of homes in Minneapolis. It was proposed that any combination rest home, nursing home and hotel be allowed to operate in industrial zones of Minneapolis subject only to the State Fire Marshal and without further licensing by any city or state agency.

The only Minneapolis nursing home bill to pass the 1955 legislature, though, provided that nursing homes must comply with the zoning ordinances. Thus, the City had at least the legal power to control the location of nursing homes.

Despite the fact that since 1951 Minneapolis had no legal right to inspect and license nursing homes for building, fire and sanitation reasons, it carried on to a great extent as though it had. Licenses came up for renewal or cancellation each year by the City Council. Before taking action the Council Licenses Committee requested the recommendations of the Building Inspector, Bureau of Environmental Sanitation (Health Division), and the Fire Prevention Bureau. While the nursing home operators technically did not need to subject themselves to inspection by these city agencies, actually they did and by and large seemed to favor effective city licensing.

As of January 1, 1956, the City was again given effective inspectional authority when the State Board of Health designated the City Health Commissioner as its deputy to inspect and supervise nursing homes in the city. In effect, this restored the inspectional power of the City, although now the Health Commissioner enforces the State regulations, not city ordinances.

The city's new inspectional program is being initiated and directed by the industrial health physician. The Health Department for some time has had limited staff for all health inspection programs, but the Health Commissioner has said he plans to reassign departmental personnel in order to carry out the nursing home program.

The Department of Building Inspection is another major city agency involved in inspecting nursing homes. It is charged with certifying as to the safety of both old and new buildings. The Inspector of Buildings says that because of limitations of staff his department has had to give most of its attention to inspection of new buildings under construction, and therefore has not been able to give adequate time to existing buildings, the type which are used for most nursing homes. As a consequence, in the past, the department has made perfunctory inspections of nursing homes.

Since early 1954, however, the Inspector of Buildings has undertaken a more thorough inspection of nursing homes. Nursing homes are annually checked out according to the requirements listed on a check sheet, which summarizes the building code relating to nursing homes. While the effect of this more orderly system of inspection is delayed due to the Council's sprinklering ordinance passed in 1954 (see below, Chapter VIII - 9), the improved inspection system should have good effect in time.

The Minneapolis Fire Prevention Bureau inspects nursing homes mostly as the result of complaints. The recently-retired chief of the bureau said he did not have personnel to do much else. The work of the bureau is closely coordinated with the work of the State Fire Marshal.

3. Control by Welfare Board and Relief Division

The Welfare Board and Relief Division keep in touch with their clients after they are admitted as patients to nursing homes. Welfare Board case workers visit their recipients as soon as they enter a nursing home. They also make a visit upon request of a recipient, relative or nursing home operator. It is rare that a patient is not visited every two weeks, but in no case is the interval greater than three months.

In addition, the agency's medical social worker and home economist visit upon complaint. If complaints are many against a nursing home, a complete study is made and a report is given to the Minneapolis Health Department.

The Minneapolis Relief Division reviews its cases generally every six months. This does not mean, though, that the worker would only go to a home every six months, because patients come and go. All complaints are referred to the City Health Department.

Summary

Although the city and county governments do not own facilities for the care of chronically-ill medical indigents, they exercise important influences on the establishment and operation of the facilities.

City and county welfare patients comprise over one-half the patients in nursing homes. This large percentage of the total patient load, and the fact that the County Welfare Board sets the schedule of rates for welfare cases, has a significant influence on the economics of the nursing homes. The federal and state governments share in this influence and responsibility through their participation in financing and supervision.

The State Health Department licenses nursing homes to protect the health of persons needing care. The city government no longer has authority of its own to provide similar licensing of nursing homes, but has recently been deputized by the state to perform inspections for the state.

In short, the facilities for the chronically ill are essentially private establishments over which government exercises considerable control.

VII

A PERSPECTIVE FOR CONSIDERING MINNEAPOLIS NURSING HOMES

Before proceeding to a consideration and evaluation of conditions in Minneapolis nursing homes at the present time, it is necessary to establish yardsticks for measurement. In doing this, it is recognized that organized concern for the care of the long term patient is relatively new compared with other areas currently receiving public attention in the fields of health and welfare. This newness provided one of the inherent difficulties in making this study, for it created problems of definition and policy.

In a new area like this, therefore, standards must be considered as even more tentative than usual, subject to continual change with increasing research, discussion and professional and public awareness of the problems involved.

A. Commission on Chronic Illness Recommendations for Nursing Homes and Related Institutions

The CCI in its June 1955 News Letter issued a set of recommendations for long-term patients, encompassing the total field of care for the chronically ill, not just the nursing homes. The comprehensiveness of these recommendations emphasizes a point which must not be forgotten: attacking the problems of the chronically ill requires a broad, complex approach, involving the cooperation of government, public and private welfare agencies, many professions and a number of types of institutions.

The recommendations pertaining to nursing homes and related institutions are as follows:

> "37. Nursing homes and related institutions are essential for some phases of long-term illness. They are presently being operated under a variety of auspices -- public; proprietary; and nonprofit voluntary such as religious and fraternal. Though there are many that are rendering excellent service, too many are operating unsatisfactorily.
>
> Simultaneously and concurrently many of these institutions must yet equip themselves to provide safe and adequate care and become properly aligned with other community resources serving the chronically ill. Only when this is accomplished can they fulfill their role acceptably and solve the problem of many long-term patients who otherwise must resort to inappropriate - and probably more expensive care.
>
> Individual physicians, medical societies, and hospital staffs particularly are urged to recognize the nature of the contribution which care in nursing and convalescent homes and homes for the aged can make and to help bring about the necessary reforms.

"38. On the basis of its studies and analysis of the problems, the Commission believes that development of these institutions as elements of general hospitals is one of the best ways of raising standards, and recommends this arrangement. When outright affiliitation is impossible, a close and active working relationship should be maintained.

"39. Standards of medical, nursing, and personal care in many of these institutions are not acceptable and must be raised. Two major factors are involved: (a) knowledge of what to do and how to do it; (b) better financing.

a. Knowledge of what to do and how to do it. The Commission on Chronic Illness endorses and commends the nursing home standards recommended by the National Social Welfare A sembly's Committee on Aging in 1953, and the suggested procedure for establishing and maintaining them.

Through educational programs and proper exercise of their jurisdiction, licensing and standard setting authorities can effect great improvements in physical facilities and care in nursing homes and related institutions. Recent legislation and the knowledge resulting from recent studies of patients and institutions have produced an unprecedented opportunity for progress in this field. Licensing and standard-setting authorities are urged to move vigorously to take advantage of this auspicious situation.

b. Better financing. Financing is probably the most neglected and unresolved area in improving care in the bulk of non-hospital institutions. The efforts of licensing authorities and nursing home operators to apply new knowledge and otherwise raise standards can succeed only if better financial support is forthcoming for these institutions and the improvement of their standards, the Commission recommends that:

Private insurance and prepaid medical and hospital plans extend the scope of benefits offered to include this type of service.

Philanthropic agencies - national voluntary organizations devoted to specific disease categories, community chests, united funds, religious and fraternal groups, for example - consider this type of service as a need that deserves support commensurate with other types of care.

Tax funds be sufficient to support a program of inspection, licensing, education, and supervision."

B. Standards established by State law and the State Health Department

The regulations adopted by the State Board of Health set forth the minimum standards for the construction, equipment, maintenance and operation of nursing homes. Most other sources which we consulted seemed to base their judgments on minimum standards. These sources are described in Chapter VIII.

The Minnesota State Plan for distributing Hill-Burton funds for the construction of nursing home facilities, on the other hand, sets forth higher standards for nursing homes. Here are some ways in which these standards differ from the minimum standards:

. . . To be classified as "suitable" under the long range State Plan, a nursing home building must be of fire-resistive construction and "adequate for providing care," that is, it must have the necessary functional arrangements and facilities for rendering medical and nursing care. These include structures designed for care purposes with wide central halls; an elevator if patients are housed on more than two floors; nurses' stations, utility and day rooms provided and equipped as required; bedrooms which arrange readily for patient care and all patient rooms with access to corridors.

The minimum standards under licensing regulations are not as comprehensive regarding functional arrangements listed above.

. . . Under the State Plan the nursing home should have an affiliation with a hospital. This "makes possible the development of a smoothly operating mechanism for referral of patients from one facility to another. It makes available the type of facility best suited to the need of the individual patient and it is an important step in freeing hospital beds now occupied by long-term patients who do not require hospitalization. It provides an opportunity for training all types of personnel giving care to chronically ill persons." "This arrangement permits the ready referral of nursing home patients to the hospital for diagnostic services or treatment during acute stages of illness; it provides for better medical and nursing supervision; it avoids the duplication of some of the basic facilities and services such as food service, laundry, boiler plan, etc."

No such requirement of affiliation with a hospital is in the licensing standards.

. . . The Federal regulations as established for the Hill-Burton program are considerably in excess of the State regulations as they concern areas for recreation, occupational activities and dining areas.

. . . The Hill-Burton plan considers 25 beds as the minimum acceptable size of a nursing home consistent with efficient and economical operation.

A home providing care for three or more aged or infirm persons requiring or receiving chronic or convalescent care is subject to licensure.

C. Different concepts must be kept in mind

Thus there is a substantial difference between the type of nursing home care contemplated by the State Plan and the type permissible under the licensing standards. The latter establishes minimum requirements, whereas the former is directed toward a higher goal.

In considering the present nursing home care and changes for the future, it is necessary to keep in mind these different concepts.

D. Other considerations in making appraisal

In this study, we are concerned with the care being given to each chronically ill person who is the government's responsibility, that is, the medically indigent person, and the policies that government has set up to assure that he receives adequate care. Obviously, if some of the medical indigents are cared for in homes which are not providing adequate care, it can not be fairly said that the government's policies and program are being properly carried out, even if the larger part of the indigent are receiving good care or even excellent care. Thus, while we are naturally interested in knowing the average level of care, we are most interested in knowing whether all are getting at least the minimum acceptable standard of care.

At the same time, though, we are conscious of the fact that nursing homes have been, and are, the objects of much public criticism, and that sometimes this criticism has been indiscriminate, failing to give credit where due and to recognize that there are variations in the quality of nursing homes and the care they give. We doubt that such criticism in the long run can have the best effect. Therefore, while we are principally concerned with evaluating the minimum service that is being given, we are also concerned with giving a balanced view of the favorable as well as the unfavorable aspects of that service.

VIII

HOW ADEQUATE IS PRESENT CARE IN NURSING HOMES?

Judged on the basis of minimum standards, we arrived at these conclusions:

There is a clear need for additional beds for the chronically ill and the aged. This includes chronic disease hospitals, boarding care homes, and homes for the aged with infirmaries.

Overall, the condition of present facilities and the care being provided in them is fair. Generally there has been a notable improvement in facilities in recent years. Some homes are providing excellent care with good safety and sanitary conditions.

Yet the following conditions exist in a number of homes, and indicate that the nursing home picture is far from satisfactory:

. . . Staffs are inadequate in numbers and insufficiently trained for, and adapted to, the job of handling the chronically ill.

. . . Buildings are old and cheerless. They do not meet minimum requirements of safety and have inadequate space for recreational and therapeutic activity and for separate utility rooms. Overcrowding exists. There are insufficient toilets and lavatories.

. . . Nursing home operators make little effort to get their patients on their feet. Efforts at rehabilitation are minimal.

. . . Physicians' orders and diagnoses are not on file for all patients. Some patients rarely if ever see a physician. There is need for better liaison among the medical profession, welfare departments, families of patients, and nursing home operators. Efforts are now being directed toward improving this situation.

. . . Important equipment for rehabilitation is lacking.

. . . Beds for private patients and young adults are especially lacking.

. . . It is apparent that the handling of drugs is becoming a problem in some nursing homes and that over-sedation may be used to render patients less bothersome. The Federal Government through the Food and Drug Administration has some powers in this field and has conducted investigations locally.

Based on the higher standards used by the Wilder survey and in the State Health Department plan for distribution of Hill-Burton funds, the nursing home situation in Minneapolis is of course more unsatisfactory.

. . . Many people who are in need of nursing home care are living in a less suitable place because of the shortage of adequate nursing home facilities.

. . . Many of the homes now serving as nursing homes, while they do meet minimum standards of sanitation and safety, are not suitable for effective nursing care. They are less than the minimum size indicated for economical and efficient operation, lack the necessary internal arrangements and other physical conditions, and do not have the close relationship with a general hospital that is desirable.

The remainder of this chapter is a summary of the sub committee's research on the adequacy of nursing home care and a more extended summary of the findings summarized above.

Findings

1. Sub committee visits to homes

In the early summer of 1954 the sub committee visited a large sample of nursing homes in the City of Minneapolis. The purpose was to give the sub committee a first hand acquaintance with the homes and to make informed laymen's judgments as to some of their more apparent characteristics. Appendix 1 describes the methods used in planning and making the visits to the homes.

a. Summary of results

Does staff appear neat, alert?--With few exceptions the answer was "yes".

If patients work in home, what jobs do they perform? If they assist in patient care, explain. -- 16 of the 20 cases in which information was provided indicated that the patients did no work. Such work as was done appeared to be mending, dishwashing, simple cleaning. No evidence was found of patients being used to care for other patients.

Do patients seem well cared for and as content as their physical conditions permit? -- Almost unanimously, the answer was "yes". One comment: "Yes, but there seems little effort to retard physical deterioriation through inactivity."

