

## EXECUTIVE SUMMARY

### CHAPTER ONE

#### Introduction

In August, 1983, The Little Hoover Commission released a comprehensive analysis of institutional long-term care in the state. That report, entitled THE BUREAUCRACY OF CARE, led to a process of legislative and regulatory recommendations. These reforms, collectively entitled "The Nursing Home Patients Protection Act" (NHPPA), became law in March, 1985.

A substantial number of the recommendations made in THE BUREAUCRACY OF CARE resulted in modifications of the existing regulatory procedures by the agency most directly concerned with the oversight of all nursing homes in the State, the Licensing and Certification Division (LCD) of the Department of Health Services (DHS). The 1985 NHPPA reforms also had a series of less well-defined effects on the operators of the almost 1,200 nursing homes in the State and on the welfare and well-being of the more than 105,000 residents for whom these facilities are probably their last home.

The overall goal of the NHPPA legislation was to put in place a series of reforms which would result in improvement in the quality of care given in California nursing homes. These improvements, it was hoped, would take place both in the efforts of those charged with nursing home monitoring and oversight, namely LCD in DHS, and would also be reflected in the practices undertaken by the nursing home industry collectively and in individual facilities.

This Report makes the explicit assumption that significant legislative and regulatory progress was made with the enactment of the various provisions of the 1985 NHPPA. However, a number of disparate tasks associated with improving the quality of life and quality of care in nursing homes were not resolved with the passage of the NHPPA legislation in March of 1985.

### CHAPTER TWO

#### Goals of this Study

The tasks associated with improving quality of life and quality of care in nursing homes were not completely resolved by the passage of NHPPA. Impediments to continued progress toward the overall goal of providing a system of excellent long-term care remain.

The overall goal of this study is to provide findings and make recommendations to enhance the quality of care and the quality of life in California nursing homes. In addition, this Report will

aid policy-makers in determining how these overall objectives are being reached---or thwarted.

The Commission undertakes this 1986-1987 reassessment of nursing home care and regulation with these goals:

1. To assess the central components of the NHPPA legislation to see if and how they are being implemented.

2. To assess professional and public perceptions of quality of life and quality of care being provided to nursing home residents.

3. To assess some problem areas unattended to, or problem areas unintentionally created by the 1985 NHPPA legislation. In addition, there are important new issues that have arisen in the fast-changing health environment that bear a direct relationship to nursing home regulation and care.

### CHAPTER THREE

#### Sources of Information and Methods of Study

This Report relies upon three forms of information: (i) quantitative data as have been made available to the Commission, often from LCD; (ii) the expertise of the Commission's Nursing Home Advisory Committee; and, (iii) the solicitation of information from other key actors in the service and regulatory system, including consumers and consumer representatives.

### CHAPTER FOUR

#### The Department of Health Services Monitoring and Enforcement Process: Citations Assessed

##### Background

The number of citations and the total assessed fines issued to California nursing homes has increased substantially since the passage of NHPPA in March of 1985.

The following Table summarizes citation activity by type, year, and assessment for the period 1983-1986:

### Citations Issued

| Year | #    | "AA"<br>Assessed | #   | "A"<br>Assessed | #     | "B"<br>Assessed |
|------|------|------------------|-----|-----------------|-------|-----------------|
| 1983 | N.A. |                  | 190 | \$1,077,500     | 967   | \$200,025       |
| 1984 | N.A. |                  | 197 | \$1,108,000     | 1,074 | \$307,150       |
| 1985 | 32   | \$777,000        | 318 | \$3,162,580     | 1,612 | \$1,380,040     |
| 1986 | 47   | \$819,550        | 366 | \$2,800,000     | 1,430 | \$1,100,000     |

Source: LCD, February, 1987

The total number of all citations issued for 1983 was 1,157 (with total assessed fines of \$1.36 million); for 1984, 1,271 citations were issued (with total assessed fines of \$1.41 million); and in 1985, 1,962 citations were issued (with total assessed fines dramatically increasing to \$5.31 million). In 1986, a total of 1,843 citations were issued; they were assessed at \$4.7 million.

While the number of violations issued increased for both "AA" and "A" citations, it decreased for "B" citations from 1985 to 1986. Total assessments also decreased from \$5.3 million to 4.7 million, an 11% decline in total assessments from 1985. Even with this decline in total assessments, the 1986 total assessments of \$4.7 million are still significantly higher than the pre-NHPPA 1984 total of \$1.4 million.

Industry data indicate that complaints concerning conditions in nursing homes do matter: 41% of the citations and violations issued in the first nine months of 1986 were based upon information supplied by persons complaining about nursing home conditions.

### Findings

4-1. The current administration of DHS and LCD has striven for the implementation of a more effective enforcement policy. This has led to an increase in citation activity (although there have been substantial decreases in the average assessment of violations from 1985 to 1986). Conditions in long-term care in California require on-going regulation and monitoring.

4-2. In 1983 and 1984, 69% of facilities received no citations. In 1985, 60% of nursing homes received no citations. Put differently, 40% of the almost 1,200 facilities in the State (or 480 facilities) did receive some form of citation in 1985. These figures remained essentially the same for 1986.

4-3. Some 11% of facilities account for a fully 40% of the citations issued. These figures lend some credence to the belief that there may be a "core" of facilities which are particularly troublesome.

## Recommendations

4-1. LCD should continue its good faith efforts at fair enforcement practices. These practices should not be deterred.

4-2. Reporting of LCD numbers of citations issued, total fines assessed, and average fines assessed should be undertaken on an annual basis by LCD in order to monitor the enforcement activities of LCD.

4-3. Mechanisms for the effective and timely handling of the increasing number of complaints received by LCD is an integral part of the enforcement process. Such mechanisms should include timely notification to the complainants of the status of their complaint, and the type of action taken or planned.

4-4. LCD should examine citation statistics annually in order to identify which facilities receive a disproportionate number of citations. These "core" facilities should be carefully monitored.

4-5. The listing of "core" facilities should be kept current and should be shared with the community-of-interest, including the Ombudsman Program at the State and sub-State level, the trade association, and other local and State agencies and consumer groups.

