STATE OF CALIFORNIA EDMUND G. BROWN JR., *Governor*

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

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SUPPLEMENTAL REPORT

LICENSING AND CERTIFICATION ACTIVITIES

OF THE

STATE DEPARTMENT OF HEALTH

STATE OF

CALIFORNIA

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March 1977

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In January 1976, this Commission issued a report on "The Administration of State Health Programs". The report dealt with the full range of health activities conducted by the State and included a chapter on the Licensing and Certification Division of the State Department of Health. This chapter focused on deficiencies in the administrative organization and operations of this division. The Commission study dealt only briefly with fundamental problems which haunt the nursing home industry.

After issuance of its report, and the failure of the administration to provide a satisfactory response, the Commission called a series of public hearings to review the report's findings and recommendations.

Three hearings dealt with the department's licensing and certification activities and problems which affect the operation of licensed facilities which provide skilled nursing services. The hearings were held in Sacramento on September 21, 1976; in San Francisco on October 13, 1976; and in Los Angeles on November 17, 1976. The Commission posed the following questions:

1. How has the Department of Health responded so far to the findings and recommendations of the Commission's report?

2. What needs to be done to simplify and strengthen procedures relating to regulation, inspection, consultation, enforcement, citation, publication of performance ratings, denial and revocation of licensure, and orderly transfer of operations or patients following revocation of license for a skilled nursing facility (SNF)?

3. What is the relationship between SNF quality of care and ownership; levels and methoes of reimbursement; margins of profit; staff training, standards, and wages; preadmission evaluation of patients needs; and case types?

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4. Is the State making an adequate attempt to promote alternatives and innovations in provision of long-term care?

5. Is adequate emphasis being placed on rehabilitation, normalization, avoidance of social isolation and protection of rights of patients?

6. What role should be played by consumer advocacy groups, the clergy, public interest law firms, conservators, and the staff of State and local health departments in upgrading the quality of long-term care?

Testimony was provided by the Department of Health, consumer advocacy groups, federal officials, county officials and representatives of the industry. The numbers of citizens in attendance was impressive, as was the often shocking nature of their testimony. Although there are many satisfactory nursing homes and community care facilities in this state, the Commission was informed in the course of these hearings that substandard quality of care was still too common, that nursing home staff were frequently untrained and otherwise unqualified, and that patient needs were secondary to the profit factor in some facilities. Los Angeles County licensing and inspection officials stunned Commission members with their testimony that only five facilities in Los Angeles County of over 800 were deemed satisfactory. Although the Department of Health supplied the Commission with a detailed response to the Commission report relating to the organization and operation of the Division of Licensing and Certification, little evidence has been noted to date of improved operations.

This supplemental report provides information to the Governor, the Legislature, and the general public in two areas: (1) changes in the organization and operations of the Division of Licensing and Certification which have resulted from the findings and recommendations of the Commission study and (2) new findings and recommendations resulting from extensive testimony to the Commission on fundamental and persistent problems which plague the nursing home industry.

The Commission recognizes that the State Department of Health cannot alone solve the complex problems of disadvantaged citizens in need of long-term care. The Governor, the Legislature, and most importantly, the people of this State must indicate their determination to see to it that decency prevails in the treatment accorded to its most disadvantaged citizens. In this spirit, this supplemental report presents our major findings and recommendations.

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SUPPLEMENTAL REPORT ON
LICENSING AND CERTIFICATION DIVISION
STATE DEPARTMENT OF HEALTH
MARCH 1977

ADMINISTRATION

1. Reorganization.

Finding: In a written response to the report of the Commission, (appended hereto), Dr. Charlene Harrington, manager of the Licensing and Certification Division, outlined the reorganization of this Division. The Commission is satisfied that nearly all of the recommendations of the Commission have been adopted and are in various stages of implementation. (It is noted that both Dr. Harrington and her deputy, Jim Miller, were appointed to run this Division after they had both served as members of the Health Task Force of the Commission and were responsible for the staff work leading to the findings and recommendations in our report relating to the Division.) The members are frustrated however with the slow progress of the Department in adapting the organizational structure and procedures of the Division to more adequately oversee the nursing home and community care facility industry.

Recommendation: The Commission recommends that the Division complete its move with all haste toward major administrative reorganization as outlined in the Commission report released more than one year ago. Its efforts at stronger enforcement should be expanded statewide and supported by the Administration.

2. Regulation.

Finding: The Commission finds that regulations are too voluminous, not sufficiently consistent with federal regulations, and preoccupied with physical plant standards at the expense of standards relating to professional care, humane treatment and the quality of life.

Recommendation: Regulations relating to nursing homes should be revised thoroughly and simplified. State and federal officials should work closely together to attain conformity between State and federal standards. More attention needs to be placed on staff performance at both professional and supportive levels.