Daily chart on each patient? -- About three-fourths said a chart was kept. In several cases where charts were not kept, it was said that charts were not needed, evidently because homes were for aged and not all residents were patients.

Building clean, in good repair? -- 21 of the 23 answers were "yes".

Halls clear, not used for storage? -- All clear.

Ramps for wheel chairs? -- 17 of the 21 reported no ramps. A substantial number of visitors indicated that ramps are not necessary. Several commented that all patients are ambulatory.

Telephone on each nursing floor? -- 13 out of 22 reported "no".

Adequate call-system for patients? -- 14 of 18 said "yes". Several homes without call-system justified their position by their claim that attendants were always within calling distance of patients.

Fire drills for those without sprinklers? -- 11 of 15 said "no". Comments by some of the homes without fire drills and sprinklers: "Fire drills would frighten patients." "Most patients are aged and bedfast". "Extinguishers . Outside escapes 1st and 2nd floors." "Fire extinguishers, night watchmen, nurse on night duty."

Bed linens, blankets clean? -- All 21 who answered said "yes". Comments ranged from "fair" to "immaculate."

Adequate washing facilities for staff? -- Without exception "yes", although a few said the facilities were marginal.

Easy chair for each ambulant and semi-ambulant person? -- 23 reported "yes".

Describe recreation facilities. -- Most frequent comments: TV, radio, porches, day rooms, game tables. Other comments: most patients too old, patients infirm, living room with TV very little used.

Is kitchen clean? -- One kitchen was considered marginal, one not clean. The rest were marked clean.

Does it (kitchen) appear well-equipped? -- All but one were judged well-equipped, although there were these com ents: "No dish washer." "Old fashioned kitchen, but probably adequate." "Barely adequate." "Equipment o.k. but not enough of it."

What facilities are there for physiotherapy and rehabilitation? -- Six indicated no facilities whatsoever. Comments: "Send patients to General (hospital) or Nicollet Clinic." "Patients taken to day room each day. Encouraged to walk". "Not needed." "Have plans for a full-time worker." "Operator is emphatic in saying the patients have lived and worked long and now want only to lie in bed or sit in a chair and exert themselves not at all." "Have tried, but patients objected." "Most patients seem to be terminal." "Youngest aged 73 years, other 88 and 90 years." "Done by staff. Whatever doctor orders, parties given." "Five (employes) giving physiotherapy."

Is there a waiting list for entrance in the home? If so, how many are on the list? -- With few exceptions, the homes said they have waiting lists or could have them if they wanted them. In the latter case, they keep no waiting list and are able to fill vacancies whenever they occur because of the demand. Most report several calls a day for a bed. Several said the County Welfare Board calls daily to learn about possible vacancies.

What does the operator consider the major problems in providing good service? -- Seven operators reported no major problem. Four said specifically that help is a problem (nurses are "fly by night" variety), while two said specifically that it is not a problem.

Other comments: "Educational program should be started to acquaint people with conditions as they are." "More recreation." "Could take in more bed patients if we had more room." "Inadequate toilet and bathing facilities." "Good food."

b. Difference between nursing homes and homes for the aged

Generally speaking, homes for the aged provide nursing care only in their infirmaries, as distinguished from nursing homes.

The visiting teams found that some homes for the aged were clearly better than others, just as there were variations among the nursing homes. However, on the whole the homes for the aged clearly impressed the sub committee more favorably than the nursing homes, from the standpoint of physical facilities, appearance of personnel and general atmosphere.

2. Interviews with public officials

Members of the sub committee interviewed several public officials who are responsible for various aspects of the care given by nursing homes to the medically indigent. They are the Minneapolis Health Commissioner, the former superintendent and head social worker of Minneapolis General Hospital, the director of social work at the University Hospitals, the licensing inspector of nursinghomes and head of the Bureau of Environmental Hygiene of the City of Minneapolis Health Department, and the social worker in charge of referrals to nursing homes from the Hennepin County Welfare Board. Here is a summary of their comments on the quality of care in the homes.

a. Minneapolis Health Commissioner

The City Health Commissioner said that in his opinion the quality of nursing care in the majority of nursing homes is the largest problem to be solved. He said that licensing regulations should be passed which, first, allow the City of Minneapolis to be the inspecting agent, and second, give the inspecting agent broad enough powers to prosecute operators who either are breaking licensing regulations or who, for moral reasons, are unfit to be operators of establishments for the care of the sick.

b. Licensing inspector of nursing homes and head of Bureau of Environmental Hygiene, Minneapolis Health Department.

There are seldom complaints on the quality of the food, but sometimes on the quantity. It is not easy for the operators to obtain nurses for nursing homes, since the work is harder than it is in hospitals. At times mentally subnormal employees are engaged. It is difficult for the Health Department to get rid of undesirable individuals. When the drug bills of a home seem too high, they are checked by the health inspectors. Since the State Board of Health regulations went into effect in February 1952, all the new nursing homes are better, although it is a problem to make the operators of the older homes make certain improvements, such as in kitchen effects, increased space around beds, bedpan hoppers, etc.

c. Director of social work at University Hospitals.

The University Hospitals sends patients to only a limited number of nursing homes (12 to 15), since it can use only those which give excellent nursing care and whose operators are willing to work with the hospital staff. The hospital selects the best of the homes, and it has remarkable success with them. The first requirement is good nursing, and the second is adequate transportation. Medical care is well controlled in these particular homes, thenursing homes acting as another wing of the University Hospitals. The nursing homes with 12 to 20 beds are preferable to large institutions, where politics may creep in. The patients themselves like the smaller homes better.

A facility for younger adults from 20 to 40 years of age is distinctly needed.

Places should be found where the University Hospitals rehabilitation patients can stay.

Overall direction of Hennepin County nursing homes should be instituted, in order to take care of the specialized requirements of the 1,500 patients in nursing homes in Hennepin County at any one time.

d. Former superintendent of General Hospital and director of social work.

On the whole, the nursing home facilities are adequate. The main problem is the personnel, which in some homes is not of as good a quality as in others. There is a frequent turnover of personnel, partly because the remuneration is often insufficient for a living wage, and partly because to some employees, work with the aged is discouraging and unrewarding.

Many licensed homes have no registered nurse in charge during part or the whole of the 24 hours period,not even a licensed practical nurse. Some homes do not have sufficient employees to get the patients out of bed, so that no type of rehabilitation is tried.

The operators of the homes are very selective in the type of patients they will receive. This is perhaps the reason there are no accomodations exclusively for the young group. There is a great need for a facility to care for young adults. These do not fit happily into existing care facilities where the atmosphere is rather depressing for the young. There is a need for facilities for children. Regulations of course forbid caring for children in nursing homes.

Minneapolis General Hospital staff has had few complaints from patients or their relatives about the nursing homes, other than the usual minor complaints of a patient, under medical care, concerning visiting hours, food, etc.

e. Social worker of Hennepin County Welfare Board

He recognizes with the people from General Hospital that there is a complete lack of facilities for young people.

Some of the licensed homes employ sub-normal workers.

While it would be desirable to move patients from homes that are not up to standard, this is not possible, since there is no real vacancy in beds.

3. Report of survey of nursing homes in Hennepin County by Hospital Licensing Unit of State Health Department -- January 1951

During the fall of 1950 the Minnesota Department of Health surveyed nursing homes in Hennepin County with special reference to the type of nursing care required by patients in these homes and the provision for medical and nursing supervision. It was expected that the information would serve as a basis for establishing standards, and for setting up educational programs for nursing home personnel. It was also believed that the data might be useful to agencies referring patients to these homes.

The study was carried out as part of the routine licensing visits.

Much of the information gathered in the Health Department's study was statistical data on which later information has been provided through the Commission on Chronic Illness (see above, page IV-2), so there is no point in repeating it here. The following is additional information and comments not made in any other studies. It should be borne in mind that this study was made in the fall of 1950.

a. Medical care

The department was especially interested in ascertaining whether physicians' orders were on file or whether nursing homes are carrying out treatment without specific, written directions for care. It found that orders were on file for slightly less than one-half of the patients in the homes.

"Operators frequently expressed a need for more guidance from physicians. They are concerned over their inability to secure specific written directions for treatment for many of the patients transferred from the public hospitals (University and Minneapolis General) and would much prefer it if someone from the hospital (physician, social worker, or head nurse) could visit the patient when he is first admitted to the nursing home and advise on the details of his care. . .

"Nursing home operators would like to have patients seen at regular intervals. 'We go along not knowing whether we are doing the right thing or whether there is something more that we might do,' they say. This puts too much responsibility on the nursing home operator for day-to-day care. . .

"When it comes to 'private pay patients' it frequently is difficult to persuade responsible relatives that the patient should be seen by a physician periodically and some relatives object to even an annual examination. Several

operators reported that in order to secure medical care for patients they have defrayed the costs out of their own funds."

"There are few written diagnoses, medical histories, or progress notes in nursing homes. . ."

b. Nursing care

"Contrary to fairly widespread opinion, there appear to be few persons in Hennepin County nursing homes who do not need some form of nursing care. . . The study seemed to indicate that nursing homes on the whole are caring for many very ill and very difficult care cases. In the opinion of the State Health Department visitor who participated in the study made by the Minneapolis Health Department two years ago, there are more of the difficult nursing cases now than at that time. In spite of this fact, the majority of nursing home operators appear to be making a greater effort to get patients out of bed, if for only a few moments each day."

c. Facilities for nursing care

"There has been considerable improvement in facilities for giving care. This is particularly marked if compared with facilities available when nursing homes first came to the attention of the State Health Department at the time the licensing law went into effect.

"Licensing representatives recall, for instance, when medicine cabinets were merely a few shelves or perhaps a drawer in a kitchen cupboard, china closet, or bathroom cabinet and 'pink pills' were migled with 'white pills' in a cardboard box of dubious origin. Now many homes have well lighted, locked and orderly medicine cabinets with medicines plainly labelled and medicinelists on the door or at the nurses' station for the guidance of attendants dispensing medications.

"Likewise, new equipment of good quality-- wash basins, bed pans, wheel chairs, back rests, bed cradles, and other comfort devices -- have replaced the makeshift equipment of the 'early days'. In general, equipment is stored in a more orderly fashion, although utility rooms are still lacking in most homes. This is due partly to reluctance to give up space for this purpose and partly due to the expense involved in installing flushing rim hoppers and suitable work counters and cabinets. There are practically no handwashing facilities for personnel apart from kitchen or bathroom used by patients.

"Some homes have made a beginning in providing facilities for a few simple diagnostic procedures. . . Because of a criticism that first-aid equipment had not been readily available for an emergency, special inquiry was made into the provision for handling burns, cuts, bruises, poisoning and other emergencies. Most homes have the supplies ordinarily found in any home medicine cabinet or first-aid box, but not all homes have assembled them in a place known to and readily available to all personnel in the home. In many homes, emergency telephone numbers, were posted in the office or at the nurses' station.

"In spite of the fact that medical records are meager, record-keeping is one of the areas in which greatest improvement was noted....

"Perhaps the greatest lack of facilities for getting patients well, or at least for making them more comfortable and 'self-helping' is the lack of space for physical and diversional therapy ... Few homes have adequate space, in halls, dayrooms, or patients' own rooms, for carrying out an active program of rehabilitation."

d. Nursing home team

"Authorities in the field of chronic illness care frequently refer to the desirability of having a 'nursing home team' (physician, social worker, and nursing home operator), yet in the study that was completed there was little indication of 'teamwork', that is, of concerted planning for patient care. Case conferences would seem a necessary part of teamwork...."

4. Degree of Nursing Home compliance with State licensing requirements as revealed by State Health Department's inspectional visits.

Licensing inspectors from the State Health Department, regulatory agency for nursing homes, make periodic inspectional visits to nursing homes throughout the state, On these visits they check to see that the homes are complying with the minimum standards set down in state laws and the regulations of the Health Department. They use a check sheet to assure coverage of all necessary points in the inspection

In addition, each home must make an annual application for license and an annual report on personnel.

The Health Department has tabulated for this sub committee the information gathered from the license application and personnel report for 1954, and from check sheets filled out in the most recent visits. (The latter took place mostly during the first half of 1954). Below is a summary of the status of the homes' compliance with the licensing requirements.

	Number of homes on which data available	Non-complying
Supervising nurse on staff	53	2
Within licensed capacity	53	3
Person available at all times	52	0
Night nurse available if over 12 beds	49	5
Disturbed patients in home	43	0
Physician for each patient	44	1
Diagnosis on file	38	19
Physicians' orders for all patients	37	14
Physicians on call	37	0
Stairs well lighted	44	2
Handrail on stairs	43	7
All patients rooms above ground	40	1
All patients rooms with acess to hall	45	4

	Number of homes on which data available	Non-complying
All outside rooms	45	0
Nursing equipment satisfactory	35	2
Satisfactory window space	43	0
Wheèl chairs	40	3
Invalid walkers	39	18
Toilets: not less than 1-8 ratio	47	10
Lavoratories: not less than 1-8 ratio	45	6
Tub or shower: not less than 1-20 ratio	40	4
Separate utility room	47	37
Separate day room	47	14

Evidently the most frequent cases of non-compliance are: lack of separate utility room, lack of separate day room, lack of invalid walkers, physicians' orders not on file for all patients, diagnosis not on file, lack of handrails on stairs, and insufficiant number of lavatories.

Difference between Nursing Homes and Homes for the Aged

Of the 58 homes included in the Health Department's survey, 44 were nursing homes, 14 homes for the aged. Generally speaking, cases of non-complience were proportionately greater among the nursing homes than among the homes for the aged.