## CHAPTER FIVE

### The Enforcement Process: Collected Fines, Uncollected Fines, And Uncollectable Fines

#### Background

The enforcement activities of the Licensing and Certification Division (LCD) of DHS have changed since the passage of NHPPA. If enforcement is measured by the number of citations given, and the amount of assessments associated with these citations, clearly there was an increase in 1985. While overall citation activity decreased very slightly in 1986 (from 1,962 to 1,910, a 3% decline), it remained far above the pre-NHPPA levels of 1984 and prior years. In 1985 total citation assessments were \$5.31 million, in 1986 they were \$5.10 million, an assessment decline of 4%.

While the number of citations issued has risen in the past two years, and the amount of fines assessed has also significantly increased, the amount of monies actually collected from citation assessments is quite low and it appears to be dropping. While there are a series of complicated reasons for this situation,

nonetheless the relationship between fines assessed and fines collected poses a major threat to the enforcement process and thus to the nursing home reform efforts of NHPPA.

Assessments and Collections, 1983-1986

| Year | Assessed    | Collected | %Collected<br>(this year) | %Collected<br>(year prior) |
|------|-------------|-----------|---------------------------|----------------------------|
| 1983 | \$1,365,525 | \$476,344 | 34.8                      | N.A.                       |
| 1984 | \$1,414,150 | \$335,850 | 23.7                      | 24.5                       |
| 1985 | \$5,319,890 | \$449,635 | 8.4                       | 31.1                       |
| 1986 | \$5,101,550 | \$631,185 | 12.3                      | 11.8                       |

Source: LCD, February, 1987.

These figures indicate that the amount of fines assessed has increased 373% from 1983 to 1986. However, the amount of fines collected increased only 25% in this period of time. Furthermore, the slow growth in the amount of fines collected yearly means that, relative to the amount of fines being assessed, the percentage of fines collected has declined to 11.8% in 1986. Only 8.4% (\$449,635) of the \$5,319,890 total assessed in penalties in 1985 has been collected to date.

There is another way to view these figures: of the \$5.3 million assessed in 1985, fully \$2.1 million is not collectable under current law. Thus, \$3.2 million was collectable. LCD collected \$1.1 million (through penalties received in settlements, minimum penalties paid, full penalties paid, or through Medi-Cal offsets). Using these figures, the 1985 collection rate is 34%. Both the 8.4% and the 34% rate are accurate 1985 collection rates. Either figure, if used alone, reveals only a part of the complex relationship between assessments and collections.

If citation activity increases and collection of assessments is only a small fraction of the original amount assessed, this can seriously imperil the entire enforcement effort and render it a procedural nightmare for those who have labored to see that nursing home enforcement and oversight activities are fairly and aggressively pursued.

While collection figures are influenced by waivers and adjudication time, nonetheless, if we look at the collections in 1986 for what are presumed to include some number of 1985 assessments, the percentage collected ranges from 11.8% to 12.3%. Moreover, as of early in 1987, more than 88% of the fines assessed in the first year of NHPPA (1985) have not been collected. In NHPPA's second year, 1986, the fine collection rate was only 11.8% for fines assessed in the first NHPPA year (1985), and only 12.3% for the 1986 year itself. The LCD predictions that 1986 would see

significantly increased collections, based upon collections of 1985 assessments in 1986, did not materialize. Whether 1987 brings increased collections of 1985 and some 1986 assessments remains to be seen. Barring changes in existing procedures, there is little reason to be optimistic.

In 1982 the Auditor General recommended against the practice of removing assessments for all corrected first "B" citations. The California nursing home industry opposes such a proposal. Given that these "B" citations amount to one-fifth of the total assessments levied in 1986, and that, if corrected and not repeated, none of them will have a fine associated with them, it is easy to see why the industry would prefer the status quo in this regard. Under current law, over \$1.1 million in fines assessed for "B" citations in 1985 are not subject to collection.

### Findings

5-1. The integrity of the LCD enforcement effort is greatly impaired by the very low rate of citation assessments actually collected. The collection of between 11.8% and 12.3% of the fines assessed in 1986 is unacceptable public policy; it can reduce the entire enforcement process to largely empty efforts.

5-2. The largest group of assessments made in 1985 (39%) are listed as "pending adjudication." These citations and cases represent \$2.07 million in assessments. The slowness of the collection process is clearly related to increased appeal and litigation activity that is taking place by facilities in response to the increased enforcement effort.

5-3. The second largest group of 1985 citations is the \$1.1 million in assessments, for first-time "B" citations: this represents 20.8% of the year's total assessments. At the present time these citations have little or no deterrent value, and they are not subject to fines if compliance is assured through submission of a plan of correction to LCD and if not repeated within one year. In 1982 was a recommendation by the Auditor General that "B" citations become subject to assessment.

### Recommendations

5-1. LCD and the Office of the AG should assure that the citation assessment collection rate improves significantly. The alternative to this would be a continuation of litigation delays and a collection rate which leaves at least 66% of collectable assessments uncollected. Neither of these situations is acceptable.

5-2. Legislation should be enacted whereby assessment would not be waived for those first-time "B" citations issued in the areas of patient care, nursing services, medications, and patient's rights.

## CHAPTER SIX

### The Department of Health Services Enforcement Process: The Enhanced Enforcement Effort (EEE)

#### Background

In May of 1985 DHS instituted a program calling for surprise inspections often based upon complaint histories of facilities which were believed to be particularly deficient in rendering care. This program is called the Enhanced Enforcement Effort (EEE).

From May of 1985 until the end of that year, LCD conducted 27 EEE reviews. In 1986 the number of EEE reviews declined to 16. The 1986 figures represent a 41% decline in the number of EEE surveys undertaken in 1985. It is also important to note that EEE surveys were initiated in May, 1985, and thus the 1985 EEE surveys do not represent a full year.

These data reveal that while the number of "AA" and "B" citations given during EEE surveys fell from 1985 to 1986, and while there was a small increase in "B" citations, the major results of the 1986 EEE effort was in the areas of Willful and Material Omission (WMO) or Willful and Material Falsification (WMF) of records, where there was a ten-fold increase in the number of violations issued.

The nursing home industry has expressed displeasure at the EEE undertaking. They believe that there are inadequate criteria developed for which facilities LCD selects for an EEE survey.

