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STATE OF CALIFORNIA

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Assemblyman

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Executive Director

THE BUREAUCRACY OF CARE

Continuing Policy Issues for Nursing Home Services and Regulation

August 1983

THE BUREAUCRACY OF CARE

Continuing Policy Issues for Nursing Home Services and Regulation

A REPORT

OF THE

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY
Nathan Shapell, Chairman

and

THE NURSING HOME STUDY ADVISORY COMMITTEE
Lieutenant Governor Leo T. McCarthy, Chairman

Prepared by

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University of California, Berkeley

and

Elisabeth Wadleigh, J.D.

August 1983

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Honorable George Deukmejian
Governor of California

Honorable David A. Roberti
President pro Tempore of the Senate
and Members of the Senate

Honorable Willie L. Brown, Jr.
Speaker of the Assembly
and Members of the Assembly

Honorable James Nielsen
Senate Minority Floor Leader

Honorable Robert W. Naylor
Assembly Minority Floor Leader

Dear Governor and Members of the Legislature:

In the early Fall of 1982, the Little Hoover Commission received information documenting that health care standards in nursing homes were not being adequately enforced. In order to obtain first-hand knowledge, members of our Commission visited four nursing homes in Los Angeles and the San Francisco Bay Area. Commission members observed examples of dirty, understaffed facilities which were providing a demeaning environment for the residents. No one could say these individuals were receiving quality health care. Following these visits, the Commission conducted a public hearing in October 1982 during which it heard testimony from over twenty witnesses describing cases of neglect, physical and sexual abuse, and the frustration of dealing with the State's "bureaucracy of care."

This was not the first time the Commission or the Legislature has heard and witnessed such horrors. Since 1970, Assembly and Senate committees, as well as the Little Hoover Commission, have held extensive hearings on conditions in nursing homes and the State's licensing and certification activities. Although past efforts have resulted in the enactment of numerous laws to correct problems, the reorganization of licensing activities, and increased public awareness, these changes have apparently not been sufficient.

Although reports have been issued, legislation passed, and improvements made in many facilities, it has never been enough to eradicate the problems which continue to persist. The "system" for licensing nursing homes and monitoring conditions in these facilities has lacked the strength necessary to eliminate the most severe problems. Many of the problems are quite complex and go beyond new statutes and regulations; government cannot mandate love and caring.

Nevertheless, the Commission believed more could be done to protect the 105,000 frail and elderly individuals living in California's 1,200 nursing homes. At the conclusion of the October 1982 hearing, the Commission pledged to go beyond simply writing another report which might only serve to take up space on a bookshelf.

In response to these special problems, the Commission appointed a Blue Ribbon Advisory Committee chaired by Lieutenant Governor Leo T. McCarthy and represented by the Assembly and Senate policy committee chairs responsible for aging issues, the State Department of Health Services, the legal profession, consumer groups, the State Ombudsman, academia, the California Nurses Association, and the nursing home industry itself.

This Advisory Committee invested hundreds of hours assisting the Commission's expert consultants, Dr. Stephen R. Blum and Elisabeth Wadleigh, J.D., in collecting extensive information, contacting scores of individuals, analyzing eighteen different nursing home policy issues, and developing detailed recommendations for the Legislature and the Administration to implement. The study findings include the following:

- The Department of Health Services' Licensing and Certification Division (LCD) has not determined whether its function is best served as a "friendly consultant" role or an adversarial "strict enforcement" role. As a result, survey teams appear to operate at either or both extremes.

- No regular ongoing training program is presented for all LCD staff. LCD relies substantially on "the buddy system" for on-the-job training.

- LCD does not see facilities at their worst because the federally-required inspection process is too predictable.

- LCD still fails to focus as much as possible on matters concerning patients' mental and physical well-being. Its "abbreviated survey" for better facilities saves time, but relies on traditional regulatory approaches instead of building upon newer patient-oriented screening techniques. LCD does not take full advantage of available outcome-oriented measures of quality, and it does not sufficiently seek and use information from patients, facility staff, and others in a consistent and purposeful way.

- 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, and public demand has grown for more and larger fines.

- Our review of available statistics revealed that facilities appeal 60% of A and 35% of B citations. Recent review conferences upheld only 12% of the violations heard, modified 77%, and dismissed 11%, and fines were reduced by well over half.

- Recalcitrant repeat violators should spend time in jail. 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 LCD, other prosecutors are uninterested. However, prosecutors state that LCD seldom or never refers cases to them, and referred cases are seldom adequately documented.

- For patient protection, LCD needs to have and to use a full range of enforcement sanctions. Instead, we find that available options are not used enough, and that useful options are not available.

- Everyone concerned with nursing homes is information-poor. There is widespread misinformation and misperception.

- 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 cost and consequences of this argument are significant.

- Medi-Cal patients are not as "desirable" to facilities as private patients, due to the discrepancy between the two payment rates. Consequently, many facilities do not accept them or have set quotas limiting the number they will accept. Medi-Cal discrimination often extends even to patients who are already living in a Medi-Cal participating facilities. Even with patients who have lived there for years, if the facility's self-imposed "Medi-Cal quota" is filled at the time of conversion, patients may be told to pack up and leave.

- Most "nursing care" in nursing homes is done by Nurse Aides (72+%). 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.

- Present law and regulations require a (bare) minimum of 2.8 nursing hours per patient day in nursing homes. In calculating this standard, the hours of a R.N. or L.V.N. are <u>doubled</u>.

- LCD is hampered by lack of professional staff. In the past two years, cutbacks have forced closure of one office. LCD has lost a significant number of staff in 1982-83.

In order to better ensure that the State fulfills its moral and legal responsibility for protecting and providing quality care for patients of nursing homes, the Advisory Committee and the Commission recommend the following:

1. Inspections should be broken into segments to be conducted at random times throughout the inspection cycle.

12. The 2.8 nursing standard is not very useful, not informative of patient needs, and perhaps harmfully low. It should not, nevertheless, be eliminated until a more accurate and stringent patient-centered standard can be devised and applied.

13. Funds are needed to replace the positions lost due to cut-backs. The enforcement process will eventually suffer from such cut-backs.

The work of the Nursing Home Study Advisory Committee and this Commission does not stop with the submission of this report. In fact, this is only the beginning of a very long process facing us as well as the Governor and the Legislature. Each of us must now make the commitment to introduce legislation, develop regulations, provide information to the public, commit resources, and enlist the cooperative assistance and support of the citizens of our communities to translate the words and ideas in this report into reality in order to provide the quality of care and the protection our elderly and frail citizens of California need in nursing homes. Because people's lives are at risk, this government's responsibility must never be compromised nor its performance be second rate.

Respectfully submitted,

Leo T. McCarthy

LEO T. MCCARTHY, Lt. Governor
Chairman, Nursing Home Study
Advisory Committee

NATHAN SHAPELL, Chairman
Commission on California State
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Attachment

cc: David Swoap, Secretary
Health and Welfare AGency
Peter C. Rank, Director
Department of Health Services

*Prior to final adoption of the report, Mildred Simmons was replaced as Deputy Director of Licensing and Certification. As a result, she was not available to review the final report although she had provided comments on the draft report.

The old have been made to feel that they have been sentenced to life and turned into a matter of public concern. They are the first generations of full-timers and thus the first generations of old people for whom the state, experimentally, grudgingly and uncertainly, is having to make special supportive conditions.

Ronald Blythe, The View in Winter (New York: Harcourt Brace, 1979), page 5.

TABLE OF CONTENTS

		Page
Executive Summary		i-xxxvii
I.	LONG-TERM CARE PROVIDERS AND REGULATORS: PAST HISTORY AND CONTINUING PROBLEMS	1
A.	Introduction and Overview: Long-Term Care in California	1
B.	The Little Hoover Commission and Long-Term Care	4
C.	Methods Used for This Study	6
D.	Objectives of This Study and Report	6
E.	Brief Overview of Major Issues	8
II.	THE LONG-TERM CARE ENVIRONMENT: KEY ORGANIZATIONS IN A NON-SYSTEM OF CARE	12
A.	Community-Based Long-Term Care and Alternatives to Institutionalization: An Overview	13
B.	The Long-Term Care Industry in California	16
C.	The Licensing and Certification Division of the State Department of Health Services	21
D.	The Public and Consumer Groups	25
E.	The Long-Term Care Triangle: Interactions in the Present Non-System	30

Page

III. BARRIERS TO MORE EFFECTIVE ENFORCEMENT IN LCD: INCONSISTENT ROLE DEFINITIONS AND INADEQUATE TRAINING 32

A. Roles, Objectives, and Philosophy of LCD: The Need for a Clear Statement 32

Findings:

1. LCD's regulatory posture lacks consistency 32
2. LCD's direct responsibility to residents needs operational clarity 33
3. LCD's relations with the industry appear ambiguous . . 33
4. LCD maintains no systematic relations with consumers . . 34
5. Enforcement is hampered by staffing shortages . . . 34

Recommendations:

1. LCD's role must clearly emphasize enforcement . . . 36
2. Clear public statements must stress protection of residents . 36
3. Consistent use of three ordered enforcement methods . . 36
4. Establish a balanced Advisory Committee. 37
5. Ongoing outreach and consultation with consumer groups . 37
6. Provide funds to increase LCD staff 37

B. The Urgent Need for More and Better Training for LCD Staff 38

Findings:

1. Training and monitoring are scattered or nonexistent . . 38

Recommendations:

1. Statewide, uniform training programs for inspectors . . 42
2. Regularly repeated training designed to achieve LCD performance objectives 43
3. Encourage cooperative training programs with consumer participation 44
4. Develop evaluation and accountability measures . . . 45
5. Improved guidelines, integrated with training and monitoring activities 45

Page

IV. INSPECTION: INADEQUATE EVALUATION OF QUALITY . 47

A. Inspection Timing: Problems of Predictability and Infrequency 49

Findings:

1. Predictable timing results in inaccurate evaluations . . 49
2. Less frequent inspection of better facilities would be risky . 52

Recommendations:

1. Segmented/interim inspection to reduce predictability and keep current 56
2. Procedures to deal with tipoffs and alleged tipoffs . . . 58
3. Guidelines on initiating off-hours inspections 58
4. Information and guidelines for spot-check inspections . . 59

B. Inspection Focus: Need to Center More on Residents, Less on Paper 59

Findings:

1. Inspections are criticized for focus on paperwork . . . 61
2. Medi-Cal inspection of care is ill-coordinated with LCD inspection 63
3. Resident-oriented abbreviated inspection is a useful first step 65
4. Outcome-oriented standards have not been fully utilized . 68
5. A broad range of information is not sought from all sources . 71
6. Patients' rights violations are hard to prove and harder to cite 73

Recommendations:

1. Coordinated Medi-Cal and Licensing/Certification inspections . 75
2. Resident and outcome-focused screening for all facilities . 75
3. Outcome-oriented care management system and satisfaction index 78
4. Statute or regulation to expand LCD's sources of information 78
5. Community volunteers to help obtain and process information 81
6. Amendments to render patients' rights more enforceable . 81

Page

C. Complaint Inspections: Response Has Improved But Frustrations Remain 82

Findings:

1. Complaint response procedures are much improved, but gaps remain 83
2. Verifications may be lost by failure to make full use of witnesses 85
3. Poor communication with complainants reaps a bitter harvest . 87
4. Frustrated complainants have no clear right of appeal . . 90

Recommendations:

1. Statutory right of appeal for complainants 90
2. Amendment to ensure equal treatment for oral complaints . 91
3. Amendment to clarify acceptability of eye-witness evidence . 91
4. Further guidelines for prioritization of complaints . . . 91
5. Training and procedures to improve public relations . . 92
6. Distribution of information on free services from local groups 92

D. Inspection Results: Inconsistency Aggravated by Unorganized Approach 93

Findings:

1. Lack of careful written analysis promotes inconsistency . . 93
2. Efforts to clarify citation guidelines have fallen short . . 95
3. Inspection methods foster inconsistent results . . . 104
4. Training and monitoring are scattered or non-existent . . 106

Recommendations:

1. Clarified statutes/guidelines on issuing citations . . . 107
2. Regulations to help distinguish A and B violations . . . 108
3. Inspection assignments and techniques to improve consistency 110
4. Integrated manuals, training and monitoring 110

V. ENFORCEMENT: INADEQUATE ASSURANCE OF COMPLIANCE 111

A. Fines: Present System Works in Some Cases, Not in All . 112

Findings:

1. Effect of present fines and recent regulatory changes is unclear 112
2. Some confusion remains over automatic fines for repeat violations 115
3. Automatic fines for first B violations would be premature . 118
4. Higher fines are controversial, but justifiable . . . 119

Page

5. Present fines are ineffective for rights violations, retaliation 121
6. Inconsistent A and B fines will persist under present guidelines 124
7. Inadequate "corrections" avoid daily fines and some repeat fines 125
8. Fines for misleading records would cut two ways . . . 127

Recommendations:

1. Increased fines for A and repeat or uncorrected B violations 128
2. Data analysis and study of other proposed changes in A and B fines 129
3. B violation redefined to protect patients' rights . . . 131
4. Increased fine for retaliation offenses 132
5. Clarification on fines for repeat B violations 132
6. Expanded guidelines for assessment of A and B fines . . 133
7. Detailed sample correction plans 133
8. Fine for falsified records 134

B. Appeals: Reductions, Reversals, Inequities, and Delays . 134

Findings:

1. Most contested citations are modified, but reasons are unclear 135
2. Facility control of evidence creates problems of proof . . 139
3. Statutory definitions can be met, but poor case preparation makes some citations hard to defend 143
4. Informal conferences (CRCs) are speedy but lack balance . 147
5. Court costs and delays weaken sanctions and distort public record. 153
6. Arbitration, available since January 1983, has not yet been tried 158

Recommendations:

1. Citations enforced in superior, municipal, or small claims court 159
2. Broader rights to participate in citation review conferences . 160
3. Use of arbitration and analysis of its results 161
4. Presumption that care not recorded was not provided . . 161
5. Expanded regulation and fine for false care records . . 162
6. Expanded correction/documentation teams for problem facilities 163
7. Staffing, training and procedures to enhance enforcement ability. 163
8. Ongoing data collection used to improve training and guidelines 164

Page

C. Alternative Sanctions: Limited Use, Limited Options . . 165

Findings:

1. Criminal and civil prosecution are effective but little used . 165
2. Successful receiverships are unlikely under present law . 173
3. Limits on referral are inadequate; limits on admission are needed. 176
4. Withholding Medi-Cal reimbursement would bring benefits and risks 178
5. Publicity is a powerful tool that is too seldom used . . 179

Recommendations:

1. Referrals to and cooperation with law enforcement agencies . 181
2. Amendment raising misdemeanor fine for willful and repeat violators 182
3. Criminal statutes dealing with retaliation, abuse, and neglect 182
4. Amendments to make receivership more available and effective 184
5. Statutory power for LCD to halt all admissions to a facility . 186
6. Statutes employing Medi-Cal reimbursement to effect sanctions 186
7. Statute and policies requiring use of press releases . . 187

VI. INFORMATION: THE HIGH PRICE OF DEFENSIVENESS AND PARANOIA 189

A. Attitudes of Mistrust: The Problem of Inadequate Information 189

Findings:

1. Lack of coordinated effort characterizes long-term care . . 189
2. The public fears nursing homes 190
3. The nursing home industry is self-protective 190
4. Bureaucratic intractability discourages public involvement . 191
5. Adequate statewide information is key to a functional partnership 193
6. The Torres-Felando Long-Term Care Reform Act provides legislative foundations 194

Recommendations:

1. A Statewide automated information system 194
2. Consumers and the public must have more active roles . . 195

Page

Findings:

B. Consumer Information Service: The Need to Address Public Concerns 195

1. LCD has proposed a management information system . . 195
2. The proposed LCD system has no provision for public access 197
3. Consumers need coherent nursing home information . . 197
4. Los Angeles County's consumer information service is a prototype 199
5. Blocks to access cripple an information system . . . 200
6. Intimidation seriously impedes public involvement . . . 201
7. Consumers need systematic opportunities to participate . . 202
8. Community, family and residents' councils increase public involvement 203

Recommendations:

1. The LCD information system must include a consumer information service 204
2. A consumer information service with six components . . 205
3. Penalties and deterrents against intimidation and retaliation . 206
4. LCD must formally incorporate consumer input . . . 207
5. Facilities should establish resident, family and community councils 208
6. Expanded role for Long-Term Care Ombudsman programs . 208
7. LCD should establish an interagency coordinating council . 208

C. Education for Empowering Consumers: The Public's Right to Know 209

Findings:

1. Consumers lack ways to become selectively involved . . 209
2. Consumer input will improve industry training programs . 210

Recommendations:

1. Seminars and workshops for consumers 211
2. Ombudsman Program should receive funds for consumer outreach 211
3. Formalized consumer input mechanisms for industry training . 211
4. Nurse assistant training should be expanded 212

VII. TO IMPROVE CARE IN A CONSTRAINED FISCAL ENVIRONMENT 213

A. The Cost of Care: Is More Better? 214

Findings:

1. The nursing home industry in California is a major enterprise 214

Page

2. The increasing number of nursing home chains raises concerns 215
3. The industry correlates increased reimbursement with quality care 215
4. Profit formulas used are inadequate and inconsistent . . 216
5. The relationship between cost and quality has not been demonstrated 218
6. The chain phenomenon is important in the cost-quality relationship 221
7. Consumers have no impact on the cost-quality relationship . 225
8. Flat-rate Medi-Cal reimbursement encourages profit maximization. 226

Recommendations:

1. Develop options for long-term care consumers . . . 227
2. Reduce constraints on the supply of beds 228
3. Re-examine reimbursement mechanisms 228
4. Form a special Task Force 231
5. State sponsored research on the cost-quality of care relationship 231
6. Evaluate the need for a profit ceiling 232

B. A Private-Pay Resident Converts to Medi-Cal: Cause for Eviction? 233

Findings:

1. Evictions have negative effects, and are potentially numerous 233
2. When facilities take on residents, they take on obligations . 234
3. Evictions are part of a broader Medi-Cal discrimination problem 235
4. The state has an obligation to ameliorate Medi-Cal discrimination 239

Recommendations:

1. Requirement that facilities reveal Medi-Cal policies in advance 239
2. Prohibition on transfer because of conversion to Medi-Cal . 239
3. Adequate mandatory bed-hold for hospitalized Medi-Cal residents 240
4. Statute prohibiting all forms of Medi-Cal discrimination . . 240

C. New Care Providers for Nursing Homes: The Geriatric Nurse Practitioner 241

Findings:

1. "Nursing" home does not mean nursing care 241
2. Physician services to residents are minimal, at best . . 242

Page

3. Geriatric nurse practitioners (NPs) are a needed provider . 243
4. Nurse practitioners: needed professionals caught in a "turf" battle 245

Recommendations:

1. Encourage the use of geriatric NPs in nursing homes . . 246
2. Nurse practitioners should be employed in nursing homes . 246
3. NP reimbursement rates should be a fixed percentage of physician rates 247
4. Develop incentives for facilities using geriatric NPs . . 247
5. Geriatric NPs must not be calculated as nursing staff . . 247

D. Nursing Hours and Standards: Bad Numbers for Bad Reasons 248

Findings:

1. Present standards for nursing hours are unsatisfactory. . 249
2. Changing the nursing hours standard has major consequences 250

Recommendations:

1. The present 2.8 standard must remain until improved . . 251
2. An improved standard must include resident acuity measures 252
3. LCD should immediately inspect all facilities below standard . 252
4. Change the formula for calculating nursing hours . . . 252

VIII. MATTERS WHICH NEED FURTHER INVESTIGATION . . 254

A. Should Legal Fees for Nursing Homes Be Considered a Medi-Cal Reimbursement Cost? 254

B. Does the Movement of LCD Staff into Industry Jobs Constitute a Conflict of Interest? 257

C. Can Incentives Be Developed For Providing Good Care? . . 259

D. What Happens When Care Providers Do Not Speak The Same Language as Residents? 262

E. What Precautions and Procedures Are Needed When A Facility Changes The Clientele It Serves? . . . 267

END NOTES 270

APPENDICES 282

APPENDICES

		Page
I-A	Nursing Home Study Advisory Committee	282
IV-A	Nature of "A" and "B" Violations Cited (LCD Chart)	283
IV-B	Complaint Data, 1st Quarter 1983 (LCD Chart)	284
IV-C	Sample Rating and Resident Satisfaction Scales (Iowa)	285
IV-D	Sample Interpretive/Procedural Guidelines (Michigan)	287
V-A	Summary of Violations and Appeals 1978--First Quarter 1983 (LCD Chart)	293
V-B	Details on Violations, Fines and Appeals	294
V-C	Fines and Appeals 1978-80 (LCD Chart)	296
V-D	Recommended Fines Under Current A-B-C System vs. A-B-C-D System	298
V-E	Report, Survey on Nursing Home Prosecutions, May 1983	299
V-F	Sample Guidelines, Referral to Local Prosecutors, (Los Angeles County)	314
V-G	Proposed Amendments to Receivership Law	316
V-H	Sample Guidelines, Issuance of Press Releases (Los Angeles County)	318
VII-A	Sample Medicaid Discrimination Statutes (Ohio)	320
CALIFORNIA ASSOCIATION OF HEALTH FACILITIES RESPONSE TO REPORT		322
ACKNOWLEDGEMENTS		328

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 INADEQUATE 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 Infrequency

Findings

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.

	CURRENT FINES	PROPOSED FINES
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 concises, 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 printouts, 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.

CHAPTER I

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

A. Introduction and Overview: Long-Term Care In California

Each day more than 105,000 Californians call one of the 1,170 long-term care facilities in the state their home. These are nursing home residents. Most of them are quite old; many are quite frail. Most of these residents are female and the great majority are English speaking Caucasians. For all but a very small percentage of these people, a nursing home is likely to be their last home.

The State of California has a special interest in these citizens for two key reasons. The first reason is our humanitarian responsibility to our fellow citizens: many nursing home residents have little functional autonomy; their physical and mental health status means that a large number of these persons are not well. Because they are frail they are also vulnerable: they must have quite basic needs taken care of by others entrusted with their care. Some estimates say that as many as 75% of nursing home residents have no visitors during an average month. Often these older Californians are, as one author puts it, "old, alone, and neglected."[1] The State has the obligation, through the Department of Health Services, to make as certain as possible that these persons are taken care of, and that they are well taken care of.

The second reason for a key State interest in nursing home residents is that more than 70% of them have exhausted their financial resources, be they personal or family. As such, they are recipients of Medi-Cal benefits. Medi-Cal presently pays the cost of care for approximately 78,500 of the 105,000 nursing home residents, the remainder are still able to be supported by private (e.g., personal or family) funds. The budgetary considerations for long-term care, and specifically Medi-Cal, are not insignificant: for the 1982-1983 fiscal year the State paid nursing homes between $36.08 and $39.45 per day (the rate varies by number of beds and by locale) to provide for the care of Medi-Cal residents. The costs, in the aggregate, are substantial: there are more than 35 million patient days per year in California's long-term care facilities, of these there are 25 million Medi-Cal patient days per year. The annual expenditure to Medi-Cal is more than $1 billion. Put another way, presently Medi-Cal is expending more than $2.5 million per day every day of the year to provide for the care of these impoverished nursing home residents.

Oversight for the quality of care of nursing home residents is largely the responsibility of the Department of Health Services, and, more specifically, the Licensing and Certification Division (LCD) of the Department. LCD is charged with assessing both whether nursing home facilities should be licensed to provide care in the state, and whether they should be certified to continue to participate in the Medicaid (Medi-Cal in California) program.

The attention of those concerned with conditions in nursing homes turns, appropriately, to the operations and administration of the LCD as well as to its relations with the nursing home industry and with the

public. In order to attempt to oversee the quality of the care within nursing homes, LCD maintains a staff of professionals who inspect nursing home facilities, both in response to complaints and in response to federal laws which call for periodic regular inspections.

The California Health Facilities Commission estimates that long-term care facility expense increased 38% from $1.2 billion in FY 1979-1980 to $1.7 billion in FY 1983-1984:

> In FY 1980-1981, the [California] long-term care industry as a whole demonstrated a net income of $47.6 million. Investor-owned facilities showed a net income of $51.7 million, not-for-profit facilities showed a net loss of $3.8 million and governmental facilities showed a loss of $367 thousand.[2]

Long-term care in California involves large State Medi-Cal outlays. It also involves more than $51 million in net income for proprietary facilities (in FY 1980-1981; these figures have increased). A long-term care enterprise generates a number of concerns for both the consumers of nursing home services and the State.

Administrative oversight of the huge and complex long-term care undertaking is largely accomplished by LCD which has a budget of $14.2 million for FY 1983-1984. This LCD budget--which has been cut back in the past two years--must provide survey staff for all 1,170 long-term care facilities and their 105,000 residents. In addition, it must provide some oversight services to another 1,500 health care facilities, such as hospitals, throughout the State. The task, by any manner of consideration, is a massive one.

Given the vulnerable condition of many nursing home residents, most of whom are elderly, and given the numbers of persons and numbers of dollars involved, it is entirely appropriate that the State has had a continuing interest in assessing the efficiency and effectiveness

of the system of caring for nursing home residents. It is true that long-term care is, as representatives of the nursing home industry regularly state, a significantly regulated undertaking. This is a reflection both of the need to be especially watchful with this population and of a historic and continuing need to create, maintain, and improve standards of care.

B. The Little Hoover Commission and Long-Term Care

The Commission takes the position that, far from being too highly regulated, the circumstances and conditions within nursing homes demand continuing attention in the form of legislative and regulatory oversight. This viewpoint is premised on the continuing concern that a number of long-term care facilities are substandard. The consequences of substandard care in nursing homes can be particularly devastating and tragic. Policies to improve oversight and regulatory activities must be regularly assessed and strengthened wherever needed. Conditions in nursing homes in California continue to raise genuine concerns about the health and safety of residents. While LCD and the long-term care industry may, as each claims, have come a long way in improving care, nonetheless there are many areas where substantial improvements remain to be made.

This study has been undertaken as a result of a Public Hearing held on October 27, 1982, by the Commission on California State Government Organization and Economy, which is also known as "The Little Hoover Commission." Testimony from an array of persons concerned with, or responsible for, long-term care in the State including the Director of the Department of Health Services, the Deputy Director for

the Division of Licensing and Certification, representatives from other interested State agencies, a number of family members of nursing home residents, and representatives of consumer and community groups was heard at our Commission's October hearing. Senior officials representing the nursing home industry also testified. Supporting documentation was submitted to the Commission by a number of persons who testified and a large amount of additional material was received from persons who could not be present at the hearing.

This report synthesizes the materials presented to the Commission at or in response to the October 1982 hearing. Shortly after the hearing Commission staff analyzed the testimony and supporting documents in order to ascertain the major areas of concern raised by the hearing. At the same time, the Commission appointed a blue ribbon Advisory Committee, Chaired by the Lieutenant Governor, to assist in the process of analyzing the central topic areas of the Public Hearing. The names of the members of the Advisory Committee are listed in Appendix I-A of this report.

The Advisory Committee met three times between January and June of 1983. In addition, the Advisory Committee divided into four Task Forces. The Task Force groups met at least three times each between January and June 1983 to develop White Papers for the Commission to be utilized for consideration of findings and recommendations presented in this Report. Each Task Force had representatives from the nursing home industry, consumer groups, and LCD, as well as other parties who brought particular interest and expertise to the Commission. In preparing White Papers, the four Task Force groups were asked to reflect their own analysis of the issues and not to reach consensus

where it did not exist. This report attempts, in its Findings and Recommendations, to account for those differences in points of view.

C. Methods Used For This Study

The Commission contracted with the senior author of this Report in January 1983. The Advisory Committee to the Commission was constituted so that it included representatives of consumer groups, State offices, the long-term care industry, and LCD. An additional group of people concerned with all or some of these issues were contacted. This second group included representatives from academia, other health professionals and other interested citizens. In addition, the authors of this report met with individual consumers and representatives from consumer groups, and made a number of contacts with persons and groups outside of the State who have expertise in one or more of the topic areas covered by the Report. There were also individual meetings with long-term care providers from the proprietary trade association, the California Association of Health Facilities (CAHF), as well as with the Deputy Director and some senior staff from LCD.

D. Objectives Of This Study and Report

The central objective of this report is to provide a detailed set of Findings and Recommendations which will reduce existing barriers to the effective enforcement of legislation and regulations designed to maintain and improve the quality of long-term care in California. Secondly, the study provides a detailed set of Findings and Recommendations intended to decrease the present poverty of information that surrounds almost all aspects of long-term care in California. Thirdly, the study analyzes

and makes Findings and Recommendations concerning a number of topics (including the present reimbursement system for long-term care) which address ways to improve care in a constrained fiscal environment. Finally, the study comments on a number of related matters which require further information and investigation before detailed Findings or Recommendations can be offered.

This Report seeks to provide the State with a detailed portrait of some of the major issues which are present when considering long-term care in California. Toward that end, we present Recommendations for possible legislative action, as well as for regulatory and administrative actions to be taken by the Department of Health Services and LCD.

This report seeks to provide the long-term care industry with an analysis of major issues which are of direct concern to the industry as well as the State: issues relating to the enforcement activities of LCD, to the need for information-sharing, and to ways in which we believe the industry can and should strive to improve care.

Finally, this report seeks to provide the public with an assessment of the major concerns and issues within the nursing home industry and its regulation by the State, and to make Recommendations for changes which we believe could make long-term care a more "open system" for consumers and the general public. Testimony before our Commission and at other public hearings has amply demonstrated over the past decade that larger segments of the public seek to know and understand more about the operation, administration, and regulation of the nursing home industry. While long-term care is business and while LCD is part of the State bureaucracy, the broad spectrum of long-term care is, finally and most importantly, persons seeking the information and

knowledge to make better personal and policy choices in order to care for themselves and their loved ones.

E. Brief Overview of Major Issues

The history of concern with long-term care in California--and throughout the country and at the federal level as well--reflects three significant phenomena:

- The nursing home industry is large and well-organized and made up almost wholly of proprietary providers.
- Consumers and the general public, as well as the State (LCD in particular) are not perceived as very powerful and are not very well organized.
- Responsibilities for the oversight of long-term care rest with LCD which is often bureaucratic, sometimes inconsistent, and always caught between a cohesive long-term care industry and often frustrated concerned citizens.

These disparities in power and organization have consequences in terms of both nursing home residents and long-term care regulatory policy. Present organizational and power relationships influence and determine policy in a manner that is not as open and equitable as is needed and possible. The Commission, through this report, will make Recommendations with the goal of bringing further cooperation and improved communication to the long-term care environment. Doing less than this would be to continue a set of circumstances which are too often inimical to nursing home residents and their families--and to the State and general public as well.

The Commission's 1982 hearing was its second examination of long-term care in general and LCD in particular. The first Commission Hearings were held in 1976-1977. In addition, the State Auditor General had also conducted studies of LCD, both in 1977 and in 1981-1982. In all four of these inquiries, in 1976-1977 and in 1982-1983, there have been a number of common major issues and themes:

- There is a lack of consistency in the LCD enforcement and survey process.
- There continue to be numerous reports of poor care, some of which have had tragic consequences for nursing home residents.
- The response time of LCD to investigate complaints is often in excess of the 10 working day period required by law.
- There are ongoing reports that the public in general, and the consumer groups concerned with nursing homes specifically, simply cannot get adequate information. This is true of information about the nursing home industry and about particular facilities. It is also of information from LCD. Both the long-term care industry and LCD counter these reports with statements that their best efforts are unrecognized and unappreciated.
- The number of concerns about long-term care facilities which are absentee-owned continues to increase. There are allegations that these facilities, often a part of chain operations, provide less humane care and, in the process, garner large profits.
- The long-term care industry continuously argues that, whatever faults may be found in the quality of nursing home care, they are largely the result of inadequate reimbursement by the State Medi-Cal program. The industry asks again and again whether it is

possible to provide good care with what they believe to be inadequate Medi-Cal reimbursement.

- Concerned officials and consumer groups, which have become somewhat more active in the past five years, continue to question the dominant role of proprietary nursing homes in the business of caring for the frail elderly. Allegations are made of unreasonable profits coupled with marginal or substandard care.
- There are ongoing allegations by nursing home staff, by residents, and by the families of residents of intimidation by some nursing home administrators and owners. These involve threats to fire staff or to evict residents because of complaints to the authorities. Furthermore, persons who have braved such intimidation repeatedly tell of poor treatment by officials to whom they reported.

Both LCD and the Department of Health Services have testified before the Commission that conditions in nursing homes have substantially improved. The Deputy Director of LCD believes the Division will continue to diligently enforce regulations which will lead to continual improvement. The long-term care industry makes a somewhat similar statement: it is admitted that there are some "bad apples" in the provider community, but the claim is made that they are now substantially fewer in number than in the past. Representatives of the long-term care industry state that, given low levels of Medi-Cal reimbursement, circumstances throughout the industry are generally good and are getting better.

In order to arrive at a balanced assessment of these issues and provide an accurate account of long-term care in California at this time,

we have sought to supplement hearing testimony and information with as many sources as possible.

CHAPTER II

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

This Chapter provides an overview of the long-term care environment in California. As any person seeking appropriate services for the elderly well knows, whatever else that environment may be, it is not organized in any rational way--whence the term "non-system" in the title above. Our focus here is mostly on organizations concerned with institutional long-term care in the State, that is, nursing homes.

The Chapter is divided into five brief sections: (A) a discussion of the emerging developments of various alternatives to institutionalization, (B) a description of the nursing home industry in the State, (C) a description of the State role in long-term care, specifically that of the Licensing and Certification Division (LCD) of the Department of Health Services, (D) a description of the role of the public and of public consumer groups specifically concerned with long-term care and the elderly, and (E) a description of the interactions and relations between the State, the nursing home industry, and the public. These are the key forces influencing long-term care in California.

A. Community-Based Long-Term Care and Alternatives to Institutionalization: An Overview

Only 5-6% of California's elderly reside in nursing homes at any one time. Most elderly people continue to live at home. However, the chances that an elder will spend some portion of his or (more likely) her life in a nursing home are about one in four, and those chances increase for persons over 75. Nationwide, the "typical" nursing home resident is an 82 year old, Caucasian, English-speaking female.

There are multiple problems with our present policy of over-relying on institutionalization for many elderly people. As Dr. Philip Weiler has observed:

> Long-term care is caught in a pincer movement. On the one side is the burgeoning needs of our steadily increasing number of elderly people, and on the other side is the escalating costs of care due to inflation coupled with shrinking resources to meet the demographic projections. In spite of the growing expenditures on long-term care--which amounted to over $20 billion [nationally] in 1980--the system is still inadequate, inflexible, and primarily directed toward nursing homes and the medical model of care. Community support systems and other options that keep the elderly out of hospitals and institutions are usually neglected. For example, costs of meals and housekeeping services are readily paid for institutionalized patients, but are usually not reimbursable for those at home who may be equally ill or incapacitated.
>
> These problems have led many to look toward alternative solutions, such as home health/homemaker services, adult day health care, and domiciliary care. Such options make sense from a number of standpoints...There is no place quite like home, and the current system, if not changed, will be overwhelmed by the year 2000 when there will be over 13.5 million persons over the age of 75 in the United States.[1]

In California these concerns have come together in the passage into law of the Torres-Felando Long-Term Care Reform Act (AB 2860), in September 1982 (Chapter 1453, State Statutes). This law is designed to promote a continuum of home, community-based, and institutional

care. The goal is to consolidate services so that a person would, ideally, be dealing with one large and coordinated system, rather than the present fragmented non-system. Section 3 of the Act summarizes the present situation:

> The Legislature finds and declares, that in this state, at least four different state agencies and 19 state governmental units at the department level administer 29 different categorical service programs for the elderly. Each categorical program has its own eligibility, needs, assessment criteria, and service coverage limitations. This non-system of long-term care has led to the ineffective use of resources and unnecessary premature institutionalization.

Essentially the goal of this law is to begin planning for the creation of a State Department of Aging and Long Term-Care which would be responsible for the coordination of all programs for the elderly, and for those "functionally impaired disabled individuals" whose chronic conditions require some form of long-term care. There is growing evidence that devising such a "continuum" of care would both prevent premature institutionalization, especially to nursing homes, and be cost-effective. Such alternatives to nursing homes are premised on the belief that personal dignity and autonomy are better and more easily preserved outside of institutional settings.

There have been a small number of alternative programs in the State for the past few years, most notably the Multipurpose Senior Services Program and, more recently, some Adult Day Health Centers. The proprietary health sector is watching these developments with interest, both for what they may mean as potential competition for nursing homes and for the potential new markets that they may represent. Several major proprietary health services organizations are already providing home health care services. AB 1138 (1983), spon-

sored by the proprietary nursing home trade association, the California Association of Health Facilities (CAHF), carried by Assemblyman Felando, would provide for "pilot projects" in which proprietary nursing homes could operate Adult Day Health Centers. The long-term care industry would like to see such Centers operate inside existing nursing homes. Significant consumer group opposition has formed, fearing, as a Gray Panthers statement puts this matter:

> If the same business entity runs both a nursing [home] facility and an Adult Day Health Center program, inevitably there will be a built-in conflict of interest. It will be in the operator's interest to have the ADHC participants move into the nursing [home] facility, with its higher reimbursement rate.

The nursing home industry is also concerned that its market will be affected by two additional factors: the number of empty hospital beds in the State and the (presently very slow) growth of programs for community-based long-term care. The proprietary trade association, CAHF, already talks of the nursing home market "softening" in some areas of the State. Given that nursing home occupancy rates average more than 94% in facilities Statewide, and that there are long waiting lists in many areas, these concerns appear, at best, questionable.

At the present time the Long-Term Care Reform Act is essentially a law calling for <u>planning</u> to set in place a continuum of care. Very little action has been taken by the State to begin to implement the planning called for in the new law. In the meantime, interested consumers are turned away from the few community-based efforts: there are growing waiting lists <u>there</u> too.

It may be that community-based long-term care services offering a broad continuum of health and social services <u>is</u> an idea whose time has come in California. But, for the present, it is little more than a newly

passed law, some pilot programs, and potentially large numbers of consumers who could, but are not presently able to, benefit from such services. This being the case, long-term care in California still is largely defined as nursing home care.

B. The Long-Term Care Industry in California

There are approximately 1,170 long-term care facilities in California. For Fiscal Year 1980-1981, 86% of these facilities were proprietary, and 88% of the 105,143 total long-term care beds were in those proprietary facilities. There were 35,307,849 patient days in FY 1980-1981. Medi-Cal paid for 25 million of the patient days, 71.2% of the total. Medicare paid for only 2.3% of the patient days; the remaining patient days (26.6%) were paid for with private funds. This data, like most of the useful quantitative information about long-term care in the State, comes from the annual Economic Criteria for Health Planning reports published by the California Health Facilities Commission.

Many of the nursing homes in the state provide good care with income from private-pay residents and the reimbursement from Medi-Cal they get from the State. These good facilities work hard to provide an atmosphere that, while it can never be quite "like home," nonetheless is clean, provides good personal care and nutritious food, and has employees who are obviously dedicated to working with the elderly. The work is often not easy: many of the residents of nursing homes can be quite demanding in terms of their needs, and most are unable to provide much for themselves.

This report discusses in Chapters IV and V the citation and fine system which, as part of the regulatory system, seeks to maintain care

that is free from health or safety risks for nursing home residents. The number of citations issued in the past five years has been steadily declining and both the industry and LCD state that the cause is better conditions in most long-term care facilities.

Data supplied by the California Health Facilities Commission indicate that 60% of all the long-term care facilities in the State have no "A" of "B" citations given them in a year. Fully 90% of the facilities in the State receive no "A" citations in a year. "B" citations relate to the "health, safety, or security of residents," and "A" citations, the most serious citation, relate to "imminent danger that death or physical harm would result." While there are a large number of California nursing homes that are free of "A" or "B" citations, there are doubtlessly multiple reasons that could be given for the decline in the number of citations that are being issued. (This issue is discussed in detail in Chapter V, Section A.)

There are facilities in the State that provide far better than an "acceptable" level of care. Often, but by no means always, these are facilities in which higher fees are charged for care and the number of Medi-Cal residents is small or none. But it is also the case that virtually every area of the State has nursing homes with fine reputations and included among these are facilities with significant numbers of Medi-Cal residents.

If long-term care is a business, it is also a developing profession. More and more nursing home administrators have received training, as well as continuing education, in long-term care. Training and in-service programs have also been developed for nurse assistants to meet their new State certification requirements. Many of these education and

training programs represent genuine efforts on the part of the long-term care community to continue the development of its members in skills necessary for, and sometimes unique to, working with the long-term care resident.

Given difficult working conditions, and the attitudes of some in our society toward the elderly and nursing homes, it is clear that some of the ill-will that is "splashed" on nursing homes in general needs to be concentrated into a "stream" more carefully aimed at bad facilities. Good facilities, their staffs, owners and administrators do need more understanding and appreciation for the efforts they make.

However, there are continuing problems in nursing homes. If "only" 10% of facilities get "A" citations, that means over 100 of them have been cited for circumstances which posed "imminent danger" of death or physical harm to at least one resident. If 60% received no "B" citations, that means 40%--or more than 400 facilities--were cited for circumstances that were harmful to the health or safety of their residents. In short, while we may have come some distance in providing better care, we still have a great distance to travel to improve the overall conditions for all nursing home residents.

Most of the 1,000 proprietary facilities in the State are members of a trade association, the California Association of Health Facilities (CAHF). CAHF offices in Sacramento, Los Angeles, and San Diego represent the best interests of the proprietary long-term care industry in matters of legislation, regulation, reimbursement, community and public relations. The organization publishes a weekly newsletter containing a legislative section on current bills which CAHF supports or opposes. CAHF members are encouraged to participate in various

programs developed by the national association of proprietary nursing homes (American Health Care Association), such as "Quest for Quality," a program to provide peer review and quality assurance.

CAHF works to develop professionalism among long-term care providers in the State. They are regularly consulted by LCD concerning the implementation of nursing home regulations. They have developed a data base in the Sacramento office that is more current (and may be more accurate in some areas) than some of the data available from the State, specifically that from LCD.

CAHF does sponsor educational programs for its members, though information on the number and topics of such programs was not available when this report was written. They also sponsor quarterly meetings of the membership to discuss current topics of (often legislative) importance. Guest speakers at such meetings have included many of the top State officials in the area of health care.

In addition to representing facilities' interests with LCD, the organization annually sponsors a range of bills in the California legislature. Two examples in the present session are a bill that would permit a new care provider, the Nurse Practitioner, to work as an "independent provider" in nursing homes and a bill that would reduce the ability of the California Health Facilities Commission to collect and maintain information on long-term care "standards of effectiveness," such as staffing patterns and such measures of "profitability" as now exist. (See Chapter VII for more detailed discussion of costs and profits, and Table VII-1 for some "effectiveness criteria" data). These two different bills represent a small portion of the legislative concerns of the nursing home industry.

The fastest growing sector of the proprietary nursing home industry undoubtedly are the chains. CAHF operationally defines a chain as an individual or corporate group with control of facilities with 1,000 or more beds. Using this definition CAHF estimates that there are 15 chains in the State. They own or lease approximately 40,000 of the 105,000 nursing home beds in the State, almost 40%. Almost all of the chains are absentee-owned, and most are held, at least in part, by stockholders. Most nursing home chains are considered active "growth" stocks.

The non-profit facilities in the State also have a professional trade association, the California Association of Homes for the Aged (CAHA). CAHA maintains one office in Sacramento with eight staff members. The organization sponsors about five educational programs for nursing home administrators per year and they provide some legislative update material in their membership newsletter. Their membership varies between 220 and 240 facilities. (Thus, virtually all nursing homes in California belong to either CAHF or CAHA.)

There has traditionally been a degree of organizational distance between the California Association of Homes for the Aged and the California Association of Health Facilities. The non-profit homes see themselves as fundamentally different than the proprietary facilities. As Bruce Vladeck and other well-known analysts of the long-term care industry have pointed out, there may be some differences in overall quality between the profit and non-profit facilities and, <u>generally</u>, non-profit facilities are thought to be better. But, like most generalities, this one breaks down in specific cases.

The non-profit sector of the nursing home industry deserves careful attention, even though it is smaller than the proprietary sector. Just as the chain phenomenon bears examination in the for-profit sector, it may also become an important concern in the non-profit sector. At least one California non-profit health care corporation has purchased several non-profit nursing homes, then taken the net income (or "surplus," in non-profit language) from these facilities and given it to the non-profit hospital of the parent corporation. (For a discussion of this phenomenon, and some case data, see Chapter VII and Table VII-1 Section A).

C. The Licensing and Certification Division of the State Department of Health Services

LCD is the regulatory agency for the 1,170 long-term care facilities in the State. While the Division has multiple other functions and must monitor almost all health-related facilities in one capacity or another, much of the LCD effort is devoted to the inspection of nursing homes and to responding to complaints about conditions in nursing homes. The task is large and the task is complex. The LCD seeks to effectively monitor the care of 105,000 elderly nursing home residents. Sometimes it does this well, with thoughtfulness and professional skill, and sometimes it fails to the point that everyone gets frustrated and little or nothing gets accomplished for anyone.

The LCD licensing Procedure Manual contains this statement of "Objectives of Licensing and Certification Division":

> The goal of the LCD is to ensure quality health care services to each patient throughout the state through enforcement of regulations regardless of patients economic status, race, age or sex. To accomplish this goal the Division develops and

> establishes standards for services to be provided by facilities. The Division utilizes professionals in all health disciplines. Standards developed by the Department are in a continual state of refinement based upon the latest scientific, professional, and humanistic knowledge and experience. The Department continually informs the public and providers of current quality of care standards.[2]

LCD became a key office for matters concerning long-term care in 1973, when two important events took place:

- AB 1600, sponsored by Assemblyman Leo McCarthy, was passed and became The Long-Term Care, Health, Safety and Security Act (Chapter 1057, State Statutes). This bill was responsible for creating the system of nursing home regulation, citations, violations and fines which we have today. The law lays out basic definitions for life-threatening ("A") violations and for health, safety, and security ("B") violations.
- The Departments of Public Health, Mental Hygiene, Social Welfare, and Health Care Services were consolidated into the new State Department of Health. Previously separate licensing programs were also consolidated. Subsequent reorganizations took place in 1978, creating the present Department of Health Services, but these have not effected the function of LCD in significant ways.

Thus, since 1973, LCD has become the "arm" of long-term care regulation in the State. It is LCD employees who survey (inspect) nursing homes, and it is LCD employees who respond to complaints about those facilities. Section 1436 of Assemblyman McCarthy's law calls for "ongoing training for inspectors charged with implementing" the new law. (See Chapter III, for Findings and Recommendations concerning the present inadequate training programs for LCD inspectors.)

LCD must, as its basic objective and goal, "ensure quality health care services to each patient throughout the state" by being attentive to the needs of residents, any complaints of the behalf of consumers, and the concerns of the long-term care providers. To accomplish these tasks LCD spent about $14 million in Fiscal Year 1982-1983. The LCD budget is made up of funds from the State General Fund as well as from the Federal government. At the present time, no licensing fees are being collected from long-term care facilities by LCD, pending outcome of a court case brought by the industry.

The LCD budget was reduced by more than $1 million due to Federal cut-backs in the past two fiscal years and this, in turn, resulted in the loss of 59.5 positions. Statewide LCD staff has been reduced from 378 to 318.5 during this period, a loss of 16%. In the summer of 1983 the State was informed that the Federal government was willing to increase the LCD budget by $1.7 million for the present Federal fiscal year and that the new $1.7 million would be added to the LCD budget in future federal allocations. Since the federal fiscal year, which runs from October 1 to September 30, is different than the State fiscal year, which runs from July 1 to June 30, this means that, if the State Department of Finance approves of this expenditure, LCD will have to expend $1.7 million new federal dollars in less than 90 days (between mid-July and September 30, 1983)! In the next federal fiscal year the $1.7 million will be built in and, assumedly, will be spent in a more rational way over the full year. If the State Department of Finance approves expending $1.7 million federal dollars, LCD proposes to step up survey activity which had been slowed due to cut-backs.

LCD staff totals 227.5 full-time positions in five district offices, four district sub offices, and headquarters in Sacramento. In addition, all LCD activities for Los Angeles County are undertaken by a contract with the Health Department of Los Angeles County. The Los Angeles operation has a staff of 91, bringing the total LCD staff to 318.5. When speaking of LCD, one generally calls it "the State." Yet the fact that the Los Angeles County program is an almost functionally separate entity leads to some confusion when one attempts to analyze both data and testimony about LCD. This arrangement has been one of concern to at least the past three Deputy Directors of the Division. Each has stated that they intended to make relations between the Los Angeles County LCD operation and all other LCD operations more functionally close.

Los Angeles County has 33% of the State's long-term care facilities, almost five times more than the second-ranked county (Alameda County, with 7%). The LCD office in Los Angeles is directed by a capable career civil servant who has the advantages of some autonomy and a good deal of bureaucratic wisdom and longevity. In our view there are real advantages to the present arrangement and we would hope that it not be seriously challenged for reasons that are more related to organization charts than to effective enforcement and monitoring. The Los Angeles County LCD office, for example, handles approximately 2,000 complaints annually about long-term care facilities. This is about 65% of the State total. That office also has an information system, publicity guidelines, and a number of other useful programs in place which can be prototypes for statewide LCD use, and which we discuss elsewhere in this Report.

The Deputy Director of LCD (until she was replaced on June 30, 1983) has been an active member of the Advisory Committee for this Commission. She and her staff have been most cooperative in answering a large number of requests for further information concerning the regulations and guidelines of LCD. As discussed elsewhere in this report, much of the data received from LCD was difficult to analyze and replies to virtually every one of our multiple requests had to be individually compiled by the Division. LCD knows that its data-gathering and data-analysis capabilities are severely limited and has proposed a new management information system to help with these difficulties. In Chapter VI we discuss our concerns that the proposed new system will immensely improve management information but that it makes no provision for public information-sharing.

D. The Public and Consumer Groups

We have chosen in this Section to treat both the general public and consumer groups together. This is done because not only are consumer groups part of the general public, but they are often virtually the only way that the general public is either heard from or gets information about long-term care.

Some nursing homes actively encourage public involvement in their facilities. It is not uncommon to hear nursing home operators speak of the "apathetic public" whom they cannot get interested in long-term care issues or in visiting nursing homes. This mood may be less "apathy" and more a combination of dismay and fear. In any event, it is true that the largest numbers of the "general public" do not know much about long-term care in general, and often do not take whatever

opportunities may be present to become more knowledgeable and involved. On the other hand, there remain nursing homes in which the administrator has not encouraged such public knowledge and participation. This seems to be the case in those not infrequent situations where the facility does not want to be on public view and where facility resistance and public fear combine to produce increased isolation for nursing home residents.

The Commission's Public Hearings in 1976-1977 and 1982 received testimony from representatives of consumer groups and from individual family members of nursing home residents. Given that many "consumers" of long-term care are frail or debilitated, they are not often heard in debates about long-term care. The debates are about them, but often their interests and wishes must be represented by others.[3] In these hearings the interests of nursing home residents are voiced primarily by consumer groups, and by staff and volunteers from the Long-Term Care Ombudsman program, who spend countless hours in nursing homes mediating and resolving problems for and between residents, facility administrators and other employees.

While both the nursing home industry and LCD perceive the general public as apathetic about nursing home issues, they are occasionally troubled by what they call "the groups." Consumer advocacy groups, deeply committed to nursing home reform, spend long hours coming to know the LCD regulations. They correspond with LCD, asking for explanations of, or changes in, the regulations because of actions which they believe to be inimical to the rights or needs of nursing home residents. Though their numbers are small, consumer advocates do influence both LCD and the industry. They accomplish a great deal

with a great deal of energy and little or no money. Their tone varies from the reasonable to the aggressively confrontational. They believe themselves to be caught in an important battle where they, as David, are engaged with two powerful and often-elusive Goliaths, the industry and LCD. Having very few resources, these groups tend to be loosely organized: they are more an informal working network than a formally functioning coalition. They are invaluable, concerned critics of nursing home operations and of some LCD policies and regulations.

The closest the consumer groups come to having formal representation is the federally mandated, and federally and State funded, nursing home Ombudsman Program. With headquarters in the Department of Aging in Sacramento, this program operates with a very small paid staff in thirty-two California counties. Staff provide training and minimal support services to the volunteers who serve as Ombudsmen in long-term care facilities. As the name implies, the Ombudsmen are not, strictly speaking, an "advocate" group at all: they serve as a conduit, as facilitators and mediators, between the "inside" world of the nursing home resident and the "outside" world of the long-term care industry, LCD regulations and surveyors, and the community.

One would think that the Ombudsman Program would be a vital and leading part of the "aging network," which includes such programs as Meals on Wheels, the efforts of the Area Agencies on Aging, and others. But this is more true in rhetoric than in fact. In the 1982-1983 legislative session the Ombudsman Program came close to losing a substantial portion of its State funding because, in part, of interagency in-fighting. This was the result of the focus of the Department of Aging primarily on issues of concern to the elderly outside of

institutional long-term care. In some ways one can understand this: only 5-6% of older Californians are in long-term care facilities at any one time and there are great and pressing needs, especially in this time of budget cutbacks, within many human service programs. And yet, one would have hoped that there might have been some coming together around the budget request of the Ombudsman program, rather than a budget and "turf" battle.

At the national level, the association of the proprietary long-term care trade associations (the American Health Care Association) is considering going before Congress to attempt to get the national mandate for the Ombudsman Program restricted. This has not happened in California, where an attempt has been made to build a working relationship between the Ombudsman Program and CAHF and CAHA. However, local ombudsmen across the State are more aware than any other group of the "bureaucracy of care." Seeking to work with local LCD staff, on the one hand, and local long-term care facility administrators on the other, nursing home ombudsmen sometimes get little understanding or cooperation from either and find themselves, with the resident (or family), "caught in the middle."

The general public's involvement with long-term care is more disorganized, more frustrated, and less actively concerned than the consumer groups. Representatives of the public who testified at the Commission hearing were citizens who had become frustrated and/or concerned as a result of the treatment received by a family member or friend in a nursing home. These are not people who are active in consumer or advocate groups, but rather those who visit facilities to be with a loved one. Their letters of complaint are poignant, bitter, and

tell of lengthly attempts to resolve a particular situation with a long-term care facility. They have entered the bureaucratic maze and gotten nowhere, while a resident is not treated well and, in too many cases, deteriorates or dies. This happens while the frustrated family member tries to figure out how to correct a situation in which they, like the resident, are increasingly powerless.

The Commission received a number of letters from such persons who, knowing of the Public Hearing held in 1982, wrote to us asking that an incident or circumstance be rectified. Such letters, often in the form of complaints, usually and eventually reach LCD. However, LCD's complaint investigation process, as the 1982 Auditor General's Report makes clear, is far from consistent and frequently does not yield active and satisfying outcomes for the persons who write. (See Chapter IV, Section C.)

