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Chronic illness and the Richmond Nursing Home

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CHRONIC ILLNESS AND THE
RICHMOND NURSING HOME

by

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A Thesis

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of the University of Richmond

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INTRODUCTION

The problem of aging and chronic illness has become more acute with the 1960's and more in the public attention than ever before. Projected figures for 1970 estimate 9.1% of the population will be in the aged group. In 1965 one out of five under 17 was affected by chronic disabilities. Both the private and public sectors of the economy are involved in seeking solutions.

This thesis deals with the administrative area of the public sector. The thesis attempts to state the problem, point out knowledge and recommendations in the hospital administration field and show the Richmond Nursing Home's accomplishments are based on sound principles and good management of Public Administration.

The Richmond Nursing Home is a city (public) institution and is a bureau of the Department of Welfare of the City of Richmond. The institution is a nursing home licensed for 200 beds and the population is predominantly 65 years and older, although there is no age limit to acceptance requirements.

In presenting the major accomplishments of the Home, criticisms and comparisons are presented. Some criticisms could

not be included due to the confidential nature of the doctor-patient relationships. Patient interviews were not included because of the unreliability of a large group of the population which are out of touch with reality, require medical interpolation or just do not understand treatment they are receiving and object though the medical staff has specifically prescribed such treatment.

Comparisons are of a more detailed nature on the State level but prove hard to find on the national level in other than general statistics. There, indeed, seem not to be available many references to institutions of the nature of the Richmond Nursing Home or in the field of nursing homes.

CHAPTER I

GENERAL CHARACTERISTICS

The problem of aging, chronic disease and disability faces every individual. Involvement generally takes three forms. First, as a taxpayer who, with the entrance of the state into the welfare field, pays in his earning years for our government forms of medical care, it behooves him to take interest in politics. He should be interested in how and where the state spends his money. Second, in the family responsibilities are cyclical. The parents provide for the children's future and the children when grown provide for their elderly parents. Third, as a citizen with a life expectancy of over 70 years and a probable retirement age of 65, he should plan ahead with provision for costs of medical care in old age.¹

¹Ruth and Edward Brecher, "Nursing Homes." A Consumer Unions Reprint (originally published January, February, March and April 1964 of Consumer Reports), p. 3. Hereafter cited as Brecher, Consumer Reports.

Chronic diseases (e. g., arthritis) and conditions (e. g., impairment of the spine) tend to increase in number as age increases. However, the young as well as the old may suffer limitations from the same causes. Surveys by the Public Health Service dramatize the problems for old and young alike. Eight out of ten of those 65 years or older suffer from chronic conditions, five out of ten of those have limitations affecting their activities. One out of five of the population under 17 years old has one or more chronic illnesses and two out of every 100 are limited in activity.¹ Of those 65 years or older, 83.4% suffer with one or more chronic conditions. Approximately 87,300,000 people in the United States suffer at least one chronic condition and there is a growing trend toward greater disability.² An average of 22.2 million persons or 12.2% of the population not residing in institutions reported they were limited to

¹U. S. Department of Health, Education, and Welfare, Public Health Service, Vital Health Statistics, Chronic Conditions and Activity Limitations July 1961-June, Charles S. Wilder, Division of Health Interview Statistics, Series 10, Number 17, May 1965, p. 3. Hereafter cited as HEW, Chronic Conditions.

²U. S. Senate, Special Committee on Aging, Developments in Aging, 1966, Report No. 167, 90th Congress 1st Session, April 12, 1967, p. 7. Hereafter cited as Senate Special Committee on Aging, Developments in Aging, 1966.

some degree in their activities as a result of chronic disease or impairment. The six leading causes were heart conditions, arthritis and rheumatism, mental and nervous conditions, impairment of back and spine (except paralysis), impairments of lower extremities and hips, and hypertension without heart involvement.¹

The costs encountered nationally by medical needs, not counting time lost on the job, are enormous. The losses were termed "tragic" by the Special Committee on Aging of the U. S. Senate in its 1966 report. The economic toll associated with illness, disability and death due to chronic disease amounted to \$57.8 billion in 1963. Yet in the same year, at best, \$3 billion was spent on all forms of preventative medicine. The Committee recommended much larger expenditures on a national basis with emphasis on early detection as the most practical approach. Such action would ". . . offer the possibility of converting 'an ounce of prevention' . . . into an avenue of health for the nation."²

Institutions rendering care in the chronic disease field have grown in number with the problem and demand. In the U. S. more

¹HEW, Chronic Conditions, p. 1.

²Senate Special Committee on Aging, Developments in Aging, 1966, p. 7.

than 13,000 nursing homes now exist with 600,000 beds and 6,000 related personal care facilities with nearly 250,000 beds (1967). Some 300,000 nursing home beds, about half of the total in the U. S., have been built in the last five years. More than \$1.5 billion was spent in 1961-66 on nursing home construction, mostly in the private sector. Nursing home facilities have been growing at a rate of 12% per year. Sixty thousand nursing home beds were opened to the public in 1965, nearly 70,000 in 1966. Eighty-seven per cent of the homes and three-fourths of the beds are privately owned, 5% of the homes are church owned, 3% of the homes are non-proprietary and 5% are government owned.¹

The residents of the homes are to a large extent what are referred to as long-term patients. The Commission on Chronic Illness (1949-56) had a definition of long term illness which merits quoting.

Chronic disease comprises all impairments or deviations from normal which have one or more of the following characteristics: are permanent, have residual disability; are caused by non-reversible pathological alteration;

¹Virginia Nursing Home Association, 14th Annual Convention, (Richmond, Virginia, Nov. 13-15, 1967), p. 78. Hereafter cited as VNHA, 14th Convention.

require special training of the patient for rehabilitation; may be expected to require a long period of supervision, observation or care.¹

The definition does not include all persons with a chronic disease, but only those who require "30 days in a general hospital or more than 3 months in another institution or home including medical supervision and/or assistance in achieving a higher level of self-care and independence."²

Characteristics of institutional populations are generally designated by age. The Public Health Service estimates include both Nursing Home and Personal Care, and Geriatric and Chronic Disease Hospitals. In the Nursing Home and Personal Care Institutions, approximately 12% are under 65 years old while approximately 70% are 75 years old or older. The average is 77.6 years old; the average age for males is 75 and for females 79.

¹Commission on Chronic Illness, Chronic Illness in the United States, Vol. II, Care of the Long Term Patient (Cambridge, Massachusetts: Harvard University Press, 1956), p. 5. Hereafter cited as Commission on Chronic Illness, Chronic Illness in U. S.

²Ibid.

Sixty-six per cent of the institutional population are female.¹ The average approximate length of stay is three years. Thirty-five per cent remain less than one year, five per cent remain ten years or more. Residents of nursing care homes remain 2.5 years; personal care homes, 3.4 years; and personal care with nursing service 3.8 years.² Health characteristics of those in Nursing and Personal Care homes show a less disabled and more ambulatory group. Fifty-seven per cent are out of bed except for normal sleep and rest, three-fourths are continent, half are mentally unaware of their surroundings and four-fifths have no serious problems with hearing or vision.³

Forty-eight per cent of patients in Long Stay Geriatric and Chronic Disease Hospitals are 75 years old or older and 27% are under 65 years old; 70.9 years old is the average age.⁴ Average length of stay is 3.1 years with 42% remaining less than one year,

¹U. S. Department of Health, Education and Welfare, Public Health Service, Vital Health Statistics, Characteristics of Residents in Institutions for the Aged and Chronically Ill April-June, 1963, Gooloo S. Wunderlich, Division of Health Records Statistics, National Center for Health Statistics, Series 12, Number 2, Sept. 1965, p. 1. Hereafter cited as HEW, Characteristics.

²Ibid., p. 6.

³HEW, Characteristics, p. 7.

⁴Ibid., p. 12.

and 7% more than ten years. Health characteristics show slightly less ambulation and slightly more awareness than the Nursing Homes and Personal Care Homes due to the younger populations.¹

¹Ibid., pp. 14-15.

CHAPTER II

HISTORICAL AND DEVELOPMENTAL ASPECTS

Early Action

There has always been poverty, but there has not always been the distinct problem of the chronically ill and aging. Though the great strides in medicine and preventative measures, infant mortality was greatly reduced and the characteristic of an aging population developed. Chronic illness became a recognized phenomenon only in the third and fourth decades of the 20th century. Until then it had not been statistically set apart for consideration.¹

In 1900 the average expected length of life was 48 years.²

At age 60 in 1900, 3 years of retirement could be expected.³

¹Scholarly efforts are now being made to review the poverty problems in perspective with contemporary problems in the series by Blanche D. Coll, "Perspectives in Public Welfare," appearing in the winter-spring publications of Welfare Review (1967-68), an HEW publication. (Washington, D. C.: U. S. Government Printing Office, November-December 1967), p. 8. Hereafter cited as Coll, Welfare Review.

²White House Conference on the Aging, Report of the Virginia Committee (Richmond, Virginia, November 13-15, 1967), p. 21. Hereafter cited as White House Conference on the Aging, Virginia Committee.

³U. S. Department of Health, Education and Welfare, The Nation and Its Older People, Report of the White House Conference on Aging. (Washington, D. C.: U. S. Government Printing Office, 1961), p. 117.