5. Physicians' opinions on nursing homes and nursing home care

In the belief that the community's physicians are in an excellent position to observe nursing homes and are the most qualified group to evaluate the care that is given there, the committee sought to poll the experiences and opinions of a typical sample of the physicians in Minneapolis. A questionnaire was prepared with the assistance of two physicians who are members of this sub committee, and was distributed by them to members of the medical staffs of nine voluntary hospitals in Minneapolis in the summer of 1954. The questionnaire and polling technique undoubtedly had limitations which could be improved. However, the sub committee believes the results do have significance for this study.

211 physicians filled out the questionnaires and turned them in. Of these, over two-thirds indicated they had treated patients in nursing homes in the period July 1953 through April 1954. The average physician in this group had patients in about three different homes.

Also, about two-thirds of the physicians had referred patients to nursing homes during this same period. The average physician in this group referred about six patients.

About one-third of the responding doctors were general practitioners, 33 were surgeons, 33 were in internal medicine, 16 in pediatrics and about 15 in obstetrics and gynecology. The remainder had other specialties.

In brief, the physicians had these things to say:

.....One-half of the physicians aaid they had found no shortage of beds for their patients. One-quarter said they had found a shortage, and another quarter did not indicate their findings. Those who found shortages felt they were most frequently for the senile and bedridden.

.....The average physician said he continued caring for about 69% of his patients after admission to a nursing home. At one extreme, 79 said they cared for less than 20% of their patients after they were admitted to nursing homes, and at the other, 70 said they cared for up to 100% of their patients in the nursing homes.

.....Over two-thirds of the physicians indicated that their patients or relatives of their patients had complaints about Minneapolis nursing homes.

Major complaints were on nursing care (61 cases), cost (56), food (49), attitudes of personnel (36) and other patients (28). On the other end of the scale, complaints were relatively few on size, crowding, cleanliness, lighting, patients regulations and the number of beds.

..In general, the physicians thought the nursing homes were fair, comparing them with the quality they desired for their patients. Here is a summary of their responses:

Excellent	5
Excellent to fair	1
Good	47
Good to fair	3
Fair	76
Not so good	1
Fair to poor	2
Poor	9
Don't know	5
No answer	52

The respondents were asked to elaborate on the rating they gave the nursing homes. These comments are summarized in appendix 2.

6. Appraisal from records of City inspection agencies.

As noted in Chapter VI, legally the City of Minneapolis has no authority to inspect nursing homes, except for the power exercised by the City Health Commissioner:since January 1, 1956 as deputy of the State Board of Health. As a matter of voluntary cooperation by the homes, however, Inspection has continued to some extent by the Department of Building Inspection and the Fire Prevention Bureau. The heads of these agencies gave the sub committee the result of recent nursing home inspections. Before presenting them, a word is needed about a pertinent action by the City Council in 1954.

For some time prior to May 1954 it had been apparent to the various inspectional agencies, notably the State and City Fire Marshals and the City Inspector of Buildings, that many nursing homes could not comply with the prohibition on frame building (type 5) and still stay in business. They recommended that the City permit these homes to continue operating if they installed automatic sprinkler systems. On May 11, 1954, therefore, the City Council passed an ordinance permitting all such non-complying homes now licensed to continue to operate until May 1, 1957, and to continue beyond that date if by then they have installed an approved sprinkler system.

a. Building inspections

In early 1954, the Inspector of Buildings decided to undertake a more thorough inspection of nursing homes than had been done previously. A check sheet was prepared on all the major items for compliance by the nursing homes . The final item was a question: "In your opinion does the building conform to ordinance requirements?" Following is a summary of the buildings inspectors' answers:

Compliance in every respect	12 homes
Non-compliance with sprinkler and other requirements	29 homes
Non-compliance with requirements other than sprinkler	6 homes

The most frequent examples of violations other than the lack of a sprinkler system were failures to have basement ceiling plastered, basement stud partitions plastered, enclosure of boiler room, fire door from basement to first floor, and the proper number of means of egress with proper enclosures.

b. Fire prevention inspections

Records of the Fire Prevention Bureau in June 1955 showed that of the 64 nursing homes and homes for the aged listed in the 1955 state directory of licensed institutions, 16 were in need of getting a sprinkler installation by the 1957 deadline. Twelve homes had orders out for violation of other sections of the code enforced by the bureau. The acting chief of the bureau said these were mainly for lack of fire extinguishers and rubbish in corridors.

7. The C C I Survey on the Supply of beds

The information gathered by the Commission on Chronic Illness in its recent survey provides a fairly precise statistical measure of the quantity of care available.

Average percentage occupancy

Bed Capacity	Proprietary nursing care homes	Nonproprietary nursing care homes	Chronic disease hospitals	Primarily domiciliary care homes for the aged
Under 10	100.0	-	-	-
10 - 14	107.7	-	-	-
15 - 24	97.8	-	-	93.8
25 - 34	100.5	-	-	86.9
35 - 49	92.7	95.2	-	-
50 - 74	95.9	109.6	98.6	80.2
75 - 100	87.0	-	-	92.9
100 and over	-	-	92.2	98.1
Total	97.0	104.3	94.2	95.7

It is clear from these figures that on the whole the institutions were being used almost to capacity, and that a number of them were being used in excess of capacity.

8. The Wilder Report on supply of nursing home beds in Ramsey County

In 1950 the St. Paul Committee for the Chronically Ill undertook to determine the number of chronically ill patients who needed chronic hospital care and their ability to pay for such care. The committee's study, conducted by the research staff of the Wilder Charities, was based on a survey of 26% of the physicians of Ramsey County. The physicians were asked to enumerate the chronically ill persons in the community, the types of facility care they needed, the type of care they were currently receiving, and their financial ability to meet the cost of such care.

The physicians' estimates of needs may be summarized as:

		Total		WHERE CARE SHOULD BE GIVEN:		
				Own home	nursing home	chronic hospital
		No.	%			
		1,250	100%	400	290	560
		100%	-	32%	23%	45%
Where care is now being given:	Own home	705	56%	345	120	240
	Boarding-home	70	6%	-	25	45
	Nursing home	75	6	5	30	40
	Chronic hospital	400	32	50	115	235

Thus, while in this sample 75 persons were receiving care in nursing homes, in the judgment of the physicians there were actually 290 persons who needed such care. In general, they believed a shift of the chronically ill from a less intensive to a more intensive type of care facility was needed.

Later thinking, reflected in the State Hospital Plan for 1955-56, indicates that the relationship between nursing home beds and chronic hospital beds should be about 4 to 1, rather than 23 to 45 suggested in the Wilder study. However, one conclusion still stands: The needs for nursing home beds is not truly reflected by the number of people now occupying nursing home beds. Many persons now cared for in their own homes or boarding homes should be cared for in nursing homes.

The State Health Department, commenting on the experience of St. Louis County with new chronic disease facilities, has noted that providing for the chronically ill must take these factors into account:

1. The increased growth and aging of the population.

2. The chronically ill, long term patients presently in acute general hospitals (estimated to occupy 10% - 20% of such beds.)

3. That proportion of the patients now residing in State mental hospitals which might be discharged to communities if proper facilities were available.

4. Those individuals now residing in hotels, lodging houses, etc. who need care.

9. Nursing home needs under Minnesota State Plan for 1955 -56

Under the federal Hospital Survey and Construction (Hill-Burton) Program, Congress has authorized an annual grant to the states through 1957 to assist in constructing and equipping needed hospitals, public health centers, and related medical facilities, including nursing homes and chronic hospitals. Before a state can receive Federal grants for construction purposes, it must submit an over-all State Plan to the Surgeon General of the United States Public Health Service for approval.

The State Board of Health is responsible for the Hill-Burton program in Minnesota and thus for the development of the construction plan and its annual revisions. The 1955 - 56 revision outlines the bed needs and priorities for the state's nursing home construction program.

In spite of the fact that the needs for nursing home beds are so great, the Hill-Burton funds are extremely limited ($65,434 in 1955, $68,056 in 1956 and an anticipated $132,356 in 1957).

Homes for the aged and similar domiciliary facilities are not eligible at this time for assistance under the Program.

"A nursing home should have an affiliation with the community hospital.. The goal of nursing home careshould be that of making available to the patient the maximum opportunity for rehabilitation, and whenever possible resumption of a happy, economically useful life in his own home."

The minimum nursing home size consistent with efficient and economical operation is said to be 25 beds.

Existing homes are classified as suitable, replaceable and unsuitable. To be suitable, a building must be fire resistive and "adequate for providing care", which means having the necessary functional arrangements and facilities for rendering medical and nursing care.

Replaceable buildings are buildings which conform with the nursing home regulations and are equipped with a sprinkler system.

Unsuitable buildings are (1) Buildings which are neither fire-resistive nor sprinklered; (2) Buildings which at present do not conform with nursing home regulations regardless of the type of construction; and (3) Buildings which, by reason of obsolescent or uncorrectable functional arrangements are not suitable for use as a nursing home, regardless of the type of construction.

Under these requirements it appears difficult for converted old residences to be considered suitable.

The Minnesota Plan sets nursing home bed needs at 4 per 1,000 population. For Minneapolis this amounts to about 2,084. Since homes for the aged are not included and 660 nursing home beds are judged unsuitable, Minneapolis is figured to have 872 suitable and replaceable nursing home beds. 1,212 additional beds are proposed.

10. Liaison among physicians, welfare departments, nursing home operators and patients' families.

One of the sub committee's early findings was that there were shortcomings in the liaison among physicians, welfare departments, patients' families and nursing home operators. There was lack of awareness and understanding of state regulations with respect to medical care in nursing homes and lack of cooperation in carrying out the regulations.

These regulations require that (a) every patient have a physician to supervise his care while he is in a nursing home, (b) admission records contain a diagnosis of the patient's illness and definite instructions for his care and treatment and be signed by a physician, (c) medication or treatment be given only on a physicians' written order, and (d) every nursing home designate at least one physician to be called in emergency cases.

When the League's findings were brought to the attention of the parties involved, the Hennepin County Medical Society called a meeting on March 19, 1956 of representatives of the Society, the Hennepin County Welfare Board, the Twin City Association of Nursing Homes, the City and State Health Departments and this sub committee to discuss the liaison problem and consider improvements. These were the major conclusions:

a. The Nursing and Boarding Care Home Placement Form developed by the Minneapolis Health Department is to be made available by the department to Minneapolis General Hospital and other Minneapolis hospitals for completion by the attending physician just prior to the time the patient is transferred to a nursing home. The completed form will accompany the patient to the nursing home for inclusion in the patient's chart.

b. Copies of the Placement Form will also be supplied by the Minneapolis Health Department to those physicians who utilize Minneapolis nursing homes for completion on their private patients prior to admission to a nursing home.

c. The City Health Department will issue a directive to all Minneapolis home operators relative to this matter and include a supply of Placement Forms for each home.

d. Through the mechanisms described in items a-c above, all patients, public as well as private, admitted to Minneapolis nursing homes should have the completed Placement Form with them at the time of admission. It remains the responsibility of the nursing home operator to see that such a Placement Form is completed by the admitting physician, that the name of the attending physician (if other than the admitting physician) is indicated on the Placement Form, and that the Placement Form is inserted on the patient's chart.

e. The Hennepin County Welfare Board has adopted the Placement Form as developed by the Minneapolis Health Department and will use it as a basis of payment for welfare cases. The initial visit will be authorized by the Hennepin County Welfare Board.

f. Each patient in a nursing home will be required to have an examination by his attending physician at least once every six months at which time progress notes must be filed on the patient's chart. The attending physician, or in cases of emergency, the physician designated by the home, may be called more frequently if warranted by the patient's condition.

g. Problems and complaints relative to the medical care of patients in nursing homes will be referred to the Medical Advisory Committee to the Hennepin County Welfare Board whose scope will be enlarged to include private as well as welfare patients. All other complaints will be referred to the Rest Home Committee of the Hennepin County Medical Society. (It is recommended that the name of this committee be changed from "Rest Home" to "Nursing Home.")

h. Since higher rates of payments are made by welfare boards for bedridden cases than for ambulatory cases, there is little incentive for nursing home operators to encourage bedridden patients to become self-sufficient. Some solution must be found for this problem.

i. It was recommended that the association of the nursing home operators should be organized and developed to the point where general directives and information made available to its executive body can be readily disseminated to all of its members.

j. It is expected that this liaison will improve patient care and record keeping, both on the part of nursing home operators and the attending physician.

Summary of findings

In summarizing the findings detailed in the preceding pages of this chapter, we list the favorable and unfavorable aspects of present nursing home services, for the reasons given at the end of Chapter VII.

1. The availability of beds

Considering the minimum standards set down by the State Health Department for licensing purposes, there is an inadequate number of nursing home beds in Minneapolis. This is in spite of the fact that the number of available beds has increased substantially in the past 10 years, and continues to increase.

The C C I survey found nearly all beds being used. Some homes were operating beyond licensed capacity. The latest inspectional reports by the State Health Department showed the same general situation.

Nursing home operators reported they had waiting lists or could have them if they wanted them.

The County Welfare Board needs to make a daily check of all homes to locate vacant beds.

A substantial percentage of doctors said they found a shortage of beds. A large number of doctors reported no shortage, but evidence indicates that in many of these cases the doctors (1) had special arrangements with certain homes, (2) had patients demanding less complicated nursing care, (3) had patients who were able to pay above the minimum charge.

Considering the higher standards used in the Wilder survey and the State Plan, the shortage of beds is quite pronounced.