We know little about members of the public who do not testify, do not write, and do not regularly visit a nursing home. Occasionally they will call a consumer group, if they know of one, and state their concerns. That group, in turn, will assist them in reporting a complaint to LCD or in getting access to relevant information. However, we suspect that there are all too many instances where members of the public never take this step.

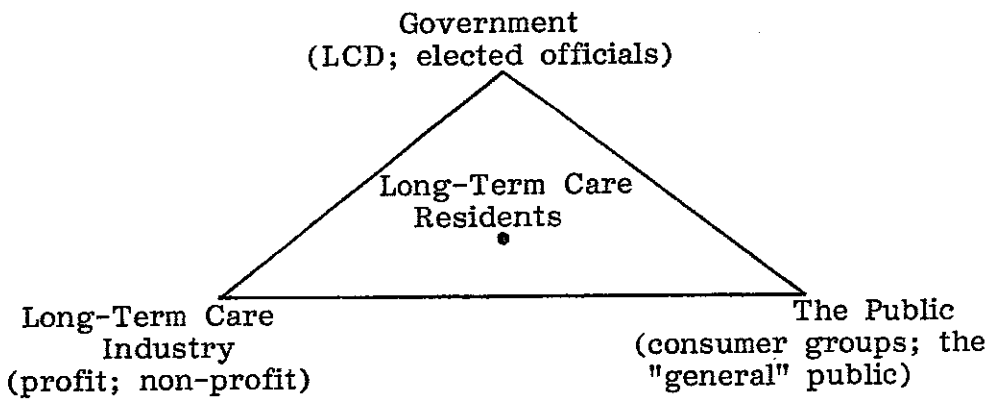
The general public, as we noted in Section A, <u>does</u> seem to have a growing awareness that there are alternatives to institutionalization for those persons who, with some assistance, can continue to remain at home. Public reaction to such programs has government policy planners concerned because of what they call "excess demand." That is, <u>if</u> such

programs are more broadly available they would be wanted and used by large numbers of persons, which may involve high government costs.

For the public, then, the question "What shall we do about Grandma?," still has not been adequately addressed or answered.

E. The Long-Term Care Triangle: Interactions in the Present Non-System

We visualize the present long-term care environment as a triangle:



The triangle is one way to represent the array of forces that influence long-term care, an environment which has, or ought to have, the resident at its center. The discussion in this chapter suggests that this drawing is inaccurate insofar as it represents the triangle as having three equal sides. This is not so: the leverage, the power, and the choices that the public has are distinctly less than the leverage, power and choices of government and the industry. The public is information-poor, choice-deprived, and often feels as if it has little input into the on-going process that takes place between the industry and the government, specifically LCD. This makes the triangle "lopsided," fragile, and distorted. An equilateral triangle represents what ought to be; it does not accurately represent what is.

As a consequence of present imbalances in the long-term care environment, there is a need to build into the triangle supports which create and maintain an equal balance. Toward that end, much of the remainder of this report focuses on two issues: improving the regulation of nursing homes, and increasing power, via knowledge and information, for the public. If these two things are not done, relationships between long-term care providers and long-term care regulators will, in effect, more and more exclude the consumer. Such a policy of de facto exclusion of the public and of the nursing home resident, limits, rather than expands, the type and quality of choices that a consumer may have. This means that long-term care would be provided and regulated exclusively by "professionals." That very professionalization has, in part, brought about the present non-system--the present bureaucracy of care.

CHAPTER III

BARRIERS TO MORE EFFECTIVE ENFORCEMENT IN LCD: INCONSISTENT ROLE DEFINITION AND INADEQUATE TRAINING

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

Findings

1. LCD's regulatory posture lacks consistency.

LCD is charged with the responsibility of regulating quality of care and quality of life in all long-term care health facilities in California. Over the years, a philosophical "tug-of-war" has existed over whether this function is best accomplished by adopting a consultant role vis-a-vis nursing homes or by adopting an adversarial enforcement role. In recent years, there have been perceptions that both extremes, at times, have dominated LCD. As operating philosophies, both extremes are counterproductive in maximizing quality assurance.

LCD has not identified, in clear terms, how these two conflicting perspectives of their role should be reconciled. There is a perception, on the one hand, that individual inspector teams at times arbitrarily operate at either or both extremes of the confrontation-consultation continuum and, on the other, that the role defined by the administration of LCD shifts with the political winds.

The Commission recognizes that many LCD staff members are dedicated professionals. In dealing with very difficult and demanding circumstances, the LCD inspectors deserve and require clear and consistent written regulations and guidelines. They also deserve the assurance that, in following regulations and guidelines, they and their work will be insulated from the political fluctuations of the moment.

2. LCD's direct responsibility to residents needs operational clarity.

While it is appropriate for inspectors to recognize the practical impact or hardship on providers caused by alternative courses of action, there should be no equivocation as to whose interests should prevail, when such considerations conflict with the best interests of residents. There is a perception that some LCD communications reflect an interest in maintaining "friendly relations" with providers, and this has, at times, clouded the Division's fundamental commitment to residents. This needs to be avoided.

3. LCD's relations with the industry appear ambiguous.

LCD maintains frequent contact with long-term care industry organizations. LCD regularly consults with the industry regarding the formulation and implementation of policies and procedures governing nursing home regulation. While this is necessary and appropriate to some extent, it is in the best interest of the residents, the industry, and of the LCD administration and inspectors that the Division maintain a professional arms-length relationship with facilities. Both the reality and the appearance of excess congeniality impair the credibility and effectiveness of inspectors. Conversely, the reality and appearance of

overly hostile or adversarial encounters with facilities may also impair the credibility and effectiveness of inspectors in obtaining corrective action.

Inspectors must be clear and comfortable in their multi-faceted role based on the primacy of their obligation to safeguard residents' interests. They must know that they will be judged on their professional performance and not on whether the outcome comports with shifting political sentiments within the State or LCD (i.e., sentiments resulting either from a need to maintain a friendly rapport with the industry, or to portray itself as being "tough" on enforcement issues.)

4. LCD maintains no systematic relations with consumers.

No ongoing contact is maintained with public representatives or with consumer advocates that is comparable to that with the industry. This failure deprives the LCD administration of a needed balance in perspective for policy and regulation development. It also raises fears among consumer groups that LCD decisions lack consideration of public concerns. Very recently LCD initiated some formal meetings with consumer groups, but more is needed.

5. Enforcement is hampered by staffing shortages.

The LCD enforcement process is hampered by lack of professional staff. In the past two years LCD has been forced to reduce the number of its regional offices, and has reduced the number of its staff, largely as a consequence of Federal cutbacks to the State's health programs. These cutbacks to LCD staff are counter-productive: information systems and amendments to regulations are not very useful

unless there are persons out in facilities observing them whenever there is a need. LCD has seen its responsibilities grow year by year, yet its professional staff has shrunk. This makes no sense, in terms of quality-control, enforcement, or, ultimately, in cost savings to the entire long-term care system. LCD staffing cutbacks mean that more has to be done with fewer people and, in nursing homes, the consequences of that are either unwise or tragic. It is clear that problems of role clarity and consistency cannot be resolved when there is insufficient staff to do the job.

The absence of adequate LCD staff has the following adverse consequences, in the opinion of the Commission:

- It assures the predictability of inspection timing.
- Insufficient time is available to work out meaningful plans of correction with facilities.
- Without sufficient staff it is unlikely that LCD can effectively implement its dual role as enforcer and consultant, resolving complaints with advice and suggestions where appropriate.
- There is insufficient time for effective training.
- There is insufficient time for the burdens of litigation undertaken in cooperation with the Department of Justice, local district attorneys and city prosecutors.
- There is insufficient staff for repeated inspections in problem facilities to permit regular monitoring and evidence accumulation.

Recommendations

1. LCD's role must clearly emphasize enforcement

The role of LCD must be identified in clear, functional and consistent terms to all audiences, whatever their interest. The statement of role must identify the manner in which LCD staff should relate to residents, facilities and the industry, the public and consumer groups, other agencies, and law enforcement. In the interest of the nursing home resident, enforcement should be clearly identified as the primary LCD mandate. Consultation should be viewed as a distinctly important and always secondary role.

2. Clear public statements must stress protection of residents

LCD should prepare and provide public statements, written in unqualified terms, stating that its overriding mission is to protect the interests of long-term care residents.

3. Consistent use of three ordered enforcement methods

The LCD's role in securing corrective action or in securing changes in practices or behaviors should be defined as including three ordered steps to be utilized as necessary:

- Negotiating the means of compliance
- Demanding compliance
- Litigating to ensure compliance

When regulations are violated, deficiencies and citations must be issued as required by law. However, just as the legal sanctions for violations vary partly according to the facility's responsiveness, the approach taken in order to secure responsive action should vary.

Conferring about the means and the timing of corrections is always the first step. If the response is unsatisfactory, a more insistent posture is needed. For example, assessed fines would be higher and it would be made clear that LCD is ready to use stronger measures if the problem remains unresolved. Finally, with continuing or repeat violators, LCD must actually invoke those stronger remedies, backed with vigorous court prosecutions where necessary. Chapter V discusses LCD's enforcement options in detail.

4. Establish a balanced Advisory Committee

LCD should form a balanced Advisory Committee with representatives from the nursing home industry and resident and/or consumer groups to meet bi-monthly to assure ongoing communication between all participants.

5. Ongoing outreach and consultation with consumer groups

LCD must seek out and maintain contact and consultation with interested citizens, residents, advocates, and consumer groups throughout the state.

The Department regularly conducts "rap sessions" with providers in various parts of the state. Representatives of the Long-Term Care Ombudsman Program and other consumer advocates should always be invited and encouraged to attend these sessions.

6. Provide funds to increase LCD staff

Staffing cutbacks in LCD do not serve the State's best interest. As aware as we are of the fiscal constraints that are present in the

State budget, we recommend immediately providing funds for additional professional positions that have been lost to LCD as a consequence of Federal cutbacks. The exact increase should be based upon a thorough staffing analysis. Corresponding increases need to be supplied in travel and support personnel. Without these vital replacements LCD will only be fighting a battle of attrition with its staff and budget. The ultimate "loser" in such a battle is the nursing home resident.

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

As was discussed in the preceding section, much needs to be done to make sure that LCD clearly articulates its role, objectives, and philosophy. The nursing home industry and the public alike have often been confused by what they see as inconsistent actions taken by LCD. The LCD task and role is a difficult one, inevitably requiring the use of personal judgment and professional interpretation of complex regulations and guidelines. This role becomes even more difficult when the training of LCD staff is inadequate.

Findings

1. Training and monitoring are scattered or nonexistent.

To combat inconsistency in complaint procedures and in application of standards for issuing citations and assessing fines, the Auditor General in 1982 stressed the need for improved LCD staff training and self-monitoring. Official responses so far, apart from the proposed computerized Management Information System (see Chapter VI) have

provided very little detail on how these improvements are going to be carried out. Further, extreme limitations on staff time and resources make major sustained efforts unlikely.

Training--Some improvements, but more needed: Federal training on application of federal standards consists of a basic course given in Baltimore (received by 79 out of 99 inspectors as of March 1983). There are also intermittent classes on particular subject areas. Although they continue to be offered and all expenses are paid by federal funds, LCD reports that it has been unable to obtain permission to send inspectors to these out-of-state sessions. For example, California inspectors recently missed a federal program in Seattle on subjects which had been identified as particular problem areas, such as rehabilitative and restorative nursing, dietary staffing, infection control, quality indicators for nursing and dietary, and patient care plans.

Training on application of state standards has been minimal in the past. This is not surprising in view of the fact that LCD's annual training budget runs around $54,000, or about 0.4 percent of its entire budget. This equates to only $140 per professional staff person per year. For the most part, training is done by supervisors, using didactic teaching, reading, observing, discussion, planning, "buddy system," etc., and informal "rap sessions" at district offices. It is the perception of the Commission that reliance on the "buddy system" tends to perpetuate the good and the bad habits, methods, biases, etc., of the training inspector (although no study has been conducted to validate this perception).

No standard "hand-outs" are used in training, which apparently is based only on the regulations and interpretive guidelines. It takes

about a year for a new inspector to become competent in all aspects of the job.

Only recently, due to efforts by the Sacramento district office, has this training begun to be more systematized. Portions of the Sacramento draft program seen by the commission deal with orientation rather than with conduct of inspections, but the approach seems promising.

The first formal training since 1979 on how to write and document citations was given in late 1982 by the Attorney General and Department of Health Services legal staff. Other than a brief agenda and a one and a half page handout of suggestions, no written description was available of its content or teaching techniques. In May 1983 a major federally-funded statewide training program was held. When asked to supply the curriculum, LCD sent only the agenda. Thus, the Commission is unable to evaluate that training at this time.

Recently, the California Association of Health Facilities and LCD conducted joint training on the new 1982 State regulations, to which ombudsmen were also invited. This represents a new trend. It has been hailed for its contribution to mutual understanding and efficient use of resources, but also criticized because of the impression it conveys to some outsiders that participants are becoming too "friendly" to properly perform their separate roles under the regulatory system.

Training also involves the problem of affordability. Without special funding, training programs, which may be less costly for some, may still be too expensive for others. Those most likely to be left out are consumers and volunteer ombudsmen. It is essential that these groups participate in long-term care training programs.

Less expensive LCD-sponsored informal local "rap sessions" which have been held primarily with industry, LCD inspectors, supervisors, and the Deputy Director can help minimize this effect. However, as mentioned earlier, consumer groups and interested citizens are not systematically encouraged to attend these sessions. When this discrepancy is corrected, "rap sessions" will in no way take the place of formal training, but they will offer opportunities for improved understanding, communication, and cooperation.

Commission Advisory Committee participants all agreed that, to assure consistency, it was essential to have a carefully designed variety of training sessions and to schedule these on a regular and frequent basis. But the Auditor General found that no continuous provision for training new staff or for regular refresher courses existed.[1] Despite the recent moderate increases in training activity, real limitations on funding and staff time (see Chapter II) indicate that only with the most determined continuing efforts to create innovative opportunities can LCD hope to achieve the kind of professionally designed and routinely implemented complete training system it needs.

Monitoring--too soon to tell: The Auditor General found that, except for Los Angeles County's independent operation, there were inadequate procedures for gathering objective information about and routinely assessing the consistency and quality of district office performance.[2] The recommendation was that LCD determine its information needs, establish a system for obtaining the information, and implement procedures for using the information to assess performance.

LCD's 120-day response to the Auditor General's report stated that the Field Operations Branch Chief is "monitoring" handling of

complaints, citations, and fines. A Program Review Team was being established to submit an overall analysis, to be implemented within six months from the time it is submitted. LCD also reported that headquarters monitors a variety of reports on number and timing of complaint investigations, A and B citations, fines assessed and collected, referrals, etc. However, these are the same reports which the Auditor General found inadequate.[3]

Our Commission found that the Department does not now review the quality of field notes or other documentation in evaluating the performance of inspectors. Nor is the quality of the plans of correction secured by inspectors specifically reviewed as part of the performance evaluation process. However, supervisory personnel do accompany inspectors on inspections on occasion to evaluate performance.

No matter how well focused the Department's objectives and no matter how well designed and implemented its training procedures, achievement of its objectives can only be assured through effective supervision, control and accountability of inspector staff.

LCD has begun to produce profiles to identify trends in inspection findings by facility or by inspector, but major reliance for improved monitoring is being placed on the computerized information system discussed in Chapter VI.

Recommendations

1. Statewide, uniform training programs for inspectors

Any effort to infuse consistency and reliability into inspector services must include a statewide training program. The Commission strongly recommends, as a high priority, that the LCD develop an

internal group of its most capable staff to organize and administer such a comprehensive training program. This group should be assisted by representatives of consumers and the nursing home industry where appropriate, and by the Departments of Education and Justice. Final responsibility must reside with LCD. The Los Angeles County training program should be carefully examined as a possible model from which to develop a statewide program.

2. Regularly repeated training designed to achieve LCD performance objectives

Recommendations on training emphasize above all the need to calendar constant repetition of training programs. The programs themselves must be designed specifically to implement and achieve clearly stated performance objectives for both inspectors and their supervisors. They should include:

- relationship to the resident, staff, and public--developing awareness of sensitivities and eliminating excessive congeniality and hostility,
- specific inspection techniques and standards, including standards of performance for inspectors,
- writing of deficiencies and citations,
- methods and standards for supportive documentation,
- securing meaningful correction plans,
- the operation of health facilities, including techniques of supervision, control of facility staff, etc. to assist in such compliance consultation as can be given to facilities,

- problem resolution techniques--including the appropriate use of (i) negotiating the means of compliance, (ii) demanding compliance, and (iii) litigating to ensure compliance,
- additional training for supervisors, including management and monitoring skills, penalty assessment principles, and (for those who handle citation review conferences) additional intensive training on regulations, citation criteria, how to weigh evidence and how to conduct conferences.

3. Encourage cooperative training programs with consumer participation

Formalized mechanisms should be established for incorporating consumer input and participation in curriculum development and training programs for LCD staff. While there will be some areas of concern only to LCD, in many cases cross-fertilization can be economical and stimulating, and can help reduce misunderstandings. Residents, families, ombudsmen, providers, professionals, and community members should all be encouraged to help develop curriculum, handouts, and videotapes, and to teach or be resources for specific subjects. Less expensive local trainings may produce a better balance of participants than massive statewide efforts. Continuing LCD-sponsored local "rap sessions," plus the recently developed series of meetings among industry, aging network, and consumer groups may be able to help combat any misunderstandings by nonparticipants about what all these people are doing in the same room together.

4. Develop evaluative and accountability measures

Specific emphasis should be placed on developing accountability of inspectors to regulations and guidelines and overall LCD objectives. In developing detailed information gathering and monitoring programs, LCD should include specific measurements for consistency of results at each stage of the evaluation and enforcement processes, analyze these on a routine basis, offer incentive rewards for staff who achieve desired results, and automatically trigger manual revision and training steps in any area where results are unsatisfactory.

To achieve the reliability and consistency sought after, supervisors should frequently accompany inspectors into the field to observe and evaluate the methods utilized. Performance evaluations should be specifically tied to achievement of the key objectives:

- Securing meaningful plans of correction from facilities;
- Quality of field notes and other documentation;
- Consistent application of inspection methodology, sampling criteria, etc.;
- Performance of the multi-faceted role effectively and appropriately in varying circumstances.

5. Improved guidelines, integrated with training and monitoring activities.

To achieve consistent performance, LCD needs a better organized, comprehensive procedure manual coordinated with the interpretive guidelines for regulations. Content should be carefully analyzed to reduce gaps, fuzziness, and inconsistencies, and sample forms and form letters should be included where appropriate. Some suggestions on

content are contained in Chapters IV and V, covering subjects such as issuance and classification of citations, timing and predictability of inspections, improvements in the complaint system, assessment of fines, and enforcement efforts. Suggestions and drafting assistance from a balanced group of interested parties should be solicited.

The procedural and interpretive guidelines should be integrated with training and monitoring programs. For example, training should include both role-playing based on manual and guideline sections, and work sessions to suggest and draft ways of improving them. When monitoring analysis uncovers an area of inconsistency, the manual and guidelines should be reviewed for clarity, and training should be designed to focus on remediation.

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We cannot overemphasize the importance of these Recommendations for LCD training. The problems perceived by the public and by the nursing home industry in working with LCD will not improve without better LCD staff training. New information systems, regulations, and resources--all of which are proposed here--will be neither as useful nor as effective as they could be if the LCD staff is better trained.

CHAPTER IV

INSPECTION: INADEQUATE EVALUATION OF QUALITY

Background

The goal of the inspection process is to produce consistent, accurate, and useful evaluations of each facility, such that LCD's resources and impact can be focused on those facilities and practices which have unacceptable effects on residents.

The state quality-inspection system is largely dictated by federal requirements, because almost all California nursing homes participate in federally-financed programs (Medicare or Medi-Cal). The state must "certify" these facilities for participation, using federal procedures which involve a huge workbook covering hundreds of standards, prescribed forms for recording deficiencies and correction plans, and rigid requirements about inspection timing. Inspectors look simultaneously for compliance with both federal certification and state licensing standards, and basic state findings are recorded at the end of the federal forms.

State standards may be stricter than federal, but it would be impractical to implement standards which were radically different in design. Also, state procedural innovations, such as permitting better facilities to be inspected less frequently, can be negated by contrary federal requirements, such as requiring a full inspection at the end of each year.

The U.S. General Accounting Office recently found that nursing home residents are increasing disabled and dependent and that states are experiencing increasingly difficulty in paying Medicaid expenditures. The GAO concluded that, where increasing demand is combined with efforts to reduce costs, adequate inspection and certification procedures are crucial to ensure that minimum health and safety requirements will be met.[1]

Yet, federal funds for state-conducted inspections have decreased. According to one report, after the funding cuts states began finding fewer deficiencies; meanwhile, follow-up inspections by federal inspectors reported the same number of deficiencies as found in prior years.[2] In California, 27,745 federal deficiencies were noted between May 1981 and May 1982, but only 24,062 between May 1982 and May 1983--a drop of 13 percent. The number of "A and B violations" under state law has also been declining.[3]

Whatever the reason for this decline, there are several longstanding concerns about the general nature and quality of inspections. Analysis of the structure and provisions of the federal-state system, and of the administrative methods by which LCD implements it, leads to the following conclusions about predictability of inspections; appropriateness of timing, focus, and complaint handling; and consistency of results.

A. Inspection Timing: Problems of Predictability and Infrequency

Findings

1. Predictable timing results in inaccurate evaluations.

Facilities do know when to expect inspections, and do try hard to look their best at such times. That is clear from the testimony heard by this Commission[4] and by the Assembly Committee on Aging,[5] and from consensus findings of our Advisory Committee. As we have pointed out in the past,[6] advance knowledge limits LCD's ability to obtain an accurate view of California's nursing homes. Since statute prohibits advance notice, and provides that public employees who give such notice shall be suspended without pay,[7] why does the problem persist?

No illegal tipoffs were found: No allegations of tipoffs by LCD staff could be verified. LCD says it emphasizes in staff training that anyone giving advance notice will be disciplined; its Procedure Manual also stresses that all visits must be made without prior notice. The risk of inadvertent "leaks" is guarded against by planning schedules as late as possible and by not posting them on office walls. (Los Angeles County also reports that inspectors do not sign out on the first day of the visit, that scheduling information is not left lying about the office, and that discussions with providers and others are noncommittal about when a visit will occur.) However, the above guidelines do not appear in the LCD Procedure Manual, and do not seem to be explained routinely to people who complain about perceived tipoffs.

According to LCD, apparent tipoffs may occur because Medical-Social Review visits, which are a function of the Medi-Cal Division and not of LCD, do give advance notice so that staff and records can be

available. Thus, when a facility says "We're being inspected tomorrow," that could be a reference to Medi-Cal's review of whether residents are receiving appropriate levels of care, rather than to LCD's review of overall quality. Though LCD headquarters says that it explains this possibility to people who complain about perceived tipoffs, the sample letter provided did not do so. Again, there is no evidence in the Procedure Manual of any standard procedure for correcting public confusion over this issue.

Regular scheduling causes predictability: Until recently, federal law required a one-year contract for Medicare and Medi-Cal participating facilities. That statute has been amended to remove any durational limits, but regulations are still undergoing revision. Existing regulations require full inspection by LCD within a few months of the end of the one-year term. Since 30 days are needed for paperwork, and since the state frequently "runs late," facilities can tell, often within 30 days, approximately when they will be inspected.

The basic problem is not merely the one-year term. It is related to the need for a full inspection near the end of that term. Under the less detailed state statute,[8] LCD would be free to break its visits into segments, each focused on specific aspects of the facility's operation, and staggered unpredictably throughout the year. Among other things, that would prompt more consistent quality control efforts by facilities, and would provide more frequent opportunities for LCD to catch early warning signs of deterioration and to identify repeat violations.

The California Association of Health Facilities (CAHF) worries that with "segmented surveys," inspectors might try to justify the extra time by finding more deficiencies, that the extra expense may increase

licensing fees, and that "better" facilities would still have many inspections instead of being rewarded by having fewer (but see Finding 2 below).

LCD, which formerly led the way in urging use of "segmented surveys," stated in May 1983 that this approach would be too costly because of extra travel and "dead time," and that it now preferred a "random interim" inspection approach. That would involve a flexible cycle in which the time of the next full inspection would be fixed according to how well the current inspection came out. Then, sometime during that interval, a surprise inspection of some kind would occur. Based on its findings, the time until the next full inspection could be lengthened or shortened. Maximum time between full inspections would be two years.

The "random interim" model probably could be implemented if federal regulations are changed to resemble current California law (see Finding 2 below). The "segmented" model probably would require a federal waiver.

Off-hours inspections are not stopping off-hours deterioration: Testimony by relatives and facility staff contain numerous examples of poor care on night and weekend shifts.[9] We do not know how often inspectors drop in at such times to discover what may be going on. LCD reports that from March 1982 to February 1983, District Offices and Los Angeles County performed roughly 30 weekend and 330 evening inspections, but these figures do not separate initial entries from overtime stays.

LCD feels that where complaints pinpoint a time-related problem, time-related inspections "pay off," but that other off-hours visits are of

negligible value. Negative factors cited include extra cost, disruption for residents and LCD staff, and the need to talk with top facility staff and to observe how most staff pursue their daily routines. Apart from the surprise value of occasionally beginning regular full inspections at odd hours (e.g., Sunday morning), and the advisability of mini-inspections at random hours for facilities which repeatedly violate the same regulations, LCD does not see sufficient benefits to justify routine off-hours inspections where no specific clues point to off-hours violations.

The volume of recurring testimony indicates, however, that off-hours understaffing continues as a major problem for some facilities. Conceivably, all such problems have been discovered but efforts to correct them have faltered. It is reasonable to believe, though, that some have remained undiscovered because LCD was not in the right place at the right time. While timely presence cannot always be achieved, it can be promoted by systematically expanding existing oral guidelines and by distributing them in written form as an official statement of duty and a basis for consistent decisionmaking (see Section D below).

2. Less frequent inspection of better facilities would be risky.

A facility with documented violations already receives more inspections than a good facility. There will be follow-up visits for the purpose of confirming that correction plans have been implemented, and there will probably be more complaint investigations as well.

On the theory that LCD's resources should be spent more on this type of monitoring and less on time-consuming full inspections where

detailed study is not needed, the Legislature in 1982 provided that facilities which have had no serious violations in the past two years may go uninspected for up to two years.[10] But LCD cannot use this flexibility without a change in federal regulations. Though it has been proposed that federal contracts for better facilities should run for two years, Congress is considering a moratorium on this and other regulatory changes. One reason is that assumptions underlying the proposed changes may be seriously flawed.

Federal plan fails to identify good facilities: One trouble with any plan to focus resources by cutting back on regular contact with better facilities is that measures of quality are imperfect. For example, federal officials (in defiance of their own regulations) have tried to identify facilities which can be inspected less frequently. They ranked federal regulations by relative importance, and recommended that states inspect facilities which violate the most important regulations twice yearly, those which violate only regulations of medium importance yearly, and those which violate only minor regulations every two years. Even its promoters caution that this system, taken alone, provides an uncertain measure of quality.[11] In Maryland, 30 percent of facilities qualifying for the two-year inspection cycle under the above standards were discovered within the next few months to be out of compliance with vital regulations.[12]

Interestingly, according to a 1982 federal computer printout, 46 percent of California's nursing homes had violated the most important regulations, and 48 percent had violated regulations of medium importance. Only 6 percent qualified for the two-year inspection. This would hardly result in budget savings. Perhaps not coincidentally, the

FY 1984 federal budget request now assumes that all facilities which have not violated the most important regulations would go on a two-year cycle.[13] Such a system may save money, but cannot assure that basic standards are met on an ongoing basis.

LCD plan recognizes danger of infrequency: Under a federal waiver, LCD has taken a different approach. Rather than letting some facilities go longer without an inspection, LCD has been conducting "abbreviated surveys" for facilities identified as "better" (basically, those with no truly egregious state or federal violations in the past year or so). The result has been a 40 percent saving of time, but rather than being refocused on the worst facilities or on essential staff training, that time has been absorbed in the effort to meet LCD's ongoing obligations. (As seen in Chapter III, LCD has been given new duties in other fields, but its staff has been cut rather than increased.)

As in the federal example, simple lack of very serious prior violations has not proved a reliable indicator of current quality. Almost 10 percent of abbreviated inspections have uncovered such major problems that a full-depth federal inspection was necessitated, and numerous others found problems in particular subject areas that required deeper analysis.[14] A variety of federally-waivered state demonstration projects will be evaluated in 1983. Results may determine whether new federal regulations will permit "better" facilities to be inspected less frequently, or will take some other approach to the problem of diminished inspection resources. For more on abbreviated inspection approaches, see Section B below.

In view of the rapidity with which facilities can more in and out of compliance, LCD has stated that it intends to conduct some sort of interim inspection in all cases, regardless of rules which might permit as much as two years to pass between inspections. In some cases, a Medi-Cal care review, a complaint investigation, or even a correction follow-up might serve as the interim inspection.

Inspection might also be triggered by notice of management changes. By law, if ownership changes LCD must be notified, do a full inspection, and issue a new license. LCD must also be told about any change in administrator, though an inspection will not necessarily follow.[15] There are no written guidelines on this. The orally-stated policy is to consider the entire situation; inspection may not be needed if a facility is taken over by an administrator with a good prior record. There are no clear rules for reporting changes in other key personnel, such as the Director of Nursing or Food Service Supervisor. Federal rules do require facilities to submit a general staffing report every quarter, and LCD will visit if it raises questions. But these reports are viewed by many as meaningless paperwork and there are federal plans to eliminate them.

Summary of means by which LCD may obtain ongoing information: To supplement its comprehensive inspections (which themselves could be done in segments or augmented by brief random interim inspections), LCD may obtain more timely information from correction follow-up visits, complaint investigations, Medi-Cal care review reports, and other mechanisms such as notice of ownership and personnel changes or reports from other agencies and organizations. Many of these are described in Sections B and C below.

Recommendations

1. Segmented/interim inspection to reduce predictability and keep current.

The Commission strongly recommends that regular full inspections be broken into several subject areas, each to be inspected at unannounced at random times within the inspection cycle. Though this would increase staff travel time and paperwork, multiple important benefits more than justify the expense. If each inspection used a focused screening process (see Section B below), visits to the better facilities would be relatively brief. If multiple brief visits were too inefficient, facilities with good current results and a reliable past record could receive somewhat fewer inspections (e.g., the entire inspection would be divided into two rather than, say, three parts). Details can be worked out with help from a balanced group of providers, consumers, aging network, and agency staff.

The "random interim" approach now advocated by LCD seems second-best. As presently stated, it leaves too much to administrative discretion. If already-existing visits for other purposes can fulfill the "interim" requirement, then apart from assuring that somebody will drop in if nobody else happens to do so, nothing has really changed. However, if the cost of segmented inspections is truly prohibitive, and if detailed guidelines can assure that whoever does the interim inspection really knows what to look for, looks for it, and reports it in consistent fashion, the "random interim" approach might be an acceptable alternative to the preferred "segmented" approach.

Until more reliable ways are developed to identify better facilities and to learn of sudden changes, facilities with "good" records should

not be inspected infrequently. Minor increases in time between inspections would be acceptable, but major adjustments should continue to focus on the length and depth of inspections (see Section B below). There should be little room for administrative discretion in this. LCD, commendably, is fully aware of the problem and wants to maintain a fairly frequent presence in every facility. But commitment, however strong, can be compromised by severe budget limitations.

If LCD is unable to maintain an appropriate inspection schedule, Health & Safety Code Sec. 1422 should be amended to require that any facility on a two-year cycle must receive at least one official mini-inspection sometime during that cycle. Accompanying this official duty should be any funds needed to carry it out. Similarly, though federal regulations need amendment to permit less predictable timing, they should not be written so that two years could pass without any meaningful inspection. This point needs to be emphasized in a Resolution by the Legislature and in the efforts of California's Congressional delegation.

To the extent that "better" facilities are inspected in less depth or somewhat less frequently, the resulting savings must not continue to disappear into the welter of other LCD obligations. According to Health and Safety Code Sec 1422(a), resources saved by using a more flexible inspection cycle are to be used for other inspections concentrated wherever most effective. This Commission's Advisory Committee determined that such resources should be used in "problem" facilities by means of repeated surveys, segmented surveys, or both. LCD should be assured sufficient staff to carry out the legislative intent.

2. Procedures to deal with tipoffs and alleged tipoffs.

Stated procedures for avoiding inadvertent disclosure of inspection plans should be incorporated systematically into the Procedure Manual, training, and internal monitoring programs. A form letter should be drafted explaining these procedures, the law concerning illegal tipoffs, and the legitimate ways in which facilities become aware of impending inspections, to be sent to people who express concern about perceived tipoffs. The Procedure Manual should instruct all staff to report allegations about tipoffs, and should assign to a specific person in each office the responsibility for investigating such allegations and conveying their findings, along with the form letter when appropriate, to all parties concerned. These procedures should help LCD to prevent and uncover any actual tipoffs, and to defend itself against accusations and hard feelings caused by inadequate public understanding.

3. Guidelines for initiating off-hours inspections.

Visits initiated off-hours should be encouraged and decisions to make them should be systematized. For example, complaint-handling directions should build in a decision point on whether night/weekend inspection might be fruitful, and should include examples of appropriate situations. The initial rule should be that where there is doubt, an off-hours visit is to be made if at all possible. Results should be analyzed to determine when off-hours visits are rewarding and when they are not, and these findings should be used to further define the guidelines. Higher initial costs are justified by systematic development of experience-based criteria; eventual costs of a carefully-focused system, probably not a great deal higher than at present, are justified

by increased ability to obtain evidence about and deal with what is, in some facilities, a serious ongoing problem.

4. Information and guidelines for spot-check inspections.

The Department should amend Title 22 Administrative Code Sec. 72211 to require facilities to notify LCD of personnel changes in the key Director of Nursing and Food Service Supervisor positions. Those who regularly spend time in facilities, such as Medi-Cal reviewers or ombudsmen, should report other changes in key personnel, along with observations on recent quality trends. Any such information should in turn lead to a systematic decision on whether spot inspection is called for and what would be the best timing. As with off-hours inspections, the existence of written guidelines would serve not only to clarify decisionmaking but also to remind of the very fact that a decision needs to be made.

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

Background

A standard annual inspection is conducted by a registered nurse and a "generalist," and takes 3-7 days, depending on facility size. Before starting out, the team reviews recent information about the facility in LCD's files. Then, after a brief entrance conference with the facility administrator, they do an "initial walkthrough" to obtain an overview and to note and discuss with facility supervisors any problems observed.

They then analyze in detail many areas of concern (e.g., physician, nursing, dietary, pharmaceutical, activities, health records, in-service training, patient rights, staffing, disaster control, trust accounts), using a workbook which breaks down each federal regulation into small component parts. This review looks a great deal at policies and records, but will be influenced by what was seen on direct observation. "Interpretive Guidelines" for most regulations are contained in extra federal and state booklets. Generally, these suggest when sampling techniques or interviews should be employed, but do not say how to carry them out.

The team then discusses its findings, notes them in the workbook, and prepares documents which are given to the facility and become part of the public record--a list of deficiencies (all requirements that are unmet), and state citations for the most serious deficiencies. At an exit conference with facility administrator and supervisors, each deficiency and citation is discussed. Correction plans are either agreed upon and entered on the list of deficiencies right away, or submitted by the facility within 10 days. (For more on correction plans, see Chapter V, Section A.)

Federal regulations require ninety-day follow-up visits to see whether corrections are completed as planned. But proposed revisions would make the timing flexible and would permit on-site visits only where necessary. Though some say this applies only to correction of paperwork deficiencies, that is not how the regulation is worded.[16] In fact, even without this change, the state is already spending less time on follow-up visits.[17]

Findings

1. Inspections are criticized for focus on paperwork.

A major concern expressed before both this Commission and the Assembly Committee on Aging[18] is that inspections focus not on resident well-being, but instead on paperwork. Some facilities say they are penalized for paper violations despite good patient care. Some consumers say that inspectors avoid non-quantifiable areas like patients' rights, and feel unable to cite reported neglect or indignities "because facility records are in order." Yet LCD stoutly maintains that, while it must enforce all regulations, its overriding focus is on patient care. What is happening?

LCD's statistics on A and B violations (which represent only the most serious deficiencies) indicate that roughly half are categorized as "patient care" and only 1 percent as "patient rights," with other categories ranging between 1 percent and 22 percent of the total (see Appendix IV-A). What, exactly, is a "patient care" violation? Interpretation of LCD's statistics is uncertain (see note, Appendix IV-A). But an independent study found that in the San Diego office in 1980, the most frequent A citations for "patient care" involved gross negligence resulting in a critical decline in resident health, poor care of severe bedsores, and infliction of extreme physical or emotional abuse resulting in injury. B citations for "patient care" most frequently involved negligent development of care plans and failure to notify doctors of changed conditions.[19]

Probably at least half of cited violations do involve patient care. And, since A and B violations by definition must relate to health, safety or security, many of those listed in other categories undoubtedly

also affected resident well-being. But one cannot tell whether the "paper emphasis" of which facilities complain appears in the other deficiencies that are written up but not cited as serious. Assuming it does, one still cannot tell whether this represents "nitpicking," or action to correct situations, however benign, that clearly violated a regulation which LCD is legally bound to enforce. Further, one cannot tell whether, as other witnesses claim, many conditions exist that directly affect resident well-being but do not receive citations. Even if only a portion of recent testimony is credited, some such conditions do exist. For example, Assemblyman Felando, summarizing for the Commission the areas of concern heard by his committee in 1981, included the following:

> 1. That the care the elderly received in nursing facilities was dehumanizing, and not dignified.
>
> 2. That the administration and staff attitudes caused the elderly to be afraid to raise their voice in dissatisfaction about their treatment.
>
> . . .
>
> 4. Concern about the quality and quantity of staff caring for the elderly: felt that staff needed to be better trained and more sensitive to the elderly residents.
>
> . . .
>
> 7. Another concern was that the inspectors did not look at the elderly residents but rather paper work and the halls.
>
> . . .
>
> 10. Witnesses reported how family members were left in their own excrement, tied in wheel chairs for hours, not fed at regular hours, and food being cold. . . . Witnesses testified to the harshness of treatment, stealing from the elderly, and just not paying any attention to calls for help.

Perhaps many of these conditions have been noted, but not properly remedied--a failure in the correction process. Perhaps, however, the inspection process is failing to discover or verify some of them in the first place.[20] The following findings identify some factors which may limit LCD's ability to discover or verify all resident related problems, or which may account for the perception by public and facilities that inspection focuses on paper rather than on residents.

2. Medi-Cal inspection of care is ill-coordinated with LCD inspection.

Federal law would permit LCD to perform both its present certification inspections and the federally-mandated "Inspection of Care," which in California is called Medical-Social Review (MSR) and is now done by the Medi-Cal Division. MSR looks at each Medi-Cal resident, reviewing records and talking with resident and staff to see whether the resident is appropriately placed and receiving adequate care.

Medi-Cal reviewers now visit facilities monthly, and have been asked to keep an eye open for problems of a general nature, discuss them with facility personnel, and report serious ones to LCD. LCD says it only occasionally receives such information, though it does receive copies of the standard Medi-Cal evaluation reports. Three examples of these from 1980-81 contained useful details and were received by LCD within a week or two. Three 1982 examples had little detail and were received in an average of three weeks. Based on this small sample, whatever coordination has existed seems to be deteriorating.

By contrast, states such as New York have combined the two inspections. Since 1981, New York patients and patient records have

first been observed systematically to identify certain "Sentinel Health Events" such as bedsores, accidents, behavior problems, weight changes, catheters, etc., whose presence could indicate faulty care. A carefully-designed "protocol" sheet (also used as evidence for enforcement proceedings) is filled out and handed on immediately to the licensing/certification inspectors. They then focus an in-depth review, also using detailed criteria, on areas where an unusual number of "Sentinel Health Events" were found. Apart from a basic review of facility-submitted forms and of information in department files, most of the inspection depends on what is found by looking at residents. The fewer the problems, the shorter the inspection.

CAHF has expressed concern that combining care and certification inspections will prevent MSR from offering consultation and positive feedback. In New York, the teams are still separate, though one member overlaps for coordination and communication purposes. In Iowa, the licensing/certification inspection form has a space for "good things about this facility that I would like to recognize." The Commission is not convinced that having LCD perform both functions would necessarily eliminate MSR's unique characteristics, though it would (and should) render MSR information more useful and available for enforcement purposes.

The Association of Health Facility Licensure and Certification Directors, in a January 1983 position paper, reported that:

> data gathered in regard to the individual patient reviews fulfills 50% of the requirements of the certification survey and thereby reduces costs to each program. Some states, having already consolidated the processes, have demonstrated that:
>
> 1. the quality of both patient reviews and facility surveys is enhanced significantly since data common to both

processes are collected concurrently . . . and the evaluations are comprehensive.

2. cost effectiveness increases significantly since staff and support costs decrease.

3. expeditious corrective and/or enforcement actions can be taken . . . as a result of information obtained . . . .

LCD would like to combine federally-mandated care and certification inspections, as was in fact recommended by this Commission in 1976.[21] LCD states that an attempt made then failed due to poor design, and that this may explain why its proposals to try again have met with resistance.

3. Resident-oriented abbreviated inspection is a useful first step.

As seen in Section A above, LCD is using "abbreviated surveys" for all but the worst facilities. The facility fills out a form giving routine information (e.g., names, licenses, committee meetings, training sessions, fire and disaster drills, resident profiles, staff hours). This frees the inspector to focus more on observing care and conditions. The 534-item federal workbook is reduced to 152 items--those seen as most related to residents' health and safety. A major deficiency in a particular area triggers a full inspection of that area; if any area is deficient overall, that triggers a full facility review using a standard federal workbook.

In FY 1982, 45 percent of SNF inspections were of this type;[22] the goal is 60 percent, though some will undoubtedly revert to full inspections. A 40 percent saving in inspector time, the ability to focus more on patient care, and decreased disruption for better facilities are cited as advantages of abbreviated inspections. On the other hand, they subject "better" facilities to less detailed oversight despite the fact that

better facilities cannot be identified reliably in advance (see Section A above). Also, since they do not turn up as many specific deficiencies as a full inspection, it will be unfair to compare deficiency and citation records of facilities inspected by the two different methods.

Federal monitors compared abbreviated with standard inspections and found that abbreviateds do identify most of the same serious violations, but not as many in the areas of nursing and pharmaceutical services. They conditioned further waiver on better performance in these areas, and recommended other improvements such as permitting inspectors to write up observed deficiencies under regulations that are not part of the short workbook, and training and monitoring to assure that paperwork is selectively validated and that full inspections are done when appropriate.[23]

The waiver granted to California was for a plan intended not to rewrite federal regulations, but only to reduce inspection time and impact on the better facilities. Models developed in some other states (e.g., Wisconsin, Iowa) have taken a different approach. They are also intended to refocus inspection time away from "better" and toward "problem" facilities. But rather than simply extracting intact certain portions of the federal regulations, and using traditional methods to look for compliance, they attempt to reflect important regulatory goals through entirely new instruments and techniques. Standards include some "outcome" measures (see Finding 4 below). Techniques include precise in-depth sampling, planned interviews, and rating scales instead of yes/no evaluations.

In Iowa,[24] the new approach is being used to screen all facilities, not only the "better" ones. Every facility receives the same relatively

brief inspection using quality ratings in key areas of care (see Appendix IV-C). Further attention (and the disruption of being subjected to inspection) is pinpointed according to these findings. This results in more focus on residents and outcomes, less time spent in better facilities, and more comparable statistics, since the same procedure applies to all facilities.

Depth of inspection in California now depends partly on past record of violations and partly on results of a short inspection using traditional standards and techniques that are conceded by most authorities to be imperfect. Uniform and innovative resident-oriented screening appears to be a more promising system, but only if such approaches really uncover at least the same violations as would the traditional approach.

A federal evaluation of several "short-survey" experiments is expected later this year. Meanwhile, Wisconsin reports that quality of care found under its new method was exactly the same as under the old. However, they had actually expected quality to improve because more time than before would be spent on problem areas. Instead, inspectors tended not to see situations as suitable for follow-up and, as in California, inspection time was saved rather than re-allocated to trouble spots. Increased supervision is planned to counteract this tendency. Iowa reports similar results; using scores from its rating scales, it has now set quantitative threshholds to trigger in-depth inspection in each area. Iowa also suggests using a different inspector to conduct the follow-up, thus reducing any tendency to overlook problems in order to avoid extra work.[25]

4. Outcome-oriented standards have not been fully utilized.

Federal regulations employ "input" and "process" standards. "Input" standards assume that if a facility has certain structures and supplies, certain numbers of staff with certain types of training, and certain policies and procedures, the likely result will be adequate patient care. Thus, inspectors spend much time documenting the existence of all these prerequisites. "Process" standards look at the care delivered and whether it was appropriate to the situation. MSR teams make this sort of analysis; so do LCD inspectors when they review patient care and patient care records. California's regulations were revised in 1982 to incorporate more process standards.

"Outcome" standards would evaluate whether the facility has produced appropriate results, given the overall condition of each resident, regardless of the "input" and "process" used. State and federal patient care plan regulations do require that individual needs be assessed, objectives be stated, and care be planned and delivered to meet these objectives. Theoretically, this provides a basis for outcome-oriented inspections. But care plans remain just one component in the overall welter of input and process-oriented regulations. Inspectors must analyze many separate service areas, using individual outcomes where possible to provide clues and evidence as to whether the right input or process exists.

At bottom, appropriate individual outcomes are the goal of nursing home regulation, and not merely evidence of something else that presumably helps the facility meet that goal. True "outcome" standards have been difficult to design, but models do now exist. The simplest system, described below, would only reorganize existing regulations so

that both care and inspection could focus more on needs and outcomes. A more sophisticated outcome-oriented approach is described in Chapter VII, Section A, Recommendation 3.

Care management system focuses on setting and meeting individual goals: Revised federal regulations, proposed twice since 1980, would require facilities to use a Patient Care Management System (PCMS). Based on a thorough interdisciplinary assessment of every resident's needs, a care plan would set specific time-limited goals and assign specific staff responsibilities for meeting those goals. Periodic reevaluations would determine whether the goals have been reached and what new needs have arisen; the cycle would repeat as necessary, with full reassessment annually.

Extremely detailed initial assessment is the major innovation; otherwise PCMS mainly consolidates existing care plan standards into a clear conceptual framework. Maryland uses a similar system, which has received federal equivalency status. After overcoming some initial reluctance to accept new procedures, and after careful training of both facility staff and inspectors, Maryland reports better patient care, less time and less paper emphasis for inspections, more unified and consistent documentation, and numerous other advantages.[26] The industry nationwide has supported PCMS; its associations and large corporations have developed some similar quality-assurance and problem-oriented records systems of their own.

Though LCD says that it can and does enforce such a system using existing regulations, as explained above these are not organized to produce either care management or inspection results which are optimally outcome-oriented. As Maryland discovered, a substantial

change in present attitudes and procedures is called for. At the very least, reorganizing existing regulations into a system like PCMS would make it easier for facilities to understand their obligations and for inspectors to discover and prove failures in meeting those obligations.

Resident satisfaction is desirable and can be measured: "Outcome" consists not only of medical or psychosocial improvements as measured by experts, but also of subjective satisfaction as felt by residents and their families. Satisfaction can be affected by unrealistic expectations, lack of expectations, personality differences, etc., and may fail to coincide with the observations of "experts." In Iowa, for example, satisfaction seems very high and evaluators express uncertainty about what this really means.[27] But satisfaction is presumably one desirable outcome, and asking about satisfaction also serves to increase the respondents' self-esteem and to provide clues for follow-up investigations.

The industry has developed quality assurance programs that measure satisfaction with questions such as "Are you encouraged to make decisions? Can you be alone if you want to? Do people call you by the name you want to be called?" Iowa uses a resident satisfaction scale running from 1 to 5, as part of its quality-oriented inspection process (see Appendix IV-C). Asked whether it uses any similar approach, LCD responded that resident contact is emphasized, and inspectors are supposed to ask questions. But there is no list of suggested questions and no particular number of residents to be spoken with. LCD stated that people are not good judges of their own situations, that asking standard questions would be demeaning and would

lead to "canned" answers, and that professional nurse-inspectors will naturally interact with patients and ask meaningful questions.

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

Information from residents, staff, and others can provide resident-oriented clues about areas which may need closer scrutiny, ideas for correction plans, etc. It can also provide another overall perspective of the facility, a context in which to evaluate, for example, whether the intent of a regulation is met, or what fine may appropriately be assessed. Finally, asking for information provides those who are consulted with a sense of participation and an opportunity to resolve misunderstandings about LCD's desire and ability to focus on patients rather than on paper.

Federal and state interpretive guidelines do suggest, in connection with a large number of different regulations, that staff or resident interviews are a good technique to use. However, interview topics have not been pulled together into a coherent package and there are no details on selecting whom to interview or how to use particular techniques and questions to accomplish stated purposes.

Also, information is not requested from regular visitors such as family, friends, clergy, ombudsmen and volunteers. In some states (e.g., Florida) such contact is required by law. LCD says that really concerned visitors are usually present at some point during the inspection and will initiate talks with inspectors. But LCD is not required to notify them that inspection is taking place, and inspections now tend to occupy fewer days than in the past. LCD also says that some people are reluctant to talk in the facility, but there are no special procedures

for emphasizing that comments are welcome and explaining how to reach LCD on the "outside."

Neither is there any opportunity for a resident representative or ombudsman to take part in exit interviews. Their informal participation in discussions of deficiencies and how to correct them could contribute both to problem resolution and to mutual understanding.

In some states the licensing agency is required by law to hold an open meeting within each facility. In Texas, the intent is to elicit complaints, so facility personnel may be excluded. In Oklahoma, the intent is to open up communication, so staff, residents, friends and relatives, and other agencies are all encouraged to participate. However, sometimes people are unwilling to speak out in the presence of facility staff, or even of licensing personnel. Also, for LCD to organize and run meetings in almost 1,200 nursing homes every year would place more demands on an already-stretched staff and budget. If general open meetings were held in the community, more public interest might be stimulated, but resident participation might be diminished. A flexible approach that attempts in each situation to accommodate the needs and concerns of interested parties would be difficult to administer but would yield the most positive results.

Although inspectors review LCD's own files, relevant reports from ombudsmen, community organizations, resident/family/community councils, or industry are not requested for those files. Asked about this, LCD expressed interest in the idea of phoning the ombudsman prior to inspection to learn about areas of special interest or concern.

Finally, help from community volunteers is not utilized in conducting the inspection itself. Though nobody except LCD staff should have

power to write up violations, volunteer assistants could conduct interviews and develop supplementary information on quality of life concerns. Consistency should be achievable through training, the cost of which could be kept down by limiting it to particular subjects and skills. (See also Chapter III, Section B on training). A minority of the Advisory Committee felt that training could not achieve sufficient consistency, and preferred to involve the community only as facility visitors, members of councils and committees, or participants in industry peer assistance programs.

See also Chapter VI on consumer/community participation.

6. Patients' rights violations are hard to prove and harder to cite.

Though all deficiencies must be corrected, fines are available only for those which can be cited as relating to "health, safety, or security." Some conditions, especially patients' rights violations, may affect residents' well-being without having a provable relationship to "health, safety or security." For example, residents have a right

> to be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and care of personal needs. Title 22 Administrative Code 72527(a)(10)

Even in other states which fine any patients' rights violations, whether or not related to health and safety, there are reports that some inspectors do not always write up an event such as failure to draw a privacy curtain, because it does not seem "worth" a hundred dollars. To the resident, it destroys the quality of life; to an inspector on the lookout for bedsores, it seems inconsequential. Similar problems may exist with other rights such as freedom of communication and association.

Further, though rights violations are noted as deficiencies, and even occasionally cited, there is potential confusion over whether violation of a particular right is a "violation" at all. Both statute and regulation speak of establishing policies and making them known to residents; neither actually states that the facility is obligated to follow those policies.[28]

Finally, it may be hard to prove that certain violations even exist. Paper may stand up better in court than human witnesses. This fact, coupled with LCD's conservative views on the subject, frustrates those who say that neglect and indignities are given insufficient attention when the evidence that they exist is oral rather than physical (see Section C below).

How is it shown that indignities occur or that autonomy is not respected? Federal guidelines suggest checking LCD's own complaint records for clues; looking at facility records of policies, procedures, staff training, and written notices of rights given to individual residents; talking with staff and residents to see whether duties and rights are understood and what experience has been. If oral evidence is discounted as unreliable (or even absent due to fear), a case must be built mainly on the facility's own records. If records are in order, there is seldom any physically observable evidence that they do not reflect reality; if records are not in order and LCD cites a violation, it may be accused of "nitpicking" over paper. (See also Chapter V, Section B, on case preparation.)

Recommendations

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

The Department of Health services should move review of Medi-Cal residents' care (MSR), now performed by the Medi-Cal Division, to LCD along with the experts and budget necessary to do the job properly. As seen in Finding 2, this should result in more patient-oriented inspections and more on-the-spot capacity to identify and correct problems, at less overall cost to the state. Care should be taken to assure that MSR reviewers may continue to offer praise and limited consultation where appropriate.

Regardless of who performs MSR, its forms should be designed to include very specific indicators of potential care deficiencies, and recording of detailed observations as needed. These forms should be used as a basis for "complaint" investigations, as evidence, and to help focus LCD's in-depth investigations (see Recommendation 2). If the two functions are not combined, much more specific training, procedures, and monitoring should be developed to assure that useful information passes between the Divisions and is acted upon in timely fashion.

MSR should continue on a monthly basis, and prior notice should be reduced or eliminated if possible. This, combined with training, forms, and procedures designed to identify and report possible problems, might make it safe to space expensive regular inspections somewhat farther apart.

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

Trends in federal and state law are toward less frequent inspection of "better" facilities. The Commission commends LCD for using a

worse). For more consistency, the inspection should use ratings in place of yes/no answers (see Appendix IV-C), so that the scores themselves would indicate degree of excellence.

3. Outcome-oriented care management system and satisfaction index.

Federal regulations should be reorganized around a Patient Care Management System concept, under which the facility would repeatedly evaluate each residents' needs and set precise outcome goals, and inspectors would determine whether the evaluations were proper and the goals were met. This change should be urged by legislative resolution and by members of the California Congressional delegation. Meanwhile, LCD should seek federal permission to reorganize its own regulations as was done by Maryland. As noted in Finding 4, this does not change the content of regulations so much as it organizes them to permit more focus on outcome-oriented evaluation.

