

## EXECUTIVE SUMMARY

### THE BUREAUCRACY OF CARE

#### Why This Study Was Undertaken

This report presents Findings and Recommendations based on extensive research and a public hearing of this Commission conducted on October 27, 1982 on "The Licensing and Certification of Nursing Homes." This Commission also held several public hearings in 1976-1977 on this subject. Since that time, there have been other inquiries by other agencies, including a study of the Licensing and Certification Division (LCD) of the State Department of Health Services conducted by the State Auditor General in 1982. The Auditor General's Report detailed several key areas where administrative oversight by LCD of the long-term care industry was not effective.

The Commission hearing in 1982 examined both conditions in California nursing homes and conditions in the State's primary regulatory agency for nursing homes, LCD. As with the Commission's hearings in 1976-1977, a large number of issues, in addition to the operations of the LCD, were presented. This report takes the major issues raised at the 1982 hearing and examines the existing information about them in order to provide an assessment of the central regulatory and policy issues concerning long-term care in California at this time. The report has as its goal to present an analysis of the issues and to make recommendations to improve the quality of care for nursing home residents

through strengthened regulations and more effective and consistent information for consumers and the public.

#### Methods And Scope of the Study

Shortly after the 1982 hearing, the Commission appointed an Advisory Committee, Chaired by Lieutenant Governor Leo McCarthy, to aid the Commission in analyzing the topic areas for this report. The Advisory Committee met three times between January and June of 1983 to discuss the major issues raised in the public hearings, to suggest approaches for this study, and to assist in developing recommendations.

Members of the Advisory Committee included persons from the long-term care trade associations, representatives from citizens groups concerned with long-term care, the Deputy Director of the Licensing and Certification Division, and other State and public officials. The Advisory Committee was divided into four Task Forces each of which met several times in order to discuss in detail the particular issue areas in which they had concern and expertise.

What follows is a summary of findings and recommendations as they appear in this report.

#### Chapter I:      LONG-TERM CARE PROVIDERS AND REGULATORS:                   PAST HISTORY AND CONTINUING PROBLEMS

The State of California has a continuing concern for and commitment to long-term care. At the present time, more than 105,000 Californians are residents of long-term care facilities. Seventy percent of these are Medi-Cal recipients. In addition to a substantial fiscal in-

vestment, the long-term care environment involves tremendous human resources--residents, community members, service providers, and State employees. Each participates in different capacities and varying degrees. Present disparities in power and organization among these participants impact both regulatory policy and the provision of care to residents.

Many of the problems and issues raised in this report were also heard at the Commission's earlier hearings, thus indicating the tremendous resistance to change in some areas of long-term care. There are also new issues which are likely to have significant consequences for nursing home residents and long-term care policy in the future.

Chapter II: THE LONG-TERM CARE ENVIRONMENT: KEY  
ORGANIZATIONS IN A NON-SYSTEM OF CARE

The roles, capacities, problems, and perspectives of each of the primary participants in the long-term care environment are described in detail. The nursing home industry, LCD, and the public (including residents and consumer groups) are the three constituents whose focus is, or should be, the nursing home resident. California lacks a true system of long-term care services for two major reasons: (1) the slow development and unavailability of community-based alternatives to institutionalization, and (2) the lack of a functional interdependence among the key participants in the present non-system.

Chapter III: BARRIERS TO MORE EFFECTIVE ENFORCEMENT IN  
LCD: INCONSISTENT ROLE DEFINITION AND INADE-  
QUATE TRAINING

A. Roles, Objectives, and Philosophy of LCD: The Need For A Clear  
Statement

Findings

1. LCD's regulatory posture lacks consistency. There has been an ideological "tug-of-war" within LCD over the years. Is its function best served by a "friendly consultant" role or an adversarial "strict enforcement" role? LCD has not identified in clear and consistent ways how these perspectives are reconciled. The result is that inspection teams and LCD administration appear to operate at either or both extremes. This is counter-productive for the nursing home industry, the public, and for LCD.

2. LCD's direct responsibility to residents needs operational clarity. The perception of LCD's interest in maintaining rapport with providers has, at times, led to confusion about the Division's fundamental and unequivocal commitment to nursing home residents.

3. LCD's relations with the industry appear ambiguous. LCD maintains frequent contact with long-term care industry organizations. This takes the form of consultation about policy and regulation formulation, as well as "rap" sessions for providers. While this is necessary to some extent, an arms-length relationship with the industry is in the best interests of all participants in long-term care.

4. LCD maintains no systematic relations with consumers. The lack of ongoing contact with public representatives and consumer advocates skews long-term care policy development and regulation. Although LCD has recently initiated some formal meetings with consumer groups, more is needed.

5. Enforcement is hampered by staffing shortages. Information systems and regulatory amendments will have little impact unless there are adequate professional staff positions to maintain them and perform required operations. It makes no sense that LCD's responsibilities grow each year, while its professional staff shrinks.

#### Recommendations

1. LCD's role must clearly emphasize enforcement. Consultation with facilities should be a distinctly important, yet always secondary role.

2. Clear public statements must stress protection of residents. LCD needs to have clear, written statements which identify that its overriding mission is to protect the interests of the long-term care resident.