Major efforts to assess statistically chronic disease and impairment problems were not made until the post World War II years. By 1958 the percentage of aged in the population was 8.8; the projected figure for 1970 is 9.1% of the population.¹

With the extension of life through improved medicine and the higher standard of living, the former deadly diseases often became chronic diseases, the childhood ailment of a chronic nature was less likely to sap the individual's strength, indeed he might expect an improved status with serious complications delayed until old age. One of the problems with aging is that it coincides with retirement and/or lessened income, and at the same time the possibility of developing degenerative diseases or disabilities often requiring long term care. Problems of full employment and employment policies in the 1920's and 1930's still influence our retirement policies today. With the scarcity of jobs in the 1930's, the younger generation was in competition with the older for existing jobs. The population explosion was in some way responsible though the main reasons were economic. As a counter to the developing problem of availability of jobs and the growing possibility of living past prime

¹White House Conference on Aging, Virginia Committee, pp. 21-22.

earning time (20-64 year old span) private and public solutions were sought.¹

The 1929 crash and resulting economic losses caused the public sector to intervene in a major way in the welfare field. New Deal legislation such as the Social Security Act of 1935 was passed as a forced savings program. County and city boarding houses which had sprung up developed into nursing homes. This was because the residents were living longer, developing with age more disabilities and therefore requiring nursing attention. Inflation and war materials demands prevented betterment of worsening lots. With later discovery of penicillin, sulfa drugs and Salk vaccine, lives were getting longer. Federal Old Age Assistance was extended to more persons in states. This newer aid required state licensing standards to be established by those states.² Today Medicare is a reality.

The 1950's marked a definite recognition of the problem of aging and chronic disease by the public at large as an important national problem.³ New capital, both private and public, entered

¹Ibid.

²Ibid.

³U. S. Department of Health, Education and Welfare, The Nation and Its Older People, Report of the White House Conference on Aging (Washington, D. C.: U. S. Government Printing Office, 1961), Foreword. Hereafter cited as HEW, White House Conference.

the market along with new and improved methods. There was a new view taken of the patient, one of the right to live with dignity and respect; his plight was not hopeless.¹

Commission on Chronic Illness

One of the finest and perhaps most comprehensive studies to be done on the problem of prolonged illness was by the Commission on Chronic Illness. The Commission was an independent voluntary organization created by the American Hospital Association, American Medical Association, American Public Health Association and the American Public Welfare Association. The approach of the Commission was that of prevention. It considered one of its major responsibilities to be the study of what prevailed and what should have pertained with regard to care for prolonged illness. Completed over a period of seven years (1949-1956), the Commission's findings, recommendations and conclusions bear reviewing for two reasons: first, for historical perspective and second, to present examples of what has been done in line with those recommendations.²

¹Brecher, Consumer Reports, p. 5.

²Commission on Chronic Illness, Chronic Illness in U. S., p. xi.

Major elements of the problem of long-term care included the following. There was a need

. . . to integrate care of the chronically ill with general medical care, to incorporate rehabilitation in all phases of care, to extend mental health services and refocus the objectives of most mental institutions, to de-emphasize institutionalization as a solution to the problem, to improve and extend all the present means of financing long term care and develop new ones, to increase the number of trained personnel and improve the quality of their training, to develop in every community and at state and national levels ways to coordinate facilities and services, to carry on vigorous programs to accelerate the change in attitudes toward long term illness and to gather additional facts on the extent of the problem and the utilization of medical care resources for long-term care.¹

A number of these points need to be emphasized in this thesis. There was and is a tendency of professional groups and the public to separate the short-term acute illness from the long-term or chronic illness. The tempo of general hospitals responds to the more moving spectacle of acute illness and molds itself for emergency and acute problems. Yet chronic illness accounts for the major share of all serious illnesses and its isolation from other forms is precluded by size of population alone. What is advisable is integrated care of acute and chronic illness in general medical

¹Commission on Chronic Illness, Chronic Illness in U. S., p. 13.

care. An "application of prevention" requires that care and rehabilitation be one continuing process.¹

Rehabilitation is an important element of care and prevention. Its integration in the overall plan of recovery is essential. Recovery from an acute illness is not necessarily complete recovery. Failure in the area is due to lack of emphasis and subsequent recognition rather than lack of knowledge. Disabilities are literally created in situations where proper rehabilitation would have prevented deterioration. For instance, a limb that has been broken may have healed as far as bone breakage is concerned, but muscle strengthening may very well be needed as well as restoration of coordination long unpracticed. An individual released as fully recovered may not know how to restore the lost functions and fail to do so into older age when the body's recovery ability fails, is incomplete or takes a much longer time. Proper preventative measures often obviate need for rehabilitation.²

Efficiency is a necessary element with very close connections to economics. At what level and in what place can care be rendered most completely and least expensively? Overemphasis on institutional

¹Ibid., p. 14.

²Ibid.

care has been costly while producing less than desirable results. The Commission reported that less than one-fourth of all chronically ill patients are in hospitals and other medical institutions. Yet of this number ill, many could be cared for better and more economically at home under suitable conditions.¹ The debate of institutionalization versus some other means of care is not new. In a discussion of poverty in 1824, New York Secretary of State John U. N. Yates suggested four ways of handling the poor: contracting out to townsmen at a lump sum, auctioning off to the lowest bidder, almshouses, or home relief. He decided strongly for almshouses, believing them to be the most humane of the alternatives. His plan was to use them as self-supporting work houses.²

But collectivization has not proved the panacea hoped for. The Commission on Chronic Illness called for a selective process of determining what was needed rather than blindly and irresponsibly pulling patients together and away from the home and community, thereby destroying psychological outlets, dignity, and familiar personal contact. The Commission stated flatly that more and more

¹Ibid., p. 15.

²Coll, Welfare Review, p. 5.

beds is no solution to the chronic illness problem and new buildings to house potential treatment patients at all levels of need is wrong.¹ The economic principle of efficient use of scarce means demands economy in human action and in use of resources. Planning must match needs to resources or affluence is soon lost be the unit family or state. Briefly, the use of funds private or public in a preventative manner precludes waiting until a situation has become critical. The time to act, to plan, to develop is before the crisis, not afterward.²

A statement by the Commission summarizes the perspective:

The cost of programs to provide care to the long-term patients should be measured first in terms of human values, of effectiveness and productivity. The most economical use is that which returns a person as quickly and as fully as possible to the highest attainable state of health and social effectiveness. Practices in conflict with this conclusion must be eradicated and procedures consistent with it substituted.³

¹Commission on Chronic Illness, Chronic Illness in U. S., p. 15.

²Ibid., pp. 17-18.

³Ibid., p. 424.

CHAPTER III

CARE AND TREATMENT

Objectives and Community Care

What are the objectives of care? At the White House Conference on the Aging (1961), the Virginia Committee stated:

The basis of all objectives is the concept that prevention of disease and disability can be achieved if responsible professional and lay people recognize the need for, and assume leadership in, the planning and administration of the [preventative] activity.¹

In other words, the Committee called for organized community effort, which requires recognition of the problem and appropriate action to solve it. Prevention is the best way and in the long run the only way of dealing with it.²

As was pointed out earlier, institutional care is not the panacea to chronic illness. Care in the community and home need to be emphasized where such will provide most rewarding to those involved. In chronic illness where most often the individual is aged,

¹White House Conference on the Aging, Virginia Committee, p. 36.

²Ibid.

the challenge is to gain attention, to motivate, and to involve. This can often best be attained by keeping him in the home setting. Desire for responsibility, for activity, retention of dignity and self-esteem, indeed, the desire to live, are best facilitated by the familiar surroundings of home, rather than as the inmate of an institution.¹

One problem, however, is that when a patient is received from a family into an institution, unless immediate steps are taken to prepare the family for later reacceptance, such may prove impossible. There may very well no longer exist a place for the relative to re-enter and/or financially re-entrance may not be feasible.²

Care in the community (foster homes and personal care homes) and at home costs less than in an institution. This is because the services rendered by the institution are of a more intensive nature, raising the cost per bed. If standards are to be raised, or even maintained, alternatives to institutions, particularly

¹Ibid., p. 55.

²John R. Griffith, Taking the Hospital to the Patient (Battle Creek, Michigan: W. K. Kellogg Foundation [1966]), p. 9. Hereafter cited as Griffith.

the intensive care and therefore the expensive ones, must be further developed and utilized.¹

Proper diagnosis will determine what level of care is needed, rather than just transferring the patient to an institution when a problem of home care arises.² Briefly, alternatives to institutional care are:

- 1) day care services with reduced cost and home-life interests and friends retained;
- 2) organized home care which often reduces or eliminates nursing home services after hospital illness;
- 3) housing for the aging where supervision and needed services are provided with convenience of location, and costs are less than that of nursing home or hospital;
- 4) foster homes offering family atmosphere and economy;
- 5) sheltered workshops offering creative relief from boredom and post retirement idleness.

In conjunction with these different levels and alternatives and with diagnostic facilities there is subsequent need for information and referral centers to make known to the community the availability of such services.³

¹Commission on Chronic Illness, Chronic Illness in U. S., p. 166.

²Ibid., p. 167.

³Brecher, Consumer Reports, pp. 5-6.

Institutional Care

If it becomes necessary to seek the more intensive services of a nursing home or hospital, then there is no substitute for that quality of service. There are a number of generally agreed upon criteria for the judging of good institutional care.¹ Policies and practices should be clear, well chosen and meticulously carried out in regard to long term patients. Admission and discharge policies cannot afford to be capricious or arbitrary. They should not allow the admission of a patient whose particular illness the institution is not prepared to treat. Aid, in that case, should be rendered by referring the patient to the proper institution. Discharge should not be made without a plan of care for maintaining patient gains and escaping exacerbations. Responsibility should be shared by family, physician and patient as well as institution. The institution, however, cannot avoid its responsibility when no other responsible agent outside the institution exists.²

Administrative practices must operate a program "by business means but not for business ends." This calls for cost

¹Commission on Chronic Illness, Chronic Illness in U. S., p. 170.

²Ibid., p. 169.

control and efficient and complete records management, both administrative and professional. Clearly stated institutional objectives facilitate success in this area by keeping treatment quality high.¹ It should be noted that adequate care is equated with adequate financing. "Public ignorance and indifference perpetuate the notion that by some alchemy an institution can provide good care for less than the cost of good care."² Staffing and equipment to be of high quality require adequate financing. Low support will mean the sacrifice of availability of care or the quality of care.³

Design and construction of an institution should suit the type of institutional goals and patient. Emphases should be placed by management and staff on adequate working space, light, air, color, safety, sanitation, convenience of operation and economy of effort.⁴ The best way to facilitate the latter is through adequate

¹Ibid., pp. 174-5.

