The Role of the County Home Nursing Program in Providing Care for Public Assistance Recipients in Illinois, June 1945 Through December 1954

Frank P. Higgins
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THE ROLE OF THE COUNTY NURSING HOME PROGRAM IN PROVIDING
CARE FOR PUBLIC ASSISTANCE RECIPIENTS IN ILLINOIS,
JUNE 1945 THROUGH DECEMBER 1954

by
Frank P. Higgins

A Thesis Submitted to the Faculty of the School of Social Work
of Loyola University in Partial Fulfillment of
the Requirements for the Degree of
Master of Social Work

June
1955
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CHAPTER I

INTRODUCTION

Purpose. This thesis is intended to show the need for chronic care facilities in Illinois which brought about the enactment of Rennick-Laughlin bills by the Illinois State Legislature in 1945. The importance of this legislation in enabling local governmental units to convert existing county homes into chronic care facilities and vesting in the Illinois Public Aid Commission responsibility as the standard setting agency for the county nursing homes will be related. The development of the county nursing home program from 1945 through 1954 will be traced, and the utilization of the beds made available by the conversion of county homes to nursing homes for chronically ill recipients of public assistance will be emphasized. The extent to which the county nursing homes met the need for chronic care facilities will be evaluated, and some estimate made of the potential for future expansion of the program. The current trends in thinking concerning care of the chronically ill will be discussed in relation to their possible influence on the county nursing home program in the future.

Scope. The time span of this study will include historical reference to the dearth of chronic care facilities in Illinois in the years just prior to 1945, and some allusion to the "poor houses" through the years since they were started in 1877, but primarily the study will be concerned with the span of nine years, from 1945 through 1954. The main focus will be directed toward the
increase in the number of beds for chronic care patients made available as a result of the Rennick-Laughlin legislation. The discussion of the standards set by the Illinois Public Aid Commission, and the methods employed by its representatives and the county home committees to reach an agreement on patient rates is pertinent to the whole theme, as adherence to the standards and an agreement on rates are essential to the total development of the program.

The study will be a generalized discussion of the total county nursing home program in the state and references to specific county homes will be employed only to give an example or to demonstrate a point.

The county home program is not static, and changes and improvements are constantly being made. The information in this study is based on the latest reports and records available through December 1954 when current statistical material is cited.

Sources. The information used here has been gathered mainly from periodicals and reports. Public Aid in Illinois, the official publication of the Illinois Public Aid Commission was of great value in supplying information. From 1945 through 1954 there were fifty-one articles in this publication pertaining to county nursing homes and the problems pertaining to caring for the chronically ill. Some of these articles are cited as references for material included in the study, and others supplied background information although no specific material was used from them. Four articles which appeared in the June, November and December 1945 and February 1946 in Public Welfare, the monthly journal of the American Public Welfare Association, provided some helpful information. An article published in the Social Service Review, Vol. XX, No. 4, December 1946 contained much pertinent and authoritative information.
The first interim report of the Committee to Investigate Chronic Diseases Among Indigents made to the Sixty-Fourth General Assembly, Springfield, Illinois, June 7, 1945 and the Second Interim Report concerning Care of the Chronically Ill in Illinois published by the Commission on the Care of Chronically Ill Persons published in August 1948 provided a great deal of statistical information.

Other sources of information used have included inter-organizational memoranda and bulletings and exhibits of the Illinois Public Aid Commission, and the monthly, quarterly and yearly reports on the county nursing homes, available in the Champaign Regional office and the Chicago office.

Considerable information was obtained in personal interviews with Norman H. Paulson, County Home Consultant, Stephen J. Green, Chief Division of Field Operations, James M. Brown, Regional Director, and C. H. Colwell, District Representative, all of the Illinois Public Aid Commission. Personal experiences in preparing and editing county nursing home reports, and participating in discussions and negotiations with county boards of supervisors and county home committees have contributed to the author's background information on the subject.

Method. The writer has personally collected and read all periodicals, reports, bulletins and memoranda referred to above, and extracted the most pertinent and useful information to be incorporated in this study. Over the past year from March 1954 to March 1955 the writer has been engaged in working with the county nursing home program in Piatt, DeWitt and McLean counties and during that time has gained knowledge and understanding of the philosophy, standards, goals, and reporting systems utilized by the county home committees and
superintendents or managers and will include in this study such information from personal experiences that are significant. During that same span much of the information gained with Mr. James M. Brown, Mr. C. H. Colwell, Mr. Norman Paulson and Mr. Stephen J. Green have been incorporated in notes which will be used to supply information for the study.

**Plan of Presentation.** The material is divided into four phases which are (1) the need for chronic care facilities based on information gathered by individuals in the employ of the Illinois Public Aid Commission and the published information prepared by the legislative committees. (2) The action taken by the Sixty-Fourth General Assembly of the Illinois Legislature in 1945 in passing the enabling legislation, the Rennick-Laughlin bills, which paved the way for conversion of county homes into county nursing homes and the responses of the Illinois Public Aid Commission and the county boards of supervisors to the legislation. (3) An evaluation of the development and progress of the county nursing home program in Illinois as of December 1954, and the potential for future expansion of the program. (4) Current thinking regarding the total problem of the chronically ill and how it may affect the future of the county home program.

**Terminology.** References in this study to county homes and "poor houses," is synonymous. Officially the name of the county institutions prior to conversion to county nursing homes has been the county home in most counties, but common usage gave preference to the use of the term "poor house" or "poor farm." The term "county farm" in this text refers to the institution or institutions prior to the time of conversion to a county nursing home while "county nursing home" will be the term applied to any such institution which has been converted.
The term "public assistance" is used to include general assistance which is dispensed by the township supervisors to persons in need, as well as Old Age Assistance, Blind Assistance, Aid to Dependent Children, and Disability Assistance which are known collectively as categorical assistance programs and are administered by the Illinois Public Aid Commission. Old Age Assistance as the program is presently known was officially named Old Age Pension at the time the county nursing home program began. The present appellation became the official name of the program in the General Assembly of 1953. This differentiation is mentioned since references to the program pertaining to events of the past will employ the term Old Age Pension, and references to the same program in the present will employ the term Old Age Assistance.

Disability Assistance was not in existence as a categorical program until the Social Security Act was amended in 1950 to provide for Aid to the Totally and Permanently Disabled. The first payments to Disability Assistance recipients in Illinois were made in December 1950. This explains why no reference is made to Disability Assistance when the discussion embraces the years from 1945 to 1950.

The term "private pay patients" is a reference to patients who are not recipients of any type of public assistance, and are supported from their own resources or those of relatives. This term is applied only to the persons who are completely independent of public assistance. Persons who are supported partially from their own resources or by relatives, and partially from public assistance funds are counted as public assistance recipients. The term "private-pay patients" is used rather than the term "private patients" because the designation is used primarily to describe the source of payment for
statistical purposes and not to classify patients according to economic ability, or as recipients of a particular type of service.
CHAPTER II

THE NEED FOR EXPANDED FACILITIES TO CARE FOR THE CHRONICALLY ILL IN THE STATE OF ILLINOIS

A study of many social agencies will reveal that the needs of the people they serve has dictated, in a large measure, the services they dispense. Many agencies begin operation with a statement of purpose which focuses on one particular need in the community, and through their experience in operation find that they must expand their services in order to meet the needs discernible upon actual contact with the recipient of the agency's services. The crippled child requires medical care, but, further, the parents may need advice and counseling; the unmarried mother may contact an agency for advice on placing her child, and herself present a challenging problem of family and community maladjustment. Faced with such multiple problem situations, the agency helps to the extent of its own facilities, or refers to another agency whose function more appropriately meets the need.

The Illinois Public Aid Commission which is charged with the responsibility of meeting the needs of the aged, the blind, the dependent child, and now the disabled also has been faced with the requirement to alter its focus from time to time in order to meet the needs of the recipients of the categorical programs. From the beginning of the program, the workers in the county departments were aware that providing an assistance grant to a recipient of Old Age Assistance did not always answer the problem of need. They found that the need
for medical care and supervision was far more extensive than had been antici-
pated. Persons suffering from crippling physical handicaps, illness or the
general deilities of old age were found to be living alone with no care avail-
able, or living with relatives who were either unable or unwilling to give them
the individual attention they needed. This condition existed throughout the
state. The common problem was a shortage of facilities to care for the con-
stantly growing number of chronically ill persons in the population.

The growth of the problem of inadequate facilities for the chronically ill
was one which was compounded of neglect of the problem of chronic illness and
the focus of the medical field primarily on combating acute illness. This neg-
lect of chronic illness has resulted in the necessity to provide for great num-
bers of incapacitated and indigent persons. Owing to the reduction in preva-
lence and duration of acute illness and the increasing proportion of older per-
sors in the population, chronic diseases have become one of the nation's major
health problems.¹

The major problem facing the representatives of the Illinois Public Aid
Commission, relating to the need for chronic care facilities was, primarily, to
provide for the needs of the aged and the blind who were in need of care and
service, because of illness and handicaps apart from those of tuberculosis and
mental illness.

In Illinois, as in the rest of the nation, hospital facilities were taxed

¹Mary C. Jarrett, "Combatting Chronic Illness," Public Welfare, III (June
1945), 129.
to the limit to provide care for persons suffering from acute illnesses. The chronically ill requiring long-term hospitalization were becoming a burden on these facilities, because many persons, who could have convalesced in nursing homes, could not be discharged from the hospital because there was no place the patient could go and receive the care and attention needed. Therefore, hospitalization of Old Age Pension recipients often was longer than the illness necessitated and consequently more expensive than the patient's condition justified. Of course, self-supporting persons faced this same problem but the experiences of the employees of the Illinois Public Aid Commission with respect to Old Age Pension and Blind Assistance recipients focused attention on the total problem.

In some counties there was such a dearth of beds for chronic care patients that arrangements often had to be made for space in nursing homes forty and fifty miles from the patient's home. This made the adjustment to the new surroundings more difficult for the patient, and created a transportation problem for relatives who wished to visit.

Even the counties fortunate enough to have private nursing homes within their boundaries were severely handicapped in their efforts to obtain care for public assistance recipients by reason of the inadequate provisions for an allowance for such care through Old Age Pension or Blind Assistance grants. In October 1944 provision had been made for the maximum grant for recipients living in nursing homes to be increased to $75.00 per month, but the better nursing homes could demand and receive higher rates from private-pay patients.²

Many of the nursing homes willing to provide care for $75.00 were sub-standard, and the care provided was of dubious quality. The additional facilities which came into existence as a result of the increased remuneration for care were far from sufficient to meet the needs of the aged or the blind who required long term nursing care.