3. Consistent use of three ordered enforcement methods. The role of LCD should be to secure corrective action, when indicated, by using three methods in order: (i) negotiating the means of compliance, (ii) demanding compliance, and (iii) litigating, when and if necessary, to ensure compliance.

4. Establish a balanced Advisory Committee. LCD should form a well-balanced Advisory Committee designed to assure regular consumer group input. The Committee should be made up of consumers, LCD

staff, providers, and members of the aging network. "Rap sessions" should include local consumer groups, including but not limited to the local Ombudsman program and the Gray Panthers.

5. Ongoing outreach and consultation with consumer groups. LCD must seek out and maintain contact and consultation with interested citizens, residents, ombudsmen, advocates, and consumer groups throughout the State.

6. Provide funds to increase LCD staff. Though the Commission is aware of the fiscal constraints in the State budget, funds are needed to replace the professional positions lost to LCD during the past two fiscal years. Any increases should be based on a thorough staffing analysis.

B. The Urgent Need for More and Better Training for LCD Staff

Findings

1. Training and monitoring are scattered or nonexistent. LCD inspectors are not being sent to all-expense paid federal training programs and training on the application of State standards is minimal. No regular ongoing training program is presented for LCD staff. The \$54,000 training budget for the current year is less than one-half of one percent of the Division's total budget. This equates to only \$140 per professional staff person per year.

Recommendations

1. Statewide, uniform training programs for inspectors. A high priority must be given to statewide on-going training of LCD staff.

LCD must develop an internal working group charged with developing training programs. This group should consult with the long-term care industry and consumer groups, as well as with the Departments of Education and Justice.

2. Training courses should be designed to achieve LCD performance objectives. Courses should be developed to achieve clearly stated performance objectives. Topics which should be considered include methods and standards of documentation; inspector's relationship to residents, facility staff, and the public; and securing meaningful plans of correction.

3. Regular repetition of training programs. Training is not something that can be accomplished in a single session or workshop. Regular updating is needed to maintain performance consistency and effectiveness.

4. Develop evaluation and accountability measures. Evaluation is needed both to assess the performance consistency of inspectors throughout the State and to determine the effectiveness of training programs. Supervisors should frequently observe inspectors in the field.

5. Encourage cooperative training programs with consumer participation. Residents, families, ombudsmen, providers, and community members should be encouraged to develop curriculum, teach, and otherwise contribute to LCD training.

6. Integrated system of procedural and interpretive guidelines. LCD needs a well-organized, concise, comprehensive procedure manual coordinated with the interpretive guidelines for regulations and with training and monitoring programs.

## CHAPTER IV: INSPECTION: INADEQUATE EVALUATION OF QUALITY?

A. Inspection Timing: Problems of Predictability and InfrequencyFindings

1. Predictable timing results in inaccurate evaluations. LCD does not see facilities in normal, everyday circumstances. Because federal requirements make inspection predictable, facilities can be on their best behavior when inspectors arrive. Also, in spite of some off-hours inspections, some facilities still have understaffing and poor care on nights and weekends.

2. Less frequent inspection of better facilities would be risky. "Better" facilities cannot be identified reliably enough, and can change too rapidly, to justify inspecting them every other year. LCD policy therefore is to inspect such facilities less thoroughly, but not less frequently.

Recommendations

1. Segmented/interim inspection to reduce predictability and keep current. Inspections should be broken into segments to be conducted at random times throughout the inspection cycle. If that is too costly, or a federal waiver cannot be obtained, one brief random visit within a variable inspection cycle might be acceptable, but only if it is designed with care. LCD must have sufficient staff so that time saved by inspecting "better" facilities in less depth can be spent on segmented inspections and problem facilities, rather than being spent on LCD's other obligations.

2. Guidelines for increased off-hours and spot-check inspections.

More visits should be initiated outside regular business hours, in order to discover inadequate night and weekend care. Spot-checks based on events that suggest, or that might precipitate, a sudden change in quality of care should also be expanded and systematized.

B. Inspection Focus: Need to Center More on Residents, Less on Paper

Findings

1. Medi-Cal inspection of care is ill-coordinated with LCD inspection. An opportunity for more resident-centered inspections is lost because information received from the Medi-Cal Division's review of individual residents is not always timely and useful, and LCD inspections are not designed to take advantage of this information in a systematic way.

2. Patient-oriented abbreviated inspection is a useful first step. LCD's "abbreviated survey" for better facilities saves time and focuses on the regulations most concerned with patient care. But because of federal requirements, LCD has had to use standard regulatory approaches instead of building upon more promising resident-oriented screening techniques.

3. Outcome-oriented standards have not been fully utilized. "Outcome" standards would measure quality by whether results of care are as good as can be expected. Current inspections do look at results, but mainly as evidence about whether a facility used the resources and processes required by regulation. Ideally, outcome should

be the directly-measured goal, and not merely evidence that certain resources and processes have been used which may help a facility meet that goal.

4. A broad range of information is not sought from all sources.

LCD interviews some residents and facility staff, but not in systematic fashion. Reports and information from ombudsmen, family, friends, volunteers, clergy, other agencies and organizations are not sought out. Community volunteers are not called upon for assistance with this type of information-gathering or with the inspection process in general.