²Ibid., p. 178.

³John D. Gerletti, C. C. Crawford, Donovan J. Perkins, Nursing Home Administration (Downey, California: Attending Staff Association, 1961), p. 299. Hereafter cited as Gerletti, Nursing Home Administration.

⁴Commission on Chronic Illness, Chronic Illness in U. S., p. 179.

standards of care in written form to be used as guide lines. Such standards are to be found through state licensing and/or voluntary accreditation organizations.¹

In terms of actual care, personnel plays the leading and decisive role. Adequate staffing is the least expensive and most efficient way of handling expressed treatment policies. The staff are the motivators, the emotional stabilizers and basic directors of patient progress. Without stable, sympathetic understanding and genuine interest in people by staff, progress will be little, if any. Salaries and job satisfaction must be high if good results are expected.²

Rehabilitation is probably the most important single concern in chronic illness. The National Council on Rehabilitation defines rehabilitation as "the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable." Further "rehabilitation is an innate element of adequate care and properly begins with diagnosis." This definition holds whether the patient is one who may be employable or one whose only realistic hope may be for a higher level of self-care.³

¹Ibid., p. 181.

²Ibid., p. 173.

³Commission on Chronic Illness, Chronic Illness in U. S., p. 133.

Rehabilitation is a long run investment. Progress for the chronically ill patient is slow but the returns are readily measurable in both spiritual and economic terms. Whether at home or in a hospital, rehabilitation as an integral part of recovery often aids acute patient recovery. As was mentioned earlier, knowledge is not lacking; desire to apply such an approach, an "of the mind" staff is needed for results.¹ Again staffing plays the deciding role; with a trained and purposeful staff even the most limited equipment can be used effectively.² The hopeless attitude toward the chronic disease victim that was once generally accepted is now inexcusable.³

Perhaps the biggest obstacle to progress is the lack of coordinated services. Such coordination means awareness of what other services are available in a particular community and coordinating with them for services not otherwise available. Coordination may be among local institutions, members of a care team, public and voluntary organizations, between levels of government or between teaching hospitals and smaller satellite institutions.

¹Ibid., pp. 134-135.

²White House Conference on the Aging, Virginia Committee, p. 41.

³Ibid., p. 47.

The benefits are obvious in terms of proper care at the proper time, reducing cost disability present and potential, and providing efficiency of operation as no one institution can afford to duplicate a service already available in the community or have its own particular services ignored. A central counselling service might well prove desirable in facilitating institution to institution and patient to institution relationships.¹

¹Commission on Chronic Illness, Chronic Illness in U. S., p. 19.

CHAPTER IV

A SOLUTION - RICHMOND NURSING HOME

Qualifications

Both in principle and practice the Richmond Nursing Home stands as an example of an institution which has consistently sought and succeeded in developing an excellent program for the chronically ill. The Richmond Nursing Home operates as a bureau in the Department of Public Welfare under the Director Herbert G. Ross. Administrator of the Home itself is Robert L. Gordon who has directed its development since May, 1951. The Administrator, in general, directs all functions of the Richmond Nursing Home to accomplish effective, economical, and satisfactory results for patients, employees, and public. "He is responsible for the maintenance of high professional standards of patient's health, safety, and comfort."¹

¹Bureau of Richmond Nursing Home, Department of Public Welfare, Annual Report 1966-67 (Richmond, Virginia: City of Richmond, 1968), p. 2. Hereafter cited as Bureau of Richmond Nursing Home, Annual Report 1966-67.

There is also a Welfare Advisory Board for the Department of Welfare composed of Richmond citizens with a subcommittee delegated from the main body for the Home.¹ Appointment to the Board is by the City Council and it is Council to whom the Board is responsible. The Director of Public Welfare may advise the Council in choice of appointments. The subcommittee for the Richmond Nursing Home (Bureau) is chosen by the Chairman of the Board. Members are appointed four at a time in six year staggered terms. A cross section of the community is represented by the Board as far as is possible.² Of those on the 1966-67 Board, eight were white, four were Negro; eight were male and four were female, one of whom was Negro. The religious views were predominantly protestant, but contained one Quaker and one Jewish member. No Roman Catholic was on the Board although Roman Catholics have been represented in past years. The occupations were: two ministers (Jewish and Baptist), two housewives, one physician, one employee of the Virginia Employment Commission, one executive of the Virginia Tuberculosis Association, one barber and one teacher.

¹Interview with Mr. Robert L. Gordon, Administrator, Richmond Nursing Home, in the months of March, April, and May, 1968. Hereafter cited as Interview, Gordon.

The function of the Board and subcommittee is advisory. It serves as a connection to the community in case of criticism and as a voluntary third party which seeks to understand and even support action. Critics of the Department often enjoy appointments and come to a better understanding of the problems and what can and cannot be done. The subcommittee meets once a quarter on the first Monday of that month and discusses issues, criticism and new information and reports to the Board. Priority is given to the Department of Welfare in any recommendations from the subcommittee¹ to the Board directed to the Director, City Manager or City Council. The object is to serve the best interests of the whole department.

The most outstanding accomplishment of the Board was the ordinance passed by City Council in the 1959-60 fiscal year authorizing the Director of the Department of Public Welfare to charge patients of the Richmond Nursing Home any amount up to the full cost of care deemed feasible. Such is an example of the potential of the Board if communication by the Administrator is effective. As is shown in Table III, costs for the City have decreased as outside sources of payment, such as patient payments, have increased.²

¹Ibid.

²Ibid.

Accreditation of the Richmond Nursing Home included the top rating by the National Council for the Accreditation of Nursing Homes, Intensive Nursing Care Facility. The definition included nursing service offered under the supervision of a full time Registered Professional Nurse, and a Registered Professional Nurse on duty at all times. The other two related ratings of service were Skilled Nursing Facility and Intermediate Care Facility, each offering less care respectively.¹ Following the National Council, the American Hospital Association as a national accreditation agency had made periodic surveys and recommendations to insure high quality and had approved the Home as an Extended Care Facility. The Social Security Administration, beginning its program of accreditation in the latter half of the 1966-67 fiscal year, approved the facility as meeting the requirements for participation as an extended care facility under the Health Insurance Benefits Program for the Aged (Title XVIII of the Social Security Act).² The

¹The National Council for the Accreditation of Nursing Homes, Standards for Accreditation (Chicago, 1965), p. 2.

²Letter from Social Security Administration, Department of Health, Education and Welfare, Regional Office, to Richmond Nursing Home concerning licensing continuance, October 5, 1967, p. 1 (in the files of General Administration Division, Richmond Nursing Home). (Typewritten.)

accreditation for the fiscal year 1967-68 by the Social Security Administration was received August 15, 1967, retroactive to July 1, 1967. The Health Department of the Commonwealth of Virginia has licensed the Richmond Nursing Home as a 200 bed nursing home.¹

Responsibility

As a public institution for the City of Richmond the responsibility accepted is residual only, i. e., acceptance on the grounds of inability to pay for complete service elsewhere and/or inability to obtain the level and type of service elsewhere. A medical statement from a physician stating the need of care offered by the Richmond Nursing Home is another requirement. There is no age limit to being accepted. Finally, the patient must be a resident of the City.²

Investigations into the qualifications of patients are carried out by Medical Social Service, Medical Division, Richmond

¹Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 1.

²This requirement of residency for care has an unbroken tradition from the very first in dealing with poverty in the United States. Responsibility, it was felt, lay with that community which had benefited from the individual's labor and taxes. (Coll, Welfare Review, p. 2.)

Nursing Home, and the Social Service Bureau, Department of Public Welfare. Separate arrangements are made with responsible persons such as family or guardians, or agencies to pay up to and including the per diem rate for treatment.¹

Philosophy

The goal of the institution is to serve a proper role in the community. Emphases include "the need to meet the total nursing care of geriatric, chronic and convalescent patients through the provision of well equipped facilities that are properly and adequately staffed with qualified personnel," the need to promote and preserve individual and personal integrity with enriching services of emotional, physical, social and spiritual motives, and the need to provide opportunity for "the growth and development of staff and others who contribute to the well being of the patient and operation of the homes."²

The concept of institutional care rests on preventative medical care in maintaining the optimum level of care as the "most

¹Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 2.

²Ibid., p. vi.

economical level of care," and in utilizing "the least expensive facility proving adequate care preferably located close to the individual's home."¹ As will be shown later, the intensive care nature of the Richmond Nursing Home forbids retaining a patient whose health no longer requires such high level care. Instead, a community program was developed with other "homes" offering the less extensive and less expensive services needed. This concept, in other words, incorporated using only that facility that provides the necessary care for the patient. The spectrum begins with the acute general hospital care and is followed by nursing homes for chronically ill (mental hospital for mental care), homes for aged and foster homes for custodial care, and finally private homes for home care. The general hospital is the most intensive and expensive; the private home the least intensive and the least expensive.²

Medical programs are "of the mind" in application of rehabilitative measures which produce dynamic results with proper programs. In the study by the Commission on Chronic Illness mentioned in Chapter II, the "of the mind" attitude (motivated) in

¹Ibid., p. viii.

²Ibid.

staff to patient rehabilitative efforts was stated as a necessary element. The aim of the program at the Richmond Nursing Home is to try to treat patients as individuals and in a spirit of optimism. The emphasis of the program is preventative medical care through "early and accurate diagnosis" and "prompt and competent treatment."¹

Organization

There are seven divisions in the Richmond Nursing Home Bureau. These divisions are 1) General Administration in the Administrator's Office, 2) Housekeeping, 3) Plant Operation, 4) Medical, 5) Nursing, 6) Rehabilitation, and 7) Dietary.²

1) General Administration includes the office of the Administrator, Volunteer Services and the Business Office. The Chaplaincy Service is also coordinated through General Administration. The program is to provide executive direction, coordination and control for the Home. The Business Office handles such duties as the annual reports, financial matters and storage. Patients' accounts are a major responsibility of this office and it has expanded

¹Ibid., pp. vii, ix.