Parallel to the recognition of the need for chronic care facilities for public assistance recipients in Illinois there had been so much concern with the problem in its entirety that legislative committees were appointed in 1941 and 1943 to study the need for chronic care facilities. The 1941 Committee was hampered by the war activities and accomplished little, but the Committee in 1943 was more active. This Committee was known as the Committee to Investigate Chronic Diseases Among Indigents and its duties were defined as follows:

1. To make a complete and thorough survey of the number of persons in Illinois in indigent circumstances who are afflicted with chronic diseases not already provided for in existing state institutions and who require hospital care at public expense.

2. To determine and recommend the location or locations for institutions to administer to such persons which are best suited to adequately and efficiently administer to and care for such persons.

3. To prepare and submit estimates of the cost of any proposed construction of such institutions, of the cost of equipment, and the annual cost of maintenance.

4. To draw or cause to be drawn, a bill for introduction in the Sixty-Fourth General Assembly, to provide for the construction, equipment and operation of such institutions or institutions as the Committee determines to be necessary.

All findings, determinations and recommendations of the Committee shall be reported to the Sixty-Fourth General Assembly at the same time the bill drawn by the Committee is introduced, and thereupon the Committee shall cease to exist.³

³Interim Report: To Sixty-Fourth General Assembly. A Report by the Committee to Investigate Chronic Diseases Among Indigents (Springfield, 1945), 21, 22.
Soon after this Committee started its work the members determined that sound planning could not be accomplished by limiting the inquiry to the needs of the indigent. The Committee, therefore, extended the inquiry into chronic illness and physical impairment as it affects the entire population of the state of Illinois, without regard to their ability to pay for care.

Moreover, the Committee did not limit the inquiry to the feasibility of establishing state institutions for the chronically ill for two reasons. The first reason was the unavailability of building materials under war time conditions. The second reason was the costliness of such institutions and the general undesirability for the morale and rehabilitative potentialities of the chronically ill persons.  

The interim report of the Committee to Investigate Chronic Diseases Among Indigents was presented to the Sixty-Fourth General Assembly on June 7, 1945. The report was divided into three major sections, (1) the nature of chronic illness, (2) the extent of chronic illness in Illinois, (3) facilities currently available in Illinois for care of the chronically ill. For the purpose of this study the material excerpted from the report pertains mainly to sections two and three but the following quotation from section one is impressive in its analysis of the underlying reason for providing more chronic care facilities:

The almost miraculous reduction in the number of deaths caused by the acute infectious diseases—such as typhoid fever, smallpox, pneumonia, etc.—has meant that persons who otherwise would have died as a result of these acute conditions are, instead, living longer and are being made helpless for long periods of time preceding death by arthritis, heart disease, high blood pressure and strokes, kidney disturbances, or cancer.

Seventy-five years ago fourteen of every fifteen deaths which occurred in the United States were due to diseases which struck swiftly, and  

Ibid., 22.
came to an end with only short periods of illness preceding death. Today these so called 'chronic' conditions account for one of every two deaths, and the full effect in the nature of diseases causing death is only beginning to be evident. The greatest advances in the control of the acute infectious diseases have come within the last twenty-five years—some within the last five or ten—and the full effect of these advances has yet to be felt.\(^5\)

The Committee concluded with an agreement with the Surgeon General of the United States Public Health Service that chronic disease is "the nation's number one health problem."

The extent of chronic illness was based on a survey made by the Illinois Public Aid Commission by applying figures from the National Health Survey to the same age groups in Illinois as reported in the 1940 census, and slightly modified by original studies. One factor noted was that chronic illness is more prevalent in the middle age group from age forty-five through sixty-four than for persons age sixty-five and over. The greater need for care outside the home for the older group is predicated on the assumption that as age increases, the possibility of care in the home decreases. Parents and other persons in the home, who have been caring for the invalid, grow old and become unable to continue care for the patient. Thus we find that a little more than one-third of all chronic invalids are sixty-five years of age and over, and about one-half of all invalids needing care outside their own homes are over sixty-five.

At the time the aforementioned report was made the percentage of the population in Illinois over age sixty-five receiving Old Age Pension was 21.4 per

\(^5\)Ibid., 4, 5.
cent.\textsuperscript{6} The estimate on a mathematical basis of the number of chronic invalids receiving Old Age Pension was approximately 7,000, and to this number could be added recipients of general assistance administered by the township supervisors and some recipients of Blind Assistance.\textsuperscript{7}

Table I indicates the results of the study on the number of chronic invalids in Illinois.

**TABLE I**

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Total Population</th>
<th>Per cent of Age Group</th>
<th>Chronic Invalids</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>7,898,000</td>
<td>1.14</td>
<td>90,200</td>
</tr>
<tr>
<td>Under 5</td>
<td>547,000</td>
<td>.17</td>
<td>900</td>
</tr>
<tr>
<td>5-14</td>
<td>1,161,000</td>
<td>.26</td>
<td>3,000</td>
</tr>
<tr>
<td>15-24</td>
<td>1,361,000</td>
<td>.38</td>
<td>5,200</td>
</tr>
<tr>
<td>25-34</td>
<td>1,327,000</td>
<td>.49</td>
<td>6,500</td>
</tr>
<tr>
<td>35-44</td>
<td>1,193,000</td>
<td>.94</td>
<td>11,200</td>
</tr>
<tr>
<td>45-54</td>
<td>1,055,000</td>
<td>1.42</td>
<td>15,000</td>
</tr>
<tr>
<td>55-64</td>
<td>686,000</td>
<td>2.51</td>
<td>17,200</td>
</tr>
<tr>
<td>65-74</td>
<td>400,000</td>
<td>4.81</td>
<td>19,200</td>
</tr>
<tr>
<td>75 and over</td>
<td>168,000</td>
<td>7.20</td>
<td>12,000</td>
</tr>
</tbody>
</table>


\textsuperscript{6}"Number of Persons Dependent Upon the Four Major Public Aid Programs in Illinois By County and Assistance Payments for the Month of June 1945" *Public Aid In Illinois* (August 1945), 22.

\textsuperscript{7}*Interim Report*, 6.
Limiting the study of the need for chronic care facilities to an estimate of the chronic invalids in Illinois did not reveal the true story. A further study included all persons who were either chronic invalids or afflicted with chronic disease or physical impairment which could lead to chronic invalidism. Table II shows the results of the second study applying the same mathematical adjustment used in Table I, estimating that 21.4 per cent of the population age sixty-five and over were receiving Old Age Pension in 1945, the number in this group with chronic disease or permanent impairment would be in excess of 58,000. If one-half of this number eventually requires care outside of their own homes there is a potential of over 25,000 of the Old Age Pension recipients who could be in need of chronic care facilities in the present or at some future time. Increasing this number are the recipients of general assistance and Blind Assistance.

Table II shows the result of this second study.

Tables I and II when studied with the thought in mind of the total potential number of persons who might eventually require chronic care, regardless of age or ability to pay for the care, strongly emphasizes the degree of competition for the available chronic care facilities. Keeping these statistics in mind the third section of the report of the Committee to Investigate Diseases Among Indigents has greater significance. This was the report on the facilities currently available for care of the chronically ill.

The number of private nursing homes in Illinois admitting public assistance recipients as of March 1945 was one hundred sixty-three. Of these

8 Ibid., 7.
eighty-four were in Cook County and seventy-nine were in the other counties in the state. The approximate bed capacity was 3500. Twenty-one hundred of the beds were located in 101 counties and 1400 in Cook County. Fifty-one of the counties outside of Cook County had no nursing homes admitting public aid recipients, and in twenty-nine counties there was only one nursing home which would admit public aid recipients.

**TABLE II**

ESTIMATED NUMBER OF PERSONS IN ILLINOIS WITH CHRONIC DISEASE OR PERMANENT IMPAIRMENT

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Total Population</th>
<th>Per Cent of Age Group</th>
<th>Persons with Chronic Disease or Permanent Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>7,898,000</td>
<td>18.8</td>
<td>1,483,000</td>
</tr>
<tr>
<td>Under 5</td>
<td>547,000</td>
<td>3.4</td>
<td>18,700</td>
</tr>
<tr>
<td>5-14</td>
<td>1,161,000</td>
<td>6.8</td>
<td>79,300</td>
</tr>
<tr>
<td>15-24</td>
<td>1,361,000</td>
<td>8.3</td>
<td>112,800</td>
</tr>
<tr>
<td>25-34</td>
<td>1,327,000</td>
<td>15.9</td>
<td>211,200</td>
</tr>
<tr>
<td>35-44</td>
<td>1,193,000</td>
<td>22.1</td>
<td>263,600</td>
</tr>
<tr>
<td>45-54</td>
<td>1,055,000</td>
<td>27.3</td>
<td>288,300</td>
</tr>
<tr>
<td>55-64</td>
<td>686,000</td>
<td>34.4</td>
<td>236,100</td>
</tr>
<tr>
<td>65-74</td>
<td>400,000</td>
<td>46.7</td>
<td>186,800</td>
</tr>
<tr>
<td>75 and over</td>
<td>168,000</td>
<td>51.4</td>
<td>86,200</td>
</tr>
</tbody>
</table>

In addition to the private nursing homes there were forty-nine private institutions for the aged in Illinois, supported by fraternal, religious, or national groups, admitting public aid recipients as of May 1945. Twenty-one of them were in Cook County and twenty-eight distributed among twenty-two other counties in the state. The number of beds in these homes ranged from six to 263, but an exact account of the total number of beds were not reported. There was not much of a potential for additional admissions to either the private nursing homes or private homes for the aged since waiting lists indicated that these homes were usually filled to capacity.

There were also a number of boarding homes throughout the state where room, board, and some care was given, but the amount and quality of the care depended on the attitude and disposition of the manager of the home. With the absence of any accurate measure of the quantity and quality of the care given the value of these homes as chronic care facilities was unknown.