Recommendations

1. Coordinated Medi-Cal and Licensing/Certification inspections.

Medi-Cal care review functions should be either combined or fully coordinated with LCD functions, taking care to retain positive feedback.

2. Resident and outcome-focused screening for all facilities.

Rather than abbreviated traditional inspection of facilities with better past records, LCD should try to obtain federal permission for a similarly-brief screening inspection of all facilities, based on innovative standards and techniques carefully designed to uncover problems affecting resident well-being. The inspection would then either be terminated (rewarding good facilities by subjecting them to shorter inspections) or "go deep" in areas pinpointed by both screening and patient care reviews. This focuses time on current problems as identified by resident-oriented and outcome-oriented techniques.

3. Outcome-oriented care management system and satisfaction index. We initially recommend two cautious first steps toward outcome-oriented standards. Existing resident care regulations should

be retained, but should be reorganized into a "care management system" which makes it easier for both facility and inspector to focus on assessment of individual residents' needs and on meeting need-related goals. Also, LCD should develop a resident satisfaction index for use as an aid to investigation and, if reliable enough, as the basis for a regulation.

4. Expanded information sources, with help from community volunteers. LCD should be required to seek and consider additional information about facilities using systematic interviews with residents, family, staff, and ombudsmen; public meetings; and active solicitation of comments and reports from other individuals, groups, and agencies. Volunteers should be trained to help with this task.

C. Complaint Inspections: Response Has Improved But Frustrations Remain

Findings

1. Complaint response procedures are much improved, but gaps remain. Complaint-handling recently has improved in promptness, but prioritization standards still have weak spots. One of these stems from the fact that, though LCD's stated policy is to treat oral complaints the same as written, the statute requires response only if a complaint is in writing.

2. Verifications may be lost by failure to make full use of witnesses. LCD's practice of requiring independent verification for witness statements frustrates complainants, and may prevent LCD from taking action on some legitimate violations.

3. Complainants are frustrated by poor communication and lack of appeal rights. There are numerous reports of a variety of communication difficulties at some district offices. Also, the law does not set forth an appeal procedure for complainants, and LCD has not publicized the possibility of informal appeals.

#### Recommendations

1. Statutory right of appeal for complainants. To promote fairness and alleviate frustration, dissatisfied complainants must have the right to request an informal conference, in which the facility may also participate.

2. Statutory amendment to ensure equal treatment for oral complaints. To help assure that investigation will never depend on the courage or sophistication of the complainant, the statute should require LCD to reduce oral complaints to writing.

3. Clarification on acceptability of eye-witness evidence. The statute should require consideration of all traditional forms of evidence. LCD should find a violation if an eye-witness statement is credible, persuasive, and available in case the citation is contested, unless it is outweighed by other evidence to the contrary.

4. Training and procedures to improve public relations. Training, guidelines and form letters should focus on giving complainants complete information and helping them understand procedures and rights. LCD should also distribute to complainants information about free services available from local groups and agencies.

D. Inspection Results: Inconsistency Aggravated by Unorganized Approach

Findings

1. Lack of careful written analysis promotes inconsistency. LCD is staffed by dedicated professionals, but is ill-equipped to make consistent evaluations. Efforts to clarify guidelines on issuance of citations have been unsuccessful (detailed examples are provided). Inconsistency is unavoidable, but is exacerbated in this case by unclear analysis, disorganized methods, and over-reliance on oral communication.

2. Inspection methods foster inconsistent results. In a field requiring subjective judgments, training and guidelines cannot altogether eliminate various inspector biases. But effects of these biases are exacerbated when inspectors repeatedly cover the same facilities, when their evaluations must be in yes/no form, and when their sampling instructions are imprecise.

Recommendations

1. Clarified guidelines on issuing citations. A balanced task force of consumers, providers, agency personnel and other interested parties should assist LCD in developing guidelines, and a cooperative training program, to improve consistency of evaluations. For example, to help distinguish A and B violations, factual examples should be developed as required under existing law. In some cases, the statute itself may need clarification.

2. Inspection assignments and techniques to improve consistency.

Inspectors should be rotated even more frequently than at present, and sampling instructions should be more detailed. In problem areas, rating scales (instead of yes/no answers) and comparison or averaging of several opinions should be tried.

CHAPTER V: ENFORCEMENT: INADEQUATE ASSURANCE OF  
COMPLIANCE

A. Fines: Present System Works in Some Cases, Not in All

Findings

1. Effect of present fine system is unclear. The citation and fine system, perhaps more through stigma than through financial impact, does motivate some improvements. But some facilities seem to have ignored the system quite comfortably. Most assessed fines either are not paid because a first B violation is corrected, or are paid off at the lowest rate by not contesting, or are reduced or dismissed on appeal.

2. There is still some confusion over fines for repeat violations, but fines for first B violations would be premature. Recent changes in statute and procedures on fines for repeat violations still are not working smoothly. Confusion over whether the first repeat B violation should receive a treble fine has temporarily hampered enforcement efforts. However, once repeat fines are working properly, addition of automatic fines for first B violations may prove to be unnecessary.

3. Higher fines are controversial, but justifiable. There are strong arguments both for and against raising fines: for example, the consumer price index has more than doubled since present fines were instituted, and they are no longer commensurate with the seriousness of violations or the resources of many facilities; on the other hand higher fines might not be needed if existing fines could be more speedily and strictly enforced (but see Section B below).

