EXECUTIVE SUMMARY

CHAPTER I

Inadequate Care, Inadequate Oversight: The Medical Care of California's Nursing Home Residents

Introduction

In the past decade, the Little Hoover Commission has shown continued concern with the quality of life of California's elderly population in general, and its nursing home population in particular. In a 1983 Commission report entitled THE BUREAUCRACY OF CARE, the Commission extensively studied conditions in California nursing homes and made a series of recommendations which led to the enactment of the Nursing Home Patients' Protection Act (NHPPA) of 1985.

In late 1987, the Commission agreed to conduct an inquiry into the subject of the quality of the medical care and its oversight provided to California nursing home residents. The Nursing Home Advisory Committee utilized in the prior two Commission studies was reconstituted, additional members were added to reflect the specific medical concerns of the inquiry, and a series of Advisory Committee and Sub-Committee Working Group meetings were held throughout 1988 in order to address these concerns.

In the Spring and Summer of 1988, the Commission held two Public Hearings (one in Los Angeles, the second in Sacramento) where a

number of interested parties were able to provide testimony concerning their personal or professional experience with regard to medical care in nursing homes.

Background

The provision of medical care to the more than 115,000 residents of California's nursing homes is a complex subject about which far too little is known. This lack of knowledge stems, in some large part, from the fact that this subject has been not a major concern for any single state agency or professional organization. Thus, there is a real paucity of quantitative data concerning the quality of the medical care provided---or not provided---to the institutionalized elderly in California. Neither state government regulatory and oversight agencies, nor the nursing home industry, nor the physician community itself, have made a major and sustained effort to improve the medical care provided to these most frail and vulnerable citizens.

Much of the medical care provided to nursing home residents appears to be sub-standard compared to that received in acute care hospitals. As one physician who testified at the Commission's Public Hearing on this subject described it, the medical care found in nursing homes is "shoddy." These sub-standard conditions are all the more deplorable because they appear to be the accepted norm in many nursing homes.

The Role of Physicians in Long Term Care

Substandard medical care can lead to a variety of undesirable psychosocial and medical consequences, which, in the worst instances, may be life-threatening. Poor medical care for long term care residents appears to have at least two central characteristics: the inattention of the physician to the changing medical needs of the long term care resident and the unavailability of long term care physicians.

Many persons concerned with reimbursement and regulatory issues in the long term care environment believe that virtually any further regulatory activity which is recommended with regard to either nursing homes and/or physicians who work in nursing homes will be counter-productive and result in additional physicians refusing to work in nursing homes. Ultimately, the Commission rejects this view. The Commission believes that concerns with funding and provider reimbursement cannot be considered independently from the needs to improve the quality of institutional and medical care for nursing home residents.

Problem Prevalence and the Paucity of Data: Information from State Agencies Regarding Medical Care of Nursing Home Residents

The quality and quantity of the data that are available from state agencies concerning the medical care of California nursing home residents is miniscule. The overall paucity or absence of such data is, in itself, one distressing indicator of the low

priority which this issue has had for both the Licensing and Certification Division of the Department of Health Services and, especially, for the Board of Medical Quality Assurance of the Department of Consumer Affairs.

The Role Of the Licensing and Certification Division of the State Department of Health Services In the Medical Care of Nursing Home Residents in California

Licensing and Certification Division surveyors visit long term care facilities at least annually. Consequently, they are the best trained and most experienced "eyes and ears" who regularly visit long term care facilities. Clearly these professionals, along with the professional staff and volunteers working with the Ombudsman Program, can and should be used to aid in the determination of whether adequate standards of medical care are being provided for the facility's residents. To a large extent, this is not the case.

From January of 1986 through May of 1988, Licensing and Certification referred 131 cases to the Board of Medical Quality Assurance; of these cases, only 13 concerned long term care. While there may well be other cases that Licensing and Certification Division could have referred to the Board of Medical Quality Assurance, nine months after the Commission began its inquiry into this subject, Licensing and Certification still did not know how many other cases its Regional Offices may have referred directly to the Board of Medical Quality Assurance,

or how many of those cases may have concerned the provision of medical care services in long term care facilities.

The Role Of the Board of Medical Quality Assurance In the Medical Care of Nursing Home Residents in California

The Board of Medical Quality Assurance of the Department of Consumer Affairs is responsible for the licensing, oversight and regulation of physicians and other specified health care practitioners in California. There is often a perception by members of the public that the Board of Medical Quality Assurance and similar regulatory agencies are "captives" of the very professions they are empowered to oversee.

The Board should demonstrate, clearly and soon, that the medical care of the more than 115,000 nursing home residents in California is an integral part of the medical care system which it is charged with overseeing. Such concern must be demonstrated by a clear and present commitment that will significantly increase the resources of the Board with regard to long term care oversight and significantly increase the accessibility of the Board to the public. The Board needs to demonstrate to the medical care community that standards for the delivery of medical care in long term care facilities will be judged on stringent criteria for professional behavior which equal or exceed those found in other medical practice settings.

The Role Of the Nursing Home Industry In the Medical Care of Nursing Home Residents in California

Illustrative of the mixed feelings of dismay and dependence that the nursing home industry has with physicians is the nursing home industry's request that the citation and fine system now in place be changed so that nursing homes are not given citations or fines if they have made unsuccessful efforts to contact a physician. In these circumstances no action of any kind is taken by any oversight agency against a physician. The physician is essentially free of regulatory oversight and possible sanctions. The nursing home takes the responsibility, and may bear the cost of a citation or deficiency for the patient's change in health status even if the nursing home tried to secure the services of the physician.

The Commission does not recommend a change in this regulatory policy----nor does the Licensing and Certification Division support any such change. The ultimate responsibility of the long term care facility for the resident is to secure appropriate medical care in a timely fashion. Calling a sometimes non-responsive physician begins, but by no means exhausts or completes, the long term care facility's responsibility.