The Committee to Investigate Chronic Diseases Among Indigents found an existing potential for providing care for the chronically ill in the county homes and infirmaries. These were the old "poor houses" distributed throughout the state and still operating in seventy-two counties in March 1945. Originally authorized in a law passed in 1877 to provide for the establishment and maintenance of county poor houses, there had been poor houses established in all but two of the counties. In March 1944 the Illinois Public Aid Commission made a study of the county homes and at that time there were eighty-three in existence. Twenty-seven were considered as adaptable for conversion to homes for the chronically ill with minor renovation. Twenty-three were determined adaptable with substantial renovation. Thirty were considered not adaptable,
and there was not enough information available on the other three to justify an opinion as to their adaptability.9

By March 1945 there were eleven more county homes closed which correspondingly reduced the number not adaptable to conversion. The main reason the county homes were regarded as a good potential for care of the chronically ill was because they represented buildings which could be adapted to meet the need at a lower cost than an alternative plan to provide the same number of beds by construction of new buildings. Another advantageous factor was that the county homes were distributed throughout the state by county which offered the possibility that a patient could obtain needed care in his home county, or perhaps a neighboring county.

Table III lists the seventy-two county homes still in operation in March 1945, showing the bed capacity, the number of occupants and the percentage of occupancy as of November 1944. The capacity of the county homes shown in this table must be regarded with qualifications since in some instances it has been based on the number of persons the home was able to accommodate in an emergency and was not indicative of ability to provide comfortable and sanitary living conditions, even on a room and board basis. For instance, Piatt County was shown as having a capacity of fifty, but the present County Nursing Home is at absolute capacity with thirty patients. McLean County Home shows a capacity of 120, but the county nursing home has only a capacity of eighty-three, because a second building used when it was a 'poor house' has not been converted to accommodate patients. There was also some difference in capacities of the

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9Ibid., 18.
### TABLE III

POTENTIAL FACILITIES FOR CARE OF THE CHRONICALLY ILL REPRESENTED BY COUNTY HOMES IN OPERATION IN ILLINOIS AS OF MARCH 1945

<table>
<thead>
<tr>
<th>County</th>
<th>County Capacity</th>
<th>Number of Inmates as of November 25, 1944</th>
<th>Per Cent Occupancy as of November 1944</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Counties</td>
<td>7,264</td>
<td>4,303</td>
<td>59.2</td>
</tr>
<tr>
<td>Adams</td>
<td>75</td>
<td>32</td>
<td>42.7</td>
</tr>
<tr>
<td>Brown</td>
<td>15</td>
<td>3</td>
<td>20.0</td>
</tr>
<tr>
<td>Bureau</td>
<td>100</td>
<td>42</td>
<td>42.0</td>
</tr>
<tr>
<td>Calhoun</td>
<td>25</td>
<td>3</td>
<td>12.0</td>
</tr>
<tr>
<td>Carroll</td>
<td>31</td>
<td>26</td>
<td>83.9</td>
</tr>
<tr>
<td>Cass</td>
<td>18</td>
<td>8</td>
<td>44.4</td>
</tr>
<tr>
<td>Champaign b</td>
<td>100</td>
<td>41</td>
<td>41.0</td>
</tr>
<tr>
<td>Clark</td>
<td>13</td>
<td>4</td>
<td>30.8</td>
</tr>
<tr>
<td>Coles</td>
<td>40</td>
<td>20</td>
<td>50.0</td>
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<td>Effingham</td>
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## TABLE III (continued)

POTENTIAL FACILITIES FOR CARE OF THE CHRONICALLY ILL
REPRESENTED BY COUNTY HOMES IN OPERATION
IN ILLINOIS AS OF MARCH 1945

<table>
<thead>
<tr>
<th>County</th>
<th>Capacity</th>
<th>Number of Inmates as of November 25, 1944</th>
<th>Per Cent Occupancy November 1944</th>
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</thead>
<tbody>
<tr>
<td>Jo Daviess</td>
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<tr>
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<td>130</td>
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<td>6.0</td>
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<tr>
<td>Lee</td>
<td>49</td>
<td>25</td>
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<tr>
<td>Livingston</td>
<td>70</td>
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<td>McLean</td>
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<td>Macoupin</td>
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<td>Madison</td>
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<td>74.6</td>
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<tr>
<td>Monroe</td>
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<td>76.7</td>
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<td>Morgan</td>
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<td>10</td>
<td>13.2</td>
</tr>
<tr>
<td>Moultrie</td>
<td>15</td>
<td>9</td>
<td>60.0</td>
</tr>
<tr>
<td>Ogle</td>
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<td>Peoria</td>
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<tr>
<td>Randolph</td>
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<tr>
<td>Rock Island</td>
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<td>47.5</td>
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<tr>
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<td>300</td>
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<td>53.0</td>
</tr>
<tr>
<td>Saline</td>
<td>16</td>
<td>5</td>
<td>31.3</td>
</tr>
</tbody>
</table>
### TABLE III (continued)

POTENTIAL FACILITIES FOR CARE OF THE CHRONICALLY ILL
REPRESENTED BY COUNTY HOMES IN OPERATION
IN ILLINOIS AS OF MARCH 1945

<table>
<thead>
<tr>
<th>County</th>
<th>Capacity</th>
<th>Number of Inmates as of November 25, 1944</th>
<th>Per Cent Occupancy November 1944</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schuyler</td>
<td>30</td>
<td>7</td>
<td>23.3</td>
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<tr>
<td>Scott</td>
<td>25</td>
<td>3</td>
<td>12.0</td>
</tr>
<tr>
<td>Shelby</td>
<td>25</td>
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<td>24.0</td>
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<td>Stephenson</td>
<td>90</td>
<td>25</td>
<td>27.8</td>
</tr>
<tr>
<td>Vermilion</td>
<td>137</td>
<td>100</td>
<td>73.0</td>
</tr>
<tr>
<td>Warren</td>
<td>100</td>
<td>23</td>
<td>23.0</td>
</tr>
<tr>
<td>Wayne</td>
<td>14</td>
<td>5</td>
<td>35.7</td>
</tr>
<tr>
<td>White</td>
<td>100</td>
<td>8</td>
<td>8.0</td>
</tr>
<tr>
<td>Whiteside</td>
<td>65</td>
<td>25</td>
<td>38.5</td>
</tr>
<tr>
<td>Will</td>
<td>91</td>
<td>90</td>
<td>98.9</td>
</tr>
<tr>
<td>Williamson</td>
<td>12</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Winnebago</td>
<td>176</td>
<td>114</td>
<td>64.8</td>
</tr>
<tr>
<td>Woodford</td>
<td>32</td>
<td>9</td>
<td>28.1</td>
</tr>
</tbody>
</table>

*Table derived from Illinois Public Aid Commission report entitled "The Status of County Homes in Illinois as of November 25, 1944," adjusted to exclude County Homes which were discontinued after November 1944.

*bThe hospital facilities of these four county homes are registered by the American Medical Association.

*cThe Douglas County Home was discontinued March 1, 1945 and leased to an individual as a grain farm. It had a capacity of twenty-one inmates. In November 1944, it had three inmates in residence. Douglas County, however, maintains a hospital separate from the County Home. This hospital with a capacity of forty and an average occupancy of twenty-seven is registered by the American Medical Association.

*dThe Lake County General Hospital is maintained separately from the Lake County Home. The Lake County General Hospital is registered by the American Medical Association.

converted homes resulting from structural changes and rearrangement of floor plans, sometimes increasing, sometimes decreasing the bed capacity.

The reason for the low percentage of occupancy on November 1944 was the effectiveness of the Social Security legislation in depopulating the 'poor houses', which was one of the results expected and hoped for when the law was passed. As the persons sixty-five years of age qualified for Old Age Pension they were enabled to move out into the community, or else becoming a recipient enabled them to remain outside the "poor house" once they lost their previous source of support. There was considerable irony in the fact that the 'poor house' had become the hope for the aged and chronically ill. Through the years the county home had fallen into ill repute and the "poor house" had become synonymous with the idea of a life of degradation and deprivation. Over the hill to the poor house was the final step preceding ignominious death and ultimate burial in Potter's Field.

Residents of Illinois could not point to other states and disclaim any incidents of mismanagement and abuse in the county homes, because in every instance the management was just as good as the manager, or the persons in control of the local government.¹⁰ A good manager with adequate help and facilities and the backing of a good board of supervisors could run a good home. Too often some of the ingredients needed for a good administration were lacking, and in some instances all of them. A sadistic manager, motivated by greed and an indifferent or unsympathetic board of supervisors could make life in a

¹⁰Information from a personal interview with Stephen J. Green, Chief Division of Field Operations, Illinois Public Aid Commission.
county home a bleak and miserable existence. The practice of the county boards was to lease the farm to a manager who agreed to care for poor sent to him at a certain rate per day. A penurious county board could force the rate down so low that the manager had to provide meager food and accommodations to realize anything for his labor. Or a greedy manager could fill his own purse at the expense of the inmates by providing inadequately for them, even though the county boards made a reasonable per capita allowance to him.

There were a variety of ills which contributed to the bad reputations of the institutions, but the extreme cases of neglect and abuse involving starvation diets, filth and corporal punishment focused public attention on the administration of county "poor houses" and brought notoriety to even the ones where no such abuses were practiced.

To cite a few examples, in Clinton County, the manager was unable to have the bedding washed because he feared it would fall to pieces and the county board would not provide funds for replacement. In Ogle County one inmate bit off the ear of another, and the superintendent had the offender's teeth removed. A woman was chained to a tree in Stephenson County for theft, and in Greene County an idiot was tied to a tree because he had killed it by constantly walking around it.11

The history of the "poor houses" had been replete with such incidents, all contributing to the poor reputations of the institutions.12 Such was their

11 Ibid.
reputation that in an attempt to abolish the "poor houses," the federal Social Security Act, and similar acts within the states patterned on the federal acts so as to qualify the states for federal grants-in-aid for assistance to the needy aged, blind, and dependent children prohibited these new types of assistance and social services to inmates of public institutions. This stipulation was designed to put the institutions out of business by depopulating them to a point where the remaining inmates would be discharged to the community to be cared for through other arrangements.13

The county homes survived the era of depopulation, and although depopulation had occurred there were still seventy-two county homes operating in 1945. Moreover, in some counties the county homes offered the only chronic care facilities available to the public assistance recipients. The services and facilities were not good, but for the person not needing hospital care and requiring some care and attention they had to suffice when he had no other place to go. Even persons receiving Old Age Pension and Blind Assistance were returning to the county homes for care when individual arrangements could be made with the township supervisor to arrange for the admission and to bear the expense of maintenance. The latter was necessary because the person going into the home had to sacrifice any assistance he was receiving from the categorical assistance programs. As early as 1941 several county boards of supervisors had evaluated their county poor houses and decided that they no longer needed this type of institution in their communities. Using county funds, these county boards made changes in the appearance, atmosphere, objective, staff and

13Ibid.
equipment of their institutions and changed them over into facilities for care of the sick, infirm, and chronically ill. Some of these homes were providing services far superior to those provided in neighboring private nursing homes, and at less cost.\textsuperscript{14}

The low occupancy level of the county homes had made their operation costly and burdensome to the county boards of supervisors. This fact, coupled with the problem the Illinois Public Aid Commission was facing in providing adequate care for the chronically ill, led to some planning by representatives of the Commission and the county boards toward some practical and mutually beneficial solution through utilizing the county home facilities.