A balanced study group should research existing indices of resident/family satisfaction and develop one for use by LCD. If the result is sufficiently even-handed, a regulation should be proposed; otherwise, the index would be used as an investigatory technique and refined, based on analysis of results, until suitable for direct regulatory purposes.

4. Statute or regulation to expand LCD's sources of information.

The legislature may need to make clear, as have some other states (e.g., Florida), the importance of seeking information from all knowledgeable and interested sources. Such a law would establish general

approaches, but leave details to LCD, with a report to the legislature after two years.

Expected improvements include: partial correction of the "imbalance between paper and patients;" more evidence and clues as to provable violations or areas where attention should be focused; impressions of overall quality which can inform the exercise of LCD's discretion; new suggestions for design of correction plans; greater sense of worth and commitment for those consulted. Arguments against such a statute include the problem of interpretation (how much information and from whom?) and the possibility that if LCD failed to comply with the letter of the law, facilities might raise this as a technical defense. If LCD were to promulgate regulations, a statute might not be necessary. Possible wording in either case:

> In making its determination as to the degree of compliance with statute and regulations, and the overall quality of care and services, the department shall consider the results of
>
> (a) Private interviews and surveys of a representative sampling of residents, families and guardians of residents, and facility staff; detailed guidelines for sampling and interviewing shall be developed and utilized.[29]
>
> (b) Participation in the exit interview by an ombudsman and a resident/family representative, if available.
>
> (c) Meetings of and with the facility's resident/family/community councils, if these exist, and with ombudsmen who have been active at the facility since the last major inspection.
>
> (d) A notice posted prominently in the facility stating that the department welcomes all comments of any kind, and explaining how to obtain a private interview. During inspections, a similar notice shall be posted at the facility entrance, indicating that an inspection is in progress.
>
> (e) An annual public meeting to be held in the local community or at the facility. Notice of the meeting shall be given to residents, their closest relatives or guardians,

the ombudsman, and other groups or agencies that work with the facility.

(f) Any reports submitted by agencies and organizations. Reports shall be requested from Medi-Cal Division, ombudsman, professional licensing, law enforcement, Health Systems Agency. Reports of others, such as consumer, provider and professional organizations, shall be considered if received.

If, due to lack of staff or volunteer assistance, the department fails to fulfill these obligations completely, a facility may not use such failure as a defense against enforcement actions.

While this may seem to demand much staff time, in some cases it merely adds structure and emphasis to functions which, according to interpretive guidelines and policy statements, are already being performed. Also, for the most part the wording does not specify that LCD must conduct interviews and meetings, but only that it must consider their results. Because these are information-gathering procedures, rather than evaluations of whether specific violations have occurred, trained volunteer assistance can be used to gather and summarize information for easy use by LCD staff.

LCD's duty would be to develop precise procedures and assign responsibilities so that the information is gathered by proper methods and in useful form, and is routinely received and promptly reviewed by LCD to identify problems for investigation as complaints or as part of the next inspection. Particularly in the case of public meetings, though, difficult questions of sponsorship, location, responsibility, and participation will need to be worked out with the assistance of a balanced advisory group.

5. Community volunteers to help obtain and process information.

LCD should consider training volunteers (e.g., retired health professionals or members of service organizations) to assist with inspections and information gathering. They could, for example, do additional investigations into the psychosocial aspects of resident well-being, make second evaluations for comparison purposes in areas where consistency is a problem (see Section D below), arrange meetings, and gather and analyze the sorts of information outlined in Recommendation 4 above.

6. Amendments to render patients' rights more enforceable.

To underscore the importance of patients' rights, Health & Safety Code 1424(b) should define B violations as relating to "health, safety, security, or welfare."[30] See Chapter V, Section A, Recommendation 3 for details.

Patients' rights regulations should be revised to make unequivocally clear that denial of a right, and not merely denial of information that a right exists, is a violation. A balanced volunteer study group should attempt to improve regulations, interpretive guidelines and investigatory techniques so that existence of violations, and their connection with resident health and safety, can be better demonstrated.

C. Complaint Inspections: Response Has Improved But Frustrations Remain

Background

LCD must make an unannounced "onsite inspection" within 10 days of receiving any written, signed, adequately detailed complaint alleging a violation, unless it is intended to harass or is without any reasonable basis. The complainant has rights to confidentiality, to accompany the inspector, and to be "promptly informed of the department's proposed course of action."[31] Findings are entered on federal deficiency/plan of correction forms, and on state citations if appropriate, and these forms are available for public inspection.

There were around 3,500 complaints each year from 1977-1981, rising to 3,700 in 1981 and dropping to 3,100 in 1982. (Los Angeles County, with around 33 percent of all nursing homes, receives about 50 percent of all complaints.)

LCD keeps no statistics on the subjects of these complaints. Data specially compiled for the first quarter of 1983 (Appendix IV-B) show roughly half as "patient care" and about 10 percent as "patient rights," though the meaning of these categories is not entirely clear. In the first 6 months of 1981, Los Angeles County reported that half of its complaints concerned neglect, physical and verbal abuse, or bedsores. The others dealt with staffing deficiencies, sanitation, missing money or property, poor food, shortage of supplies, inaccurate charts, problems with medication or treatment.[32] Various studies indicate that anywhere from 34 percent to 93 percent of all A violations, and 15 percent to 41

percent of all B violations, have been cited as a result of complaint investigations.[33]

Since complaints deal mostly with matters of direct concern to residents, and lead to a fair proportion of all citations issued, closer analysis is in order relating to the testimony of those who felt that complaints to LCD were shrugged off, were discounted, or "did no good."

Findings

1. Complaint response procedures are much improved, but gaps remain.

The Auditor General found in 1977 that LCD lacked uniform procedures for investigating complaints. In 1982, the Auditor General found that 42 percent of complaints were investigated late and that inconsistent priorities were used to determine their urgency. Then LCD distributed Procedure Memo #83-5, setting forth standard recordkeeping and investigating procedures and criteria by which complaints are assigned for investigation within 24 hours or within 10 days (or within 90 days in the case of less urgent general information found in news reports, Medi-Cal reviews, etc.).

LCD reports that in the final few months of 1982, only 12 percent of complaints were investigated later than the 10-day limit; effects of the 1983 memo on appropriateness of response time in individual cases are still unknown. Though the memo is a great improvement, it contains the following flaws which could perpetuate some inconsistent or ineffective responses.

Oral complaints are not assured equal treatment: Though the statute speaks only of written complaints, LCD's policy has been to treat oral complaints the same as written. This eliminates the possibility that discovery of violations might depend upon the bravery, education, or sophistication of the person reporting them. In fact, the Auditor General found that almost the same percentage of oral complaints are validated, as written. Unfortunately, it was also found that despite policy statements, three of five District Offices gave lower priority to oral complaints.[34] LCD says that this problem is now under control. However, in terms of written policy, Memo #83-5 still confuses the issue by defining the 10-day category in terms of written complaints. Thus, if an oral complaint does not meet the 24-hour criteria, there is no written policy that it must be investigated. This is in keeping with statute, but not with LCD policy or with good practice.

Priorities do not take account of need to preserve evidence: The new 24-hour response category is based on whether an imminent threat to residents' life and safety is alleged. This accords with the Auditor General's recommendations, but may inadvertently block verification of other complaints where the imminent threat is merely that evidence may disappear if not promptly observed or preserved. For example, a bruise may fade or, if the complainant has discussed the problem with the facility, records may be altered. While "imminent threat" complaints must take precedence, "vanishing evidence" complaints should otherwise receive prompt attention.

Guidelines on information from other sources are imprecise: Information from particularly reliable sources, such as ombudsmen or Medi-Cal reviewers, receives no special priority in Memo #83-5. Yet state

law demands priority for ombudsman complaints, unless others involve immediate threat to life or health.[35] And the Auditor General found that, in the one office which routinely followed up Medi-Cal field services reports, 56 percent of those allegations were validated (compared to a 39 percent overall rate).[36]

More generally, the memo says that "other information or reports" (mentioning only Medi-Cal by name) shall be assessed and investigated according to the 24-hour and 10-day criteria, and that if for some other reason they merit investigation, it shall be done within 90 days. The intent to treat all information as a potential complaint is a good one. The memo does not spell out a routine for routing incoming reports to a specific person whose function is to scan them immediately for potential complaint material, but LCD says supervisors know what to do.

2. Verifications may be lost by failure to make full use of witnesses.

LCD does not keep detailed complaint statistics. By "rough guess," 60 percent of complaints lead to a finding that state regulations have been violated. That includes cases in which the complaint itself is unverified, but other findings are made which do constitute violations. By contrast, the Auditor General found that only 39 percent of complaints were verified.[37] LCD's ad hoc figures for first quarter 1983 (Appendix IV-B) show only 28 percent of allegations substantiated. Since complaints averaged 1.9 allegations each, up to 53 percent of complaints may have been verified.

Thus, anywhere between 40 percent and 60 percent of complaints are not verified. LCD guesses that around 10 percent of complaints allege situations which, however true, do not violate any law or regu-

lation. Others cannot be verified because they are based on hearsay and legally acceptable corroboration cannot be found. Some may go unverified if inspection is delayed until evidence becomes unattainable. Finally, numerous witnesses have testified that LCD does not give their reports of observed neglect or abuse the full weight they would be accorded in other law enforcement settings.[38]

Until LCD is better able to record and analyze its investigations, no determination can be made of how many verifications fail, and why they fail. But if any legitimate violation goes uncorrected because of mistaken evidentiary policies, LCD loses a chance to protect patients, and complainants become unnecessarily cynical or hostile.

In Advisory Committee discussions a small minority interpreted Health & Safety Code Sec. 1423 ("If upon inspection or investigation the director determines . . .") to preclude citations based on evidence not directly observable by LCD inspectors. However, the Commission views the term "investigation" in its generally accepted sense, as seeking all forms of evidence and weighing each piece according to its credibility and admissibility.

LCD does use witness statements in conjunction with other evidence, but has not relied on statements standing alone. LCD says it is rare to have an eye-witness who is willing to testify, without also having substantiation from facility records or inspector observations. While this may be true with very serious violations (which often create physical evidence right on the resident), and with facilities that keep honest and thorough records, it may not be true in all potentially dangerous situations.

For example, if a regular visitor says that a mentally confused resident is not eating adequately, or being exercised properly, but facility records show all in order and there are no other witnesses, LCD policy would require waiting until the resident has become visibly debilitated before exerting any authority beyond informal warning. Another example is ongoing mental or light physical abuse, which can also cause deleterious effects that are not immediately revealed in a resident's condition or in facility records. Where the witness is credible, and especially where facility records have not been credible in the recent past, a blanket policy favoring the records seems wrong. Also, because of its implication that some evidence is more worthy than other evidence, a policy which assumes that what cannot be seen by an inspector cannot be proved might tempt some overworked inspectors to do a less-than-thorough search for corroborative evidence.

LCD has expressed some willingness to reconsider its former policy should a case present itself where, despite lack of observable evidence, a credible eye witness is willing to testify under oath.

3. Poor communication with complainants reaps a bitter harvest.

To realize that some complainants feel frustrated after dealing with LCD, one need only read recent testimony. In this Commission's files, for example, is the following 1982 account from an ombudsman:

> I called my L & C office . . . [and] related to the evaluator that I heard a patient screaming for help from the hall and there was no staff available, so I knocked on the woman's door and she indicated that I should enter. She was seated on the edge of a bedside commode, was unable to hold herself up due to contractures, and was leaning perilously forward, in imminent danger of falling on her face . . . . I held her in place and rang for help, which was slow in coming . . . . The evaluator to whom I spoke reacted to this by asking me what my qualifications were, to be invading the privacy of a

> patient in that way. She did not express concern about the patient in question, nor about staff training, nor about the fact that the facility was seriously understaffed. She indicated that I should deal with the administrator, whom she recommended highly, and implied that she was not only uninterested in dealing with this complaint, but was also unable to deal with it because she had not witnessed the incident herself.

In our files are accounts of letters and complaints submitted, with the perceived result that "absolutely nothing changed," or of having to badger LCD to obtain followup reports and then receiving forms which contain no meaningful information.[39] There is a copy of a letter from a LCD administrator which mis-states the law on the complainant's right to accompany the inspector, and refuses to provide information by mail. The testimony conveys a general perception that concerns are belittled and that there is no point in asking LCD for help.

Those who testify at hearings represent only a small percentage of the 3,500 complaints received yearly. Since many complaints lead to citations, some complainants surely feel satisfied. The state ombudsman says:

> The reported experience of the local projects with the LCD, ranges from extremely negative to somewhat neutral to, in several cases, one that would be considered good. The range of opinion and experience reflected by our local projects suggest, to a large extent, that the LCD district offices and sub-offices seem to operate quite autonomously from the central administrative office and from each other . . . with respect to the way in which [they] carry out their duties and work with community and consumer groups and complainants.[40]

LCD responds first that many of the above stories, if true, violated policy; second that the public does not understand its limitations when investigating complaints; and third that it cannot give detailed explanations to individual complainants. Still, LCD must act to meet these criticisms. The alternative is an appreciable amount of needless hostility (in which case LCD wastes valuable time in self-defense) or

needless cynicism (in which case LCD loses future information about possible violations of the law it is supposed to enforce).

The Sacramento District Office recently developed a training program containing advice on improving public relations. Also, a general training session in May 1983 stressed better communication with complainants. More specifically, Memo #83-5 instructs the inspector to contact the complainant right away, if possible, to explain rights, elicit more information, and describe the proposed course of action. However, no standard informational form letter has been adopted.[41]

Further, though the memo requires detailed findings, observations, and conclusions to be entered on the complaint form, what complainants receive is the standard federal deficiency form or state citation notice. Some of these contain details, but many do not; the memo does not require that the forms or covering letter state what facts were alleged and found. Complainants are especially frustrated by receiving a form that says merely, "no noncompliances are found." Asked about this, LCD stated that supervisors have now been told to write cover letters explaining what was found and, if there were no violations, stating that even so, the facility has been advised of the matter.

In the past, LCD has cooperated with frustrated complainants to work out better written procedures. The Procedure Manual contains unusually specific sections on protecting complainant anonymity and helping representatives exercise their right to accompany the inspector into the facility. According to testimony, these sections were developed by "negotiation" between LCD and a consumer group which had problems in those areas.[42]

Often LCD fails to receive complaints, through no fault of its own, because residents and families fear retaliation within the facility. The state has a strong interest in hearing consumer concerns, and should make efforts to assure that it can do so. See Chapter VI, Section B.

4. Frustrated complainants have no clear right to appeal.

Unlike some other major states (e.g., Illinois, Michigan), California law sets forth no avenue of appeal for a complainant who is dissatisfied with LCD's response. In practice, one may protest first to the District Administrator, then the Chief of Field Operations, and finally the Deputy Director. This is informal, and complainants receive no notice that the opportunity is available.

Recommendations

1. Statutory right of appeal for complainants

In order to promote fairness and alleviate frustration, the legislature should add the following to the end of Health and Safety Code Sec. 1420:

> A complainant who is dissatisfied with the department's determination or investigation may request an informal conference, in which the facility may participate as a party. The department shall establish procedures for requesting and conducting the conference, and for further administrative appeals, and shall give all complainants notice of such procedures. If a facility requests an informal conference which concerns a matter covered by a complaint, the complainant shall receive notice and may participate in the conference as a party.[43]

An established appeal procedure, known to complainants, will be used by some and therefore will take some staff time. The Commission considers this time well spent in the interest of operating an open and equitable system conducive to mutual respect and understanding.

2. Amendment to ensure equal treatment for oral complaints

Health and Safety Code Sec. 1419 should be revised so that notice of alleged violations may be submitted in writing, by telephone, or by personal visit, and an oral complaint shall be reduced to writing by the Department.[44] This assures that investigation will not depend on the courage or sophistication of the complainant. It enacts current LCD policy and reduces the likelihood of confusion in the implementation process. Meanwhile, LCD should clarify its written instruction to reflect this policy.

3. Amendment to clarify acceptability of eye-witness evidence

Health & Safety Code Sec. 1420 should state that an "onsite inspection" shall collect and evaluate all available evidence, including but not limited to observed conditions, statements of witnesses, and facility records. Section 1423 should be clarified similarly. In practice, if a statement (weighed with and against other available evidence, if any) is not persuasively credible or reliable, or there is doubt that it would be available in case a citation is contested, LCD may decline to find a violation. Otherwise, the violation should be written up. Joint training for inspectors, ombudsmen, community and family groups would increase the likelihood that statements will be furnished in useful form and will be acted upon appropriately.

4. Further guidelines for prioritization of complaints

Prioritization guidelines should be further refined to take account of the need to preserve evidence, to grant proper priority to ombudsman complaints, and to specify the procedure for assuring prompt

evaluation of reports from other agencies. See also Section A, Recommendation 4, and Section B, Recommendations 1 and 4.

5. Training and procedures to improve public relations

Training, backed by written guidelines, should emphasize improved attitudes toward, and communication with, complainants. Standard letters should explain generally what types of problems and evidence LCD can handle and what rights complainants have. Forms should reveal the facts alleged and how they were verified or not verified. Again, a standard letter could help complainants understand such forms. The policy stated in Memo #83-5 that forms are to be mailed to complainants on request is a good one and should be implemented by all offices. Since all information except names of individuals is public record, if a complainant requests more detail it should be provided readily. See Chapter VI on access to LCD information.

6. Distribution of information on free services from local groups

Each LCD office should offer to distribute to complainants (with a disclaimer of endorsement) a brief description of free services available from local ombudsmen, advocacy and service organizations, industry and professional associations, and other groups. The description should be supplied by the groups themselves, so extra LCD staff time would not be needed. The purpose of LCD distribution is to reach people at the height of their concern, especially those whom LCD for any reason has been unable to help.

D. Inspection Results: Inconsistency Aggravated by Unorganized Approach

Background

The Advisory Committee found that LCD is staffed by dedicated professionals, but that inspections of substantially identical facilities by different teams may still produce vastly different findings. Though some results which appear inconsistent on paper may not be so when viewed in context, for the most part genuine inconsistency is acknowledged to be endemic in the field of nursing home regulation. Further, under certain bureaucratic conditions, inconsistency can be fostered rather than inhibited. The Auditor General found in 1982 that:

> The department inconsistently applies health standards because it lacks adequate guidelines for interpreting these standards, because it has not monitored the citation process, and because it has not provided sufficient training to district office personnel.

Findings

1. Lack of careful written analysis promotes inconsistency.

LCD uses federal and state "interpretive guidelines" which explain the purpose of each regulation and how to inspect for compliance with it. There is also a thick Procedure Manual covering administration, licensure, inspections, citations, and enforcement, and providing extra interpretive guidelines in some substantive areas. The Manual's stated purpose is to define policies, functions and activities, and to be used for training and for developing and simplifying standardized procedures.

However, as seen in this Chapter and Chapter V, the Manual covers some subjects in disorganized or misleading fashion, and others not at all. Recent memos in response to Auditor General recommendations contain similar failings, though some (e.g., revised complaint handling, Section C above) have been better-drafted than others (e.g., guides for distinguishing A and B violations, see Finding 2 below). During this study, a number of orally-explained policies and procedures could not be found in written form.

In general, LCD leadership seems uncomfortable with detailed, structured, written analysis, preferring to operate on a person-to-person basis. Inevitably, some statements transmute or dissolve between one conversation and another, or in the process of translation to bureaucratic paper. Others made in haste reveal failure fully to analyze the question:

> Q: How consistent is the methodology used . . . in conducting surveys? Would greater consistency be beneficial? If so, what specific recommendations can you offer for increasing consistency in the performance and evaluation of surveys?
>
> A: . . . The survey team complement and associated time spent in facilities vary between district offices due to differences in staffing makeup . . . and facility profile . . . (types of facilities, and whether abbreviated survey can be utilized). The utilization of workbooks used to conduct surveys and the forms used to record deficiencies was found to be consistent among the districts.

LCD's leadership makes commendable efforts to get "out in the field" and interact with staff who do the real work. But in a large bureaucracy dealing with unquantifiable matters, no important principle should be communicated only by word of mouth. The spoken word is essential for emphasizing, reminding, and explaining, but it is ephemeral. While clearly organized written guidelines based on careful un-

derlying analysis cannot ensure consistency, consistency is impossible to achieve without them. They do not replace the exercise of professional judgment, but clarify the steps to be taken and the questions to be answered. They provide a common basis for training and monitoring of results, and a common place to turn when doubts arise.

Inconsistent application of the law has negative effects on facilities, on attempts to evaluate and compare facility quality, on LCD's allocation of resources, and on determinations about whether and how the law is actually working. The next finding therefore discusses in more detail one important area where improved analysis is needed.

2. Efforts to clarify citation guidelines have fallen short.

Every deficiency must be corrected, but all are not necessarily subject to fines or other sanctions. Those which violate state (rather than only federal) statute or regulations are classified according to potential effect on residents' health and safety.[45] Deficiencies with only a minimal relationship to health and safety are "C" violations, which receive no citation or financial penalty. For the more serious "A" and "B" violations, however, the inspector must issue a citation.[46] These carry both stigma and the possibility of civil fines (see Chapter V, Section A). Also, because of their seriousness and because more detailed records are kept about them, A and B violations have come to serve as the major practical indicator of facility quality. For both these reasons, it is important that inspectors evaluate violations in a consistent manner.

LCD, and Attorney General's enforcement staff, say that the "quality" of citations has improved--that is, they are more substantial

and therefore easier to uphold. If more violations are uncontested or upheld on appeal, that could indicate that the worst inconsistencies are being eliminated. LCD can provide useful statistics only as to those violations appealed to an informal conference, which leaves an information gap for those which go directly to court (see Chapter V, Section B). For 1978-1982, at informal conferences only, it is true that a lower proportion of appealed B violations are upheld. The percentage of appealed A violations which are upheld, on the contrary, is lower than before.[47]

In any case, the Auditor General studied citations issued in 1981-82, found unacceptable variations in the levels assigned to similar violations, and recommended that clear written criteria be developed. Closer analysis reveals some specific areas of confusion where improved criteria can help.

Example--no help in distinguishing A from B violations: Statute and regulations define A violations as follows:

> Class "A" violations are violations which the state department determines present either (1) imminent danger that death or serious harm to the patients . . . would result therefrom, or (2) substantial probability that death or serious physical harm to patients . . . would result therefrom. A physical condition or one or more practices, means, methods, or operations in use in a . . . facility may constitute such a violation . . . . Health & Safety Code Sec. 1424(a)

> Substantial probability means that the likelihood of an event is real, actual and not imaginary, insignificant or remote. 22 Admin. Code Sec. 72701(a)(1)

> Serious physical harm means that type of dangerous bodily injury, illness or condition in which: (A) A part of the body would be permanently removed, rendered functionally useless or substantially reduced in capacity, either temporarily or permanently and/or (B) A part of an internal function of the body would be inhibited in its normal performance to such a degree as to temporarily or permanently cause a reduction in physical or mental capacity or shorten life. 22 Admin. Code Sec. 72701(a)(2)

"B" violations are defined as follows:

> Class "B" violations are violations which the state department determines have a direct or immediate relationship to the health, safety, or security of . . . facility patients, other than class "A" violations. Health & Safety Code Sec. 1424(b)
>
> Direct relationship means one in which a significant risk or effect is created and does not include a remote or minimal risk or effect. 22 Admin. Code Sec. 72701(a)(3)

The Auditor General, looking at actual files and at staff evaluations of hypothetical sample cases, found that these A and B criteria were applied inconsistently, both within and among the district offices.[48] In response, LCD issued Memo #83-1. The memo states that professional judgments about the seriousness of a situation will vary according to the individual resident and "possible extenuating circumstances," and that "the decision to issue a citation, and the determination of the level of the citation, must be done in an objective way based on an analysis of the facts of the individual case." Attached to the memo is a one-page sample analysis that uses a "tree" of yes/no questions. The sample does not distinguish between A or B violations. It is not discussed here in detail because it is being amended.

Nor has LCD designed the sort of regulations envisioned by the legislature, "setting forth the criteria and, where feasible, the specific acts that constitute class 'A' and 'B' violations under this chapter."[49] Regulations do not set forth specific acts, but instead give examples of specific regulations and say that their violation could be an A (or B) violation, if the circumstances met A (or B) criteria.[50]

The statutory definitions themselves also create apparent inconsistencies. B criteria in particular are so broad as to cover a huge range of violations. For example, two B citations were issued for failure to restrain residents in wheelchairs; in one case the resident had to sit

slumped over, and in the other case the resident fell from the chair and was "left lying on the ground moaning and covered with feces."[51]

Example--Confusing information on effect of mitigating circumstances: The statutory definitions for A and B violations are concerned only with whether some act, practice, or condition violated the law, and whether this violation presented certain risks to patients. In keeping with traditional health and safety law, no exceptions are made for good intentions, lack of resources, etc. If the violation exists, and if it is responsible for certain harm or risk of harm, it is an A or B violation. (See Chapter V, Section B, for discussion of "strict liability.")

Mitigating factors are, however, taken into account in fixing the time for correction and assessing the amount of civil penalty. Factors include seriousness and extent of violations, number of residents affected, availability of equipment or staff, good faith efforts, and prior record.[52]

Since inspectors, in varying degrees, feel natural sympathy where mitigating factors exist, they need to understand that the law requires such factors to be ignored in issuing citations and applied only at the correction and sanction phase. But the Procedure Manual does not mention this principle and Memo #83-1, purporting to clarify issuance of citations, actually refers to "possible extenuating circumstances" as a valid reason for issuing different levels of citations for similar violations. This subject demands especially rigorous analysis to help inspectors implement the statutory intent consistently. Some examples illustrate the point:

Mitigating factors could reduce actual risk or harm and legitimately lower the level of violation. For example, there was testimony that a

fall from a wheelchair which caused facial injuries and a broken leg received only a B citation (for failure to have an adequate care plan regarding restraints). LCD explained that it was not an A because the facility quite properly sent the resident to the hospital right away.[53] Assuming all this to be true, the result seems incorrect because the actual harm caused by the violation clearly met criteria for an A citation. On the other hand, if the fall resulted in lesser injuries, and quick action by the facility prevented a probable escalation of those injuries, the B citation would be correct. The original violation may have caused a real risk of A-type injuries, but the facility acted to reduce or eliminate that risk.

The effect of mitigating circumstances can also sometimes be clarified by looking at how the regulation is worded. For example, compare the properly screened, trained, and supervised staff member who suddenly attacks a resident, with a properly-treated resident who nevertheless has a bedsore. In each case, the facility is taking all specific preventive actions required by regulations. In the former case, it has still violated regulation 72315(b) which says that the resident "shall not be subjected to . . . physical abuse." In the latter, it has not violated regulation 72315(f) because that regulation does not say that patients shall not be subjected to bedsores. Instead it says that the facility must provide "care to prevent" bedsores. However, Procedure Manual 402.3 perpetuates two apparent misinterpretations. It first says that if a bedsore develops, Sec. 72315(f) is violated. It then says that even so, no citation shall be issued if the facility properly followed and documented all procedures and orders. This both misin-

terprets the regulation and gives the impression that mitigating circumstances can affect whether a violation should be cited.

The above analysis is not intended to determine what the law really means, but only to illustrate the potential for confusion and inconsistency when guidelines appear to differ from statutes or regulations, and the difficulty of arriving at guidelines that do interpret them accurately.

Example--Unclear what is important enough to write up or cite: The Procedure Manual says that inspectors "must use discretion in determining if a violation exists," but offers no principles or examples to inform that discretion. Yet there are indications that inspectors vary in the strictness with which they write up deficiencies. For example, a facility criticized for having 21 deficiencies notes plaintively that this number is "very low for this inspector."[54] LCD reports that:

> Staff now utilize a more reasonable, professional approach with facilities, issue verbal citations on minor deficiencies . . . . Management has directed staff to work with facilities to bring them into compliance, rather than to cite deficiencies, on minor problems.

These directions are given orally, and include an example involving a single dead light bulb. If discovered in a storage closet, oral notice and immediate correction are reasonable. If over a resident's bed, or otherwise related to patient care, the deficiency is written up. Neither the principle nor the illustration appears in print. Thus the public may not learn of it at all, inspectors must operate on memory alone, and it is difficult to discipline one who ignores orders because the orders are not on record.

The Manual also says that a citation must be issued if a violation meets A or B criteria, but again refers generally to the use of discre-

tion in making that determination. What is a citable (B) violation? The Auditor General found that inoperative call-signals were cited as B in one facility, uncited as C in another, and seen as no violation at all in a third.[55] Testimony in Commission files indicates that some inspectors may issue fewer B citations because they feel unable to substantiate that a missed meal, or leaving a resident to lie in urine, has a direct or immediate relationship to resident health, safety, or security. By another view, B citations are under-issued because until recently they could seldom be fined, and inspectors have seen them as a meaningless paper exercise. (See Chapter V, Section A, for recent developments affecting this.)

More specifically, as of 1983 no citation is permitted for a violation reported by the licensee as an unusual occurrence, as long as there is no associated harm, prompt measures were taken to correct it and prevent its recurrence, and LCD first learned of it from the licensee's report.[56] So far, this principle has not been incorporated into Manual or memos.

Example--uncertain how many violations to write up for a single event: The statute says:

> Where no harm to patients or guests has occurred, a single incident, event, or occurrence shall result in no more than one citation for each regulation violated.[57]

That sounds pretty straightforward, until one looks more closely. First, the Auditor General found inconsistency in determining which regulations was violated.[58] Because fines often depend upon repeated violation of the same regulation, accurate identification of all regulations involved is very important. Second, as the Auditor General also discovered, one situation frequently violates several different regula-

tions.[59] For example, one resident hits another resident and the facility fails to notify either resident's doctor. This violates as many as 12 regulations.

LCD says that in such a case, inspectors are told to make the most appropriate regulation an A violation, and to back this up with B violations on all the others. (Note: this instruction does not appear in writing.) But in 1982 training, the Attorney General's office advised:

> Don't overdo citations--if one fact situation is involved, it is usually best to issue one citation and cite to the various regulations involved . . . . Many times the evaluator will issue one A citation based on [one regulation] and two B citations based on [two other regulations]. Since facilities frequently do not contest B citations, we may be precluded from alleging the facts relating to the B citations and therefore not be able to show the total picture. (Emphasis in original.)

In the case described, LCD says the facility was cited for 12 A violations. In the end, most were dismissed or reduced to corrected Bs, and the case was settled for a $4,000 fine. The result may have been fair, but a record that shows so many As "bargained away" can give the impression that this is a terrible facility and that LCD is biased in favor of the industry.

What is the right thing to do? The statute is no help. Sec. 1423(b) (above) does not demand a separate citation for each regulation, but only sets an upper limit. However, Sec. 1424 (a)(b)[60] says that if a violation creates certain dangers, it is an A (or a B) violation, and is to be fined accordingly, and Sec. 1423(a) says that a citation shall be issued for an A or B violation. Whether or not the statute envisions one citation per violation, citations seem to be a means of communication, and fines seem to attach to violations, not to citations.

Thus, in the example above, under the statute there seem to be 12 A violations. LCD can choose among evils. It can stick with 12 A violations, with obviously unfair results. It can "bargain down," as above, causing public misunderstanding and potential inconsistencies. It can consider mitigating factors and call most violations B's, probably violating the law as discussed above. It can ignore some regulations, violating the law and making it impossible to fine repeat violations of those regulations. It can issue two citations naming a total of 12 regulations, causing confusion over the difference between citations and violations, and leaving it unclear whether there are 12 A violations and 12 fines (unfair) or only 2 A violations and 2 fines (possibly violating the statute).

An attempt to develop systematic written guidelines might have brought these problems to the surface. While awaiting clarification, the guidelines could at least inform inspectors and public which approach was being taken, and state the factors to be weighed in applying that approach. The Procedure Manual contains no such analysis, and only a few hints. Section 307.00 instructs inspectors to look at the reason, rather than just the event, to see whether the real problem is unclear policy, inadequate training, etc. It also says: "The citation may indicate one or more violations of laws or regulations." Memo #83-4 amends this (without referring to it specifically, or to the 1982 training handout quoted above) by saying: "The citation must have only one section number identified as the violation cited." The reader who searched and found all these statements would still be unsure what to do.

More confusion arises where several residents are affected by one violation. Studies have found that one citation may list affected residents as examples, and another citation may list them as separate "counts," resulting in multiple violations and multiple fines.[61] Logically, such differences would occur if the citations with separate counts involved actual harm to several residents, making separate citations permissible under the statute. But, though citations with several counts are common, the Procedure Manual does not recognize them. Instead it instructs flatly:

> If it is determined that a violation or the underlying reason for the violation applies to or potentially applies to more than one patient or incident, a single citation rather than multiple citations should be issued, referencing specific patients or incidents as examples of facility practice.

Conclusion--guidelines are a continuing weakness and a major challenge: Examples dealing with issuance of citations indicate that some statutes are unclear and some guidelines are confusing or even misleading. However, this is an inherently-inconsistent field in which precise evaluations are impossible and professional judgment plays an important role. In attempting to reduce inconsistency by informing the use of discretion, guidelines should not become so precise that implementation would lead to unfairness. Also, they should not be stated in such a way that LCD's failure to follow any part would enable facilities to avoid enforcement "on a technicality." Thus, development of appropriate guidelines represents a major challenge for LCD.

3. Inspection methods foster inconsistent results.

Since inspectors must make subjective judgments on whether a facility is meeting the intent of each regulation, some inconsistency is

inevitable. In seeking ways to narrow the range of variation, these factors emerged:

Natural individual biases exist. They are revealed in the subjects that receive most attention (often those in which the inspector has special expertise), the amount of digging through records or conducting "body checks," and the strictness or leniency of approach. Training and guidelines can narrow the range of individual differences but cannot eliminate it completely.

When the same inspectors return repeatedly to the same facilities, these natural biases may result in varying "pictures" of quality for essentially similar facilities. Facilities are also tempted to focus improvement efforts mainly in areas important to "their" inspectors, regardless of which areas most need improvement or most affect residents' well-being. At present, inspectors' geographical assignments are said to be rotated about every year and a half. One obstacle to more frequent rotation in larger districts is the inconvenience and expense associated with travel distances. There, rotation may be possible only within smaller sub-areas and may depend more heavily on interchanging individual team members.

The basic, federally-mandated inspection form asks inspectors to check whether each element has been met or not met. Such individual yes/no decisions have no built-in corrections for bias. The two-inspector team surveys some areas independently according to expertise, shares responsibility for other areas, and works together to prepare the written list of deficiencies. Thus, at least where one team member is aware of uncertainty, a kind of averaging or consensus

effect might take place. But there is no formal arrangement for averaging several scores.

Similarly, no use is made of rating devices which replace yes/no decisions with a scale from, say, 1 to 5 (see Appendix IV-C). This provides more guidance for inspectors' discretion and results in less pronounced variations because borderline situations may be evaluated less arbitrarily. Iowa reports that more consistent results have been achieved since rating scales were adopted.[62]

Close examination of a sample of residents and their records is an important part of the inspection process. The Procedure Manual does not cover sampling; interpretive guidelines for a number of regulations suggest it, sometimes specifying a 10 percent random sample but never giving more detail. LCD says that a 10 percent random sample is reviewed, including all basic categories of residents (heavy care vs. light care, about to be discharged vs. newly admitted, private pay vs. Medi-Cal). In practice, however, the sample seems to consist of any patients who are seen to have problems when the inspectors make their initial walk-through, plus enough randomly-selected records to fill out the required number. The Advisory Committee concluded that sampling criteria are so imprecise that inconsistent results are almost inevitable.

4. Training and monitoring are scattered or non-existent.

To combat inconsistency, the Auditor General stressed the need for improved staff training and self-monitoring. Details on these are provided in Chapter III. Major points related to inconsistency of inspection results include: Apart from basic federal training, LCD offers no regular or integrated formal instruction in application of

standards or use of inspection techniques. LCD's training time and resources are so limited that it tends to rely on the "buddy system," and to grasp available opportunities rather than to develop coherent plans. Similarly, inspector performance is monitored only on an informal basis, using no standard guidelines on subject, frequency, or goals, and based on an inadequate management information system. LCD is trying to improve in these areas, but needs more resources if it is to succeed.

Recommendations

1. Clarified guidelines on issuing citations.

A balanced task force of interested parties (perhaps with help from student interns in appropriate fields of study) should help LCD analyze the decisions inspectors must make and develop structured guidelines for making those decisions in consistent fashion. A look at what other states do might be informative. For example, Michigan (see Appendix IV-D) takes the inspector step by step through identification and evaluation procedures, providing definitions and reminders about investigation and documentation needs at appropriate points. The supervisor and other administrators receive similarly detailed instructions.

When agreement cannot be reached on what the law intends, statutory changes are needed. For example, a legal opinion should be obtained on whether mitigating circumstances which do not change the degree or causation of danger may influence decisions on issuing or categorizing violations. Guidelines should then state when specific

factors should be taken into account, and give examples of situations likely to cause confusion.

Similarly, a legal opinion is needed on whether every regulation violated must be cited and fined. If so, amendments should be drafted that will attempt to achieve fairness by open means known to all, rather than by ad hoc administrative adjustments. Guidelines should promote consistency by stating a general rule, followed by criteria for making exceptions to that rule. The following is a structural example only, not intended to suggest substantive policy:

- For enforcement purposes, a citation may cover more than one violation. But fines are to be assessed for each violation, not for each citation, and all violations are to be tracked in order to identify later repeats (refer to section giving tracking procedure).

- Each regulation violated by a particular occurrence or practice must be cited if, viewed alone, it meets criteria for an A or B violation. For each such violation, a fine must be assessed. EXCEPTIONS: (list criteria permissible under statute and designed to promote fairness).

- There will not be more than one citation or fine for each regulation violated by a particular occurrence or practice, UNLESS harm to patients has resulted. In that case there will always be one extra violation cited and fine assessed for each resident harmed. EXCEPTIONS: (list criteria for not adding extra cites/fines).

Written guidelines should also cover subjects such as when to write up a violation, and how to identify and index every regulation violated.

2. Regulations to help distinguish A and B violations.

As required by law,[63] regulations should be developed, in cooperation with providers and consumers, using factual examples based on the most common situations to illustrate when violation of particular regulations would be an A violation, and when only a B (or a C). Each example must contain enough factual detail so that apparently

similar situations can be distinguished from it, when appropriate. However, details should relate to the harm or danger involved, and not to mitigating factors such as good faith or lack of resources (unless the law is revised or officially interpreted to permit this).

The following is not a recommendation, but only a concept to consider if the recommended regulations using factual examples fail to achieve sufficiently consistent results. In some states, regulations themselves are categorized as A or B according to how serious their violation would usually be; thus, any violation of a B regulations is a B violation, regardless of actual effect.[64] This is an extremely rigid approach which removes most inspector discretion and can lead to unfair results. It might, however, be possible to classify each regulation into a "default" category, which would mean that if a B regulation were violated it would be a B violation unless the inspector documented certain factors related to actual risk or harm which would change it to an A or a C. Again, examples would be used to clarify intent. In effect, current standards would still be applied, but with more consistency because in borderline cases the default category would tend to be used.

As a last resort, the statute might be amended to provide four violation categories rather than three. This could help remedy the overbreadth of the present B category. Narrower categories might improve consistency both in classifying and in assessing fines, though use of examples would still be essential. Again, this is not a recommendation but merely a possibility to consider if the problem persists. Further details are provided in Appendix V-D.

3. Inspection assignments and techniques to improve consistency.

Inspectors should be rotated among facilities as frequently as feasible. This would minimize the effects of individual interests and attitudes on inspection results, encourage facilities to be more introspective, and reduce perceptions of favoritism or vendettas. Other recommendations which could help include segmented surveys (see Section A above) and more special teams for "problem" facilities (see Chapter V, Section B).

Sampling instructions should be more detailed so that evaluations are made on a more comparable basis. In subject areas found to be most plagued by inconsistency, LCD should try using rating scales (see Finding 3 and Appendix IV-C). Either a federal waiver could be sought or the ratings could be translated into yes/no answers for federal purposes.

4. Integrated manuals, training, and moderating.

As described more fully in Chapter III, for consistent results LCD needs a better organized, comprehensive Procedure Manual coordinated with the Interpretive Guidelines to provide definitions and routines which can guide the exercise of professional judgment. Training should include role-playing based on the Manual and work sessions to improve it. Performance monitoring results should help pinpoint Manual areas needing clarification.

CHAPTER V

ENFORCEMENT: INADEQUATE ASSURANCE OF COMPLIANCE

Background

The goal of the enforcement process is to protect residents by producing permanent, genuine correction of violations and motivating facilities to prevent future violations. This is accomplished by making it more unpleasant to disobey the law than to obey it. If permanent corrections do not result, the worst violators must be removed from business.

While inspection and evaluation are heavily influenced by federal law, enforcement takes place mainly under state law. If a violation does not relate to residents' health, safety, or security, enforcement is limited to approval and monitoring of a correction plan. With more serious violations, inspectors issue A or B citations which may carry fines. If the overall pattern of violations at a facility indicates serious problems and failure to improve, trebled fines and civil or criminal prosecution are available. Ultimately, where conditions present a major threat to the health and safety of residents, the facility can be placed in receivership, have its certification to participate in federally-funded programs removed, or have its state license to operate suspended or revoked.

In general, analysis of the enforcement options available to LCD, and the manner in which they are utilized, leads to the following

conclusions about adequacy of fines and corrections, promptness and equity of citation appeal procedures, and availability and use of additional sanctions.

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

Background

If an inspector finds a serious violation of state statute or regulation, he or she issues an A or B citation. (This process is discussed in Chapter IV, Section D.) The inspector's supervisor then assesses a fine somewhere between $1,000-5,000 for As and $50-250 for Bs.[1] Violations that are not corrected on time must also be fined $50 a day.[2] Fines for repeat violations must be trebled.[3] Until 1983, there could be no fine for any B violation which was corrected on time; now a B which repeats a prior violation may be fined even if it is corrected.[4] If the facility decides not to contest, it pays only the minimum fine ($1,000 or $50) regardless of the amount originally assessed.[5]

Findings

1. Effect of present fines and recent statutory changes is unclear.

Most facilities receive a number of (federal) deficiencies or (state) violations, but do not receive A or B citations because their state violations are not found to be related to residents' health, safety, or security. About 40 percent of facilities have violations so serious that A or B citations are issued; only about 10 percent receive A citations.[6]

LCD says the trend is to fewer citations, fewer contested citations (thus more fines paid off at the minimum rate), and fewer daily fines

for uncorrected violations. Appendix V-A shows that the number of Bs has dropped steadily and radically, from over 2,000 in 1978 to 856 in 1982. Around 250 As were issued in 1978 and 1979, rising slightly in 1980 but dropping to around 150 in 1981 and 1982. No figures are available on daily fines for uncorrected violations. As shown in Section B, Finding 1, the percentage of citations contested probably has also dropped, and (at least at informal conferences) a higher proportion of Bs, but a lower proportion of As, probably are being upheld (as to level, but not necessarily as to amount of fine). Most fines are either paid off at the lowest rate by not contesting, eliminated by correction, or reduced/dismissed on appeal.

Because statistics usually do not distinguish among the above causes, figures on fines assessed and collected reveal little about trends or about overall effectiveness of the system. The figures showing fewer citations issued and appealed are subject to varying interpretations. For example, facilities may be getting better. Or, citations may be getting better. (LCD says it is using "a more reasonable, professional approach and issuing only verbal citations on minor deficiencies." This might eliminate some weaker cases.) Or, citations may be getting worse. (The same policy might lead some inspectors to overlook or underrate serious violations, which would also make for fewer citations and less incentive to contest.)

The industry, LCD, and the Attorney General's office feel that facilities are better and that recent citations have been better, i.e., that the system is working as intended to bring about real improvements.[7] But testimony of ombudsmen, local law enforcement officials, and others before this Commission and the Assembly Committee on Aging

reveals the perception that a number of facilities are not better, and that some have been able to avoid major penalties despite repeated serious violations.[8]

This Commission's Advisory Committee was of the opinion that A citations do affect the future conduct of most facilities which receive them, though there are some serious exceptions. Opinion differed on B citations. Some facilities do change, but most members felt that many "borderline" facilities have tended to disregard B citations, avoiding fines by paperwork "corrections" (as was found by the Auditor General),[9] and clearing the violations from their records by contesting with full knowledge that the state cannot afford to prosecute them (see Section B below).

The Commission finds that in some number of cases, the citation and fine system has not yet brought about desired improvements. But it is not entirely clear what changes would give the system greater leverage. The consensus of the Advisory Committee subgroup studying the citation system was that the size of fine was not so important as the stigma of being cited, and timely and effective enforcement of whatever fine is issued. By this view the recently-acquired power to fine repeat B violations, if combined with speedier and more certain enforcement of those fines, might solve many problems without necessitating more or higher fines. However, the group would not accept the general argument made by one member that, since facilities are already "strictly liable" for violations, adding more automatic fines or larger fines would be basically unfair (see Section B, Finding 3).

The Advisory Committee recognized that civil fines are not criminal fines. Their goal is not to punish, but only to draw attention to a

problem and motivate the facility to correct it. Thus, for example, most subgroup members were still willing to view a first B citation as a "fix-it" ticket, like an order to get a tail light repaired. If it is repaired, the public purpose is accomplished and there is no need for an automatic fine. In the past, the flaw in this scheme was that meaningless "correction plans" were accepted and that the cycle of citation-correction-no fine could be repeated endlessly. But since January 1983, B violations which repeat a former violation may be fined, even if the repeat violation is corrected (see Finding 2). Because uncorrected violations are also subject to daily fines (see Finding 7), constant violators may now be unable to avoid some sort of fine. The practical impact of this could be sizable, but has not yet been felt. The resulting uncertainty renders tentative both findings and recommendations in this entire subject area.

The Commission agrees that the goal is not to make the industry suffer, but only to be sure that residents do not. The question is whether the present system, including recent improvements, can accomplish this goal. The following findings examine this question in more detail.

2. Some confusion remains over automatic fines for repeat violations.

LCD does not keep statistics on repeat violations. The Auditor General found that 84 percent of facilities reviewed had repeated from one to fifteen violations, including some involving "critical health standards.[10]

> An assessment of civil penalties . . . shall be trebled and collected, except as provided for by law, for a second or subsequent violation occurring within any 12-month period, if a citation was issued and a civil penalty assessed for the

> previous violation occurring within such period . . . . Health and Safety Code Sec. 1428(e).

Despite this seemingly-mandatory law, treble fines for repeat violations have been rare. The Auditor General found that only 21 percent of repeat violations in a 1981 sample were tripled. This was partly because under former law, no fine could be imposed for any corrected B violation, but also because LCD had no mechanism for reviewing a facility's past record, and no clear understanding of what constituted a repeat violation.

Now, LCD's Procedure Memo #83-4 establishes a violation history sheet for each facility's file and instructs supervisors to review it when assessing fines. If inspectors are consistently noting every regulation violated, this should make tracking of repeats much simpler. The memo also defines a "repeat" by instructing supervisors to treble the fine for any second violation of the same regulation whether it is an A or a B violation. From here on, however, the picture becomes cloudy. The problem stems from reform legislation enacted in 1982, which was intended to fine automatically any repeat B violation, even if corrected, but to allow for adjustment on appeal if the result was inequitable.[12] The statute reads:

> If a class B violation is corrected within the time specified, no civil penalties shall be imposed, unless it is a second or subsequent violation of the same regulation occurring within the period since and including the previous full annual licensing survey inspection or 12 months, whichever is greater. In no case shall the period extend beyond 13 months. At the informal conference, the director's designee may waive or reduce the penalty as specified in subdivision (a) of Section 1428 . . . . The decision to waive or not to waive these penalties shall not be reviewable. Health and Safety Code Sec. 1424(b).

LCD's orally-stated interpretation was that this statute, in conjunction with Sec. 1428(e) above, requires trebling of any repeat B

violation. By other views, however, it envisions only an ordinary B fine ($50-250) for a second B violation. That violation would then become a "prior" and the next repeat would be trebled automatically under Sec. 1428(e).[13]

In clarifying when to treble fines, LCD emphasizes in Procedure Memos #83-4 and #83-6 that the fine for any repeat violation of the same regulation must be trebled. However, Memo #83-4(8) undermines LCD's oral statements about including corrected Bs in this category, by alluding only to former law under which such violations could receive no fine whatsoever:

> . . . A second violation of the same regulation can be trebled without regard to whether it is an A or a B. <u>However, as required in Health & Safety Code Section 1424(b), no penalty may be imposed when a "B" is corrected within the specified time</u> (emphasis added).

Also, the Procedure Manual still says that there is no fine for a corrected B, and so do various forms apparently still in use. Thus, written policies continue to implement former law, and do not recognize the 1982 amendment either as to the basic B fine for a repeat B violation, or as to LCD's expanded interpretation requiring that such a fine be trebled. LCD states that wording is based on advice from the Office of Legal Services.

What actually has happened with 1983 repeat violations? There are no statistics, and even an informal picture could not be provided due to legal controversies over the trebling of repeat B fines.

There is another potential impediment to proper implementation of some repeat fines. Since major inspections in some cases could now be as much as two years apart (see Chapter IV, Section A), limiting B fines or trebling to repeats that occur within a 12-13 month span

(which reflects the time between major inspections under former law) may no longer be appropriate. Especially if segmented, interim, or screening inspections cannot be implemented, such repeats could go undiscovered for over a year.

See also Section C on civil/criminal prosecution of repeat violators.

3. Automatic fines for first B violations would be premature.

Frustration with repeated, unfined, "corrected" B violations has produced suggestions that all Bs should receive automatic fines, just as As now do.[14] LCD itself once recommended this, though acknowledging that it might lead to more contested B citations.[15] But LCD now feels that increased contests will exacerbate the Attorney General's enforcement problems and that this risk outweighs any potential gain. LCD prefers to rely on its new power to fine repeat Bs, which should add weight to the first B as warning of a possible fine, perhaps even a treble fine, in the future.

In Advisory Committee discussions, industry representatives worried about imposition of automatic fines in one-time no-fault situations. But others stressed that citations without fines encourage frivolous appeals, because such violations disappear from the public record due to the fact that the state cannot afford to enforce them (see Section B below). The consensus was that no automatic fine should be imposed until it is seen whether the new repeat B fines provide enough leverage to produce lasting corrections.

4. Higher fines are controversial, but justifiable.

Fines range between $50-250 for B violations and $1,000-5,000 for A violations. These levels have not been changed since enactment of the statute in 1973. Meanwhile, the Consumer Price Index has risen by 117 percent,[16] and, as seen in Chapter II, Section B, ownership has been changing from "mom and pops" to corporations which have more extensive resources. This, plus the drastic reductions in fines which occur for various reasons (see Section B), means that the amount of potential fine can provide little real incentive to correct or prevent serious violations. Thus, a number of recent witnesses and reports have recommended increased fines.[17]

At the maximum end of the scale, it has been suggested that As be raised from $5,000 to $10,000 and Bs from $250 to $1,000. The increased B fine was proposed by LCD itself in 1977;[18] in addition to the factors cited above, proponents urge this increase in order to fill the current gap between a $250 top B fine and a $1,000 bottom A fine.[19] Higher fines might also make Bs "worth" enforcing (see Section B below).

At the minimum end of the scale, one report suggested raising the minimum B from $50 to $300.[20] However, for various reasons demand to raise the lower limits has been rare. A low fine may be suitable where a facility has few resources or a genuine "no-fault" violation. Also, the option of paying off a fine at a low minimum encourages facilities not to contest citations, which focuses energy on correction, saves LCD's time, and produces a timely and accurate public record. On the other hand, that feature of the law may make the system appear overly lenient. For example, a facility in August 1982 was assessed $30,000

for six A violations, decided not to contest, and thereby "bought out" for only $6,000. If the worst A violation were fined $10,000, that facility would pay off $60,000 at $6,000, a situation which is bound to raise questions.

A number of arguments are made against changing fines at this time. CAHF says that since human error is inevitable, the focus should be on repeat violators and we should wait to see whether fining repeat B violations will improve performance (see Findings 2 and 3). CAHF fears that fines will be assessed too high and will therefore be reduced on appeal, leading to an appearance of pro-industry bias (see Finding 6, and Section B below). CAHF argues that substantial amounts are already collected (see Appendix V-C), that fines are not a revenue measure but a means of changing behavior, and that the present system has improved behavior in many cases. The Attorney General's office has expressed concern that it is already hard enough to convince a judge there has been an A violation, and it would be harder still if the penalty were higher. Overall, the Advisory Committee subgroup which studied this issue concluded that:

> [T]he amount of the civil penalties is not truly significant . . . the enforceability of the citation and its penalties [is] significant. This viewpoint is predicated on the recognition that the purpose of the citation system is not to raise revenues or to be punitive per se, but rather to provide leverage to effect remedial action . . . . It is recognized that the fact of the issuance of a citation and the stigma which frequently attaches thereto is significant. . . . If the arbitration provisions are utilized or if litigation provisions are reformed to permit timely and effective enforcement, so that citations will not be contested without regard to the merits of the individual citation, . . . even the nominal civil penalties of existing law would likely remain adequate to effect the purposes of the act.

However, the Advisory Committee as a whole focused more on the fact that inflation has halved the real value of fines, and on the feeling

that fines are not commensurate with the seriousness of A and B violations. Though the Committee reached no final conclusion, this Commission finds these concerns to be legitimate. Section B below raises doubts as to whether adequately prompt and effective enforcement is attainable. In that regard, increased fines might improve the likelihood of court enforcement for at least the most serious B citations. Even given slow and uncertain enforcement, increased fines could motivate improvements by creating greater stigma and at least the threat of a greater financial sacrifice.

5. Present fines are ineffective for rights violations and retaliation.

Fines are needed to make patients' rights enforceable. As found in Chapter IV, Section B, only 1 percent of citations are for patients' rights violations, partly because it is difficult to prove the relationship of rights violations to citable "health and safety" goals. Given this difficulty, the importance of assuring basic human rights, and the general vulnerability of residents, it has been suggested that there should be an automatic $500 fine for violation of patients' rights.[21] In some states (e.g., Michigan and Illinois), rights violations are fined $100, which is paid directly to the affected patient. Still another approach, which avoids establishing a separate fine, would expand the definition of B violations to include those affecting health, safety, security, rights or welfare.[22]

CAHF argues that LCD should focus on situations which severely harm the individual, that some such situations might go unattended if rights violations take too much LCD time, and that rights should be handled through training and community involvement (see Chapter VI).

However, the Commission finds that most of the items listed as "patients' rights" are basic to human well-being, especially for frail and dependent people who must live in an institutional setting. Examples include rights to privacy in treatment and personal care; to decide about (and even refuse) treatments; to be free from mental abuse and unnecessary chemical or physical restraints; to be able to communicate, associate, and express grievances; not to be transferred without proper cause; and to be treated with consideration, respect, and recognition of dignity and individuality.