²Ibid., p. v.

greatly with the need for extensive Medicare records accounting.¹

At present there are 14 persons in the Business Office.

The Chaplaincy service coordinates all religious services and activities and is independently staffed and financed on a voluntary basis. Financial support comes from the churches of greater Richmond, channeled through the Chaplaincy Service Committee of the Clergy Association of the Richmond Area.² Volunteer services release regular nursing home staff from routine for technical duties; they perform amenities which contribute to more pleasant environment and foster favorable public relations. The motivating factor is good and brings old and young alike together for holidays and remembrances that might otherwise prove less than complete.³

Volunteers come from the Richmond area and may be any age. In the 1966-67 fiscal year over 51,000 hours were volunteered; the number of volunteers ranged from 350 to 600. Recruiting is the job of the Volunteer Supervisor who endeavors to match patients to volunteers so that both may benefit from their experiences. Recruiting often is done in churches, high schools, and businesses.

¹Ibid., p. 8.

²Ibid., p. 6.

³Ibid., p. 5.

Anyone interested may apply or give a gift. The skill of the volunteer is often the only limit of how much he may do for the patient and Nursing Home.

For 1966-67 fiscal year, total expenditures were \$1,171,245 with General Fund Income at \$491,781 and Net City Cost at \$679,464. The Cost Per Patient Day was \$18.62.¹ This cost reflects only the basic rate not including rehabilitation or other special services.

2) The Housekeeping Division provides the necessary services of institutional housekeeping in maintaining clean, orderly and pleasant conditions. Institution grounds located at 210 Hospital Street are six acres in size. General Work Relief recipients in the welfare program are organized through the Social Service Bureau. They work for their city-provided relief and because of their usually low ability are assigned tasks in the Housekeeping Division.²

3) The Plant Operation Division is responsible for the safety and security of the physical plant and its contents. Subdivisions include Building Maintenance Service, Equipment

¹Ibid., p. 8.

²Ibid., p. 11.

Maintenance Service, Security Service (Policing), and the City Laundry which services the City in part as well as the Home.¹

4) The Medical Division may be broken down into two areas of responsibility: Para-medical Services under a Medical Administrator, and Medical Staff under a Chief Physician. There are two areas of operation: Inpatient and Outpatient Services. The Inpatient Service is by far the larger area in treatment of medically indigent and welfare recipients. Diagnostic facilities in conjunction with the Home are the Medical College of Virginia Hospitals and Clinics, Richmond District Clinic and the State Health Department. A full staff of part-time physicians, interns and externs is maintained and the Chief Physician directs the medical program per se. Pharmaceutical services are provided daily, including service to welfare clients in other nursing homes. Medical Social Services, i. e., social work with social problems in the community concerning the patient, are available and well utilized; medical records are maintained and consultants are available on call. Special services are arranged with the Medical College of Virginia which is near the Home.²

¹Ibid., pp. 13-14.

²Ibid., pp. 16-18.

The Medical Services Outpatient program is proportionately small but does provide medical and para-medical treatment for welfare recipients in the community proprietary nursing homes. Every 30 days each patient in the nursing homes is examined as a preventative measure by the physician from the Richmond Nursing Home.¹

The proportion of the Richmond Nursing Home's cost comes to approximately \$22,000 for the fiscal year 1966-67. The Social Service Bureau, which has direct control over the patients in the Outpatient program, pays for most of the services of the welfare recipients including room, board, laundry and any prescriptions and appliances prescribed by the physician from the Home. The approximation of the Home's costs has to do with the laboratory costs at the Home which are not separated from the Inpatient program costs. In the 1966-67 fiscal year the average daily census of those patients in the 14 proprietary community nursing homes was 108, or approximately 37% of the total medical daily average of the Richmond Nursing Home's Inpatient and Outpatient programs.²

¹Ibid., p. 20.

²Interview with Mr. Ernest E. Best, Controller, General Administration, Richmond Nursing Home, 8 April 1968. Hereafter cited as Interview, Best.

Included in the costs of the Outpatient programs is the once weekly clinic held at the Richmond Nursing Home for Social Service Bureau welfare clients. In the fiscal year 1966-67, 1,100 persons were treated by this clinic.¹ The Home provides a non-emergency service for transportation purposes to and from community facilities and agencies.²

5) The Nursing Division, the major working division in terms of personnel, provides direct nursing service for the patients on a 24 hour a day schedule. In the 1966-67 fiscal year, 541 patients were treated for 62,909 patient days with an average of 3.1 patient hours in a 24 hour period. The statistic does not represent the exact amount of time spent on all patients or on any one patient but is a fairly accurate way of assessing how much services are being rendered. It is the formula used by the American Hospital Association and American Medical Association for analysis and comparison.³

¹Ibid.

²Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 20.

³Interview, Best, 16 July 1968.

Ninety-nine full time nursing positions are maintained of which 97 are filled. Fourteen are Registered Nurses, one is a Certified Tuberculosis Nurse, forty-two are Licensed Practical Nurses, fifteen are Orderlies and twenty-five are Nurses Aides. Computed patient hours include all the above personnel except the orderlies. Nursing Aides are trained at the Home and fifteen were graduated in 1966-67. Barber and cosmetology services are also provided as motivational factors to the patients and as elements of good nursing care.¹

6) The Rehabilitation Division provides medically prescribed therapeutical services in three areas: educational therapy, occupational therapy, and physical therapy.

Educational therapy is provided by a teacher from the Richmond Public School System and is under the guidance of a consultant speech therapist. The teacher also provides instruction to school age patients and assists in the sheltered workshops.²

Occupational therapy utilizes "self-help," manual, creative, recreational and social, educational, prevocational and industrial

¹Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 25.

²Ibid., p. 28.

activities to gain from patients the desired physical function and/or mental response. Examples of this therapy would be weaving looms which may be weighted and adjusted to aid the patient in exercising, cooking and doing housework from a wheelchair, and relearning to do daily tasks through various practices. The sheltered workshop aids in this task in allowing patients to make dolls, ceramics and such as creative expressions. It increases their span of attention, especially with the stroke cases, and may allow more complex operations to be learned later.¹

Physical therapy treats physical disorders to restore whatever physical function has been disabled in the patient. Examples of treatment are whirlpools, hot packs, Infra-Red and Ultra Violet light treatments, and muscle strengthening exercises.² A treatment team consisting of the teacher, occupational therapists, and physical therapists analyze the patient's problem and decide which treatment would be most appropriate and of greatest value to him based on his personal history and the prescriptions of the psychiatrist. A follow up of the patient's progress is standard practice. There are in-service

¹Ibid.

²Ibid., pp. 30-32.

training classes and similar experience programs held in conjunction with the Richmond Professional Institute, and the Rehabilitation staff attends training classes and conferences throughout the year.¹

The results of the total extended care facilities services for 1966-67 fiscal year were as follows: 124 were discharged; 38 died; only 105 remained at the Home with 91 under active rehabilitation therapy.²

7) The Dietary Division serves the Home for patients, employees, and others. Diet planning and menu formulations along with the regular and therapeutic diets for the patients, all of which are prescribed by a physician, are the responsibility of the division. Provision of special diets is an important element of therapy in many cases and is a safeguard of the patient's health. The Superintendent of the Dietary Service is a certified dietitian.³

Progress--Services

The Richmond Nursing Home has a long and varied history. The original purpose of the structure, which was built over a

¹Ibid., p. 29.

²Ibid.

³Ibid., p. 35.

hundred years ago, was that of an almshouse. It served as a hospital and a school during the Civil War and was returned to use as an almshouse after the war. Other additions were made over the years (1900, 1932, 1938, 1950) and in 1960-61 the new modern laundry was built. In 1967 a new storage building was added. At present a new dietary facility is being planned.¹

The largest growth to date, however, has been the development of services and corresponding change of character of the Home. In a letter from Dr. A. Ray Dawson, Director of Rehabilitation, Department of Mental Hygiene and Hospitals, Commonwealth of Virginia, February 1, 1967 to Mr. Robert L. Gordon, Administrator, Dr. Dawson mentioned that in his survey of the rehabilitation services of the Richmond Nursing Home the gradual but nonetheless impressive results of good management over the past decade.

It was my observation that the total medical treatment of the patient was excellent. The charts that I received and the patients that I interviewed revealed professional care of a high order. The personnel of the Home, in general, and the staff in particular, displayed sincerity, empathy and purpose. These characteristics are vital in treating the

¹Ibid., p. 1.

type of patients in an institution of this type. Laissez faire seems to be the national trend unless actively guarded against.¹

Dr. Dawson states of the transition from "City Home" to "Nursing Home":

This transition has been gradual, but to one who had not visited the institution for a decade, it was most striking and obviously complete.²

Six events that were set apart as important in the transition also appeared in the 1965-66 Annual Report. The first was the discharge of the last able-bodied indigent person housed in the "City Home" (June 30, 1953) which allowed the subsequent licensing as a nursing home as all patients remaining were chronically ill (July 1, 1953). On June 30, 1956 the last of the dependent and neglected children were discharged into foster homes. In May of 1959 the name of the institution was changed to Richmond Nursing Home due to the changed nature of the institution. Responsibility

¹Memorandum from Roy A. Dawson, Director of Rehabilitation, Department of Medical Hygiene and Hospitals, Commonwealth of Virginia, to Robert L. Gordon, Administrator of Richmond Nursing Home, February 1, 1968, p. 1. Hereafter cited as Dawson Memorandum (in the files of the General Administration Division, Richmond Nursing Home). (Typewritten.)