2. Staff

Favorable

The sub committee uniformly found in its visits to the nursing homes that the staff appeared neat and alert.

All homes inspected by the State Health Department had a person available at all times. Only two homes did not have a supervising nurse on the staff.

Unfavorable

The City health inspector, the Superintendent of General Hospital, the Hennepin County Welfare Board social worker and a number of doctors pointed out the difficulty of holding competent nurses and the sub normal character of some of the help. One of the major complaints of patients and their relatives was the attitude of the personnel.

Many nursing home operators reported to the sub committee visitors that their chief problem is help.

3. Nursing Care

Favorable

The sub committee generally thought the patients seemed well cared for and content. They noted that none of the patients were used to care for other patients, a charge which had been heard.

University Hospitals reported that medical care was well-controlled in the selected homes to which their patients were sent.

The State health inspectors reported in 1951 that the majority of operators were trying to get patients out of bed. They report no disturbed patients in the homes.

Steps are being taken to improve liaison among physicians, nursing home operators, welfare departments and patients' families.

Unfavorable

The City Health Commissioner recently said that the quality of nursing care in the majority of the nursing homes is the largest problem to be solved in the nursing home field

The State Health Department in its earlier report found physicians' orders on file for less than one-half the patients, few written diagnosas, medical histories or progress notes. In its most recent inspections the department still reported that physicians' orders are not always on file, and no information on diagnoses as a guide for the nursing home operator.

The major complaint of patients and relatives reported by the doctors, was nursing care.

4. Building

Favorable

With few exceptions, the sub committee's laymen's observations during its visits, revealed the homes to be in good repair and clean. The halls were clear.

The State Health Inspectors found only one building with all patients rooms not above ground level. They found satisfactory window space in all the homes.

Unfavorable

The sub committee found most homes without ramps for wheelchair patients.

The State Health Department inspectors found a general lack of utility rooms and day rooms. They pointed out a lack of handrails on stairs and an insufficient number of lavatories in many homes.

The City Inspector of Buildings found most of the nursing homes were not in compliance with the building code on one or more points.

The State Plan considers 660 nursing home beds as unsuitable.

5. Housekeeping

Favorable

The sub committee reported all blankets appearing clean, kitchens clean, halls clear andbuildings generally clean.

Complaints reported by doctors were relatively few regarding cleanliness of homes.

Unfavorable

The City Fire Prevention Bureau had 12 orders out on violations of various kinds, including rubbish in corridors.

6. Equipment

Favorable

The sub committee noted that easy chairs were provided and the adequacy of such recreation facilities as television and radio. Members found the kitchens adequate.

With very few exceptions, the State Health Department found nursing equipment satisfactory.

Unfavorable

Nursing home operators reported to the sub committee that pecreation is a problem.

The State Health Department found practieally no hand washing facilities, and that not all homes have first aid supplies readily available.

Invalid walkers are lacking

Telephones were not available on all floors, the sub committee found.

7. Physiotherapy, rehabilitation

Unfavorable

The sub committee reported a lack of facilities for rehabilitation, except for one home visited.

General Hospital representatives aaid no rehabilitation was tried due to the lack of trained staff.

The State Health Department in its earlier report said the greatest lack in the homes was a lack of space for physical or diversional therapy.

8. Overall Rating

Favorable

University Hospitals said it had good success with the better homes.

General Hospital representatives said that on the whole the facilities are adequate. They reported few complaints from patients and relatives.

Unfavorable

Representatives of the University Hospitals, General Hospital and the Hennepin County Welfare Board found a great need for nursing homes for young adults between the ages of 20 and 40.

University Hospitals also found a need for nursing home facilities for its rehabilitation patients.

General Hospital finds some nursing home operators refuse to accept patients who could benefit from care in their homes.

The State Health Department in its earlier report felt the need for concerted planning for patient care, between the attending physician, a social worker and the nursing home operator.

The physicians found the homes fair.

Over two-thirds of the doctors had patients with complaints about nursing homes. The three major complaints were on care, cost of care and food.

9. The Trend

Favorable

In 1951 the State Health Department noted a considerable improvement in the general facilities of the nursing homes during the preceding 10 years.

Several physicians commented in 1954 on the great improvement in the past several years.

Unfavorable

The City Health inspectors in the fall of 1954 found that it was still difficult to get the operators of the older homes to make improvements.

IX

HOW MANY MORE BEDS ARE NEEDED?

In Chapter VIII we concluded that there is a need for additional nursing home beds in Minneapolis. How large is this additional need, and what is the future trend likely to be? Answers to these questions have a bearing on the measures adopted to overcome the present shortage.

A. Estimated bed needs

Projections of needs for hospital beds and related facilities have come to be based on ratios of beds to population, with modifications according to local circumstances. Such ratios are developed out of experience with actual needs and resources over a period of years. As experience grows, of course, the ratios are revised from time to time.

In 1950, James A. Hamilton and Associates, hospital consultants, prepared a comprehensive appraisal of community hospital needs in Hennepin County for the Minneapolis Hospital Research Council. In projecting bed needs they used ratios of 1.48 beds per 1,000 population for chronic disease hospitals and 2.95 beds per 1,000 population for care in nursing homes and homes for the aged for a total of 4.43/1,000. Their estimates were based on information from the 1938 National Health Survey of the United States Health Service indicating by age group the number of persons having some chronic illness and a ratio indicating the number of chronic invalids included in the 1930 United States Census.

The City of Duluth and St. Louis County, Minnesota, have provided more than five beds per 1,000 population in chronic disease hospitals, nursing homes and homes for the aged. It has been found that this number of beds is inadequate to serve the need, particularly with respect to the patient who is in a position to finance his own care.

The most recent ratio of beds to population which we have found is that developed and used by the State Health Department in the Minnesota State Plan for Hospitals, Public Health Centers and Related Medical Facilities. The State Plan projects an overall ratio of five beds per 1,000 population, with nursing home and chronic hospital beds in a four to one ratio.

In measuring existing resources to determine the margin of need under this formula, the State Plan excludes homes for the aged and beds which are not "suitable". After these deductions, this is the way Minneapolis rates:

	State Plan	City of Minneapolis		
	Proposed number of beds per 1,000 population	Suitable and replaceable beds		
		Total	Per 1,000 Population	Additional beds prop.
Nursing homes	4.0	872	1.60	1,308
Chronic hospitals	1.0	78	.13	467
Total	5.0	950	1.73	1,775

B. How Sound are the Estimates?

There are points on both sides.

As noted earlier, the requirements set forth in the State Plan are closer to being optimum requirements than minimum requirements, and naturally so in view of the purpose of the plan. Beds in Minneapolis not considered suitable under the plan include many which, as a matter of fact, are now providing service above the minimum standards.

On the other hand, these factors must be kept in mind:

Chronic illness can be expected to increase as time goes on. Some comments on this tendancy were brought out in Chapter IV. Booz, Allen and Hamilton, hospital Consultants, made this statement in their May 1955 report to the Minneapolis Hospital Research Council: "There is substantial evidence that the incidence of chronic invalidism is increasing at a more rapid rate than the growth of population, largely because of the increasing ratio of older people."

There is one other factor which is frequently cited as a potential demand for more nursing home beds. This is the existence of many persons who belong in nursing homes but are not now there.

In evaluating this factor it is necessary also to consider the persons who are now in nursing homes but should be in other facilities.

We have some figures which enable us to evaluate this problem in a general way. The CCI Survey in Minneapolis asked the operators of the chronic care facilities to classify the patients in their establishments as to their need for care.

Their judgments were as follows:

	PERSONS IN :			
	Proprietary nursing homes	Non-proprietary nursing homes	Total No.	Total %
Could not ordinarily be given care in own home	670	63	733	70%
Might be given care in own home	228	25	253	24%
Mainly boarding care	35	32	67	6%
Total	1,033	120	1,053	100%

To actually give care in the person's own home necessitates adequate space, proper living arrangements, and a number of other conditions. It is our belief that the public welfare agencies, which have charge of over half the patients in the nursing homes, are keeping the indigent in their own homes whenever possible. Probably then, about 75 of the 253 who might be given care in their own home from the standpoint of medical care could as a practical matter be shifted there from nursing homes.

We can assume that all 67 who are receiving mainly boarding care could be put in boarding homes.

Of the 733 who could not ordinarily be given care in their own homes, probably some should actually be in a chronic hospital rather than in the nursing home. The State Plan estimates that 1 in a 1,000 population need chronic hospital care, or about 545 for Minneapolis. Doubtless many of those who should be in chronic hospitals are now in acute hospitals. Assuming that about one-half the 545 are in acute hospitals, leaves about 273 who should be in nursing homes.

Overall, therefore, assuming that chronic hospital beds were available in adequate supply, cases only needing boarding care were put in boarding homes, and persons who could be adequately cared for in their own homes were placed there, we could expect that about 415 nursing home beds would be vacated (75 to private homes, 67 to boarding homes, 273 to chronic hospitals).

On the other hand, certain conditions would tend to increase the number of nursing home patients. Acute hospitals are now considered to have 10% to 20% of their patients who could be cared for at the lesser cost level of the nursing homes. With the present census of voluntary hospitals in Minneapolis at about 2,000, a 15% rate would mean a shift of about 300 patients to the nursing homes.

In addition, we have heard statements from reliable authority to the effect that people are now in their own homes or in boarding homes who actually need the care of a nursing home. We have seen no figures cited on Minneapolis, but understand the number is substantial. The doctors polled

in the Wilder Survey estimated that persons in their own homes or in boarding homes who needed nursing home care amounted to about 50% of those who were already in nursing homes. In St. Louis County, where a number of chronic hospitals have been opened in recent years, persons needing care for chronic illness seemed to "come out of the ground" when the facilities became available.

Finally, Minnesota's Commission on Aging pointed out that many of the patients in state mental hospitals are senile cases who could be taken care of in nursing homes and if so handled would release needed beds for mental cases who could benefit from treatment. On June 30, 1954, 1,952 of the patients in the state hospitals were senile cases. Minneapolis' proportionate share of this total on a population basis would be about 350.

On balance, therefore, it seems that a relocation of chronic patients to suit the patient to the facility would result in a net need for a substantial number of additional nursing home beds. It seems that this would be so even if a major policy decision were not made to take senile patients out of state hospitals and place them in nursing homes.

C. Summary and conclusion

While it appears to this sub committee that the bed ratio for nursing homes established by the state plan is more an optimum than a minimum for the present in view of current conditions, it is not unrealistic in the longer run. This is particularly so if there is a lag in the rate of construction of additional chronic hospital beds; if greater effort is made to place in nursing home facilities persons who are now in facilities providing a lower level of care; if efforts are made to replace homes now considered substandard; and if action is taken to transfer senile cases from mental hospitals to nursing homes.

X

WHAT SHOULD BE DONE?

Our County and City Governments have a responsibility for providing nursing home care for the medically indigent who have chronic illness. We have found that the care now being provided is not adequate in quantity or quality. What should our County and City governments do to make it adequate?

Several basic points need to be kept in mind:

1. Solution of the nursing home problem for the medically indigent involves the State and Federal governments as well as the local governments. The Federal government shares in the financing of old age assistance grants and, since 1955, in Hill-Burton funds for the construction of nursing homes. The State also shares in O A A grants, administers the Hill-Burton funds, and has the responsibility of inspecting and regulating nursing homes. With O A A patients constituting such a large share of the indigents for whom our local governments must provide nursing home care, it is imperative that our local governments (especially the County) share the responsibility for improving care with the other levels of government. The County should recognize its responsibility but should not be expected to undertake more than its own fair share.

2. Solution of the nursing home problem for the medically indigent in many respects involves solution of the problem for non-indigent patients as well, since together they constitute the total demand for nursing home facilities.

3. Greater public understanding of the needs of the chronically ill is essential. To this end, we recommend widespread education in the growing needs of the chronically ill and the results of research and study that have already been applied to the problem. In particular do we commend careful study of the June 1955 recommendations of the Commission on Chronic Illness. They are quoted in part in chapter VII above.

4. An adequate approach to the problem requires concerted action by the total community--government, professions involved in patient care, welfare agencies, civic groups and individuals. The 1955 recommendations of the Commission on Chronic Illness indicate the comprehensive type of approach which is necessary.

A reading of these recommendations should be sufficient to impress anyone with the brashness of the sub-committee if we were to try to detail the steps that should be taken in Minneapolis and Hennepin County to improve the inadequate conditions in nursing home care that we have found. We believe, however, that our research to date has qualified us to at least suggest some steps that need to be taken, particularly in the area of action by our local governments.

A. Improving the present system of propritary and nonprofit voluntary homes

Since private enterprise is the traditional American system, and this is the system in effect in the nursing home field in Minneapolis, we should first explore how the present system can be improved, and try to determine whether adequate improvement is likely to occur soon enough to meet the unsatisfied needs.

1. What improvements are needed and how can they be achieved?

There appear to be five specific needs for improving the quality and quantity of care in the present nursing home system: (a) increasing the number of available beds, (b) improving inspection and regulation, (c) improving personnel, (d) improving liaison among professional groups, nursing home operators, welfare agencies and patient's family, and (e) improving the self-regulation of nursing home operators.

a. Increasing the number of beds.

The sub committee was impressed by the fact that an increase in the number of beds is needed not only to provide beds for those who otherwise will go without, but also to improve the standards in existing homes by increasing the competition for patients. The sub committee frequently heard the comment that the lack of competition among nursing homes is a basic cause of sub standard care. It was said that the shortage of beds forced public agencies to place their patients in marginal or sub-marginal homes which would not be considered if more and better facilities were available. Representatives of both the County Welfare Board and the City Relief Division have said that the value of competition has been shown in recent months. The two agencies have been able to get better patient care in a number of instances by removing patients from less satisfactory homes and transferring them to better homes.