Under a 1982 statute, residents whose rights are violated may now sue the facility privately and obtain up to $500, costs, and attorney fees.[23] Because it depends on residents' awareness and determination, and on availability of legal assistance, this option is unlikely to bring about all necessary corrections. However, specific findings cannot yet be made.

Increased fine could both deter retaliation and facilitate its prosecution: In view of continuing fearfulness on the part of residents, families, and facility staff (see Chapter VI, Section B), it has also been suggested that the special fine for retaliation against those who express grievances be increased.[24] That fine now has a maximum of $500;[25] the proposal was that this should become a minimum. LCD itself once recommended that the maximum be raised to $2,500.[26] By one rationale, the maximum fine for retaliation should be the same as the maximum fine for an A violation, since that is the most the facility could "save" by suppressing a single complaint involving violation of a single regulation.

CAHF feels that fears of retaliation are almost always without foundation, and, as with patients' rights, that it would be better to resolve problems through community participation than through fines. LCD reports that retaliation is very difficult to prove because facilities can, if they choose, simply develop records that show legitimate reasons for their actions. Also, in LCD's experience, most victims would rather not remain at the facility, and would rather not become embroiled in controversy.

Given these contentions, the Commission finds that increased penalties can serve several purposes. Reluctant witnesses may be less reluctant if their sacrifices might lead to more than a "slap on the wrist" for the facility. Similarly, the cost of prosecuting such cases would be easier to justify if a larger fine were at stake. Both of these factors could combine to draw cases out into the open, which in turn would help determine whether retaliation is actually happening or whether, as CAHF contends, it is a common fear without basis in reality. Also, if substantial fines were imposed in only one or two cases, this would deter others who might be tempted to retaliate, and further encourage those who have feared to report grievances in the past. Finally, a sizeable fine would reflect the importance this state attaches to free expression of grievances.

An expanded definition of retaliation should have similar effects. See Section C below for discussion of this and of criminal penalties for retaliation. Chapter VI, Section B, contains related recommendations.

6. Inconsistent A and B fines will persist under present guidelines.

The Auditor General found that fines were being assessed inconsistently within the permissible dollar range. For example, an A violation involving one bedsore was assessed $5,000, while another where the bedsore caused worse harm was assessed only $1,000. Some supervisors assessed the maximum amounts while others related amounts to severity of the violation. Clear written assessment criteria, plus periodic training and monitoring, were recommended.[27]

The statute does not offer guidance on assessing fines, but provision related to their appeal state factors to be considered. These include the nature of the violation and how it relates to statutory purposes, seriousness of and similarity between repeat violations, extent of relationship to health, safety and security of residents, and good faith shown in correcting the violation.[28] There is one regulation on fine assessment, covering A violations only, which lists gravity (degree of probability, severity of harm, extent to which law is violated), good faith (awareness of law, diligence in complying, prior accomplishments, other mitigating factors) and previous violations.[29] LCD's Procedure Manual says only that fines are to be assessed by the supervisor, rather than the inspector.

LCD's response to the Auditor General gives no details on training or monitoring, but points to new Procedure Memo #83-6 as establishing the recommended clear criteria. The memo says that fines depend on the individual situation, reprints the terms of the A violation regulation described above, and restates that regulation for use with B violations. LCD says the memo is based on advice from the Office of Legal Ser-

vices. Though it adds nothing new, it does communicate existing criteria more methodically.

By contrast, consider the Iowa system. Inspectors fill out a nine-factor form to guide those who will assess the fine. Because Iowa has only 400-500 nursing homes, one group of people can then review all forms and assess all fines, a collective process which promotes consistency.[30]

To the extent that the permissible ranges of A or B fines are expanded (see Recommendation 1 below), the challenge of reducing inconsistent assessments will be greater than ever. Also, no technique for increasing the consistency of fines can succeed alone. Until LCD clarifies the level and number of citations to be issued (see Chapter IV, Section D), inconsistent citation practices will naturally result in inconsistent fines.

7. Inadequate "corrections" avoid daily fines and some repeat fines.

There is a mandatory $50 fine for each day a violation continues past the specified correction date.[31] A partial correction is not enough; no waiver is permitted.[32] There are no statistics on the number of these violations or the amount of fines assessed or collected. Apparently most corrections are made on time, but the question is whether they are genuine.

LCD's Procedure Manual explains, we believe properly, that the violation to be corrected consists of the practice which caused a particular incident. The incident is seen as an example or result of the violation, not as a violation in itself. Thus, the public may see a terrible injury and wonder how LCD can claim the violation was correct-

ed; if preventive measures are taken to avoid recurrence, a correction has in fact been made.

However, the Auditor General found that inadequate correction plans[33] were being accepted, and that inadequate follow-up was done to see whether plans were implemented.[34] According to recent testimony, others perceive similar failings.[35] Further, federal rules requiring on-site reinspection to be sure corrections have been made are about to be changed in favor of money-saving flexible follow-ups, often conducted by telephone.

In response to the Auditor General, LCD issued Procedure Memo #82-5, requiring that correction plans state how the correction will be done (both temporarily and for the long run), who is responsible for doing it, how they will monitor to prevent recurrence, and the date by which the plan will be implemented. Regulations provide guidelines on setting time for correction.[36] The memo also covers related procedures such as review of the plan by both inspector and supervisor, and stresses the need for special care with facilities that have a history of repeat violations. Another memo, #83-4, establishes a tracking system for citations and instructs that if a correction notice is not received within 10 days after correction is due, the clerk shall notify the inspector's supervisor.

Review of a small sample of correction plans approved in 1983 found some that were more precise and others that were no better than before. Parroting the regulation and using "inservice training" as a panacea both persist, as in the following examples:

<u>Violation</u>: The administrator has not planned, organized and directed all the responsibilities delegated by the governing body.

Correction Plan:	The administrator has planned, organized and directed all responsibilities delegated by the governing body. The administrator will monitor.
Violation:	The doses of drugs administered to patients were not properly recorded on the medication record by the person who administered the drug on at least 20 occasions in 12 of 12 medical records reviewed.
Correction Plan:	Inservice will be provided on proper documentation of medications recorded by persons administering drugs.

LCD is aware of continuing problems, and stressed in recent training that plans may not be accepted which do not cover the points in Memo #82-5.

Now that LCD is able to fine any uncorrected violation, any A violation, and any repeat violation, correction plans remain important for two reasons. First, if inadequate correction is accepted, the facility avoids the daily $50 fine. If it is for a first B, fines are avoided altogether. All the facility has to do is escape discovery of repeats within the next year, and it may begin all over again with a clean slate. Second, proper correction plans can be an important management tool for the facility itself. By insisting on more carefully designed plans, LCD can influence a facility's ability to bring about permanent improvements.

8. Fines for misleading records would cut two ways.

The Assistant Attorney General has suggested an automatic fine for failure to keep patient care records up to date, because what looks like a violation may be dismissed on appeal when facility staff testify that the "missing" care was given, but simply not recorded.[37] The

problem with fining incomplete records is that it increases focus on paperwork, both by LCD and by facility staff. It also is likely to increase the number of falsified records, leading to still more "paperwork" regulations and fines. On the other hand, inaccurate care records can damage a facility's ability to provide appropriate care, as well as LCD's ability to enforce the law. This problem is covered in Section B, Finding 2, below.

Recommendations

1. Increased fines for A and repeat or uncorrected B violations

After weighing the factors presented in Finding 4, the Commission recommends that maximum potential fines for A violations be raised to $10,000. In view of the life-and-death nature of A violations, an increase which does not even raise the fine to its original real-dollar level is not out of line. This Commission is not sufficiently optimistic about improving the enforceability of existing fines. As seen in Section B below, informal conferences presently reduce fines by over half, arbitration has not even been tried in its first six months of existence, and other proposals to speed enforcement all contain flaws. Where swift and sure enforcement is uncertain, the stigma and financial risk of higher potential fines are needed to motivate additional improvements.

Maximum potential fines for B violations should be raised to $1,000. In addition to the above rationales, a complete range of fines should be available, without the current $750 gap between the highest B and the lowest A. Also, higher B fines are apparently essential to justify the cost of enforcement, either in court or by arbitration (see Section B below). This recommendation is based on the assumption that

LCD does not have power to treble the fine for a first repeat B; if that assumption is incorrect, then results of trebling should be studied under Recommendation 2 before making changes in maximum fines for B violations.

Because of the existence of no-fault violations and small "mom and pop" facilities, minimum fines should not be raised appreciably. For B violations, however, the $50 floor should be raised to at least $100. These recommendations would result in the following changes:

	CURRENT FINES	PROPOSED FINES
A	$1,000 - $5,000	$1,000 - $10,000
B	$ 50 - $ 250	$ 100 - $ 1,000

2. Data analysis and study of other proposed changes in A and B fines.

Based upon analysis of data as described below, and all other available information, a balanced study group should consider the need for further changes such as increased or decreased fines, automatic fines for all B violations, or formulas which relate fines to facility size or to the amount of money "saved" by the violation. (Such formulas are used in some other states to more consistently arrive at an amount sufficient to induce correction. In Illinois, for example, an A fine is $4.50 per resident plus 25 cents per resident day until corrected; a B fine is figured at $3.00 and 10 cents respectively. If understaffing contributed to the violation, an amount is added equivalent to the extra cost of hiring appropriate staff.)

Detailed data will be needed to measure, correlate, and identify trends in factors such as the following (these are examples, not intended as a comprehensive outline of information needed):

- consistency in numbers and levels of citations issued,
- whether all regulations violated are being identified and tracked,
- appropriateness of correction plans and actual corrections,
- number and percentage of violations repeated,
- how these were fined (rule applied, amount, waiver, collection, etc.),
- number and percentage of violations not corrected on time,
- how these were fined (if not collecting $50 per day, why not?),
- number and percentage of contested citations (A, first corrected B, repeat B, trebled, uncorrected, etc.) and grounds for contest (separately for CRC, directly to arbitration, directly to court),
- number and percentage of each which were upheld/modified in specific ways/dismissed on first appeal, and why (separately for CRC, arbitration, court),
- number and percentage of further appeals of each type dismissed by Attorney General without prosecution,
- number and percentage of further appeals upheld/modified in specific ways/dismissed, and why (separately for arbitration, court),
- amount of fine assessed, reduced, collected at each stage,
- cost to prosecute at each stage of appeal.

Another important area for study is what happens when maximum fines are raised but minimum fines remain low. This might exacerbate several existing problems: facilities may "buy out" or bargain down to

ludicrously low fines, and assessments within each category may be more inconsistent than ever. If so, one suggestion for study would be to use four categories instead of the present three (see Appendix V-D for example).

3. B violation redefined to protect patients' rights.

Patients' rights violations, at least those related to individual well-being, should be fined. It is good that residents now have a private right of action, but it is also unrealistic to expect most residents to make full use of that right. Patients' rights are important enough to have a place in statute and regulations; therefore the state should have some means of convincing facilities to observe those rights.

The recommended approach is to insert the word "welfare" into the definition of a B violation:

> Class "B" violations are violations which . . . have a direct or immediate relationship to the health, safety, security, or welfare of [residents]. Health and Safety Code Sec. 1424(b)

"Welfare" should be defined to cover emotional well-being, which has been difficult to protect under present "health, safety, and security" language. Though model statutes cover both "welfare" and "rights,"[38] that might permit fines for some violations which, under the circumstances, had no real potential for embarrassment, frustration, humiliation, etc. California law intends that fines apply to actual situations, not theoretical ones. However, if it proves too difficult to interpret the term "welfare" fairly and consistently, use of the word "rights" should be considered or, alternatively, use of a separate flat fine for all rights violations.

4. Increased fine for retaliation offenses.

For the reasons enumerated in Finding 5, the definition of retaliation under Health and Safety Code Sec. 1432 should be expanded, the fine should be raised to a range of between $500 and the amount of the highest potential fine for an A violation, and such acts should be made a misdemeanor. See Section C, Recommendation 3, for details.

5. Clarification on fines for repeat B violations.

Based on Finding 2, Health and Safety Code Secs. 1424(b) and 1428(e) should be amended to clarify treatment of repeat B violations and to adjust time frames for repeats. If B fines are increased, a first repeat B violation should receive a standard B fine, with standard possibilities for modification upon review. That violation would be the basis for an automatic treble fine for subsequent repeats. However, if basic B fines are not increased, trebling the first repeat B, as LCD tried to do in 1983, would be necessary to make contested fines enforceable and to stimulate improvement. In view of the new potential for less complete inspections and for greater than one-year intervals between inspections, both sections should define a repeat as any violation of the same regulation occurring within a two-year period.

The Office of Legal Services and LCD should clarify memos and forms to reflect the new law, rather than pre-1983 law under which corrected Bs could receive no fines. Standard procedure for any visit to a facility for any purpose should include checking for repeats of violations cited in the past year. Also, a spot check should be made before the statute of limitations runs out on unfiled contested violations. If LCD is understaffed, an ombudsman or other frequent visitor

to the facility should be consulted, and a visit made if the report raises questions. Upon discovery of a repeat violation, prompt determination is needed on whether to notify the Attorney General for filing of an unfiled prior (see Section B) or law enforcement authorities for potential criminal prosecution (see Section C).

6. Expanded guidelines for assessment of A and B fines.

The Office of Legal Services and LCD must develop more detailed guidelines (possibly including examples) for consistent assessment of fines. Present criteria should be expanded to include the amount the facility would save by continuing the violation, and the size of fine needed to make this facility, given its financial resources, pay attention. Factors could be evaluated by inspectors and supervisors on a standard form, then reviewed by a small group in each district office which would jointly assess all fines for that office. Training and monitoring should help to assure that criteria are followed consistently. If inconsistent fines remain a problem, an A-B-C-D system might be considered (see Appendix V-D).

7. Detailed sample correction plans.

Detailed sample correction plans should be developed for common situations where such plans are difficult to design. If LCD does not wish to do all the facilities' thinking for them, the samples could be used simply as guidelines for evaluating plans that facilities submit. Some LCD consultants already have "boilerplate" in the word processor which might help with this task. The following example is not profes-

sionally developed and is meant only as a bare beginning for purposes of illustration:

> Inservice training will be given by _____ before __/__/__ to the following staff: _____. Repeat or refresher training will be given every __ months. Makeup opportunities for staff who miss this training will be _____. Topics covered will include _____ (specific list). For each session, facility records will show the date and instructor, and will contain student signature sheet, outline of topics covered, and post-exam papers demonstrating that the material has been learned. Samples of all resources and handouts used will be available for inspection. _____ will be responsible for assuring that this plan is followed and that accurate records are kept.

Also, correction plans should be compared with plans for prior violations to assure that an ineffective plan is not approved repeatedly.

8. Fine for falsified records.

As detailed in Section B, Recommendations 4 and 5, if care does not appear in the facility's records, there should merely be a presumption that it was not given. However, falsified care records should be fined as an A violation.

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

Background

If the facility disagrees with a citation (whether the violation exists, whether it is an A or B violation, amount of fine, time allowed for correction, whether correction has been accomplished), it may request an informal review conference (CRC). If still dissatisfied (or if it prefers to skip the CRC) it may demand a complete trial in Superior Court. Or, starting in 1983, either side may request binding arbitration.[39]

Findings

1. Most contested citations are modified, but reasons are unclear.

LCD statistics (Appendices V-A, V-B, V-C) do not offer a clear picture of the appeal process. Table V-1 extracts those items for which figures can be compared across years, and Table V-2 analyzes the more detailed information available for first quarter 1983, which is too small a sample to be fully reliable. In summary, these two charts reveal that since 1978 the rate of CRC appeals is down, and the percentage of citations reduced to a lower level or dismissed at CRC is higher for As, lower for Bs. The overall appeal rate (including direct court appeals) cannot be compared. Recently it was 60 percent of As and 35 percent of Bs; 11 percent of all violations issued were ultimately appealed to court. Recent CRCs upheld 15 percent of As and 9 percent of Bs, modified 70 percent of As and 84 percent of Bs, and dismissed 15 percent of As and 7 percent of Bs; fines were reduced by well over half. As seen in the 1983 chart under "interpretation," most violations end up unfined, paid off at the lowest rate, or with reduced fines.

Table V-1

CITATION REVIEW CONFERENCES

Cases appealed directly to court are not included: therefore this table does not represent the total number of appeals

	A VIOLATIONS			B VIOLATIONS		
	1978	1982	1st Q 1983	1978	1982	1st Q 1983
Total violations	255	152	62	2084	856	211
Appealed to CRC	183 (72%)	67 (44%)	34 (55%)	704 (34%)	162 (19%)	58 (27%)
OF THOSE APPEALED:						
Level sustained (but fine possibly reduced)	109 (60%)	35 (52%)	17 (50%)*	434 (62%)	125 (77%)	40 (69%)
Reduced to lower level or dismissed	74 (40%)	32 (48%)	17 (50%)*	270 (38%)	37 (23%)	18 (31%)

Table based on LCD information in Appendices V-A and V-B.

*Figures differ on LCD charts. Appendix V-A is source; V-B shows 21 (62%) sustained and 13 (38%) reduced.

Table V-2

ADDITIONAL APPEAL INFORMATION

Based only on first quarter 1983 (Appendix V-B)

	A VIOLATIONS	B VIOLATIONS
Total violations	62	211
Appealed to CRC	34 (55%)	58 (27%)
Appealed directly to court	3 (5%)	17 (8%)
Total appeals	37 (60%)	75 (35%)
RESULTS (CRCs ONLY) (PERCENT OF VIOLATIONS HEARD)		
Violations heard	34	58
Sustained intact	5 (15%)	5 (9%)
Fine reduced	16 (47%)	35 (60%)
Reduced to B	8 (23%)	
Reduced to C		14 (24%)
Dismissed	5 (15%)	4 (7%)
FINES OWED		
Before CRC	$141,500	%15,750
After CRC	57,000 (40% of orig.)	4,550 (29% of orig.)
APPEALS TO COURT		
Direct	3	17
After CRC	4	7/9*
Percent of total issued	11%	11%/12%*
Percent of contested	19%	41%/45%*
INTERPRETATION (PERCENT OF TOTAL VIOLATIONS)		
No contest	25 (40%) paid off @ $1,000	136 (64%) corrected and unfined or paid off @ $50
CRC	29 (47%) fine reduced/dismissed 5 (8%) upheld with fine intact (4 appealed further)	53 (25%) fine reduced/dismissed 5 (2%) upheld with fine intact (7/9 appealed further)
Direct to court	3 (5%) results unknown	17 (8%) results unknown; often dismissed (Finding 5)

*Figures on p. 1 of LCD chart differ from those on p. 2 (Appendix V-B).

Little is known about what happens to citations which facilities appeal to the courts. Cases referred to the Attorney General during a given year often culminate a year or two later, but statistics are reported by year rather than by tracking each violation (Appendix V-A). Thus one cannot compute the percentage of cases dismissed or settled; roughly 10 percent of court As and at least half of court Bs are dismissed without penalty (see Finding 5). Details on results (i.e., whether upheld, modified, or overturned) also are unavailable.

Similarly (Appendix V-C), one cannot compare fines assessed against fines collected, or determine what proportion of assessed fines is lost at each stage (i.e., correcting B violations, "paying off" at minimum rates rather than contesting, reduction at CRC, dismissal by Attorney General without prosecution, reduction by settlement or court decision).

The law automatically reduces or eliminates some fines in order to encourage corrections and non-contests. The appeal system is supposed to make adjustments in the interest of fairness, and includes a good deal of "plea-bargaining," costs, and delays. These features combine to produce a large number of reductions and dismissals, especially as to the amount of fines. This creates an image of ineffective enforcement which can tend to anger the public, frustrate inspectors, and encourage some facilities to file unfounded appeals and to drift in and out of compliance.

Records do not reflect the reasons why LCD loses appealed cases. Reasons that have been suggested include differences in judgment about seriousness of a violation (see Chapter IV, Section D, on inconsistency), the fact that much of the evidence comes from the facility itself,

difficulty in meeting statutory definitions, inadequate investigation and case preparation, overpowering of LCD witnesses by facilities' experts, and inability to afford prosecution of low-fine violations. The following findings explore some of these problems, and also some other reasons for perceived inequities in the present citation appeal system.

2. Facility control of evidence creates problems of proof.

The control that a facility can exercise over records, witnesses, and events creates a major evidentiary advantage. LCD cannot be in a facility constantly (rarely as much as 1 percent of the time), and may have no way to test the reliability of facility records in determining what has happened or why. (See Chapter IV, Sections B and C, on other information sources.)

Incomplete records lead to dismissed citations: Sometimes records fail to reflect treatments or other care which should have been provided. For example, a citation is issued because a bedsore has developed and, according to records, appropriate care was not given. The failure to document care leads to a reasonable inference that the care was not in fact given. But on appeal, facility staff might testify that the care was given but simply not documented. It is rare that LCD can rebut or even validate such testimony. According to the Attorney General's office, if LCD cannot prove the staff are lying, the citation is likely to be dismissed or reduced;[40] A or B standards are difficult to meet based on recordkeeping violations alone. (CAHF, however, says that judges do not accept the word of a nurse or aide without further corroboration.)

The Attorney General's office suggested a $500-1,000 fine for failing to record treatment or services rendered, if the condition that was inadequately documented caused harm to a resident. But a fine for failure to record care that was actually provided can cause both LCD and the facility to focus more on the records than on the care itself. The Advisory Committee concluded that accurate records are vital, not just as a way to prove violations, but also as the facility's basis for planning and providing future care. From this perspective, any gap or mistake in the records is a potential threat to residents. But the Committee did not propose to fine all such records, feeling that because of human error virtually every facility might be fined, that focus would shift too much toward paper, and that falsification of records might significantly increase.

What is needed is perhaps impossible--to encourage accurate records without shifting focus away from care and protection of residents. The Advisory Committee suggested attempting to offset the facility's evidentiary advantage by giving greater weight to the reasonable inference that a failure of documentation reflects a failure of care. This would be accomplished by a legal presumption that care not recorded was not given, which the facility could overcome only by "clear and convincing evidence." Thus, unless the facility could tip the evidentiary balance scales very clearly, a citation for failure to give care could be upheld based on omissions in facility records and despite staff testimony to the contrary.

False records are hard to detect and fine: However, where the problem is not merely omission but falsification, the Advisory Committee recommended a large and automatic fine. Records do sometimes show

that care was given just as it should have been, when in fact it was not. The Assembly Committee on Aging heard testimony from an aide that overworked staff fill in charts with whatever response is known to be correct, from an ombudsman that staff were reportedly asked to chart untrue things,[41] and from a rabbi that food intake records for a resident he visited regularly showed he was eating when in fact he was not.[42]

Advisory Committee members reported that care is sometimes charted at the start of a shift, before it is actually provided, but staff may later be too busy to give all the care. Regulations say that the date, time, and dosage or type of drug or treatment must be recorded (or initialed) by the person administering it, but do not require that recording take place after administration.[43] Also, the words "drug or treatment" may not cover all care which should be recorded in this fashion. However, there is another regulation which could be interpreted to encompass all these concerns:

> Patients' health records shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each patient . . . . Title 22 Administrative Code Sec. 72543(f)

If a record is false, how can this be discovered and proven to the satisfaction of a court? If, as just described, the original record is false, the only proof would be in a resident's deteriorated condition or by eye-witness evidence from staff or regular visitors. But where an original record has later been altered, other clues are available. The Procedure Manual instructs inspectors to photocopy relevant records immediately. This makes it easy to identify any later alterations or additions. However, inspectors do not always follow these instructions (see Finding 3). Also, there are no written instructions on other ways

of detecting falsified records, though the subject is said to be covered occasionally in training. LCD says that to place such information in the Manual, which is a public record, would simply advise falsifiers how to avoid discovery.

Professional practice does permit alteration of records, if the original was inaccurate and if the alteration is made openly, in chronological order, and without obscuring the original. But any change that appears clandestine would violate the health records regulation quoted above. For example, an inspector photocopied incomplete records, and later found they had been replaced by complete ones. This was cited as a B violation.[44]

However, it is difficult to prove in any particular case that a paperwork violation meets A or B standards. The Advisory Committee felt that any falsified record represents a threat to residents and should be fined heavily and automatically. That is, if falsification is proven, the effect upon health and safety should not have to be proven separately. Further, though omissions may well be inadvertent, actual entries showing proper care are probably willful in nature. If entries were required to be made by the caregiver <u>after</u> giving the care, a false entry would logically be made with knowledge that it was false. The writer could have inadvertently entered an inaccurate time, dose, etc., but where that entry showed the <u>correct</u> care instead of the care actually given, the Commission finds a rebuttable presumption of willfulness to be more than justified.

In Medi-Cal facilities (almost all facilities), genuinely willful falsification of records with intent to defraud is a state and federal crime, and conviction can cause loss of professional licenses. However, LCD

has no practical routine for referring such cases to prosecutors (see Section C below).

3. Statutory definitions can be met, but poor case preparation makes some citations hard to defend.

Statutory definitions are not too difficult to meet: The Assistant Attorney General has found the definition of A violations to be the most difficult obstacle to their successful prosecution.[45] It calls for "a substantial probability" of "death or serious physical harm," and facilities are said to escape by showing that "people never die from that." Without the word "substantial," the argument goes, proof of A violations would be more realistically possible. But a subgroup of the Advisory Committee reviewed the expanded definitions provided by regulation[46] and concluded that the definition clearly covers temporary impairments as well as life-threatening situations, and is both adequate and appropriate. Without data or cases to show that the definition is being misinterpreted by judges, this Commission cannot find that it is improper.

B violations require a "direct or immediate" relationship to residents' health, safety or security, which has been said to create an ambiguity. The Committee subgroup consensus was that this does cover violations which create a risk of harm, and not just those which create actual harm, and that the potential ambiguity has not been a problem.

Another perspective on definitions was provided by industry representatives, who argued that facilities should not be "strictly liable" for violations caused by factors beyond their control. Instead, they should be able to defend by proving that they had used reason-

able care. This argument was not accepted by the Advisory Committee. It is not known how frequently violations occur which could in no way have been reasonably prevented by the facility. But it was felt that LCD would have difficulty refuting such arguments because much of the evidence must come from the facility and its staff (see Finding 2 above). Also, strict liability traditionally has been applied in a number of regulatory settings, including health and safety. See also Chapter IV, Section D, Finding 2.

LCD's cases are not always thoroughly prepared: To support citations, one must prove facts. An Advisory Committee subgroup found:

> The Department's inability to . . . [provide] appropriate and necessary evidence is seriously in doubt. The conclusionary survey reports and the independent recollections of surveyors, over time, cannot provide sufficient detail to support such actions. Only well taken and preserved field notes of surveyors can contain the details required. Yet, no consistent or systematic method of preparing or maintaining field notes is prescribed by the Department. Safeguards to assure preservation and availability of such field notes is lacking.

A recent survey of local prosecutors also reveals frustration with LCD evidence (see Section C below). A Deputy District Attorney testified before this Commission that inspectors were good, but were untrained in gathering, preserving and presenting evidence. He said:

> They get to the citation review conference, and the facility is saying where is the record. Well, nobody thought to make a copy of the record . . . . I said, where did you get it, who did you get it from, when did you get it? Gee, I didn't know that was important.[47]

In late 1982, the Department's legal office and the Attorney General's office gave training on citation criteria, documentation, and evidence-gathering. LCD could provide no details on this apart from a short handout with 13 suggestions that ranged from spelling names

correctly to having an expert review A citations. LCD's Procedure Manual also offers some guidance. Several sections discuss when and how to take photographs, obtain witness depositions and affidavits, gather records, and record specific types of information. There are examples of witness statements and of the type of factual detail needed, and simple forms for field notes and photo identification. But the material is scattered. For example, some useful information is in the back under "legal/enforcement" and is not referred to in the sections dealing with inspections and preparation of citations.

If time-consuming "heavy documentation" is not done from the start, details and examples which later turn out to be important may be lost. Yet it is not practical to make equally-detailed notes at all times. Recent instructions are that whenever a situation seems likely to involve a citation, temporary suspension, or other legal action, legal advice is to be sought before inspectors leave the facility, rather than after the investigation is completed. However, no such instructions appear in the Procedure Manual; instead we are informed that "district administrators know it."

At one time, a special multidisciplinary team was sent to analyze and develop evidence at "problem" facilities. In 1977, this Commission heard testimony on the effectiveness of these teams and also on industry perceptions that team lawyers exerted disproportionate influence. The Commission was assured that the special team approach would continue in some form.[48]

"Special teams" now are drawn according to need from among seven San Diego and Sacramento supervisors and inspectors (RNs, manager, and generalist) and a physician. Other experts, such as pharmacist,

medical records specialist, or people from the audit and legal offices, are consulted as needed. These ad hoc teams must perform a variety of functions at a variety of facilities. In 1982 and early 1983, they did 27 surveys that had nothing to do with long-term care, 11 SNF "validations," and 21 complaint investigations, of which 16 "possibly" dealt with long-term care.

LCD says that to maintain complete teams for special investigations only is not cost effective. The Assistant Attorney General says that case preparation was no better with old-style special teams, and that it is more important to have the proper experts available on call. On the other hand, teams skilled in deep analysis and case preparation have been recommended by this Commission's Advisory Committee, and also in model nursing home enforcement statutes.[49] Available information does not reveal whether the present teams actually deal with all "problem" nursing homes, enlist other specialists as appropriate, and investigate and document so carefully that their cases stand up on appeal. However, since the above figures indicate that well under half of the work of these seven people had to do with nursing homes, and no work could be identified with certainty as focused on documenting deficiencies at chronic problem facilities, we must conclude that though the "old model" is inefficient, the "new model" probably spreads too few people over too large a field.

A related concern is LCD's general ability to call upon expert assistance. Gaps in expertise affect evaluation, case preparation, and prosecution. Though consultant services are generally adequate, the Advisory Committee found a need for physicians (statewide) and dietitians and pharmacists (in Los Angeles County). Further, LCD's exper-

tise may not be flexible enough. For example, according to the Attorney General's office, LCD's general medical consultants are very competent, but courts tend to be more impressed with facilities' highly specialized geriatric and other experts.[50] LCD says it is not authorized to omit some full-time staff positions and use the funds for contracts with a variety of top experts who could be "on-call" to provide analysis and testimony as needed.

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

The facility has five business days to decide whether to contest a citation. By not contesting, it earns the right to "pay off" the fine immediately at the minimum rate. If it contests, LCD must provide an informal citation review conference (CRC) within another five business days.[51] But the Procedure Manual permits continuances; recently, average business days between notice of contest and CRC have varied among district offices from 6 to 41, with a statewide average of 16 days (Appendix V-B).

The conference is not an administrative hearing; there are no technical rules of evidence, no subpoenas, no formal cross-examinations, no recording of testimony. The facility may be represented by legal counsel, present oral and written information, and explain mitigating circumstances. LCD's inspector should attend to substantiate the alleged violation. Both sides may present witnesses, but complainants and other affected parties have no clear right to participate in CRCs, unless called as witnesses.[52]

The idea is to obtain speedy resolution of most cases at an informal meeting, and protect due process rights through a complete new

hearing in court if the facility remains dissatisfied. The result is indeed speedy in its pre-judicial stages. Recently, district offices have taken from 2 to 10 weeks between citation and CRC (Appendix V-B, p. 2). However, as seen in Finding 1, 19 percent of contested As and 45 percent of contested Bs have ended up in court; a full court hearing is costly and can take years to complete.

Some other states rely instead on a more formal administrative hearing coupled with more limited judicial review. According to informal reports, this takes many more months for administrative resolution, but less time and money for cases appealed to court. The "informal conference" approach at least achieves rapid resolution for a majority of contested citations. The trouble is that any system which does not operate out in the open, with impartial judges and commonly-understood rules, may become biased or may simply be perceived as biased by concerned non-participants.[53]

Unbalanced participation makes for uncertainty about balanced results: If a citation is modified or dismissed, parties to complaints must receive a written statement of reasons.[54] This may be done routinely, but LCD could not provide sample copies. The CRC decision itself is a public record, and sample decisions did summarize briefly what happened and what evidence influenced the decision. But complainants often seem unaware of these documents and LCD has no standard notification procedure or letter.

Complainants and others affected by a violation have no formal way to be heard at the CRC. The Procedure Manual stresses that CRCs should be "limited to necessary participants;" thus even direct witnesses do not necessarily take part. For example, a complainant testified

that a facility received a B citation for refusing to permit her representative to accompany the inspector investigating her complaint. However, she reports that:

> Mr. --- decided that [her representative's] testimony would not be necessary, and would not allow him to attend [the CRC on this citation]. The citation was dismissed . . . .[55]

The representative's participation may or may not have been necessary, but the complainant felt shut-out and unsure whether justice had been done.

In discussions of opening up participation, LCD's major concern was that CRCs would be lengthier and more complex, and if they were moved to facilities to permit resident participation, LCD staff time and travel expense would increase. CAHF favored participation by complainants or their representatives, and observation by an ombudsman, but felt that admitting anyone affected by an alleged violation would make conferences too unwieldy. Until it is tried, one cannot tell which and how many extra participants will emerge, and thus how complex or costly CRCs would become.

Does the worried nonparticipant actually have cause for concern? Finding 1 shows that well over half of assessed fines disappear at the CRC, and only about 12 percent of violations heard remain unmodified. From discussions with LCD staff, it appears that CRCs often serve a "plea bargaining" function by which LCD dismisses citations where evidence is less than airtight, and facilities receive somewhat reduced penalties on stronger citations. Does this mean that a large number of citations or fines are being issued incorrectly? If so, do these result from inadequate training and guidelines, or from deliberate overstatement in the expectation that bargaining-down will follow? Or, were

they perfectly appropriate to begin with, and reduced because of unbalanced CRC presentations or inadequate training of CRC decision-makers? Each of these in its own way would result in unfairness, excess energy spent on contests, and misleading public information. The answer is unknown, but there are indications that some modifications may result from flaws in the CRC rather than in the original citation.

Some factors exist which could lead to unbalanced results: There once were three hearing officers whose entire job was to travel the state and conduct all CRCs. Presumably (there are no data on this), constant experience produced knowledgeable and confident officers, the small number of officers produced relatively consistent results, and separation of functions reduced the likelihood of bias. But, due to travel and uneven workloads, separate officers are not cost-effective. CRCs are now conducted by LCD's district administrators. A staff member who has performed in both roles says that, though the administrators receive no particular training apart from sitting in on two or three CRCs, results are equally good.

Is there evidence to support this conclusion? As seen in Finding 1, B violations are being upheld more often than before, which could reflect LCD's decision not to cite minor violations (making Bs more substantial and easier to uphold). But with As, the trend seems in the opposite direction. This might signify that when facilities bring in their "big guns," non-specialized LCD administrators are ill-equipped to weigh the evidence evenhandedly. For example, a Deputy District Attorney testified:

> We also found that hearing officers are untrained in the evaluation of evidence. A situation which is portrayed to a

> hearing officer, which could be fairly obvious to a trained individual in the evaluation, shall we say, of evidence of a past deed, oftentimes was dismissed because the industry would then pose a hypothetical to the hearing officer, and quite frankly he would be buffaloed out of enforcing any fine.[56]

Given LCD's unclear guidelines for determining whether a regulation is violated, levels and numbers of citations, amount of fine to be assessed, effect of mitigating factors, etc.,[57] it is not an easy matter to deal with strenuous protestations of unfairness from facility representatives. For example, in one of two sample CRC decisions provided by LCD, a B citation was reduced to a C. In some rooms at this facility, hot water had exceeded temperature limits by up to 36 degrees. The decision acknowledged that this met B standards, but reduced it because due to a "miscommunication" the facility had corrected the problem the same day believing it would then be reduced to a C. No fine was at stake either way, but the public record now indicates that this condition did not endanger residents, when in fact it did. (See Chapter IV, Section D, Finding 2, on whether mitigating circumstances should change the level of a violation.) The other sample decision properly held that the definition of an A violation was met and properly reduced the fine in view of the facility's good record.

According to a LCD administrator, LCD seldom brings witnesses, but many facilities bring both lawyers and administrative spokesmen from corporate headquarters, and the hearing officer is inundated with records, doctors' statements, and lab reports. At the same time, they may fail to bring facility staff who were actually involved in the violation. This administrator would phone the facility to talk to such missing witnesses, and assumes that others would do likewise. But

without CRC training or guidelines, there is no formal way of passing on such suggestions.

The presence of a facility attorney (which LCD says occurs in at least 50 percent of CRCs and almost guarantees effective case presentation) is practically never balanced by presence of an attorney for LCD. If "legal questions" are raised, a Department attorney is consulted, but the generalized persuasive or even intimidating effects of legal advocacy are not balanced out. However, because facilities have reputations, finances, and even businesses at stake, they are entitled to present their best possible case. They should not be denied attorneys because LCD cannot afford to use them. Therefore, other means, such as broader participation and improved training and guidelines, must be relied upon to correct any resulting imbalance.

Do these factors actually produce improperly-balanced decisions? One administrator says he has no problems, but that others have said they might sometimes "cave in" in borderline cases. Again, the Deputy District Attorney testified:

> [I]n our experiences . . . the industry in general has the Department of Health tied up in knots . . . . [I]nspectors . . . are frustrated by a lack of support that they receive from their superiors within the Department, and this frustration probably stemmed in large measure from intimidation that was thrust upon them by the industry at citation review conferences, and by their lawyers at various and sundry judicial and administrative hearings.[58]

There are no data to show whether such opinions are valid. In the "hearing officer" era, a study was done of the reasons for modifications, but that study cannot be located. Until May 1981, headquarters reviewed all CRC decisions to provide consistency and feedback, but that is not done now. We do not know why citations or fines are modified and dismissed (e.g., technicalities, inadequate documentation,

new evidence, mitigating circumstances, alleged facts don't support result, etc.). Nor can we tell which inspectors, regulations or situations have the most difficulty.

This makes it difficult to determine whether the modifications that occur at CRCs unduly favor facilities, or to say that different CRC rules would correct any such imbalance. Also, without information on why citations and fines are modified and dismissed, LCD cannot systematically improve faulty standards and procedures so that more will ultimately be upheld. If LCD could achieve a consistently high percentage of decisions upheld on appeal, it could reduce inappropriate use of the appeal process and make more enforcement more efficient, which would lessen the need to increase fines and would create public records that reflect current conditions.

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

The facility may contest a citation in superior court, either directly or following a CRC decision.[59] When that happens, the Attorney General must sue the facility and prove the entire case de novo (from the beginning). Finding 1 indicates that 11 percent of all recently-cited violations have been appealed to court (almost 20 percent of contested As and over 40 percent of contested Bs), and explains why little is known about the outcome of such cases. There are two major impediments to efficient enforcement under this system:

Citations with low fines are not prosecuted and disappear: The policy is not to prosecute citations which carry little or no fine. The superior court, accustomed to dealing in large figures, is not enthusiastic about such cases, and they do not help to pay LCD's legal bills.

Since 1980, well over 90 percent of all cases dismissed without any legal penalty have been B violations. Of court cases concluded in 1981 and 1982, under 10 percent of As were dismissed and over 60 percent of Bs. (Appendix V-A; LCD and the Assistant Attorney General estimate that closer to 85 percent of Bs met this fate.)

The Auditor General has found that this policy prompts facilities to at least temporarily correct a B violation, thus eliminating the fine, and then to contest the citation anyway.[60] Since they know it will be dismissed, they appeal regardless of the merits simply to clear the violation from their record, presenting a better public image and precluding the possibility of a fine for later repeat violations. The Auditor General recommended either automatic fines for repeat B violations, or automatic fines for all B violations. The former recommendation seems to have been followed (subject to some uncertainty, see Section A above). What effect will this change have upon prosecution of B citation in court?

Current policy is to prosecute all A violations and any other violations associated with them. Absent a special request from LCD, isolated B violations are set aside. They will be filed if another substantial violation crops up later, to which they can be attached. Just before the one-year statute of limitations runs, the Attorney General checks with LCD to decide whether waiting violations should be filed or dismissed.

If LCD's files reveal no recent problems, there is usually no visit or other check on whether the correction is still in effect before letting the citation die. Now that repeat B violations are fined, such a procedure is needed. Also, prompt reporting of repeats to the Attorney

General is vital, because if the prior violation is not filed within the one-year limit, the repeat is not a repeat and cannot be fined. Yet the Procedure Manual still contains old transmittal instructions stating that there is no fine on a corrected B and that it will usually not be prosecuted.

When a repeat B violation is discovered and reported to the Attorney General, what will happen? Presumably, if the fine is substantial both violations will be filed. However, if fines are not trebled, or raised as recommended in Section A above, $250 will be the most at stake and repeat violators might still escape prosecution. Some of the alternatives discussed below might help, but none is without potential problems.

The other effect of fining repeat Bs may be to make lasting corrections more common. Since that is the citation system's goal, arguably there is no harm in dropping prosecution of a corrected violation. On the other hand, this says, in effect, that a facility can have one fairly serious violation of every regulation, every 14 months, and still look acceptable because all citations can be dismissed on the public record.

Citations which are prosecuted become mired in delays: Although statute stresses the need for speedy resolution in superior court,[61] speed is hardly the hallmark of these cases. In Los Angeles County, for example, in the first three months of 1983 citations dating back to 1980 and earlier were at various stages of the court process, including interrogatories, requests for documents, requests for admissions and answers, at-issue memoranda, settlement attempts and conferences, continuances and reschedulings of trial dates. This Commission's

Advisory Committee found that one- or two-year delays in securing trial dates are common, despite legal preferences and contrary to the purposes of the statute.

The Advisory Committee discussed alternatives, but predictions about how they would work had to be based mainly on assumptions, and no one plan emerged as clearly the best choice. Some felt that arbitration should be further tested before making new changes, but so far, nobody has even requested it (Finding 6 below). Also, the situation calls for an improved overall system, rather than making efficient resolution solely a matter of choice. (One proposal was to make arbitration mandatory; that came too late to permit study of its ramifications. It might resemble administrative hearings as discussed below, perhaps somewhat faster but at somewhat higher cost.) Some suggested changing from an informal conference followed by full court hearing, to an administrative hearing followed by limited court review. However, this would increase delays for well over half of all contested violations, i.e., the cases which do not go to court (Finding 4 above).

Since superior court jurisdiction normally begins at $15,000, which is more than the amount at issue in many nursing home enforcement cases, one option is simply to move smaller cases to municipal court. LCD in 1977 recommended that B citations should go to municipal court;[62] LCD in 1983 agrees that if there are no legal restrictions, this change should be made. Some committee members felt that municipal court calendars would be less clogged; others felt that this would vary from place to place. Some felt that these cases would be too complex for lower courts to handle comfortably; others disagreed. Some are said to fear that local prosecutors would take over, which might lead to

inconsistency and even sometimes to the filing of massive numbers of cases. But the Assistant Attorney General has stated that his office could prosecute municipal court cases. As for numbers of cases, all citations must originate with LCD, and prosecutors, whoever they are, cannot enforce more citations than LCD refers.

Rather than sending all Bs to municipal court and all As to superior court, the statute could simply require filing "in a court of competent jurisdiction." Then cases under $15,000 would go to municipal court, and cases under $1,500 could be filed in small claims court without using the Attorney General at all. This would bring some portion of court-contested cases to a much swifter and less costly final conclusion. However, a facility which lost in small claims could seek an entirely new hearing in a higher court. For such cases, small claims would just add another layer of appeal and costs and delays would be no better than at present. Also, it is not clear whether a small claims decision can support a later criminal prosecution for repeat violations (described in Section C). This has obvious negative implications, but if true it might also inhibit frivolous appeals.

Still another suggestion would leave A violations as they are, but treat B violations as infractions like "fix-it" tickets. They would be adjudicated in municipal court with curtailed discovery and a 45-60 day time limit. Committee opinion was divided, with industry representatives concerned that the issues were too sophisticated and that criminal stigma would attach, and some others feeling that such problems would not occur, and that this approach comes closest to guaranteeing speedy resolution for B violations. No legal opinion was obtained on the due

process implications of combining informal conferences with infraction proceedings.

This Commission finds that the goal of an appeal system is to reduce frivolous appeals as well as to resolve genuine controversies with fairness, speed and certainty, so that facilities know where they stand and the public record is accurate and up-to-date. We find that results under the present system are unacceptable; that no single alternative is certain to bring the greatest improvement; and therefore that the alternative first attempted should use the existing system rather than constructing or expanding specialized systems. The option of using the court of competent jurisdiction appears able to achieve swift and inexpensive resolution for a greater number of cases than does the present system, though there may well be exceptions. Without experience, it is impossible to say whether nursing home citations are too complex for small claims or municipal courts to handle. When findings can be made on the nature and extent of these or other remaining problems, further action can be contemplated.

6. Arbitration, available since January 1983, has not yet been tried.

One new means of resolving contested citations more speedily was enacted in 1982.[63] Either LCD or the facility may request binding arbitration through the American Arbitration Association for a citation or citations totalling no more than #15,000. This would be completed within a few months from the time arbitration was requested, and appeal to court would involve only a limited review of the arbitrator's decision.

No findings can be made about how this is working, because nobody has requested arbitration. The assumption on both sides seems

to be that fees, which would be paid by the losing party, may be too high. Since fees may vary according to the amount in dispute, the length of the hearing, the complexity of the case, etc., they are hard to predict. A one-day hearing could cost $200 or even less, but after that costs could rise by around $325-450 a day. Legal advice received by LCD was that they generally would have little to gain, and possibly money to lose, by seeking arbitration. CAHF has advised its members that arbitration is faster and generally less expensive than court, but that speed is an advantage only where the facility, rather than LCD, has most of the relevant information.[64]

Recommendations

1. Citations enforced in superior, municipal, or small claims court.

Because speedy resolution of contested violations is essential to effective enforcement, and because failure to prosecute many B violations results in frivolous appeals and misleading records, and may cause inability to fine repeat violations, cases involving smaller amounts of money must be moved from superior court to a swifter and less expensive forum.

Health and Safety Code Sec. 1428(c) should be amended to require that cases be filed "in a court of competent jurisdiction," and to permit LCD, instead of the Attorney General, to file small claims cases. More cases, though not all, should be speedily resolved in this way. LCD and prosecutors should keep full records so that results can be studied. If further improvement is needed, the alternatives in Finding 5 can be considered.

2. Broader rights to participate in citation review conferences.

In the interest of perceived fairness and of actual fairness (balanced presentation of all relevant arguments and evidence), people whose rights are to be protected by LCD must be able to observe and contribute to decisions affecting those rights. To meet this goal, sacrifice of maximum speed or simplicity is justified, especially in view of other imbalances, e.g., unequal use of lawyers.

At a minimum, Health and Safety Code Sec. 1428(a) must be amended to allow a complainant or his/her representative to participate as a party in the informal conference. (See Chapter IV, Section C, Recommendation 1). Since actual participation by such parties may be minimal, a neutral observer, such as an ombudsman, must also be permitted to attend.

Because citations are often issued without a complaint, balanced participation would be better achieved by including all affected parties, rather than complainants only. The statute might say, as in some other states,[65] that any person whose substantial interests are adversely affected by department action or inaction may request or participate in a conference. Detailed notice of these rights and of the conference subject, time and place should go to complainants, direct victims of the violation, and known witnesses, and should be posted in clear view at the facility.

Concerns about cost and complexity of conferences should be dealt with on the basis of reality rather than assumptions. The broadest latitude should be permitted at the outset, and compromises enacted only if events prove there is no alternative. While awaiting enactment of this legislation, LCD should open its conferences as described and

begin collecting data on results, positive and negative. Also, LCD should in any event assure that complainants receive a copy of the CRC decision.

3. Use of arbitration and analysis of its results.

The Advisory Committee concluded that speedy resolution is a high priority for providers, enforcers, and consumers alike, and urged the Office of Legal Services/LCD, and facilities as well, to make use of arbitration. Considering the cost of having the Attorney General file a case in court, and the consequences when cases are dismissed without prosecution, it is hard to believe that it would never be worth the risk for LCD to initiate arbitration proceedings. LCD can begin with relatively simpler citations supported by sounder evidence, to limit chances of having to pay major costs. Whenever arbitration is used, LCD should keep complete records on its costs, speed, results, appeals, etc. These should be used to develop guidelines on when it is in LCD's interest to request arbitration.

4. Presumption that care not recorded was not provided.

The legislature should add the following to to Health and Safety Code Sec. 1424:

> Where the administration of medications, treatments, or other care is not documented as required by law, it shall be presumed that the required medication, treatment, or care has in fact not been provided. In any action based upon such alleged failure, the licensee may rebut such presumption only upon a showing of clear and convincing evidence.

This would help LCD prove its cases, but still allow facilities to avoid sanctions by bringing substantial proof that they did provide care. Results should be studied; if numerous citations continue to be

modified, as described in Finding 2, the next step would be to provide that when the presumption is rebutted, the inaccurate records shall be deemed a B violation. This would penalize facilities a relatively small amount for keeping misleading records in a way which related to resident health or safety and which put LCD to the trouble of prosecuting a citation. It would not fine every omission, but only those that made LCD believe that the situation affected residents' health, safety and security.

5. Expanded regulation and fine for false care records.

The Department should amend Title 22 Administrative Code Sec. 72313(c) to cover all types of care that are charted, and to state that the person who gave the care must chart it only after the care is given. Also, 72543(f) should give fair warning by spelling out, or incorporating by specific reference, details on acceptable methods of altering records.

The legislature should add the following to Health and Safety Code Sec. 1424:

> Any willful falsification, or willful material omission, in patient care records shall be an A violation. When an entry made in patient care records shows that required medication, treatment or care was given, and in fact such medication, treatment or care was not given, for purposes of this Chapter it shall be presumed that the entry was made with the knowledge that it was false. In any action under this Chapter based upon such alleged willful falsification, the licensee may rebut such presumption only upon a showing of clear and convincing evidence.

LCD, in cooperation with law enforcement authorities, should develop a confidential memo on methods of detecting and proving falsified records, to be used for purposes of training and monitoring. To help protect against use of the memo by falsifiers seeking to avoid

detection, Health and Safety Code Sec. 1439 should be amended to include this memo among LCD documents which are not open to public inspection. Procedures should also be jointly developed on when to refer falsified records for criminal prosecution.

6. Expanded correction/documentation teams for problem facilities.

"Special teams" should be expanded so that one can be formed as needed in each district office, to repeatedly visit the most chronically problematic facilities until all serious problems are resolved through cooperative action or through litigation. The team should consist of the office's top long-term care specialists. As at present, consultation with other specialists should be available as needed. Though an attorney should not be a regular team member, an attorney should be consulted routinely both before and during the team's work at each facility, to assure that investigation and documentation will support any formal enforcement actions which may later be required. The team should be appropriately trained and monitored.

7. Staffing, training, and procedures to enhance enforcement ability.

LCD should be permitted to contract with highly-specialized experts who would be on-call to help prepare cases and to testify. LCD should attempt to recruit inspectors who express interest in or demonstrate aptitude for accurate, reliable, and consistent recording and preservation of observations and other evidence in an objective professional manner.

Guidelines, procedures, and training on how to develop and preserve evidence, and when to seek assistance with this task, should be

clarified and expanded with assistance from the Office of Legal Services, Attorney General, and local prosecutors. The Procedure Manual should contain one carefully-designed section dealing with these matters in depth; other sections should refer to this, and add more specialized information as needed. (Instructions on falsified records would be kept confidential, see Recommendation 5.) One standardized, recoverable form should be adopted for the uniform taking of notes so that events can be reconstructed later without relying mainly on memory. An adequate system of preserving and assuring the availability of such notes should also be established.

District administrators must have specialized training and guidelines for handling CRCs. Examples of subjects to be covered: understanding all legal criteria, evaluating evidence (and knowing when and how to seek more evidence), handling argumentation techniques (e.g., hypotheticals), running a conference so as to preserve order, balance, informality and openness.

On enforcement for repeat violations, see Section A, Recommendation 5.

8. Ongoing data collection used to improve training and guidelines.

Information should be collected and analyzed on numbers of and reasons for successes and failures at each level of review. Results should be applied systematically to refine regulations and guidelines that do not yield sound citations, to develop better inspection and documentation procedures, to inform inspectors about why their findings are modified or dismissed, and to train CRC officers where they are insecure or inconsistent.

C. Alternative Sanctions: Limited Use, Limited Options

Background

In different situations, different sanctions are effective. Citations and fines do not always spur meaningful improvements. But removing a license or decertifying a provider from federal programs may be too harsh, either to the facility or to the residents who are uprooted and who may have trouble locating other beds. To achieve fairness and to protect residents, LCD needs a full range of options. Instead, we find that available options are not used much, and that some useful options are not available.

Findings

1. Criminal and civil prosecution are effective but little used.

Standing out above all else at this Commission's 1982 hearing was wholehearted agreement that those responsible for repeated serious violations affecting patient care should spend time in jail. When first raised, the idea was greeted with open applause;[66] both Commissioners and witnesses offered repeated and enthusiastic support. The president of CAHF, asked whether he would favor jail sentences if lives were jeopardized, said that if the system were fair and direct guilt were involved, he would.

The Assembly Committee on Aging recently heard testimony by the Los Angeles City Attorney that prosecution of repeat violators is:

> . . . a cost effective means to cause incompetent operators to give up their licenses or close up shop . . . as well as deterring marginal operators from allowing their facilities to run down. It is perhaps the most effective enforcement tool to assure quality health care.[67]

The Auditor General in 1977 found that apart from the Los Angeles City and District Attorneys, local law enforcement agencies practically never filed nursing home cases.[68] According to a May 1983 survey conducted for the Commission by the Los Angeles City Attorney (see Appendix V-E), the picture today is not radically different. Of the 58 prosecutorial offices, 33 responded. In the past three years, the only office outside Los Angeles that filed a criminal complaint under Health and Safety Code 1290 for violation of nursing home regulations was Lassen County, which had filed one. Somewhere between six and twelve other offices had filed, or expressed interest in filing, civil cases under Business and Professions Code Sec. 17200.

Why does this gap exist? When should nursing homes be prosecuted, and what benefits can be expected?

Widespread use is hampered by indifference and by inadequate evidence: LCD reports that 33 cases were referred to enforcement agencies in 1982. Los Angeles County, with around 33 percent of the state's nursing homes, referred 85 percent of those cases. Only 5 others were referred; information is not available on where they went or what happened to them.

LCD maintains that local law enforcement agencies are uninterested in nursing home cases. But 67 percent of respondents to the 1983 survey (Appendix V-E) said that in the past three years no case was referred to them by LCD; even in counties with large numbers of nursing homes, that number was 63 percent. Similar percentages reported no contact of any kind with LCD during that period. One county stated that getting LCD to send copies of citations was like "pulling teeth." Another reported that it had obtained an informal

agreement to receive citation copies, but "the agreement has not been completely adhered to . . . without occasional renewal efforts by this office and the completeness of information is unverifiable."