The Committee to Investigate Chronic Diseases stated in its report that they recognized that there was no use for the old type "poor house" under present day conditions, but they recognized that the seventy-two homes still in operation represented a resource which should be given careful consideration.\textsuperscript{15} Consistent with this thinking, the committee included in its report to the legislature the recommendation that consideration be given to the possibility of converting county homes into homes for the infirm and chronically ill, when this could be done with proper regard to construction, sanitation, and general hygiene so as to safeguard the health, safety, and comfort of the patients. This recommendation had been acted upon in the Rennick-Laughlin bills before the formal report of the committee was published in June 1945.

The greatest obstacle to conversion of the county homes into chronic care

\textsuperscript{14}\textit{Ibid.}, 484.

\textsuperscript{15}Interim Report, 16, 19.
facilities lay in the stipulation of the Social Security Act, Section 3 of Title I and Section 1003 of Title X prohibiting matching of state expenditures for the needy aged and the needy blind who were inmates of a public institution. The provisions in the Old Age Pension and Blind Assistance Laws of Illinois provided that to qualify a person must not be "an inmate of or be maintained by any municipal, county, state or national institution." This was a problem in addition to the problem the county boards of supervisors faced in financing the conversion of the homes, changing the objectives and standards of the institutions, and education of the public attitude toward the old "poor houses" providing a new kind of service.

Setting the tone of the thinking of persons interested in the project at the time Mr. Raymond M. Hilliard wrote:

In developing our whole tradition of public responsibility for the general public welfare and also for individuals who need financial aid or services beyond their capacity to pay, I believe we have made a mistake in ruling out the public institutions from the same progressive evolution that has occurred in the field of home relief since 1935, which saw the enactment of federal and state Social Security legislation. I believe we need good public medical and nursing institutions. I believe we need them first and perhaps most extensively at the local and county level where the patient can live and continue to be near his friends and relatives. Such local public infirmaries are just as important as having local public schools, local public libraries, and local public health and other public services.\(^\text{17}\)

\(^{16}\) *Illinois Revised Statutes* 1943, Chapter 23, paragraph 411 d and 287 a 3-b.

\(^{17}\) Hilliard, p. 481.
CHAPTER III

THE RENNICK-LAUGHLIN LAW: ENABLING LEGISLATION WHICH OPENED THE DOORS FOR THE COUNTY NURSING HOME PROGRAM

The Rennick-Laughlin bills introduced by Senators Frederick W. Rennick of Buda and Edward E. Laughlin of Freeport were passed by the Sixty-Fourth General Assembly. The principal objective of these bills was to develop additional facilities for the chronically ill by making it possible for the county governments to convert the outmoded "poor houses" into modern county homes for persons who are destitute, infirm or chronically ill.

The series of Senate Bills 210, 212, 213 and 534 accomplished the following objectives:

1. Senate Bill 210 provided that recipients of Old Age Pension who need institutional care will be permitted to retain their status as Old Age Pension recipients if they reside in a county home provided that the facilities for such Home with respect to its construction, sanitation and general hygiene are in conformity with standards prescribed by the Illinois Public Aid Commission for safeguarding the health, safety, and comfort of the inmates and patients of such Home.

2. Senate Bill 534 provided that Blind Assistance recipients who need institutional care will be permitted to retain their status as Blind Assistance recipients if they reside in County Homes, provided such homes meet the stand-
ard prescribed by the Illinois Public Aid Commission.

3. Senate Bill 212 was renamed the "Act to provide for the establishment of county poor houses" to "An Act in relation to the establishment, maintenance, and operation of county homes for persons who are destitute, infirm and chronically ill or who are unable to pay for their care and maintenance therein; and to authorize the care and maintenance of needy residence in county homes of other counties.

4. The Senate Bill 213 revised the Pauper Law to delete all references to "poor houses." Instead there is substituted the term "county homes for the destitute, the infirm and the chronically ill."

This bill together with Senate Bill 212 removes all language in existing acts pertaining to County Homes which implied that residents of such homes were necessarily paupers.¹

Summarizing these bills, we see that the restrictions, which prevented persons living in the institutions from being recipients of Old Age Pension and Blind Assistance, were removed. However, since the federal law continued to impose this restriction, this meant that the state would receive no matching funds for recipients who were living in these institutions.

Furthermore Senate Bill 210 and 534 placed on the Illinois Public Aid Commission the responsibility for setting standards on construction, sanitation and service to the patients which in essence enabled the Commission to obtain the maximum service and comfort available for the money paid in behalf of the recipients.

¹Interim Report, 23, 24.
Senate Bill 212 was an important one inasmuch as it gave the local governmental bodies the authority to convert and construct facilities for the chronically ill. This bill, along with Senate Bill 213, attempted to legislate away the stigma of the old "poor house" by removing the terminology from the law. Important, too, is the provision that enables the county homes to open their doors to the residents of other counties. This last has been important in enabling those residents of counties where no adequate facilities are available, to obtain care in neighboring counties.

In accordance with the power vested in the Illinois Public Aid Commission as the standard setting authority over the county homes attempting to qualify as approved county homes in which recipients of Old Age Pension and Blind Assistance recipients could reside and continue to be eligible for assistance, the following Standards for County Homes were prescribed:

Fire and Sanitary Hazards
1. A current report from the Division of Fire Prevention State Department of Public Safety, shall establish that there are no fire hazards.
2. A current Report from the Division of Sanitary Engineering, State Department of Public Health, shall establish that there are no existing sanitary hazards.

Medical and Nursing Care
1. Provision shall be made for physicians services at regular intervals, and for emergency calls by a physician when a patient's condition requires this.
2. The staff of nurses, nursing attendants, and other personnel in the home shall be of sufficient number and physical ability to meet the patient's requirements and to maintain adequate standards of comfort and sanitation. Attendants giving personal care or nursing service to patients shall be sufficiently trained and experienced.
3. Facilities for easily summoning an attendant during the day or night shall be provided all patients.
4. All drugs and medicines shall be properly labeled and stored in a locked cabinet or closet to which patients do not have access. No one shall administer any sedative or narcotic drug, such as is sold
only upon prescription, unless a physician has ordered the superintendent or employee, in writing, to administer such drug to the patient. In general, no drugs except such ordinary ones as aspirin, mild laxatives, gargles and sodium bicarbonate, shall be administered except by direction of the physician.

5. An adequate diet, evaluated with due regard to the quality, quantity, and preparation, shall be furnished to all patients. Special diets, when recommended by the physician, shall be furnished.

6. Methods of physical restraint shall not be used except in homes licensed by the Division of the Alienist to give care to persons with chronic mental disease or defect. If a person is so feeble physically so there is danger of falling from his bed, sideboards shall be used on the bed.

Physical Arrangements
1. The home shall be sightly, both within and without, and shall provide reasonable comfort for all residents.
2. The home shall be maintained in a clean and sanitary condition.
3. Adequate lighting and heating facilities shall be provided and maintained.
4. Adequate bathing and toilet facilities, on the same floor as the sleeping rooms wherever possible, shall be provided and shall be maintained in a sanitary condition.
5. Patients shall not be placed in rooms partially or completely below ground levels. Non-ambulant patients shall not be placed in rooms on any floor above the second.
6. Every patient shall have a separate bed in an adequately ventilated room having one or more windows. Number and spacing of beds in each room shall be such that overcrowding does not exist.
7. Adequate clean linen shall be supplied, with bed linen changed not less often than once a week and more often than this when the patient's condition so requires. For example, the bed linen of a bed patient shall be changed at least twice a week.
8. Clean clothing shall be supplied as frequently as the patient's condition requires.
9. Provision shall be made for bathing twice a week, and assistance shall be given to patients needing it. Bed patients shall be bathed more frequently when their condition requires it.

Cost of Care
1. The amount to be allowed in the old age pension or blind assistance grant for care in a county home that has met the requirements for approval shall be determined by agreement with the county board of each county, taking into consideration the amount paid by township for the same type of care. This rate shall be subject to review in one year.
Procedure
1. The county board or county home committee shall advise the county superintendent of public assistance if approval of the home is desired.

2. The county board or county home committee shall prepare written requests for fire and sanitary inspection addressed respectively to the Division of Fire Prevention, and the Division of Sanitary Engineering. These requests shall be given to the county superintendent of public assistance, for transmittal to the Commission, so that arrangements can be made for immediate inspection. If an inspection has been completed within six months and a written report is available, another will not be necessary at this time.

3. The county board or county home committee shall prepare a statement indicating that recipients of Old Age Assistance and Blind Assistance will be accepted for care at the agreed rate.

4. The county superintendent of public assistance shall submit to the Commission a written report concerning the home, and shall submit it with the request for inspection and the operating cost statement.²

In addition to the above regulations the Commission also adopted a regulation limiting its authorization of blind assistance and old age pension grants to residents of such homes only if the recipients were suffering from an infirmity which made them unable to obtain proper care in other living arrangements.³ This regulation served to reserve the chronic care facilities for persons actually in need of such services and eliminated the possibility of filling the homes with persons who could obtain adequate care in their own homes or boarding homes. Even before the legislation became effective, widespread interest was shown in it by the local communities, particularly county boards of supervisors who operate the county homes. This community interest seemed to

²Raymond M. Hilliard, "The Development of County Homes for Care of the Chronically Ill," Public Welfare, III (December 1945).

³Ibid.
indicate that the program would be successful. Proper stimulation and direction of community interest was achieved by the Rennick-Laughlin bills.4

County homes in Illinois are operated by the county boards. The Illinois Public Aid Commission prescribes standards for those homes wishing to sell care to old age pension, and blind assistance recipients and helps county boards to achieve and maintain these standards by providing consultant service and by having Commission representatives meet with the county boards to discuss the problems relating to the homes. All policies concerning the homes, however, are set by the county boards. Intake policy, personnel policies, patient rates, administrative organization, and plans for changes in the physical structure are all the concern of the county boards. Most county boards appoint a County Home Committee to act for the entire board in matters concerning the county home. This committee reports to the county board at regular intervals on the progress of the home, and to receive the sanction and advice of the entire county board in matters pertaining to the home.