#### Findings

6-1. LCD has done well in initiating and utilizing the funds for the EEE undertaking. It has aggressively surveyed facilities where complaint histories, or particularly outstanding events, have led LCD to believe that a pattern of poor care may exist.

6-2. The LCD EEE undertaking appeared to shift focus somewhat in 1986, at least in terms of citations issued and violations assessed. The number of EEE surveys decreased 40%; however total EEE assessments increased 15%.

6-3. LCD has inadequate resources to conduct the needed number of EEE inspections. LCD estimates that 5% of the State's nursing homes should receive EEE inspections each year. LCD presently is able to conduct some 24 EEE inspections, or less than 2% of the State's nursing homes.

### Recommendations

6-1. The case-by-case rationales used by LCD in selecting facilities for EEE surveys need not be made more specific, and should not be elaborated in the form of specific criteria. LCD should be judicious in its choice of EEE sites, but should not be required to produce specific guidelines for EEE surveys.

6-2. While the EEE undertaking is presently less than two years old, there has already been a shift in the type of violations and assessments that are coming from such efforts. LCD should continue to be prepared to undertake EEE surveys where there is substantial likelihood of finding evidence of threats to the health, safety, or well-being of residents that would typically result in the issuance of "A" or "AA" citations.

6-3. LCD should receive additional resources so that EEE inspections can be conducted in 5% of the State's nursing homes annually.

## CHAPTER SEVEN

### Litigation Delays: Justice Delayed Is Justice Denied

#### Background

The oversight and enforcement process for long-term care facilities in California resides both in the DHS and in the office of the Attorney General (AG). If there is to be a comprehensive program of both timely monitoring with initial action on citations and their assessments (undertaken, in large measure, by LCD) and a timely program with action taken on contested and major citations and assessments (undertaken, in large measure, by the AG's office), it is clear that cooperation between these two offices is not only useful, it is mandatory.

The significant increase in enforcement activities at LCD has resulted in a situation where the single largest percentage of collectable assessments for 1985 is the category called "awaiting adjudication." This phrase means that these citations and their assessments have either been sent to the AG's office, or filed in court by the AG, and that no resolution has yet been reached. At the present time, the resolution of these cases

## enforcement process.

Given the fact that the broad majority of these citations are issued for violations of patients' health, safety, or rights, it is all the more important that they be acted upon in a timely fashion by all parties concerned. If this does not take place it would seriously diminish the enforcement effort.

## Findings

7-1. As a consequence of NHPPA and LCD's EEE program, the overall level of litigation activity undertaken by the AG with regard to nursing home matters has increased dramatically.

7-2. The costs of the overall nursing home enforcement effort are substantial and growing for the State, specifically for DHS/LCD which provides a significant allocation of funds to the AG's office for legal staff to undertake the AG's citation enforcement and collection efforts. For Fiscal Years 1984-1985 through 1986-1987, DHS/LCD has provided the AG's office with \$1.34 million for this purpose. The proposed DHS/LCD allocation for the coming Fiscal Year is \$762,702, an increase of 61% over the 1986-1987 allocation.

7-3. The costs of litigation to individual facilities is also growing, as more and more legal action is taken by them to appeal or contest citations and assessments. This total cost is not known. The cost of legal services, however, is an "allowable cost of doing business" for those facilities holding Medi-Cal certification (93% of the facilities in the State), and thus this cost will be a part of the overall increase in yearly costs that are included in the Medi-Cal cost reports of facilities which are used to calculate the Medi-Cal reimbursement rate.

7-4. Information and data sharing between LCD and the AG does not take place in a coordinated fashion, especially with regard to the preparation and movement of citations from LCD to the AG.

7-5. Basically "B" citations are "lost." If, after five years, the facility has taken not moved a case forward, the citation remains and the assessment, if any, stands. This five year period will not arise for those "B" citations that were issued and contested in 1985 until 1990. The AG does not have the resources to pursue these cases on its own and, as a matter of policy, has had to give virtually all "B" citations last priority.

## Recommendations

7-1. The funds DHS/LCD are expending for the legal services of the AG's office clearly did not anticipate the growth in litigation that has taken place as a consequence of NHPPA. A joint DHS-AG Task Force should be formed immediately to undertake an accounting of the costs of the enforcement effort, both for LCD and for the AG. The 61% increase in resources that LCD plans to expend with the AG's office in Fiscal Year 1987-1988 may be inadequate. To the extent the AG's office is understaffed the enforcement effort is seriously undermined.

7-2. The cost of legal services associated with facilities seeking counsel for efforts to appeal citations or their assessments should be a line-item on the Medi-Cal cost reports. Regulatory changes should be enacted so that court costs, including attorney fees, of nursing home litigation are paid for by the prevailing party. In those cases where the facility does not prevail in court, payment of court costs should not be an allowable Medi-Cal expense, but should come from facility profit or surplus.

7-3. The new management information system of LCD, ACLAIMS, should immediately be interfaced with the AG's office and a system devised so that the status of a citation should always be known, regardless of whether it is in LCD or has gone to the AG.

7-4. The five-year period of time that facilities presently have to bring contested "B" citations to trial serves only to delay the enforcement process which makes cases grow "stale" and keeps too many contested citations in an unresolved status. Legislation should be enacted which reduces the period of time that a facility has to file a memo to set bring the case to trial from its present five-year limit to a period within 6 months that DHS/LCD and the AG have responded to a facility's summons.

7-5. The AG's office should add to the ACLAIMS system all serious violations and enforcement activities (including, but not limited to, "A" citations and license revocation proceedings) which are pending in the AG's office. A complete picture of all pending actions must be available to the AG, LCD, and interested other parties, including, of course, those who brought or are a party to the circumstances described in the case or complaint.

7-6. The AG's office has not received some citations from LCD in a timely manner. On occasion CRC decisions are not issued until a year or more has passed from the date the citation was issued. Regulations should be changed to require LCD to fully prepare all "AA" and "A" citation cases for the AG within 45 days of the issuance of the citation or 45 days after the issuance of the CRC decision on the citation. Every effort must be made to expedite the issuance of CRC decisions as well.

7-7. A joint AG-LCD Task Force should be convened with the intent of assigning priority to cases in order that they be handled expeditiously.

7-8. Representatives of the LCD staff who prepare cases for the AG should be coordinated with more closely by representatives of the AG's office.