4. Present fines are ineffective for patients' rights violations and retaliation offenses. Many violations of patients' rights regulations, such as lack of respect for privacy or dignity, are not fined because their relation to health and safety is hard to prove. Also, intimidation of residents or staff who express grievances, which is much feared but hard to prove, can be fined only \$500 under present law. A more significant potential fine would deter retaliatory acts and also encourage victims to report them, and would be more in keeping with the seriousness of the offense.

### Recommendations

1. Increase fines and study other potential changes. Maximum fines should be raised to \$1,000 for B violations and \$10,000 for A violations. To allow for no-fault violations, and for small facilities with few resources, minimum fines should not be raised substantially; the minimum B fine should be raised to \$100. First B violations, if corrected, should not be fined at present, but this option should be studied along with other suggestions, based on experience under these proposed increases.

	<u>CURRENT FINES</u>	<u>PROPOSED FINES</u>
A	\$1,000 - \$5,000	\$1,000 - \$10,000
B	\$ 50 - \$ 250	\$ 100 - \$ 1,000

2. B violation redefined to protect patients' rights. Expanding the statutory definition of B violations to include those related to patients' "welfare" will permit appropriate fining of patients' rights violations.

3. Increased fine for retaliation offenses. The maximum fine for retaliation should equal the maximum fine for an A violation. Retaliation should also be a misdemeanor (see Section C below).

B. Appeals: Reductions, Reversals, Inequities, and Delays

Findings

1. Most contested citations are modified, but the reasons for this are unclear. Available statistics are limited, but indicate that facilities appeal roughly 60 percent of A and 35 percent of B violations. Recent review conferences upheld 12 percent of violations heard, modified 77 percent, and dismissed 11 percent, and fines were reduced by well over half.

2. Facility control of evidence creates problems of proof. Facilities have an evidentiary advantage because LCD cannot be on the scene constantly, and must therefore rely on evidence that is within the facility's control, especially care records, to show what has happened and why. Citations based on records showing that care was not provided may be overturned if facility staff testifies that it was provided, but simply not recorded. Records showing that proper care was pro-

vided, when in fact it was not, are hard to detect and, if detected, are hard to fine as A or B violations.

3. Poor case preparation makes some citations hard to defend.

Inspectors are dedicated and competent, but lack sufficient training, guidelines, and procedures to prepare documentation that will reliably withstand challenges on appeal. Also, the former multidisciplinary "special team" approach for problem facilities has been reduced to ad hoc teams drawn from among seven people who also carry other responsibilities.

4. Informal conferences (CRCs) are speedy but lack balance.

Citation review conferences are appropriately swift and informal, but complainants and affected residents have no legal right to participate. This, plus lack of specific training for hearing officers and heavy use of facility attorneys, leads to a perception that at least some of the many CRC modifications and dismissals may result from an imbalance of power and input.

5. Court costs and delays weaken sanctions and distort the public record.

Very little is known about what happens when appeals reach superior court, except that many low-fine B violations are not prosecuted at all due to the expense of litigation. It is not yet clear how this policy will operate with the new fines for repeat B violations. Another barrier to effective court enforcement is that trials are delayed up to several years. Yet so far, neither LCD nor any facility has invoked the arbitration option provided by 1982 statute, because of concerns that it could prove too costly. None of the proposed alternatives to superior court enforcement is without flaws.

## Recommendations

### 1. Presumptions and fines for misleading resident care records.

To balance facilities' evidentiary advantage, there should be a rebuttable statutory presumption that care which does not appear in facility records was not in fact provided. Regulations should require the caregiver to record care only after it is given. If care records contain actual entries or alterations showing that proper care was given, and LCD can prove that the care was not given, there should be a rebuttable presumption that the entry or alteration was made the the knowledge that it was false. Willful falsification of patient records should be an automatic A violation.

2. Staffing, training and procedures to improve case preparation. LCD should recruit and train inspectors for evidence-gathering and documentation. Special correction/documentation teams should be expanded so that sufficient long-term care specialists from various disciplines are available and trained to deal specifically with problem facilities. Reasons for losses on appeal should be analyzed and standards, procedures, and training should be revised accordingly.

3. Broader participation and better balance in citation review conferences. All affected parties should have a statutory right to participate in citation review conferences, and the presence of an impartial observer such as an ombudsman should also be permitted. LCD staff in charge of these conferences should be thoroughly trained for the purpose.

4. Citations enforced in superior, municipal, or small claims court. The statute should be amended to place citations "in a court of competent jurisdiction." Then LCD could file cases under \$1,5000 in

small claims court for rapid, inexpensive decisions, and the Attorney General could file cases between \$1,500 and \$15,000 in municipal court. Results should be analyzed; other options are outlined if further improvement is needed.

5. Use of arbitration and analysis of its results. Both LCD and facilities should move without further delay to gain experience with arbitration. In the future, guidelines based on this experience can assist in selecting cases best suited to be resolved through arbitration.