²Ibid., p. 2.

was and is still residual. March 31, 1964 came the accreditation by the National Council for the Accreditation of Nursing Homes as an "Intensive [care] Nursing Home." In June 1965, the Richmond Nursing Home was approved as an "Extended Care Facility" by the American Hospital Association,¹ the highest rating of nursing care given in the field.² Most recently 1967-68 fiscal year the Joint Council for the Accreditation of Nursing Homes, combining AHA standards and endorsement along with several other national organizations, surveyed the Richmond Nursing Home and informally stated their findings. Stated was the good possibility that the classification of the Home may be changed to Class II Hospital. If so, and formal notification appears to be a matter of time, it will represent another step in the Home's growth.³

Dr. Dawson added in his letter what he considered to be a 7th milestone of progress. In May of 1966 a Utilization and Case

¹Bureau of Richmond Nursing Home, Department of Public Welfare, Annual Report, 1965-66 (Richmond, Virginia: City of Richmond, 1967), p. 48.

²American Hospital Association, Journal of the American Hospital Association, Guide Issue, Vol. 40, Number 15, 2 parts (Chicago, Aug. 1, 1966), p. 288.

³Interview, Gordon.

Review Committee was inaugurated. The purpose was quoted by the doctor from the inauguration order and is also quoted here.

The Committee will review all cases to determine the medical necessity for admission, duration of stay, and professional services rendered for the purpose of promoting the most efficient use of available facilities and services. This review will emphasize identification and analysis of pattern of patient care in order to maintain consistent high quality. The review functions will be conducted on a continuing basis and will include comparison of internal and external data.¹

Dr. Alan Hecht, Chief Physician of Medical Staff, Medical Division, praised the Utilization Committee. Partly a result of requirements for the Medicare funds, efficiency had been improved and essential growth in services are being made possible. The Committee consists of Dr. Hecht, one of the four ward physicians on a rotating basis and Mr. Vernon Harris, Medical Administrator, Para-medical Services, Medical Division. Department heads are on call when necessity dictates their presence. Reviews are held once a week with follow-up reviews no more than six weeks afterward, more rapidly changing patients being reviewed more often.

¹Dawson Memorandum, p. 2.

The patients' cases are reviewed by the Committee individually affording maximum attention rather than in samples as at some larger institutions.¹

Progress-Treatment Statistics

Another way of measuring the growth and development of the program of the Home is in terms of patient treatment statistics. The accreditations of the Home indicate "intensive care." Such a program has been developing since 1952 (Table I). At present the average stay at the Richmond Nursing Home is 116 days, the maximum of any one being 365 days. There has been a steady decline in the number of day's stay. The rise in rate of stay from 1965-66 of 109 days to 116 days in 1966-67 was due to the closing of four less intensive nursing homes in the community.² The trend to shorter lengths of stay is continuing and 1967-68 at present is averaging 91 days of stay for treatment.³ Although the Richmond Nursing Home is licensed for 200 beds, approximately 16 are down at any

¹Interview with Dr. Alan Hecht, Chief Physician, Medical Staff, Medical Division, Richmond Nursing Home, 12 April 1968. Hereafter cited as Interview, Hecht.

²Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 45.

³Interview, Gordon.

one time for renovation (eight in the male and eight in the female wards). The population averages 170 persons with the highs in the 180's. The turnover due to deaths and discharges seldom necessitates a waiting list and waiting periods when they do occur are not longer than two weeks. Contrary to the national fetish for more and more beds mentioned in the beginning of this paper, the Home's 1951-52 to 1966-67 progress has been to treat the same number of patients in one-half the total beds and in 33,879 fewer patient days.¹ (Table I) This, again, is due to the ability of the Richmond Nursing Home to discharge patients no longer needing intensive care to the community at less cost to all concerned and freeing beds for those needing the vast array of services provided.² (Table II) Agreements with community homes of relatively lower intensity levels of care are made with the provision that should the patient become too sick for the care provided there, he will be reaccepted for treatment at the Richmond Nursing Home.³

¹Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 45.

²Ibid., p. 43.

³Interview with Mr. Vernon C. Harris, Medical Administrator, Para-Medical Services, Medical Division, Richmond Nursing Home, 5 April 1968. Hereafter cited as Interview, Harris.

Analyzed from another angle, the average length of stay from admittance to date of survey, the Home averaged 1.69 years for the 1965-66 fiscal year and 1.68 for 1966-67.¹ The national average was three years for Long Stay Geriatric and Chronic Disease "Hospitals"² and approximately the same for Nursing Home and Personal Care Homes (less intensive services).³ In terms of Government Nursing Homes nationally with 200 beds, the average length of stay was approximately 2.5 times as long (4.3 government vs. 1.69 Richmond Nursing Home). The average percentage of patients over 65 years old for the Geriatric and Chronic Illness Hospitals was 73% and 70% over 65 years old in Nursing Homes and Personal Care Homes.⁴ The Richmond Nursing Home's average is 77% for those over 60 years old. The number of discharges due to deaths on the national level (one-third of discharges)⁵

¹Interview, Gordon. ²HEW, Characteristics, p. 12.

³Ibid., p. 6. ⁴Ibid., p. 12.

⁵U. S. Department of Health, Education and Welfare, Public Health Service, Vital Health Statistics, Utilization of Institutions for the Aged and Chronically Ill April-June, 1963, E. Earl Bryant and Carl A. Taube, Division of Health Statistics, National Center for Health Statistics, Series 12, No. 4, Feb. 1966, p. iv.

is very close to that of the Home (30% 1966-67).¹ In view of the general equal comparison of the Home nationally as to population and the approximately 100 days per year average patient stay, the requirements that a patient on Medicare be treated within 100 days is an approaching reality, with 54% of the individual cases in 1966-67 being treated within that 100 day limit.²

The character and program of the Home as pointed up by the statistic is that of chronic disorders with population predominantly aged. The intensive nature of treatment and discharge policies has created and continues to create a sicker population than most nursing homes see and which hospitals on the acute level do find readily acceptable.³ Dr. Dawson in the aforementioned letter of survey spoke of the high order of rehabilitation demanded of the Richmond Nursing Home patients, frequently at a one to one ratio of staff to patient.⁴ The Rehabilitation Division has had patient

¹Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 38.

²Ibid., p. 41.

³Interview with Miss Margery Peple, Superintendent, Rehabilitation Therapies Division, Richmond Nursing Home, 11 April 1968. Hereafter cited as Interview, Peple.

⁴Dawson Memorandum, p. 3.

referrals for rehabilitation treatment amounting at times up to 85% of the Home population.¹

Progress: Perspective Through Public Criticism

Analysis and perspective may be aided by looking at criticized aspects of the Home from the public sector. Newspaper editorials and articles from the years before Mr. Robert L. Gordon became administrator and up to the middle 1960's show the challenges, growth and final accreditations from agencies whose growth and appearance were often parallel with the rise in standards at the Richmond Nursing Home. The average stay of 116 days per patient in 1966 along with the qualification as a Medicare institution in 1966 (100 days maximum paid days of care) is a primary example. (Table I.)

The change from a "poorhouse" to a high intensity extended care nursing home did not take place over night. As an almshouse the attitude toward the poor had been to house them together. But as times changed the clients changed and the aged began to be housed in the almshouse. After the death of the Superintendent of the then City Home (Richmond Nursing Home), the Director of Public Welfare took over the job, incorporating the duties into his office. Conditions

¹Interview, Peple.

at the Home were not good, but were reported to be better than the Detention Home or the City Jail.¹

The problem of poor conditions was not so emphasized as taken for granted. What seemed of major concern at the time was the fact that children were kept in the Home. The dependent and neglected children of the City were kept at the City Home for lack of another place to keep them. This was in violation of a state law. The average stay was six months and ages were from infants to teenagers.² The problem, not wholly the fault of any administrator, continued to face the city. In December of 1954 tuberculosis patients were also being kept at the Home in lieu of shipment to Pine Camp, the city's Tuberculosis Hospital. Fear was that the children might become infected, though separated by locked doors.³

The month earlier the stigma of staying at the city's "poorhouse" was reported to have a bad social effect on the children attending the public schools. Pictures of patients at that time showed them with their faces blocked out for fear of recognition. The effect

¹Richmond News Leader, December 13, 1948.

²Ibid., December 13, 1948.

³Ibid., December 12, 1948.

must have been worse on the children. There were 74 housed there at the time.¹ A Times-Dispatch editorial in December advised the City Council to look into the budget and see what could be done to clean up the conditions of the Home where the "poorhouse rats" were being housed.²

After several alternatives had been considered by the City Council, it was decided that a larger foster care program for the City would be the best and most economical method of dealing with the children.³ By June 8, 1956 all children had been removed from the Home to foster homes, freeing the City's conscience.⁴

The other main problem was the up grading of the institution itself. The building was built at the beginning of the Civil War. Though built well, the years had worn on the structure, especially with the failure to maintain repairs and the "lack of supervision" in the years of 1948 to 1951. The newly appointed Director of Welfare

¹Richmond Times-Dispatch, November 28, 1954.

²Ibid., December 18, 1954.

³UNDATED CLIPPING FROM
Richmond Newspapers, Inc., approximately January 12, 1955.

⁴Department of Public Welfare, Annual Report, 1955-56, (Richmond, Virginia: City of Richmond, 1956), p. 17.

in 1951, Mr. Raleigh C. Hobson, began what was termed a "crack down" on the conditions of the Home.¹ In that same month Mr. Robert L. Gordon was appointed as superintendent, filling the vacancy created three years earlier.²

The first moves by Mr. Gordon were to stop the "petty thievery" and poor utilization at the Home which up till then had been a "large municipal rat hole" through which thousands of dollars had been slipping, \$5,000 in lost sheets and \$500-600 on food savings. Security measures such as an inventory control system and a high barbed wire fence around the premises aided the goal greatly.³

In May of 1952, Mr. Howard Carwile, a candidate for City Council, attacked the City Home as an institution "teeming in filth and brutality." The accusations were denied by the City Departments of Health and Welfare and Mr. Hobson mentioned the greatly improved conditions of the Home.⁴

¹Richmond News Leader, May 17, 1951.