7-9. "B" citations which are appealed to CRC should be conducted as an administrative hearing where conclusions of law and findings of fact are made by an LCD Independent Hearing Officer. A facility may only overturn a CRC decision by filing a writ of mandate in Superior Court.

## CHAPTER EIGHT

### Receivership: An "Intermediate Sanction" In Need of Changes

#### Background

Currently, there is a shortage of beds in California long-term care facilities. This fact, plus the known transfer trauma that accompanies moving residents out of a facility, makes the state reluctant to completely close facilities. Various ways have been devised that would take a facility that is in serious trouble, as measured by performance and citation history, and keep it open, while placing it under exceptionally careful monitoring in order that immediate rectification of problems can commence. Among the ways in which these actions, collectively called "intermediate sanctions," can be undertaken is by DHS/LCD requesting and the court ordering that a facility be placed in receivership. Such a court action involves the appointing of a receiver whose task it is to undertake needed changes in operating the facility so that the quality of care is immediately improved and thus few, if any, residents need to be moved.

Receivership has only been used once to date, at a facility in Morro Bay. The Morro Bay experience, it seems safe to say, pleased neither the nursing home industry nor the various consumer groups nor LCD. The present procedure is fundamentally flawed and in need of changes before it can be used more effectively.

#### Findings

8-1. The single case of the use of the receivership provision of the law did not work in a timely or effective manner.

8-2. Based on a single experience, the nursing home industry resists significant changes in the manner in which the receivership process is implemented.

8-3. LCD and consumer groups believe that receivership is a viable enforcement tool, can yield an effective and fair "intermediate sanction," and is in need of modification in order for this to take place in a more timely and satisfactory manner.

### Recommendations

8-1. Legislation should be enacted to make receivership a more viable enforcement tool. The legislation should include provisions for: requiring the state to establish minimum qualifications for a receiver; requiring LCD to maintain a list of qualified receivers; requiring that the powers and duties of the receiver be more clearly delineated under law; requiring that patients or guardians be permitted to petition for receivership, seeking an ex parte order if need be; a current owner or operator may be continued; and, the powers and duties of the receiver should include the requirement that the receiver engage in sound business practices.

8-2. Notwithstanding recommendation #1 above, DHS/LCD should convene a Receivership Planning Group to examine the ways in which receivership might be better implemented.

## CHAPTER NINE

### Theft And Loss of Possessions In Nursing Homes---And of Dignity And Autonomy As Well

#### Background

No one knows just how much theft takes place in long-term care facilities; no one knows just how much is lost either; and, finally, no one knows how much of what is "lost" is in fact stolen, or how much of what is alleged to be the result of a theft is in fact a "loss." What is known is that the number of complaints about "missing" articles belonging to residents of nursing homes continues to rise.

Often what "disappears" are the very items which may provide a nursing home resident with some small amount of individuality: clothing (especially if it is new), rings, and vital convenience items such as radios and televisions, even if the latter are chained down. In addition, glasses, dentures, hearing aids, and

other valuable health-related prosthetic devices are among the items most often described as either "lost" or stolen.

Neither loss nor theft should be "expected" or tolerated by anyone---not LCD, not facility management, not families and loved ones, and certainly not by the residents themselves. However, this tragic problem continues in some facilities and the theft and loss of belongings continues to cause frustration, sadness and anger in the lives of all who are concerned with long-term care: the State, ombudsmen, professional providers, families and loved ones, and, of course, the victims themselves, who often lose not only vital possessions, but also what little remaining dignity they may be attempting to preserve.

### Findings

9-1. The Director of LCD spoke for virtually all members of the Advisory Committee when he said "There seems to be consensus by residents, enforcement officials and the industry itself that theft and loss is a prevalent problem; that it is a source of much trauma and upset to nursing home residents, and that all of us involved in nursing home care must deal more aggressively to prevent theft and loss of personal possessions."

9-2. There is presently little in regulation or legislation which deals with this issue in all its complexity. There are two existing regulations in this area. These regulations have not often been used by LCD in their enforcement efforts. Mr. Toney, in his testimony at the public hearing, said that this will change: "...in order to reinforce the requirement for facilities to allow patients to retain possessions, and to make reasonable efforts to safeguard such items, we will put facilities on notice that we plan to emphasize enforcement in the area of theft and loss in the coming year."

### Recommendations

9-1. Nursing homes need to work actively and cooperatively with LCD, local law enforcement agencies, and concerned consumer groups to develop loss and theft prevention activities and programs. A policy for replacing lost or stolen articles should be implemented.

9-2. The Commission supports Mr. Toney's decision to form a representative Task Force as an important first step to better define what the "reasonable" efforts are that facilities must take to protect patients' belongings. The Commission is in accord with Mr. Toney's decision "not... to specify for facilities what

actions they must take to demonstrate reasonableness," but rather to "provide guidelines for facilities as well as for [LCD] staff."

9-3. Facilities should undertake the following activities in developing their theft and loss programs: (a) maintain accurate inventories of patients' personal property, making certain that the inventory is verified at regular intervals (and also at times of higher incidence of theft and loss, e.g., holidays and birthdays), (b) utilize marking or engraving devices which identify patient belongings especially including, but not limited to, glasses, teeth, hearing aids, jewelry, and major convenience items such as TV sets and radios, (c) establish facility policies and procedures on theft and holding staff inservice training concerning these policies to show that theft is a serious problem and will be treated seriously by the facility, (d) actively involve residents and families through both patient and family councils to enhance awareness of facility policies and ways in which residents and families can be of assistance, (e) keep a theft and loss log (which should be open to the public) and complete a missing item report within 48 hours of a report of a theft or loss where the replacement cost is \$25 or more. Copies of this report are to be given or sent to LCD and to the resident and/or family promptly, preferably in a form which also advises the resident of his or her legal remedies if they believe a theft has been committed, (f) report all thefts where the replacement value is \$100 or more to local law enforcement and actively solicit their cooperation in treating these incidents as worthy of their assistance and attention, and (g) purchase theft and loss insurance for residents' belongings if available and affordable.

Sanctions should be instituted for licensees who knowingly retain an employee who has been convicted of stealing. Failure to report loss or theft should be grounds for issuance of an appropriate citation for each instance of failure to report.