A major factor in stimulating the addition of beds is the adequacy of financing. Is there enough money in the nursing home business to call forth capital and labor for the construction and operation of more nursing homes?

Adequacy of current financing. Is the public welfare rate schedule high enough to compensate the nursing home operators adequately? Such indirect evidence as we have seen indicates that the payments are adequate. We cite these indications:

County and city social workers maintain that grievances among the operators over rates are rare. Each patient's rate is independently considered and at that time the operator has an opportunity to agree to or dissent from the proposed rate.

The former head of the Twin City Association of Nursing Homes, Mr. Carleton Boyce, in a letter to the sub committee cites the difference between rates at hospitals and charges at private nursing homes. He suggests, however, only that the cost of maintenance for care of patients should be reviewed periodically. This appears already to be the practice.

The gradual increase in number of nursing homes (see page V-3) seems to bear out the contention that welfare rates at nursing homes are adequate, at least to finance the standard of care presently given.

Availability of capital. Is enough capital available to facilitate purchase or construction of nursing home buildings? It appears not.

Mr. Boyce stated: "It is estimated that new construction would cost between $3,000 to $4,000 per bed. Hospital construction, of course, is many times that. Financial institutions have been very reluctant to provide financing for this type of construction because of its single purpose utility. As a result, the private operators have had to rely upon reconverting old structures no longer useful for private dwelling."

Our checking with several large lending institutions in Minneapolis resulted in these findings:

Applications are considered on the character and status of the individual applicant. The nursing and rest home business itself does not allow for too much latitude on the part of the lending institutions. By Federal law lending institutions may make loans of 10 year maximum. The home operators feel they need 20 year loans.

Since loans are based on 60% of the property valuation, in the case of homes that were formerly one or two family dwellings appraised value is bound to be very low.

Thus it does appear that there are difficulties in financing the construction of nursing home facilities.

The Federal government has recognized this difficulty in recent years in two ways. First, it has expanded Hill-Burton fund grants to include nursing home facilities as well as hospitals. Second, President Eisenhower has urged federal insurance of mortgage loans made by private lending institutions for construction of nursing homes and other private medical care facilities.

The effect of zoning. Do zoning regulations deter an increase in nursing home facilities? Yes, but probably not to the detriment of the total community interest, because more than the need for nursing homes must be considered in zoning regulations.

The nursing home operators association feels that zoning prohibitions against multiple dwelling in single family zones tend to restrict the supply of nursing home beds. In a letter to this committee the former president of the association states: "In Minneapolis we find that the largest and most suitable mansion-type homes which are gradually being abandoned by the families as too cumbersome or inefficient for private dwellings are located in areas restricted against multiple dwellings. There are many beautiful homes located in the fine old residential districts which have been vacated and stand empty because no longer useful for single family dwellings. These homes are spacious, well lighted, in fine surroundings and would make ideal nursing homes. The only other alternative is to tear the homes down or reconvert, in violation of zoning ordinances, to rooming houses, or small apartments. There have been several instances where these old homes, vacant for years, have been rezoned and have been converted to nursing homes. The nursing home does not deterioriate the value of property, nor does it constitute a neighborhood nuisance. The operators of the homes generally have taken good care of the outside appearance and lawns and have remodelled to keep them in excellent condition The residents of the nursing homes rarely get out of the home, and, of course, cannot disturb the neighbors in any way. In many instances conversion of the old mansions to nursing homes has enhanced the value of surrounding property."

The sub committee has consulted with several realtors who are familiar with the type of neighborhood referred to by Mr. Boyce. They have said that it is difficult to generalize on the effect on neighborhood property values of opening a nursing home in such areas. It will depend, among other things, on the trend of the neighborhood -- whether it is on the downgrade and to what extent -- the particular residence converted, and the quality of the particular nursing home operation.

The question of the availability of multiple dwellings for conversion to nursing homes runs directly into the problem of standards of nursing home facilities. As noted, [illegible], multiple dwellings can be converted in such a way as to meet state and local regulatory requirements. However, in the main, they can not be converted to become "suitable" homes as that term is defined under the State plan for distribution of Hill-Burton funds. For one thing, they are usually not large enough to house adequately the 25 beds that are considered minimal for providing good service. Recognizing that the State plan sets forth a goal to shoot at, and that multiple dwellings do provide a practical way of increasing the number of beds which, after all, do meet minimum standards, it does seem desirable to facilitate the conversion of such dwellings to nursing homes, particularly for those patients requiring less intensive nursing care, or to boarding care homes where no nursing care is required.

So far as the specific question raised by Mr. Boyce is concerned, however, it should be recognized that zoning policy and administration must take into account all the human and property values of the city and its individual neighborhoods, not just those involved in the expansion of nursing home facilities. This is therefore a question which the Planning Commission and the City Council must settle on the basis of more facts than we are able to assemble within the scope of this study.

We note that the Planning Commission and the Council are aware of the desire of nursing home interests to use more converted single family residences. On recommendation of the commission, the City Council in December 1955 established a limited business district between LaSalle Avenue, Lyndale, Loring Park and Franklin. This area was a single family residence district, with many of the large type residences referred to in Mr. Boyce's statement. Under a limited business district, multiple dwellings will be permitted. However, a special City Council permit is required to revise existing structures.

We understand that since the establishment of this limited business district there have been no applications for conversions of dwellings to nursing homes in this district.

Expansion of other facilities for chronic illness care. As we have noted several times during the course of this study, there is a close interrelationship among illnessess -- those treatable in the home as well as in various types of institutions -- and among the facilities available for their care. Increases in the supply of one type should help relieve the demand for others. We note also the increased emphasis being given to the use of foster homes for the aged, and the concern for the provision of low-cost housing for the aged. To the extent that nursing homes now house persons not needing nursing care, the latter will serve to draw off some of the current demand on chronic facilities.

b. Better inspections.

An important factor in the maintenance of good standards in any field subject to governmental regulation is adequate enforcement of regulations. This means, first of all, that there must be frequent and careful inspections, to determine to what extent the regulated businesses are complying with regulations, to apprise those regulated of the meaning and intent of regulations, to help them meet the requirements, and if necessary, to initiate action to see that they comply.

We have seen that inspections of Minneapolis nursing homes have been below par. The State Health Department has had an inadequate staff to provide sufficient coverage of the entire state. From 1951 until January 1, 1956, the City of Minneapolis was essentially shorn of legal authority to license and regulate nursing homes except as to zoning requirements, although some inspectional activities were carried on without sanction of law.

With the recent deputization of the City Health Commissioner by the State Board of Health to perform nursing home inspections in Minneapolis, the City has taken a long step forward in improving regulation and inspection of nursing homes. Dr. Karl Lundeberg, Health Commissioner has shown a real appreciation of the nature of the problem (he took the initiative to have the State deputize the City). He has tackled the assignment with commendable energy and yet has appreciated that inspection and regulation to be successful must be based firmly on education and cooperation with those regulated. He has undertaken to confer and work with the nursing home operators, as illustrated by development of the new Placement Form and the procedure for improving liaison among the operators, physicians, welfare agencies and others concerned. (see VIII -13)

Yet encouraging as these developments are, we must recognize continued limitations. The City can only inspect for compliance with State regulations, it can not impose its own regulations. Since State regulations are minimum and are scaled to statewide application, it may develop that in some cases they are not adequate for the problems arising in a large urban center. In addition, without the regulatory power the City does not receive the license fee. It still goes to the State. This is an important consideration since it affects the ability of the City to employ an adequate number of inspectors.

Finally, the City still has no authority to inspect nursing homes for building safety and fire hazards. While here again the State regulations on fire safety do have an effect, they do not cover in the same detail the provisions of the building code, and the State Fire Marshal's office has the whole state to cover.

It seems to the sub committee that because the City has the most intimate concern with the standards of nursing homes, it should have direct authority to protect itself by licensing and inspection. Legislation should be sought in the 1957 Legislature to restore these powers to the City Government, and adequate staff should be provided to carry them out.

With regard to improvement of State regulatory activity, it would appear that with improvement of local regulation the State could accept a cooperative arrangement in which the City would be responsible for making the inspections in the first instance and thus would exercise delegated power, with the State Health Department auditing the inspections periodically and assisting where-ever necessary.

The details of the relationship between the State and the City regulatory and licensing activity will need study. Separate licenses by both the City and State are not desirable. Preferably a single City-State license could be issued following approval by the City, with either jurisdiction having the authority to revoke the license if the minimum standards of either agency are not met.

c. Getting and keeping good nursing personnel.

A recurrent complaint from the several sources consulted in our survey concerned nursing home personnel. Many nursing home operators reported to the sub committee's visitors that help is their chief problem.

The City Health Inspector, the former Superintendent of General Hospital, the Hennepin County Welfare Board social worker and a number of doctors pointed out the difficulty of holding competent nurses and the subnormal character of some of the help. One of the major complaints of the patients and their relatives was the attitude of personnel toward the patients.

No doubt the lack of sufficient personnel results to some extent at least from limited financing, although more generous financing alone would not necessarily bring about improved nursing home personnel. Another cause was pointed out by the former superintendent of General Hospital and touched on by others contacted, including several doctors. This is, that some employees find working with the aged is discouraging and unrewarding.

The personnel problem is a nationwide problem. In his recent health message, President Eisenhower asked for federal aid to meet personnel shortages in the health field. The CCI has said:

"Personnel shortages in the professions concerned with the chronically ill remain so serious as to constitute a major block to improvement of care. The number of personnel must be increased by better recruiting, assistance with the costs of education, better salaries, and other inducements to enter and remain in practice. This is particularly applicable to the classes of personnel associated with physicians in patient care.

"In addition, changes in curricula for undergraduate, graduate, and post-graduate education are needed to produce personnel interested in and equipped to care for long-term patients."

d. Shortcomings in liaison among physicians, welfare agencies, nursing home operators, patients' families.

State Health Department regulations state: "Each patient or his guardian or the agency responsible for his care shall designate a licensed practitioner of the healing arts for the supervision of the care and treatment of the patient during his stay in the nursing home."

The January 1951 report by the State Health Department on nursing homes in Hennepin County stated: "Operators frequently expressed a need for more guidance from physicians." While the state inspection reports (page VIII-7) indicate that in only one of 44 cases did state inspectors find that there was not a physician for every patient, the CCI survey indicated that the median time elapsed since the last visit of a physician was 10 months.

It must be noted, however, that when a patient is in a nursing home, the physician may visit him only on request of the patient, family or welfare agency, or in case of an emergency the nurse in charge may call for medical assistance.

The existence of misunderstandings as to the responsibilities of the various parties involved in nursing home care, and the inadequacy of cooperation among these groups led the sub committee to the conclusion that improved liaison was necessary (see page VIII -13).

Social workers and nurses, as well as physicians, are members of professions devoted to improvement of the health and welfare of the individual client or patient. They should continually strive to improve the caliber of nursing care through their individual efforts with patients in nursing homes and as professional groups through publicity and raising of standards.

e. Improving the self-regulation of nursing home operators.

No doubt the single group with the greatest stake in improving the present system of nursing home care are the nursing home operators themselves. This is of course especially true of the proprietary home operators. They are beneficiaries of the present system, and receive the bulk of the more than $2,000,000 of annual governmental expenditures for nursing home care in Hennepin County.

They have an opportunity to make reasonable profits. But with this opportunity goes responsibility to provide the type of service which would stimulate and retain confidence on the part of the public and their elected representatives.

Yet all the evidence that this sub committee has seen indicates that the operators have not shown much energy and initiative in raising their own standards, in disciplining their own members so that the standing of the total group will not be lowered by the substandard practices of a minority.

The nursing homes are licensed facilities subject to supervision and advice from government. As a matter of self-preservation, the nursing home operators should undertake more self-policing and self-regulation, to the end that they raise their own standards. As they do this, they should be bothered less by regulations and criticisms and be less subject to competition from publically owned and operated facilities.

2. What are the prospects for improvement?

a. More beds

The prospects are mixed. The possibility of federal mortgage insurance proposed by the President is probably good in view of the growing awareness of the financing problem, but we have seen no estimate of what bed expansion could be expected, or how soon. A favorable zoning change has occurred, but has not brought forth additional nursing homes.

The possibility of indirect relief from diversion of patients to other facilities seems good. First, there is growing recognition of the value of keeping people in their own home, and increasing use of Homemaker and Housekeeping Service and Visiting Nurses Service. There is also growing emphasis on foster home care and low-cost housing for the aged. These trends should continue.

Secondly, expansion of hospital facilities, including chronic facilities, in Minneapolis is in prospect. The Ford Foundation grant of $1,700,000 to Minneapolis hospitals and the imminent launching of the $15,015,000 United Hospital Fund drive will provide substantial stimulus. Tied in with this will be continued grants to hospitals of Hill-Burton funds from the federal government if the program is extended beyond fiscal year 1957.

b. Better inspection and regulation

The recent arrangement between the State and City governments promises to improve nursing home regulation and inspection. The extent of the improvement will depend on many things, important among which will be the type of legislation, if any, enacted at the next legislative session, and the City's willingness and desire to finance the services of inspectors.

c. Better nursing personnel

As noted, this is a nationwide problem. It will require a long time to be solved and will necessitate overcoming the effects of low salaries, a lack of nurses' interest in this type of work, and lack of emphasis on chronic illness care in the professional nursing organizations.

d. Improved liaison among physicians, welfare agencies, nursing home operators, patients' families.