Rates for care, as they apply to old age pension and blind assistance recipients, are negotiated by Commission representatives with each county board. In general the rate agreed upon is based on cost of operation, with appropriate allowances for expenses incurred in transforming the poor house into a chronic care institution.

Conversion of old buildings to county homes is costly and the county boards approached the action with considerable caution. They carefully

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4Hilliard, Social Service Review, IX, 485, 486.
evaluated the need for the service in the county, weighing the need against the existing chronic care facilities in the county. If the need were apparent the county boards ascertained the extent of the interest of the people in the communities in having such facilities and attempted to gauge the proportion of interest and support they could obtain from the civic organizations, church groups and the professional medical persons. They then obtained estimates on conversions that would be required in relation to the standards set up by the Illinois Public Aid Commission. These estimates considered not only the required structural changes, but also the continuing costs of operation and maintenance. Finally the plan for financing the conversion was agreed upon by the county board. If a bond issue were required, the proposition had to be placed before the public so that the people of the county could make the final decision on whether or not the money should be spent. Cook County floated a bond issue for new construction and renovation of Oak Forest Institutions. Bond issues were necessary for new construction in Monroe, Randolph, and Rock Island counties. It is understood that two attempts to pass a bond issue for new additions were defeated in DuPage County. The remaining counties have met expense of conversion from regular county revenues and local contributions. All of this preliminary planning is done by the local governmental units, and the Illinois Public Aid Commission enters into such planning only at the invitation of the county board of supervisors or county home committee, and then the role of the Commission representatives is an advisory one, and recommendations are made on the basis of knowledge gained from experience with similar projects in other counties.
Once a county board has reached the point where they are ready to go ahead with a conversion, they usually keep in touch with representatives of the Illinois Public Aid Commission to facilitate the planning as the project progresses. When the structure is complete, the proper inspections made, and the home approved on the basis of safety and sanitation, the county home committee and the representatives of the Illinois Public Aid Commission meet for a discussion of the patient rate to be paid in the home. This conference includes a complete review of the degree of service and care the patients will receive for the rate paid.

The rate negotiation is essentially an agreement on the actual or estimated costs which will collectively make up the per diem, per patient cost of operation. When new homes are opened, many of the costs of items, of necessity, must be computed on estimates, and later adjusted to actual cost when the group again meets for a rate negotiation, usually at the end of the first year of operation. The items considered in arriving at the rate are: food, salaries, fuel, electricity, telephone, ice, water, supplies, contractual services, insurance, transportation, miscellaneous items, property repairs or additions, furnishings and equipment.

Since subsidies were not available to meet the large initial outlay for cost of conversion, these costs were met from the general revenue of the county. These large expenditures, which of course could not be covered from current income from nursing home operations, are usually returned to the county over an extended period of years by consideration of a share of the amount in each year’s operations to be included as a factor in the rate charged for patient care. Through this method each patient meets a proportionate share of
this cost according to the period he benefited from the services of the institution. For example, if the computed amortization allowance for a given county nursing home is $7 per month per capita and the estimated basic operational costs are $93 per month per capita the rates are established at $100. For an average population of fifty the return of conversion expense to the county in this instance would be $7 multiplied by fifty patients, or $350 per month, or $4,200 per year. The amount of return to the county will vary from year to year according to the average population served during the period.

The Illinois Public Aid Commission will consider the costs of necessary additional capital improvements as a valid factor in the rate for care only when the Commission has determined that such improvements are essential, and that the cost is properly chargeable to the county nursing home, and the plan for paying for the necessary improvements takes into account accepted business practices with respect to spreading the costs in relationship to the life expectancy to such improvement. The Commission has an understanding with each county home committee that local representatives concerned will discuss with Commission representatives any major expenditures before they are incurred. This controls rates from becoming unduly high and prevents unwise or unnecessary expenditures. The Commission will make no objection, however, if such expenditures are not reflected in the rates and are paid from other county revenues, or community resources.

The rate agreements are based on the premise that all patients will be charged the same amount regardless of their ability to pay and the source of payment. This study is primarily concerned with chronic care facilities made possible for public assistance recipients as a result of the Rennick–Laughlin
legislation, but the legislation actually made possible moderate cost facilities for all of the chronically ill, including the persons able to pay for care from their own resources. The point to be made here is that the rate agreed upon by the Illinois Public Aid Commission applies to private pay patients as well as public assistance patients.

The cost of converting the homes has varied greatly throughout the state, but one fact is certain and that is the utilization of the existing facilities which were available has greatly reduced the expense of providing chronic care facilities when measured against the possible costs of new buildings. In 1945 an appropriation for the building of five infirmary units in Connecticut was based on an estimated figure of $1,100 per bed, a conservative figure. Yet one of the first three counties in Illinois to embark on this program converted the home and included such items as an elevator, a fire escape, a new well, and equipped rooms and facilities for a hundred patients at a cost of $260 per bed.\(^5\)

Speaking at an open meeting of the Crawford County Board of Supervisors in Robinson, Illinois in 1953, Mr. Norman Paulson, County Home Consultant for the Illinois Public Aid Commission stated that costs for a proposed new facility in that county should be estimated on the basis of not less than $5000 per bed. Using that measuring stick, a new eighty bed facility would cost a minimum of $400,000. In July 1954 the McLean County Nursing Home opened as an eighty-three bed facility after the expenditure of $225,000 to convert and equip a building which had been in a deplorable state of deterioration. The

\(^5\)Ibid., 487, 488.
transformation of this building was accomplished over a period of five years from regular county revenues at a cost of a little over $2700 a bed. Conversion costs to qualify Cook County's Oak Forest Infirmary as an approved chronic care facility were $3,500,000 for the 2,250 bed facility in 1948. 6 Piatt County Nursing Home, a twenty-nine bed facility, was converted for less than $25,000 in 1947. Later an elevator was installed in the Piatt County home at a cost of approximately $18,000. Tazewell County's conversion for an eighty-three bed facility cost $50,000 in 1949. 7 Macon County's conversion in May 1948 was at a cost of $100,000 for an eighty-two bed nursing home. 8 Cost of conversion, of course, varies with the size, condition, and over-all plan of the building so there is no common measuring stick to determine what the conversion of a particular size will cost, but the samples given here clearly indicate that the costs are far below the $5,000 per bed estimate for a new structure.

The low cost of conversion enabled the patients to be kept at low rates, which was explicitly one of the aims of the Rennick-Laughlin legislation. The cost of patient care has mounted since the initiation of the program in direct proportion to the increased cost of construction, food, salaries and all of the other items which are computed in arriving at the patient rate. The cost of


patient care in the first months of the program in the first homes which were
opened ranged from forty dollars per month to fifty-five dollars per month.
This cost covered generally board, room, laundry and nursing and personal care.
Additional amounts were included in the grants for clothing, as needed. In
1954 the rates ranged from $74.00 per month in Livingston and approximately
that in Lake County to $150.00 per month in Cook County. The cost of care in
Cook County’s Oak Forest Infirmary is higher because of the medical and hospi-
tal facilities available to the patients at no additional cost.

To measure the effectiveness of the Rennick-Laughlin bills in providing
the impetus to the county nursing home movement, the rate of conversion of the
homes is an acceptable guide. The bills were passed in June 1945 and in April
1947 fifteen county nursing homes had been approved and were in operation. The
facilities were located in the following counties: Champaign, DeKalb, DeWitt,
Fayette, Henry, Jackson, Knox, Lee, Livingston, Menard, Mercer, Rock Island,
Vermilion, Warren and Whiteside. These homes had a total bed capacity of 916
and within a few months of the time they opened they were either at capacity,
or near capacity.\(^9\)

In addition to the converted homes which were in operation by April 1947,
four other homes in Peoria, Ford, Macon and White Counties were near comple-
tion. These four homes had a combined bed capacity of 480. In addition eight
other counties reported progress on conversion plans for county homes which
would eventually provide facilities for an additional 500 patients. In addi-
tion to the twenty-seven homes mentioned, twenty-three counties with buildings

\(^9\)Second Interim Report Concerning Care of the Chronically Ill In Illinois
by the Commission on the Care of Chronically Ill Persons, (June 1947), 267.
of widely differing adaptability and state of repair, were in the process of converting their county homes into acceptable nursing care facilities or had plans under consideration, or were in varying stages of progress in evaluating the possibility of such conversion. Among the counties with no county home buildings, ten were giving serious consideration to the program, either through boards of supervisors, or through leading citizen groups which had recognized the urgent need and the potential good that could be accomplished in the light of the need for this type of service in their communities. Since there were no buildings available in these latter counties, interest was in the direction of possible purchase of a suitable building or of possible erection of a new building in co-operation with neighboring counties.

Eventually, some of the counties where interest had been shown in creating chronic care facilities, abandoned or postponed their plans for conversion or construction because of the expense involved or indecision regarding the need for the institutions. However, the progress made less than two years after the Rennick-Laughlin legislation was enacted, indicated it did open the door for positive advances toward alleviating the shortage of beds for chronically ill persons in Illinois.

Furthermore, the interest and movement was not inspired by any one person or organization. The progress made represented the combined planning, effort and interest of many persons and organizations. Among the organizations active in promoting the program were county officials, particularly the county boards of supervisors, personnel of the Illinois Public Aid Commission, medical

\[10\] Ibid.
societies, civic and religious organizations.

The changes in the function of these homes with approved plans of operation brought a change in their population, indicating that the program has been serving the purpose intended by providing much needed facilities for persons requiring specialized care. Of the total number of patients receiving care in the fifteen homes in operation in April 1947, 56 per cent were Old Age Pension and Blind Assistance recipients, 27 per cent General Relief recipients, and 17 per cent were private-pay residents. The fact that 17 per cent of the patients were private-pay patients served to indicate that early in the program the stigma of the "poor houses", which some predicted would cling to the buildings regardless of their changed function, was being eradicated in the minds of many persons in the community more rapidly than had been expected.