9-4. Absent the development of "reasonable efforts" by a facility to prevent theft, "B" citations should be issued for each instance of theft and negligent loss. "Paper compliance" which provides a pro forma minimal theft and loss program will not serve to exempt a facility from the appropriate citation.

9-5. Items which have been lost or stolen should be either replaced or reimbursed by the facility, either through their theft and loss insurance or by the facility directly if that theft or loss, with reasonable precautions, could and should have been prevented. If it is determined that the facility did not have an adequate theft and loss program in place, replacement costs should not be an allowable Medi-Cal expense.

9-6. We concur with the recommendation developed by the AG's Bureau of Medi-Cal Fraud (BMCF) Advisory Council on Nursing Home Abuse and Neglect that no facility may knowingly hire or retain any employee who has been convicted of a crime of theft within a period of five years preceeding his or her date of hire.

9-7. All prosthetic devices vital to everyday health and functioning (such as glasses, dentures, and hearing aids) should be replaced in a timely manner by the facility regardless of whether they have been "lost" or "stolen." The Commission believes that Medi-Cal should reimburse the facility when it has purchased these vital replacement items for its residents. Existing Medi-Cal regulations regarding such replacements should be amended to permit reimbursement of facilities for these devices in these cases.

## CHAPTER TEN

### The Attorney General's Bureau of Medi-Cal Fraud Advisory Council's Report on Nursing Home Abuse and Neglect

#### Background

This chapter addresses a number of issues concerning long-term care services and regulation that fall within the purview of the Bureau of Medi-Cal Fraud (BMCF) of the Attorney General's (AG's) office. The BMCF has jurisdiction under federal law to receive complaints of patient abuse and neglect in nursing homes.

When the Commission's Nursing Home Advisory Committee was reconvened for purposes of this Study, a number of issues arose in their discussions which are, in part, within the purview of the AG's BMCF. These issues included relationships with local law enforcement agencies in regard to long-term care; training of local District Attorneys, as well as local police and sheriffs departments; devising ways in which BMCF could work more closely with the Department of Aging, and specifically the Ombudsman Program, as well as work more closely with DHS, specifically with LCD in regard to nursing home oversight and enforcement.

#### Findings

10-1. The Commission believes the cooperation suggested in the BMCF Report between its offices and DHS/LCD, Social Services, and, when appropriate, local law enforcement agencies can significantly enhance the overall enforcement effort. The BMCF's commitment of increasing cooperation with DHS/LCD in regard to patient abuse and neglect, employee training, the problems associated with theft and loss, and consideration of employee background checks are each worthy endeavors which may, in the aggregate, have positive impacts on the enforcement system.

10-2. The proprietary nursing home industry is not in support of finger-printing nursing home employees. This procedure has the strong endorsement of law enforcement agencies throughout the

State. Such a requirement already is law for Community Care Facilities which are administered by the Department of Social Services.

### Recommendations

10-1. The BMCF Advisory Council Report should serve as the major agenda item for a joint BMCF/LCD Task Force to examine ways in which further cooperation between these two agencies may be developed and continued.

10-2. LCD should not be omitted from any of the reporting requirements in those matters addressed by BMCF Council. LCD is, and should remain, the agency with primary responsibility for monitoring patient care.

10-3. Legislation should be enacted which requires the fingerprinting of all current and all future nursing home employees who provide direct patient care services.

10-4. The BMCF data system should be linked to LCD's ACLAIMS system in order that both agencies may provide and retrieve information in a timely fashion. BMCF investigation status reports should also be part of the ACLAIMS system, and such information should be made available to inquiring consumers.

10-5. The Commission supports legislation which would formally give BMCF authority to aid and assist in the oversight and enforcement activities concerning nursing homes and their residents.

## CHAPTER ELEVEN

### Voluntary Medi-Cal Decertification: Legalized Evictions

#### Background

The NHPPA legislation made illegal the forced removal of nursing home residents from a facility when they "spend down" their private funds and "convert" to Medi-Cal. That legislation, it was thought, would stop a particularly insidious form of discrimination against frail elder nursing home residents which forced their removal, and often traumatic relocation, from the facility that they have regarded as their "home" solely because they had exhausted their own resources and had become eligible for support from Medi-Cal.

This Commission, and the NHPPA legislation, did not anticipate that there would remain a presently-legal way in which wholesale removals of Medi-Cal residents from certain facilities could continue unabated. This procedure, called voluntary decertification, is relatively easy to accomplish at present: if a facility chooses to stop participating ("voluntarily de-certify") in the Medi-Cal program, it must notify DHS/LCD of its intent, and then, shortly thereafter, may remove all of its Medi-Cal residents, since the facility will no longer receive Medi-Cal reimbursement for those residents once it decertifies.

At the February, 1987 Public Hearing, the Commission's Chairman expressed the belief that actions such as this were an example of the "sheer greed" of the nursing home industry. The Chairman of the Commission's Nursing Home Advisory Committee, Lieutenant Governor Leo McCarthy, expressed the view that such actions amount to what he called wholesale patient "dumping."

LCD reviewed the voluntary decertification actions taken in the three year-period 1984-1986 and found that 26 facilities had voluntarily decertified. The total bed capacity of these 26 facilities is 1,885. Based on facility Medi-Cal census data gathered by LCD, it was determined that there were approximately 544 Medi-Cal patients (or 29% of the 1,885 beds in these 26 facilities) at the time they decertified.

Facilities which had voluntarily decertified may, at some time thereafter, decide to seek recertification. Assumedly such a strategy would be undertaken by a facility which had believed that it could, after voluntarily decertifying, fill to capacity with profitable private pay patients and then found out that this was, for whatever reason, not the case. Rather than face empty beds, such a facility might seek to recertify with Medi-Cal, thus starting "fresh" with a zero Medi-Cal census. However, once recertified, the facility could carefully limit its Medi-Cal population to whatever levels it wished.

### Findings

11-1. Voluntary decertification by long-term care facilities is a legalized form of resident "dumping" and presents significant fiscal, emotional, and health hazards to the affected residents. It must be stopped immediately.

11-2. The 26 voluntary decertification actions of the past three years---- resulting in the immediate eviction of more than 550 residents, and leading to the eventual evictions of what may be an additional 1,200 more residents of these facilities in the future--- represents an already-serious problem which may well grow worse.