We have seen groundwork laid for improvement in this area in recent weeks with the adoption of a new Placement Form and procedure to tighten up on the provision of medical care in the nursing home. We believe that the community can look for noticeable improvement in this area.

e. Better organization and self-regulation of nursing home operators

It is difficult to assess to what extent the nursing home operators will raise standards of care through their own organization. However, the fact that the organization has seemed relatively weak until now, and that it has been exhorted by outside sources such as the City Health Commissioner to become more active for the benefit of the operators, indicates that some improvement is in the offing from this source.

3. Are there inherent limitations in the present system?

Before summing up our conclusions on the possibility of getting adequate nursing home care under the present system of proprietary homes and non-proprietary voluntary homes, it is necessary to comment on two obstacles to good nursing care that are said to exist in a system so heavily dependent on proprietary homes. These limitations are the inability of inspectors to guarantee high quality of performance in a nursing home, and the inconsistency of the profit motive with the provision of nursing home care.

a. Inspections. The argument in support of the inherent limitation of a system based upon government inspection may be summarized thus:

There are two requirements for good nursing home care: (1) the provision of proper environmental conditions, such as a safe and properly designed building, good beds, adequate ventilation, and a high standard of cleanliness and maintenance; (2) medical, nursing and personal care, involving proper diet, administration of drugs, and the necessary "tender loving care" of physicians and nurses. The former lends itself much more easily to checking by inspectional personnel. This is evident from the catalog of items that State inspectional people are required to observe. But even with reasonably frequent inspections it is possible for nursing home operators to maintain their homes in substandard conditions between inspections.

The effectiveness of inspections in maintaining adequate standards of medical nursing and personal care is even more limited, however. This is true even with close checking by physicians and social workers, because of the case of relaxing standards of service when they are not present.

In defense of reliance on inspections these arguments can be made so far as Minneapolis is concerned; (1) It is unfair to judge the effectiveness of inspections by the type which has existed in Minneapolis. The State has had an inadequate inspectional staff. The City has lacked staff and until recently also lacked authority. (2) The CCI and other national organizations place a good deal of emphasis on the value of inspections, and have developed many suggestions for improving inspections.

b. The profit motive.

We have found arguments on both sides of this question.

(1) The profit motive is not a deterrent to good nursing care.

(a) Many homes operated for a profit are providing good care.

(b) Publications of nationally recognized groups interested in the chronically ill have not questioned the basic value of proprietary nursing homes. Homes can be in business for profit and still be dedicated to patients' welfare.

(c) The physician is concerned with the welfare of the patient, yet at the same time he is also seeking a reasonable profit.

(2) The profit motive is a deterrent to good care.

(a) Hospitals have come to be predominantly non-profit institutions.

(b) Virtually by definition, an institution operated for profit must more often than not resolve questions of "profit or patient" in favor of profit.

(c) In the past nursing homes in Minnesota could not develop as governmental facilities because of the original social security law, which forbade old age assistance patients to be cared for in governmental facilities. This gave an impetus to proprietary institutions which otherwise might not have existed.

(d) Substandard care is found more frequently in the proprietary homes than in the homes run by voluntary organizations.

We believe that these inherent limitations do exist in nursing home care under the proprietary system, but that they are far less important influences than other factors we have cited.

4. Needs will not be met by reliance on present developments alone.

We concluded in the previous chapter that a substantial increase in nursing home beds is needed in Minneapolis. We have seen that this increase is needed not only to make beds available to persons now unable to get beds because of the short supply, but also to improve the standards of care in existing beds through the force of competition for patients. This competitive influence is probably as important as any factor in the improvement of standards of care.

Forces are at work to increase the supply of beds -- liberalization of zoning and mortgage loan requirements, the Ford Foundation grant, the UHF drive and the availability of Hill-Burton grants, additional beds at the Variety Club Heart hospital and Sister Kenny Institute. But liberalization of mortgage loans is still uncertain at best. Rezoning will not necessarily provide "suitable" beds in the sense of facilities designed for nursing home use. The UHF drive and Ford Foundation grants will have limited effect as they draw off patients now in nursing home facilities who should be in chronic facilities.

Efforts in these various directions should be encouraged by all means, as well as actions to improve quality of care through other means, such as improved inspections, better personnel, better liaison among physicians, welfare agencies, nursing home operators and patients' families, and improved self-regulation of the nursing homes.

But it is clear to us that these developments alone are not going to meet the need for additional nursing home services.

C. What action should be taken to increase nursing home service?

Government, voluntary non-profit organizations and proprietary organizations must all expand their services for the chronically ill, and this in the end will lead to greater expenditures by all groups.

We may note here that in coming to this conclusion with respect to one of the three, government, we have taken cognizance of the already high level of its expenditures in this City and State. A discussion of this matter is presented in chapter XI.

1. New agency needed to provide leadership and coordination in action, research and education (1)

Expansion of nursing home service will need forceful community leadership along several lines: (1) Widespread education in the growing needs of the chronically ill and the results of research and study that have already been applied to the problem. (2) Study of the basic problems involving a more exact determination of unmet need, the cost of meeting that need, and policies to be followed in meeting the need and sharing all the cost. (3) In both (1) and (2), coordination of the efforts of groups that are concerned with the problem including the City and County welfare agencies, the nursing home operators association, hospitals, voluntary health and welfare agencies, and organized groups that are working in some specific area of chronic illness, as cerebral palsy, polio and heart.

In some cities local commissions on chronic illness have been established to provide the educational, research coordinating services needed. This sub committee has explored the possibilities of having an existing community organization undertake the leadership in setting up such an agency, but so far without success. We are convinced of its urgency, however, and therefore will continue to sound out various responsible groups and individuals in the community with the eventual hope of stimulating the formation of an agency which can provide very important services which we have outlined.

(1) This committee recommendation was not fully accepted by the Board of Directors. See transmittal letter.

Decisions on the long range major policy questions mentioned above will not be easy and will require the best thinking of the community. It is important that they be approached with a full use of available facts and consideration of the many ramifcations involved. On the basis of our research we have outlined in Chapter XI what we believe these major questions are, and some of the important factors that must be considered.

2. Use of Minneapolis General Hospital for Chronically Ill

From time to time, attention has been called to the possibility of establishing a unit for care of the chronically ill medically indigent at Minneapolis General Hospital. In 1952 this was one of the matters which Mayor Hoyer asked the Citizens League to look into.

The possibility seems logical, because (1) the hospital is set up primarily for the medically indigent; (2) though it is now devoted to the care of acute illness, there has been a long-run steady decline in acute cases; (3) there are advantages in a close physicial and operational relationship between acute and chronic hospital care.

It is therefore important to consider use of General Hospital as a possible additional resource for chronic illness care.

a. Present status of hospital.

At the time Mayor Hoyer raised the question about the hospital, there had been discussion on the Minneapolis Board of Public Welfare about building a new hospital building or wing to house acutely ill patients. The discussion dealt with the use of facilities expected to be vacated. The Welfare Board actually had plans drawn for the new building.

The Citizens League's Health, Hospitals and Welfare Committee in August 1953 concluded that no new building should be built at that time but that by 1963 several new facilities should be added to existing buildings: surgical suites, and recovery rooms, laboratory facilities, and out-patient facilities. Since 1953 the surgical suites have been brought up to acceptable standards by air-conditioning, installation of non-conductive floors, and other improvements. 1956 bond funds have been requested to build a recovery room adjacent to the surgical suite. Laboratory facilities and out-patient facilities are generally unchanged.

The Health, Hospitals and Welfare Committee found that the hospital was "far from overcrowded" in 1953. This situation is basically the same now, although some of the changes that have been made have reduced the vacant space. Thus, the installation of cubicle curtains to replace the old-fashioned wooden moveable partitions, and the furnishing of bedside tables for each bed, have increased the amount of space taken up by each bed, and thereby have reduced the bed capacity of the hospital. Rated capacity declined from 629 in 1952 to 529 in 1955.

Some of the changes now being considered would also reduce the unoccupied space in the hospital. We may note at this point that in 1953 the League recognized the inefficient use of space and recommended that a study be made to remedy it.

To sum up the present status of General Hospital as an acute general hospital:

Currently the hospital is operating at a relatively low level of occupancy - about 55%. The hospital superintendent does not, however, consider this excessive in view of the scattering of vacancies among the several services and the fact that the institution is an emergency institution and thus must be prepared to accomodate an increased load with no advance notice. (This is what happened when the Cargill plant exploded last year). The building is basically sound and fireproof, except for the out-patient unit which according to the 1953 League study, should be replaced.

There seems to be general recognition, however, that despite its soundness as a structure, the existing hospital is physically organized in such a way as to make operation inefficient and costly. For this reason the Board of Public Welfare requested the City Council, through its Long Range Capital Improvements Committee, to budget $10,000,000 in the future for a new building. The LRCIC in its preliminary report did not place this project on its list for work within the next six years. The request is now being reviewed by the LRCIC's task force on public buildings.

The MGH representative on the UHF has not indicated any plans for new construction or expansion of facilities at the hospital.

b. General Hospital has characteristics sought by State plan in grants for chronic hospital and nursing home facilities.

In the consideration of possible use of General Hospital for chronic illness care, it is of more than passing interest to note that the State plan for hospitals and related facilities sets forth criteria for grants to chronic hospital and nursing home units for which General Hospital seems well qualified.

The plan sets forth criteria for measuring the number of suitable chronic hospital beds, the number that should be in existence, and the number proposed to make up the difference. The plan does not allocate beds among the state's communities. They are held in a pool for distribution on a regional basis, as separate units or wings of existing general hospitals. The plan sets forth several priority criteria for establishing chronic disease units of general hospitals:

"1. As operating units (at least 30 beds) of established regional or community general hospitals which are at least 100 beds in size; where the percent and type of occupancy of the existing general hospital is such as to warrant the addition of such a unit; and where a realistic program in physical and occupational therapy and rehabilitation is already underway, based on the experience of an existing, adequately staffed and functioning department.

"2. Because of the difficulties anticipated in staffing these hospitals, it appears desirable to develop the training facilities first in order to assure insofar as possible, personnel to staff similar institutions in the future. Therefore a priority criterion has been adopted as follows:

'Priority will be given to those projects in the chronic disease category which will be operated as units of approved teaching hospitals. For the purpose of applying this criterion the hospital shall be rated according to the number and caliber o the approved teaching programs conducted and the extent of an interest in the existing program in rehabilitation and priority given accordingly.'"

The plan for nursing home units indicates a clear need for more beds in Minneapolis, but indicates that relative to the rest of the state the need is not so great. However, in the discussion of priority criteria for distribution of project funds, the plan lists these important factors in addition to relative need:

"1. Nursing home units of hospitals where the nursing home will be operated as an integral unit or part of the hospital. In applying this criterion consideration will be given to the size and character of the existing hospital (a fire - resistive structure with approximately 30 beds except in sparsely settled areas where fewer beds have been designated), the possibility of adding additional beds without necessitating major changes in the existing physical plan and the interest in and extent of a planned program for providing rehabilitation services including physical, occupational and recreational therapy.

"2. The size and character of the proposed nursing home unit which is consistent with efficient and economical operation.

"3. During the initial phase of the program when Federal funds are extremely limited, consideration will also be given to the provision of a demonstration project which will be readily available to a large segment of the population and which can be used as a model to follow in planning future nursing homes both with and without aid under this Program. In applying this criterion, consideration will be given to that community hospital which presents the most realistic program for the rehabilitation of nursing home patients and which will utilize the proposed facility as an integral part of its teaching program."

c. Importance of hospital as center for training personnel in care of the chronically ill

We may make special note of the importance of the teaching program pointed out in the State plan as it applies to General Hospital. Since the hospital has an excellent nursing school, it is in a good position to help prepare nurses -- licensed practical as well as registered nurses -- in the care of the chronically ill. As we have seen, the short supply of nurses trained in such illness and willing to work in that field is one of the main long-run problems in improving chronic illness care. Similarly, the intern-resident training program, the excellent ancillary services, and the interest and facilities for research make the hospital well-suited for training medical personnel.

d. Chronic hospital beds should be established at General Hospital (1)

There must be careful study of the basic policy questions we have raised before the total chronic illness problem can be attacked with the proper overall approach. We are convinced, however, that one step should be taken without awaiting the settlement of these problems. We believe that the City Welfare Board should assume active responsibility in establishing chronic disease hospital beds in conjunction with existing facilities at Minneapolis General Hospital. The number of beds should be consistent with the needs of service and should provide adequate facilities for teaching personnel in the care of the chronically ill, but our study of the problem indicates that the number should be at least 50 beds for effective operation.

(1) This committee recommendation was not fully accepted by the Board of Directors. See letter of transmittal.

Our reasons for urging this action now are as follows:

(a) The need for additional chronic beds is very great. Establishment of a chronic illness unit at the General Hospital would not mean committing the community to a policy for the solution of the total unmet need.

(b) The need for personnel trained in the care of the chronically ill is very acute, and the existing training facilities at General Hospital are excellent.

(c) The criteria for grants used by the State for distribution of Hill-Burton funds indicates that the hospital should have good possibilities of getting Federal grant assistance.

(d) The State plan criteria indicate the excellent potential that the hospital has for a chronic disease unit: overall size, an existing program of physical medicine, the necessity in the statewide picture of developing training facilities first, as at General Hospital, and the importance of the unit's being part of a teaching program.