The rapid growth of the county home program continued through 1948 and 1949, and then levelled off. Additional conversions from 1949 through 1954 have been infrequent. This is understandable in view of the fact that in the first year of the program, the conversion of the homes was rapid in those counties where the structural changes to the buildings required were slight and the costs comparatively low. As time has gone by, the expenditures for conversion prior to the opening of the homes have been more expensive. The soaring construction costs have hindered some counties from furthering plans for conversion, particularly where construction of other public buildings have been required.

\[11^{11}\text{Ibid.}, 270.\]
The manner in which the county nursing home program has grown from 1945 through 1954, by county is shown below:12

1945
Whiteside County Nursing Home

1946
Champaign County Nursing Home
DeKalb County Nursing Home
DeWitt County Nursing Home
Fayette County Nursing Home
Henry County Nursing Home
Jackson County, Sunset Haven
Lee County Nursing Home
Menard County, Sunny Acres
Mercer County Nursing Home
Rock Island County, Oak Glen
Vermilion County Nursing Home
Warren County Nursing Home

1947
Ford County Nursing Home
Knox County Nursing Home
Livingston County Nursing Home
Peoria County Nursing Home

1947
Piatt County Nursing Home
White County Nursing Home

1948
Cook County, Oak Forest Infirmary
Grundy County Nursing Home
Macon County, Macon Acres
Macoupin County Nursing Home
Shelby County Nursing Home

1949
Boone County, Maple Crest
DuPage County Nursing Home
Lake County Nursing Home
McDonough County, The Elms
Tazewell County Community Nursing Home

1951
Monroe County Nursing Home

1952
Randolph County Nursing Home

1953
Rockford Township Hospital and Nursing Home
(Originally approved April 1950 as
Winnebago County Nursing Home)

1954
McLean County Nursing Home
Wabash County Nursing Home
CHAPTER IV

THE COUNTY NURSING HOMES OPERATING IN DECEMBER 1954

The Committee to Investigate Chronic Diseases Among Indigents had reported seventy-two county homes in operation with a total bed capacity of 7,264 as of March 1945. Nineteen to twenty-two of these homes, possibly more, were in such condition that they could never be adapted to use as chronic care facilities. The balance were considered to comprise a potential for conversion to care for the chronically ill, a maximum potential of fifty-three homes, and an estimated minimum of forty-five. By the end of 1954 thirty-four conversions had been accomplished, producing a total of 4,977 beds, and approved according to the standards set by the Illinois Public Aid Commission.

In 1945 the county homes were occupied at 59.2 per cent of capacity, and the thirty-four county nursing homes are now occupied at more than 90 per cent of capacity, and many of them have waiting lists for admission.

The ratio of public assistance recipients to private pay patients receiving county nursing home care is now 4 to 1. This proportion varies from county to county and the range is from a ratio of 9 to 1 public assistance patients over private pay patients in Oak Forest Infirmary, Shelby and Macon County Nursing Homes to almost 1 to 1 ratio in Randolph, Ford and Boone counties. Mr. Norman T. Paulson has noted a trend toward an increased number of private pay patients in the past two years, and he expects this trend to continue.
Table IV shows the thirty-four nursing homes listed alphabetically by county, the date approved by the Illinois Public Aid Commission, and the bed capacity of each.

Patient rates were discussed briefly in Chapter III, but some further explanation of the differential is required here. We have noted that the agreed rate negotiated by the county home committees and representatives of the Illinois Public Aid Commission applies to all persons regardless of the source of payment for their care. There is, however, a dual rate in the DuPage County Nursing Home based on the type of care required, but not on the source of payment. In this home the ambulant patient receives care for $80.00 per month and the bedridden patient $125.00 per month. Normally, the rates are based on the calendar month, and are the same for each full month regardless of the number of days in the particular month. The rates, however, are broken down into daily costs so that a person residing in the home for only part of a month is charged on a per diem rate multiplied by the number of days. One county, Lake County, charges according to a daily rate, which results in varying charges according to the number of days in the month. The daily rate in Lake County is adjusted each three months with the new rate being based on the operating costs for the previous quarter. A previous statement has been made that meetings are held at least once a year when the representatives of the Illinois Public Aid Commission and the county home committee agree on a rate for the ensuing year. Either party can request an adjustment in rate at any time the current rate appears to be out of line with current costs of operation. Usually a meeting is held at the end of the first six months of the fiscal year in order to discuss the expenses and earnings at that point. The rates by frequency
## TABLE IV

**APPROVED COUNTY NURSING HOMES**

**DATE OF COMMISSION APPROVAL**

**AND BED CAPACITY**

<table>
<thead>
<tr>
<th>Approved County Nursing Home</th>
<th>Date Approved</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boone County - Maple Crest</td>
<td>June 1949</td>
<td>44</td>
</tr>
<tr>
<td>Champaign County Nursing Home</td>
<td>February 1946</td>
<td>150</td>
</tr>
<tr>
<td>Cook County - Oak Forest Infirmary</td>
<td>April 1948</td>
<td>2,250</td>
</tr>
<tr>
<td>Dekalb County Nursing Home</td>
<td>September 1946</td>
<td>75</td>
</tr>
<tr>
<td>DeWitt County Nursing Home</td>
<td>March 1946</td>
<td>42</td>
</tr>
<tr>
<td>DuPage County Nursing Home</td>
<td>February 1949</td>
<td>139</td>
</tr>
<tr>
<td>Fayette County Nursing Home</td>
<td>April 1946</td>
<td>34</td>
</tr>
<tr>
<td>Ford County Nursing Home</td>
<td>July 1947</td>
<td>46</td>
</tr>
<tr>
<td>Grundy County Nursing Home</td>
<td>July 1948</td>
<td>45</td>
</tr>
<tr>
<td>Henry County Nursing Home</td>
<td>July 1946</td>
<td>138</td>
</tr>
<tr>
<td>Jackson County - Sunset Haven</td>
<td>October 1946</td>
<td>33</td>
</tr>
<tr>
<td>Knox County Nursing Home</td>
<td>February 1947</td>
<td>107</td>
</tr>
<tr>
<td>Lake County Nursing Home</td>
<td>February 1949</td>
<td>103</td>
</tr>
<tr>
<td>Lee County Nursing Home</td>
<td>March 1946</td>
<td>64</td>
</tr>
<tr>
<td>Livingston County Nursing Home</td>
<td>March 1947</td>
<td>70</td>
</tr>
<tr>
<td>McDonough County - The Elms</td>
<td>May 1949</td>
<td>43</td>
</tr>
<tr>
<td>McLean County Home</td>
<td>July 1954</td>
<td>83</td>
</tr>
<tr>
<td>Macon County - Macon Acres</td>
<td>May 1948</td>
<td>82</td>
</tr>
<tr>
<td>Macoupin County Nursing Home</td>
<td>April 1948</td>
<td>80</td>
</tr>
<tr>
<td>Menard County - Sunny Acres</td>
<td>March 1946</td>
<td>42</td>
</tr>
<tr>
<td>Mercer County Nursing Home</td>
<td>February 1946</td>
<td>54</td>
</tr>
<tr>
<td>Monroe County Nursing Home</td>
<td>February 1951</td>
<td>130</td>
</tr>
<tr>
<td>Peoria County Nursing Home</td>
<td>July 1947</td>
<td>175</td>
</tr>
<tr>
<td>Piatt County Nursing Home</td>
<td>July 1947</td>
<td>29</td>
</tr>
<tr>
<td>Randolph County Nursing Home</td>
<td>July 1952</td>
<td>90</td>
</tr>
<tr>
<td>Rockford Township Hospital and Nursing Home</td>
<td>May 1953</td>
<td>102</td>
</tr>
<tr>
<td>Rock Island County - Oak Glen</td>
<td>July 1946</td>
<td>185</td>
</tr>
<tr>
<td>Shelby County Nursing Home</td>
<td>March 1948</td>
<td>48</td>
</tr>
<tr>
<td>Tazewell County Community Nursing Home</td>
<td>March 1949</td>
<td>83</td>
</tr>
<tr>
<td>Vermillion County Nursing Home</td>
<td>March 1946</td>
<td>186</td>
</tr>
<tr>
<td>Wabash County Nursing Home</td>
<td>July 1954</td>
<td>30</td>
</tr>
<tr>
<td>Warren County Nursing Home</td>
<td>March 1946</td>
<td>55</td>
</tr>
<tr>
<td>White County Nursing Home</td>
<td>July 1947</td>
<td>96</td>
</tr>
<tr>
<td>Whiteside County Nursing Home</td>
<td>November 1945</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>4,977</strong></td>
</tr>
</tbody>
</table>

distribution as of December 1954 are shown in Table V. The variance in rates

TABLE V

FREQUENCY DISTRIBUTION OF PATIENT RATES
IN THIRTY-FOUR COUNTY HOMES
AS OF DECEMBER 31, 1954

<table>
<thead>
<tr>
<th>Rate</th>
<th>Number of Nursing Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>$70 to $79</td>
<td>2*</td>
</tr>
<tr>
<td>80 to 89</td>
<td>7</td>
</tr>
<tr>
<td>90 to 99</td>
<td>9</td>
</tr>
<tr>
<td>100 to 109</td>
<td>3</td>
</tr>
<tr>
<td>110 to 119</td>
<td>6</td>
</tr>
<tr>
<td>120 to 129</td>
<td>6**</td>
</tr>
<tr>
<td>130 to 139</td>
<td>-</td>
</tr>
<tr>
<td>140 to 149</td>
<td>-</td>
</tr>
<tr>
<td>150 and over</td>
<td>1</td>
</tr>
<tr>
<td>**Total</td>
<td>34</td>
</tr>
</tbody>
</table>

* Includes Lake County Translated into a monthly rate at $2.39 per diem.