²Ibid., May 26, 1951.

³Ibid., September 26, 1951.

⁴Richmond Times-Dispatch, May 31, 1953.

In line with the changing status of the Home, the State Health Department licensed the Home as a nursing home (July 11, 1953). Renovations, begun in 1952, were progressing well with 80% of the planned work completed. The replacement of the old wooden porches with the enclosed steel and concrete ones was one of the major projects. At that time it was planned that the institution serve for another 15-25 years.¹

Renovations and improvements continued and by 1959 the change was so recognizable that an editorial reported the following "heartening success story" of the Richmond Nursing Home, once the City Home:

Once a reeking fire trap, run by political appointees with no experience in institutional management, the Home today is a modern little hospital for the chronically ill. It has ceased to be a poor house, a last refuge for penniless oldsters with no place else to die. . . . In place of the sick green walls of other years and the pervasive odors of senility, the visitor to the Home finds pleasant words, professional nursing services . . . a sense of competent hands at work.²

In 1957 the controversy of whether to keep the City Home or Pine Camp, the City's former Tuberculosis Hospital, arose.

¹Richmond Times-Dispatch, October 30, 1952.

²Richmond News Leader, May 24, 1959.

After a study by the Richmond Area Community Council and a visit by the Council members to the two institutions, it was decided to merge at the City Home. Though the City Home grounds were limited on three sides (Shockoe Valley, Hebrew Cemetery, and Shockoe Cemetery) and a street on the fourth side, the grounds and buildings were in better condition than at Pine Camp.¹

As can be seen from Table IV the budget of the Richmond Nursing Home expanded greatly in the last ten years of operation. In 1961 the food situation at the Home was called "below par but edible." Reasons given were costs of food going up, special diets, patients not liking to eat powdered eggs or milk, and lack of staffing. There were 240 patients and enough staff for 180 patients. The plan was for better care through more money and qualification for more state and federal aid.² A new laundry was added in November, 1961.³

Renovations were again mentioned in 1962 with replacement of the last wooden porches, repair to plaster and repainting taking

¹Richmond Times-Dispatch, October 29, 1957.

²Richmond News Leader, March 8, 1961.

³Richmond Times-Dispatch, November 9, 1961.

place. Things were not completely finished when a teenage visitor reported shock at some of the conditions of the rooms still to be completed. The Mayor of the City invited the girl to discuss the situation and what was being done for the patients in services as well as appearance. Thirty per cent of the renovation remained and Mr. Hobson, Director of the Department of Public Welfare, stated that "All we need is a little patience, a little money, and a little more time."¹

Money, time and good administration also got the accreditations mentioned at the beginning of Chapter IV. Constant inspections keep the institution on the upward movement of standards and services. Critics of the Home now require professional status and professional consultation.

Most recent criticism is from the Social Security Administration and the Joint Commission on Accreditation of Hospitals. Letters dated May 21, 1968 and April 30, 1968, notified Mr. Gordon of approval and accreditation and made recommendations for improvement while stating their observation of the continuing rise

¹Richmond Times-Dispatch, January 21, 1962.

in the level of services and constant renovation.¹ Deficiencies generally involved incidental accounting procedure, staffing and fire drills. All are in the process of being corrected in the continuing effort to improve services to the community.²

Development Problems

In the development of the intensive nursing care services at the Richmond Nursing Home there are problems connected with its continuing growth and changing character. Basically two problems stand out, staffing and financing. Nursing is a nationwide problem in terms of both salaries and numbers. The Richmond Nursing Home has experienced a loss in nursing care hours due to these problems. Both competitive salaries and training are constantly being utilized in a continuing solution.³

¹Letter from Social Security Administration, Department of Health, Education and Welfare, to Richmond Nursing Home concerning Medicare licensing, May 21, 1968 (in the files of General Administration Division, Richmond Nursing Home). (Typewritten.) Letter from Joint Commission on Accreditation of Hospitals, John D. Porterfield, Director, Chicago, Illinois, to Richmond Nursing Home, April 30, 1968 (in the files of General Administration Division, Richmond Nursing Home). (Typewritten.)

²Interview, Best, July 16, 1968.

³Interview, Gordon.

Miss Margery Peple, Superintendent, Rehabilitation Therapies Division, reported staff problems both from salary and personnel shortage, and spoke of the urgency of the situation due to increasing pressures from the aforementioned increasingly sicker population of the Richmond Nursing Home. (See pp. 32 & 49.) Medicare, which has made more money available, has also increased the number of patients seeking care in rehabilitation. Her prominent need is trained personnel in the field of physical therapy, particularly physical therapists, where salaries are not competitive with those paid by the State of Virginia or by institutions outside the state. Salaries are established on the basis of those paid by private industry and by the State. Salaries paid by the City may be as much as 95% of the State's salaries but no more. This policy of salary comparison is an unwritten rule of the Director of Personnel--that the City shall not be in advance of the State or market in salaries. Inflation, if nothing else, necessitates periodic increases at all levels of government and the City, being no exception, must increase its salaries to remain competitive. Physical Therapists are low in supply and high in demand, many of them having been assured jobs with agencies before even beginning physical therapy training. Richmond Professional Institute

provides a nearby Occupational Therapist Training Center from which aids, trainees and therapists may be drawn. No such center exists for Physical Therapists. Attempts to raise salaries have been made and a recent increase in Physical Therapist salaries has helped.¹

For a salary to be raised it must first be handled through the Personnel Office. Justification for the increase must include a statement of where the needed money is to come from. An ordinance is drawn up by Personnel with the Budget Officer's approval and City Council holds a public hearing so that citizens may express themselves on the matter. With the approval of Council, the recruiting may begin at the new salary level.²

In connection with staffing and loads on services, Dr. Hecht mentioned the good ratio of physicians to patients in the Home, and the availability of consultants for the problem treatments and the close proximity of the Medical College of Virginia for special services. He also mentioned the smaller outpatient program which remained small because of the heavy load on services from the

¹Interview, Peple

²Interview, Gordon.

Richmond Nursing Home's population itself. As was mentioned earlier, a sicker population requiring more care and the increased loads from Medicare patients have mainly contributed to the heavy load. The best program at this moment was that of a monthly review or more if necessary of welfare patients in nursing homes by a Richmond Nursing Home physician.¹ In 1966-67 an average daily census of 108 patients was treated in 14 proprietary nursing homes. This program, however, does represent a preventative measure of great long run economic and individual savings.²

The financial problem encountered by the Home is patient payments. With welfare recipients, Medicare patients, Social Security recipients and private income clients, the billing and cost accounting is a large job. Mr. Ernest Best, Controller, dramatized the situation in an interview. Because the Richmond Nursing Home is the best and most complete facility in the state, particularly with the close proximity of Medical College of Virginia, the patient population even for a City residual care institution is quite varied. Coupled with Medicare the billing for cost of treatment

¹Interview, Hecht.

²Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 20.

is to multiple agencies, private and public as well as the patient himself. Medicare has meant better cost accounting and subsequent new sources of income other than the City. It has also meant an increase in paper work by 11 times since January 1, 1967. One of the solutions is a program of conversion to computer billing and cost accounting conversion to the city auditor's system. The streamlining will take several years to complete and is already under way.¹

During the same 1950-51 to 1966-67 fiscal years, the financial goal of establishing a self-supporting institution has met with steady success. General Fund Income was .6% of the total cost of operation in 1950-51 while City costs were 99.4%. Total cost was \$302,733. In 1966-67 General Fund Income represented 42% and City Costs 58% and though the 1953-54 City Costs were 58.8% (total cost \$381,404.), the total costs in 1966-67 were \$1,171,245. The latter represents a tremendous increase in services with a maintenance of General Fund Income proportion. With the participation in Medicare, better case accounting and

¹Interview, Best.

billing, and increase in welfare rates, the City's Cost percentage is estimated to drop to 33.1% in 1967-68 and to 26.6% in 1968-69.¹

(Table III.)

Budgetary Considerations

The Richmond Nursing Home as a Bureau of the Department of Welfare submits its budgetary requests along with the other city agencies to the Bureau of Budget of the City Manager's Office. Before submission the Administrator goes over the requests of each division with the division head. It is and has been the Administrator's policy to request no more than is necessary, neither over nor under estimating needs due to inflation or plan of growth. The Budget Officer, of course, is aware of plans and difficulties and follows as closely as possible actions taken. The same scrutinizing then takes place on the department level.

The Department of Welfare's Budget is submitted to the Budget Bureau. Before final submission to the City Manager for City Council's approval, each department and bureau is expected to and does meet with Budget Officers for justification of its items.

¹Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 5.

In other words, they must fight for their appropriations. In the end, the Budget Officer makes his decision based on what monies the City Manager will allow him. Priorities are served and other items may be delayed or denied.¹ City Council seldom cuts the budget although it may demand justifications and explanations for any part.