A first step in establishing a chronic illness unit at the hospital should be to get the opinion of the medical administrative staff on how best the unit can be established. The change has implications for staffing, equipment, costs, management, physical plant, teaching program, relations to University Hospital, to mention a few with which the medical administrative staff is most familiar and would be most concerned.

This recommendation will require additional expenditures at General Hospital to provide the chronic facilities and to operate them. The amount of these expenditures will depend upon the details of setting up and operating the unit, which will have to be worked out in consultation with the medical administrative staff.

We recognize that the City already is faced with a difficult financial problem in operating General Hospital as an acute facility. We urge that no action be taken in setting up chronic facilities which would in any way jeopardize adequate financing of acute care. We note, however, these factors which affect the financial aspect of providing chronic beds at the hospital:

(a) The possibility of Federal grant assistance for establishment of the chronic unit should be extremely high, for the reasons already cited from the State Plan.

(b) The City should derive patient revenue from the County through OAA patients' coming there for care.

(c) The Citizens League has suggested the enactment of a local earnings tax as a means of helping meet the City's overall revenue problem.

Because of the importance of the relationship between the City and the County in this project, from both a service and a financing standpoint, we urge that officials of the two units work on it as a joint venture.

It may develop that the hospital eventually will become a city-county institution. There is considerable community interest in this possibility, as evidenced by the City Council's Ways and Means Committee's decision to explore the possibility as a solution of the hospital's finance problem, the suggestions of both city and county officials from time to time, and the expressions of employee groups. In addition, another sub committee of this Health, Hospitals and Welfare Committee is currently exploring many of the ramifications of the suggestion.

We do not believe that our suggestion -- that the City now establish a chronic unit at the hospital, and do so in close cooperation with the County Welfare Board -- need affect the eventual resolution of the question of whether the institution should become other than a city institution.

We have stated our general conclusion of this study that the facts definitely point to substantial additional governmental expenditures if the unmet need for good nursing home care is to be met. Therefore, while it is difficult to recommend added outlays at General Hospital in the face of its present financial situation, we believe it should be done as an important start in the overall move to provide more facilities in the community.

3. Use of Glen Lake Sanatorium for the non-tubercular chronically ill

Glen Lake Sanatorium, like Minneapolis General Hospital, has been mentioned as a possible solution to the need for beds for the chronically ill in this community. There are differences, of course, which make Glen Lake in some respects more adaptable to chronic care than General Hospital, and in some respects less adaptable. It is a County institution, and the County government has more stake in chronic illness care for the medically indigent than does the City. Also, it clearly has unused capacity and this is increasing as tuberculosis comes more and more under control (bed occupancy averaged 539 in 1952 and 357 for the first four months of 1956).

On the other hand, the best chronic facilities are those that are closely tied in with facilities for acute care, so that there is ready access to staff, equipment and procedures for acute care, and chronic patients may easily be shifted to more intensive care if their condition warrants it. Authorities have stressed the value of having chronic disease units as operating units of general hospitals. (But large institutions are well-adapted from the size standpoint to the installation of x-ray, and other specialized facilities).

A disadvantage of Glen Lake compared with General Hospital is the greater transportation problem for patients and staff. Also, presently it has little teaching and research.

Finally, legislation would be needed to authorize the use of the sanatorium in total or in part for non-tubercular adults. Efforts to achieve this doubtless would run into the important question of the State's policy on future use of the sanatorium. Glen Lake is the outstanding TB institution in the state and there are indications that the State government would like to retain it as a TB hospital and let other sanatoria in the State close down.

The uncertainty of the sanatorium's position in the total State tuberculosis picture, and the greater problems involved in adapting it to general chronic care, compared with General Hospital, lead us to the conclusion that the sanatorium can not be considered a practical additional resource for general chronic care in the very near future. However, we believe the possibility of such use should be constantly borne in mind as the State tuberculosis picture and the continuing study of chronic illness needs and resources evolve.

4. Operators of proprietary nursing homes should act to expand facilities

Operators of proprietary nursing homes should take action to increase the supply of nursing home facilities and the care given. As we have noted, we believe that the proprietary home operators are beneficiaries of the present system, and it is to their interest to make it work satisfactorily.

We have suggested that they should raise their own standards by better policing and self-regulation. As a further step, we suggest that the organization of nursing home operators investigate the possibility of promoting the financing and construction of a new nursing home building to serve as a model private institution. This model could demonstrate for potential investors and operators the possibilities of investment in the nursing home field. If the investigation indicated the feasibility of such a pilot project and it were constructed, it would serve as the best proof private operators would have that private enterprise could fill more of the unmet need for additional beds than is generally expected.

5. Action by voluntary, non-proprietary groups

Charitable, fraternal, religious and congregate organizations have provided an increasing number of facilities for the aged. While they are not designed specifically for the chronically ill, they do constitute a resource for care of their residents who become ill through their infirmaries.

We particularly urge that these organizations establish or expand their homes for the aged and also establish more bona fide nursing homes.

6. Facilities for young adults

A specific area that needs emphasis in the total unmet need for chronic beds is young adults. National studies indicate that fifty per cent of the chronically ill are under 50 years of age. Considering that the average age of nursing home patients in Minneapolis is well over 70 years, it is no wonder that we found a shortage of nursing home facilities for young adults. We suggest, therefore, that the committee recommended above take particular note of the need for establishing facilities for chronic and rehabilitation services for young adults.

7. Related facilities and low-cost housing

A vital part of the community effort to increase the supply of beds for the chronically ill is the increase in related facilities, as we pointed out repestedly in this study. We have already mentioned homes for the aged.

We also urge that discussions and plans for increasing low-cost housing take into consideration the fact that some of the aged would not need to be in nursing homes if adequate low-cost housing were available. Thus new low-cost housing, particularly if it is made available on priority to the aged, single or married, should contribute to a lessening of the demand for nursing home beds.

D. Financial difficulties of the non-indigent

While this study has been focused on the medically indigent, we have observed repeatedly in the course of our study that many times those not eligible for public assistance have had real difficulty in getting adequate care, and in paying for it. We are impressed by the fact that no prepaid insurance plans now exist in Minnesota, similar to hospitalization insurance, whereby the non-indigent could make some provision in advance for the cost of nursing home care. We understand such medical insurance plans exist in several states, including New York and Massachusetts.

We recommend that organizations providing prepaid medical insurance investigate the possibility of extending coverage to insurance for care in nursing homes and other chronic illness establishments.

An increasing proportion of patients receiving care for acute illness at General Hospital have had hospitalization insurance as a resource. Prepaid medical insurance for chronic care probably would help reduce governmental assistance payments for chronic care as well as making it easier for the non-indigent to purchase such care.

E. Drugs

The fact that the Federal Food and Drug Administration recently has had an agent in the Minneapolis area investigating drug-handling in nursing homes confirms what we had heard many comments about during the course of this study: that abuses in handling of narcotics exist in some nursing homes.

We strongly urge that nursing home operators, inspection officials, physicians and all others concerned take immediate action to eliminate these practices and prevent their recurrence.

XI

MAJOR UNANSWERED QUESTIONS

In the preceding chapter we referred to major policy questions which need to be faced in raising the overall level of community services for the chronically ill. These questions should receive the careful study of the new agency on chronic illness we recommend for establishment.

Our work has enabled us to identify some of these major questions, and to consider some of the factors involved in answering them. In this chapter we present the results of our study in the belief that they will be helpful in the additional discussion and decision-making that is necessary in the community's continual dealing with the chronic illness problem.

These are the questions:

(1) How much more money should be spent? (2) How much of this should be government's responsibility? (3) How should government's responsibility be shared among the several levels of government? (4) In what direction should public money be used: to make loans to private enterprise? to assist non-profit groups and other charitable organizations? to finance construction and operation of governmental facilities? or a combination of two or more of these?

A. How much additional should be spent?

This is a question on which considerable more research is needed. We have indicated that we can not expect to meet the entire need, which is probably near the 1,308 new beds estimated by the State. But how much of this should be the goal? There are differences of opinion, particularly among the operators of private nursing homes. There are also differences of opinion on the cost of construction. For example, Mr. Boyce of the Twin Cities Nursing Home Association estimated the cost of constructing nursing home facilities at $3,000 - $4,000 per bed. At this cost it would require $3,924,000 to $5,232,000 to meet the total Minneapolis need estimated by the State. On the other hand, authoritative information from the State Health Department indicates a bed cost of $5,000 to $7,000 which would make the total $6,540,000 to $9,156,000 for Minneapolis facilities.

B. How much should be government's responsibility?

The second part of this question -- how much of the total needed expenditure should be borne by government -- will also require considerable additional study. Obviously, from the factors we have cited in the earlier part of this chapter we can look for expansion of some degree of the proprietary facilities. Also, charitable and religious organizations will continue to add to their facilities. The extent to which the latter expand, however, may depend upon what assistance government is prepared to give to charitable and religious organization in terms of loans and direct aids.

It must of course be recognized that the financial resources of our governments are limited. Locally, we have demands from many other areas which also have unmet needs -- schools, traffic, police and fire protection, to mention a few.

How limited our resources are, and the relative degree of unmet needs among various governmental functions, are of course matters of judgment.

A current study of the League's Taxation and Finance Committee is concerned with Minneapolis' comparison with the 40 other cities over 250,000 population with respect to the ratio of total state and local taxes per capita in 1953 (local taxes include taxes of all over-lapping governments such as a county, school district or sanitary district). Minneapolis ranked 10th out of the 41, with a percentage of 8.22 compared with the top of 11.58 and a median of 7.23.

In expenditures, Minneapolis (not including share of state expenditures) ranked 8th out of 41 in categorical public assistance, the highest ranking of any of its functions. Categorical public assistance finances the lion's share of indigent care in nursing homes. Other functions ranked as follows: police - 36, fire - 35, highways - 29, education - 21, health and hospitals - 16, recreation - 13.

Information recently published by the Minnesota Institute of Governmental Research (Bulletin No. 37, January 1956) indicates that adding in state expenditures will probably make Minneapolis rank even higher in categorical public assistance. The Institute says: ". . . Minnesota had 51,643 (OAA) recipients in rolls in August (1955) as compared with 41,025 in Iowa, and 42,944 in Wisconsin. Why Minnesota should have more on the rolls than Wisconsin is difficult to explain except that our eligibility requirements are more liberal.

"In respect to monthly grants for old age assistance, Minnesota was sixth highest in the nation, with an average monthly grant of $69.63 for the month of August, 1955. Only Colorado, Connecticut, Massachusetts, New York, and Washington exceeded Minnesota. Wisconsin was ninth highest with $65.72, and Iowa twenty-first with $57.75.

"High medical costs are a key factor in high grants for old age assistance in Wisconsin and Minnesota. Only Illinois, Massachusetts, and New York paid out larger amounts for medical care than Minnesota in the month of August, 1955. If a reduction in state expenditures is desired, Minnesota might well review its policies with respect to old age assistance grants."

The comparison with other cities should indicate caution in efforts to increase the overall level of governmental expenditures and welfare expenditures.

C. How shall government's responsibility be shared among the several levels of government?

As we have noted repeatedly, all levels of government now share responsibility for the chronically ill, medically indigent in that they participate in various ways in the financing and administration of the nursing home care programs. We are not prepared at this time to go into the complex questions involved in intergovernmental relations and responsibilities in this field, except to point out that in the long run the program of government action to improve and increase nursing home services must be worked out among City, County, State and Federal governments.

D. In what way should public money be spent?

Should public funds be granted directly to help finance proprietary or charitable facilities? Should governmental agencies spend the money directly in construction and operation of homes? Or should some combination of these policies be followed?

We analyze in the following paragraphs the advantages and disadvantages of government ownership and operation of chronic illness facilities. We gave these points thorough consideration before making our recommendation in Chapter X that a chronic disease unit be established at General Hospital. As indicated there, we do not believe that this action would commit the community to an answer to the overall question of private vs. public ownership of chronic illness facilities.

We also note below a widely-publicized suggestion that State financial aid be used to stimulate construction of additional nursing homes and homes for the aged.

1. Advantages and disadvantages of government ownership and operation of nursing home facilities.

This question has two elements: service and cost.

a. Service - advantages.

1) Direct governmental action to construct and operate nursing home facilities should lead to easier planning to meet needs. At present the government generally must depend on the anonymous reaction of the market to the public and private demand for facilities.

2) Government will be able not only to plan better, but to act more expeditiously to meet a need.

3) Direct government operation should provide better government control over the caliber of service provided. While the medical profession's interest and concern will be vital in patient care, the fact that administration and supervision are the responsibility of a government employee should provide better direct control by the welfare agencies who are in the last analysis responsible for the welfare of the indigent chronically ill person.

This is in part a result of the lack of the profit motive and also the fact that inspectional activities, which are especially important during times of short supply of beds, do have limitations in their effects, as was pointed out above.

4) Considering the type of administration whichMinneapolis and Hennepin County have had from General Hospital and Glen Lake Sanatorium in recent years, we would be justified in expecting good administration from a governmentally-owned and operated nursing home facility in this community. This is not to overlook the fact that many factors are involved in the high quality administration found in the two existing institutions: good medical staffs, high salaries, good relations with the University of Minnesota Medical School, and a minimum of political interference.

5) A government owned and operated facility could serve as a model to stimulate improved service in other facilities. The State plan recognizes the importance of a model. Although it does not say specifically that a government facility would need to be the model, this would seem to be a logical development as is evident from this statement: "During the initial phase of the program (Hill-Burton program for nursing homes and related facilities) when Federal funds are extremely limited, consideration will also be given to the provision of a demonstration project which will be readily available to a large segment of the population and which can be used as a model to follow in planning future nursing homes both with and without aid under this Program."

b. Service - disadvantages.