The Assistant Attorney General has recently met with the District Attorneys' Association for purposes of education and coordination; LCD plans to send its district administrators out to build bridges with local district attorneys, and to develop referral guidelines with their cooperation. (See Los Angeles referral guidelines in Appendix V-F). At present, there is a brief chart in the back of the Procedure Manual which mentions some crimes, but instead of giving guidelines for referral, Sec. 502.2 says only:

> When referring cases to local district attorney for criminal actions, the case must first be sent to the Office of Legal Services . . . [which recommends whether to refer].

Interpretive guidelines for specific regulations seldom mention possibly-associated crimes. Suggested referrals are few and tend to be noncriminal (e.g., regulation 72353: report irregularities to State Board of Pharmacy). Generally, those who actually handle cases receive no reminders to be alert for crimes and no help in recognizing situations which should be referred for a decision on whether to notify local prosecutors.

LCD's inability to identify repeat violators, seen by the Auditor General as a major impediment to using criminal prosecution,[69] may be less of an impediment now (see Section A above). But Procedure Memo #83-4, designed to track citations and identify repeats, deals only with LCD's own sanctions without mentioning referral to local law enforcement agencies.

A final barrier lies in the fact that because of the high burden of proof and the limitations of criminal discovery, thorough initial investigation and documentation are especially important. As seen in Section B above, that is not always LCD's strong point. In Los Angeles, licensing personnel work closely with the City and District Attorneys and receive special training from them to minimize these failings. Elsewhere, the 1983 survey elicited favorable comments in two counties, but otherwise the picture was grim. One county indicated that "evaluators do not consider themselves 'investigators;'" another told of attempting to obtain more information on a referred case and receiving no help. A third reported:

> evidence and allegations gathered by licensing personnel . . . are collected insufficiently for criminal prosecution in all cases. . . . Our contact is always generated by this office or licensing personnel operating outside of the Department's chain of command. Criminal or civil enforcement through D.A.'s is not viewed by this Division as their function. Without adequate changes in the training and orientation of the only government personnel in a position to gather evidence in such cases, . . . the present . . . material is insufficient to meet the criminal burden of proof.

Criminal prosecution of willful or repeat violators is speedy and effective in appropriate cases: Criminal prosecutions have a "ripple effect" on marginal operators, due to the publicity and stigma they engender. The prospect of finding themselves in court with pimps and pushers makes people work harder to provide acceptable care. Some recent examples from the Los Angeles City Attorney illustrate other goals attainable by criminal prosecution under Health and Safety Code Sec. 1290, which covers willful or repeated violation of nursing home laws and regulations:

- Rapid removal of poor operators from business: After Mrs. L took over two facilities, they deteriorated and began collecting A and B citations for patient care violations. Fines

were paid but conditions did not improve. A 24-count criminal complaint for repeated violations was filed. Within four months, Mrs. L had been placed on probation, on condition that she pay $8,000 in fines and get out of the nursing home business. (Even without probation, such convictions can lead to denial of operating or professional licenses and of participation in Medicare and Medi-Cal.)

- Rapid correction and close oversight of serious problems: Mrs. R had run a fairly good facility, but in 1980 it began to receive citations for bedsore problems, and Mrs. R's attitude toward inspectors became increasingly hostile. Though conditions were not yet as serious as in some cases, criminal charges were filed in an attempt to reverse the decline. In September 1981, Mrs. R pled "no contest" to one count and was placed on probation under conditions which covered bedsores in great detail. (Note: Meanwhile, she had contested the original citations; that case was still pending in August 1982, a year after the criminal case was concluded.)

- Punishment of egregious offenders: A particular facility was considered one of the worst in the city. Ownership involved a series of corporate holding companies, stock transfers which were later rescinded, bankruptcy, 23 bank accounts in 8 banks, etc. Due to the statute of limitations, only the most recent owner could be prosecuted. Bank records were subpoenaed showing his control of the facility and his misadministration of needed funds during the crucial periods. He pled "no contest" and was sentenced to 40 days in jail. Since he no longer owned the facility, and his administrator's license had already been revoked, the purpose was simply retribution for the appalling conditions in that facility and warning to other operators who might be tempted to engage in such profiteering.

The second example points up an important issue about criminal prosecutions. Advisory Committee members disagreed on whether that case should have been filed. Where there is willful behavior, or recalcitrant and uncaring repeat violation, criminal prosecution is clearly appropriate. But anything short of that is questionable, in view of the shocking and stigmatizing effect on defendants who may be merely inept or negligent. On the other hand, statute and caselaw clearly look to strict liability based on repeated conduct, with little concern over whether the defendant could have prevented the violation. Preferably, those few who are grossly negligent or willful repeaters should be

criminally prosecuted, and civil prosecution or other sanctions (see below) should be used for inept repeaters.

Other limitations on criminal prosecution include high burden of proof, jury trial, and right against self-incrimination. Also, fines are low ($500, plus a percentage which goes for law enforcement purposes), though cases with a great many counts can carry sizeable fines. Several counties in the 1983 survey proposed increasing maximum Sec. 1290 fines to $5,000 or even $10,000, an amount which is allowed under some other misdemeanor statutes.[70] CAHF responds that this would be confiscatory, and that 25 counts might be fined $250,000. This Commission finds that if, for example, 25 residents died due to grossly negligent repeat violations, that penalty would be proper. The court can always set a lower fine, or even no fine at all, according to the circumstances. CAHF also argues that increased fines do not lead to increased prosecutions, citing experience after federal fines for Medicare-Medicaid fraud were raised to $25,000. We find that the goal is not increased prosecutions but deterrence, which may be accomplished by only a few publicized high-penalty cases.

Other criminal statutes may also apply, but there are gaps: In certain cases, more specific criminal charges may be filed. Some of these have to do with impeding the regulatory system, such as obstructing inspection[71] or operating without a license.[72] Others are specific to health facilities, such as detaining a resident for nonpayment,[73] or to Medi-Cal, such as false claims.[74] Still others are of a general nature, such as assault and battery, rape, gross negligence, false imprisonment, grand and petty theft, etc. In some states, nursing home owners have even been prosecuted for reckless homicide or

intentional homicide, when their cost-cutting efforts were linked clearly to deaths from neglect or starvation.

For some situations, new criminal statutes are needed. In 1976, the Los Angeles City Attorney made findings on extensive fears of retaliation for expression of grievances and on the state's interest in having grievances brought to light (see Chapter VI, Section B), and recommended that Health and Safety Code Sec. 1432 include criminal penalties.[75] Retaliation is a crime in some other states (e.g., Wisconsin) and under model statutes.[76] The City Attorney also noted that present law protects only where a "proceeding specified in this chapter" is involved, and that the state would clearly wish to protect the voicing of grievances to any person or organization, regardless of whether such proceedings were involved. On difficulties of proof, and justification for increased fines, see Section A, Finding 5.

Similarly, the City Attorney pointed out that, because of Health and Safety Code Sec. 1290, nursing home operators, administrators and licensed nurses can be criminally liable if they, for example, repeatedly fail to administer ordered treatments. Yet health professionals from outside the nursing home could repeatedly prescribe dangerous drugs which are contraindicated, or fail to prescribe for a clear illness, and even if this were willful and caused injury they would suffer no criminal sanctions. After citing federal findings on the incidence of medical neglect and errors related to nursing home residents, the report recommended criminal penalties for reckless and wanton conduct by any health care professional.[77]

Findings were also made on the need to expand mandatory reporting of suspected patient neglect or abuse under Penal Code Sec.

11161.8.[78] At present a patient has to be hospitalized before health professionals must report suspicions. This fails to protect possible victims who remain in a nursing home. California lags behind many other states that provide criminal penalties both for those in nursing homes who fail to report suspected neglect or abuse, and for the abusers themselves (e.g., New York, Texas).

Civil prosecution for unfair business practices is complex but effective: Testimony from the San Diego County District Attorney described an alternative approach available to local law enforcement agencies: "We contend that inadequate patient care constitutes an unlawful and unfair business practice."[79] Thus, under Business and Professions Code Sec. 17200, a local prosecutor may file a civil suit for injunction and financial penalties.

This type of suit has been used in several counties. It can be extremely time-consuming and expensive to litigate, though often a facility will enter a consent decree that imposes penalties and an injunction without actually going to trial. It allows extensive discovery of records and profits and is especially useful with chain facilities, because convoluted ownership and accounting practices can be uncovered and the labor can be made worthwhile by using results in cases involving other facilities owned by the same chain. Its best features are sizable fines and innovative injunctions. One respondent to the 1983 survey stated:

> I believe that 17200 constitutes a better method of enforcement than criminal proceedings. Owners violated the law to make money in a lucrative business. The way to prevent them from cutting corners is to take away the profit motive. Various novel approaches to securing compliance can be undertaken by the Court under 17203 which ensures that patients are properly cared for and that money needed for patient care is not diverted to assessments for civil penalties.

2. Successful receiverships are unlikely under present law.

Under a 1982 statute, LCD may ask a court to appoint an outsider to run a facility temporarily, if continued operation by its licensee is likely to cause serious harm to residents.[80] The purpose is to avoid unnecessary closure, simultaneously protecting residents and upgrading the facility. If upgrading is impossible, the purpose become orderly closure and transfer of residents.

Ideally, receivership brings a transformation like that of the Village Nursing Home in New York City. There, temporary takeover by a receiver provided time for the local community to develop funding and expertise, and then to purchase and operate the facility itself. However, in New York and elsewhere, many receiverships have not reached this pinnacle of success. Some fail to upgrade and succeed only in assuring orderly transfer of residents out of the doomed facility. Others upgrade but improvements may not last, especially if management is resumed by former operators. However, the potential for real improvements does exist, and threats of receivership may also stimulate voluntary upgrading by some facilities which tend to treat mere citations and fines as a "cost of doing business."

Unfortunately, LCD's two attempts to use the receivership remedy have been thwarted by inability to locate an acceptable receiver. It is difficult enough to obtain qualified receivers at short notice, for a job of uncertain duration and immense difficulty, but it is even more difficult under California law. The statute is unduly restrictive. As long as a licensed administrator is in charge at the facility, there is no reason why the receiver must be a licensed administrator. A hospital, or a charitable organization, may be willing to take overall responsibil-

ity. Then administrators could be attracted by the challenge of doing the job they know best, without the burden of extra and unfamiliar legal responsibilities. Many other states (e.g., Connecticut, Illinois, New York, New Jersey) follow this approach.

However, since good administrators are available mainly through the industry itself, industry commitment and cooperation will still make the difference between success and failure in many cases. So far, LCD has received a list of potential receivers from CAHA, but not from CAHF.

If LCD for any reason failed to seek receiverships in seemingly appropriate situations, the people to be protected--the residents--could not obtain a court decision on whether a receiver was needed. In several states (e.g., Illinois, Michigan, Missouri, New Jersey) residents can petition for a receiver. LCD fears that this power might be abused. This Commission finds that those who are directly affected should have access to court on the usual expectation that petitions will be in good faith. The grounds for appointment should be the same regardless of who petitions. However, LCD's knowledge, expertise and responsibility can be acknowledged by requiring that it be notified and participate in proceedings, and that it be able to "veto" a proposed receiver.

LCD is concerned that some facilities threatened with receivership may choose bankruptcy instead. Bankruptcy judges are unaccustomed to health and safety issues, but LCD might still enlist their assistance. For example, the Massachusetts Attorney General once intervened in bankruptcy proceedings and explained the need to protect residents;

the judge issued a restraining order against resident abuse and appointed a receiver.[81]

Other problems are predictable. For example, receivership is available only as a last resort and only to protect residents from serious harm or death. This is more restrictive than in some other states (e.g., New Jersey). It causes uncertainty over whether the remedy can be used to delay a sudden voluntary closure, and it allows facilities to slide so far downhill that reversal of the slide by new management may in some cases be impossible.

Once appointed, a California receiver faces an uphill battle. It can easily take a year or two to rehabilitate a run-down or mismanaged facility enough to attract buyers or return it to former management.[82] But the law permits only three months, renewable only under terms which will often be unrealistic.[83] Some other states leave the term up to the court (e.g., Missouri, Illinois) or permit a longer initial term (e.g., Oregon, 18 months).

Even more limiting are the financial restrictions. First, there is no contingency fund for emergencies and basic upgrading, apart from a one-month advance of Medi-Cal reimbursement. Some other states (e.g., Oregon, Maryland, Wisconsin) have a revolving fund, sometimes derived from special fees for this purpose. Second, there is no specific power for a court to set aside arrangements between affiliates that call for excessive prices. On the contrary, California receivers <u>must</u> honor <u>all</u> leases and mortgages.[84] Other states (e.g., Florida, Illinois, Missouri, Wisconsin) make clear that owners can be prevented from reaping unreasonable profits at the expense of patient care.

LCD's difficulty in locating competent receivers is not surprising in view of the above limitations on who they may be and what they are able to do. But statutory amendments, together with essential industry cooperation, should improve the prospects for success.

3. Limits on referrals are inadequate; limits on admissions are needed.

Limiting a deficient facility's ability to admit new residents serves two functions. Loss of income can induce prompt improvement. Meanwhile, no new residents will be subjected to substandard conditions, and present ones may benefit because staffing and other resources do not have to stretch so far. Bed shortages may discourage use of this remedy, but much less so than alternatives requiring transfer of residents en masse.

Statute requires that public agencies which refer residents give preference to facilities without A or B violations in the past 12 months, and, conversely, that they not refer residents to facilities with uncorrected A violations or five or more uncorrected B violations.[85]

Except for the computerized system in Los Angeles County (Chapter VI), the means for making available such information are inadequate. LCD prepares a voluminous Annual Report summarizing each facility's citations and fines, and action taken on them. An abbreviated version is sent to county welfare departments, but because nonreferral depends on noncorrection, the information is usually out of date by the time it is published.[86] Also, public agency referrals focus on Medi-Cal residents whose low payment rates reduce the incentive value of nonre-

ferral. These factors, plus bed shortages in many areas, have rendered the remedy virtually useless.

In the next few months, additional authority related to actual Medi-Cal admissions should become clear. First, an Attorney General's opinion has been requested on whether present law permits restricting Medi-Cal admissions at facilities whose ability to meet residents' needs is in doubt. Second, a federal regulation will probably be signed to implement a statute[87] providing that if substantial federal deficiencies exist, but do not immediately jeopardize resident health and safety, a state may give notice that it will not pay for Medicaid residents admitted after a certain date, until the facility comes into substantial compliance or is making good faith efforts to do so. The facility must first have been given a reasonable opportunity to correct, followed by reasonable notice and opportunity for a hearing to dispute the finding of noncompliance.

What is still lacking is the ability to cut off admissions of highly-prized private pay residents. LCD has occasionally achieved this result by voluntary agreement with an understaffed facility that might otherwise lose its license. In some states, the power to halt all admissions exists by statute. LCD is interested in acquiring this power, but CAHF argues that private pay residents can shop around, so no power to halt their admission is needed. Chapter VI finds that ability to shop around is limited by lack of information or inability to make sense of information. This plus other pressures (e.g., need for an immediate bed within visiting distance) can bring private applicants to even seriously substandard facilities. The rapidity of corrections

under threat of admissions halts in other states indicates that facilities do have something to lose, and act accordingly.

Some states stop admissions based on a monthly list of facilities that have an A or five B violations uncorrected. As with public agency referrals, this system is unwieldy, rigid, and usually out of date. Wisconsin has repealed such a statute, and Illinois has not yet implemented a similar one. On the other hand, states like Florida report real success with a different approach. There, an inspector who finds any condition that "presents a threat to the health, safety, or welfare of the patients in the facility" may phone the licensing director, who may authorize an immediate moratorium on admissions. This remains in effect until deficiencies are corrected, or until an administrative hearing results in reversal of the decision. Reports indicate that the remedy actually is used only a few times a year, but that its existence is a potent force for improvement.

4. Withholding Medi-Cal reimbursement would bring benefits and risks

LCD would like to withhold Medi-Cal reimbursement as an inducement to make corrections. Apart from any power to withhold reimbursement for new Medi-Cal admissions (see Finding 3 above), a 1982 law provides that:

> Any costs or penalties assessed pursuant to the provisions of this chapter shall be paid within 30 days of date decision becomes final. If a facility does not comply with this provision, the state department shall withhold any payment under the Medi-Cal program until the debt is satisfied. No payment shall be withheld if the department determines that it would cause undue hardship to the facility or to the patients of the facility. Health and Safety Code Sec. 1428(h)

LCD believes that this procedure, located in the arbitration section, is being used to collect overdue fines, however they were finalized.

In some states (e.g., Texas), large amounts of reimbursement may be withheld until a violation is corrected. LCD expresses reservations about this approach, since residents could suffer if there is a cash flow problem.[88] Further, Texas newspaper reports indicate that suspensions are brief, that temporary corrections must be followed by complete payment of all money owed, and that the effect is negligible on any but the smallest facilities.[89] The Texas Attorney General's Nursing Home Task Force reported in 1977-78 that the system fails to discourage poor care, because poor care saves money while "vendor hold" merely interrupts cash flow.

An Attorney General's opinion has been requested on whether present law permits withholding of Medi-Cal payment to facilities with questionable ability to meet the needs of existing and potential Medi-Cal residents.

5. Publicity is a powerful tool that is too seldom used.

At a recent national convention,[90] a licensing director observed that when her annual report reaches the press, she sees action; facilities don't like appearing on that list. Ombudsmen and advocates from other states agreed that publicity corrects problems "quicker than anything." Advisory Committee discussions of the citation and fine system concluded that corrections are prompted most of all by desire to avoid stigma. An appropriate sanction, broadly publicized, is the best deterrent.

Information about LCD's findings is a matter of public record.[91] Chapter VI discusses how the public can use this information; the concern here is over the fact that the Department seldom informs the

press of LCD actions in order to induce correction and prevent other violations.

LCD reports that the Department's press office issues releases when accusations are filed to suspend or revoke a license, and LCD will answer press inquiries at any time. But citations are not publicized; LCD says that, especially in urban areas, the media are not interested in nursing home news, and that if such news were regularly published it would become "old hat" to the public and lose most of its force. LCD sees professional rather than public stigma as the major preventive force and says that CAHF members keep track of each others' violations, and that operators are mortified to have fellow professionals show up and offer "peer assistance." However, the Commission finds that systematic efforts to obtain publicity for enforcement actions will bring some appreciable amount of coverage that can greatly assist LCD's efforts to obtain correction and deter violations.

In some states (e.g., Michigan) press notices are required by law at the time a citation is issued (though a delay until it is upheld at the first level of appeal would seem more fair). Inconsistencies in the citation and enforcement process might intensify such due process concerns; however, LCD stresses that citations are not to be given for minor violations. This, combined with the chance for a prior appeal, means that publicizing what is after all a matter of public record should seldom cause gross unfairness.

Los Angeles County issues press releases on citations and other enforcement actions, plus general news, consumer information, and highlights on good facilities. Publicity for good facilities is a desirable incentive. It is said that media are uninterested in positive news;

notifying small neighborhood newspapers may bring better results for both positive and negative releases. It is also pointed out that even excellent facilities can suffer a change for the worse. This is a legitimate concern, but recognition of positive programs is too valuable a tool to discard on that account. Careful choice of facilities, plus a statement warning that nursing home quality can change rapidly and telling where to obtain the latest information, could reduce the risk of inadvertent deception.

Recommendations

1. Referrals to and cooperation with law enforcement agencies.

LCD should adopt guidelines for referring cases to local law enforcement authorities, similar to those used in Los Angeles County (Appendix V-F), with limited amendments by agreement with various local prosecutors. Situations appropriate for criminal prosecution should be spelled out so that facilities know what to expect. The basic guidelines should be printed in the Procedure Manual, and also broken into components and inserted at relevant points in the manual and interpretive guidelines so that potential referrals will not be overlooked. Similarly, all specific crimes (e.g., false records, false imprisonment, assault, etc.) should be discussed in general guidelines and also in sections on the subject areas where they are likely to crop up. Procedure Memo #83-4 should be changed to assure that when repeat violations are discovered they will be referred as appropriate.

Cooperative communication and training programs between licensing and law enforcement should be continued and systematized. As suggested by a respondent to the 1983 Survey (Appendix V-E), prosecu-

tors should prepare a manual on prosecuting nursing homes to include form compliants, jury instructions, points and authorities, and suggestions on evidence gathering and investigations (see also Section B, Recommendations 6 and 7).

2. Amendment raising misdemeanor fine for willful and repeat violators.

To provide a range of potential fines which will actually deter or punish repeat violators according to the seriousness of their misconduct and the extent of their resources, and to encourage criminal prosecution in appropriate cases, the legislature should increase the fine for a misdemeanor under Health and Safety Code Sec. 1290 to a maximum of $10,000 (the same as the proposed maximum civil penalty in Section A, Recommendation 1).

3. Criminal statutes dealing with retaliation, abuse, and neglect.

Based on Finding 1 above, and Section A, Finding 5, the legislature should enact the following statutes and amendments on retaliation, abuse and neglect:

o Health and Safety Code Sec. 1432 relating to retaliation against complainants should provide broader protection. Also, in addition to carrying a higher civil penalty (Section A, Recommendation 4), such acts should be a misdemeanor with a high potential fine. This makes a clear statement that California will not tolerate any discrimination against or intimidation of those who speak out about conditions in nursing homes. It also allows for differences in amount and form of retaliation by providing flexible penalties, including a wide range of

potential fines plus the speed and stigma of criminal proceedings when appropriate. It should encourage witnesses and prosecutors and also deter offenders. Suggested wording:

> No licensee or any agent of a licensee shall discriminate or retaliate in any manner against any person receiving the services of such licensee's facility, or against any employee of or volunteer or ombudsman at such licensee's facility, on the basis, or for the reason, that such person or employee or any other person has presented a grievance to any person, organization or governmental entity, or initiated or participated in an inspection or any other proceeding specified in this chapter. A licensee or his agent who so discriminates or retaliates shall be guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not to exceed ten thousand dollars ($10,000) or by imprisonment in the County Jail for a period not to exceed 180 days, or by both such fine or imprisonment; and subject to a civil penalty of no less than five hundred dollars ($500) and no more than ten thousand dollars ($10,000) [i.e., the amount of the highest fine for an A violation], to be assessed by the director.[92]

LCD, law enforcement agencies, providers, ombudsmen, consumers, and others should work together on training and guidelines for obtaining proof of retaliatory acts and protecting facilities against false accusations.

- In order to treat all health professional evenhandedly, and to assure that responsibility rests where it really belongs, it should be a misdemeanor for any licensed health professional to cause willful or repeated acts or omissions which either:

  (a) constitute a wanton or reckless disregard for the health, safety, or well-being of a person under the licensee's care, or

  (b) result in actual injury to a person under the licensee's care and in which the licensee is in violation of the statutes or regulations pertaining to that license.

Violation should mean a mandatory jail sentence and maximum fine of $50,000.[93]

- California needs a carefully designed and comprehensive statute covering abuse and neglect of nursing home residents, and the mandatory reporting of such abuse and neglect. Though the need and the general principles are clear, the details raise many difficult questions. A beginning should be made in both areas right away, followed by study of results and of experience under the variety of statutes in other states, which would lead to later amendments or expansion.

4. Amendments to make receivership more available and effective.

To reduce the impediments discussed in Finding 2, the legislature should amend Health and Safety Code Sections 1325-1335 as follows:

- Under Sec. 1327, it should be possible to appoint a receiver when there are substantial or habitual violations, or when closure is imminent but adequate relocation plans have not been made (text in Appendix V-G). This does not broaden the statute too far, because the section goes on to limit appointment to situations where "there is no other reasonably available remedy to protect the patients.
- Sec. 1327 should be amended to permit petition by a resident of the facility, or the resident's representative. The department should receive notice, participate in proceedings, and propose the receiver (this might simply mean approval of a receiver nominated by the resident) (text in Appendix V-G).
- Under Sec. 1327, the receiver should be a licensed nursing home administrator or other responsible person or persons, except that no owner, licensee or administrator of the facility shall be appointed.

- Under Sec. 1329(a)(5)(D), contracts, leases, and mortgages between affiliated parties should be avoidable by court order to the extent that they exceed reasonable value (text in Appendix V-G).
- In addition to the Medi-Cal advance available under Sec. 1329(d), the statute should create a contingency fund to meet receivership expenses when facility funds are insufficient to do so (text in Appendix V-G). Initial and supplemental funding could come from special nursing home fees, as under 1981 Oregon Laws Ch. 868. Another possibility would be to amend the law so any funds collected by a receiver and not applied to receivership expenses would go to the fund rather than to the licensee. These and other funding alternatives should be studied before legislation is proposed.
- The length of receivership under Sec. 1331 should be changed from 3 to 6 months; the court may, of course, set a shorter time as appropriate.[94]

Also, LCD should develop a panel of potential receivers and a volunteer technical advisory board, working together with provider, professional, and other interested groups, and taking advantage of existing industry peer review and quality assurance programs where appropriate. The Commission urges CAHF to cooperate with such efforts, as CAHA has done.

If necessary, the Department should attempt to develop cooperative procedures with bankruptcy courts, so that residents will receive needed protection and enforcement efforts will not be undermined or avoided simply because two entities do not understand each other's problems and powers.

5. Statutory power for LCD to halt all admissions to a facility.

To stimulate corrective and preventive action, and to protect residents, the legislature should enact a statute along the following lines:

> The department may impose an immediate moratorium on all admissions to any facility when the department determines that any condition in the facility presents a threat to the health, safety, or welfare of the residents in the facility. The moratorium shall remain in effect until said threat is removed or until the decision is reversed at a subsequent hearing.[95]

A prompt administrative hearing should be provided for, either specifically or by reference to an appropriate existing system. See also Recommendation 6 on Medi-Cal reimbursement sanctions.

6. Statutes employing Medi-Cal reimbursement to effect sanctions.

Once federal regulations are published, the legislature should enact a statute that conforms with federally-required standards and procedures for withholding Medi-Cal reimbursement related to new admissions.

If Health and Safety Code Sec. 1428(h) does not already so provide, the legislature should amend the statute so that any fine which is legally due and unpaid after 30 days may be withheld from Medi-Cal reimbursement.

Broader power to withhold Medi-Cal money should not be enacted at this time, as it might injure residents in financially marginal facilities. Also, with more solvent facilities, it could create the image of strong enforcement without the reality.

7. Statute and policies requiring use of press releases.

The press has immense power to stimulate improvements. In order to assure that attempts to invoke this power are made regularly, uniformly, and fairly throughout the state, the legislature should enact a statute listing enforcement actions (filing for revocation, temporary suspension, or receivership, criminal prosecution, issuance of injunction, citations when not contested or after the first level of appeal, imposition of federal sanctions, [other major sanctions if enacted as recommended]), and stating that as to such situations,

> The director shall issue a press release to newspapers in the area in which the facility is located, explaining the action taken and the conditions upon which the action is predicated, with such additional detail as the director finds appropriate.[96]

Rather than issuing releases from a central office, the Department should develop detailed guidelines and then delegate the task to LCD's district offices. Releases should be distributed to local neighborhood and "throwaway" newspapers, and a variety of other media, and records should be kept on which media and which types of releases yield the best coverage.

Guidelines should cover policy issues and inter-agency coordination (see Los Angeles policy in Appendix V-H). Guidelines on contents, using citations as an example, might include identification of facility and owners (including names of individual owners in the case of small corporations), LCD's factual findings, the correction plan, whether this is a repeat violation, other violations within the past year, the amount of the fine, whether (and on what grounds) the facility plans to contest, etc. See sample Los Angeles release in Appendix V-H.

The Department and LCD should also adopt a broader policy, as in Los Angeles County, of issuing releases on regulatory developments, volunteer opportunities, how to select a nursing home, where to report complaints, and awards for excellence. Strict criteria (more than the mere absence of citations) should be established under which excellent facilities and programs could be singled out fairly for special mention, and readers should be warned that quality can change rapidly. The goal would be to use the power of the press as a positive incentive as well as a negative one, and to assure that the public image of an entire industry is not biased by releasing only negative information.

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, coordinated efforts of the government, the public, and the nursing home industry. Appeals for a combined effort have been made by representatives from every sector--community volunteers, LCD, the California Association of Health Facilities, district attorneys, and facility staff. The present long-term care environment is characterized by anything but cooperation and openness.

The true character of institutional long-term care in California at present is reflected in the accusations and "finger pointing" which precede virtually every one of the appeals for cooperation in the testimony. These accusations reveal an ongoing pattern of widespread misinformation and misconceptions by which, and because of which, the chronic problems of long-term care are perpetuated and exacerbated. A critical lack of accessible and accurate (i.e., comprehensive and up-to-date) information about long-term care creates and sustains the polarization of the state, the public, and the nursing home industry

and results in an atmosphere of defensiveness and, sometimes, almost crippling paranoia.

2. The public fears nursing homes.

The public, comprised of a quite small aging-advocacy network and the vast numbers of uninformed citizens, expresses paranoia in two forms. First, the general public fears that nursing homes are "houses of death" and, as such, are to be avoided at all cost. But, for the more than 105,000 residents in nursing homes in California, the price of that avoidance is very high. The second form of paranoia among the public is the belief by some that there is an active policy of silence, perpetrated by both the nursing home industry and LCD, so that the public cannot truly understand more about government regulators or the long-term care industry. Consumers and potential consumers of long-term care are desperately information-poor. The individual consumer does not know what information is available nor where it can be found. Even if some of the initial impediments can be overcome, the consumer is likely to find what information is available to be incomplete, out-of-date, often highly technical and/or coded in ways difficult to understand (if it is generated by LCD), or simple generalized rhetoric (if the source is the nursing home industry).

3. The nursing home industry is self-protective.

It is not difficult to trace the origins of a belief in a policy of silence. A continuing history of inquiry, public outcry, regulation and enforcement has led to a defensive "once burned, twice cautious" posture on the part of the industry. Our Commission's investigation, as

well as others, not to mention the individual consumer's efforts to find decent care for a frail elder, often cannot get beyond this defensive wall.

4. Bureaucratic intractability discourages public involvement.

Paranoia is also reflected in the widespread belief in the intractability of the bureaucracy of LCD. LCD is not perceived as operating in full public view and the Division has not adequately developed and maintained information for the consumer and for the public in general. At the moment, only people with a certain level of education, skill and incentive, e.g., a knowledgeable bureaucrat, some of the long-term care ombudsmen, and the occasional persistent advocates, can take the time, skill and energy to make use of the information in LCD files.

Despite the fact that LCD repeatedly says that this information is available to the public and that anyone can examine it upon request, nonetheless the general impression conveyed in the testimony is that LCD is guarding information rather than purveying it. An example is the following letter:

> Although, you have been told several times on the telephone and in writing that the Department [LCD] has a public record inspection policy (you were sent a copy) that makes available to anyone all of our public records for viewing, at this office, . . . you still insist on special treatment by requesting that we take the time and effort to reproduce and mail you copies of records about which you have no specific information--maybe only a name . . . .
>
> No other patient advocacy group or interested persons, to my knowledge, demands or coerces, through political pressure, for such special treatment.

This is a portion of a letter written by a LCD district office supervisor in response to a consumer inquiry. It is an example of why LCD is viewed by many as the "bureaucracy of care." The letter

illustrates, at the very least, a reluctance on the part of at least one LCD district office to make public information readily available to the public. The letter is minimally polite and asks this particular consumer to drive about 100 miles round trip to the LCD office to see the information. However, as some mentioned in the testimony, even physical presence at an LCD office does not necessarily guarantee easy access to files.

As a result of the inaccessibility of timely and accurate information, distorted perceptions of one another are projected by the three groups--LCD, the nursing home industry, and the public. The industry too often sees the public as either unreasonably demanding, uninformed or aggressively "out to get us." While the industry has Consumer Relations Committees, it continues to take aggressive self-protective actions in the Legislature and, at the local level, sometimes with Ombudsmen and/or consumer groups such as CalPIRG (California Public Interest Research Group). LCD is perceived by many to have kept the consumer and general public at bay by professional jargon and aloofness. Consumer or advocate groups see the industry as intentionally withholding information and/or presenting misleading information; they see LCD playing a passive and guarded role in the dissemination of "public" information.

The "professional" stance of LCD often generates the impression that either they are bureaucratically remote from the consumer or, conversely, they are "too close" to the industry. LCD, on the other hand, often seems to view the public as, once again, uninformed, unprofessional, and generally lacking credibility. Both LCD and the public are constantly confronted by a nursing home industry which is

well-financed and reasonably sophisticated in its regulatory activities. What has developed in this murky environment is misinformation and a tendency toward "cooperation" between the two elements which, as "professionals," understand each other--the nursing home industry and LCD.

5. Adequate statewide information is key to a functional partnership.

While the State, consumers and general public, and the nursing home industry are irrevocably interdependent, in fact they are anything but a functional partnership. The present relationship of misunderstanding and mistrust has precipitated not only a tremendous waste of energy and resources, but the channeling of resources into the construction and maintenance of all sorts of protective barriers. This situation is both the cause and the result of the widespread inaccessibility of accurate, timely and meaningful information. At precisely the time when the need for information for the public has never been greater, the difficulty of getting it has also never been greater.

A truly effective information system in California must have provisions to ensure that all participants in long-term care know (1) that accurate information is available, (2) where and how it can be gotten, (3) what it means, and (4) how to apply it to their needs. The first two objectives require the development and implementation of an automated, statewide long-term care information system and service. The second two objectives require a comprehensive outreach program to ensure that such a system is understood and utilized. Testimony to the Commission consistently shows that there is neither a coherent and

accessible information system, nor a systematic outreach effort in California at this time.

6. The Torres-Felando Long-Term Care Reform Act provides legislative foundations.

The new Torres-Felando Long-Term Care Reform Act, calling for the creation of a Department of Aging and Long-Term Care, provides an opportunity for a statewide nursing home information system and mandates cooperation among all long-term care participants for a comprehensive and coordinated continuum of services for the elderly and the disabled. However, the planning efforts called for in the first year of this law have not yet begun. As such, it will probably be some time before actual implementation of the continuum of care notion takes place. While the very real need for a consumer-oriented nursing home information system cannot be delayed, the Commission believes that this nursing home information system can and should be integrated into the cooperative efforts that it is hoped will take place between all agencies and programs for the elderly and disabled under this law.

Recommendations

1. A statewide automated information system

An effective long-term care system urgently requires the development and implementation of a comprehensive information system. This system must have provision to improve information sharing by all participants in the long-term care environment.

2. Consumers and the public must have more active roles

The development and enactment of effective long-term care policies requires the more equal and active participation of concerned citizens. (See detailed Recommendations in Sections B and C of this Chapter and in Chapter IV, Section B.)

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

Findings

1. LCD has proposed a management information system.

In their response to the Auditor General's 1982 report,[1] LCD proposed an automated Licensing and Monitoring System (LAMS). LCD's proposed system is only a (much-needed) management information system. Its function is to tighten internal control of State and local operations of LCD and to increase the Division's ability to regulate nursing homes by identifying trends of substandard care and ensuring sanctions.

The proposed management information system is divided into two subsystems: (1) a Facility Information Subsystem (FIS) will contain data on facility license application, issuance and renewal; facility demographics; and profiles of owners, directors and administrators; and, (2) a Facility Violations Subsystem (FVS) containing violation, citation and complaint data; a means of establishing priorities for complaints, tracking them, and analyzing responsiveness to them; a violation history for each facility with outcomes of legal actions and a means of tracking and assessing penalties for repeat violations; a means to increase the efficiency and specificity of the inspection process and

documentation; and a largely automated response to inquiries about facilities. Important performance features of the information system are (1) facility data files are regularly maintained and updated by LCD district office staff, (2) it has an online inquiry system, and (3) it can provide a series of summary reports, including facilities by district, individual facility profile, citation/violation summary, and complaint file activity. The district LCD offices are to be responsible for the accuracy of the data. The interaction between the Facility Information and Facility Violation Subsystems is continuous to allow cross-file referencing.

Since LCD proposed the system described above, the Division has made additional revisions. The revised information system has been dubbed ACLAIMS, Automated Certification and Licensure Information Management System. The inclusion of the word "certification" is in expectation of federal funding for the system and of its exportability for use in other states. In federal Fiscal Year 1982-1983 LCD received $635,000 from the federal government earmarked for "increased survey activity." In order to begin the development and installation of ACLAIMS, the Division asked the State Department of Finance to increase their funds by this $635,000. The request was denied and LCD is now seeking additional federal funds specifically for the implementation of the information system.

This management information system, in both its original and revised forms, appears to effectively address the issues raised by the Auditor General's report (e.g., deficiencies in processing of and response to complaints, inefficient monitoring of district office operations and potential program problems, unreliable, duplicated and/or useless

reporting, and poor means of identifying substandard care trends). The estimated cost of development, installation, and production of the LCD system before the ACLAIMS revision was $902,583 for the first year. Operation in subsequent years was estimated at $278,819, assuming no additional development costs or cost increases.

There will, doubtlessly, be a need for some staff for the implementation of an information system. LCD has told the Commission that the Federal government is anxious to have the system implemented and has funding available for it. It is to be hoped that Federal support will not be lost through either Department of Finance or Department of Health Services inaction in approving the implementation of the system.

2. The proposed LCD system has no provision for public access.

The LCD system is only a partial solution to the problems heard by this Commission. With its emphasis on facilities and violations rather than the public and care, this system will not automatically address the concerns raised by consumers in the testimony. LCD's information system is at present designed exclusively as a management-regulating tool. As such, it has no provisions for--

- public access,
- consumer input,
- distribution of information to the public,
- a facility rating or comparability system or mechanism.

3. Consumers need coherent nursing home information.

There is a steadily growing number of concerned citizens who will need to think of the possibility of using nursing homes at some point in

their lives. They should not have to suffer from the lack of information and the subsequent anxiety that now attend the subject. Thus, access points--ways of making useful and accurate information available--are a critical problem. Access involves not only providing ready entry to a coherent information base, but also eliminating blocks to access, such as bureaucratic delays or unresponsiveness by government and sincere cliches by the industry. Consumers in this State contend with all these problems, as numerous accounts in the testimony indicate.

It is important to distinguish between availability of information and the true ease with which it can be obtained and applied. The typical consumer or citizen, particularly in the larger urban areas of the State, may locate literally dozens of public or private agencies or consumer groups which attempt to provide a variety services for the elderly. They can be located, with some confusing effort, by starting with the telephone book. Many of these groups have referral services, brochures, pamphlets, or fact sheets. However, each booklet or pamphlet usually has a different source, often reflects a different perspective, may use different measures and criteria, and is invariably either incomplete when printed or out-of-date when used.

The average consumer does not have the knowledge or time to sift through and somehow make sense of all this scattered data. Even when information is available, which is often not the case, the consumer is at a loss. This is true both in urban and rural areas--there are different problems in each, but both areas are information-poor. The first priority for relieving this poverty of information is, therefore, the development and maintenance of a system which serves the consumer

and provides the general public with coherent, concise and useful nursing home information.

4. Los Angeles County's consumer information service is a prototype.

A prototype Consumer Information Service (CIS) has been in use in Los Angeles County since 1976. The Nursing Home Information and Referral Service, operated by the Los Angeles County Health Department is computerized and information from the system is accessible to anyone by phone. Each caller is asked to answer questions about the health condition, personal service requirements, language spoken, religious preference, special diet, financing (i.e., Medi-Cal, private), and preferred location of the person needing nursing home placement. On the basis of this input, the system generates a list of facilities meeting the criteria. The list contains the facility name, address, and phone number, information about ownership, senior staffing turn-over (i.e., length of employment of administrator and director of nursing), staffing patterns, and the names of the Medical Director and Activities Director. A facility profile includes the inspector number, a list of violations and/or deficiencies from the most recent inspection, and a violation summary taken from the two most recent annual inspections. Finally, facilities are categorized as either "available for referral" or "do not refer." These two categories are determined by the number and type of violations a facility has relative to the countywide average, as well as other factors. This system was originally developed in cooperation with the nursing home industry, but the proprietary industry now opposes its operation. While the system does have difficulties,

we believe the effort should be to modify and expand it, not to discontinue its use.

5. Blocks to access cripple an information system.

It is essential to recognize that, even with an efficient and comprehensive automated consumer information service in place, blocks to access can occur. A major block to information access is bureaucratic inefficiency or unresponsiveness. The Commission heard reports of obstructive attitudes, the "purging" of inspection files, and carelessness with confidential information by LCD staff. Witnesses at the 1981 Commission on Aging hearings told of excessive interrogation and of requiring appointments when access to LCD files was requested.

There is, in addition, the impediment posed by the use of unclear reporting procedures and specialized language or codes. For example, in Alameda County, Ombudsman Trainees are required as a class assignment to go to the district LCD office and review a facility file. Prior to their visit to LCD, the trainees go through a three-hour session, which includes an explanation of the state inspection process and a presentation by a LCD inspector. The inspector goes through an actual file step by step. Despite this orientation, most trainees report real difficulties understanding the material and/or locating relevant information in inspection files in an LCD office. They are unable to make trend evaluations, because some files contain only the most recent inspection report. They are also often unable to determine a facility's current citation record because there are no reports in the file or the reports do not specify the type of citation ("A" or "B"). Consider,

then, the plight of the uninformed and untrained ordinary citizen in search of information at an LCD office.

It is evident that, while LCD information is, in theory, open to public access, in fact LCD does not function at all well in this capacity. With its extensive enforcement responsibilities in California's 2500 long-term care facilities and hospitals and only eleven district offices throughout the State, LCD is not adequately equipped to handle growing consumer interest in and demand for information. Our recommendations for a Consumer Information Service attempt to address these pressing issues.

While present needs for a Consumer Information Service (CIS) "inside" LCD may take precedence, eventual operational management of the CIS should come under the jurisdiction of a non-regulatory, consumer-oriented agency, such as the Department of Consumer Affairs. Alternatively, if the ideal of the functional continuum of long-term care services described in the 1982 Torres-Felando bill is to be realized in this State, a comprehensive CIS covering all levels of care for the elderly and disabled will have to be developed. Ultimately, then, the CIS could be managed by the new Department of Aging and Long-Term Care, with distribution and access terminals located in each of the designated Community Long-Term Care Agencies, as well as other access places.

6. Intimidation seriously impedes public involvement.

The most serious impediment to free flow of information is fear of retaliation either against staff or residents and/or their family members, by a facility.

Retaliation is what a facility can do, or threaten to do, to an employee or resident if they complain or protest. The intimidation of residents, in the extreme, takes the form of either eviction or abuse. There are also countless small ways in which residents can be intimidated on a daily basis, such as a delayed response to a call button or discourteous behavior by a nurse assistant. Because nursing home residents are a captive audience--often isolated and without alternatives--day-to-day "small" infractions quickly add up to an overwhelming problem. This kind of subtle intimidation effectively silences many residents and their families.

An equally serious form of intimidation has been perpetrated against facility staff by some nursing homes. Several accounts by licensed nurses and nurse assistants indicated that some nursing homes can and do fire employees who report incidents or problems. According to one witness, employee intimidation includes not only the fear of losing one's job and actual firing, but also harassment and being blacklisted by other facilities.

Intimidation is a clear block to free flow of long-term care information, not to mention a violation of individual rights. It stops the flow of information at its source--the crucial point at which care is delivered by provider to consumer.

7. Consumers need systematic opportunities to participate.

The need for incorporating input from the general public and consumer advocates is really also an access issue. It is critical to establish points of access for getting information out of the Consumer Information System. But it is no less important to establish formalized

methods for putting consumer information into the system. Of the three components of the "long-term care triangle" (i.e., government, public, and industry), the consumer and public have the least authoritative voice. Yet, as the testimony continually shows, family members and public representatives are often most concerned about current conditions and problems in nursing homes. What they lack is a systematic way of making their voices count, i.e., of impacting both the regulatory and the service provision components of long-term care.

The ability to respond aggressively to problems which arise in nursing homes between annual inspections can be accomplished by an efficient complaint handling system. This is one important mechanism for public input, but input should also be encouraged in additional ways.

8. Community, family, and residents' councils increase public involvement.

Several states have laws which require or encourage the formation of councils to work within nursing homes. Some states (e.g., Colorado, Illinois) require a resident council in each facility and assign it specific duties. In view of the vulnerability of nursing home residents as a group, however, the potential for domination by facility representatives should be reduced by requiring only that facilities encourage and cooperate with residents' own efforts to form a council, and that a neutral observer such as an ombudsman be permitted to attend.

Family and friends' councils are also being developed in some facilities as a means of coordinating efforts, communicating information, and providing mutual emotional support. In addition to resident and

family councils, there are also community councils which may include residents, family, volunteers (ombudsmen, friendly visitors, church volunteers, etc.), and community members. In some states these are required by law. For example, Iowa requires a care review committee for each facility, and North Carolina requires a nursing home advisory committee for each county. Facility staff and others employed by the nursing home industry are not permitted to be members of these committees and councils.

Councils are intended to maintain residents' rights and to promote community involvement in nursing home care. Increased community presence in facilities serves two additional and important functions: (a) it can reduce the threat of intimidation, and (b) it increases the numbers of consumers who can provide experiential input to the State and the long-term care industry. Industry organizations themselves are encouraging their member facilities to have such councils. The importance of formalized mechanisms to promote resident and public involvement in long-term care cannot be overemphasized. For related Findings and Recommendations on this subject see Chapter IV, Section B.

Recommendations

1. The LCD information system must include a consumer information service

The LCD system should not be implemented unless and until it is modified to include, from its inception, a Consumer Information Service as described below.

2. A consumer information service with six components

A modified and expanded version of the Los Angeles County Consumer Information Service (CIS) should be available statewide. A CIS component can be interfaced, without extensive modification, with the proposed LCD management information system. In addition to the performance capabilities in use in the Los Angeles system and proposed in the LCD system, we recommend that the statewide CIS also include, but not be limited to:

(i) An online inquiry system accessed through a statewide toll-free "800" number. This number should be required to be placed in bold print and in clear view in all nursing homes. It should be advertised in the media. The "800" number may link callers to a central information office; identical read-outs and/or print-outs should be available in all LCD district offices. Planning should include provisions for increasing the number of terminal locations throughout the State, perhaps in the lobbies of all Department of Motor Vehicles or Employment Development Department offices, which are far more numerous than the eleven district LCD offices statewide (ten under the Deputy Director plus the Los Angeles office). Print-outs should be made available at cost.

(ii) The Consumer Information Service will generate lists of facilities which meet consumer criteria similar to those used by the Los Angeles County system. Facility location should be referenced by several categories, including county, city, zip code, and "nearest available." Print-outs should be mailed at cost upon request.

(iii) Each facility profile will include data on services provided, a history of sustained citations, a history of verified complaints, and a summary of care trends covering the most recent four-year period.

(iv) The Consumer Information Service should have a means of generating timely follow-up reports to all complainants. These reports should include the action taken, the date of the action, the facility's response, the current status of the inquiry, results of any appeals, and, where appropriate, suggestions for alternative action by the complainant.

(v) The Consumer Information Service could contain a comparability rating system for each facility. A fair rating system can be devised by the joint efforts of LCD, consumer groups and the industry. It must be uniform throughout the state and should include three to five categories: (superior,) above average, average, (below average,) and do not refer. The difficulties of such a task are acknowledged; the wide perception of the need for such a system makes such an undertaking mandatory. (See Chapter VIII, Section C.)

(vi) The Consumer Information Service should have a means of automatically distributing reports on facilities to designated consumer groups in relevant service areas. Formalized reporting channels should be established between LCD, the State Long-Term Care Ombudsman and designated local Ombudsman Programs. This recommendation is in addition to, and not meant as a replacement for, a widely available print-out/read-out dissemination system.

3. Penalties and deterrents against intimidation and retaliation

While retaliation may be difficult to prove, we recommend a significant increase in the civil penalty, plus potential criminal sanctions, for proven incidents (see Chapter V, Sections B and C, for details).

Also, facilities should be required to pay a fired employee during an appeal process, if the firing was 60 days after the employee made a complaint against the facility. Payment would be required only if there is no convincing evidence of wrongdoing by the fired employee.

The existence of such potential sanctions should help to deter acts of intimidation. Also, Recommendation 5 below, on resident, family, and community councils, would provide outside presence and mutual support which can help both to deter intimidation attempts and to encourage the filing of grievances in spite of such attempts. Intimidation itself is more likely to be reported to the authorities if the victim does not feel alone in a battle against the institution on which he or she depends.

4. LCD must formally incorporate consumer input

Chapter IV, Section B, recommends a number of ways in which LCD should obtain information from consumers and the public. These include interviews with a representative sampling of residents, families or guardians of residents, and facility staff; meetings with resident/family/community councils; consultation with ombudsmen; considering results of an annual public meeting held in the facility or the local community; acquiring and considering reports from other interested individuals and organizations. It is also recommended that citizen volunteers be trained to help with LCD's inspection and information-gathering efforts. The results of all these efforts should be summarized and made available through the Consumer Information Service.

5. Facilities should establish resident, family, and community councils

A statute or regulations should require that each facility encourage and assist efforts to form residents' and family/friends councils within the facility. A balanced task force should study whether such councils should be required by law, what their responsibilities should be, and what jurisdiction, membership, and duties they should have. Meanwhile, efforts to form various types of community councils should be strongly encouraged in each facility. Membership should include the ombudsman, family members and guardians, and a broad range of other community volunteers. Monthly meetings with facility staff and the residents' council should be the rule, and more frequent presence in the facility by non-resident council committee members should be encouraged.

6. Expanded role for Long-Term Care Ombudsman programs

The Long-Term Care Ombudsman Program should have a key facilitating role in the coordination of community involvement programs within each service area. Direct, two-way reporting channels should be specified among LCD, consumer groups and the local Ombudsman.

7. LCD should establish an interagency coordinating council

A formal interagency coordinating council should be established by LCD. The first five recommendations above deal with consumer participation in facilities. The interagency coordinating council, composed of appointed agency and consumer representatives, will ensure systematic consumer input. Agencies represented on this coordinating council should include the Departments of Justice, Education, Consumer

Affairs, Health Services, and others as appropriate. The council should also include consumer and industry representatives.

The above suggestions are intended to increase community involvement and have recent broad legislative support in the Torres-Felando Long-Term Care Reform Act. These efforts should be linked to efforts mandated in Section 9867(c) of that newly-enacted law.

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

Background

The previous section dealt with provisions for the first component of a comprehensive long-term care information system, i.e., an accessible information base. While that section concerns the "now it's here, come and get it" side of an open information system, the present section addresses the equally important "how can I use it and why should I want to?" issue. This is the "applied-side" of an information system. The objective is to develop a knowledge base which empowers the public so that they may be able to become active users of long-term care information.

Findings

1. Consumers lack ways to become selectively involved.

The vast majority of consumers and interested citizens may never become actively involved in a community council, an Ombudsman Program, or other volunteer group. Nonetheless it is of critical concern that the State provide opportunities for these people to become selectively involved in long-term care by assuring that they (1) know that a credible Consumer Information Service exists and (2) know how to use,

rather than be used by, the long-term care system. A Consumer Information Service printout will most certainly contribute to the average consumer's confidence when he or she is attempting to select a nursing home. But how much will it help, when this same consumer encounters one of the attitudes mentioned earlier (e.g., professional aloofness, bureaucratic remoteness, and indifference) after having placed a relative? Will this person lapse into resignation? Or will he or she know how to use the next element of the network?

2. Consumer input will improve industry training programs.

The consumer and general public have the right to know that state inspectors, service professionals, and industry employees are participating in ongoing training and development programs. Such training is critical to the effective performance of their duties as public servants and care providers. (Training Findings and Recommendations for LCD are discussed in detail in Chapter III.) The nursing home industry is no less in need of ongoing staff development programs. These should focus less on the technicalities of compliance and more on the care of the frail elderly and disabled.

It is crucial, however, that training programs not increase the already broad gap between the public, the industry and LCD. To this end, the acquisition of technical and specialized information is only part of an adequate staff development program. Just as consumers must be given an authoritative voice in both the input and output phases of the information base, so too must they be given an active role in the continuing education of State long-term care staff and providers.

Recommendations

1. Seminars and workshops for consumers

Regular and ongoing seminars and workshops designed to empower consumers should draw from problem issues reflected in the non-technical reporting mechanisms (e.g., citizen inspections, community council evaluations, etc.) which provide input to the Consumer Information Service and from other informal sources. LCD and the industry should be present; sponsorship should be undertaken by the Department of Aging and Long-Term Care.

2. Ombudsman program should receive funds for consumer outreach

The Ombudsman Program should receive and utilize additional funds specifically for consumer outreach programs specified under its entitlement as follows: (a) advise the public about, or arrange for availability of, current State, local, and Federal inspection reports, statements of deficiency and plans of correction for individual long-term care facilities in the service area; (b) promote visitation programs; (c) create and assist in the development of resident, family and friends councils; (d) sponsor community inspections or evaluations of nursing homes; (e) present community education and training programs to nursing homes, human service workers, families, and the general public about long-term care and residents' rights issues.[2]

3. Formalized consumer input mechanisms for industry training

Formalized mechanisms should be established for incorporating consumer input and participation in curriculum development and training programs for industry personnel. Facility training and inservice

programs should be expanded to include consumer participation. LCD regulations should specify guidelines for consumer input.

4. Nurse assistant training should be expanded

The requirements for the education and certification of nurse assistants should be broadened. Both in-class and "internship" requirements should be extended as a condition of certification. As needed, this education should be supplemented by coursework in English-as-a-second-language (see Chapter VIII, Section D).

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This Chapter has sought to provide a variety of routes to the same goal: increased information for consumers and the general public, and decreased defensiveness among both LCD and the nursing home industry. Some of the misperceptions and misunderstandings presently held by virtually all parties who have interest and concern with long-term care can be diminished or removed with implementation of these Recommendations. To do otherwise is to invite deeper frustration. We can do better.

CHAPTER VII

TO IMPROVE CARE IN A CONSTRAINED FISCAL ENVIRONMENT

Background

This chapter addresses interrelated topics concerned with various strategies that have the overall goal of improved care for nursing home residents. The first, and largest, portion of this chapter deals with the continuing quandary posed by questions of the relationship(s) between costs, profits, and care. While that issue forms the major part of the chapter, it is not the major focus of this report, nor of our Commission's hearings.

We have chosen to set issues concerned with reimbursement, costs, quality, and profit, within the overall context of the issues presented to our Commission. The major issues before the Commission were largely concentrated in the areas of enforcement and regulation and also with the poor quality of information concerning all aspects of long-term care available to consumers. These two areas form the central foci of this report. However, it is doubtlessly true that virtually all aspects of long-term care are heavily influenced by issues of costs to the public and to the State in the form of Medi-Cal expenditures.

In addition to concerns with costs and quality of care, several other key issues that were raised at the Commission Hearing are addressed in this chapter. These include problems associated with Medi-Cal "conversions" (or, more explicitly, Medi-Cal evictions) whereby

private pay residents of a Medi-Cal participating nursing home are sometimes told to move out when their personal funds are exhausted and they become Medi-Cal eligible. This is an issue with far-ranging consequences, both legal and fiscal, for residents and for the entire long-term care industry.