C. Alternative Sanctions: Limited Use, Limited Options

Findings

1. Criminal and civil prosecution are effective but little used. Those few operators who are willful and serious repeat violators should spend time in jail. Criminal probation can also put operators out of business or subject their practices to intense scrutiny. Yet a recent survey located only one such case filed in the past three years outside the City and County of Los Angeles. According to county prosecutors, LCD seldom refers cases to them, and referred cases are seldom adequately documented. There are also some gaps in criminal statutes, mainly related to resident abuse and neglect, and retaliation for expression of grievances.

Civil prosecution of repeat violators for unfair and unlawful business practices offers opportunities for extensive discovery, consent decrees, large fines and innovative injunctions. Use of this remedy is also hampered by poor coordination between authorities.

2. Successful receiverships are unlikely under present law. Delicensing and decertification are a last resort because they are so harsh on both facilities and residents, yet LCD's two attempts to invoke receivership have failed for lack of an acceptable receiver. Industry cooperation, plus statutory amendments to broaden the choice of receivers and to attract more receivers by increasing their chances of success, can help remedy this problem.

3. LCD has inadequate powers to limit admissions and to withhold Medi-Cal reimbursement. LCD at present cannot halt admissions to a substandard facility--a power which has proven quite effective in some other states. A forthcoming federal regulation will allow states to withhold payment for new Medi-Cal admissions, but a state law must be passed in order to use this power or to limit private-pay admissions.

4. Publicity is a powerful tool that is too seldom used. Publicity, an extremely flexible and potent tool, is not used by the Department except for major enforcement actions. Los Angeles County publicizes citations, too, and also other information including recognition of good facilities. Positive publicity is risky, because facilities can change rapidly, but it is valuable and precautions can be taken which will limit the risk.

### Recommendations

1. Referrals to and cooperation with law enforcement agencies. LCD should adopt guidelines for referring cases to local prosecutors, similar to Los Angeles County guidelines, and should expand recent efforts to join with prosecutors in improving communication and training.

2. Increased misdemeanor fine for willful/repeat violators. To provide a range of potential fines capable of deterring or punishing the worst repeat violators according to the seriousness of their misconduct and the extent of their resources, the criminal fine for willful and repeat violators should be raised to a maximum of \$10,000.

3. Criminal statutes dealing with retaliation, abuse, and neglect. The statute setting a \$500 civil penalty for retaliation against complainants should be amended to broaden the coverage, to raise the civil penalty, and to make such retaliation a misdemeanor. Procedures should be developed to facilitate proof of retaliatory acts.

Health professionals should receive a large fine and a mandatory jail sentence for certain willful or repeated acts or omission with regard to nursing home residents. A comprehensive criminal statute should be enacted covering abuse and neglect of nursing home residents and mandating the reporting of such abuse and neglect.

4. Amendments to make receivership more available and effective. Receivership amendments should permit a wider choice of receiver, allow residents to petition for receivership with LCD participation, invoke receivership in more situations and permit it to last longer, allow the court to set aside financial arrangements between affiliated parties to the extent that the price is unreasonable, and establish a revolving contingency fund. LCD should develop a panel of potential receivers and others willing to assist them, and industry should assist in this effort.

5. Statutory power to limit admissions and Medi-Cal reimbursement. A new statute should provide that when LCD finds conditions which threaten health, safety or welfare of residents, it may declare an

immediate moratorium on admissions. Another statute, linked to forthcoming federal regulations, should permit withholding of Medi-Cal payments for new admissions under specified conditions.

6. Statute and policies requiring use of press releases. A statute should be enacted requiring the Department to issue press releases about specified enforcement actions. The Department's press office and LCD should adopt guidelines, similar to those used in Los Angeles County, related both to enforcement actions and to broader, more positive information about specific facilities and about nursing home-related activities. Issuance of releases under these guidelines should be delegated to LCD district offices.

## CHAPTER VI: INFORMATION: THE HIGH PRICE OF DEFENSIVENESS AND PARANOIA

### A. Attitudes of Mistrust: The Problem of Inadequate Information

#### Findings

1. Lack of coordinated effort characterizes long-term care. The effective delivery and regulation of long-term care services cannot be accomplished without the integrated efforts of the State, the public, and the nursing home industry. A lack of good information sustains the current polarization in the long-term care environment, and is both the cause and result of the widespread lack of accurate, timely and meaningful information.

2. The public fears nursing homes. The persistent notion among the general public that nursing homes are "houses of death" and the

concern among consumer advocate groups that LCD and the industry maintain a policy of silence both confirm the poverty of information.

3. The nursing home industry is self-protective. A long history of public outcry and increased regulation of nursing homes has led to a defensive posture by the industry.

4. Bureaucratic intractability discourages public involvement. LCD has not adequately developed and maintained information for the consumer and the general public. Factors such as reporting jargon, distance to a district office, and inconsistent access policies create an impression of bureaucratic remoteness.

B. Consumer Information Service: The Need to Address Public Concerns

Findings

1. LCD has proposed a management information system. The proposed LCD system focuses solely on internal management of state and local operations and on increasing the Divisions' ability to regulate facilities. The proposed system does not organize information to meet the needs of consumers.

2. Consumers need coherent nursing home information. The first priority for relieving the poverty of information is the development and maintenance of a system which provides consumers and the public with concise, useful, and easy to obtain information about nursing homes. The Los Angeles County Nursing Home Information and Referral Service provides relevant and up to date information. The information is available to anyone by telephone.