## Recommendations

11-1. An urgency statute should be enacted in order to stop the process of evictions from nursing homes which are taking place as a consequence of voluntary decertifications. The Commission suggests that there are two ways in which this recommendation may be enacted. They are presented here in order of preference:

(A) Require all facilities as a condition of licensure to be certified for participation in the Medi-Cal program. Such a requirement already exists in the Health and Safety Code for all licensed Adult Day Health Centers.

(B) Require that any presently certified nursing home in the State not be permitted to voluntarily decertify from Medi-Cal unless all of the following conditions are met: (1) notice of intent to decertify is filed with DHS/LCD, and a notice provided all residents informing them that they may remain in the facility notwithstanding the request for decertification, and (2) that the facility must not subsequently evict any current Medi-Cal or private pay resident from the facility at or after the time the notification is filed, and (3) that all those patients admitted after the notice of intent to decertify has been filed with DHS/LCD must be notified both orally and in writing at the time of admission and prior to signing an admission contract that the facility intends to withdraw from the Medi-Cal program and that the facility will not be required to keep a new resident who converts from private pay to Medi-Cal after the facility has decertified.

11-2. Any facility which does voluntarily decertify in accordance with the requirements specified in recommendation 1-B above may not subsequently apply for Medi-Cal recertification unless the facility enters into a binding five-year Medi-Cal provider contract with DHS.

## CHAPTER TWELVE

### Fair And Informed Admission Contracts And Policies

#### Background

For a number of years there has been concern expressed about the content of the admission agreements that are used when a person prepares to enter a nursing home. A number of consumer groups, representatives of the Ombudsman Programs, and legal services for the elderly programs have consistently noted some admission agreements which contain multiple clauses, often of dubious legality, which effectively severely disadvantage the applicant for admission to a long-term care facility.

The nursing home market in California is constrained: occupancy rates in virtually all facilities are more than 90% on any given day, and the average occupancy rates over a year may well run close to 100%. Often the severe limitations on consumer choice which exist in the present California nursing home market are exacerbated by many nursing home admission agreements. Often such agreements further limit individual choices in multiple ways which can, and do, have serious effects on the resident's quality of life, as well as the financial obligations undertaken as a patient inside a nursing home.

### Findings

12-1. Frail elders seeking admission to nursing homes are a particularly vulnerable consumer group. They often have special needs of assistance in understanding their rights and obligations. More often than not, the first time that such persons may see a nursing home admission agreement is during the admission process itself.

12-2. At present there is virtually no specific regulation of nursing home agreements under California law. As such, present law provides little protection to the prospective consumers of long-term care services.

### Recommendations

12-1. Admission agreements should be available for potential consumers for their inspection and review at a time prior to, and separate from, the admission process itself.

12-2. Legislation should be enacted that:

(a) Consolidates the disparate legal requirements that must be a formal part of the admission process.

(b) Directs DHS/LCD to: obtain a copy of each current admission agreement; review the current admission agreement as part of the annual survey or as the result of a complaint, and issue appropriate citations for the use of each unlawful or misleading clause in the agreement.

(c) Regulates the print size of the admission agreement and requires a good faith attempt be made by the facility to obtain the signature of competent new residents on the admission agreement.

(d) Requires an easily understood description of the facility's charges.

(e) Prohibits blanket consent to treatment clauses.

(f) Gives notice to the patient in the agreement of the existence of grievance procedures and appeal rights.

(g) Prohibits listing grounds for discharge or transfer which are unlawful under state or federal law.

(h) Describes patients' rights.

Violation of any section of this legislation should be grounds for LCD to issue an appropriate citation for each and every section or sections violated.

## CHAPTER THIRTEEN

### Consumer Information Services: A Vital Component of Care

#### Background

Prior to the enactment of NHPPA, LCD had received State and federal joint funding and approval to automate much of their record keeping. LCD has spent four years in creating a management information system (MIS). Such a system was originally recommended to LCD in the 1982 Auditor General's Report. The new system is called the Automated Certification and Licensing Administrative Information Management System (ACLAIMS).

In our 1983 Report, the Commission was concerned that the ACLAIMS system might well be a substantial aid to the administration and management needs of the State, but that there was little evidence that the planned system would effectively also serve the needs of consumers in providing them with vitally needed information about the long-term care system in California. In 1983 we were concerned that ACLAIMS as then described would have no provisions for: public access, consumer input, distribution of the information to the public, and finally, it did not include a facility rating or comparability mechanism. This being the case, THE BUREAUCRACY OF CARE and the subsequent NHPPA legislation called for the creation of a consumer information system (CIS).

In meetings held in late 1986 and early 1987, the Commission's Advisory Committee for the present Study was given the opportunity to examine some of the initial material that was to be included into the CIS portion of ACCLAIMS. Operating initially from LCD regional offices, the first iteration of the ACLAIMS CIS should be operational in a limited number of sites within the coming months. Mr. Toney has assured members of the Commission's Advisory Committee that he will conduct ongoing consultations with various

groups----representing other State agencies such as the Department of Aging, and specifically the ombudsman program, as well as representatives of consumer and advocacy groups and, of course, representatives of the nursing home industry---to insure that the CIS is as responsive as possible to their somewhat different needs.

### Findings

13-1. The commitment of LCD to mount a State-wide CIS appears to be nearing fruition.

13-2. As LCD's CIS prepares to go on-line, LCD and those consulted in the design and implementation of the system need to make certain the ACLAIMS CIS meets the intent of the NHPPA mandate: it must be useful and accessible to a variety of clients.

13-3. The nursing home industry has requested LCD to exclude some information from the CIS, most specifically the record of all citations and violations which were "without merit."

### Recommendations

13-1. The ACLAIMS system is, and will probably remain, a major management tool. To the extent that this is so, the CIS portion of the system will always be in danger of being considered of lesser importance than other parts of the system. LCD should convene a CIS Advisory Group to assist in the initial implementation of the CIS, and, equally important, to provide suggestions for ways in which the initial configuration of the system can be expanded so as to include as much information as possible to as many people as possible in language that is as complete and easy to understand as possible.

13-2. The creation of the ACLAIMS system is a necessary first step. The real test of the system's applicability and utility will come from the comments and suggestions of diverse users and the development of mechanisms to quickly implement agreed-upon changes in the system.