Other issues concerning efforts to improve care in a constrained fiscal environment include whether and how new care providers, such as (Geriatric) Nurse Practitioners, should be utilized in nursing homes; and whether the present minimum standards for nursing hours in long-term care are appropriate. This Chapter will make recommendations based on findings in these areas. We turn first to the complex issue of costs, quality of care, and profits.

A. The Cost of Care: Is More Better?

Findings

1. The nursing home industry in California is a major enterprise.

In California the "average" facility is more than a million dollar a year enterprise. Occupancy rates for long-term care facilities in this State average about 95 percent. Allowing for a few days to make admission arrangements when a bed becomes empty, it can be argued that long-term care in California is virtually a "full-house." Many facilities have long waiting lists; especially difficult to find are Medi-Cal beds for the seriously ill, the so-called "heavy care" patients. The California Health Facilities Commission estimates Fiscal Year 1983-1984 Statewide long-term care facility revenues at 1.735 billion dollars, and expenses at 1.715 billion dollars. Approximately 72 percent of the residents of nursing homes Statewide are Medi-Cal recipients. In FY

1980-1981 there were over 35 million long-term care patient days; 25.1 million of these days were paid by Medi-Cal. Thus, a very large portion of nursing home revenue is State monies in the form of Medi-Cal reimbursement. To these figures must be added the reminder that 85 percent of the long-term care facilities and 88 percent of the beds in the State are operated as for-profit businesses (data are for FY 1980-1981).

2. The increasing number of nursing home chains raises concerns.

A growing number of nursing homes are part of multi-facility chains. The proprietary trade association, California Association of Health Facilities, estimates that some 40 percent of the State's 105,000 long-term care beds are owned or leased by chains. This figure has virtually doubled in the past five years and is projected to rapidly increase. The "name of the game" in long-term care, both in California and throughout the nation, is the acquisition of so-called "mom and pop" single-owner facilities by groups or corporations who own or lease multiple facilities. Sometimes ownership is concentrated locally, but, with increasing frequency, chains are acquiring facilities throughout the State and in several different areas of the country.

3. The industry correlates increased reimbursement with quality care.

The argument of a large segment of the nursing home industry in regard to quality of care appears consistent and simple. It is continually heard in the Legislature and at all public hearings concerning either regulation or reimbursement issues. That argument, baldly stated, is that increased reimbursement is the best way to assure better

care. In a slightly more elaborate form, the argument is often stated this way: The burden of regulation on the nursing home industry is both counter-productive and quite expensive. With increased reimbursement rates and increased freedom from onerous regulation, the quality of care would surely improve. In sum, more is better. This Commission, on the other hand, finds that there are important issues which this argument does not address.

4. Profit formulas used are inadequate and inconsistent.

First, it is extremely difficult to find out just how profitable long-term care is. Industry-produced narrative and financial statements concerning "profitability" appear complex in calculation and modest at "the bottom line." The California Health Facilities Commission, in its annual Economic Criteria for Health Planning reports, is in the unenviable position of trying to devise "profitability" data about long-term care. For Fiscal Years 1977-1979 "profitability" was measured by calculating, from facility cost report data, the Rate of Return on Owner's Equity (ROE), one of the fairly common standards used by businesses to state profits. For that period of time:

> Three statistics are used to describe industry performance relative to the return on the owner's equity standard. Using the arithmetic mean, average return on owner's equity was 41.0%. Mean profit as a percent of revenue was 9.1% and mean net income per patient day was $0.86. The median return on owner's equity was 24.7%. The median profit as a percent of revenue was 3.4% and the median net income per patient day was $1.00. Using a weighted mean, the average return on owner's equity was 20.1%. The weighted mean profit as a percent of revenue was 2.7% and the weighted mean net income was $0.80.[1]

Regardless of what else that paragraph may mean, two things stand out. First, the average person will have no idea whatsoever

what that paragraph means. "Average person" means both the vast majority of the public and most persons concerned with long-term care at the State level. The second thing we can say of the figures in that paragraph is that it is clear that one can make choices. Depending on the percentages one chooses, "profit" can be said to range from 2.7 percent to 41.0 percent! How one chooses to calculate and describe the word "profit" has very large consequences. It is clearly in the best interest of the nursing home industry, both for "image" and for seeking increased reimbursement rates from Medi-Cal, to report a "profit" percentage that is as modest as possible.

Beginning with FY 1979-1980, the Health Facilities Commission chose, after a heated and inconclusive debate within their Long-Term Care Advisory Committee, to change the index of profitability from Return on Equity to two new figures: (i) net pre-tax income per patient day and (ii) net pre-tax income as a percentage of health care revenue. For FY 1979-1980 these new figures are:

TABLE VII-1

Type of Ownership	Net Pre-tax Income/Patient Day (Median)	Net Pre-tax Income As a Percent of Healthcare Revenue (Median)
For profit chain (N=585)	$1.18	3.5%
For profit non-chain (N=418)	$1.12	3.1%
Church (N=69)	$0.10	-6.3%
Other non-profit (N=93)	$0.23	-7.9%
Government (N=7)	0	-39.2%
Overall Industry (N=1,172)	$1.03	2.7%

Source: California Health Facilities Commission, Economic Criteria for Health Planning, FY 1983-1984, Long Term Care Facilities Report IV-83-5, December 20, 1982, Volume II, pages 14, 71.

The Health Facilities Commission believed that there were serious technical problems in attempting to calculate accurately the "old" Return on Equity standard (which yielded the "high" figure of 41 percent). The "new" standard or measure of profitability yields a far lower percentage range, i.e., 3.1 and 3.5 percent for proprietary facilities. The proprietary nursing home industry can now say, as it does, that its "profit rate" is less than 4 percent. The new index makes this an accurate statement. In addition, the new index has the obvious advantage of decreasing the heat and visibility that were associated with the "old" profitability figure of a 41 percent Return on Equity for the industry. The result of the new measure, with its "low" 3.1 to 3.5 percent profits is that the vast majority of people remain confused about what these new "low" figures mean, about how they are calculated, and about what their policy consequences are. The Commission does not necessarily support either of these methods for measuring profit rates. Rather, we suggest that this situation is part and parcel of the endemic information-poverty which the public continues to suffer when trying to untangle the fiscal and programmatic web that is long-term care.

5. The relationship between cost and quality has not been demonstrated.

A second problem with the "more is better" argument is that it is not known whether it is true. A prominent long term care policy analyst, Dr. Bruce Vladeck of the Robert Wood Johnson Foundation, recently summarized concerns in this area in The New England Journal of Medicine:

> . . . [W]e have to think more closely about the relation between the quality of [long-term care] services and their cost. The implicit assumption of a strong and positive relation between the two is central . . . . Yet there is hardly any empirical basis for such a belief. To be sure, there is some level of expenditure below which high-quality services are simply impossible. All other things being equal, more resources are likely to produce better results. But all other things are hardly ever equal, especially when services are as intimate, personal and nontechnological as most of the services provided in nursing homes. Many nursing homes provide first class service at relatively low cost. Some expensive nursing homes are awful. Nursing homes are predominantly small, autonomous institutions, in which the skills and personalities of individual operators and nursing directors have an overriding influence on quality of care.
>
> State regulators know that money isn't everything. That provides a primary rationale for much of what they do and, in an era of budgetary stringency, helps them sleep at night. More money is always preferable to less, and adequate sums may be a necessary condition for high quality care. But they are never a sufficient condition, and when the sufficient conditions are present, more money may not be so necessary.[2]

The Vladeck article was written as a companion piece to another in the same issue of the Journal. In that article, "Nursing-Home Care In The United States," Dr. Nicholas Rango argues:

> The argument connecting the pursuit of profits (or surplus [in the case of "non-profit" nursing homes]) with a marginal quality of care is analytically consistent and supported by some empirical evidence.
>
> According to this argument, a nursing home operator seeks to maximize revenues and to minimize expenses in order to gain the highest rate of return on investment. The most effective way for a facility to maximize revenues is to maintain a full census while excluding economically undesirable applicants, especially Medicaid [Medi-Cal in California] recipients with severe dependency. An operator can minimize expenses by scrimping on the time and money spent on training, counseling, and rewarding the salaried staff...A second way to scrimp is to restrict the economic rewards (i.e., salaries, wages, and benefits) offered to professional and nonprofessional workers. Finally,...an operator pursuing profits may try to function with the bare minimal number of staff needed to comply with regulatory standards. Thus, the question arises whether profit maximization inevitably leads to a deterioration in both quality and quantity of staff performance in a service industry in which the resident population is both

> captive and isolated. Although the evidence is compelling that many nursing homes have acquired the worst characteristics of what Goffman has described as 'total institutions,' the relation of profits to quality continues to be a poorly researched question. However, one recent study of 46 proprietary skilled-nursing homes in the same geographic area of California has demonstrated a consistently negative relation between profitability (defined as total annual revenues minus total annual costs divided by total annual patient days) and the quality of patient care (measured as the number of nursing hours per patient day).[3]

From the information provided in Table VII-2 (page 223), it would be possible to say that what Dr. Rango calls "scrimping" may be occurring in profit as opposed to non-profit facilities and, to a somewhat lesser degree, in key expenditure areas in the chain versus non-chain for-profit facilities. However, with such gross data, one person's "scrimping," can be viewed as another person's "economizing" or "good management." Clearly, finer levels of analysis are still very much needed. The best measures of "quality of care" are not adequate; they need expansion and refinement, and they need to be resident-centered.

While it certainly is true that nurse assistants (about 70 percent of the "nursing staff" in any California nursing home) are often paid at or near the minimum wage, it is not known that if we increase those salaries, we then also increase quality of care. Nor does it follow that providing funds to increase wages for some long-term care employees means that those wage increases will always go directly to the employee.

Given the real need to see long-term care employees receive decent salaries and benefits, increases need to be carefully designed so that (i) they do not wholly or partially disappear into the profits of a facility rather than go to employees; and, (ii) their relation to quality of care is more carefully evaluated and determined.

6. The chain phenomenon is important in the cost-quality relationship.

A third issue in the "more is better" argument hinges on the phenomenon of chain operations. The California Health Facilities Commission unfortunately presently defines a "chain" on its data base as an owner with more than one facility. A far more useful definition is that of the California Association of Health Facilities (CAHF), which has operationally defined a chain (or what they call a "multi-facility operation") as consisting of a group of facilities with a common owner that controls more than 1,000 beds. On this latter definition, CAHF estimates that there are some 15 chains with approximately 320 facilities and approximately 40,000 beds in California in 1983.

What does this growing chain phenomenon mean in terms of costs, profits, and quality of care? In May of 1983 the magazine Modern Healthcare published a survey of for-profit nursing homes using industry-supplied figures for 1982. Some quotations from that article are useful in understanding the chains and their importance:

> Major investor-owned nursing home companies increased the number of beds they operate by 30.4% to 244,410 [nationwide] . . . The nursing home systems included in the survey . . . bought 57,370 beds in 1982, that was up 84.6% from 31,079 acquired in 1981.
>
> ...
>
> By 1990, 50% of all nursing home beds will be operated by between five and ten nursing home companies, said Robert Van Tuyle, chairman of Beverly Enterprises, Pasadena, CA. Beverly--the largest nursing home chain in the nation--already owns about 5% of the 1.4 million nursing home beds. The 32 companies included in the inspection together operate about 17%.
>
> ...
>
> Multihospital systems boosted the number of nursing home beds they operated last year by 46.8% to 56,638 . . . . But 73% of that growth stemmed from one multihospital chain--National Medical Enterprises Inc., Los Angeles. NME's

> Hillhaven Corp. subsidiary in Tacoma, Washington, boosted its nursing home beds almost 66% to 30,757 . . . .[4]

The same article shows changes in financial status for the 32 chains in the Modern Health Care survey from 1981 to 1982. Revenues increased 58.1 percent (up to $1.862 billion); profits increased 48.9 percent (up to $82.2 million), and assets of these chains increased 88.5 percent (up to $2.210 billion). Clearly, this is a "growth industry" and one to which the State should give close attention given the increasing concentrations of resources found in these chains.

The survey shows Beverly Enterprises ranked number one in the country in terms of both number of beds (72,482) and number of facilities (618); Hillhaven Corporation (a subsidiary of National Medical Enterprises) ranks number three in terms of both beds (30,757) and facilities (249); and Flagg Industries ranks number twenty-two in terms of beds (2,052) and number eighteen in terms of number of facilities (19).

Each of these chains operates in California. Using data supplied to the California Health Facilities Commission from Long-Term Care Facility Disclosure Reports for Fiscal Year 1979-1980, we can see how those chains performed relative to other chains in the State and relative to Statewide data for all types of facilities. We have also included data here from a relatively new and potentially quite important phenomenon, a chain of nursing homes that is related to a non-profit hospital. The Guardian Foundation facilities are part of the Alta Bates Corporation, which includes the non-profit, acute care Alta Bates Hospital in Berkeley, and several other health-related enterprises. Guardian had 658 beds in 8 facilities in 1982.

Table VII-2

MEDIANS FOR SELECTED CHAINS
FY 1979-80

	For Profit					Non-Profit			
				Statewide			Statewide		Overall LTC Industry State-wide
	Beverly	Hillhaven	Flagg	Chains	Non-Chains	Guardian	Other Non-Profit	Church	
Expense Per Patient Day									
Housekeeping	$ 1.28	$ 1.79	$ 1.13	$ 1.46	$ 1.41	$ 1.23	$ 1.63	$ 1.58	$ 1.46
Laundry and Linen	$ 0.80	$ 0.84	$ 0.71	$ 0.84	$ 0.86	$ 0.81	$ 1.01	$ 1.18	$ 0.87
Dietary	$ 4.01	$ 4.79	$ 4.60	$ 4.30	$ 4.69	$ 5.02	$ 5.46	$ 6.32	$ 4.55
Administration	$ 5.17	$ 5.33	$ 5.14	$ 4.68	$ 4.20	$ 2.57	$ 4.68	$ 4.56	$ 4.50
Social Services	$ 0.35	$ 0.47	$ 0.37	$ 0.41	$ 0.48	$ 0.17	$ 0.52	$ 0.74	$ 0.45
Nursing	$13.73	$17.55	$13.83	$14.12	$14.21	$17.21	$18.94	$17.83	$14.45
Nursing Hours									
Nursing Hours/patient day	3.28	3.0	2.9	3.1	3.1	3.2	3.7	3.9	3.1
Percent RN	8.20%	8.1%	7.5%	6.4%	6.8%	12.1%	8.9%	9.8%	6.9%
Percent LVN	12.65%	13.1%	16.1%	15.3%	15.3%	10.4%	11.9%	11.1%	14.7%
Percent Aides	72.19%	71.7%	74.1%	72.3%	73.4%	71.6%	70.7%	69.6%	72.3%
Percent Registry	2.06%	0	0	0	0	0	0	0	0
Percent Supervisors	3.57%	4.2%	2.6%	2.8%	2.7%	3.3%	3.4%	2.4%	2.9%
Percent Other	0	3.9%	0	0	0	0	1.0%	0	0
Nursing Wage Rate/hourly	$ 4.57	$ 4.77	$ 4.49	$ 4.51	$ 4.47	$ 5.49	$ 4.64	$ 4.62	$ 4.51
Supervisor Hours/100 Nursing Hours	4.4/100	4.4/100	2.7/100	2.9/100	3.2/100	3.5/100	3.9/100	4.0/100	3.0/100
Facility Profile									
Turnover Percentage	148.4%	92.3%	237.5%	144.5%	120.8%	62.8%	82.4%	91.1%	128.0%
Percent Employees with 12 months continuous service	48.9%	30.4%	54.2%	44.0%	48.0%	60.9%	55.2%	57.8%	47.0%
Net Pretax Income Per Patient Day	$ 2.48	$ 0.55	$ 1.35	$ 1.18	$ 1.12	$ 0.24	$ 0.23	$ 0.10	$ 1.03
Net Pretax Income As A % of Health Care Revenue	7.74%	1.46%	4.17%	3.5%	3.1%	13.8%	-7.9%	-6.3%	2.7%
Number of Facilities	74	20	13	585	418	8	93	69	1165
Total Beds	8371	1931	1410	57,930	34,772	656	7226	4100	104,028
Median # Beds	113	99	98	N/A	N/A	74	N/A	N/A	N/A
Median % Medi-Cal Days	76.1%	55.8%	73.2%	75.4%	68.5%	21.6%	62.9%	51.8%	72.0%

Source: California Health Facilities Commission

Table VII-2 indicates that on the two current California Health Facilities measures of profit ("Net Pre-tax Income Per Patient Day" and "Net Pre-tax Income As A Percent of Health Care Revenue"), Beverly Enterprises does twice as well as the median for all other proprietary facilities and Flagg does somewhat better. Hillhaven, in FY 1979-1980, did poorly compared to Beverly, Flagg and other proprietary chains and even to the "Overall Long-Term Care Industry Statewide" figures.

Can conclusions of any kind be drawn from this welter of confusing data? We can conclude that an increasing number of publicly-held stock-traded corporations have emerged as a significant force in long-term care. Their management, capitalizing on those "economies of scale," which may be accomplished by central billing and group purchasing arrangements, can also reduce costs in areas such as laundry, linen, and food purchases. Furthermore, like the entire nursing home industry, the chains aggressively market to increase the number of private pay patients and, thus, to improve their profitability. All of these efforts can and often do decrease some costs and allow for increased profits. While cost savings may be on the order of pennies per day, those amounts can multiply rapidly when taking into account occupancy rates in excess of 95 percent, and the thousands of beds involved. If a chain can convert one cent per resident per day from cost to profit, and if such a chain has 1,000 beds that are 95 percent full for 365 days, then that one cent yields $3,467 per year. If it is not one penny, but dimes or dollars, the figures increase rapidly. Given that the "average" single long-term care facility is a business operation with revenues and expenses in excess of a million dollars per

year, it is easy to understand why both the industry and the State have an interest in watching the flow of these "pennies."

In the case of the non-profit chain, such as the Guardian facilities used in the example in Table VII-2, there are also consequences of some magnitude. Given that this chain keeps operating costs for housekeeping, laundry and linen, dietary, administration, social services, and nursing below the Statewide median for similar non-profit facilities, it is able to generate a "surplus." It is crucial to note that, in the case of Guardian, this "surplus" is added to by a policy of quite severely limiting the number of Medi-Cal residents who are admitted to, or who may remain in, its facilities (Guardian has 21.6 percent Medi-Cal days, other non-profits have almost three times as many with 62.9 percent and the Statewide figure is 72 percent). This operating surplus can be utilized in a number of ways. Guardian has given much of its surplus, in the form of tax-free gifts, to Alta Bates Hospital, the acute-care non-profit hospital of the parent Alta Bates Corporation. Those gifts from long-term care "surplus" can be substantial, particularly when there are very few Medi-Cal beds in the long-term care facilities. One cannot presume that, because a facility or a chain is non-profit, it is any different when it comes to considerations of "bottom line" dollar amounts.

7. Consumers have no impact on the cost-quality relationship.

Because there is a very slow development of long-term care "alternatives" to institutionalization and, thus, of a true continuum of services for the elderly, the market for long-term care services in California is virtually captive. The present high occupancy rates and the

Medi-Cal reimbursement formula do not encourage either industry competition or consumer choice. Within the industry, "competition" may simply be competition for residents who are not seriously debilitated ("light care") and who are able to pay for their own care at rates above the Medi-Cal rates. For the consumer, on the other hand, there are waiting lists and frustration.

8. Flat-rate Medi-Cal reimbursement encourages profit maximization.

The present system of long-term care reimbursement in California provides little or no incentive for facilities to perform better. Flat rate prospective reimbursement rewards a facility, with profits, according to its ability to hold down expenses, regardless of the varying needs of the residents. The nursing home industry seeks a system which would provide "positive incentives" for good care (see Chapter VIII) but it does not, in seeking to maintain the present flat-rate prospective reimbursement, address the fact that the present system provides more of an incentive to maximize profits than to provide resident-centered care. As our Commission recommended in 1977, alternatives to the present reimbursement system should be carefully investigated.

Considerations relating to long-term care are made more difficult for the consumer by the fact that the nursing home industry has a virtual monopoly on the provision of care. With near-full occupancy levels, waiting lists, and prospective (that is, guaranteed in advance) reimbursement, the consumer has little, if any, leverage. To give the consumer genuine choices in regard to the long-term care sought, will require "opening up" the system, both in terms of more information and in terms of more options for services. Finally, it will require

redesigning the present system, which provides disincentives for taking the seriously debilitated, the very people who need long-term care most and who can most appropriately utilize its avowed service focus.

A distinguished gerontological policy planner, Dr. Robert L. Kane of the Rand Institute in Santa Monica, recently stated what he believes should be goals for reform of the long-term care system. The goals Kane speaks of are:

> 1. To provide an incentive for high-quality care, defined in broad terms to include social and psychologic health.
>
> 2. To discourage market skimming whereby certain patients (usually those needing the least care in a category) are admitted while others with greater care needs are not.
>
> 3. To overcome the general tendency toward assuming that more is necessarily better and especially the perverse incentive of cost reimbursement that rewards the development of increasing dependency.
>
> 4. To minimize the negative aspects of regulation (i.e., to avoid both the recordkeeping burden and the constraints on creativity).
>
> 5. To use the free market as much as possible to encourage the expansion of good homes and the closure of poor ones.[5]

We concur with these goals and it is in their spirit that our recommendations are offered.

Recommendations

1. Develop options for long-term care consumers

More forms of appropriate placement for elders in need must be found. This does not necessarily mean building more nursing homes, although it could mean that. What it does mean is introducing into the present closed system consumer demand choices. The present long-term care system is almost wholly supplier controlled. This might be altered in several ways, including, but not limited to the conversion of some

unused acute hospital beds into long-term care beds, without the advantage of the significantly higher Medi-Cal rate now paid for such beds.[6] Real caution must be taken to make certain that hospital-based long-term care beds do not become only low-quality hospital-medical beds rather than good quality nursing home beds. Such "distinct part" facilities must have, or develop, a model of service for chronic care, rather than relying on the acute care model.

2. Reduce constraints on the supply of beds

The present supply of nursing home beds must not be further constrained; the efforts of the industry to maintain Certificate of Need occupancy standards at 95 percent should be opposed. State or local health planning agencies should have the authority to permit expansion of the supply of long-term care beds. Maintaining an artificially limited supply with the aid of the present Certificate of Need standards is costly. Too many people are being kept in hospitals, on "administrative/placement days" at high hospital rates, because a nursing home bed (often Medi-Cal) cannot be found. The industry's efforts to control supply further decreases consumer choice and increases and enhances the powerful control of long-term care services by the industry. The public should have more control over the timing and type of care of the (often final) residence.

3. Re-examine reimbursement mechanisms

Systems for reimbursement should be subject to careful and complete re-examination. The present Medi-Cal system over-advantages the 25-30 percent of long-term care consumers with private funds as well as

the vast majority of nursing homes which have waiting lists. Either the rates for Medi-Cal and private pay patients should be made, by law, identical, or significant alternatives to the present system should be developed. Among reimbursement alternatives that should be considered by the State are:

(i) The development of systems of long-term care which are prepaid and which offer a spectrum of social and medical and nursing services, taking place in a continuum of appropriate care settings. This would be somewhat similar to existing Health Maintenance Organizations, with the crucial addition of payment for long-term care. Also included in such an arrangement should be those "social" services which are central to the prevention of premature and unnecessary institutionalization. One arrangement for prepaid long-term care would be a Social/Health Maintenance Organization. Such plans could be designed either for an entire population or exclusively for the elderly who are now excluded from long-term care "health insurance" apart from Medi-Cal. The Aging Health Policy Center at the University of California at San Francisco recently published a detailed policy paper which indicates the feasibility and effectiveness of prepaid health plans.[7]

With proper waivers, a long-term care Social/Health Maintenance Organization could offer full coverage for the elderly where little presently exists, competition for nursing homes where virtually none exists, and a genuine competitive alternative to the State for the financing of long-term care where none now exists. The benefits of such a proposal could be substantial to the State and the consumer, though significant resistance might well be anticipated.

(ii) Dr. Robert L. Kane and his colleagues have recently published research (cited at the beginning of these Recommendations) which develops reimbursement mechanisms that are more directly tied to resident needs than are flat rates. Kane has developed a basic resident assessment tool which can measure whether facilities obtain achievable outcomes. This is done with a "Prognostic Adjustment Factor (PAF)" which can vary reimbursement in relation to carefully measured and predicted ways in which a particular nursing home resident's health status improves, remains the same, or declines. Regular resident interviews, assessment, and chart analysis yield a validated prediction of expected future resident functioning and, thus, can be tied to expenditures.

Variations of arrangements which seek to link reimbursement to quality of care are in use or being planned in several states (e.g., Michigan). Kane and his colleagues are apparently well on the way to developing a predictive model which can array key variables in resident care and predict how individual residents are expected to change over time. Such a resident-focused, outcome based model could be tied to virtually any existing reimbursement system, prospective, retrospective, or fee for service. The goal of this predictive model is similar to models which have used various types of "acuity index" to assess resident needs, staffing ratios, and quality of care outcomes. Such mechanisms permit the system to move away from a set of fixed inputs which must be insensitive to particular resident centered changes and needs.

4. Form a special Task Force

The Commission recommends that the State form a Special Task Force made up of senior planning and administrative officials of the California Health Facilities Commission, the Department of Health Services, industry representatives, independent research and policy experts, and informed consumer representatives to assess potential routes for increasing quality of care and decreasing reliance on the present inflexible and uncaring system of reimbursement. A "Special Task Force to Study Alternative Methods to Finance Health and Social Services for the Elderly" should be immediately established and a report issued within the year on progress that is being made in discovering feasible alternatives to the present quandary. This Task Force should also determine a clear and understandable method for stating profits.

5. State sponsored research on the cost-quality of care relationship

The State should not be passive in watching the rapid "corporatization" of nursing homes. Careful, large-scale studies of the relationship between cost and quality of care need to be sponsored by the State immediately. Two of the key issues to be explored in such studies must be the role of long-term care facility ownership (e.g., chain or non-chain) and financial status (for profit or not for profit). We suggest that this study be undertaken by non-governmental, non-profit research groups whose reputation in long-term care policy and alternative reimbursement planning is already established. There is no single State agency or Commission which, in our opinion, has the expertise to undertake such a study, although the Department of Health Services and the California Health Facilities Commission data and information

bases ought to be utilized. Such a study must be cognizant of related research and policy planning efforts being undertaken in other states (Michigan, New York, Florida, Texas, etc.) and at the Federal level by the Health Care Financing Administration.

6. Evaluate the need for a profit ceiling

Finally we recommend that an immediate study be undertaken to evaluate whether a profit "cap" should be established for those long-term care providers who exceed an agreed upon profit level. We find the argument that long-term care facilities are, at least in part, similar to public utilities persuasive given the amount of State investment in nursing homes and their resistance to market forces. If study shows the need for establishment of a profit cap, this should be undertaken by an independent Health Utilities Commission.

Such a cap should be designed to prevent continued private pay and/or "light care" patient "skimming." The cap should be subject to modification when and if long-term care market conditions change as a result of new forces entering the market. The methods for computing a level of reasonable profit should take into account comparisons with other "health utilities." The deliberations of the Health Utilities Commission should be public. Their summary reports and policies should be expressed in clear, non-technical prose for public consumption. Resistance to such a proposal would itself heighten discussion of many of the issues.

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

Findings

1. Evictions have negative effects and are potentially numerous.

> A seventy-four year old widow with a history of congestive heart failure, high blood pressure and arthritic problems, was unable to manage at home. Adult children had cared for their mother for many years, but due to her exhaustion and increased problems with ambulation, the patient was moved to a convalescent home for long-term placement.
>
> After a year of private pay status, the family had used up all their financial resources to pay for this care. The patient was then eligible for Medi-Cal. Upon conversion the convalescent facility indicated that they did not have any Medi-Cal beds available and that the family would need to move her to another facility.
>
> The family had chosen this particular convalescent home knowing that Medi-Cal was accepted at this facility. They invested all of their private funds at this facility thinking that their mother would not be "kicked out" after their funds had been exhausted. The convalescent home claimed that a two year guarantee of private pay status was in effect, but the family knew nothing about this requirement.

This case, submitted by discharge planners at a large hospital, is one of many described in Commission files and recent testimony. One testifier concluded:

> Medi-Cal evictions reveal the fact that nursing home residents are treated as commodities. Often these patients are paying well in excess of the cost of their care while private patients, and are tossed out as worthless because their care is now reimbursed at the Medi-Cal rate.

Whether done openly, as above, or with more subtlety, as where the converting resident suddenly is transferred to an acute hospital and her bed is not held, such transfers have many negative effects. The discharge planner who submitted the above case concluded:

> The emotional upset created by this situation is overwhelming for all parties. The elderly patient has to relocate and readjust to an already depressing situation. His family or "responsible party" has to deal with the stress and feelings

> of helplessness when all other financial resources except monthly income are gone. The acute hospital facility spends an inordinate amount of time trying to find another bed for the patient. [Where] there is an already existing shortage of Medi-Cal beds,...this has become a formidable task. ...Often a patient has to be placed miles away from his family (who are often elderly as well) and friends who had hoped to visit the patient on a regular basis.

According to some gerontologists, forced relocation of frail elders, especially if callously handled, can actually cause further debilitation and sometimes even death.

What is the actual extent of this problem? Nobody knows. Statistics cannot be derived from Medi-Cal authorization forms, because so often the resident is transferred first to acute care and only later to another nursing home. A recent survey of ten San Francisco nursing homes found only one that permits all converters to remain, and five that evict all converters (four of these do not participate in Medi-Cal at all).[8] The remaining four keep converters only after they have paid private rates for a certain period of time, varying all the way from 4 months in one case up to 4 years in another. Only two facilities had contracts spelling out their conversion policy; the others relied on oral agreement alone.

2. <u>When facilities take on residents, they take on obligations</u>.

Opinions differ over whether eviction of patients who convert to Medi-Cal is permissible under current law. The industry argues that Medi-Cal is a voluntary program and providers can therefore choose which and how many Medi-Cal recipients they wish to serve. Consumers argue that under state regulations residents may not be transferred except for medical, welfare, or nonpayment reasons. They say that although <u>participation</u> in the program may be voluntary, if a facility

does participate, it is obliged to accept Medi-Cal rates as payment in full for Medi-Cal recipients; thus, it would not be permissible for a participating facility to evict a converting resident for nonpayment. The Attorney General has been asked to resolve this question.

The Commission finds that when a facility admits any resident to its care, it accepts special obligations toward her; that when it forces her to uproot, it may inflict special harm upon her; and that justice therefore demands retention of converting residents by any facility which participates in the Medi-Cal program. But once this rule has been established, either by legal opinion or by remedial legislation (as has been done in a number of states), other difficulties may be anticipated.

3. Evictions are part of a broader Medi-Cal discrimination problem.

Medi-Cal evictions take place in a broader context of discrimination against all Medi-Cal residents. The Assembly Office of Research in 1980 reported clear evidence that many facilities in certain areas of the state discriminate against Medi-Cal recipients, especially those needing heavy care.[9] The report found that state-imposed limits on total bed supply and on Medi-Cal reimbursement for heavy care combined to produce market conditions which backed up such patients in acute care beds, working counter to the state's own goal of meeting the greatest needs at the lowest reasonable cost. This discrimination is likely to increase. For example, chain owners nationwide are "scrambling for more private-paying patients," and some will not buy a facility unless at least 50 percent of its residents are private-pay.[10]

The industry argues that a facility which wants to provide good care and make a profit has to limit its census of Medi-Cal residents and balance them out by charging private residents rates which are more than the actual cost of care. Thus, if facilities are required to keep all converting residents, they will attempt to compensate for any Medi-Cal/private-pay imbalances by lowering the quality of care and/or by other means such as:

- More private admission contracts under which residents remain private pay for a certain time before converting, and the facility agrees to keep them after that time. This is the solution favored by the California Association of Health Facilities. However, such contracts have been held illegal by Attorney General opinions in a number of states (e.g., Maryland), because they place a precondition on Medicaid admission in violation of the federal antifraud statute. The same would be true of other preconditions, such as required "contributions" or agreement by another person to make extra payments for Medi-Cal covered services.

- A sudden need for acute care around the time of conversion to Medi-Cal, followed by placement of a private-pay resident in the hospitalized resident's bed. This technique, already used in California, has been countered in other states by mandatory bed-hold policies. A few days does not appear sufficient; statutes more typically require that beds be held open for around 15 hospital days. In view of the difficulty and delay often experienced in locating another bed (Finding 1), this potential price is not inordinately high. A variant of this type of "medical" transfer involves residents who have come to need heavier care than the facility can provide. If true, the transfer is not only

legitimate but required by law. However, transfer of "heavy care" residents by a facility which is qualified to serve them probably violates federal law.[11]

- Limited-bed provider agreements, under which facilities contract with the state to make only a small percentage of their beds available to the Medi-Cal program. Then, if that quota is filled at the time a resident converted, the resident could be evicted for nonpayment on the ground that there is no mechanism by which the state could reimburse the facility for an additional bed. The legality of such agreements is uncertain. Some state Medicaid agencies (e.g., Connecticut) refuse to enter them as a matter of policy; Ohio prohibits them by state law.

- Refusal to accept Medi-Cal admissions, giving admission preference to the wealthiest private applicants, etc. A number of states have met such discrimination head-on by enacting statutes or regulations that mandate a first-come, first-served admissions policy (e.g., Connecticut, Massachusetts, Ohio). Minnesota's approach is indirect; Medicaid-participating facilities may charge private-pay residents no more than Medicaid rates for the same services. Both types of legislation have been upheld against the industry's legal challenges. The federal district court which upheld the Minnesota law in April 1983 said that it furthered "strong societal purposes" and that it:

> 1) may reduce discrimination against Medicaid recipients in gaining entry into nursing homes by eliminating the incentive to discriminate; 2) tends to alleviate the 'stigma' attached to receiving welfare benefits; 3) permits private pay residents to stretch their savings further and thereby stay off welfare; 4) promotes the fundamental notion of fairness that one should pay equal rates for equal services; and 5) eases the resentment of private pay patients directed toward Medicaid recipients.[12]

- Dropping out of the Medi-Cal program altogether. This has not been a major problem in states which have enacted strong anti-discrimination laws. It is a perennial threat which most facilities cannot follow up if they want to remain in business, since over 70 percent of potential residents are on Medi-Cal. (On whether Medi-Cal rates are really inadequate, and if so what should be done about them, see Section A above.)

If indeed many facilities drop out, New Jersey's approach could be considered. There, relatively few facilities participated in Medicaid, so the state passed regulations requiring every facility, as a condition of receiving its state license, to serve a reasonable proportion of indigents, either through Medicaid or directly. Those regulations were upheld by the state supreme court, which found that privately owned nursing homes are quasi-public entities, and should be required to share in the burden of caring for indigents.

This approach, while it appears more equitable in that all facilities bear the load equally, has proven something of an administrative morass in practice. The California Assembly Office of Research, in its 1980 study, preferred to keep it for a last resort, though recommendations did include conditioning all certificates of need on making available a certain quota of Medi-Cal beds. The Attorney General has since held that such conditions are not only permissible, but in some cases actually may be required by health planning laws.[13]

The Assembly Office did not consider other direct legislative controls such as those outlined above. Instead it offered suggestions on reimbursement for heavy-care residents, on changes in health planning criteria, and on alternatives to nursing home placement, all of

which were designed to open up the market and decrease both motives and opportunities for discrimination.

4. The state has an obligation to ameliorate Medi-Cal discrimination.

This Commission concludes that, to the extent that Medi-Cal discrimination is a phenomenon largely caused by state policies, the state is under an obligation to remedy its causes and to protect its victims. In addition to change in market forces resulting from recommendations in Section A above, direct prohibitions are essential.

Recommendations

1. Requirement that facilities reveal Medi-Cal policies in advance

The Department should promulgate a regulation requiring that all facilities reveal to applicants, in writing and in advance of admission, whether the facility participates in Medi-Cal, and if so, the circumstances under which the law and the facility's policy permit a Medi-Cal recipient to be transferred involuntarily. Ultimately, this requirement should be part of any nondiscrimination statute enacted by the legislature.

2. Prohibition on transfer because of conversion to Medi-Cal

If the Attorney General finds that eviction of Medi-Cal converters is permissible under current law, the legislature should protect residents by enacting a statute that states:

> No resident shall be transferred as a result of a change in status from self-pay or Medicare to Medi-Cal provided the facility participates in the Medi-Cal program.

There should be opportunity for a hearing prior to any involuntary transfer, to determine whether the transfer is legal. Also, facilities should be required to reveal Medi-Cal policies, as outlined in Recommendation 1.

3. Adequate mandatory bed-hold for hospitalized Medi-Cal residents

The legislature should require, and provide funds to pay for, retention of Medi-Cal beds during acute hospitalization, for long enough to prevent evictions based on relatively brief medical absence. That time period is longer than three days, and is probably more on the order of fifteen days.

4. Statute prohibiting all forms of Medi-Cal discrimination

In view of the extent of general Medi-Cal discrimination, plus the potential for complex tactics to avoid obligations toward residents who convert, a more comprehensive antidiscrimination policy is essential. The special Task Force proposed in Section A, Recommendation 4, should factor into its considerations the necessity for, and effects of, such a policy.

This Commission recommends that the legislature adopt the Ohio approach (Appendix VII-A), where all beds in a Medicaid-participating facility must be covered under its provider agreement, and where there may be no discrimination in either admissions or transfers. That means first come, first served, regardless of race, color, sex, creed, national origin, or source of payment. As in Ohio, exceptions would be permissible so that life care, denominational, and county facilities could give preference to their members or constituents.

If any quota approach is adopted, it should be based first on retention of current residents who convert, regardless of whether this puts the facility over its quota. Additional residents would be accepted if the quota remained unfilled.

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

Background

David Hackett Fischer, in Growing Old In America: A Short History, suggested that many of our attitudes toward the elderly can be called "gerontophobia." Many of us have a deep fear of aging and, also, of the elderly for what they show us we will become. If such a statement is accurate for the general population, it should not be surprising that it is also true for providers of care for the elderly, namely doctors and nurses.

Findings

1. "Nursing" home does not mean nursing care.

Nursing homes are misnamed. In fact, they have very few registered nurses on their staffs. Table VII-2, in Section A above, shows that less than 7 percent of the "nursing" care in long-term care facilities is provided by registered nurses. Nursing home care, the actual hands-on work of caring for residents, is done by a small number of Licensed Vocational Nurses (14 percent) and overwhelmingly by Nurse Assistants (72.3 percent). Further, the few registered nurses in nursing homes often do not do resident care; rather, they hold admin-

istrative positions, such as Director of Nursing. Their work is almost wholly supervisory and administrative.

2. Physician services to residents are minimal, at best.

The situation with physicians working in long-term care is harder to calculate. What is known can be summarized briefly: few physicians identify themselves as having geriatric training or interests, few physicians regularly see patients in nursing homes, and patterns of Medi-Cal physician reimbursement for nursing home visits are considerably lower than reimbursement for visits to a private physician in his or her office.

Dr. Robert Kane writes in Geriatrics In the United States that the institutionalized elderly often "receive superficial, indifferent care." This problem has been documented over the past two decades. Constance Williams synthesized information about medical care in nursing homes:

> 1. Only 14% of physicians (compared to the 48% of family practitioners and internists in the population) make nursing home visits. This causes discontinuity of care at a critical time for the patient.
>
> 2. There is often infrequent monitoring of medications. The average patient receives 6.1 medications and a large fraction of patients receive psychoactive drugs with no indication of mental illness.
>
> 3. In response to earlier studies indicating inadequate number of [physician] visits, Federal regulations specifying maximum intervals within which physician visits must occur 'assures a cost that may be unnecessary and which does not assure quality.'
>
> 4. Medicaid [Medi-Cal] and Medicare physician reimbursement fees are less than 75% of physicians' usual and customary fees, representing another barrier to physician services in nursing homes.[14]

Physician nursing home visit reimbursement levels are low. This was done in an attempt to control one problem ("gang visits"). But it has effectively helped to create another problem: the shortage of trained health providers on-site in nursing homes.

3. Geriatric nurse practitioners are a needed provider.

In the past several years, a new kind of provider has emerged, the geriatric nurse practitioner (NP). The Commission has sought to assess the appropriateness of making more use of NPs in long-term care facilities. At present there are only 33 Nurse Practitioners with geriatric specializations in California who have graduated from approved training programs. These new programs, which provide an intensive year of post-R.N. schooling and internship, presently exist at U.C. San Francisco, U.C. Los Angeles, and C.S.U. Long Beach. These institutions are participants in a NP project sponsored by the W.K. Kellogg Foundation and coordinated by the Mountain States Health Corporation of Boise, Idaho. There will be 35 additional graduates of these programs in 1984. There are, however, a larger number of "family" or "adult" NPs in the State in addition to the new geriatric NPs.

There are a number of functions a NP can perform in a long-term care facility:

TYPICAL GERIATRIC NURSE PRACTITIONER FUNCTIONS INCLUDE:

Admitting Physicals
Annual Physicals
Assessing, Monitoring and Managing common acute and chronic health problems of the aged (90 percent of those in nursing homes)
Staff physicals and health management
Geriatric in-service education and consultation

Family/patient counseling
Aide certification
Infection control management
Quality Assurance
Patient Care Planning
Patient Oriented Medical Record management
Pre-admission assessments
Discharge planning
Post-discharge follow-up and home health services
Patient teaching
Psychosocial/functional assessment and goal articulation
Health Screening

EXPANSION OF SERVICES POSSIBLE WITH A GERIATRIC NP:

Home Health Agency
Rehabilitation
Day Care
Community teaching, counseling and health screening
Outreach
Out-patient clinic
Contracting NP services with other agencies, facilities or physicians
Hospice Care
Family support groups
Employee Child Care
Health Screening for family members[15]

This listing is too long, especially in regard to those functions considered for "expansion of services possible with a geriatric NP." The NP's function should be to extend the nursing and medical services available in a nursing home. There is some evidence from other (less-populated) states now utilizing NPs in nursing homes (Idaho, Oregon) that they do provide cost-effective services. Geriatric NPs add a highly-trained provider presence now absent in most facilities. In a Background Paper entitled "The Costs and Effectiveness of Nurse Practitioners," the Office of Technology Assessment of the U.S. Congress notes:

> Even if one allows for supervision [by physicians] costs, NPs can provide selected services at less cost than physicians...
>
> While experience has shown that NPs and other physician extenders can lower average expenses per patient visit by as

> much as one-third, the manner in which the physician or institution uses them and the way in which time freed through task delegation is used will determine whether the potential savings is realized. If NPs are used to provide services complementary to those of the physician rather than services substituting for the physician's, the potential reduction in average per-visit expenses may be diminished or lost. In such cases, however, the complementary services often imply quality enhancement, a different (and implicitly better) visit for the same cost.[16]

We can assume that regardless of the role chosen, either "complementing" or "substituting" services, NPs would be a worthwhile addition to nursing homes in California.

4. Nurse practitioners: needed professionals caught in a "turf" battle.

At present, the California Medical Association and the physician's association for those who have contractual arrangements with long-term care facilities, the California Medical Directors Association, oppose NPs unless they are fully responsible to and in the direct employ of physicians. On the other hand, the California Nurses Association, seeking increased professional recognition, wants "independent provider" status for geriatric NPs for the purpose of billing third party payors, mostly Medi-Cal. Finally, the proprietary nursing home industry is now sponsoring a bill, being carried by Senator Maddy as A.B. 1233, amended in April 1983, which would "specify that nurse practitioners are permitted to bill independently." Here we see that the major question concerning the NP role is whether fiscal control is to lie with physicians or with NPs themselves. These "turf" issues predominate virtually all considerations of the NP issue. While the California Association of Medical Directors may argue that "quality care," not the (fiscal) control of who provides it, is at stake, this does not appear to be the case.

It is more accurate to say that the issue is the types of care undertaken by these new providers and how they are to be paid. Nobody questions the need for adequate medical supervision of geriatric NPs by physicians.

Recommendations

1. Encourage the use of geriatric NPs in nursing homes

The utilization of geriatric NPs, or, more generally, all nurse practitioners who have training and interest in working with adults and the elderly should be encouraged. Facilities with less than 50 beds should have a half-time NP, those with 50-99 beds a full-time NP. Larger facilities should have proportional numbers.

2. Nurse practitioners should be employed in nursing homes

Nurse practitioners need not be in the direct employ of either nursing homes or physicians. Given the low number of geriatric NPs presently available, an early effort to evaluate their cost-effectiveness (e.g., for decreased hospitalizations, ambulances, decreased use of and possibly fewer acute physician visits, etc.) should be undertaken by the State. If cost-effectiveness is shown, and measures of quality of care are developed to also show this effectiveness, then the State should consider, as Senator Inouye of Hawaii has proposed at the Federal level, requiring long-term care facilities to have NPs, preferably with geriatric training.

3. NP reimbursement rates should be a fixed percentage of physician rates

Reimbursement for NP services should be at some fixed percentage of present physician fees (other states use 80 percent). NPs who work in nursing homes must file a "scope of practice statement" with the Bureau of Registered Nurses indicating expertise in working with the long-term care population.

4. Develop incentives for facilities using geriatric NPs

A reimbursement incentive to nursing homes should be provided when they utilize NP services. Such an incentive should be determined in consultation with the Department of Health Services and must insure against possible "pass-through" abuses or difficulties.

5. Geriatric NPs must not be calculated as nursing staff

Utilization of a NP should not affect the present regulations regarding the minimum standards for nursing hours of care to be provided. The geriatric NP would not be counted in present "nursing hours per patient day" figures, but would be a separate category. Staffing should not be decreased because a NP is present in a long-term care facility. (See the next section of this Chapter regarding calculations of "nursing hours.")

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

Background

Section 2176.5 of the Health and Safety Code states that, for the purposes of long-term care facilities "nursing hours" means:

> . . . the number of hours of work performed per patient day by aides, nursing assistants, or orderlies plus two times the number of hours worked per patient day by registered nurses and licensed vocational nurses (except directors of nursing in facilities of 60 or larger capacity) and, in the distinct part of facilities and freestanding facilities providing care for the developmentally disabled or mentally disordered licensed psychiatric technicians who perform direct nursing services for patients in skilled nursing and intermediate care facilities, except when the skilled nursing and intermediate care facility is licensed as a part of a state hospital.

Title 22 of the California Administrative Code, Section 72329 (f), states that the number of such "nursing hours" shall be 2.8 per patient day. The law permits doubling the hours for Registered Nurses and Licensed Vocational Nurses in nursing homes. The "pure" or actual number of "nursing hours" that the State has adjudged to be the minimum for long-term care facilities is 2.37 hours per patient day, which is what 2.8 becomes when the "doubling" factor is removed.

LCD presently has regulations [Title 22, Sections 72329(a) and 72501(g)] whereby it can order a facility to increase its staffing patterns. These regulations are used and allow the Division not to be too tightly tied to the 2.8 nursing hours per resident day standard. This regulation can be used as a powerful tool to increase staffing in a facility when it appears that resident care is suffering, regardless of what the staffing pattern may be on paper.

Findings

1. Present standards for nursing hours are unsatisfactory.

Testimony given before the Commission, often by family members, repeatedly related experiences involving very limited staff in many nursing homes in the State. This testimony, and subsequent discussions by the Advisory Committee for this report revealed that noone is really satisfied with the current 2.8 standard.

As can be seen from Table VII-2, under the heading of "Nursing Hours/patient day," the reported median number of nursing hours per patient day for all ownership types of long-term care facilities is above the 2.8 required. The Statewide median for all facilities is 3.17 hours. Let us examine the nursing ratio figures in greater detail.

TABLE VII-3

LONG-TERM CARE EFFECTIVENESS STANDARDS

Variable: Nursing Hours per Patient Day
Fiscal Year 1979-1980

Ownership Type	Mean	Median	Standard Deviation	Lowest Value	Highest Value
For Profit/Chain	3.16	3.11	.53	1.39	6.25
For Profit/Non Chain	3.18	3.14	.65	1.22	9.22
Church	3.97	3.89	1.04	1.03	7.87
Other Non Profit	4.22	3.71	1.70	1.93	10.43
Government	3.12	3.47	.91	1.47	3.85
Statewide	3.30	3.17	.83	1.03	10.43

Source: California Health Facilities Commission. Data to Little Hoover Commission in April 1983.

Based upon the more detailed data in Table VII-3 we can now more clearly see that the perception of inadequate staffing often is correct. The median for all facilities Statewide is 3.17 hours. The median figure tells us that half the facilities in the State are above 3.17 and half are below. Just how far above and below the median 3.17 hours is also shown in Table VII-3:

- The median range is from a low of 3.11 in proprietary chains to a high of 3.89 in non-profit church-related facilities.
- The range from highest value to lowest value of all facilities across the State varies immensely: from a non-profit facility which reported 10.43 nursing hours, to a non-profit church facility that reported 1.03 nursing hours.
- All ownership categories had facilities in which the "lowest value" is well below the required 2.8. The range is from 1.03 to 1.93.
- There are a number of facilities, particularly those one standard deviation or more below the mean, which fall below the required 2.8 hours.

2. Changing the nursing hours standard has major consequences.

If nothing else were changed, just changing the 2.8 average has large consequences for providers and the State. If Medi-Cal were to reimburse the cost of increasing the nursing hours standard from 2.8 to only 2.9 hours per patient day (which would add 6 minutes to the existing 2.8 hours, an increase of only 3.57 percent), the cost increase to Medi-Cal would be in excess of $12 million per year.[17]

Also, if nothing else were changed, just changing the 2.8 to 2.9 and having the increased costs of so doing taken from facility profits,

would also have substantial consequences. Median net pre-tax income per patient day, in FY 1979-1980, was $1.16. If we subtract the costs of the additional 0.10 hours of resident care from that net pre-tax income, then we subtract $.459 (.10 times $4.59) from $1.16. This results in a 39.6 percent reduction in net pre-tax income per patient day in FY 1979-1980.

In addition to this quantitative data, it is important to note that the nursing hour average is only a bare minimum standard. Since a large number of facilities--and thus thousands of individual residents within those facilities--do not even receive that minimum 2.8 hours, there is reason for the dismay and anger that many feel in regard to the nursing hours per patient day average. In addition, the standard is an input measure and, as such, says little about outcomes, specifically the individual needs of residents. It is, at best, a very crude measure of staff presence. It does not indicate resident needs or status.

Recommendations

1. The present 2.8 standard must remain until improved

The 2.8 standard should not be eliminated until and unless a more accurate and stringent standard can be developed. The 2.8 standard is not very useful, certainly not informative, and perhaps harmfully low. Nonetheless it should not be abandoned until something better can be found.

The present regulation [72501(g)] which allows LCD to order increased staffing should, in no event, be modified or changed. It

represents a powerful tool for quickly getting increased staffing when it is clear that patient care is suffering. The regulations which allow for ordering increased staffing will still be needed as an enforcement tool.

2. An improved standard must include resident acuity measures

The average, to be truly useful and meaningful, needs to be combined with, or replaced by, an acceptable resident acuity index, or with some other resident-centered predictive tool (cf. Kane's "Prognostic Adjustment Factor" mentioned in Section A of this Chapter).

3. LCD should immediately inspect all facilities below standard

LCD should immediately inspect any facility which is below the 2.8 standard. Given the wide variation in staffing patterns, median data is almost meaningless. As Table VII-3 shows, the more important figures, both from an enforcement perspective and for State policy planning, are those revealing dangerous variation below the mean and the median. Methods need to be devised to have staffing data as part of an on-line system with minimum lag time and regular updates. Most life-threatening occurrences that take place in nursing homes are directly related to resident care and, in turn, to the presence or absence of staff in a facility.

4. Change the formula for calculating nursing hours

To improve public as well as State knowledge about the actual numbers of nurses in long-term care, the following changes should be made in the calculation of nursing hours per resident day:

- The doubling factor should be removed. The public should know that the 2.8 figure is inflated and that the "true" figure is 2.37 after removing the doubling of hours allowed for R.N. and L.V.N. personnel.
- When this figure is used for analysis and public discussion, it should be broken down into the actual percentages of "nursing" staff by training area. The public should know that more than 70 percent of the long-term care "nursing hours" making up the 2.8 (or 2.37) figure are nurse assistants, not licensed or registered nurses.
- No matter what action is taken with the 2.8 (or 2.37) average, it should <u>not</u> relate to the use of geriatric Nurse Practitioners in nursing homes. Just as (in facilities with 60 beds or more) directors of nursing cannot be counted in the "nursing" standard, neither should NPs. Neither the NPs, as the intermediate clinical providers, nor the director of nurses, as nursing administrator, should be counted as providers of direct nursing care.

CHAPTER VIII

MATTERS WHICH NEED FURTHER INVESTIGATION

Background

The Commission heard testimony on a wide number of issues relating to long-term care in the State. This report emphasizes those issues which seemed of paramount importance for policy, for the public, and for nursing home residents. The issues in this Chapter represent other concerns which were presented to the Commission with the belief that a circumstance or policy should be changed, but which require significantly more research before detailed Findings and Recommendations can be made.

Issues for Investigation

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

We have strongly emphasized in an earlier chapter the area of enforcement and the roles of the nursing home industry, LCD, and the State Department of Justice in enforcement activities. Enforcement requires legal consultation and services, both for long-term care providers and for the State. The question was raised at the Commission's Public Hearing whether facilities' cost of legal services should be

considered a "normal part of doing business" and, as such, should it continue to be reimbursed by Medi-Cal.

At present, the State does not know how much money those legal fees reimbursed to nursing homes by Medi-Cal amount to. Such fees are not "line-itemed" on the Medi-Cal Cost Reports submitted to the Department of Health Services nor included in any of the data gathered by the California Health Facilities Commission. Where, then, might one get the data to find out if this is a problem at all?

At the present time, the only source of such information is the long-term care facilities, their owners and operators. Unfortunately, the California Association of Health Facilities (CAHF), the trade association representing proprietary facilities, was not willing to ask its members to supply our Commission with this information. CAHF believed its members would be unable or unwilling to supply it. When asked whether the industry felt that the legal fees issue was a problem, we were assured by CAHF counsel that "only a very small amount of the total Medi-Cal reimbursement to the average facility goes for legal fees. It is just not a problem of any magnitude." When asked if this statement could be supported with some sample data from individual facilities the Commission was politely turned down.