3. Blocks to access cripple an information system. Factors which restrict access are bureaucratic inefficiency or unresponsiveness, unclear reporting procedures, and the use of specialized jargon or codes.

4. Intimidation seriously impedes public involvement. Intimidation within a facility prevents information from flowing freely. Recurring allegations of intimidation include firing and black-listing of employees and actions against residents ranging from eviction and abuse to the withholding of care or courteous treatment.

5. Consumers need systematic opportunities to participate. Consumer participation has two aspects: access to good information sources and methods for contributing to the content of those sources. Neither is currently available in any coherent system.

6. Community, family and residents' councils increase public involvement. Community presence in nursing homes is neither actively encouraged nor sanctioned at the present time. Community councils made up of family members, community members, residents, ombudsmen, and other volunteers are critical components of the quality of life of the nursing home resident.

#### Recommendations for Sections A and B

1. The LCD information system must include a consumer information service (CIS). The proposed LCD management information system should not be implemented unless it is modified to include a major consumer component.

2. A consumer information service (CIS) with six components. An expandable version of the Los Angeles County information service

should be available statewide. The information service should be created for all persons interested in long-term care, but especially for the public seeking accurate information about long-term care facilities. The CIS may include, but under no circumstances is it to be limited to, the management information system proposed and under development by LCD. Access to information from the CIS should take place both through an "800" telephone number and through terminals and print-outs, available at cost, in a wide number of state-owned facilities, such as the Department of Motor Vehicles or the Employment Development Department. The service should include a comparability rating system for facilities with at least three gradations and a system for automatic distribution of reports to designated consumer groups, such as local ombudsman programs.

3. LCD must formally incorporate consumer input. The results of interviews with residents, families, guardians, facility staff, and ombudsmen, and summaries of public meetings, should be part of the consumer information service.

4. Facilities should establish resident and/or community councils. Active councils should be strongly encouraged in each facility. Monthly meetings should be scheduled with facility staff and administrators.

5. Expanded role for Long-Term Care Ombudsman programs. Local ombudsman programs should have a key facilitating role in the development, coordination, and presentation of community involvement programs.

6. LCD should establish an interagency coordinating council. This council would be composed of staff from all government agencies

concerned with long-term care. In addition, the council should receive input from consumer and industry representatives.

C. Education for Empowering Consumers: The Public's Right to Know

Findings

1. Consumers lack ways to become selectively involved. The vast majority of people--who will not become active consumer advocates--need information resources which will enable them to make informed choices about long-term care.

2. Consumer input will improve industry training programs. The acquisition of needed technical and specialized knowledge broadens the gap between the State, the industry, and the public. Industry training programs need the balance of public and consumer input.

Recommendations

1. Formalized consumer input mechanisms for industry training. Systematic methods for incorporating consumer input into curriculum development and delivery of industry training programs should be established. Such input could come from community and residents' councils, among other specified sources.

2. Nurse assistant training should be expanded. Because nurse assistants provide approximately 72 percent of all resident care, these service providers need broader and more extensive training, with a focus on the needs and special problems of the institutionalized elderly.

CHAPTER VII: TO IMPROVE CARE IN A CONSTRAINED FISCAL  
ENVIRONMENT

A. The Cost of Care: Is More Better?

Findings

1. The nursing home industry in California is a major enterprise. Statewide 88 percent of the 105,000 long-term care beds are operated by proprietary facilities.

2. The increasing number of nursing home chains raises concerns. Some 40% of the State's nursing home beds are owned or leased by some 15 chains each of which have 1,000 or more beds. This figure has grown rapidly in the past five years and is continuing to increase.

3. The industry correlates increased reimbursement with quality care. The industry argues that a major direct route to better care is a combination of decreased regulation and increased reimbursement. Given that over 70% of the State's nursing home residents are Medi-Cal patients, the costs and consequences of this argument are significant.

4. Profit formulas used are inadequate and inconsistent. There is continuing debate about what specific financial data should be used in profit calculations. Agreed upon and clear definitions of figures, sources, and formulas are needed. For FY 1977-1979 the use of a "return on equity" formula yielded an average profit figure of 40+ percent. Beginning with FY 1979-1980 a "net pre-tax revenue as a percentage of health care revenue" formula yielded an average profit figure of less than 3.5 percent. Such a significant difference in

reported profit percentages calls both formulas into very serious question.

5. The relationship between cost and quality has not been demonstrated. Quality of care is extremely difficult to assess. Present standards are almost always "input" or "process" measures rather than "outcome" measures relating to the needs of the patients and how well they are met. While it is the case that reimbursement rates for nursing homes in California are lower than most other states, many of which reimburse facilities based upon their actual cost of operation, there is a need to carefully examine the cost-quality relationship.

6. The chain phenomenon is important in the cost-quality relationship. Multi-facility operations are increasing profits by capitalizing on "economies of scale" (e.g., central billing, group purchasing, etc.). Cost-cutting may, in some instances, be detrimental to the quality of care.

7. Consumers have no impact on the cost-quality relationship. Long-term care in California is a quite constricted market, with average occupancy rates between 92-96 percent. Long waiting lists are common, especially for seriously debilitated Medi-Cal patients, the very persons who could use the system most. Too seldom is placement a matter of the consumer's choice.