1) In recent years hospital consultants and others have been suggesting the eventual elimination of public hospitals and governmental use of voluntary institutions on a direct charge basis for the care of indigent cases. It is felt that there is a stigma of indigency attached to going to a governmental institution, and this stigma is removed when the indigent patient is cared for in the same institution as the private pay patient. This was part of the reason advanced in 1952 for suggesting that the City and County consider providing financial assistance to voluntary hospitals to add beds instead of building a new General Hospital.

Creating a special governmental facility in a field which government has not entered heretofore in this community would of course be in direct opposition to this suggestion.

2) Choice of a hospital or nursing home by an old age assistance patient is left to the patient under Federal law. This introduces an unknown element into the problem of assuring that OAA cases would go to the public institution. How important an element it would be, though, would depend on the competitive situation: the supply of beds and the quality of the service in the public institution. At the present time a public institution probably would have little difficulty in getting enough OAA cases to fill its beds.

c. Comparative costs - government versus private ownership

We have already alluded to the fact that cost considerations will require a good deal more study than we have been able to do. However, it seems altogether likely that the labor cost of operating governmental institutions will be greater than the cost of operating existing proprietary and voluntary nonproprietary institutions. Pay scales at Minneapolis General Hospital and Glen Lake Sanatorium are markedly ahead of the community pattern and it would seem that the same relationship would prevail in a governmentally-owned nursing home. Whether this cost differential to the community would be offset by, or increased by, other factors would require further analysis to determine.

2. Proposal for state assistance for construction of nursing home facilities.

Among the most widely-discussed suggestions that have recently been made for State financial aid to stimulate construction of additional nursing homes and homes for the aged is the proposal of Frank Rarig, Jr., executive director of the Wilder Charities of St. Paul. Following is an excerpt from his presentation to the Legislative Interim Commission on Public Welfare on November 10, 1955:

"In submitting this proposal I am acutely aware of the financial problems confronting the state government. I hope to demonstrate that over a period of years my proposal, if enacted into law, would result in substantial savings to the state while at the same time providing more adequate, more humane and more decent services. The size and nature of the problem is such what it cannot be disregarded. While consideration can be deferred, ultimately we will have to face up to it by providing adequate facilities. Emergency action to meet an emergency need is always more costly and less satisfactory than action based on a thorough analysis and careful planning. I well realize that if you decide to give my proposal consideration it will require careful analysis, a vast amount of planning and undoubtedly some modification. Because of the magnitude of the problem even a partial solution requires thinking and planning in large amounts both in terms of numbers of beds and millions of dollars.

"It is proposed that this Commission recommend to the Legislature that the sum of twenty million dollars by made available over a period of five years as grants in aid, on a 50-50 basis, to the political subdivisions of the state and to charitable and ellemosynary corporations for the construction of county or local nursing homes for the care of chronically ill and aged, infirm persons.

If equally matched by the political subdivisions or private charitable corporations, the expenditure of the sum of forty million dollars should provide between 5,000 to 7,000 nursing home beds. The legislation making the funds available should provide for the establishment of standards, both of construction and operation by the appropriate state departments, The State Board of Health has had experience administering the Hill-Burton funds and much of the knowledge and many of the techniques could be applied to the administration of such a state fund. Some Hill-Burton funds are to be available for nursing home construction and if the state were to appropriate such a sum, undoubtedly a substantial amount of Federal funds could be obtained to further extend the program."

Appendix I

Method used by sub committee in visiting Minneapolis nursing homes

As preparation for the visits, the sub committee was given a briefing on the general nature and characteristics of the homes, and some of their problems, by the president of the Twin Cities Association of Nursing Home Operators, Mr. Carleton Boyce. Mr. Boyce also arranged for guided tours of four homes as another orientation. The homes visited were 1500 Elliot Avenue Nursing Home, The Boreen Rest Home, The Cornelius Nursing Home, and the Drake Convalescent Home.

The sub committee drew up a check sheet for the visits, to serve as a guide to observation and a device for making comments and judgments on a uniform basis. The check sheet was based upon a similar sheet used by the State Health Department in its work, although it was necessarily more limited and more designed for laymen's use. The sub committee discussed the check sheet with representatives of the nursing homes.

The sub committee decided to cover about one half of the 50 nursing homes in Minneapolis listed in the State Health Department's Director of Licensed Hospitals and related Institutions (1952). A sample was drawn up which gave due balance to the relative number of nursing homes and homes for the aged. This sample was checked for fairness and adequacy with Mr. Boyce and the head of the nursing home section of the Hennepin County Welfare Board.

Discussions were held with representatives of the nursing homes as to the best approaches to use to assure good cooperation of the operators under the usual conditions of operation. As a result, letters were sent out in advance to all nursing homes acquainting them with the sub committee's plan. Operators of the homes were asked whether they wanted to be given 24 hours notice in advance of the sub committee's visit. Twenty homes requested such notice and about half of these were in the sample group visited.

The visits were made by eight teams of two sub committee members each. Each team visited at least three homes, and 27 homes were visited with 15 to 30 minutes in each home. Counting the four homes that were visited by the entire sub committee in May, 31 of the 50 homes in Minneapolis were covered by members of the sub committee. Following is a list of the homes visited:

Aberdeen Nursing Home	3020 Lyndale avenue south
Alliance Residence #1	3101 Aldrich avenue south
Alliance Residence #2	3101 Lyndale avenue south
American Nursing Home	1700 Elliot avenue south
Bethany Covenant Home	3309 Hayes street north-east
Boreen Nursing Home	2100 1st avenue south
Braille Center, Inc.	510 south 8th street
Central Hospital	1828 Central avenue north-east
Christian Home for the Aged	2010 19th avenue north-east
Cornelius Nursing Home	3813 4th avenue south
Drake Convalescent Home	1328 South 5th street
Eagle Nursing Home	3045 Columbus avenue

Emerson Nursing Home	2708 Emerson avenue south
1500 Elliot Avenue Nursing Home	1500 Elliot avenue south
Healthwin Nursing Home	2500 Colfax avenue south
Hyland Park Nursing Home	2304 Emerson avenue north
Home for Children and Aged Women	3201 First avenue south
Kenwood Nursing Home	2124 Dupont avenue south
Little Sister of the Poor Home For the Aged	215 Broadway north-east
Minnesota Sanitarium	1926 5th avenue south
Oak Ridge Hospital	725 Fremont avenue north
Oakland Rest Home	3732 Oakland avenue
Oaks Rest Home	4147 Lyndale avenue north
2200 Park Avenue	2200 Park avenue
Park Avenue Rest Home	2401 Park avenue
Pleasant Nursing Home	2548 Pleasant avenue
Rest Home #1	600 West 32nd street
Rest Home #2	610 West 32nd street
Riverview Nursing Home	4659 Lyndale avenue north
Samaritan Nursing Home	1810 Washington avenue south
Weddell Memorial Baptist Home	2201 Pillsbury avenue

Appendix 2

Comments of medical doctors in elaboration of the overall rating they gave nursing homes (see page VIII-II)

(Each comment is from an individual doctor. The listing is random).

Crippled patients say that they seem unwelcome if they have trouble getting about.

We definitely need clean, modern, and nurse-staffed homes to replace decrepit old homes now in existence.

Care in most places is poor and attitude of personnel is poor. Physical equipment seems adequate.

I am no judge.

Quality of nurses in homes is below that seen in hospitals. Knowledge of eye care is weak. Admittedly it is a special field.

Need a hospital for the aged with a medic in charge.

Some homes take advantage of OAA benefits.

Better nursing care.

Nursing care is seldom as good as one would like it.

I feel special training for all personnel working in nursing homes should be required, including orderlies, etc., who deal with patients in any way. The reason for this is that at least 60% of these patients are suffering from senility to varying degree, and are therefore difficult to cope with.

Ratings should be on individual homes.

Big improvement past year, due probably to improved attitude of average practical nurse or aid.

Would send more (patients) if good facilities were available.

Excellent in Franklin and Vocational and 2200 Park. Fair otherwise.

Some are poor, but try to avoid these. Most are trying to improve.

Nursing care is good considering amount patients pay while residing in nursing homes.

Physical setup unsatisfactory in most cases. Dirty. Food unsatisfactory. Special diet for cardiacs, etc., unsatisfactory.

Most places are good.

Quantity of beds seems adequate to me (limited observation) but quality of care seems to need improvement.

I think criticism from these people and their relatives are greatly exaggerated in most cases. The people I have had in these homes are mostly quite old and hard to please.

Good on occasions I have had to treat them there.

My type of patient does not require this type of hospital care.

Not involved in my practice.

Homes are too independent as there are not enough homes to create competition and better care. Religious facilities are lacking. Nurses feelings vented on patients. Some patients are favored, especially if nurses are tipped, Administration more concerned about keeping nursing help at expense of patient's feelings. Lack of understanding on part of nurses and administration. Do not realize that aged patients are often not clear mentally and are apt to be childish, outspoken. Personnel should be more tolerant and understanding.

Have very few patients in nursing homes.

No opinion. Not enough contact with these to give a valid answer.

My practice is suburban and not dependent on Minneapolis rest homes.

I suppose that nursing home care compares favorably with care at home, but in my specialty at least the nursing care does not compare with general hospital care. This is perhaps not a fair comparison, but it is of practical importance when consideration of admission these institutions comes up.

Fair. Apparently due to a lack of personnel.

They appear to me to be a necessary evil. I have not yet seen one that I would like to spend any time in. All are overcrowded, dismal, sometimes dirty. I would not recommend one to any patient except as a final resort.

Conditions and nursing care is (sic) satisfactory in higher price nursing homes.

Too many patients for the space allowed in many rest homes.

The care at one or two homes is fairly good -- but most the care is fair to poor.

I believe there are only 3 or 4 excellent nursing homes. Oak Ridge type is outstanding.

BIBLIOGRAPHY

Directories, plans, regulations

Minnesota Statutes and Regulations of the Minnesota State Board of Health for the Construction, Equipment, Maintenance, Operation and Licensing of Nursing Homes and Boarding Care Homes, 1955.

Minnesota Directory of Licensed Hospitals and Related Institutions, May 1, 1955, Minnesota Department of Health.

Minnesota State Plan for Hospitals, Public Health Centers and Related Facilities, Minnesota Department of Health, Section of Hospital Services, August, 1955.

Fire Protection Standards for Nursing Homes and Boarding Care Homes, Fire Marshal Department, State of Minnesota.

Directory of Homes for the Aged, Case Work Division, Community Chest and Council of Hennepin County, Inc., November, 1949.

Surveys, studies and reports

Recommendations on Care of the Long-Term Patient, Commission on Chronic Illness, Chronic Illness News Letter, June, 1955.

Survey of Persons in Establishments in Minneapolis which Provide Nursing and Personal Care, Commission on Chronic Illness and Minnesota Department of Health, 1954.

Nursing Home Care of Hennepin County OAA Recipients, Hennepin County Welfare Board, November, 1953.

Report of a Survey of Mental Hospitals, Rest Homes and Homes for Aged in Minneapolis, Minneapolis Health Department, February 21, 1949.

Report of a Survey of Nursing Homes in Hennepin County - January, 1951, Ethel McClure and Myrtle C. Kvenvold, Hospital Licensing Unit, Minnesota Department of Health.

Report on Development of a United Hospital Fund for Minneapolis and Hennepin County, submitted by Booz, Allen and Hamilton to the Minneapolis Hospital Research Council, 1955.

Report to Minneapolis Hospital Research Council, James A. Hamilton and Associates, 1950.

Determination of Number of Beds Needed for the Care of the Chronically Ill and the Aged in Minnesota, Based on a Study in St. Louis County, Minnesota, Minnesota Department of Health, Section of Hospital Services, June 22,1954.

Care of the Chronically Ill in Ramsey County, Amherst H. Wilder Charity, October, 1950.

Care of the Infirm Aged, Minnesota Legislative Research Committee, Publication No. 15, November, 1948.

Minnesota's Aging Citizens, Minnesota Commission on Aging, January 1953.

Resources for the Handicapped, A Survey of Hennepin County, The Community Welfare Council, May, 1952.

Surveying Community Needs and Resources for Care of the Chronically Ill, The Institute of Medicine of Chicago, The Central Service for the Chronically Ill, September, 1950.

Patients in Proprietary Nursing Homes, Jerry Solon and Dean W. Robert, M.D., in The Modern Hospital, May, 1955.

Reports of Conferences and Meetings

Minutes of Public Welfare Study Commission, April 27, 1956 and November 10, 1955.

Statement before the Interim Commission on Public Welfare by Frank Rarig, Jr., Executive Secretary, Wilder Foundation, November 10, 1955.

Report of the Study Group on Licensing and Standard-Setting, Committee on the Patient in an Institution, Conference on Care of the Long Term Patient, January, 1954.

General

Articles on the Care of the Aged, by Daniel J. Hafrey, in The Minneapolis Tribune, March 25-31, 1956.

Report of Hennepin County Grand Jury, December 31, 1953.

President Eisenhower's health message to Congress, January 26, 1956, The Minneapolis Star.

Something Can Be Done About Chronic Illness, by Herbert Yahraes, Commission on Chronic Illness, September 1954.

References

Chronic Illness, Digests of Selected References, 1950-52, U.S. Department of Health, Education and Welfare, 1953.

Fact Book on Aging, Committee on Aging and Geriatrics, Federal Security Agency, 1952.