3. Inspection.

Finding: The Commission finds that inspections have, in the past, been announced routinely to inspectors and operators of facilities; have not concentrated on facilities with chronic and recurrent deficiencies; have not provided incentives to superior performance by reduction in frequency of inspection; have not shown balanced attention to environmental safety and sanitation compared to professional performance of staff at all levels; have not assured that inspectors are made available in sufficient numbers and with sufficient skills to accomplish satisfactory compliance with standards.

Further, the relatively low number of inspections per week per inspector led the Commission to question whether the maximum efficiency and economy are being produced by the staff, as well as the effectiveness of inspection techniques and procedures.

Recommendation: The Commission recommends that SNF inspections should be conducted without prior notification either to inspectors or facilities. The frequency of inspections should be concentrated on facilities with recurrent or uncorrected deficiencies. Reduction in frequency of inspections would constitute an incentive for well run facilities. More attention should be placed on evaluation of professional performance and the quality of life in the SNF. Inspectors should be sufficiently trained to carry out their duties responsibly. Operators of facilities should fill out responses to inspection reports on matters which are simple and routine, to enable inspectors to concentrate on issues of greater importance.

4. Consultation.

Finding and recommendation: The State Department of Health has supplied consultation to SNFs to enable them to comply with standards. Cost of the consultation, however, has been borne not by those who operate facilities, but by the taxpayer. The primary role of local and state government is to assure that operators comply with standards outlined in regulations, not to provide consultation. The skills of inspectors should be shared with operators and the specifics of correcting infractions made clear. However, the prime responsibility of inspectors should not be providing consultation but enforcing regulations.

5. Enforcement.

Finding: The Commission finds that enforcement of standards of care in SNFs has been inadequate at both state and county level. Since issuance of its report, the Commission is satisfied that enforcement has become far stronger both by the State Health Department and County of Los Angeles through its contract to perform the licensing and certification function for the State.

Recommendation: On the basis of its performance evaluation by the State Health Department and the impressive testimony presented to this Commission, we recommend renewal of the contract between the state and Los Angeles County for conduct of the Licensing and Certification authority in that county. This represents a reversal of one of our recommendations in our report published January, 1976.

6. Citations and Fines.

Finding and recommendation: In both the State Department of Health and Los Angeles County's operation, the cumulative record of operators is being taken into consideration. Those who have been cited repeatedly for the same violations are being targeted for revocation. Increased frequency of inspections is being concentrated on facilities out of compliance. Because fines are being levied in accordance with recent State legislation, the casual attitude which prevailed in the past toward citations is disappearing. The Commission recommends that repeated and recurring citations should become automatic grounds for revocation action. Fines should be levied freely to accelerate correction of deficiencies.

7. Denial and Revocation of License.

Finding: When the Commission issued its report, revocation of the license of an SNF was a statistical rarity. At present, revocation actions are occuring with increasing frequency, initiated by both the State Department of Health and the County of Los Angeles. The ability of operators whose license has been revoked to renew operations under a new corporate identity is being eliminated.

Recommendation: More thorough investigations of application for licensure should be carried out prior to issuance, especially to identify operators whose license has previously been revoked. The law bearing upon revocation should be strengthened to reduce its complexity and the length of time consumed in the revocation process.

8. Publication of Performance Ratings.

Finding: Los Angeles County has developed a computerized information service which describes the current recorded status of operations of each SNF. This information is made available to citizens who need guidance in placement of family members in an SNF.

Recommendation: The State should emulate Los Angeles County, and this service should be made available to the regional offices of the Division of Licensing and Certification.

9. Maintenance of Care after License Revocation.

Finding: Historically, substandard care has been tolerated because revocation of license results in hardship to patients who have no alternative care and face removal from the community to distant, strange new environments. Experience has shown that confusion, depression and even death can accompany such unplanned, forced transfers.

Recommendation: In face of revocation, the State should be empowered to place facilities in receivership in order to meet standards; to negotiate for competent new operators; or to accomplish in an orderly fashion the transfer of patients to nearby, adequate facilities.

QUALITY OF CARE

1. Ownership.

Finding: The Commission finds that ownership of facilities bears a predictable relationship to quality of care provided. We realize that testimony on this topic indicates the need for definitive research and analysis, but testimony before the Commission repeatedly pointed out the following disturbing patterns.

Large corporate ownerships of chains of skilled nursing homes generates many problems. Corporations hire administrators whose success is usually judged more in terms of net cash flow and occupancy, rather than by the quality of services provided to patients.

In terms of the relationship of capital investment to annual revenues, this industry is not profitable unless operational costs (food, labor, maintenance, services) are cut to a minimum in order to maximize cash flow. This pressure to reduce operational costs lies at the heart of the poor care being provided to Medi-Cal recipients at current levels of reimbursement.