8. Flat-rate Medi-Cal reimbursement encourages profit maximization. The present system of reimbursement rewards a facility--with profits--according to its ability to hold down expenses, regardless of varying resident needs.

## Recommendations

1. Develop more placement options for long-term care consumers. More appropriate forms of placement for persons needing chronic care services must be found. This does not necessarily mean building more nursing homes, although that certainly should be an option. Consideration should be given to injecting competition into the long-term care market by using some of the estimated 6,000+ empty acute hospital beds in the State for long-term care. So-called "distinct-part" hospitals should be reimbursed for long-term care services at a rate far closer to the average Medi-Cal rate for free-standing nursing homes.

2. Reduce constraints on the supply of beds. The supply of nursing home beds should not continue to be completely constrained. The industry desire to keep nursing home Certificate of Need Occupancy Standards at 95% is motivated, at least in part, by the wish to see the market remain artificially constricted, and should be opposed.

3. Re-examine reimbursement mechanisms. The present flat-rate prospective form of reimbursement is not clearly best. Alternatives which should be considered include:

(a) The development of patient acuity index models which link cost and reimbursement to patient needs, and prognosis.

(b) The development of pre-paid health systems for long-term care, based upon the model of Social-Health Maintenance Organizations.

4. Form a special Task Force. The Medi-Cal reimbursement system should be subject to a complete reevaluation by an appropriately representative special Task Force. Such a Task Force should also determine a clear and understandable way of stating profits.

5. State sponsored research on the cost-quality of care relationship. Two key issues which need to be investigated are the role of the type of facility ownership (chain or non-chain) and differences, if any, between proprietary and nonprofit operations as these relate to the quality of care.

6. Evaluate the need for a profit ceiling. The special Task Force should also evaluate whether the State should establish a profit cap for nursing homes that exceed agreed-upon profit levels. Nursing homes are, in part, like public utilities and their rates and income should be carefully evaluated and, if necessary, upper limits set. These evaluatory activities should be undertaken by an independent Health Utilities Commission.

B. A Private-Pay Resident Converts to Medi-Cal: Cause for Eviction?

Findings

1. Eviction of private-pay residents once they become eligible for Medi-Cal has negative effects. Due to the difference in payment rates, many Medi-Cal participating facilities have quotas limiting the number of program recipients they will accept. In some cases even current residents are told to pack up and leave, if they run out of personal funds at a time when the facility's self-imposed Medi-Cal quota is filled. This has serious consequences for residents and their families, and for acute hospitals which often must keep these residents (at great expense to the State) while trying to locate another nursing home that is willing to accept them.

2. Such evictions are part of a broader Medi-Cal discrimination problem. If facilities are required to keep current residents upon conversion, they may try to compensate in a variety of ways, some of which are of questionable legality. They are also more likely than ever to refuse admission to any applicant who is already on Medi-Cal. Other states have laws that deal with this problem in different ways (e.g., prohibit any discrimination whatsoever against Medicaid residents, prohibit charging of higher rates to private residents than the rates received for Medicaid residents, or require all facilities in the State to serve a fair proportion of indigents).

#### Recommendations

1. Requirement that facilities reveal Medi-Cal policies. To avoid surprises and help applicants decide where to spend their life savings, facilities must reveal their Medi-Cal policies in writing before admission.

2. Prohibition on transfer because of conversion to Medi-Cal. If a requested Attorney General's opinion concludes that it is now legal for a participating facility to evict residents when they convert to Medi-Cal, a law should be enacted to prohibit such treatment of these dependent persons.

3. Statute prohibiting all forms of Medi-Cal discrimination. Overall, a comprehensive approach where all beds in a Medicaid-participating facility must be covered under its provider agreement with the state, and there may be no discrimination in either admissions or transfers (apart from preferences by life care, denominational, or county facilities for their members), seems most likely to serve the public interest.

C. New Care Providers for Nursing Homes: The Geriatric Nurse Practitioner

Findings

1. "Nursing" home does not mean nursing care. Most resident care in nursing homes is done by Nurse Assistants (72.3 percent) rather than by licensed or registered nurses.

2. Physician services to residents are minimal, at best. Few physicians have interest in geriatrics, fewer still in nursing home visits, and even fewer still in accepting the Medi-Cal rates given physicians for such visits.

3. Geriatric nurse practitioners are a needed provider. Nurse practitioners can complement and/or substitute some long-term care services provided by physicians.

4. Nurse practitioners: needed professionals caught in a "turf" battle. There is a disagreement among physicians and nurses regarding whether such nurse practitioners should be fiscally independent.

Recommendations

1. Encourage the use of geriatric nurse practitioners (NP) in nursing homes. Facilities with less than 50 beds should have a half-time geriatric NP, those between 50-99 beds a full-time geriatric NP. Nurse practitioners need not be in the direct employ of either nursing homes or of physicians. Evaluations of NP effectiveness, both in terms of cost savings and care provided, should be undertaken.

2. Develop incentives for facilities using geriatric NPs. A reimbursement incentive for facilities utilizing NPs should be considered by the Department of Health Services. This incentive must insure against the possibility of "pass-through" problems.

3. Geriatric NPs must not be calculated as nursing staff. Staffing levels must not be permitted to decrease because a NP is present in a facility.