Given the increasing corporate concentration of power and influence in proprietary nursing homes in California, the question of reimbursement for legal fees from State monies becomes a potentially significant one. Many of the larger corporate chains of facilities come equipped, like any large business concern, with their own legal departments. It is the task of such legal departments, among other things, to make certain that legal requirements in the areas of licensing and

certification of the facility are met. It is also a responsibility of these legal departments--and of any lawyer in the employ of a long-term care facility or chain, or of the trade association (CAHF)--to advise and litigate, where necessary, in their client's behalf. Every LCD office in the State knows of cases in which a "bad" facility has used multiple legal strategies. Such strategies are legally proper, but they can be costly in terms of enforcement delays, appropriate action taken for residents, and State funds.

Given the present unwillingness of the proprietary industry to supply legal fee cost information about its member facilities, they should be required to provide it. LCD, with the aid of the Medi-Cal Audits Branch, should conduct a one-time statistically valid sampling of long-term care facilities Statewide to ascertain the overall amount and average amount of legal fees which affect the Medi-Cal reimbursement rate, and analyze that data. If the results indicate that legal fees do represent a significant Medi-Cal expenditure, then the subject should be further investigated and policy options should be developed. If the results of the sample study show such fees are not a significant Medi-Cal expenditure, then the matter should <u>not</u> be dropped, but should be the subject of another valid sample taken between twelve and eighteen months later.

Information on all legal costs, sub-divided into several categories, should be a new line-item added to the Medi-Cal Cost Reports. It should also be added to the long-term care data base of the California Health Facilities Commission.

The fiscal and corporate nature of long-term care in the State is changing so rapidly that we recommend this information be gathered and

analyzed at regular intervals to see when, or if, it becomes a significant issue requiring changes in policy.

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

Representatives of several consumer groups testified to the Commission that LCD employees ("the regulators") go to work, after leaving the Division, for the nursing home industry ("the regulated"). If this is true, it would certainly pose potential for conflicts of interest, and may thus need to be addressed with legislative or regulatory changes.

LCD provided the Commission with information on all professional employees who had left the Division between January 1979 and April 1983. During that time 49 employees left; 22 of the 49 stated that they were going to go work in "private industry." LCD did not know, however, how many of its 22 former employees went to work for the nursing home industry. It is known that several of these 22 persons are now long-term care employees, including a former director of a LCD district office.

What we know at the present time--and it is not nearly enough--is that fully 44.8 percent of these former employees stated they were going to work for "private industry." Which "private industry" seems an important question. We do not know if allegations of a "revolving door" are accurate. Nor do we know what the effects of this particular phenomenon might be. The present data are totally inadequate.

Consequently, LCD should change its employee exit procedures immediately. Employment data should also be gathered retroactively for

at least those 49 people who have left since 1979. This should be done so that both the public and the State can know with accuracy how many (or how few) of its former employees go to work for the industry that they had formerly regulated.

It is fairly easy to understand why LCD employees might seek employment in the nursing home industry. It is, after all, within their professional field. It is also a place with greater promotion and salary opportunities than those generally available in State (LCD) service.

The Commission suggests that, while the argument that former LCD employees working in the long-term care industry may improve the quality of care is plausible, it is nonetheless unverified. The issue is an important and sensitive one with potential risks for effective care and regulation. For example:

- LCD is a relatively small professional "family." It is likely that a former LCD employee, now in the industry, would know or know of, present LCD employees charged with conducting enforcement and inspection activities. This familiarity could (though it need not) result in considerations of "professional courtesy" and a more "understanding" attitude on behalf of a LCD inspector toward former colleagues.

- Conflict-of-interest possibilities arise. This could happen if a former employee used his or her knowledge of the technicalities of the enforcement process to circumvent that process. There might be circumstances where the temptation to do this would be real and great. For instance, it could happen in those nursing homes where the administrator is more likely to be promoted if the facility has no citations. Such incentive programs are now operating in a number of proprietary chains.

There is a need for a thorough investigation of this issue. If the findings of such a study confirm the potential for conflict of interest, one possible way to reduce the risks to long-term care consumers would be to establish a waiting period between jobs during which time a LCD professional staff member would be prohibited from taking a job with any long-term care facility or corporation providing long-term care services in the State. This would be a precautionary measure to protect the interests of the State and of the nursing home resident in a complex and fragile situation. We would recommend a measure such as this only if it can be demonstrated that quality long-term care is threatened by the presence of former LCD employees in industry positions.

C. Can Incentives Be Developed For Providing Good Care?

Throughout the meetings of the Advisory Committee, representatives of the nursing home industry asked that consideration be given to providing incentives for good care. This is an extraordinarily complex issue, though, in our view, one that deserves active study and positive action. On the basis of the data currently available, the Commission has identified four feasible incentive alternatives.

First, the Commission believes that reimbursement incentives should not take the form of direct reimbursement increases for good care, but rather that such incentives should be provided in indirect ways. These incentives may result in less regulation for a good facility, and therefore, indirectly, fewer regulation-related costs to the facility.

Second, there are incentives in the modified inspection procedures recommended in Chapter IV, Sections A and B, which call for briefer inspections, and possibly also fewer inspection "segments," for better facilities. Certainly a major incentive for a good nursing home to "remain good," according to LCD's established criteria, would be the knowledge that its inspections will not be as time-consuming and labor-intensive as those of facilities where there are complaints or problems outstanding, or where screening procedures uncover areas that require full inspection in order to ensure provision of proper care.

Third, there are incentives in a nursing home rating system. At the present time, Los Angeles County has the only information system in the State worthy of the name. That system includes a binary rating system for the information-seeker which rates a facility in either "refer" or "do not refer" categories. Chapter VI recommended a Statewide Consumer Information Service (CIS) based on the Los Angeles County model, but with an expanded method for ranking and rating nursing homes.

The question is, would having and keeping a high rating serve as an incentive for a facility? This has been demonstrated to be the case with other "rated" institutions. While such rating systems would <u>always</u> be open to accusations of unfair bias or calculation, nonetheless it is our belief that an equitable and accurate system can be devised. One incentive for good care would be to have a facility classified in the top category for all the public to know.

If it is the case that some "bad apples" have for too long "spoiled the [long-term care] barrel," then a rating system would both improve system-wide accountability and provide rewards in the form of high

ratings to superior facilities. The creation of a rating system would allow for comparisons to be made so that highly-ranked facilities would have many potential customers.

An independent Advisory Committee should be created, under the joint sponsorship of the Department of Consumer Affairs and the Office of the Director of the Department of Health Services, to conduct a careful examination of long-term care rating systems in other states. The study should include what federal level research has been done in this area. The Committee's goal would be the design and implementation of an effective incentive-rating system as an integral part of the State-wide Consumer Information Service.

The difficulties of undertaking this task are formidable; the results will more than justify the effort. Given the nursing home industry's dismay with the Los Angeles County system, there may well be resistance to such efforts. The Commission does not believe that the "alternative" to the Los Angeles system is no system at all.

Fourth, positive publicity can function as an incentive and should be encouraged for good facilities. Particularly innovative types of care or particularly dedicated employees--both are noteworthy and merit as much public exposure as possible. While the State's role in issuing such publicity should be limited (see Chapter V, Section C), nonetheless both the State and consumer groups should actively support and cooperate in efforts to develop publicity for noteworthy facilities, activities, or staff.

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

Testimony before the Commission suggested that long-term care providers and the residents who are under their care do not always speak the same language. Communication is often difficult enough in a nursing home, especially with frail, hard-of-hearing, or disoriented residents. If that "communication" cannot take place in the native language of the resident, that resident's feelings of isolation will be compounded many times over, and other consequences could range from an occasional misunderstanding to a tragedy.

Instances were reported in which communication failed because a resident could not speak or understand English well. LCD regulations [Title 22, Section 72501(f)] require that either an interpreter or other means be provided so that such a resident can understand and be understood. LCD administrative staff believe this problem occurs rarely. When it does occur, it may be in sectarian facilities where residents may be immigrants to the United States who were never able to learn English. It is extremely important that when this situation occurs, existing regulations are followed.

More commonly, the resident's native language is English. But testimony suggested that many care providers do not speak or understand English well. Given the low status and low wages that attend many of the jobs in long-term care, it should not be surprising that many of the jobs are filled by persons whose education has not included study of English as a second language.

The Commission has not been able to establish how many long-term care residents or employees--often Nurse Assistants and staff in areas such as laundry, dietary, and custodial services--do not speak or understand English well. It is significant that the California Association of Health Facilities has provided a training manual for Nurse Assistants in Spanish as well as English. Given the large numbers of Spanish-speaking persons in the State, and especially in Los Angeles, Orange, and San Diego Counties (where fully 43.7 percent of all nursing homes in the State are located), we assume this is an issue of importance.

As with most of the other issues addressed in this Chapter, at the present time we do not know the scope of this problem. We do not know how many nursing home employees do not speak or understand English well, nor do we know in what ways this factor, combined with others such as wages and working conditions, might contribute to or result in the high turn-over rates and relatively small number of employees who remain with a facility for more than twelve months. Tables VIII-1 and VIII-2 show that the percentage of nursing home employees with more than one year of employment at a signle facility is less than 50 percent Statewide and that the employee turn-over rate is a staggering and inappropriate 128 percent Statewide. The data in these tables raise a number of serious questions which need further investigation and study. Among these questions are:

- What is the relationship of both turn-over rate and length of employment to wage rates? Who leaves, who stays? Why are there such huge variations in turn-over rate (from 0 percent to 1,243 percent)?

- Why is it that the long-term care facilities with the least number of long-term employees and the highest turnover rates are proprietary (for-profit) chain facilities? Is there something that takes place in these facilities, such as either wage, benefit, or worker organization practices, that can explain these figures?

- There are only six "government" facilities in the State. They are quite large and are, of course, non-profit. Why is it that their employee turn-over rate is more than four times lower than the State-wide median and more than five times lower than the proprietary chains? Does this mean the government facilities keep employees regardless of their competence? Does it mean that they provide better salary and working conditions? These same questions need to be asked (although the ranges are not quite as large) about the differences between profit and non-profit facilities in regard to their respective turn-over rates.

- What is the relationship between all three items listed above and the primary language spoken and understood by the nursing home employee? Are non-English speakers more likely to leave long-term care employment or certain types of facilities? What was their position and wage rate? Why did they leave?

Table VIII-1

LONG-TERM CARE EFFECTIVENESS STANDARDS

Fiscal Year 1979-1980
Variable: Percent With 12+ Months Service

Ownership Type	Mean	Median	Standard Deviation	Lowest Value	Highest Value
For Profit/Chain	44.49	44.0	22.64	0	348.53
For Profit/Non Chain	48.22	48.0	16.73	0	96.77
Church	55.98	57.75	15.23	20.31	84.85
Other Non Profit	52.47	55.18	18.32	0	93.33
Government	63.30	65.69	10.78	50.0	75.59
Statewide	47.20	46.86	20.21	0	348.53

Table VIII-2

LONG-TERM CARE EFFECTIVENESS STANDARDS

Fiscal Year 1979-1980
Variable: Employee Turnover, Percents

Ownership Type	Mean	Median	Standard Deviation	Lowest Value	Highest Value
For Profit/Chain	151.49	144.55	88.23	1.64	1243.59
For Profit/Non Chain	131.36	120.83	74.00	0	461.91
Church	98.40	91.11	61.73	7.14	295.65
Other Non Profit	96.00	82.37	60.91	3.23	353.79
Government	54.95	27.74	74.93	17.46	154.29
Statewide	136.27	128.31	82.07	0	1243.59

Source: California Health Facilities Commission,
Data provided to Little Hoover Commission, April 1983.

The Commission recommends that further data be gathered and analyzed to specifically answer (at least) the four sets of questions posed above. Assuming that there are sizeable numbers of nursing home employees who do not speak or understand English well, we would suggest the following:

- A Task Force should be convened by the Department of Health Services, in cooperation with the State Department of Education, to examine ways in which nursing home employees can begin receiving credit for adult education classes in English-as-a-second-language. Such classes should be convened, whenever possible, within the facilities themselves and be taught in the hour just before or after a shift has ended. Classes should be free; costs should be borne by the State or school districts.

- Efforts to publish materials in languages other than English, e.g., the Nurse Assistant training materials in Spanish, should be expanded. The nursing home industry should be an active member of this Task Force, and the experience other organizations have had in this area should be carefully evaluated in planning efforts.

- Coordination with other service industries that experience the same problem should be explored. Such groups should include, but not be limited to, acute hospital employees. The California Hospital Association should be a partner in the efforts of the Task Force and the programs that result.

- Smaller facilities, especially those geographically close to each other, should consider joint efforts in this language education effort. While paid employee released time is not recommended here, we feel every consideration should be given to employees who engage in these

voluntary classes and programs designed to improve their understanding and speaking in English.

- Either statutory or regulatory amendments should be put in place to require that all long-term care employees be at least minimally proficient in speaking and understanding English. This suggestion would be in effect with all new employees once the regulation is implemented. For current employees the above suggestions apply.

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

In 1983 a Hillhaven nursing home closed in Marin County so that the corporation could convert the facility from a nursing home to a facility for the treatment of drug and substance abuse. The closure was accomplished quite quickly and was within the letter of existing law and regulations. However, the Commission heard testimony from a number of citizens expressing concern about this closure and the manner in which the conversion was undertaken.

More administrative oversight may be necessary when a long-term care facility seeks to change services and/or clientele. The question that is important here is: "What are the consequences for both long-term care residents and long-term care planning and policy, when a facility proposes to leave the nursing home business in order to engage in some other health-related business activity?" Possible consequences are:

- The for-profit corporation in Marin acted solely in its own interest with little or no resident or community consultation or

participation. The not unexpected result was a feeling of anger, frustration, and abandonment among concerned citizens, residents, and families.

- The State, through LCD, was ham-strung. The change in service was apparently not a violation of existing regulations. LCD found itself in a position that was reactive. They had to offer explanations after the fact.

- The belief that health-related corporations can make such changes without the advice and/or consent of either the local community or the State grew.

The consequences of such actions, both for the health planning and policy process, and for the long-term care industry, are potentially great. We suggest, therefore, that LCD convene a Working Group to assess how this particular case, and any others similar to it, took place and what regulations or new legislation might be needed to slow or prevent such actions in the future. It may well be appropriate in some cases that changes of service focus be considered. However, procedures for protecting residents and casting more light on such undertakings must be evolved. To <u>not</u> do this would be to increase the frustration precipitated by the Marin closure. The LCD Working Group should consult with corporate health and long-term care facility administrators, but should not in any way be bound by such consultation.

The goal of this Working Group would be to design a fair process, with adequate advance public notice, for proposed conversion and/or closures. The intent of this process would not be to stop, delay, or defeat such actions, but to make certain that they are carefully

examined and debated by all concerned parties (particularly the residents and their families).

If a proposed change by a facility does not require a Certificate of Need review then, given the impact on the "health environment," on the nursing home residents, and on the residents of the community, we would propose that a "Health Impact Statement" be submitted by the facility 90 days prior to a proposed change. This Health Impact Statement should be assessed by the local health planning body as well as by State health planning office. Such an assessment should be accompanied by documentation concerning the proposed change from the viewpoint of the Department of Health Services and the appropriate LCD office.

END NOTES

CHAPTER I

1. Jeanie Schmit Kayser-Jones, Old, Alone, and Neglected: Berkeley, University of California Press, 1981.

2. California Health Facilities Commission, Aggregate Long-Term Care Facility Data for California, Report II-82-13, December,1982, p. 5.

CHAPTER II

1. Philip G. Weiler, "Evaluation of Alternatives In Long-Term Care," American Journal of Public Health, June, 1983, page 639.

2. LCD, Licensing Procedure Manual, Section 00.1, page 3.

3. There were no nursing home residents on the Commission's Advisory Committee.

CHAPTER III

1. Auditor General of California, The Department of Health Services Can Improve the Enforcement of Health Care Standards in Long-Term Care Facilities, Report P-202, August 1982, p. 35.

2. Ibid., pp. 49-57.

3. Ibid., pp. 48-50.

CHAPTER IV

1. U.S. General Accounting Office, Preliminary Findings on Patient Characteristics and State Medicaid Expenditures for Nursing Home Care, Report GAO/IPE-82-4, July 15, 1982. More findings are due mid-1983.

2. Letter to Congressman Pepper and Senator Heinz, December 1982, from Harold Gordon, Maryland's licensing chief, describing information given by Margaret Van Amringe of the federal Health Care Financing Administration (HCFA), at a meeting of the Association of Health Facility Licensure and Certification Directors in Nashville, October 1982. HCFA now says the report is unavailable and the findings were preliminary.

3. Federal figures are from the HCFA Regional Office computer, by telephone June 16, 1983. Earlier figures are not readily accessible. Comparison figures between federal and state inspections

were not provided, but see infra note 20 and Section B, Finding 3, on subjects where federal inspectors found deficiencies that state inspectors had not found. State citation figures are in Appendix V-A.

4. Commission on California State Government Organization and Economy, The Licensing and Certification of Nursing Homes, Public Hearing October 27, 1982, e.g., p. 62.

5. Assembly Committee on Aging, Care of the Elderly in Nursing Facilities, Hearing Transcript, October 9, 1981, e.g., pp. 79-81, 97-98, 135.

6. Commission on California State Government Organization and Economy, Supplemental Report: Licensing and Certification Activities of the State Department of Health, March 1977, pp. 1-2.

7. Health and Safety Code Sec. 1421.

8. Health and Safety Code Sec. 1422.

9. E.g., Commission Hearing, supra note 4, pp. 50 & 62, and letters in Commission files; Assembly Committee Hearing, supra note 5, p. 101.

10. Health and Safety Code Sec. 1422.

11. Memo from Director, Health Standards and Quality Bureau, HCFA, to HCFA Regional Administrators, Dec. 29, 1981. Transmittal letter from HCFA to National Senior Citizens Law Center, January 18, 1983. For more information on the federal plan, see 17 Clearinghouse Review 103-105 (June 1983).

12. U.S. Senate Special Committee on Aging, Nursing Home Survey and Certification: Assuring Quality Care, Hearing, 97th Cong. 2d Sess. (July 15, 1982) p. 223 (testimony by Maryland's licensing chief).

13. Reagan Administration's "Justification of Appropriation Estimates for Committee on Appropriations, Fiscal Year 1984," p. 100.

14. Health Care Financing Administration, "CASES:" California Abbreviated Survey Evaluation System. A Report on the Results of a 12 Month Evaluation [October 1981 to October 1982] of California's Abbreviated Survey Process for Skilled Nursing Facilities, U.S. Department of Health and Human Services, HCFA, Region IX, January 1983, pp. 8 and 11.

15. Health and Safety Code Secs 1265, 1267.5; Title 22 Administrative Code Sec. 72211.

16. Senate Committee Hearing, supra note 12, pp. 23, 41, 244-5.

17. HCFA Report, supra note 14, p. 5.

18. Commission Hearing, supra note 4, pp. 14, 21, 28, 44, 71. Report in Commission files from Assemblyman Felando; example in Assembly Committee on Aging, Care of the Elderly in Nursing Facilities, Addendum to Hearing Transcript, October 9, 1981, p. 117.

19. L. Kitamura and C. Barton, Critique of the Inspection/Citation Process of California Skilled and Intermediate Care Facilities: Impact on Quality of Care. (Case-in-point: Analysis of San Diego County Skilled and Intermediate Care Facilities Violation and Citation Records [1977-1980]), San Diego State University, December 1981, pp. 62-120.

20. Re-inspections done by federal teams for monitoring purposes found that the main areas where state teams failed to identify as many deficiencies as federal teams had to do with nursing services (care plans, rehabilitative care, 24-hour services) and medical records (content and protection of information). But little can be generalized from such statistics alone. HCFA Region IX, State Survey Evaluation System (SSES) FY '82 California, Attachment II.

21. Commission on California State Government Organization and Economy, A Study of the Administration of State Health Programs, January 1976, pp. 278-9.

22. HCFA Report, supra note 14, p. 2.

23. Ibid., pp. 6-11.

24. Health Care quality in Iowa Nursing Homes: Results from the Outcome-Oriented Survey, 1980-1981, Iowa State Department of Health, 1981. Statements by Iowa Licensing & Certification Director at conference of National Citizens Coalition for Nursing Home Reform, Washington, D.C., May 1983.

25. Wisconsin's Nursing Home Quality Assurance Project: Executive Summary 1978-82, Wisconsin Department of Health and Social Services, 1982. Other Wisconsin and Iowa information from reports given at conference, supra note 24.

26. H. Gordon, "Maryland Appraisal of Patient Programs," American Health Care Association Journal, September 1982, p. 51.

27. Iowa report, supra note 24, pp. 28-31.

28. Health and Safety Code Secs. 1599-1599.4; Title 22 Administrative Code Sec. 72527.

29. Adapted from Florida Stats. Ann. 400.23(3)(c).

30. American Bar Association, Commission on Legal Problems of the Elderly, Model Recommendations: Intermediate Sanctions for Enforcement of Quality of Care in Nursing Homes, July 1981, p. 8.

31. Health and Safety Code Secs. 1419 and 1420.

32. Assembly Committee on Aging, Nursing Home Care, Hearing Transcript, July 27, 1981, p. 130.

33. M. Griffin, An Analysis of Ownership Patterns and Facility Size Influences on Health and Safety Citations for Alameda County Skilled Nursing Facilities, University of California, San Francisco, printed in Assembly Committee Hearing, supra note 5, p. A-88.

    Office of the Auditor General, Long-Term Care for the Aged, Care vs. Regulations, Part II, Department of Health, Report 275.2, October 1977, p. 46.

    Author of San Diego Study, supra note 19, before Assembly Committee on Aging, supra note 32, pp. 82-83.

    LCD chart in Appendix IV-B.

34. Auditor General of California, The Department of Health Services Can Improve the Enforcement of Health Care Standards in Long-Term Care Facilities, Report P-202, August 1982, p. 15.

35. AB 2997, Chapter 1457 (1982); Welfare & Institutions Code Sec. 9721.

36. Auditor General, supra note 34, p. 16.

37. Ibid. p. 10.

38. E.g., Commission Hearing, supra note 4, pp. 14 & 25, 31 & 33, 44, 67, 89; Assembly Committee Hearing, supra note 32, p. A-67-70.

39. One letter speaks of "thick files of correspondence" which "brought no action;" another describes falls, broken bones, linen shortages, etc., and says, "Many times we submitted complaints to licensing. Evaluators were sent from time to time but absolutely nothing changed." The Assembly Committee heard similar stories, e.g., supra note 32, p. 8, and supra note 5, pp. 58-62 and 159-164. The state ombudsman told us that "we often have to badger LCD to receive written (or even oral) follow-up reports on matters that we have referred to LCD." Commission Hearing, supra note 4, p. 14. On meaningless forms, see Chapter VI, Section B, Finding 5.

40. Commission Hearing, supra note 4, p. 13.

41. Such a form letter was proposed in Los Angeles City Attorney, Recommendations for New Legislation and Regulations Relating to Skilled Nursing Facilities, Community Care Facilities, Physicians and Other Health Care Professionals, 1976, pp. 23 and 24, 77 and 78.

42. Commission Hearing, supra note 4, pp. 69-70.

43. Adapted from Illinois Stat. 111-1/2, 4153-702(g).

44. Adapted from Illinois Stat. 111-1/2, 4153-702(a).

45. Health and Safety Code Secs. 1424 and 1427.

46. Health and Safety Code Sec. 1423.

47. Information derived from figures in LCD chart, Appendix V-A.

48. Auditor General, supra note 34, pp. 30-33.

49. Health and Safety Code Sec. 1426.

50. Title 22 Administrative Code Secs. 72703 (class A) and 72705 (class B).

51. San Diego study, supra note 19, as printed in Assembly Committee Hearing, supra note 32, p. A-97w.

52. Health and Safety Code Secs. 1423, 1424(b) and 1428(d); Title 22 Administrative Code Secs. 72709 and 72711.

53. Commission Hearing, supra note 4, p. 30, and supplementary testimony on file.

54. Assembly Committee Hearing, supra note 5, pp. A-30 and A-64.

55. Auditor General, supra note 34, p. 31.

56. Health and Safety Code Sec. 1423(c).

57. Health and Safety Code Sec. 1423(b).

58. Auditor General, supra note 34, pp. 31-32.

59. Ibid. pp. A-1-3.

60. For text, see discussion earlier in Finding 2, on distinguishing A and B violations.

61. San Diego study, supra note 19, as printed in Assembly Committee Hearing, supra note 32, pp. A-97y and z; Alameda County study (Griffin), supra note 33, p. A-88.

62. Statement by Iowa licensing director, 1983 conference, supra note 24.

63. Health and Safety Code Sec. 1426.

64. In Missouri, for example, statute provides for a task force to allocate each regulation into a category depending on how serious

its violation would be. The ABA Commission model, supra note 30, p. 8, does the same but makes clear that some standards could be assigned multiple classifications.

CHAPTER V

1. Health and Safety Code Sec. 1424. See Finding 6.

2. Health and Safety Code Sec. 1425. See Finding 7.

3. Health and Safety Code Sec. 1428(e). See Finding 2.

4. Health and Safety Code Sec. 1424(b). See Finding 2.

5. Health and Safety Code Sec. 1428(b).

6. Data from California Health Facilities Commission.

7. Statements made at Advisory Committee meetings. See also Commission on California State Government Organization and Economy, The Licensing and Certification of Nursing Homes, Public Hearing, October 27, 1982, p. 72; Assembly Committee on Aging, Nursing Home Care, Hearing Transcript, July 27, 1981, pp. 123 and 126.

8. Commission Hearing, supra note 7, pp. 18-19, 32, 49-50, (and Commissioners' observations, e.g., pp. 3, 10, 73); Assembly Committee Hearing, supra note 7, pp. 78-9, 137-8; Assembly Committee on Aging, Care of the Elderly in Nursing Facilities, Hearing Transcript, October 9, 1981, pp. A-129-131.

9. Auditor General of California, The Department of Health Services Can Improve the Enforcement of Health Care Standards in Long-Term Care Facilities, Report P-202, August 1982, p. 60.

10. Ibid., p. ii.

11. Ibid., pp. 36-40.

12. Statutory intent from telephone conversation 6/29/83 with office of Assemblyman Agnos, sponsor of the reform legislation.

13. E.g., Commission Hearing, supra note 7, pp. 85-86.

14. E.g., Auditor General, supra note 9, p. 64; L. Kitamura and C. Barton, Critique of the Inspection/Citation Process of California Skilled and Intermediate Care Facilities: Impact on Quality of Care. (Case-in-point: Analysis of San Diego County Skilled and Intermediate Care Facilities Violation and Citation Records [1977-1980]), San Diego State University, December 1981, pp. 157-8.

15. State Department of Health, Division of Licensing and Certification, A Report to the Legislature on the Long-Term Care, Health, Safety, and Security Act of 1973, February 1977, pp. 21-22.

16. The average Consumer Price Index for 1973 was 133.1. For 1982 it was 289.1, or 217% of the 1973 figure, an increase of 117%. Base year (100) is 1967. Data from U.S. Department of Labor, Bureau of Labor Statistics.

17. E.g., Commission Hearing, supra note 7, pp. 6-8, 48; Assembly Committee Hearing, supra note 7, pp. A-17, A-87 (testimony from San Diego Report, supra note 14, see pp. 157-8); Assembly Committee Hearing supra note 8, pp. 99, A-129-131; Auditor General, supra note 9, p. 64; letter from Executive Director of Calpirg (California Public Interest Research Group) to San Diego Assemblyman Peace, 1/31/83, based on Calpirg's 2-year Nursing Home Study reported in 10 Calpirg Reports No. 7 (February 1983).

18. LCD Report to Legislature, supra note 15, pp. 21-22.

19. Explanation by Auditor General's office, Commission Hearings, supra note 7, pp. 7-8.

20. San Diego report, supra note 14, pp. 157-8.

21. Assembly Committee Hearing, supra note 8, pp. A-133-137.

22. Model statutes add "rights" and "welfare" to the definition of a B violation. American Bar Association, Commission on Legal Problems of the Elderly, Model Recommendations: Intermediate Sanctions for Enforcement of Quality of Care in Nursing Homes, July 1981, p. 8; Center for Public Representation, Model Nursing Home Enforcement Legislation, December 1980, p. 7.

23. Health and Safety Code Sec. 1430(b).

24. Assembly Committee Hearing, supra note 8, pp. A-133-137.

25. Health and Safety Code Sec. 1432.

26. LCD Report to Legislature, supra note 15, p. 26.

27. Auditor General, supra note 9, pp. 33-36, 62.

28. Health and Safety Code Secs. 1428(d) and 1424(b).

29. Title 22 Administrative Code Sec. 72711.

30. Statement by Iowa Licensing and Certification Director at conference of National Citizens Coalition for Nursing Home Reform, Washington, D.C., May 1983.

31. Health and Safety Code Sec. 1425.

32. Legislative Counsel Opinion No. 9131(2), June 3, 1977.

33. Correction plans are required by Health and Safety Code Sec. 1280, and also under federal law.

34. Auditor General, supra note 9, pp. 40-43.

35. E.g., Commission Hearing, supra note 7, p. 15.

36. Title 22 Administrative Code Sec. 72709.

37. Commission Hearing, supra note 7, p. 86, and testimony on file, p. 4.

38. See note 22 supra.

39. Health and Safety Code Sec. 1428. (This report does not cover the more extreme remedies of decertification, temporary suspension or revocation of license.)

40. See note 37 supra.

41. Assembly Committee Hearing, supra note 8, pp. 88 and A-130.

42. Assembly Committee Hearing, supra note 7, p. A-60.

43. Title 22 Administrative Code Sec. 72313(c) (nursing service-administration of medications and treatments).

44. San Diego study, supra note 14, reprinted in Assembly Committee Hearing, supra note 7, pp. A-97Z(s-t).

45. Commission Hearing, supra note 7, p. 86 and testimony on file, p. 3.

46. For text, see Chapter IV, Section D, Finding 2.

47. Commission Hearing, supra note 7, pp. 49, 51-52.

48. Commission Hearing, Change in LCD Leadership, August 8, 1977, pp. 97-105.

49. E.g., ABA Commission, supra note 22, pp. 37-39.

50. Assistant Attorney General's testimony in Commission files, pp. 4-5.

51. Health and Safety Code Secs. 1428(a) and (b).

52. Title 22 Administrative Code Sec. 72713.

53. For example, such a perception was summarized by the state ombudsman: "Based upon discussions with LCD staff and our experience, it appears that the LCD [inspectors] perceive that

they are outlawyered, outspent and outpowered politically by the nursing home industry. Thus, only the open and shut case will prevail." Commission Hearing, supra note 7, p. 14.

54. Health and Safety Code Sec. 1428(a).

55. Assembly Committee on Aging, Care of the Elderly in Nursing Facilities, Addendum to Hearing Transcript, October 9, 1981, p. 8.

56. Commission Hearing, supra note 7, p. 50. It is unclear whether this experience was during the hearing officer era, or later, or both. The basic point remains that CRC decisionmakers need specialized knowledge.

57. See Chapter V, Section A and Chapter IV, Section D.

58. Commission Hearing, supra note 7, p. 49. See also note 53 supra.

59. Health and Safety Code Sec. 1428(c).

60. Office of the Auditor General, Long-Term Care for the Aged, Care vs. Regulations, Part II, Department of Health, Report 275.2, October 1977, pp. 15-17; Auditor General, supra note 9, pp. 44-46.

61. Health and Safety Code Sec. 1428(f).

62. LCD Report to Legislature, supra note 15, p 22.

63. Health and Safety Code Sec. 1428(h).

64. CAHF Long Term Care News, June 17, 1983, p. 5-6, 8.

65. Wording based on Illinois Stat. 111-1/2, 4153-703, and Center for Public Representation Model Statute, supra note 22.

66. Commission Hearing, supra note 7, p. 9, raised by Commissioner Gersten.

67. Assembly Committee Hearing, supra note 7, p. A-120.

68. Auditor General, supra note 60, pp. 32-34 and Appendix E.

69. Ibid., pp. 11-14.

70. E.g., The Home Equity Sales Contract Act, Civil Code Secs. 1695 et seq.

71. Health and Safety Code Sec. 1431.

72. Health and Safety Code Secs. 1290 and 1291.

73. Health and Safety Code Sec. 1285.

74. Welfare and Institutions Code Sec. 14107.

75. Los Angeles City Attorney, Recommendations for New Legislation and Regulations Relating to Skilled Nursing Facilities, Community Care Facilities, Physicians and Other Health Care Professionals, 1976, pp. 18-21.

76. ABA Commission and Center for Public Representation models, supra note 22.

77. Los Angeles City Attorney, supra note 75, pp. 48-52.

78. Ibid., pp. 53-55.

79. Commission Hearing, supra note 7, pp. 49-54.

80. Health and Safety Code Secs. 1325-1335.

81. In re Heritage Hill, Arrangement No. 78-1745-1, D. Mass., 1978.

82. ABA Commission, supra note 22, p. 20.

83. Health and Safety Code Sec. 1331.

84. Health and Safety Code Sec. 1329(a)(5)(D).

85. Health and Safety Code Secs. 1434 and 1435.

86. Welfare departments apparently also receive a copy of the "2567" (the federal form summarizing deficiencies and correction plans). This would be timely enough, but the welfare department would have to make sense of the information, and follow up for later modifications.

87. 42 U.S. Code Sec. 1396(a)(i)(l).

88. See also testimony by Department Director, Commission Hearing, supra note 7, p. 83.

89. Dallas Times-Herald, 26 April 1981 and 6-12 February, 1983.

90. 1983 Conference, supra note 30.

91. Health and Safety Code Secs. 1439 and 1435; Title 22 Administrative Code Sec. 72503(5).

92. Adapted from recommendation by the Los Angeles City Attorney, supra note 75, pp. 20-21.

93. Ibid., p. 52.

94. States vary widely; this period is chosen by the Center for Public Representation model statute. The ABA Commission model suggests up to 24 months. Models cited supra note 22.

95. Adapted from Florida Stats. Ann., Tit. XXVII, Sec. 400.121(4).

96. Adapted from Michigan Stat. Ann. 14.15 (21799b); Michigan appears to call for a paid notice, and the notice is published without awaiting any appeals.

CHAPTER VI

1. Auditor General of California, The Department of Health Services Can Improve the Enforcement of Health Care Standards in Long-Term Care Facilities, Report P-202, August 1982.

2. "Supplemental Guidance in Implementation of LTC Ombudsman Program Requirement of the Older Americans Act, as Amended," AoA information for AAAs, Human Development Services, January 19, 1981; Sec. F. 2, p. 17.

CHAPTER VII

1. (California Health Facilities Commission, Economic Criteria for Health Planning, FY 1981-1982/FY 1982-1983, Report #82-3, Volume II, page 25.)

2. Bruce Vladeck, "Understanding Long Term Care," New England Journal of Medicine, September 30, 1982, page 890.

3. Nicholas Rango, "Nursing-Home Care In the United States," The New England Journal of Medicine, September 30, 1982, page 886. (The California study cited by Rango is M. Fottler and W.L. James, "Profits and Patient Care Quality: Are They Compatible," The Gerontologist, Volume 21, 1981, pages 532-538).

4. Suzanne LaViolette, "Nursing Home Chains Scramble For More Private-Paying Patients," Modern Healthcare, May, 1983, pages 130-138.

5. Robert L. Kane et al., "Predicting the Outcomes of Nursing Home Patients," The Gerontologist, Vol. 23, No. 2, 1983, page 200.

6. The State is seriously over-bedded in its acute care hospitals. Estimates of unused hospital beds vary, and they may be influenced by the present serious downturn in the economy. Nonetheless, there are, at present, probably more than 6,000 empty and unused acute care hospital beds in the State on any given day. Some hospitals have created so-called "distinct part long-term care facilities," in which long-term care services are offered as part of the operation of the hospital. Such "distinct part" facilities are reimbursed by Medi-Cal at actual cost or $109 per day, whichever is lower. The nursing home industry is presently sponsoring legislation to have this "distinct part rate" made equal to the rate paid in free-standing nursing homes. While the hospitals oppose

such a move, nonetheless one would suppose that some hospitals could find ways of providing long-term care at rates closer to free-standing long-term care facilities (currently about $39 per day).

7. Charlene Harrington, Robert Newcomer and Paul Newacheck, "Prepaid Long-Term Care Health Plans: A Policy Option for California's Medi-Cal Program," California Policy Seminar Final Report Number 4, Institute of Government Studies, University of California, Berkeley, April, 1983.

8. The survey was done in 1983 by discharge workers at a San Francisco hospital.

9. California Legislature, Assembly Office of Research, Facilitating Access to Skilled Nursing Facilities for Indigent Patients, February 1980.

10. Modern Healthcare, May 1983, pp. 130-138.

11. Section 504 of the Rehabilitation Act of 1973, 29 U.S. Code Sec. 794. 45 Code of Federal Regulations Part 84. Compliance review memorandum, Office for Civil Rights, Department of Health and Human Services, January 14, 1981.

12. Minnesota Association of Health Care Facilities v. Minnesota Department of Public Welfare, Civil No. 3-77-467 (D. Minn., April 26, 1983). Slip Opinion, pp. 15-16.

13. 65 Attorney General Opinions 659 at 665 (Opinion No. 82-501, December 31, 1982).

14. Constance Williams, "Geriatric Issues In Medical Education," unpublished thesis for Master's Degree in Public Health, University of California, Berkeley, May, 1983, page 4.

15. Source: Mountain States Health Corporation, Information Packet, May, 1983.

16. Lauren LeRoy, Background Paper #2: Case Studies of Medical Technologies; Case Study #16: "The Costs and Effectiveness of Nurse Practitioners," U.S. Congress, Office of Technology Assessment, July, 1981, page 15.

17. There are more than 25 million Medi-Cal days per year, multiplied by a tenth of an hour increase based upon the [FY 1979-1980] median nursing wage rate of $4.59 [.10 times $4.59=$.459]; $.459 times 25 million days is $11.47 million. These figures are higher in 1983-1984.

APPENDIX I-A

NURSING HOME STUDY ADVISORY COMMITTEE

Chairman: The Honorable Leo T. McCarthy
Lieutenant Governor
State of California

Members: William Benson
Department of Aging

Edward Feldman
Los Angeles County District Attorney's Office

Michelle Griffin
California Nurses' Association

Derrell Kelch
California Association of Homes for the Aging

Ralph Lopez
Los Angeles County Licensing and Certification Division

The Honorable Henry Mello (represented by John Delury)
Senate Health and Welfare Subcommittee on Aging

The Honorable Jean M. Moorhead (represented by Marta Zaragoza)
Assembly Committee on Aging and Long-Term Care

Roberts Nelson
California Association of Health Facilities

Ira Reiner (represented by Gary Rowse)
Los Angeles District Attorney

Mildred Simmons
Department of Health Services

Eva N. Skinner
Commission on Aging

Jean Kindy Walker
Commission on California State Government Organization and Economy

Thomas E. Warriner
Office of the Attorney General

Philip G. Weiler
School of Medicine, University of California at Davis

NATURE OF "A" & "B" VIOLATIONS CITED

(Chart Supplied by LCD)

The figures below were obtained from the Annual Citation Report completed yearly by the districts.

	1978		1979		1980		1981		1982	
	"A"	"B"	"A"	"B"	"A"	"B"	"A"	"B"	"A"	"B"
Dietary	3 (1%)	96 (5%)	4 (2%)	69 (4%)	3 (1%)	73 (5%)	1 (1%)	61 (1%)	2 (1%)	17 (2
Medication	28 (11%)	266 (13%)	19 (8%)	240 (16%)	17 (6%)	208 (14%)	5 (3%)	120 (11%)	34 (22%)	106 (12
Staffing	22 (9%)	102 (5%)	17 (7%)	85 (6%)	16 (6%)	62 (4%)	3 (2%)	28 (2%)	1 (.5%)	31 (4
Administration	19 (8%)	300 (14%)	26 (10%)	106 (7%)	37 (14%)	121 (8%)	16 (11%)	98 (9%)	9 (6%)	108 (12
Patient Care	154 (60%)	831 (40%)	155 (63%)	675 (44%)	178 (65%)	657 (43%)	118 (79%)	586 (51%)	81 (54%)	399 (45
Patient Record	3 (1%)	23 (1%)	1 (ø%)	13 (1%)	5 (2%)	31 (2%)	ø (ø%)	7 (1%)	1 (.5%)	13 (1
Physical Plant	24 (9%)	438 (21%)	23 (9%)	304 (20%)	14 (5%)	337 (22%)	4 (3%)	230 (20%)	16 (11%)	193 (22
Patient Rights	2 (1%)	28 (1%)	3 (1%)	28 (2%)	3 (1%)	25 (2%)	1 (1%)	8 (1%)	8 (5%)	16 (2
TOTAL	255 (100%)	2,084 (100%)	248 (100%)	1,520 (100%)	273 (100%)	1,514 (100%)	148 (100%)	1,138 (100%)	152 (100%)	883 (100

Commission Author's Note: Late 1982 list of regulations that were assigned to each of these categories contained some numbers which did not correspond to then existing regulations, or which corresponded to regulations not relevant to the assigned category. (E.g., 72403, physical therapy, was classified as Patients' Rights, and 72527, Patients' Rights, was classified as Administrative.) Therefore these data may not be reliable.

**A category may have more than one allegation.

C=patient care (507)
P=physical plant (207)
S=staffing (114)
A=administrative (113)
R=patient rights (86)
D=dietary (70)
M=medication (35)
PR=patient records (25)

LITTLE HOOVER COMPLAINT DATA
1st Quarter 1983
(Supplied by LCD)

	# OF COMPLAINTS	** CATEGORY OF COMPLAINTS								#ALLEGATIONS SUBSTANTIATED	#ALLEGATIONS NOT SUBSTANTIATED	#COMPLAINTS RESULTING IN "A" CITATION	#COMPLAINTS RESULTING IN "B" CITAT
		D	M	S	A	C	Pr	P	R				
BERKELEY (2 months only)	29	3	1	8	1	23	Ø	7	1	16	48	Ø	Ø
FRESNO	68	6	6	8	4	48	4	12	Ø	47	72	5	4
LOS ANGELES	373	20	14	36	68	218	8	104	44	216	517	36	26
REDDING	30	2	Ø	4	3	16	3	5	2	17	12	2	7
SACRAMENTO	68	4	1	8	Ø	53	Ø	15	1	24	6	Ø	2
SAN DIEGO	41	5	5	5	9	27	3	9	10	27	76	Ø	Ø
SAN FRANCISCO	47	2	Ø	14	9	12	2	14	12	8	51	4	3
SAN JOSE (2 months only)	32	1	Ø	8	3	17	Ø	2	Ø	16	34	5	30
SANTA ANA	134	15	6	21	7	70	5	29	16	85	301	4	3
SANTA ROSA	28	4	2	2	9	23	Ø	10	Ø	7	61	Ø	1
TOTAL	850	70	35	114	113	507	25	207	86	463	1,178	56	76
										(28%)	(72%)	(03%)	(05%)

% "A" Citations Resulting from complaints 90%

% "B" Citations Resulting from Complaints 41%

Sample Page only: Iowa Short Survey

ICF SURVEY
IOWA DEPARTMENT OF HEALTH
9/81

16. Following up on the residents above (#15), determine the extent to which their health care plans are being implemented. Your assessment may be based on asking a few selected questions to your subjects regarding their care plans or physically examining the relevant target areas.

Resident	Fully implemented	Partially implemented	Not at all implemented	Unknown	Comments if not implemented
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
Total					XXXXXXXXXXXXXXXX
Percentage					XXXXXXXXXXXXXXXX

Further comments or substantiation if needed:

ICF SURVEY
IOWA DEPARTMENT OF HEALTH
9/81

22. Quality of life. For each resident below, determine the extent to which each person is satisfied with his/her life in the facility. Your assessment may be carried out by interviews, not by administering the survey to the resident directly. Fill in the boxes with scale numbers from "1" to "5," as defined below. Enter N/A if not ascertainable.

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

Based on 10-minute interviews - Inspectors receive training in techniques.
Starting question:

Resident	If your friend were looking for a place other than home to live, what would you tell him/her about this place regarding: COMFORT	FREEDOM	FAIRNESS	SAFETY	FOOD
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
Total					
Percentage					

COMFORT--feel comfortable
FREEDOM--as much freedom as there could be
FAIRNESS--staff treatment
FOOD--well prepared

MEMORANDUM

TO: All Section Chiefs (Holders of Policy and Procedure Manuals)

DATE: 7/13/82

FROM: Robert K. Laraway

SUBJECT: Violation of Patient Rights/Civil Fines

In the accompanying material the Division's policy and procedures relative to implementing the Public Health Code Section 21799(c) - civil penalties levied against nursing homes for violation of patient rights - was developed to provide staff guidance for those circumstances which should trigger a violation of 20201(2)(e). The policy and procedure is a mechanism for assisting in identifying situations where patient care is inadequate and results in demonstrable harm/neglect to an individual.

The policy and procedure should not be interpreted that the department will not assess civil penalties against nursing homes for violation of other patient rights.

It is important to understand the policy as a prerequisite when you have violation of the identified nursing home rule. It is entirely possible and highly probable that many situations will only cause a violation of the nursing home rule without a correlary citation of 20201(2)(e).

It must also be very clear that other patient rights that are found to be in violation will be the subject of a civil fine assuming we are able to meet the requirement of Section 21799(c).

RKL:dk

Commission Author's Note:

EXAMPLE ONLY. This memo from another state is included to illustrate one way of designing more organized and detailed interpretive and procedural guidelines. It is not the only way, or necessarily the best way. It is <u>not</u> included for content, but only for organizational framework.

RESPONSIBILITY

ACTOR	
Surveyor/ Complaint Investigator	1. Conduct licensure/certification survey or complaint investigation in accordance with the procedures for those functions.
	1.1. Identify and report all violations of state or federal requirements.
	1.2. Prepare a Surveyor Report (Form LC-151).
	1.3. Compare the violations cited on the Surveyor Report to the list of State Rules for Nursing Homes which follows.

-R404 (1) & (2)
-R501
-R601 (1) & (2) & (3)
-R604 (1)
-R707
-R708 (1) thru (5)
-R709
-R803
-R903 (1)
-R904
-R1001
-R1304 (1) thru (4)
-R1305
-R1306 (1) & (2)
-R1317 (9)
-R1320
-R1322 (6), (7), (9), (10)
-R1324
-R1510 (2) (a) & (b)

2. Whenever one or more of the foregoing rules is cited, determine if demonstrable physical or mental harm occurred to any or all of the patients in the facility during the duration of the violation.

2.1. Physical harm is characterized by a deterioration of the physical health of a patient when that deterioration is caused or aggravated by one or more of the following:

ACTOR	RESPONSIBILITY
Surveyor/ Complaint Investigator	-failure to execute a physician's order in a timely and professional manner, -failure to assess a patient's needs and to plan and execute care appropriate to those needs, -failure to recognize and assess a change in a patient's condition, -failure to adequately respond to a patient's request for care when the means to fill such a request are available or can be marshalled, -failure to provide normal preventive care and/or to apply normal preventive care techniques including both cleanliness and safety, -neglect of a patient's physical needs including, but not limited to, medical and nursing care, appropriate nutrition, sanitation and housekeeping, and failure to observe routine safety precautions, -failure to adequately plan and execute plans for emergencies such as fire, natural disasters, and the need for emergency evacuation of the facility while maintaining delivery of patient care, -failure to maintain a clean, comfortable and safe environment, -infliction of any physical injury or pain, whether permanent, temporary, or transient, upon a patient by any facility employee, volunteer, physician or visitor.

2.2. Mental harm is characterized as a situation in which the patient's emotional status is either adversely affected by the behavior of an employee of the provider agency including, but not limited to by stress, anger, frustration or fear. That is, external influences which could have been avoided by normal, prudent patient management.

ACTOR	RESPONSIBILITY
Surveyor/ Complaint Investigator	Mental harm also includes the use of chemical agents or physical restraints which are administered or applied without or contradictorily to a physician's order or exceed normal standards of practice.
	Mental harm also includes the failure to provide therapeutic mental health care when requested or when the need for such care is substantiated.
	2.3. Any definition of "harm" includes pain, of however brief a duration, if that pain is of a different origin or severity than the patient normally experiences as an outgrowth of his or her mental or physical condition.
	3. Whenever a violation of a rule listed in Step 1.3 is found, the rule is to be cited and sufficient detail is to be recorded on the Surveyor Report that the documentation of the situation will be indisputable.
	3.1. In addition to complete documentation, the surveyor/investigator shall exercise a high degree of insight and professional judgments in considering if such violations may have resulted in physical or mental harm to a patient. If such harm could have resulted, the surveyor/investigator will make a comprehensive search for evidence of it. If a patient is found to have suffered physical or mental harm, the rule citation shall list section 20201(2)(3) or 20201(2)(1) of the Public Health Code.
	3.2. When such citations are made, the effect of the violation on each of the facility's patients is to be assessed. Careful notes are to be made about the impact of the violation(s) on each affected patient at the time of the surveyor or investigation.

ACTOR	RESPONSIBILITY
Surveyor/ Complaint Investigator	4. Finalize the Surveyor Report. If a patient rights violation is cited, prepare a transmittal memorandum to the work unit supervisor with a copy to the Division Chief. Include the following information: -identification of the facility, -the date(s) of the visit or investigation, -the date of the Surveyor Report, -a brief statement of the nature of the violation(s) and how it (they) constitute a patient rights violation.
Work Unit Supervisor	5. Review every Surveyor Report for citations of the rules listed in Step 1.3.
	5.1. For citations of the listed rules in which the surveyor has found that no patient has suffered physical or mental harm, review the documentation to be certain that that citation adequately reflects the absence of such harm.
	5.2. For surveyor reports which do document physical or mental harm, verify that the documentation is complete in that it specifies -the cause(s) of the harm, -the specific result of the harm, in concrete, observable terms, and -the rule and Public Health Code section violated.
	5.3. Resolve conflicts in the apparent failure to cite a patient rights violation, or in the apparent inappropriate citation of such a violation, with the surveyor or investigator.

ACTOR		RESPONSIBILITY
Work Unit Supervisor	6.	Prepare a Request for Enforcement Action requesting a patient rights violation civil fine.
	6.1.	Attach the Surveyor Report which originally documented the situation.
	6.1.1.	Procure the names of all affected patients on the supporting descriptive documentation from the surveyor or investigator.
	6.1.2.	As space permits, reproduce the patient-specific information on the back of the Request for Enforcement Action or append it thereto.
	7.	Forward the Surveyor Report, the surveyor's or complaint investigator's transmittal memorandum, and the Request for Enforcement Action to the Assistant Division Chief.
Assistant Division Chief & Chief of Internal Audit	8.	Review the Surveyor Report, the transmittal memorandum, and the work unit supervisor's recommendation.
	8.1.	Make a determination on the issuance of a fine order.
	8.1.1.	If a fine order is to be issued, prepare it for appropriate signature.
	8.1.2.	If no fine order is to be issued, prepare a memorandum briefly outlining the rationale for that decision to the Division Chief. File a copy with the Surveyor Report in the facility licensure master file. Patient specific data <u>will not</u> be included in any reports, memos, etc., which would become part of the facility file.
Division Chief	9.	Review the recommendation of the Assistant Chief and Chief of Internal Audit, and make a final decision.
	9.1.	Direct the Chief of Internal Audit to issue a fine order, if appropriate.

VIOLATION SUMMARY
(Chart supplied by LCD)

Citations	898		849.		1,041		783		643		170	
	1978		1979		1980		1981		1982		1983	
Violations	A	B	A	B	A	B	A	B	A	B	A Jan -	B March
(Annual Citation Report)	255	2,084	248	1,520	273	1,514	148	1,138	152	856	62**	211
Violations Referred to A.G.	Unknown		79	228	160	643	107	310	87	369	12	47
#Settled	Unknown		58	111	153	576	98	100	82	148	12	14
Dismissed, no legal penalty	Unknown		21	217	7	167	9	210	5	221	3	33
Violations Heard at CRC	183	704	149	414	124	249	87	296	67	162	34	58
Sustained	109	434	78	340	66	199	50	250	35	125	17*	40
Reduced/Dismissed (Annual Citation Report)	74	270	71	74	68	50	37	46	32	37	17*	18

***Please note that the violations that are referred to the AG's in a certain period of time are not necessarily the same violations that are "settled" or "dismissed/no penalty" within same period of time.**

Commission Author's Notes:

Referred to A.G. includes both cases appealed directly (without a CRC) and cases appealed after a CRC. Thus, one cannot determine total appeal rate or percentage of CRC decisions appealed.

#Settled is unclear whether includes pretrial settlement, court decisions, or both. No information on terms of settlement, on whether sustained, reduced, etc.

Sustained appears to include cases where fine reduced, as long as level of citation was not reduced.

*Does not match figures in the Chart in Appendix V-B, page 295.