** Includes the $125 per month rate for bedridden patients in the DuPage County Nursing Home.

would seem to indicate that the quality of care and service might vary along with the rates. This is not the case, since the homes all must adhere to the standards set by the Illinois Public Aid Commission, and there is no provision for the lowering of standards because of lower cost to the patient. The
Rockford Township Hospital and Nursing Home with a rate of $125.00 per month, and Cook County's Oak Forest Infirmary with a rate of $150.00 per month do include medical and hospital facilities which increases the operating cost, resulting in a consequently higher rate. Vermilion County Nursing Home with a patient rate of $95.00 has been operating since 1946 and providing care and service of an exemplary quality.¹

The standards set by the Illinois Public Aid Commission in 1945 and which have been set down in Chapter III of this study have been revised and expanded in 1950 to keep pace with the many advances made in the field of care of the chronically ill.² The revised standards are more definitive in requiring the institutions to provide a high standard of medical and nursing care for the patients, and to have specialized planning directed toward the rehabilitation of the patient. Emphasis was also placed on the requirement that intake should be limited to those persons requiring the specialized nursing program available in the county home, but acutely ill persons requiring hospitalization, should not be admitted or retained in the county nursing home unless an accredited general hospital is included as part of the program. Further, the revisions stressed the requirements of sound administrative procedures in the institutions, uniformity of reporting procedures, and continuing attention to plant maintenance and improvement subject to regular inspections by the Departments

¹Information from personal interview of author with Norman T. Paulson.

of Public Safety and Public Health, as well as placing greater emphasis on personnel, medical, nursing and dietary policies. The revision stipulated that insofar as available resources permit, the program shall include occupational and diversional activities, and specialized planning directed toward the rehabilitation of the patient.3

The revised rules and regulations made it possible for the Commission to claim Federal participation in the cost of county home care since in October 1950, the Social Security Act was amended to provide for federal participation in the payments to or in behalf of recipients in public medical institutions.4 The Illinois Public Aid Commission since October 1947 had been making the payments entirely from State funds in behalf of Old Age Pension and Blind Assistance recipients to the person in the county authorized by the county boards, usually the county treasurer, so the wording of the Social Security Amendment made possible the claiming of federal funds to help with the payment of care of recipients in county nursing homes, effective in January 1951.

The Illinois General Assembly in 1951 revised the Nursing Home Act to include county homes in the scope of the Act. The Illinois Public Aid Commission requires that county nursing homes have a current license as a condition for payment for care of recipients in county nursing homes.

At the same time the Social Security Act was amended to provide for aid to the Permanently and Totally Disabled. After this program became effective in Illinois in December 1950, as Disability Assistance, gradually recipients

3Ibid., 3.
4Polemis, p. 6.
of this category were admitted to the county nursing homes.

The success or failure of a county nursing home in maintaining high standards of care and service depends largely on the ability of the superintendent, or manager, as he will be referred to in this discussion. The county board of supervisors, acting through the county home committee, hires a manager who has administrative responsibility for the home. He is under the supervision of the county home committee and he, in turn, supervises all of the employees of the home, except in those homes where supervision of the nursing services is the responsibility of a separate person.

In the Rockford Township Hospital and Nursing Home, and the Rock Island and Peoria County Nursing Homes, the Business Manager system is used and the manager is responsible for the operation of the home, plant maintenance, personnel, and financial aspects, but the nursing service is administered by a Head Nurse, who is a registered nurse, with full responsibility for the nursing program and patient services. This system applies to a less defined extent in Randolph, Tazewell, Knox, Champaign, Monroe, White and Boone Counties where there is a delegation of responsibility for departmental administration of the nursing program and patient services to a registered nurse in charge, but under the general direction of the manager.

The second system, that of General Administration, places full responsibility for the total operation of the home on the manager, even though he gives departmental responsibility to the various departments. In some homes the manager may be a registered nurse, who assumes direct supervision of the

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5 Information from personal interview of the author with Norman T. Paulson.
nursing program.

Despite the difficulty in the first years of obtaining professional personnel, and the high rate of personnel turnover, in some areas, the quality of care required to conform to the standards set by the Illinois Public Aid Commission has been maintained. Twenty-three of the thirty-four homes have had a change of managers since the program began, and, fortunately, in almost every case the change in administration has resulted in improvement. Changes in other staff personnel has been frequent, in some areas, but the avoidance of a number of experienced staff leaving at any one time has enabled the homes to function without much disruption. At the present time, the county nursing home staff throughout the state seems to be reaching a point of increased stability and the turnover has been reduced, probably because of some salary adjustments and the increased supply of employable persons available on the labor market.

The responsibility of the local county administration to provide periodic financial reports to representatives of the Illinois Public Aid Commission, derives from the need for the Commission to know the current income and operating expenses which are the facts upon which patient rates are based. Over the nine years of the county nursing home program, these reports have been prepared by various persons, and submitted in a variety of forms, but at present a uniformity of reporting has been attained. Frequency of reporting which has been on either a monthly or quarterly basis, will soon be quarterly uniformly throughout the state. Reporting forms designed by and furnished by the Illinois Public Aid Commission will be used for all financial reports made by

\[6\] Ibid.
the management of the county home to the Commission.

Today we find that in the thirty-four counties operating nursing homes the buildings, which had been drab, bleak, and uninviting, have been transformed into attractive, well maintained properties. The strictly utilitarian furnishings which met only the basic needs of the recipients have been replaced by modern, comfortable furnishings which contribute to the general atmosphere of hominess and comfortable living. Curtained windows have been substituted for the shuttered, and even barred, windows of the past. Recreation rooms with television sets, books, and games are to be found in all of the homes, and religious and civic organizations help and even vie with one another to have a share in providing entertainment for the patients during special seasons of the year. These same recreation rooms are often used as chapels for religious services each Sunday, and the ministerial associations have been uniformly cooperative in contributing the services of the ministers. The dining halls are furnished with tables which accommodate four persons, supplanting the long table serving a dozen to twenty, which so long had been associated with the institutional type of dining. Good wholesome food, scientifically planned as a balanced diet, is served on chinaware rather than primarily economic food which used to be served as expediently as possible. Special diets are observed in accordance with medical requirements, and tray service is given to the person who is not able to go to the dining room. In the method of serving meals and the quality of food, alone, lies one of the great differences between the "poor house" and the county nursing home.

The rooms where the patients live are bright, and cheerful, and the three-
quarter beds furnished with inner-spring mattresses are vastly superior to the cots and the pads of the old "poor house." The bed linen is fresh and clean and the blankets have the same quality of cleanliness. Here, too, is one of the great differences, for in the past one of the places where the uncleanliness of an institution was manifested was in the bedding of the inmates.

Some of the rooms accommodate four or five persons, but no more than six persons and each person has sixty square feet of floor space per bed, and the ceiling above the bed is no less than seven feet above the floor. The light in each room is evenly distributed and of satisfactory intensity. Each nursing home provides bathroom facilities on every floor where patients reside, in the proportion of one toilet and lavatory for each ten residents, and one bathtub or shower for each fifteen residents.

The nursing services in the homes are under the direction of a currently licensed Illinois registered nurse or a licensed practical nurse. Adequate nursing services are supplied for the residents at all hours. Daily observation is made of each infirm resident and pertinent information is recorded on an individual record, which must be kept current. When the services of a physician are required, the physician called is one chosen by the patient, and in most instances, is the one who cared for the patient prior to his admission to the nursing home. No patient is to remain in the nursing home for care if his illness reaches an acute stage and general hospital care is required, unless there is an accredited general hospital in conjunction with the nursing

7Roland R. Cross, M.D., Minimum Standards, Rules and Regulations for Nursing Homes, Revised (March 31, 1952), 7, 8, 9, 11, 15, 16.
home. Nursing service, given to an individual patient, is based on the requirements of his condition, and individualization of treatment has been accomplished in some of these homes to a greater degree than is sometimes observed in general hospitals for the acutely ill.

Individual recognition of the patient as a person has been achieved to a high degree in a positive manner. Individual treatment was often given to residents of the "poor house" but too often it was in the form of ridicule or abuse. The patient here is treated with kindess, consideration and dignity. Individualization of treatment still has a long way to progress in the area of therapy and the rehabilitation of the patient so that he can resume community living.

The memory of the old "poor house" is passing into oblivion and in its place there is an institution which is of service to the entire community. There may still be some who consider the county nursing homes as poor houses with new paint jobs, but they are in the minority. The progress of the county home program has only been possible through the cooperation of the communities within the counties, and with their sanction. The continued good will and cooperation of the public is essential to the continued success and progress of the program. There is always a danger that once the first enthusiasm for the program has died down, a siege of lethargy and self-satisfaction will set in despite the original goals. The aged, infirm and chronically ill of the community are a community responsibility, and while the county board and manager are responsible for the operation and management of the home, the problem of care of such persons is also a responsibility of the community at large, in
that it is a part of the total health and welfare needs of the community. This means that the cooperation of all the civic, health, and welfare agencies, and religious organizations need to contribute their support to the program on a continuing basis. Regardless of the source of payment for their care, the patients of the county home are county people who need the specialized care the institution can provide.
CHAPTER V

CONCLUSION

The discussion in the second chapter indicated the need for chronic care facilities, and the following chapter dealt with the legislation which was passed enabling the county boards to finance and convert the county homes into chronic care facilities providing they met the required standards and specifications set by the Illinois Public Aid Commission. Chapter IV outlined the response of the county boards of supervisors in thirty-four counties in bringing about the conversion of the "poor houses" to county nursing homes. In this concluding chapter a recapitulation of the progress made on the program, and the potential for further progress will be given. Further, consideration will be given the total nursing care program for the future, and the alternative to attempting to cope with the growing problem of the chronically ill by providing additional chronic care institutions to take care of them. The county nursing home program should be considered in the light of its reason for being, that is, a program which was initiated to alleviate a situation which had grown over the years until it reached the proportions of an emergency. The solution of this problem in the past, and in the present, may not be the best solution for the continually growing problem of the chronically ill in the future.

Through the addition of the facilities of thirty-four county nursing homes
for caring for the chronically ill 5,000 beds were made available. Some of these beds, to be sure, were occupied and providing care for the same patients prior to the conversion to county nursing homes, but the patients were now assured of the nursing care and services required by their physical condition. Others, who had been residing in the homes, and did not require nursing care were removed and other living arrangements found for them in the community. A few of this group remained in the nursing homes, even though they did not actually require nursing services, because they had lived in the institutions so long and were so dependent on the care and guidance of others that they were not prepared to leave and adjust to the problem of community living. Of these persons there are relatively few still residing in the county nursing homes. With the passing of time some of them died, others suffered physical deterioration which necessitated nursing care, and still others eventually voluntarily left the institutions for other living arrangements.

Today the 5,000 beds are occupied by 4,000 recipients of public assistance and approximately 1,000 private pay patients. So we may deduce that the moderate cost facilities has primarily benefited the public assistance recipients, but an appreciable number of non-recipients have turned to these institutions for care rather than private nursing homes because of lower costs, and, in many instances, a higher type of care.