D. Nursing Hours and Standards: Bad Numbers for Bad Reasons

Findings

1. Present standards for nursing hours are unsatisfactory. Present law and regulations require a bare minimum average of 2.8 nursing hours per patient day in nursing homes. In calculating this average the hours of R.N.s and L.V.N.s are inappropriately doubled. The nursing hours average is focused on staff, not on patient needs. At the present time, the median for all facilities, regardless of ownership type, is above 2.8. However, this median contains immense range.

2. Changing the nursing hours standard has major consequences. If nothing else were changed and if only six minutes per day were added to the nursing average, moving it up from 2.8 to 2.9 hours per patient day, the increased cost to Medi-Cal would be almost \$12 million per year. If this increase were not reimbursed by Medi-Cal, but had to be paid from income, estimated average net pre-tax patient income per patient day would fall almost 40%. Obviously, the consequences of changing the 2.8 figure are very large.

Recommendations

1. The present 2.8 standard must remain until improved. The standard is not very useful, not addressed to resident needs, and perhaps harmfully low. It should not, nonetheless, be eliminated until a more accurate and stringent resident-centered standard can be devised and applied. An improved standard must include resident acuity measures. In the meantime, aggressive use of existing regulations which allow LCD to order increased staffing to meet specific needs must be continued.

2. Change the formula for calculating nursing hours. The doubling factor for licensed nurses should be removed and the true average should be broken down into percentages of nursing hours by training area, e.g., R.N., L.V.N., nurse assistants.

## CHAPTER VIII: MATTERS WHICH NEED FURTHER INVESTIGATION

A. Should Legal Fees for Nursing Homes Be Considered a Medi-Cal Reimbursement Cost?

It is not known how much nursing homes spend on legal fees as a "normal cost of doing business." Facility legal fees are reimbursable by Medi-Cal, yet cost data is not available from either the State or the long-term care industry as to the amount of such fees.

The Medi-Cal Audit Branch should undertake a valid sampling of nursing homes to collect data on the amount of money now reimbursed

for legal fees. Information on legal fees, sub-divided into relevant categories, should be a line-item required on all Medi-Cal Cost Reports.

B. Does the Movement of LCD Staff into Industry Jobs Constitute a Conflict of Interest?

There are reports that a number of former LCD employees go to work for the nursing home industry, including a former LCD district office director. If this is true, potential conflict-of-interest situations could easily arise.

From January 1979 to April 1983, 49 employees left LCD employment. Of those 49, 22 went to work for "private industry." LCD does not know how many of these 22 went to work for the nursing home industry.

The presence of former LCD employees in the nursing home industry may or may not have a negative effect on regulatory activities. This is a sensitive issue with potential risks and a thorough investigation should be undertaken. If it is found that there are risks to long-term care residents a way to eliminate these risks should be sought. One alternative would be to establish a waiting period during which time a former LCD professional staff member would be prohibited from taking any long-term care industry position.

C. Can Incentives Be Developed For Providing Good Care?

The nursing home industry continues to seek incentives for providing quality care. This issue is complex and deserves further

investigation to bring about positive action. On the basis of current information, the Commission has identified three possible incentive alternatives: briefer inspections, implementation of a nursing home rating system, and positive publicity.

With the possible exception of employment of geriatric nurse practitioners, we believe that incentives need to be developed which are not in the form of increased reimbursement.

D. What Happens When Care Providers Do Not Speak The Same Language as Residents?

Many nursing home employees, and some residents, do not speak or understand the same language (usually English). Staff turnover rates in long-term care average 136 percent Statewide. Turnover rates are highest in proprietary chains, which also have the lowest percentage of employees staying for twelve months or more. Given these conditions, it is important to examine the relationships between wage rates, turnover, and the potential problems of persons who do not speak or understand English well. It is also important to study the relation between staff turnover and types of ownership.

Nursing home employees who do not speak or understand English well should be afforded the opportunity and encouraged to take English-as-a-second-language classes. Either statutory or regulatory amendments should require a minimal proficiency in English for all long-term care employees working with a predominantly English speaking population. Existing regulations which require that measures be taken to assure that non-English speaking residents be able to communicate with staff need careful monitoring and enforcement.

E. What Precautions and Procedures Are Needed When A Facility Changes The Clientele It Serves?

A recent conversion of a long-term care facility in Marin County to a drug abuse treatment facility caused concern to community residents. In this case, LCD was unable to intervene because the facility apparently acted within the letter of existing law. As a result, the belief that health related corporations can make such major changes without advice or consent from the community or the State grew.

LCD should convene a Working Group to assess how this particular situation took place, how and why similar cases have occurred, and what regulations, or new legislation, should be in place to prevent such facility conversions from taking place without proper oversight. Full consideration for community and residents' wishes needs to be included in the process of deciding if and when such facility conversions may be undertaken.

A Concluding Note To The Executive Summary

The issues under review in this report are complex. They demand analyses which provide fairness and depth. The report which follows provides detailed recommendations as well as suggested language for new legislative, regulatory, and administrative actions where they are deemed appropriate. It is the wish of the Commission that this report make a significant contribution to the crucial discussions concerning long-term care and, more importantly, that it provide routes for improving the quality of life of those Californians who reside in nursing homes presently, or who will in the future.