Two-thirds of the revenues of this industry derive from government funding, yet assurance of quality of service through government regulation is widely resisted. Much of the recurrent scandal swirling over the nursing home industry has its basic origins in futile attempts by government to deal humanely with disadvantaged and elderly patients by relying on an industry which too often attempts to maximize its profits even in face of an inadequate level of payment.

Recommendation: As an initial step to resolve this situation, the State should show a preference for providing care to Medi-Cal patients in facilities operated by non-profit entities, counties and individually ow owned private facilities.

2. Reimbursement for Care.

Finding: Medicare (Title 18) reimburses providers on a reasonable cost basis. Medi-Cal (Title 19) uses a flat rate of reimbursement.

Medicare pays higher rates, attains higher quality of care and sustains patients for much shorter periods of time. (Limited to 100 days per calendar year.) Only two percent of the Medicare budget goes for care in SNFs. In contrast, Medi-Cal pays lower flat rates, attains a lower level of care and pays a much higher percent of program budget for a much longer average period of stay. This contrast raises several fundamental issues of public policy:

- Is flat rate reimbursement at inadequate levels an invitation to poor quality of care? We think so.

- Does Medi-Cal invite families and physicians to place patients unnecessarily in an SNF by providing government financing of long-term care? We think so.

If a flat rate at inadequate levels is offered for long stays in an SNF, the motivation is to cut operational expenses, reduce quality of service and maximize profit margins. When levels of care are kept inadequate for Medi-Cal patients, the cost of their care must be subsidized either by increasing rates for private patients or supplementing the Medi-Cal rate with money supplied from philanthropic sources in order to compensate for losses.

Testimony provided by operators of the Jewish Homes for the Aged indicated their need to supplement Medi-Cal rates by ten dollars a day to provide care at a level expected by the families of the aged and disabled whom they serve. If those who provide sensitive, humane and superior care require such subsidies, it seems apparent that no profit can be realized at Medi-Cal flat rates without serious deterioration in the quality of care provided.

Yet the Commission is convinced that providing a higher rate of reimbursement will not alone assure a tangible improvement in the level of care attained.

We conclude that the State must be more selective in its choice of providers by showing a preference for non-profit charitable sponsors, and county facilities which are directly responsible for the level of care of patients. Generally speaking many large, absentee corporations which operate SNFs do not display sensitivity to the needs of patients. They are not directly accountable for the level of care provided by their managers whose job security is vested more in profit-making and maximal occupancy, and less in the quality of care provided to patients.

Recommendation: The state would be well advised to abandon a flat rate of reimbursement to SNF under Medi-Cal, and to tie its reimbursements to a clearly described level of services provided with a requirement that reimbursements will not be made in face of citations which indicate an inadequate quality of either environment or service. Under these circumstances, the state would pay a rate of reimbursement necessary to attain an acceptable level of service rather than a flat rate which is generally insufficient for care, which leads some operators to cut services below acceptable levels to maximize profit, and which forces others to subsidize Medi-Cal patients to provide adequate care.

In order to succeed with this policy, the State must have authority on two fronts -- (1) the power to place in receivership any SNF which is seriously out of compliance in order to negotiate for competent new operators and (2) the power to deny Medi-Cal payments to facilities seriously out of compliance and to transfer Medi-Cal patients in an orderly fashion to an acceptable facility pending the completion of the revocation process.

3. Training, Staff Standards and Wages.

Finding: The Commission concludes that training of bedside attendants in the SNF industry is seriously lacking. Standards of staffing both professional and bedside attendants is generally poor and wages of attendants are incompatible with good morale, promotion and retention. Testimony indicates that adequate training gives access by workers to higher wages in the acute hospital industry, creating a lasting dilemma for adequate staffing of SNFs. As long as the income of this work force remains at the minimum wage and equivalent to income from welfare, hopes for real progress remain unrealistic.

Recommendation: The Commission recommends that wages of bedside attendants exceed the minimum after training and experience is attained. Reimbursements must be calculated by the State on the basis of a wage structure which is competitive with that which prevails for equivalent skills in the health industry.

4. Preadmission Evaluation of Patient Needs.

Finding: Administrators of government-financed programs which provide long-term care must invest more heavily in preadmission evaluation of needs of the elderly, the mentally disabled and the developmentally disabled.

Discharge planning after hospitalization should include the family, the physician, the social worker and especially trained nurses. Consideration must be given to the need for continuing medical, homemaker and social services; the realistic potential for mental and physical rehabilitation; and an appropriate treatment plan to maximize return of function and independence.

Too frequently busy physicians and harrassed discharge clerks will press for discharge to care in an SNF when this is neither indicated nor beneficial. Once admission occurs, the chance for examining other options disappears and the patient is literally barred from more rational and less costly alternatives.