**LCD explains the proportional increase in A violations as related to one particular facility with many violations.

GITATION ACTIVITY Quarterly SUMMARY
(Chart supplied by LCD)

Quarter: 1st MONTH: January-March YEAR: 83

DISTRICT OFFICES		Berk.	Fresno	L.A.	Redding	Sacto.	S. Diego	S. F.	S. Jose	S. Ana	S. Rosa	TOTAL	%
Violations Cited (Including Separate Counts)	A	1	5	33	2	7	3	1	1	9	0	62	2
	B	18	39	100	10	5	1	10	16	9	3	211	7
Citation Forms Issued		14	24	78	7	12	4	7	11	10	3	170	N
Number of CRC's Held		4	4	16	0	1	3	2	1	2	2	35	N/
Violations Heard at CRC (Including Separate Counts)	A	0	2	20	0	1	5	1	1	4	0	34	3
	B	6	22	10	0	0	5	3	0	10	2	58	6
Citation Forms Involved		6	6	16	0	1	8	3	1	4	2	47	N/
Violations Referred to Superior Ct. After CRC (Incl. Separate Counts)	A	0	1	2	0	0	1	0	0	0	0	4	
	B	2	2	1	0	0	0	2	0	0	0	7	
Citation Forms Involved		2	3	3	0	0	1	1	0	0	0	10	N/
Violations Referred Directly to Superior Ct. -- No CRC (Incl. Separate Counts)	A	0	0	2	1	0	0	0	0	0	0	3	1
	B	0	0	8	2	0	0	2	5	0	0	17	8
Citation Forms Involved		0	0	8	2	0	0	1	3	0	0	14	N/
Penalties Collected	By L & C	1,000	1,050	9,450		8,050				3,000		22,550	7
	By AC			2,000			3,148			2,000		7,148	2

Quarter: st

MONTH: January-March YEAR: 83

DISTRICT OFFICES		Berk.		Fresno		L.A.		Redding		Sacto.		S. Diego		S. F.		S. Jose		S. Ana		S. Rosa		TOTAL		%	
No. of CRC's Held		4		4		16		Ø		1		3		2		1		2		2		35		N/A	
A/B Viol. heard at CRC's (incl. Separate Counts)		Ø	6	2	22	20	10	Ø	Ø	1	Ø	5	5	1	3	1	Ø	4	10	Ø	2	34	58	37	%
A/B CRC DECISIONS	Sustained											4	4	1	1							5	5	15	9
	Sustained - Penalty Reduced		5	2	19	12	3			1					2	1			4		2	16	35	47	6
	Reduced to B					5												3				8	Ø	23	0
	Reduced to C		1		3		4												6			Ø	14	Ø	9
	Dismissed					3	3					1	1					1				5	4	15	7
A/B CRC CATEGORY OF VIOL.	Dietary																					Ø	Ø	Ø	0
	Medication					1																1	Ø	3	0
	Staffing			1															7		1	1	8	3	13
	Admin.				11	3	1					1	1					2				6	13	18	22
	Pt. Care			1	10	14	6			1		4	4		2	1		1			1	22	23	64	46
	Pt. Record																					Ø	Ø	Ø	0
	Phys. Plant		6		1		1							1	1							1	9	3	16
	Pt. Rights					2	2											1	3			3	5	9	7
Ave. No. Working Days Det. Ins. Cit. & CRC		10.6		24.8		18.6		Ø		44.0		23.0		16.0		22.0		49.0		13.0		22.1		N/A	
Ave. No. Working Days Det. Request & CRC		5.8		16.5		15.1		Ø		33.0		16.3		6.0		16.0		41.5		8.0		15.8		N/A	
Above Viol. Referred to Sup. Ct. After CRC		0	2	1	2	2	3	Ø	Ø	Ø	Ø	1	0	0	2	0	0	0	0	0	0	4	9	31	6
Amt. of Penalties Trip. Ann. before CRC	A	Ø		10,000		84,000		Ø		5,000		20,000		5,000		2,500		15,000		Ø		141,500		N/A	
	B	1,500		5,500		2,250		Ø		Ø		2,750		1,250		Ø		2,500		500		15,750			
Amt. of Penalties Used after CRC	A	Ø		4,000		19,000		Ø		5,000		20,000		5,000		1,000		3,000		Ø		57,000		N/A	
	B	Ø		1,150		Ø		Ø		Ø		2,500		750		Ø		150		Ø		4,550			

APPENDIX V-C

A VIOLATIONS
FINES AND APPEALS

(from chart supplied by LCD [author's comments in brackets])

		CALENDAR YEAR		
		78	79	80
I.	Class A Violations Cited	255	248	273
A.	Penalty amount proposed* [As and Bs]	$864,350	$730,400	$633,850
B.	Penalty amount collected* [As and Bs, see below]	112,275	105,000	163,100
C.	Penalty after informal** conference (Title 22, Section 72719(b))	353,950	291,750	303,075

		FISCAL YEAR		
		78/79	79/80	80/81
D.	Number of cases referred to Attorney General for suit	77	75	53
E.	Total fees incurred by Attorney General***	$260,683	$225,390	$271,439
F.	Number of suits pursued to judgment or settlement	32	45	72
G.	Amount collected as a result of judgment or as a result of settlement of suit**	32,100	144,650	208,650
H.	Amount owed as a result of judgment	8,000	0	5,000
I.	Amount owed as a result of settlement	0	0	4,000

*Current information systems do not provide a breakdown of penalty amount by type of citation. These figures represent amounts for the combined total of A and B citations.

**These figures also include some amounts resulting from B violations.

***These figures reflect total enforcement costs by the Attorney General's Office, they are not restricted to the fees related to the A/B Citation System.

[~~Regarding B~~: It is unclear if this means only the minimum fines paid in lieu of contesting the violation. LCD explained that "I.B. is total penalties collected during the year, including the amount in I.G." Since G is sometimes larger than B, that interpretation raises more questions than it answers. Regarding C: It is unclear whether this means amount collected or amount still owed. If amount collected, it is unclear whether it includes the amount in B. Figures cannot be compared because they do not all relate to the same citations.]

APPENDIX V-C (continued)

B VIOLATIONS
FINES AND APPEALS

	CALENDAR YEAR		
	78	79	80
II. Class B Violations Cited	2,084	1,520	1,514
A. Penalty amount proposed*			
B. Number of informal conferences held	704	414	249
C. Penalty after informal** conference (Title 22, Section 72719(b))			

	FISCAL YEAR		
	78/79	79/80	80/81
D. Number of cases referred to Attorney General for suit	135	141	143
E. Total fees incurred by Attorney General***			
F. Number of suits pursued to judgment or settlement	7	39	38
G. Amount collected as a result of judgment or as a result of settlement of suit**	$1,600	$14,650	$2,000
H. Amount owed as a result of judgment	0	900	0

*Current information systems do not provide a breakdown of penalty amount by type of citation. These figures represent amounts for the combined total of A and B citations.

**These figures also include some amounts resulting from B violations.

***These figures reflect total enforcement costs by the Attorney General's Office, they are not restricted to the fees related to the A/B Citation System.

[Figures cannot be compared because they do not all relate to the same citations.]

APPENDIX V-D

RECOMMENDED FINES UNDER CURRENT A-B-C SYSTEM

vs. POTENTIAL A-B-C-D SYSTEM

RECOMMENDED SYSTEM (CHANGES FINES, NOT CATEGORIES)	POTENTIAL ALTERNATIVE** (CHANGES FINES AND CATEGORIES)
A	A
violations which present either (1) imminent danger that death or serious harm to the patients . . . would result therefrom, or (2) substantial probability that death or serious physical harm to patients . . . would result therefrom. A physical condition or one or more practices, means, methods, or operations in use in a . . . facility may constitute such a violation . . . . Health & Safety Code Sec. 1424(a)	violations which create a condition or occurrence which can be predicted with substantial probability to result in the death or serious physical or mental harm to a resident
$1,000-10,000	$5,000-10,000
B	B
violations which have a direct or immediate relationship to the to the health, safety, or security [or welfare] of . . . facilitiy patients . . . Health & Safety Code Sec. 1424(b)(*see Recommendation 3 balow)	violations which create a condition or occurrence . . . directly threatening the health, safety, security, or welfare of a resident
$100-1,000	$1,000-5,000
C	C
violations having only a minimal relationship to safety or health	violations which indirectly threaten the health, safety, security, or welfare or a resident
no fine	$100-1,000
D	D
---------	violations which concern rules promulgated primarily for administrative purposes with little or no effect on the health, safety, security or welfare of a resident
	no fine

**adapted from ABA Commission model, see Chapter V, Endnote 22, p. 8

REPORT ON THE SURVEY ON NURSING HOME PROSECUTIONS

MAY 1983

BACKGROUND

In May, 1983, at the request of the Nursing Home Study Advisory Committee to the Commission on California State Government Organization and Economy (the Little Hoover Commission), the office of Ira Reiner, City Attorney for the City of Los Angeles, conducted a survey of the local prosecutorial offices throughout the State of California. The purpose of the survey was to ascertain whether or not such prosecutors were enforcing nursing home statutes and regulations through the misdemeanor criminal sanctions available under Section 1290 of the California Health and Safety Code. To the extent that such prosecutorial offices were not filing criminal complaints, the survey attempted to ascertain the reasons for such nonfiling.

On May 6, 1983, a four page survey form was sent to the District Attorney in each of California's 58 counties. In addition, a survey was sent to the City Attorney for the City of San Diego and a survey was also completed for Mr. Reiner's own office. This report is based on the returns received from 31 of the counties, as well as both of the City Attorney offices solicited. The results were tabulated and analyzed on May 31, 1983, by Deputy City Attorney Gary T. Rowse of the Consumer Protection Section of the Los Angeles City Attorney's Office.

ANALYSIS

Prior to the survey being conducted, there had been the general impression that only the offices of the District Attorney for Los Angeles and the City Attorney of Los Angeles utilized Section 1290 of the Health and Safety Code as an enforcement tool for violations of nursing home regulations (Title 22 of the California Administrative Code, Sections 72001, et seq.). The responses to the survey did little to alter this impression. Of the 33 prosecutorial offices which responded, only 3 reported having filed a criminal complaint under Section 1290 during the preceding three years: Los Angeles County District Attorney, Los Angeles City Attorney, and Lassen County District Attorney. The case handled by the Lassen County D.A. was reported to be a "relatively simple case" involving licensing requirements.

While the survey was not designed in such a manner as to allow for analysis containing any assurances of statistical reliability, the responses do allow for some insights as to the reasons behind the lack of utilization of Section 1290. The

reasons fall basically into three categories: 1) nursing home cases are not being referred to the office; 2) perceived lack of support or quality of investigation on the part of the Licensing and Certification Division of the State Department of Health Services; and 3) a preference for civil action under Section 17200 of the Business and Professions Code.

1. Nursing home cases are not being referred to the office: Of the 33 offices reporting, 22 (67%) listed that "[t]here were no cases involving Section 1290 nursing home violations referred to this office" as a reason for lack of prosecutions during the prior three years. With respect to two of the counties responding, Mono and Trinity, this was hardly surprising, since neither of them have a nursing home located in the county. Additionally, of the 58 counties in the State, 34 of the counties have less than 10 nursing home located in them. However, of the remaining 24 counties (with 10 or more nursing homes), 19 responded to the survey, and of those, 12 (63.2%) listed lack of referral as a reason. Moreover, this pattern continued in those counties with a large number of nursing homes. Of the 13 counties in the State which have 25 or more nursing homes, 11 responded to the survey, and of those 11, 7 (63.6%) reported no referrals.

The offices were also asked whether during the preceding three years they had had any contact at all with the Licensing and Certification Division of the State Department of Health Services. This would include not only contacts concerning nursing homes, but also concerning acute care facilities. Of the 33 offices reporting, again 22 (67%) reported no contact (although there were a few differences between this 22 and those reporting lack of referrals). In those counties with 25 or more nursing homes, 6 of the 11 reporting (54.5%) indicated no contact.

Even in some cases where there was contact, difficulties were reported. For example, Contra Costa County indicated that the Department of Health Services did send them copies of A and B citations, but that getting the Department to do it was like "pulling teeth". Alameda County also reported that they had been able to obtain an informal agreement that all citations within the county be copied to the District Attorney's office. They also indicated that the "agreement has not been completely adhered to over the past 5 years without occasional renewal efforts by this office, and the completeness of information is unverifiable."

2. Perceived lack of support or quality of investigation on the part of the Licensing and Certification Division of the State Department of Health Services:

Of the 8 remaining "non-prosecuting" counties which did receive referrals, 6 of them indicated that "[a]lthough cases were referred to this office involving alleged nursing home violations, the evidence presented or available was not sufficient to warrant a criminal filing." While such

evidentiary problems might be caused by factors other than lack of support or poor quality of investigation, the comments added to the survey forms did indicate problems in this regard.

Alameda County reported that "cases of possible criminal nursing home violations which this office became aware of were dependant upon evidence and allegations gathered by licensing personnel which are collected insufficiently for criminal prosecution in all cases." [Emphasis in original]. The County went went on to state that "[o]ur contact is always generated by this office or licensing personnel operating outside of the Department's chain of command. Criminal or civil enforcement through D.A.'s is not viewed by this Division as their function. Without adequate changes in the training and orientation of the only government personnel in a position to gather evidence in such cases, i.e., Department of Health personnel, the present administrative and licensing review material is insufficient to meet the criminal burden of proof."

Santa Clara County indicated that the "quality of investigation was not criminally oriented" and that "evaluators do not consider themselves 'investigators'."

Contra Costa County reported that it had one case referred to its office, but the evidence presented was not sufficient to warrant a criminal filing. It tried to get additional information on the referred case, but it could not get that help from the Division.

On the other hand, Lassen County indicated that with respect to the case that it criminally prosecuted, the case was a relatively simple case and the contact with the Division was "adequate". Santa Cruz County reported that from June 1981 through January 1983, a nursing home and a board & care facility were investigated for violations. The quality of the investigation was "good" and the Department "did a good job of monitoring further conduct."

The other two offices which criminally prosecuted cases were the District Attorney and the City Attorney of Los Angeles. In both cases, the investigations were done, for the most part, by the Los Angeles County Department of Health, which contracts with the State Department for this function. Both offices have indicated that their ability to pursue criminal prosecution is due, to some degree, to the cooperation they receive from the County Department and the thoroughness of the investigations.

3. A preference for civil action under Section 17200 of the Business and Professions Code:

Six of the counties responding indicated that a reason for not criminally prosecuting included "[t]his office enforces violations of nursing home regulations through civil enforcement actions (e.g., Business and Professions Code, Section 17200, actions.)" In addition, six other offices indicated that they

had experience with civil enforcement through an "unfair business practice" action under Section 17200, or at least believed that it was an appropriate enforcement tool.

Although the survey did not specifically elicit comments concerning civil enforcement actions through Section 17200, several counties did make their feelings clear:

Fresno County: "It is my opinion that the Business and Professions Code Section 17200 remedy is a much more effective remedy where 'on going' problems occur at a nursing home. It is a much more complete remedy in compelling a needed facility to 'clean up its act'. At the same time, there is no right to a jury trial, a preponderance of the evidence burden of proof prevails, and the Defendant will often readily agree to a Consent Decree which includes an injunction (relating to the prohibited activity) plus penalties. This is done only after the business activity has taken corrective action to ensure future compliance."

Marin County: "Four years ago, a case was referred for criminal action and there was sufficient evidence for prosecution but we elected civil prosecution because the penalties were greater than through criminal prosecution. This election to pursue civil rather than criminal remedies was based on the circumstances of the specific case."

"I believe that 17200 [Business & Professions Code] constitutes a better method of enforcement than criminal prosecution. Owners violate the law to make money in a lucrative business. The way to prevent them from cutting corners is to take away the profit motive. Various novel approaches to securing compliance can be undertaken by the Court under §17203 which ensures that patients are properly cared for and that money needed for patient care is not diverted to assessments for civil penalties."

Contra Costa County indicated that Section 1290 criminal prosecution is appropriate where conduct is willful or amounts to gross negligence. However, where conduct is more the lack of effective management and control, a civil action under Section 17200 is appropriate.

San Diego County also indicated support for the use of Section 17200. They noted that their action against Casa Blanca Convalescent Homes, Inc., resulted in a judgment of $167,500, plus costs, against the corporation, although they noted that the corporation did manage to expand from 9 homes to 35 homes during the time since the suit was filed in 1977. They also indicated that the suit took four years and one day to get to trial. They also noted that as a result of the law suit, they now

had an injunction against the corporation which they hoped prohibited future neglect.

STANDARD OF PROOF ISSUE

Question 4 of the survey related to the standard of proof used by prosecutorial offices in filing criminal charges. Of the 33 responding offices, only 20 answered Question 4, and of these, 12 responded that their office had no experience in this area and therefore did not choose between the three options. Of the eight who did select amongst the options, seven chose "'Strict liability' based on repeated conduct and with little or no concern toward proving that the owner could have prevented the violation."

The remaining respondant chose the option of "Some 'fault' or ability to prevent the violation on the part of the owner must be provable by the prosecution. No one chose the third option of "Violations must be provable as 'willful' violations on the part of the owner", which was not surprising as it is clearly more limiting than the language of Section 1290, which provides for prosecution of "repeated" as well as "willful" violations.

San Diego County cited to the case of People v. Balmer (1961) 196 Cal.App.2d Supp. 874 as authority for the "strict liability" standard of proof. The Los Angeles City Attorney's Office also cited to the cases of United States v. Park (1975) 421 U.S. 658 and People v. Travers (1975) 52 Cal.App.3d 111 for the liability of owners and operators.

COMMENTS AND SUGGESTIONS

The purpose of the survey was not to debate the relative merits of criminal prosecution under Section 1290 versus civil enforcement actions under Section 17200. The use of one tool in one case does not exclude the use of the other tool in another case, as the experiences of District Attorney and City Attorney office in Los Angeles indicates. However, some of the advantages perceived to adhere to Section 17200 actions, as indicated in this survey, serve to highlight some of the "drawbacks" to utilizing Section 1290, and may be useful in formulating recommendations.

1. Civil action under Section 17200 allows for civil discovery.

As was discussed above, concern has been expressed as to the adequacy of the investigations done by the Licensing and Certification Division, particularly with regard to the criminal burden of proof of "beyond a reasonable doubt". Questions were raised as to the effect of the 5th Amendment protections against

self-incrimination vis-a-vis the ability to get medical records once a criminal complaint had been filed. Clearly, some of these problems are alleviated significantly where pre-referral investigations are thorough and photocopies of necessary medical records are obtained, irrespective of the legal issue of whether medical records of patients can be withheld under any circumstance where the statutory requirements are complied with.

2. The penalties obtainable under Section 1290 are inadequate.

Several counties commented that the monetary penalties obtainable under Section 1290 were inadequate (maximum fine per count is $500, plus penalty assessment). Additionally, there are no provisions for payment of costs under criminal prosecution. Civil enforcement under Section 17200 is not similarly limited, as the Case Blanca judgment in San Diego demonstrated.

Of course, prosecutors are not restricted to filing one count under Section 1290. A nursing home deserving of criminal prosecution usually has large number of deficiencies and violations. The Los Angeles City Attorney's Office, for example, recently reported a nursing home case where the fine totalled $5000 (with an additional $3000 in penalty assessments), because the corporate defendant pled "no contest" to 10 criminal counts.

However, as Santa Cruz County suggested, the monetary penalty possible under Section 1290 should be increased, For example, it could be raised to a maximum fine of $5000 or $10,00 per count. Fines of $10,000 are currently allowable under other misdemeanor statutes (see, for example, the Home Equity Sales Contract Act, Civil Code, Section 1695, et seq.).

3. Injunctive relief is available under Section 17200.

While injunctive relief is, indeed, available under Section 17200, a period of probation is available under Section 1290. At the present time, where a corporation is the defendant on probation, the sanctions left for enforcement are relatively weak (since a corporation can not be placed in custody). However, if the fines available were increased, this might reduce the problem.

Other comments and suggestions arising from the survey include:

San Diego County: "Re: Section 1290 - The penalities are inadequate. The prosecution of staff members and/or administrators will not be productive unless the corporate structure is also punished.

"I would suggest such remedies as

1) revocation of corporate status, thus changing the tax status of the corporation;

2) any and all legal fees incurred by the People in prosecution be recoverable; and
3) decertification for Medi-Cal/Medicare for a period upon conviction."

Santa Cruz County: "Section 1290 should be amended to provide for felony prosecution for repeat offenders and allow for misdemeanor prosecution for negligent conduct rather than willful. Should almost be strict liability for misdemeanor [i.e., not only "willful or repeated']. Large amount of monetary penalty and injunctive relief should also be allowed."

Contra Costa County: It would be useful if there were developed and distributed, perhaps through the California District Attorneys' Association or through the Little Hoover Commission, a manual or handbook on prosecuting nursing homes. It could include form complaints, jury instructions, and points and authorities, plus suggestions on evidence gathering and investigations.

Placer County: "Section 1290 of the Health and Safety Code is an excellent avenue in prosecuting violations of nursing home regulations. However, it appears this avenue is not being utilized. Possibly there should be some coordination between the licensing agencies and their local law enforcement counterparts. Perhaps liaisons between agencies would help facilitate the use of 1290 H & S."

APPENDICES

Appendix I - Table of Counties of State of California, 1980 Population, Number of Intermediate Care and Skilled Nursing Facilities, and Selected Responses to Survey.

Appendix II - Sample of Survey Instrument

Appendix III- Summary of Survey Responses, including Number of Facilities and Responses to Questions 1 through 5.

COUNTY	POPULATION (1980)	2/ FACILITIES ICF	2/ FACILITIES SNF	NO. OF $1290 PROSECUTIONS 3/	NO $1290 SNF REFERRALS 4/	CIVIL ACTION UNDER $17200 5/	CONTACT WITH L&C DIVISION 6/
ALAMEDA	1,105,379	7	86	0	X	Yes	Yes
ALPINE	1,097	0	0				
AMADOR	19,314	0	1	0		Yes	Yes
BUTTE	143,851	2	13				
CALAVERAS	20,710	0	2	0	X		No
COLUSA	12,791	0	1				
CONTRA COSTA	657,252	1	37	0			Yes
DEL NORTE	18,217	0	1				
EL DORADO	85,812	0	2				
FRESNO	515,013	1	36	0	X	Yes	No
GLENN	21,350	0	1				
HUMBOLDT	108,024	0	6				
IMPERIAL	92,110	0	3				
INYO	17,895	0	2	0	X		No
KERN	403,089	3	15	0	X		No
KINGS	73,738	0	3				
LAKE	36,366	0	1				
LASSEN	21,661	0	2	1			Yes
LOS ANGELES 1/ COUNTY (EXC CITY)	4,510,894	6	261	2		Yes	Yes
LOS ANGELES CITY	2,966,763	3	135	4		Yes	N/A
MADERA	63,116	0	4				
MARIN	222,952	0	16	0		Yes	No
MARIPOSA	11,108	0	1				
MENDOCINO	66,738	0	5				
MERCED	134,560	0	7				
MODOC	8,610	0	1				
MONO	8,577	0	0	0	X		No SNFs
MONTEREY	290,444	1	16				
NAPA	99,199	0	8				
NEVADA	51,645	0	5	0	X		No

COUNTY	POPULATION (1980)	2/ FACILITIES ICF	SNF	NO. OF §1290 PROSECUTIONS 3/	NO §1290 SNF REFERRALS 4/	CIVIL ACTION UNDER §17200 5/	CONTACT WITH L&C DIVISION 6/
ORANGE	1,931,570	1	60	0	X	Yes	No
PLACER	117,247	0	6	0	X		No
PLUMAS	17,340	0	2				
RIVERSIDE	663,923	1	36				
SACRAMENTO	783,381	3	41	0	X		No
SAN BENITO	25,005	0	3	0	X		
SAN BERNARDINO	893,157	4	40	0	X		No
SAN DIEGO COUNTY (EXC. CITY) 1/	986,342	1	48	0		Yes	Yes
SAN DIEGO CITY	875,504	2	19	0	X		No
SAN FRANCISCO	678,974	0	27	0	X	Yes	No
SAN JOAQUIN	347,342	0	23				
SAN LUIS OBISPO	155,345	0	9	0	X		No
SAN MATEO	588,164	0	26	0			Yes
SANTA BARBARA	298,660	0	17				
SANTA CLARA	1,295,071	3	63	0	X	Yes	No
SANTA CRUZ	188,141	1	17	0		Yes	Yes
SHASTA	115,715	1	5				
SIERRA	3,073	0	0				
SISKIYOU	39,732	0	2	0			No
SOLANO	235,203	0	10	0	X		Yes
SONOMA	299,827	0	19	0			
STANISLAUS	265,902	0	18	0	X	Yes	No
SUTTER	52,246	0	2	0	X		No
TEHAMA	38,888	0	5				
TRINITY	11,858	0	0	0	X		No SNFs
TULARE	245,751	0	11	0	X		No
TUOLUMNE	33,920	0	1				
VENTURA	529,899	2	17	0	X		No
YOLO	113,374	1	7				
YUBA	49,733	0	1				

NOTES:

Survey was conducted during May, 1983, and all data are for periods through that date.

1/ The figures for Population and Facilities for Los Angeles County and San Diego County do not include the population and facilities located within the cities of Los Angeles and San Diego, respectively.

2/ FACILITIES: Information on the number of ICFs (Intermediate Care Facilities) and SNFs (Skilled Nursing Facilities) was obtained during May, 1983, from the Licensing and Certification Division of the State Department of Health Services. The figures for the City of Los Angeles was obtained from the Health Facilities Division of the Los Angeles County Department of Health.

3/ NO. OF §1290 PROSECUTIONS: This column reports the number of misdemeanor criminal complaints filed under Section 1290 of the Health and Safety Code during the preceding three (3) years. In addition, two offices reported criminal investigations which did not ultimately result in criminal complaints being filed.

4/ NO §1290 SNF REFERRALS: Where offices had reported no criminal prosecutions during the preceding three years, they were asked to designate the reasons for this. An "X" in this column indicates that the office responded that "[t]here were no cases involving Section 1290 nursing home violations referred to this office."

5/ CIVIL ACTION UNDER §17200: A "Yes" response in this column indicates that the office reported either:

(a) it uses, or has in the past used, civil actions under Section 17200 of the Business and Professions Code for nursing home enforcement, as opposed to criminal prosecution under Section 1290; or

(b) it believes that if a case was referred to it, it would use Section 17200 civil litigation.

6/ CONTACT WITH L&C DIVISION: Offices were asked whether they had any contact with the Licensing and Certification Division of the State Department of Health Services during the past three (3) years, either with respect to skilled nursing facilities or with respect to any other health care facility. Because the State Department of Health Services contracts in Los Angeles County with the County Department of Health, this question is not applicable to the County of Los Angeles or the City of Los Angeles.

SURVEY ON NURSING HOME PROSECUTIONS
for the
COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY (LITTLE HOOVER COMMISSION)

DISTRICT ATTORNEY:	
COUNTY:	
ADDRESS:	
CONTACT PERSON:	TELEPHONE: ( )

1. During the past three (3) years, has your office filed a criminal complaint against the owner or the operator of a skilled nursing facility alleging a violation of Section 1290 of the California Health and Safety Code?

   Yes /Y/

   No /N/

2. If your answer to Question #1 is "Yes", please indicate the following:

   Approximate number of cases filed: #

   Type(s) of violations alleged (*Check all that are applicable*):

   /A/ Patient care (including medical records)

   /B/ Patient trust accounts (co-mingling, theft, failur to maintain adequate safeguards)

   /C/ Unsanitary or unrepaired facilities

   /D/ Licensing requirements (including personnel requirements, staffing requirements, etc.).

   /E/ Other:

3. If your answer to Question #1 is "No", please indicate the reason(s) for this answer (*Check all that are applicable*):

/A/ There were no cases involving Section 1290 nursing home violations referred to this office.

/B/ This office enforces violations of nursing home regulations through civil enforcement actions (*e.g., Business and Professions Code, Section 17200, actions*).

/C/ This office does not have the resources available to properly pursue misdemeanor actions under Section 1290.

/D/ Although cases were referred to this office involving alleged nursing home violations, the facts alleged did not warrant criminal prosecution (*e.g., facts alleged did not constitute a crime; facts alleged technically constitute a crime, but prosecutorial discretion exercised; etc.*).

/E/ Although cases were referred to this office involving alleged nursing home violations, the evidence presented or available was not sufficient to warrant a criminal filing.

/F/ Although cases were referred to this office involving alleged nursing home violations, the criminal action was barred by the one year misdemeanor statute of limitations.

/G/ Other:

4. To the extent that you have ever prosecuted the owners of nursing homes for violations of regulations by their employees (e.g., failure to administer medications as prescribed), which standard do you use in determining whether to file charges:

/A/ "Strict liability" based on repeated conduct and with little or no concern toward proving that the owner could have prevented the violation.

/B/ Some "fault" or ability to prevent the violation on the part of the owner must be provable by the prosecution.

/C/ Violations must be provable as "willful" violations on the part of the owner.

/D/ The office has no experience in this area.

5. Has your office had any contact during the past three (3) years with the Licensing and Certification Division of the State Department of Health Services (*including facilities other than skilled nursing facilities, such as acute care facilities*)?

Yes /Y/

No /N/

If your answer is "No", to your knowledge has your office ever had contact with the Licensing and Certification Division, and, if so, when?

With respect to your response to Question #6, may that information be attributed to your office when this information is disseminated

/__/ Attributable

/__/ Confidential

6. If your answer to Question #5 is "Yes", please describe your experience with the Division, including, but not limited to:
   - the time periods involved;
   - whether it involved nursing homes or other facilities;
   - the quality of investigation, if any, done by the Division;
   - any positive experiences with the Division; and
   - any problem areas with the Division.

7. Please give any comments you may have concerning the use of Section 1290 of the Health and Safety Code as a tool of nursing home enforcement:

Please complete this survey and return it to the address given below as soon as possible. The results are needed by May 13, 1983. You may telephonically respond by calling Deputy City Attorney Gary Rowse at (213) 485-4515. He may answer any questions you have about this survey.

MAIL TO: Office of the City Attorney
of Los Angeles
Consumer Protection Section
1700 City Hall East
200 North Main Street
Los Angeles, California 90012

Appendix II

SUMMARY OF SURVEY RESPONSES

COUNTY	# OF FAC	Q.1 Y	Q.1 N	Q.2 #	Q.2 A	Q.2 B	Q.2 C	Q.2 D	Q.2 E	Q.3 A	Q.3 B	Q.3 C	Q.3 D	Q.3 E	Q.3 F	Q.3 G	Q.4 A	Q.4 B	Q.4 C	Q.4 D	Q.5 Y	Q.5 N
ALAMEDA	93		X							X	X					X	X				X	
AMADOR	1		X								X	X	X	X							X	
CALAVERAS	2		X							X												X
CONTRA COSTA	38		X											X						X	X	
FRESNO	37		X							X							X					X
INYO	2		X							X										X		X
KERN	18		X							X										X		X
LASSEN	2	X		1				X												X	X	
LOS ANGELES COUNTY 1/	395	X		2	X		X	X									X				N/A	
LOS ANGELES CITY	138	X		4	X	X	X	X									X				N/A	
MARIN	16		X													X	X					X
NEVADA	5		X							X										X		X
ORANGE	61		X							X										X		X
PLACER	6		X							X												X
SACRAMENTO	44		X							X												X
SAN BENITO	3		X							X		X										
SAN BERNARDINO	44		X							X												X
SAN DIEGO COUNTY 1/	70		X								X		X	X		X	X				X	
SAN DIEGO CITY	21		X							X												X
SAN FRANCISCO	27		X							X	X									X		X
SAN LUIS OBISPO	9		X							X												X
SAN MATEO	26		X											X						X	X	
SANTA CLARA	66		X							X										X		X
SANTA CRUZ	18		X	1	X		X	X			X		X	X		X	X				X	
SISKIYOU	2		X										X	X				X				X
SOLANO	10		X							X											X	
SONOMA	19		X																			X
STANISLAUS	18		X							X	X									X		X
SUTTER	2		X							X										X		X
TULARE	11		X							X												X
VENTURA	17		X							X												X

1/ Number of facilities includes facilities in city

Summary does not include Mono and Trinity County surveys, since these counties have no ICFs or SNFs.

(Los Angeles County)

GUIDELINES FOR REFERRAL OF CASES FROM

DEPARTMENT OF HEALTH INVESTIGATORS TO LOCAL PROSECUTORS

1. AUTOMATIC REFERRAL TO LOCAL PROSECUTOR: Certain factual situations pose a substantial probability that a misdemeanor or felony violation has occurred. These factual situations require that "automatic referrals" be made to the prosecutorial office with jurisdiction over the offense:

(A) All citations for Class A violations, at the the time the citation is issued and prior to the hearing or arbitration, if any, on the citation;

(B) All citations for Class B violations which have gone uncorrected upon reinspection;

(C) All citations for Class B violations which have been corrected but which violations are subsequently repeated within a twelve month period;

(D) All situations in a skilled nursing facility in which either a licensed or an unlicensed person engages in acts against others which constitute crimes (e.g., assault, battery, theft, falsification of medical record with intent to defraud) other than those arising out of Title 22 of the California Administrative Code;

(E) All situations in which a licensed person's conduct at a nursing home is so offensive that field surveyors recommend that the appropriate licensed agency within the Department of Health receive information concerning the alleged misconduct of that licenseee;

(F) All situations in which a pre-hearing temporary suspension of license procedures are recommended or invoked by the Health Department;

(G) All situations in which there is a breach of a facility's fiduciary duty to its patients, including, but not limited to, the comingling of patient trust fund moneys;

(H) All situations in which a recommendation is made by any field surveyor or supervisor for license revocation or suspension or termination of any Medi-Cal or Medicare provider agreements; and

(I) All incident and injury reports in which there has been actual harm, whether or not the incident or injury reports reflect an intention to violate any regulatory section.

2. DISCRETIONARY REFERRAL TO LOCAL PROSECUTOR: Certain factual situations may pose a long term threat to the health and welfare of patients, but are not so serious as to warrant "automatic referral". These factual situations should be reviewed by the appropriate supervisorial personnel within the Department of Health and referred to the prosecutorial office with jurisdiction over the nursing facility when appropriate:

(A) All situations in which the field surveyor or supervisor considers the facility to be a "problem facility", even though such problem areas may not be accurately reflected in the citations issued to the facility;

(B) Repeated patterns or practices within an eighteen month period of violations of the regulations;

(C) All facilities which are called in for informal hearings on any subject matter relating to the conduct of the nursing home operation; and

(D) All willful or negligent violations of patients' rights.

APPENDIX V-G(1)

POSSIBLE WORKING FOR AMENDMENTS TO RECEIVERSHIP LAW
HEALTH & SAFETY CODE SECTIONS 1325-1335

See Chapter V, Section C, Finding 2, Recommendation 4

Sec. 1327: (when Department may petition for a receiver)

Whenever circumstances exist indicating that continued management of a long-term health care facility by the current licensee would present a substantial probability or imminent danger of serious physical harm or death to the patients, or there exists in the facility a condition in substantial violation of this chapter or the rules established under it, or the facility has shown a pattern or practice of habitual violation of this chapter or the rules established under it, or the facility is closing or intends to close and adequate arrangements for relocation of residents have not been made at least 30 days prior to closure, the director may petition . . . .

Sec. 1327: (who may petition for a receiver)

[T]he director, or any resident of the facility or a resident's representative, may petition . . . . If the action is not brought by the department, copies of the petition, affidavits, and order to show cause shall be served on the department, and the department shall be named the proposed receiver.

Sec. 1327: (who may act as receiver) (See Chapter V, Section C, Recommendation 4.)

Sec. 1329(a)(5)(D) (receiver's powers and duties) should be amended to refer to a new section which would state that:

(a) A receiver may not be required to honor any lease, mortgage, secured transaction or other wholly or partially executory contract entered into by the owners or operators of the facility if:

(i) The person seeking payment under the agreement was an operator or controlling person of the facility or was an affiliate of an operator or controlling person at the time the agreement was made; and

(ii) The rent, price or rate of interest required to be paid under the agreement was substantially in excess of a reasonable rent, price or rate of interest at the time the contract was entered into.

(b) If the receiver is in possession of real estate or goods subject to a lease, mortgage or security interest which the receiver is permitted to avoid under paragraph (a), and if the real estate or goods are necessary for the continued operation of the facility under this section, the receiver may apply to the court to set a reasonable rent, price or rate of interest to be paid by the receiver during the duration of the receivership. The court shall hold a hearing on the application within 15 days. The receiver shall send notice of the application to any known owners of the property involved at least 10 days prior to the hearing. Payment by the receiver of the amount determined by the court to be reasonable is a defense to any action against the receiver for payment or possession of the goods or real estate subject to the lease or mortgage involved by any person who received such notice, but the payment does not relieve the owner or operator of the facility of any liability for the difference between the amount paid by the receiver and the amount due under the original lease or mortgage involved.

Sec. 1331: (length of receivership) (See Chapter V, Section C, Recommendation 4.)

A new section should be added:
(On funding, See Chapter V, Section C, Recommendation 4.)

If funds collected are insufficient to meet the expenses of performing the powers and duties conferred on the receiver, or if there are insufficient funds on hand to meet those expenses, the department may draw from the supplemental fund created under [appropriations provision] to pay those expenses. The operator shall be liable for the deficiency, and payment recovered from the operator shall be used to reimburse the supplemental fund for amounts drawn by the receiver.

[adapted from Center for Public Representation model statute; ABA Commission model is in most cases similar. Models cited in Chapter V, endnote 22.]

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

313 NORTH FIGUEROA STREET • LOS ANGELES, CALIFORNIA 90012 • (213) 974-

May 5, 1981

To: Dr. Martin Finn
Deputy Director
Preventive/Public Health Services

From: Robert W. White
Director of Health Services

Subject: Release of Information by Health Facilties Division

The following guidelines are herewith approved relating to the release of information by the Health Facilities Division. This action follows the review and discussion of the matter by Ray Rieder, Fran Dowling, Ralph Lopez, Jack Bamberg, Tony Tripi, and Dr. Martin Finn.

Names of facilities and individuals may be released following:

1. Filing of criminal actions by the appropriate prosecutor, e.g., District Attorney, City Attorney.

2. Revocation actions by the Attorney General.

3. Issuance of temporary suspensions of license.

4. Issuance of an injunction.

5. Scheduling of an inquest.

6. State review of the issuance of a citation (pertains to nursing homes).

The Health Facilities Division may discuss information contained in the public files when a specific request is made concerning a specific facility. However, in the absence of this specification, the division may discuss in general terms the scope of actions underway without naming facilities.

If a referral has been made to a prosecuting agency or other appropriate agency (BMQA, etc.) but no public action has been taken by such agency, the identity of facilities and physicians should not be released. If it is necessary to discuss a case of this type, it should be done with the approval of the prosecuting agency.

RWW:hi

LOS ANGELES COUNTY
DEPARTMENT OF HEALTH SERVICES

Contact: Ralph Lopez
974-7700

FOR IMMEDIATE RELEASE

RECEIVED
1979
Health Facilities Div.

A $1,000 civil penalty has been paid by Convalescent Hospital, a nursing home, after being cited by the Department of Health Services Health Facilities Division.

Ralph Lopez, chief of the Health Facilities Division, said a county inspection team visited the nursing home at 3:30 a.m., April 27, and found three members of the nursing staff sleeping when they should have been on duty.

The nursing home, in paying the minimum civil penalty of $1,000 for a Class A citation, did not contest the citation.

The facility is located at #

5-11-79

Commission Author's Note: This is a sample. The name and address have been blanked out for purposes of this report only.

Ohio Medicaid Discrimination Statutes

§ 5111.31 [Agreement to prohibit certain discriminatory actions.]

(A) On and after July 1, 1983, every provider agreement with a home shall:

(1) Prohibit the home from failing or refusing to accept or retain as a patient any person because he is, becomes, or may, as a patient in the home, become a recipient of assistance under the medical assistance program. For the purposes of this division, a recipient of medical assistance who is a patient in a home shall be considered a patient in the home during any hospital stays totaling less than twenty-four days during any twelve-month period.

(2) Include any part of the home that meets standards for certification of compliance with federal and state laws and rules for participation in the medical assistance program;

(3) Prohibit the home from discriminating against any patient on the basis of race, color, sex, creed, or national origin.

(B) Nothing in this section shall bar any religious or denominational home that is operated, supervised, or controlled by a religious organization from giving preference to persons of the same religion or denomination. Nothing in this section shall bar any home from giving preference to persons with whom it has contracted to provide continuing care.

(C) Nothing in this section shall bar any county home organized under Chapter 5155. of the Revised Code from admitting residents exclusively from the county in which the county home is located.

(D) No home with which a provider agreement is in effect shall violate the provider contract obligations imposed under this section.

(E) Nothing in divisions (A) and (B) of this section shall bar any home from retaining patients who have resided in the home for not less than one year as private pay patients and who subsequently become recipients of assistance under the medicaid program, but refusing to accept as a patient any person who is or may, as a patient in the home, become a recipient of assistance under the medicaid program, if all of the following apply:

(1) The home does not refuse to retain any patient who has resided in the home for not less than one year as a private pay patient because he becomes a recipient of assistance under the medicaid program, except as necessary to comply with division (D)(2) of this section;

(2) The number of medicaid recipients retained under this division does not at any time exceed ten per cent of all the patients in the home;

(3) On July 1, 1980, all the patients in the home were private pay patients.

§ 5111.32 [Patient's cause of action against home for breach of provider agreement or other duties.]

Any patient has a cause of action against a home for breach of the provider agreement obligations or other duties imposed by section 5111.31 of the Revised Code. The action may be commenced by the patient, or on his behalf by his sponsor or a residents' rights advocate, as either is defined under section 3721.10 of the Revised Code, by the filing of a civil action in the court of common pleas of the county in which the home is located, or in the court of common pleas of Franklin county.

If the court finds that a breach of the provider agreement obligations imposed by section 5111.31 of the Revised Code has occurred, the court may enjoin the home from engaging in the practice, order such affirmative relief as may be necessary, and award to the patient and a person or public agency that brings an action on behalf of a patient actual damages, costs, and reasonable attorney's fees.

§ 5111.99 Penalty.

Whoever violates ~~division (B) of section~~ 5111.26 or division (D) of section 5111.31 of the Revised Code shall be fined not less than five hundred dollars nor more than one thousand dollars for the first offense and not less than one thousand dollars nor more than five thousand dollars for each subsequent offense. Fines paid under this section shall be deposited in the state treasury to the credit of the general revenue fund.

Ohio Medicaid Discrimination Statutes (continued)

§ 3721.16 **[Residents' rights concerning transfer or discharge; hearing.]**

Except in emergencies, the administrator shall notify residents at least thirty days in advance of any proposed transfer or discharge from the home and give them the reasons for the decision, unless the transfer or discharge is otherwise authorized by law or by rules of the department of health. Transfer or discharge actions shall be documented in the resident's medical record by the home if there is a medical basis for the action.

Except in an emergency, the resident or his sponsor may challenge a transfer or discharge by requesting an impartial hearing at the home, unless the transfer or discharge is required because:

(1) The home's license has been revoked under section 3721.03 of the Revised Code;

(2) The home is being closed pursuant to section 5155.31 of the Revised Code;

(3) The resident is a recipient of medical assistance and the home's certification has been terminated or denied under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended. The administrator shall notify the resident and his sponsor of the right to have an impartial hearing when he gives advance notice of the proposed action. The resident or sponsor may request a hearing within ten days after notification of the proposed action. A hearing shall be held within ten days by the department of health. A representative of the department shall preside over the hearing and issue an order within five days as to any advisable action to the administrator, the resident, and any interested sponsor. The home or alternative setting to which the resident is to be transferred shall have accepted the resident for transfer. An impartial hearing on resident transfer or discharge is not subject to section 121.22 of the Revised Code.

§ 3721.19 **[Notice of home's nonparticipation in state assistance program; action for violation.]**

A home licensed under this chapter that is not a party to a provider agreement, as defined in section 5111.20 of the Revised Code, shall provide each prospective resident, before admission, with the following information, orally and in a separate written notice on which is printed in a conspicuous manner: "this home is not a participant in the medical assistance program administered by the Ohio department of public welfare. Consequently, you may be discharged from this home if you are unable to pay for the services provided by this home."

If the prospective resident has a sponsor, as defined in section 3721.10 of the Revised Code, whose identity is made known to the home, the home shall also inform the sponsor, before admission of the resident, of the home's status relative to the medical assistance program. Written acknowledgement of the receipt of the information shall be provided by the resident and, if the prospective resident has a sponsor who has been identified to the home, by the sponsor. The written acknowledgement shall be made part of the resident's record by the home.

No home shall terminate its status as a provider under the medical assistance program unless it has, at least ninety days prior to such termination, provided written notice to the department of public welfare and residents of the home and their sponsors of such action. This requirement shall not apply in cases where the department of public welfare terminates a home's provider agreement or provider status.

A resident has a cause of action against a home for breach of any duty imposed by this section. The action may be commenced by the resident, or on his behalf by his sponsor or a resi-

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California
Association of
Health
Facilities

1401 21st Street
Suite 202
Sacramento
California 95814
(916) 444-7600

August 3, 1983

Lieutenant Governor Leo T. McCarthy, Chairman
The Nursing Home Study and Advisory Committee
1028 State Capitol
Sacramento, California 95814

Dear Lt. Governor McCarthy:

For the last eight months, we have actively participated in the meetings of the Nursing Home Study Advisory Committee (Advisory Committee) and its subcommittees. During that time, I believe we all came to a better understanding of the problems and issues we face in providing high quality care for the elderly in skilled nursing facilities.

To share ideas, discuss information and formulate recommendations with others who are vitally interested in nursing home care was beneficial, productive and enlightening. Each meeting of the Advisory Committee provided a forum for a frank and full airing of the various viewpoints on the issues raised at the Commission's October 1982 hearing. We commend the Commission for convening this Advisory Committee and authorizing this report.

We, as health care professionals, have recognized the need for consumers of our services and the local community to become more involved in our facilities. Our goal is to become a vital part of the community. Many of our facilities have been working very diligently to accomplish this. Toward that end, we have been meeting on a regular basis with consumer groups to discuss and resolve mutual problems. Moreover, we have pushed the development of resident councils, family councils, and community councils to better share issues and resolve problems. Obviously, we have a long road ahead, but we have started taking the steps for more involvement and interaction.

With this backdrop in mind, we are encouraged by a number of proposals made by the Commission and the Advisory Committee. We also have some major concerns. We would like to outline the areas we agree with, along with those where we still have problems.

We support the recommendations calling for more consumer/community input into the decisions made by the Licensing & Certification Division (LCD). If the community has the impression that we are "too close" to

Roberts Nelson, President | Robert Taylor, President Elect | Phillip Chase, Vice President-at-Large | Lee Bangerter, Secretary/Treasurer | David Metcalf, Immediate Past President | Bruce Yarwood, Executive Vice President

or control LCD, then we have a perception problem. Such a situation is not true. By opening up lines of communication to consumers and the community, LCD will be able to clarify our relationship to them, and also be in a position to "bring us together" on issues of mutual concern. The more we communicate with each other, the less likely we are to misunderstand or misinterpret each other.

As for the philosophy of LCD, we support the recommendation that LCD's role must emphasize enforcement. Government's role must be to enforce the laws and regulations. This does not mean, however, that consultation disappears. Consultation must remain a legitimate and important function of LCD. The expertise of LCD must be shared to help us become better providers of care.

Along with a coherent philosophy, LCD must develop a consistent approach to the survey process. It is very difficult for us to have different enforcement methods in parts of the state. To ensure greater consistency, more LCD resources must be spent on training. The report's recommendations on training and on developing a system of surveyor evaluation and accountability should be implemented expeditiously.

Other recommendations that we support include appeal rights for complainants, equal treatment for oral complaints, greater use of nurse practitioners, reimbursement for "distinct part" hospitals at a rate much closer to the average Medi-Cal rate for free standing nursing homes, and an increased emphasis on positive incentives to provide high quality care. Unfortunately, we believe that the report was not very creative in outlining possible positive incentives, and we hope that this subject will be addressed in greater detail at a future date.

Finally, we wholeheartedly support an examination of the reimbursement system by a Special Task Force. As the report clearly stated, a great deal of confusion and misinformation surrounds this issue. Everyone would be well served by a comprehendible, objective study of this issue.

Although there are many recommendations in the report which deserve immediate attention, we believe that some of the recommendations are unwise, unjustified and counterproductive. We would like to take this opportunity to set forth some of our concerns about these recommendations.

Most of our objections are to the enforcement recommendations. The philosophy is strictly based on having penalties and negative incentives. Why not try to develop positive incentives and rewards. Taken as a whole, the report generally recommends harsher penalties and stiffer fines. We oppose this simplistic approach to a complex, very human situation. All of us want to increase the quality of care in nursing homes; none more so than those of us who work in them on a day to day basis. Increasing penalties, however, will not achieve this.

We are adamantly opposed to increasing the fines for either A or B violations. As the Advisory Committee discussed, changing behavior, not raising revenue, is the main purpose of the citation system. As the

report indicates, the citation system, perhaps more through stigma than through financial impact, does motivate some improvements. From our experience, we believe that the stigma is far more important than the financial penalty. As we become more and more professional, the consequences of A and B citations will increase.

In addition, we believe that increasing fines could be counterproductive. The result may be that more resources (time, energy and money) from both facilities and the state will be spent in litigation. If fines are increased, enforcement may, in fact, become more difficult as hearing officers and those handling appeals, including judges, decide that the fines are too harsh, and significantly reduce them. Currently, we are faced with the perception that fines are reduced for a variety of reasons, but rarely because the reductions are justified on the basis of fact. If fines are consistently reduced on appeal because an unreasonable amount was imposed initially, then all of us lose - especially providers and LCD because the perception will be that undue influence was used to decrease the amount.

We believe a far better approach is to focus on repeat violators. Last year, we supported legislation (AB 2841) which would do this. We believe this legislation should be given a chance to operate. If it proves to be ineffective in changing the behavior of those facilities which have recurrent problems, then additional steps may be appropriate.

We oppose the use of Small Claims or Municipal Court to enforce citations. Because we recognize the need for speedier adjudication of citation allegations (facilities want their records cleared as soon as possible), we supported the arbitration provisions which were enacted into law last year (AB 2841). Before any movement is made toward involving Small Claims or Municipal Court in citation cases, we believe that the new arbitration process should be allowed to work and be tested for effectiveness and efficiency. In addition to being premature to involve Small Claims or Municipal Court in citation cases, it may be unwise. The overwhelming majority, if not all, of the cases heard in Small Claims Court will probably be appealed, thus causing the case to be heard twice, and obviously adding delay. Moreover, Municipal Courts already have clogged calendars, and adjudication will probably not be any speedier.

We are concerned about the recommendation advocating criminal sanctions against willful and serious repeat violators. We believe that criminal prosecution must be used only in the most egregious, clearly reprehensible cases. Given the devastating personal (to say nothing of the professional) stigma associated with criminal prosecution, such cases must be entered into with the utmost seriousness. Prosecutors must remember that their function is to enforce the law, and not publicly grandstand. To prevent any possible abuses through criminal prosecution, criminal conduct must be spelled out in detail. Administrators and owners must be fully aware of what is and is not criminal behavior. We do oppose a mandatory jail sentence for "certain willful or repeated acts or omissions."

We oppose raising the fines for willful and repeat violations to $10,000. By raising the fine to $10,000 per violation, the violation is given felony status. To penalize these violations as though a felony were committed is excessive and unreasonable. Moreover, oftentimes there are a number of counts involved in these cases. For example, if 25 counts were involved, which is not an unusual number, the fine could be $250,000. Such a penalty could clearly be confiscatory in nature and challenged on that ground.

Finally, federal experience has shown that raising fines does not result in increased prosecutions. Take, for example, the Medicare-Medicaid Anti-Fraud & Abuse legislation passed a few years ago. The law raised the fine to $25,000 for fraud and abuse of these programs. No increase in prosecution has occurred. If the federal experience is any indication of the effect of substantially raising the fine, the number of prosecutions does not increase. Thus, the desired result is not achieved. Raising the fines to $10,000 would be excessively punitive, confiscatory in nature, and undoubtedly ineffective in increasing prosecutions.

We believe it is inappropriate to increase the civil penalty for retaliation against complainants and to make retaliation a misdemeanor. Our opposition stems from the fact that we see no justification for raising the fine or imposing a misdemeanor sentence. If a facility does engage in retaliation, we believe the $500 fine is more than sufficient. At the same time, we understand that the fear of retaliation is widespread, and often inhibits complainants. Increasing fines will not solve the problem. Greater community involvement in facilities, coupled with active resident councils and family councils is a better approach.

Last year, we supported the legislation to allow a facility to go into receivership. This law provides LCD with sufficient resources to impose a receivership when needed. We see no reason to change its provisions.

In addition to our opposition to the enforcement recommendations, we have problems with other recommendations. Briefly, we would like to state our objections to them.

While we understand the community's concern about the predictability of surveys, we are unsure as to the benefits of a segmented survey. Before LCD initiates a segmented survey of any kind, there must be a careful examination of the cost in staff resources and the impact on facility operation. Once again, this approach seems to us negative and does not create a positive incentive.

While we understand the Commission's position on having every facility each year go through a "screening inspection", we disagree with that recommendation. We do not think it rewards good facilities as much as they deserve. For a number of years, we have supported the two-year survey cycle for those facilities which have a good record. Facilities should receive positive incentives for providing high quality care. At the current time, there are enough checks and balances in the field to

ensure that a facility will not go two years without an inspection unless it is providing good quality care. Included in this system is, of course, the ombudsman program, concerned community groups, family and residents councils, LCD's complaint process, and any consumer information network set up as a result of the recommendations of this report. If a facility is doing a good job, why not survey it less then those who have problems. It would help to free up the limited resources of LCD so that they can focus on problem facilities.

We agree with the recommendation that consumers need more information about nursing homes, however, we oppose any rating system. Nursing homes are complex, health care facilities. To rate them on an A, B, C scale would be impossible and misleading. Moreover, facilities which are working hard to improve the care they provide, may be unjustly labeled at a particular rating level, when, in fact, conditions in the facility have improved. We believe a better approach would be to combine the Los Angeles County's information system with information on how to select a nursing home.

We are concerned about why the Commission is dealing with occupancy standards and on what basis a recommendation is made to lower the Certificate of Need occupancy standards from the 95% level. Lowering the occupancy rate for LTC beds could cause the same overbedding that the hospital industy faces. Overbedding in nursing homes, which are reimbursed on a flat rate, only results in reduced quality of care. Moreover overbedding could result in less money being spent for alternatives which are generally recognized to be greatly needed services and not without substantial cost. In some areas of the state, occupancy levels are already lowering. Given this market perspective, to decrease the 95% is not wise public policy.

We understand the Commission's concern over the involuntary transfer of residents when they deplete their private funds. From our experience, we do not believe that this is a common practice. Administrators and owners are concerned about providing a level of good care. In order to do this, money is an important, but certainly not the only, factor. If a facility provides a certain level of care based on it's private pay/Medi-Cal ratio, then that level could be jeopardized if the number of Medi-Cal recipients were to increase. Those already in the facility may then experience a decrease in their level of care because of inadequate funding. This is unfair to the current residents.

For this reason, we believe that facilities should be allowed to require in their contracts of admission that residents will remain as private pay for a certain period of time. After that time has passed, any involuntary transfer of a resident, unless it is medically justified, should be prohibited.

Page Six

We want to thank the Commission and the Advisory Committee for allowing us an opportunity to clarify our positions. We commend the Commission and it's staff for their willingness in incorporating our arguments into the Commission's report and it's recommendations. We look forward to working with you and the Commission in the future to improve the quality of life for those we all serve-the elderly residents in nursing homes.

Sincerely,

Roberts Nelson
President

ACKNOWLEDGEMENTS

This report could not have been written without the aid of many people. First among them is the co-author of the report, Elisabeth Wadleigh--she brought the invaluable combination of legal skills, a commitment to unravel complexity, and a genuine passion for fairness and improved care to this study.

In the course of preparing the report a number of people made important contributions. Maureen Connor assisted in gathering and organizing mountains of research data. Marilyn Saunders, M.P.H., assisted in the writing of Chapter VI, and made important organizing and editing contributions to the full report.

Margaret Gerould of the California Health Facilities Commission provided assistance with much of the quantitative data about long-term care facilities that appears here.

Under great time pressure and with real skill Deborah Messersmith and Peter Fisher prepared the multiple drafts of the report on the word processor.

Diana Cook of the Licensing and Certification Division responded to literally fifty or more different requests from us for information.

The Advisory Committee for this report, Chaired by Lieutenant Governor Leo McCarthy, was extremely helpful both in our meetings and in the written materials that they completed for us.

Finally, the Executive Director of the Little Hoover Commission, Richard Mahan, effectively provided insight and support to these efforts in many ways.

The senior author is finally responsible for the contents of this report.