13-3. The ACLAIMS CIS should include all citation and violation data, including whether a citation or violation has been appealed, upheld, or dismissed. This information should be maintained as a part of the public facility record in the system.

13-4. Every effort should be made to have the CIS include some information over and beyond numbers. Numeric information should be explained in prose. In addition, a brief narrative format screen should be developed by the CIS Advisory Committee which would be a part of a facility profile and which would establish some of the "tone" of a facility.

13-5. LCD should include its information from its Non-Compliance Index in the CIS portion of ACLAIMS. Following the lead of the LCD operation in Los Angeles County, LCD should devise a system whereby the ACLAIMS CIS can be enhanced by information provided by Ombudsman Program participants. The CIS should contain some minimal "findings" concerning a facility, somewhat like that done with the Los Angeles County system, or similar to the information about firms provided by the Better Business Bureau for consumers in order that they may make more informed choices.

## CHAPTER FOURTEEN

### Training and Maintaining Responsible Administrators and Directors of Nursing in Nursing Homes

#### Background

At present, there is no mechanism in place which can both monitor and "track" the performance of facility administrators or directors of nursing. These professionals, who are responsible respectively to the State Board of Examiners of Nursing Home Administrators (BENHA) and to the State Board of Registered Nurses (BRN) may perform well or poorly, work in one facility for a long period of time, or move from place to place. They are not routinely brought to the attention of their respective licensing Boards.

The result of this lack of coordination and cooperation with the Boards responsible for licensure and professional conduct of these key long-term care professionals is that such few complaints as are made to the Boards by DHS/LCD are perceived to be largely ineffective; they often result in little or no follow-up taken by BENHA, or BMQA on those (admittedly few) cases referred by LCD. Interagency cooperation is lacking; the consequences for public trust and for maintaining or improving patient care in these circumstances are far below what should be the norm and standard for these professionals.

Nursing home administrators are required to meet requirements for licensure as well as to complete continuing education hours to maintain their licenses. Neither the initial academic training required for licensure nor the continuing education requirements specify any knowledge of gerontology, geriatrics, or health care administration. There are no requirements that administrators either have some specialized knowledge of institutionalized elders, nor that they keep current with new developments in treatment and research.

## Findings

14-1. Few administrators have their licenses reviewed, suspended, or removed. This is due, in part, to the fact that BENHA lacks investigative staff. BENHA presently has only three staff members.

14-2. BENHA cannot "track" the records of administrators and in fact does not do so because of the lack of information-sharing between BENHA and DHS/LCD.

14-3. There is much that needs improvement in the area of continuing education of nursing home administrators. The present requirement of 40 hours of continuing education (CE) every two years is acceptable in quantity, but the content and quality should be carefully reviewed and improved.

14-4. Each of the three Findings above also applies in large measure to directors of nursing in long-term care facilities, and to the Board of Registered Nurses.

## Recommendations

14-1. There needs to be significantly more stringent regulation and oversight of the training requirements, licensure, and continuing education requirements of administrators and directors of nursing in nursing homes.

14-2. Legislation should be enacted which requires the following actions be taken concerning long-term care facility administrators:

(a) LCD must notify BENHA of all significant enforcement actions taken against a facility. BENHA should begin a preliminary fact-finding inquiry at that time to determine what role and responsibility, if any, the administrator had in regard to these significant actions.

(b) Each holder of a license should be responsible for notification of both BENHA and DHS/LCD within 30 days of their place of employment and this requirement should remain in force whenever an administrator moves to a new position.

In cases where an administrator who has been previously determined by BENHA, in cooperation with LCD, to have been responsible for significant enforcement actions taken against a facility, BENHA will forward this information to LCD within 15 days in order that LCD should consider an additional survey of the facility.

14-3. BENHA should appoint an Advisory Committee to assist the Board in a comprehensive review of the content and quality the courses brought to it for approval. BENHA should require that a minimum of 10 of the required 40 administrator CE hours be in gerontology.

14-4. Each of the Recommendations above should also apply to directors of nursing in long-term care facilities and to the Board of Registered Nurses. Cooperation in achieving the goals recommended here will be far more easily attained if these tasks are undertaken cooperatively by both BENHA and BRN.

## CHAPTER FIFTEEN

### Providing Increased Professional Training and Career Opportunities for Certified Nurse Assistants (CNAs)

#### Background

Nurses aides provide the predominance of the hands-on care in long-term care facilities. Data from the Office of Statewide Health Planning and Development (OSHPD) for calendar year 1985 show that nurse assistants, commonly referred to as aides, account for 71.6% of all the nursing care provided in long-term care facilities in California, and that this percentage has remained relatively consistent in the past several years. Since 1978, DHS has granted CNA certification to approximately 240,000 persons. At the present time DHS grants about 2,000 certificates monthly. There are approximately 120,000 CNAs currently employed in California.

These employees are the lowest paid of the nursing staff. The 1985 OSHPD data show that industry-wide their average hourly wage was \$4.56.

Reflecting both the difficulty of the work, as well as the low wages, the turnover rates in long-term care facilities have remained very high. In 1985, the Statewide annual turnover rates in proprietary facilities was more than 98%. Turnover rates in some facilities of well over 100% are common. These turnover rates mock the need for "continuity of care" which is so important for the dependent and lonely elder who is the resident in a nursing home.

Many CNAs find their jobs are unsatisfying and low-paying and do not stay in these positions for long. While CNA positions might be described as "entry-level" positions, this appears to be a polite way of describing jobs which are "dead-end."

Changes in aides' responsibilities and job descriptions have been few. The Commission firmly believes that a number of changes need to be made both in the administration, training, and employment of aides in long-term care facilities. Given that these persons make up more than 70% of the "nursing" care that is given in nursing homes and are, in fact, the primary "hands-on" caregivers, it is appropriate that a number of new initiatives be undertaken to improve CNA certification, training, and employment conditions which will ultimately have a direct and positive effect on patient care and thus quality of life for long-term care residents.

### Findings

15-1. CNA jobs are "dead-end" jobs for many. The administration of the CNA program, and the training offered in that program, provides no career ladders for CNAs who are often valued nursing home employees.