Control over the budget once appropriations have been made is in the hands of the City Manager. The exception to this is in a transfer of funds between departments of the city. As the end of the fiscal year approaches, original appropriations do not always meet the costs as planned. Some departments and bureaus of departments may have been able to spend less than was appropriated, some more. If the city's costs have been high during the year, such as several heavy snow falls with the cost of clearing the streets, the City Manager may have instructed the Budget Officer to keep costs and expenditures on the minimum side or to "freeze" funds until it is determined what will be the savings near the end of the year. Major equipment purchases, such as fire engines, may be delayed until May or June when a way is seen for obtaining the funds

¹Interview with Mr. G. P. Leveque, Acting Head, Bureau of Budget, Office of City Manager, City of Richmond, June 18, 1968. Hereafter cited as Interview, Leveque.

and from where.¹

Transfers of funds are made often between bureaus at the end of the year, such as between the Social Service Bureau and the Bureau of the Richmond Nursing Home. A small savings in one may mean a transfer to the other where a small deficit may be likely. Transfers may be made between divisions in the bureau, also. Control of transfers are as follows: Transfers between departments of the City are with the City Manager's recommendations and require the City Council's approval; Transfers between Bureaus of a department are on the recommendation of the department director and require the approval of the City Manager and Budget Officer; finally, transfers between divisions of a bureau are with the recommendation of the bureau administrator, may carry the approval of the department director and require the approval of the City Manager and Budget Officer. The actions are administrative except between departments, but the City Manager, of course, remains responsible for any actions to the City Council, the elected body of the City.²

¹Interview, Best, July 16, 1968.

²Ibid.

In the Budgetary Message of the City Manager to the City Council, the fairly detailed considerations of the government are explained in terms of increases and major items of concern. The Richmond Nursing Home in the 1968-69 budget, which was not cut by Council, showed additional personnel and a few large items of maintenance and replacement.¹

Table IV gives a ten year study in general of what has happened in terms of requests and appropriations. Table IV should be taken as very general, each year being different in its needs. Quantities of funds denied or delayed to the following year do not necessarily reflect the results on the Home's efforts to maintain standards of care. Timely availability of money may have meant success or failure, or a request may be delayed until the following year without serious consequences.² An example of such a need in the past, which is still unsettled, is the position of Food Service Supervisor. Required by both State and Medicare laws are six Food Service Supervisors. There are none presently employed. Six were requested in the last budget, the Personnel

¹Alan F. Kiepper, Budget Message from the City Manager to the Honorable City Council of the City of Richmond, City of Richmond, Virginia, April 5, 1968, pp. 59-60.

²Interview, Leveque.

Department authorized only three positions whose salaries are not competitive. Finally the specifications for hiring such Supervisors have been in the Personnel Board since February 1968 where no action has been taken. Should the Dietician who is quite near retirement age and who herself is covering for the vacant positions, become seriously ill and/or retire, the now critical situation would become even worse. Lack of flexibility would seem to be indicated in the ability of the Personnel Department of the City to quickly act and upon the Budget Bureau to grasp fully the needs of an institution with characteristics close to that of a general hospital.

The most recent example of a need deferred was the 1967-68 request for personnel in the General Administration to cover the increase mentioned earlier, in administrative work, due to the Medicare cost accounting. The additional staffing should have brought additional revenue from outside the City, thus paying for itself, but the appropriations were not available until 1968-69. Other unusual increases have often been in salaries which affect greatly an institution of such a service nature where personnel is the biggest cost and operating factor.¹

¹Interviews, Best, April 8, 1968, and Leveque.

In terms of requests during the ten year period (1959-60 to 1968-69) close to one million dollars was denied or deferred in actual appropriations. With the character of the Richmond Nursing Home having changed from an almshouse to an intensive care nursing home, there has been an increase in appropriations of 99.2%, a budget request granted of 90.8% and deferred or denied requests of 9.2%.¹

Mr. G. P. Leveque praised the growth of the Richmond Nursing Home as he has seen it in his 14 years of city government work (seven years in the Personnel Department and seven years in the Budget Bureau). His concern is with a just policy in dealing with the agencies and especially the Richmond Nursing Home where both the growth and the needs have been great.²

Program Comparison

Comparison of nursing homes is a rather difficult task and calls for expert opinion due to the difficulty of converting seemingly comparable institutional statistics into truly comparable ones. In the most recently proposed addition to the Richmond Nursing

¹Interview, Best.

²Interview, Leveque.

Home, that of a new dietary facility annex, such a survey of in-state institutions was held and provided interesting comparisons not unfavorable to the Richmond Nursing Home.¹

The survey was requested by the City Manager of Richmond as an inter-departmental review by Works and Welfare based on data from the State Department of Health. Criticism had arisen at the federal level where grant-in-aid funds had been requested and justification of the size of the dietary areas was in doubt. It was felt that at that level the proposed size of the annex was too large for a 200 bed facility. A group of five persons visited the institutions listed in the Department of Health's letter as comparable to the Richmond Nursing Home. The five persons were, the Administrator of the Richmond Nursing Home, the Superintendent of Structures, Department of Public Works (Richmond), the Budget Examiner (City of Richmond), a Food Service Consultant for the City of

¹Intra-city correspondence from Director of Public Welfare, City of Richmond, to City Manager, City of Richmond, concerning review of Dietary Facilities: Proposed Annex to Richmond Nursing Home, January 22, 1968, pp. 3-4, (in the files of the General Administration Division, Richmond Nursing Home). (Typewritten.) Hereafter cited as Director, Intra-city.

Richmond and the Director of Public Welfare (Richmond).¹ The result of the field trips was the full justification of the previously proposed size of the dietary area. The facility is scheduled to be built in the next several years.²

There were seven institutions proposed for the field trips of which six were visited, the seventh not having been constructed. The institutions were both government and proprietary in operation. Of the six, four were found to be not comparable by the five member group. The other two were found to be comparable with the Richmond Nursing Home. The two institutions will be identified as Institution A and Institution B.

Institution A is a long term public facility licensed as a hospital in the City of Norfolk. Approximately 50% of the patients treated there are welfare recipients. The physical plants are approximately the same size and the organization and staffing is for comprehensive medical, nursing and rehabilitation services. The difference basically is that of philosophy of care or accent on rehabilitation of patients. Of Institution B, also a public institution of

¹Garletti, Nursing Home Administration, pp. 1-2.

²Director, Intra-city, p. 7.

the Newport News area, the facility is public in operation and most of the patients are welfare clients or medically indigent. The hospital is not certified for Medicare though staffed to provide medical, nursing, and some rehabilitation services. Basic differences are philosophy of care, type and number of patients treated, personnel and operation. Table III shows pertinent statistics in comparison with the Richmond Nursing Home.¹

Of the three institutions the Richmond Nursing Home has the smallest area population but serves an age 65 and over population within that area which is larger than the other two. The Richmond Nursing Home has the smallest bed capacity, the smallest average daily census, the smallest total days of care and the smallest average treatment period. Although Richmond has the largest average daily cost, the average treatment cost is less than Institution A and more than Institution B. Richmond treats approximately the same number of patients but discharges more than twice the number of Institution A and four times the number of Institution B. In spite of the difficulty

¹Department of Public Welfare, Special Report Hill-Burton Program, Richmond Nursing Home, "Addition to East Building," (unpublished supporting papers), 1968 (in the files of the General Administration Division, Richmond Nursing Home). (Typewritten.)

of evaluating without including the community facility variables such as diseases, disabilities and other facilities, one point stands out clearly--the philosophy of care. Reflected in the statistics is the intensive treatment center of the Richmond Nursing Home striving for the most complete treatments in the shortest period of time with economy of time, effort and life the results. "The long term program is undoubtedly the most expensive and least productive program." An example in Virginia would be in her mental hospitals where those 65 years and over comprise 30.8% of the resident population, 3,500 persons, and where a relatively high percentage have only minor psychiatric problems. Cost of treatment could be reduced by adequate non-psychiatric facilities at family residence where possible, freeing the more intensive facility for its proper function. The principles of economy and preventive medicine are sound in any setting.¹

Specific advantages shown from the Richmond Nursing Home's pattern of operation (1965 comparative year) are

¹Hiram W. Davis, "Geriatric Study Commission Asked by Hospital Board," Mental Health in Virginia, Vol. 18, No. 1 (Richmond, Virginia, fall, 1967), p. 13.

1) the lower treatment period per patient receiving maximum benefits (Richmond Nursing Home - 121 days, Institution A - 200 days, Institution B - 200 days); 2) higher number of patients treated per bed (Richmond Nursing Home - 3.01, Institution A - 1.65, Institution B - 1.84); 3) highest number of patient discharges under intensive care (Richmond Nursing Home - 219, Institution A - 90, Institution B - 51); and 4) lowest number of discharges due to death (Richmond Nursing Home - 158, Institution A - 160, Institution B - 214). The philosophy has begun to show undeniable success.¹

A thorough comparison with an out of the state facility of a similar nature or, indeed, within the general field has not proved possible. Had it not been for the investigation of the seven facilities in Virginia by the professional group, evaluation and comparison would not have been so complete within Virginia.

Willingness to make such information available often carries the understanding that it will not be publicized. Undeveloped means

¹Evaluation of Comparative Institutions, Chronically Ill Public Facilities in Virginia, 200 bed and over (unpublished information), Department of Public Health, for Calendar Year 1965, pp. 1 and 2 (in the files of the General Administration Division, Richmond Nursing Home). (Typewritten.)

of accounting may very well make comparisons impossible. A small proprietary nursing home has no real or pressing demand to account on the scale and in the depth of a large municipal nursing home. In fact, there is a real question as to whether it is generally realized in the field that comparative statistics are in demand but not in supply. In the 1967 book Adult Health by two prominent doctors and educators such absence is noted.

Strangely enough, despite the fact that practically every state department of public health and a number of local health departments have an identifiable unit that is concerned with adult health, there is little reference material on the community aspects of the problem of adult health and chronic disease control.¹

Some general indications of developing programs do exist and movement to publish in the area may be dated generally from the late 1950's and early 1960's. Mentioned in The Annals (1963) was the changing character of the old almshouses to the "revitalized" positions of nursing homes with rehabilitation programs.² Such, of

¹Frank W. Reynolds and Paul C. Barsam, Adult Health, Services for the Chronically Ill and Aging (New York: Macmillan Company, 1967), p. vii. Hereafter cited as Reynolds, Adult Health.