The present system is one in which physicians are essentially unaccountable for inadequate care. In long term care settings the lack of accountability encourages patient neglect or de facto abandonment. The present system does little or nothing to

encourage continuity of medical care. In such circumstances the profession of medicine is ill served, the long term care industry is justly frustrated, and, most importantly, nursing home residents and their loved ones become victims of what a U. S. Senate Committee on medical care in nursing homes called a "shunned responsibility." Such "shunning" is neither good policy, nor is it good care. Existing policy, while it may implicitly condemn such behaviors, does little or nothing explicitly to limit or sanction such behavior except in particularly egregious cases.

Toward A More Responsible Balance: Decreasing Burdensome Regulation on Physicians, Increasing The Quality of Medical Care, and Insuring Effective Oversight

Present regulations call for notification of physicians by nursing home staff when virtually any change in a long term care resident's condition occurs. For those physicians who have a large number of long term care patients, the process of dealing with these notifications, the broad number of which are trivial from the point of view of both appropriate medical management and prognosis can be enormous. Efforts should be made to decrease this burden.

Conclusion

The Commission has gathered reliable information from a variety of sources which strongly indicates that there is much room for

improvement with regard to both the quality of medical care services delivered to nursing home residents as well as to the oversight of those services by state agencies. It is clear that substantial and prompt changes in both the delivery of medical care and in the responsible monitoring of that care are needed.

Chapter II

Recommendations

Introduction

Neither organized medicine, nor the proprietary long term care providers nor the Board of Medical Quality Assurance, the agency most directly charged with the oversight of physician behavior have been strong advocates for improving the quality of either medical care or for improving the oversight of that care with regard to California's nursing home residents. Furthermore, the state agency charged with the oversight of nursing homes, the Licensing and Certification Division of the Department of Health Services, has expressed continued reluctance to acquire any additional responsibilities which would involve Division surveyors in any direct way with responsibilities for assessing the medical care in long term care facilities.

The Commission believes that there is a significant problem with the medical care provided, or not provided, to many nursing home residents.

The Commission's Findings and Recommendations with regard to the provision of medical care services, and the oversight of those services by state agencies, are divided into three categories:

- Enforcement and the Regulatory Environment
- Roles and Responsibilities of Health Care Providers
- Medical Treatment and Other Policy Issues

A comprehensive series of regulatory, legislative, and administrative actions will be needed in order to improve the quality of medical care for California's nursing home residents, and in order to improve the quality of the state's oversight of that care.

Enforcement and the Regulatory Environment

Recommendation 1. A formal system of physician peer review should be established as a requirement for licensure and operation of all nursing homes in California (both Intermediate Care Facilities and Skilled Nursing Facilities).

Recommendation 2. An ad hoc Committee should be convened to develop guidelines and standards of practice for medical care in nursing homes.

Recommendation 3. Patient neglect, or de facto patient abandonment and mistreatment, should be clearly defined in law and substantial penalties for such conduct prescribed.

Recommendation 4. The Board of Medical Quality Assurance should establish regulations for the issuance of citations and fines for poor patient care of nursing home residents.

Recommendation 5. Investigators from the Board of Medical Quality Assurance should be granted a waiver of confidentiality for medical records for investigatory purposes.

Recommendation 6. Licensing and Certification should immediately coordinate and centralize all reports from its regional offices concerning medical care cases that are to be referred to the Board of Medical Quality Assurance.

Recommendation 7. Both the Licensing and Certification Division and the Board of Medical Quality Assurance should rapidly improve their management information and tracking systems.

Recommendation 8. An attachment to the current Admissions Agreement for every long term care facility in the state should be developed by the Board of Medical Quality Assurance and the Licensing and Certification Division describing how to access and follow-up with requests for information and complaint-filing procedures.

Recommendation 9. The Ombudsman Program should mandate as part of its training of all professional and volunteer staff a portion of their training curriculum to be devoted to describing in detail the procedures for filing requests for information or

complaints with the Board of Medical Quality Assurance and with the Licensing and Certification Division of the Department of Health Services.

Roles and Responsibilities of Health Care Providers

Recommendation 10. The Board of Medical Quality Assurance in cooperation with the University of California, the California Association of Medical Directors and the California Medical Association should develop additional training and continuing education in geriatric medicine.

Recommendation 11. Every effort should be made to increase the number of physicians with skills in gerontology and geriatrics. The Legislature should establish a California Health Services Corps to partially fund physician education for those willing to specialize in geriatrics at the University of California medical schools.

Recommendation 12. Programs which enhance the role of physician extenders, both Physician Assistants and Geriatric Nurse-practitioners, need to be further developed. Medi-Cal requirements should be modified to permit direct payment for services provided by licensed Physician Assistants, Geriatric Nurse Practitioners and other qualified Nurse Practitioners.

Recommendation 13. Medical Directors contracted by any California long term care facility after September 1, 1989 should be required to have completed a specified number of Continuing Medical Education hours in gerontology and geriatric medicine as a contractual condition of both initial and continued employment.

Recommendation 14. Title 22 of the California Administrative Code should be amended in order to significantly broaden the responsibilities of the Medical Director of any long term care facility.

Recommendation 15. No Medical Director should be responsible for more than four separate facilities or a total of 400 beds.

Medical Treatment and Other Policy Issues

Recommendation 16. Long term care facilities should establish institutional Ethics Committees.

Recommendation 17. Policy standards regarding the maintenance of mental health and the treatment of mental illness in nursing home patients need to be developed.

Recommendation 18. Standards for the operation of nursing registries which provide part-time nurses to long term care facilities should be quickly and cooperatively developed.