Recommendation: State Department of Health administrators should require skillful evaluation of patient needs prior to admission to an SNF or another long-term care facility. These evaluations should stress the potentiality of meeting the needs of each patient in a setting other than an SNF or board-and-care home.

5. Case Types.

Finding: Widespread failure to accomplish preadmission assessments contributes to the mixture, in most SNFs, of patients with a wide variety of diagnoses and needs for treatment. The aged, the mentally disabled, the retarded, the physically handicapped are too often mixed together in a fashion which is conducive neither to their morale nor recovery. As a result, demoralization, hostility, despair and hopelessness occur and lead the way to spiritual, mental and physical deterioration. The ultimate cost of poor care exceeds that of skillful and timely rehabilitation, because of the high cost of preventible, long-term institutional care. Patients suffering terminal illness, or who are bedridden should not be thoughtlessly mixed with others with potential for rehabilitation and normalization.

Recommendation: The Commission recommends that the State should prevent admission of patients eligible for government programs to an SNF which has a case type mix not compatible with the specific needs of each patient. The preadmission assessment should include a judgement relating not only to the level of care indicated, but the propriety of admission to a particular facility with consideration to the reputation of the facility.

ALTERNATIVES AND INNOVATIONS

Findings and recommendations: In providing long-term care, many sensible alternatives to care in an SNF exist. They need to be expanded, as they are now all in very short supply. The State Department of Health administration, in programs located outside of the Division of Licensing and Certification, needs to show more leadership and responsibility in the development and use of these alternatives. These programs are: Medi-Cal, Alternative Health, Short-Doyle, Regional Centers, State Hospitals, Social Services, and programs dealing with alcohol and drug abuse.

Examples of successful alternatives are listed without elaboration as illustrations:

- Extended Care Facilities
- Use of nurse practitioners
- Intermediate Care
- Homemaker Chore Services
- Day Care and Activity Centers
- Transitional Residential Care
- Financial Subsidy to Families to Provide Home Care

All administrators of State health service programs should consciously and systematically promote alternatives to care in an SNF when care in other settings is clearly preferable. Administrative regulations to foster alternatives should be drawn, and funding supplied to develop alternatives or to authorize reimbursement to organizations which supply alternative care. Services performed at home and in an SNF by nurse practitioners and other middle-level professionals should be reimbursed by the State in all of its categorical programs. Payments to members of the families of disabled patients for care at home should be tried on an experimental basis as an alternative, when feasible, to institutional care.

Rehabilitation, Normalization, and Patient Rights.

The Commission concludes that the State Department of Health is deficient in its lack of attention to rehabilitation and normalization of citizens suffering handicapping conditions.

The provision of funding for the handicapped may actually serve to their disadvantage unless the State implements a case-management approach to the worker eligible for worker's compensation payments related to illness or injury on the job has proven both cost effective and humane. Similar methods need to be applied to the aged, the mentally and developmentally disabled, and others in need of tax-supported, long-term medical, rehabilitation and social services.

The goals of administrator of such programs as Medi-Cal, Short-Doyle, Regional Center, State Hospitals, and social services do not sufficiently focus on case-management approaches to patient care paid for by the taxpayers. These program administrators should institute procedures for patient need assessment and case-management for individuals requiring long-term care, with a goal of maximizing rehabilitation and normalization, protecting patients' rights and avoiding social isolation and stigma. There are too many individuals presently relegated to SNFs who simply do not belong there.

THE ROLE OF OTHERS

The plight of elderly people and others confined to nursing homes needs to be more fully exposed to public scrutiny. Advocates for the interest of the elderly -- the Grey Panthers, for example -- are playing a crucial role in demanding long-overdue reforms.

Local public health departments need to get more involved in upgrading of long-term care. An example is the public health nursing project in Santa Clara County, designed to provide nursing care and supervision in the home. In the same vein, local medical societies also need to show more concern and commitment.

Conservators, district attorneys and public interest law firms are in a position to insist upon the protection of the legal rights of persons unable to fend for themselves. In Los Angeles County, the involvement of these agencies has had an important impact on more effective enforcement and consequent protection of the rights of the disadvantaged.

The clergy and other volunteer groups should increase the attention given to institutions providing long-term care. Their presence and a show of concern has an enormous impact on the quality of care provided, just as has occurred in the acute hospital setting.

The increasing expense to the taxpayer resulting from large settlements emanating from litigation against the State for injured and abused patients in licensed care facilities supported by public funds should be viewed with alarm and corrective action taken.

Public awareness of the problems of individuals requiring long-term protective and rehabilitative care should be increased. We recommend official recognition and encouragement of the above groups and others in a position to advocate better care for the disadvantaged.