The effectiveness of the Rennick-Laughlin legislation in helping to eradicate the idea of the "poor house" in connection with the present county homes is substantial, but the county boards of supervisors deserve credit for the manner in which they implemented the legislation with excellent interpretation
of the philosophy and attitude of the county nursing homes in relation to the patients. Moreover, this interpretation has been strengthened through community observation of the type of service and care given to the patients. In a relatively few years, the public has learned to disassociate the "poor house" from the modern, well managed and well-regulated county nursing home operation in the old but renovated building. In most instances, as the public has gained respect for the operation of the county nursing home, it has learned to take pride in it. Once this pride is strongly implanted in the people of the community the continuing success of the county nursing home is fairly well-assured. This is one of the main reasons that of the thirty-four county nursing homes in operation, there has never been any indication on the part of the county boards of supervisors or the communities that there was any regret that the conversion was made, or any consideration given to reverting the home to the status it had prior to the conversion.

These thirty-four county nursing homes represent the accomplishment of eighty per cent of the full potential of the county nursing home program through conversion of the county home buildings. The possibility of expansion of the program is now limited to eight or ten more conversions, with the lower figure the more probable. The counties in which consideration is being given to conversion and in which some structural changes have already been made are McHenry, Kane, Will, Iroquois, Adams, Madison, St. Clair and LaSalle. Crawford County had shown interest in a county home project in terms of building a complete new structure, but the interest seems to be dormant at the present.

1Personal interview of the author with Norman T. Paulson.
If plans were carried through to completion in all of these counties from 750 to 1,000 additional beds would be made available.

There remains a need in the state for chronic care facilities, and in the area where they are needed most, the potential to meet them through the county nursing home program is not great. Thus far, the majority of the county nursing home conversions have occurred in the northern and central portion of the state, while the southern one-third of the state has had few such facilities provided. Only six county nursing homes, Fayette, Wabash, Monroe, Randolph, Jackson and White are in this section of the state and the total number of beds in these institutions, 413, is less than one-tenth the total number in the thirty-four county nursing homes. Moreover, of the remaining homes having a potential for conversion, only Madison and St. Clair county homes are in this section, and the chances of the St. Clair County conversion are, at present, very doubtful. The economy of this section of the state is such that many of the counties could not seriously consider the expenditure of tax funds for the needed chronic care facilities. Suggestions have been advanced that two or more counties might erect and maintain a county nursing home on a collaborative basis, but there has been no positive action taken on that suggestion. There were only fifteen county "poor houses" in existence in thirty-four southern counties in March 1945, so that from the beginning of the program, the potential in the southern one-third of the state was limited as compared to the remaining two-thirds of the state where there were still fifty-seven "poor houses" operating in sixty-eight counties. The main benefit these southern counties have derived from the county nursing home program, besides the six
homes presently operating, has been to place some patients in homes in other parts of the state. Usually the county nursing homes will accept residents of other counties on application when the space is available. The increase in the number of private nursing homes in the southern part of the state has not been rapid, although there has been some advance.

Statewide, the availability of chronic care facilities looks much better than it did in 1945, because along with the growth of the county nursing homes there has been an increase in the number of privately operated nursing homes. Moreover, the standards and quality of the private homes has improved since 1945 when legislation provided for licensing and regulation of private nursing homes by the Department of Public Health. The Rennick-Laughlin legislation and the attendant growth of the county nursing homes did much to stimulate the growth and improve the quality of private nursing homes. The publicity given at that time to the need for facilities and the type and quality of services required promoted the establishment of nursing homes, and the competition provided by the county nursing homes required the private operators to maintain higher standards of care and service. Perhaps a greater stimulus to the growth of the private nursing homes has been the increased liberalization of the Illinois Public Aid Commission through the years in the matter of fees paid for care of assistance recipients. Whatever the cause, the result has been beneficial to the chronically ill in the state, both the public assistance recipients and persons supported from their own resources. The state has benefited because, by providing adequate medical and nursing care in the county homes, and also the private nursing homes, the cost of physicians' services has been
reduced, and hospital expenditures have been decreased because fewer recipients enter the hospital, and those who are admitted remain for shorter periods. Senile patients have been accommodated in these county nursing homes which obviated state hospital care, thus making more beds available for psychotic patients.\(^2\)

At the time the Rennick-Laughlin bill was initiated and afterwards, there was one idea that remained steadfast in the minds of the members of the Committee to Investigate Chronic Diseases Among Indigents, the members of the Commission on the Care of Chronically Ill Persons, and representatives of the Illinois Public Aid Commission and that was that institutionalization was not the complete answer to the problem of the chronically ill. Always there has been an emphasis on the desirability of rehabilitation of the patients. In evaluating the Oak Forest Infirmary in 1947 the report of the Chicago-Cook County Health Survey records the comment that the objectives of the Oak Forest Infirmary should be enlarged from that of offering custodial care to destitute and chronically ill persons to the broader objectives of rehabilitatating the patient.\(^3\) The shortage of facilities for the chronically ill had resulted in the growth of a patient group who, upon entering the county nursing homes, had so far deteriorated physically that the chances for any rehabilitation was slight, and any efforts toward that end were cursory. There was a tendency on the part of the managers and personnel of the home to regard a person admitted, as a long term, perhaps a life time patient, unless he happened to be

\(^2\)Exhibit L, p. 1.

\(^3\)Second Interim Report, 268.
admitted from a general hospital for the purpose of convalescing from an acute illness. A criticism which might be applied to the majority of the county nursing homes is that the same tendency to regard certain patients as hopelessly invalided or incurable still prevails today because the diagnostic facilities and the highly specialized treatment necessary is not available in the nursing home or in the community. Oak Forest Institution with the newly added Department of Physical Medicine is, of course, an exception. Supporters of the county home operation today point out that the condition of most of the patients upon admission to the home has reached a point where chances of rehabilitation are very remote. There is considerable justification for this attitude and recent studies have advanced the idea that an earlier concern with the physical condition of patients, when there is a better chance for rehabilitation, will result in a decrease in the demand on chronic care facilities.

A report of the Advisory Committee on Aging to the Illinois Public Aid Commission published in October 1954 commented on the fact that in the month of January 1954 the cost of all nursing home recipients, predominantly the Old Age Assistance group, was $1,042,110 and warned that with life expectancy on the rise and the age group of sixty-five and over increasing each year, the problem of financing institutional care in the future is alarming.4

The gravity of the problem is heightened because of the continued demand, on the local level, for more beds for old people in nursing homes, and because

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4Proposal To Decrease Institutionalization of the Aged Through Improved Procedures of Diagnosis and Rehabilitation, A. A Report of the Advisory Committee on Aging to the Illinois Public Aid Commission, (October 1954), 1.
of the problem in Illinois is duplicated in most sections of the United States and the Advisory Committee on Aging in Illinois reviewed the attempts of both public and private groups in other states. Finally, the methods used in Europe to meet the problem were reviewed since the increase in the proportion of aged occurred there earlier. Preliminary investigation revealed that in a few localities of the United States, Canada, Sweden and Great Britain the need for long time hospital and nursing home care had diminished. The number of older patients being discharged from hospitals to their own or family homes was increasing. Also there were reports of increased success in rehabilitating even the very old patient. There was no reason to believe that there was any significant difference between the older persons under observation in these areas and countries and the old persons who are now residing in the nursing homes and hospitals in the State of Illinois.

There are in existence a variety of programs which are successful in reducing the need for institutions and nursing homes. The special features of these programs are not generally present in the organization of health facilities for older people in Illinois. Some of these programs are:

1. The use of diagnostic-treatment centers to give a thorough evaluation of the older persons condition, physical, psychological and social, before he is transferred to an institution for further care. Following this evaluation intensive treatment is given after which the person is reallocated on terms of a reasonable prognosis of his future recovery. This is usually a transfer to a facility with a lower operating cost in terms of staff and equipment. After a period of
convalescence or rehabilitation, a permanent placement of the patient is made.

(2) In another type of program the triple process of diagnosis—treatment —rehabilitation prior to placement is greatly facilitated by a physician-social worker team based in the diagnostic treatment center. When the center is notified that the older person is too ill to be cared for in his own home, this team makes a home visit prior to the admission of the patient. In some instances admission to any institution is unnecessary when out-patient facilities are utilized and the family advised on methods of care. The individual treatment made possible through this system enables the physician-social worker team to keep the local doctor and public assistance worker constantly informed of the progress and needs of the patient.

(3) The employment of trained matrons in Sweden and Great Britain to supervise the second stage of convalescence, whether in a rehabilitation unit, a convalescent home or a nursing home is used. These matrons are trained in nursing, occupational and physical therapy, casework and institutional housekeeping. They are vitally important in promoting the final discharge of the patient. 5

The Committee for the Aging in Illinois found that the emphasis on all of the programs studied was to consider the treatment and confinement in the diagnostic-treatment center and interim care pending some degree of recovery and discharge, whereas the prevailing attitude in Illinois has been to consider

5Ibid., 4, 5.
all care for the older person as terminal care. The programs have shown some
definite and positive results in returning the older person to their homes.
Such are the results that a substantial percentage of the persons who in the
usual process would become long term patients, and probably terminal patients
in the nursing home, are being returned to their homes to lead a normal life.

As a result of the findings of the Advisory Committee on Aging in Illinois
two pilot programs have been recommended for Illinois, one in Cook County and
one in Peoria County. In each county there has been a demand and an expressed
need for additional beds for the dependent, older patient. Each county has
been incurring increasing expenditures for nursing and hospital care. Both of
the counties contain above average professional personnel and technical facili-
ties that can be used to supplement the basic demonstration program.

The Committee on Aging believes that this project will be of value in re-
ducing the expenditures of the Illinois Public Aid Commission and proposes that
in both Cook and Peoria Counties there should be built a Diagnostic Treatment
Center, associated with a general hospital, in order to make the most efficient
use of staff facilities for the care of acute conditions and a separate Reha-
bilitative Unit. Admissions to the Diagnostic Treatment Center would be limit-
ed to patients referred by the Illinois Public Aid Commission and the Illinois
State Department of Welfare at the outset. The physician-social worker team
would be in operation at this center.

The measurement of the success of caring for the chronically ill has been
in terms of the ability to provide institutional facilities for their care.
The future trend appears to be toward the positive aspect of treating them
ey early so that they may avoid institutional life. The projects in Peoria County
and Cook County will be watched with interest because they may be a hopeful and constructive step toward future care of the chronically ill.

The county nursing homes may benefit from any knowledge gained of new methods of care and treatment in the Peoria County and Cook County projects, because these methods may be the means of reserving badly needed nursing home facilities for the persons most in need of them.
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