²Milton I. Roemer, "Changing Patterns of Health Service: Their Dependence on a Changing World," The Annals of the American Academy of Political and Social Science, Thorsten Sellin, Editor, Vol. 346 (Philadelphia: March, 1963), p. 50.

course, was the case with the Richmond Nursing Home. Growth continues into the category of a hospital for the Home; and in general, such growth causes the wide variety of services and sizes that may go to make up the definition of a "nursing home."

Endorsed by Adult Health is the newly evolving concept of "progressive patient care," the matching of a patient's needs to an institution with a corresponding level of care. This concept necessitates affiliation of the institutions in the community at the different levels of care and coordinated efforts.¹

An example of an affiliation and movement toward higher community service is the Brookline, Massachusetts community where nursing homes are the third largest industry. With the local health department (the state does the licensing) acting as a neutral coordinator, the private sector, proprietary nursing homes, are coordinated with a voluntary hospital. Involved in the effort are volunteers of professional and non-professional levels, the Massachusetts Federation of Nursing Homes, and the Massachusetts Dental Society. The nursing homes are of a wide variety. There are 23 participating with beds totaling 600. A home may have from

¹Reynolds, Adult Health, pp. 27-28.

9 to 105 beds. At the time of publication, the homes in conjunction with the hospital had improved dietary, dental and recreational programs and had economized through sounder financial methods, permitting improved services at the same costs and charges.¹ Important to the movement was the goal to involve and include the private sector of the economy.

The major barrier to better care for nursing home patients is largely due to the historic isolation of the proprietary nursing home from the mainstream of medical care. A cooperative effort by a health department and hospital can do so much to break down the barriers between the nursing home and other community resources and can establish a frame work for the continuity of patient care between the hospital, nursing home, and community.²

The Department of Public Welfare coordinates and works with the Richmond area involving principally the Medical College of Virginia, the Richmond Nursing Home and the 14 community proprietary nursing homes. As was mentioned earlier, services are provided for the patients by the Department through the Home.³

¹Leon J. Taubenhaus, et al., "A Public Health Approach to Nursing Care," American Journal of Public Health and the Nation's Health, Vol. 59 (New York: American Public Health Association, 1964), pp. 53-57.

²ibid., p. 58.

³Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 43.

A final indicator of progress in the field toward the newer nature of nursing homes is in architecture. The movement has been affected by Medicare which offers payments up to 100 days of care. The "extended care" facility (offering extensive services close to those of a hospital) is being adopted in planning for joint care and residential areas. Both the social and medical aspects for the elderly are attempting to be secured.

In Portola Valley, California, Sequoia Nursing Home has a combination health center and adjacent housing project for the elderly. A similar projected combination of the health care center and residential unit is being planned for a Danish community in San Rafael, California. Several other community actions of this design are planned in such places as at Gibson Community Hospital (an annex), Gibson City, Illinois; Regina Memorial Hospital, Nursing Home and Residence, Hastings, Minnesota; St. Francis Extended Care Hospital, Charleston, West Virginia; Capistrano By-the-Sea, Dana Point, California (partially completed); and Forbes Pavillion Nursing Home, Pittsburgh, Pennsylvania (now in operation).¹ Perhaps these evidences of filling the community need show a growing awareness of the needs in the field of nursing homes and services.

¹"Nursing Homes," Architectural Record (New York: McGraw-Hill, Inc., October, 1967), p. 169-76.

CONCLUSION

The Richmond Nursing Home has been economical in its development. The monies it has were used in the best possible way. Success over the period of 1951 to 1968 has been based on long run planning and preventative medicine. To be economical means to save more lives. To be economical means happier lives. To be economical means a hard job done well.

In no field is the result of an economical operation more measurable in human lives than the medical field. Care at the level needed at the least cost means satisfaction to all those concerned, be he patient, employee or administrator. To accomplish the task of economical operations is difficult in the complexities of a large institution; they were done well and with justifiable satisfaction.

The motivated staff and administration of the Richmond Nursing Home applies well researched methods and in efficiency, if not method, leads the field in services rendered. A continued growth consistent with past performance can be expected from the Home in the future.

APPENDIX

TABLE I
 AVERAGE PERIOD OF TREATMENT
 ADULT PATIENTS ONLY
 1951-52 - 1966-67

Fiscal Year	Total Beds	Total Days of Care		Total Adult Patients Treated		Average Stay (days) of Patients Treated
1951-52	400	96,788	+	541	=	179
1952-53	400	95,929	+	564	=	170
1953-54	400	102,370	+	532	=	193
1954-55	368	96,234	+	505	=	191
1955-56	350	87,534	+	521	=	168
1956-57	350	85,217	+	473	=	180
1957-58	350	89,695	+	550	=	163
1958-59	350	89,460	+	560	=	158
1959-60	350	86,171	+	594	=	145
1960-61	300	85,180	+	587	=	145
1961-62	250	77,860	+	547	=	142
1962-63	250	72,334	+	520	=	139
1963-64	250	66,578	+	554	=	120
1964-65	200	70,365	+	540	=	120
1965-66	200	62,178	+	572	=	109
1966-67	200	62,909	+	541	=	116

In summary, when comparing 1951-52 with 1966-67, the improved patient services have made it possible to treat the same number of patients in one-half of the total beds and in 33,879 fewer patient days.

Source: Bureau of Richmond Nursing Home, Annual Report, 1966-67, p. 45.

TABLE II

SPECIAL SERVICES IN THE RICHMOND NURSING HOME

1. Ambulance Service (with dispatcher and ambulance drivers)
 2. Barber Shop (with barbers)
 3. Beauty Salon (with hairdressers)
 4. Chapel and Chaplain Service Area (with chaplain)
 5. Dental Clinic (with dentist)
 6. Laundry within facility (with laundry personnel)
 7. Medical Records (with medical records consultant)
 8. Medical Social Service (with medical social workers)
 9. Occupational Therapy Area (large, with occupational therapists)
 10. Optometry Facility (with ophthalmologist)
 11. Pathology Laboratory (certified, with pathologist)
 12. Pharmacy (licensed, with registered pharmacists)
 13. Physical Therapy Area (large, with physical therapists)
 14. Podiatry Service Area (with podiatrist)
 15. Security Service Area (with property patrolman)
 16. Speech Therapy (with speech therapy consultant)
 17. Staff Physicians (see organization and staff)
 18. Volunteer Service Area (with supervisor of volunteer workers)
-

Source: General Administration Division, Richmond Nursing Home.

TABLE III

DEPARTMENT OF PUBLIC WELFARE
Richmond Nursing Home
Source of Funds 1950 - 1969

Fiscal Years	Total Expenditures 100%	General Fund Income	Percent	City Cost	Percent
1950-1951	302,733	1,775	.6	\$300,958	99.4
1951-1952	307,850	2,317	.8	305,533	99.3
1952-1953	406,406	12,749	3.1	393,657	96.9
1953-1954	381,404	157,263	41.2	224,141	58.8
1954-1955	490,170	257,728	52.6	232,442	47.4
1955-1956	536,871	256,195	47.7	280,676	52.3
1956-1957	489,041	250,894	51.3	238,147	48.7
1957-1958	618,329	268,912	43.5	349,417	56.5
1958-1959	706,885	322,557	45.6	384,328	54.4
1959-1960	756,905	343,655	45.4	413,250	54.6
1960-1961	819,534	374,372	45.7	455,162	54.3
1961-1962	851,642	363,522	42.7	488,120	57.3
1962-1963	878,110	352,638	40.2	525,472	59.8
1963-1964	956,755	308,756	32.3	647,999	67.7
1964-1965	986,710	326,555	33.1	660,155	66.9
1965-1966	1,072,189	411,125	38.3	661,064	61.7
1966-1967	1,171,245	491,781	42.0	679,464	58.0
1967-1968 (Est.)	1,311,250	877,530	66.9	433,720	33.1
1968-1969 (Est.)	1,437,100	1,054,700	73.4	382,400	26.6

Source: General Administration Division, Richmond Nursing Home.

TABLE IV

RICHMOND NURSING HOMEA TEN YEAR STUDY OF BUDGET REQUESTS
AND APPROPRIATIONS

	1959-60	1960-61	1961-62	1962-63	1963-64
Budget Request	835,887	869,998	983,819	886,759	992,500
Initial Appropriation Grant	725,500	820,000	854,000	871,250	890,215
Difference	110,387	49,998	129,819	15,509	102,285
Initial % of Request Granted	86.3	94.2	86.8	98.2	89.7
Amt. Increase Granted Over Prior Year	18,615	94,500	34,000	17,250	18,965
Initial % Increase Granted Over Prior Year	2.6	13.0	4.1	2.0	2.2
Additional Appropriations	34,883	13,210	79,519
Total Appropriation	756,948	820,000	854,000	884,450	969,734
Actual % of Request	90.6	94.2	86.8	99.7	97.7
Actual % Increase Granted Over Prior Year	7.1	13.0	4.1	3.6	9.6
Deferred or Denied	9.4	5.8	13.2	0.3	2.3

Source: General Administration Division, Richmond Nursing Home.

TABLE IV--Continued

1964-65	1965-66	1966-67	1967-68	1968-69
1,087,058	1,124,756	1,242,659	1,655,907	1,698,879
1,003,000	1,043,800	1,174,100	1,247,800	1,437,100
84,058	75,956	68,559	408,107	261,779
92.3	93.2	94.5	75.3	84.6
112,785	45,800	125,300	73,700	189,300
12.7	4.6	11.9	6.3	15.2
30,000	32,420	. .	63,450	71,100*
973,000	1,081,220	1,174,100	1,311,250	1,508,200
89.5	96.1	94.5	79.2	88.8
0.3	11.1	8.6	11.7	15.0
10.5	3.9	5.5	20.8	11.2

* Estimated

Increase in appropriation in 10 years - 99.2%
 Budget Request Granted, As Requested - 90.8%
 Deferred and Denied Requests - 9.2%

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