15-2. The training provided CNAs is not standardized, is highly variable in quality, and may not be a priority item for the facilities who hire them. Turnover rates of 90% per year (or more) in many facilities make adequate staffing often more a priority than on-going professional training.

### Recommendation

15-1. Legislation should be enacted which has as its overall goal the improvement in the training, performance, and retention of CNAs. Toward this end the following issues should be included in regulation and legislation:

(a) The administration of the CNA program should be moved from DHS to the Board of Vocational Nurse and Psychiatric Technician Examiners. The Board should appoint a balanced and representative Advisory Committee. Certification programs should be conducted by institutions of higher education or the adult education departments of city or county school districts when there is no nearby institution of higher education. These programs may be conducted at the institution or at the facility, however curricular and administrative responsibility for approved certification training programs should reside with the approved institution of higher education or adult education program.

(b) The Board, working with the Advisory Committee, should conduct a study to develop a series of career ladder opportunities for CNAs leading to the positions of CNA-II, or LVN. The plan should consider the experience and skills of the CNA in programs designed so that he or she may advance. The career ladder program should investigate ways of coordinating this career ladder program with existing State employment programs.

(c) The basic certification program should consist of a minimum of 50 classroom hours and 100 clinical hours. A minimum of 50% of the classroom hours should be devoted to gerontology. Biannual recertification should be required and should include 24 hours of inservice training; a minimum of 12 of these hours should be presentation of current developments in gerontology and geriatrics.

(d) The Commission believes that aides should have their certification training programs completed prior to employment, and that this goal should be phased in as rapidly as possible. For the present time, however, the maximum time that an aide should have to enroll in a program should be within 45 days of employment; the maximum time that an aide should have to complete training should be within 90 days of enrollment in a training program.

(e) Reasonable fees for certification should be set at \$20 and for biannual renewal at \$15, or at a level so that the program is self-supporting. Any amendments to the fee schedule made in the future should bear in mind the low-income status of CNAs and should not make these fees burdensome.

(f) Training programs for aides should include instruction in English for non-English speaking participants. Such training must be in addition to, and not a part of, the required class hours for certification. This recommendation was also made by the Commission in its 1983 Report and is repeated here as it is even more timely now.

## CHAPTER SIXTEEN

### Citation Review Conferences: Do They Impede or Facilitate Fair and Speedy Enforcement?

#### Background

Citation Review Conferences (CRCs) are held by DHS/LCD. They provide an informal way for facilities to appeal enforcement actions. Given the increase in enforcement activity that has taken place since the passage of NHPPA, it is not surprising that there has also been an increase in CRC activity. There has been an overall increase of 378% in CRCs between 1983 and 1985.

Many of the effects begun with NHPPA in regard to CRCs are not known. For example, we do not know what has been the effect, measured in terms of both changes in outcome and in terms of satisfaction of participating parties, of the new procedure which allows consumers to be present at CRCs.

The nursing home industry has been concerned, before and especially since NHPPA, with the lack of what they consider to be

"objectivity" and "fairness" in CRCs. They believe the modification rates (that is, those citations heard in CRC which are either dismissed or reduced in penalty and/or level) should be higher, and therefore that the rate of citations sustained in CRCs should be lower.

Legislation mandated centralized CRCs was passed into law in September, 1986. LCD is presently completing the hiring of Independent Hearing Officers to conduct these CRCs. At this time it is not known what the effects of the centralization of the CRC activities are going to bring, both in terms of the new process, and in terms of the rate of citations which are sustained or modified in the CRCs.

### Findings

16-1. The centralized LCD CRC unit is not yet in operation. The use of Independent Hearing Officers is scheduled to begin about July 1, 1987. Assessment and evaluation of the outcomes of the new procedure will not be possible until sometime after that date.

16-2. There is little data concerning the effectiveness of the procedure which allows consumers to attend CRCs.

### Recommendations

16-1. The rate at which citations are sustained or modified is of interest to several parties and these data should be gathered quarterly by LCD and made available to interested parties.

16-2. LCD's new centralized CRC unit should undertake a study, using a representative sample of CRCs originating across the state, to attempt to assess the consequences of consumers being present or absent at CRCs.

16-3. LCD's centralized CRC unit should make certain that consumers (and/or their representatives) who are involved in a citation which has been appealed to CRC must be informed of the date and time of CRCs; they must be given adequate time to attend the CRC if they wish; and, in addition, they must be informed of the outcome of the CRC regardless of whether they are able to be present.

16-4. Notwithstanding the findings and recommendations made in this Chapter, the Commission also recommends that the new procedures with regard to assessments and appeals for certain first-time "B" citations should be undertaken in administrative hearings conducted by LCD's Independent Hearing Officers. The details of this proposal are contained in Chapter Seven.

## CHAPTER SEVENTEEN

### Staffing Standards In Nursing Homes: The "Doubling Factor" Used In The Calculation Of "Nursing Hours"

#### Background

Section 2176.5 of the Health and Safety Code defines "nursing hours" as "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 or licensed vocational nurses (except directors of nursing in facilities of 60 or larger capacity)..." (emphasis added).

The Commission carefully examined the issue of staffing standards in long-term care facilities in its 1983 report. At that time, in a section entitled "Nursing Hours and Standards: Bad Numbers for Bad Reasons," we made the recommendation to remove the doubling factor as confusing and artificially inflated.

Legislation was proposed which would have removed the doubling factor in 1984-1985 as part of the NHPPA package of reforms. This provision was not supported by the nursing home industry, and was not enacted. As such, the debate on the efficacy of the provision to double R.N. and L.V.N. hours in calculating the minimum number of nursing hours per patient day that are required in long-term care facilities continues.

It is not certain whether the flexibility offered by doubling is actually used by some number of good facilities and whether the use of doubling makes them good facilities. OSHPD data for 1981-1985 do reveal increases in doubled and actual nursing hours per patient day, but the increases are quite small. Further interpretation of the data is needed.

#### Findings

17-1. Speaking as the Chair of the Nursing Home Advisory Committee at its January, 1986 Public Hearing, Lieutenant Governor Leo McCarthy stated: "... the RNs [and LVNs] account for two patient/staff ratio credits, whereas CNAs count for only one (the so-called doubling factor). Consequently, while patient documentation may have been upgraded, actual patient care may have been diminished in some cases...."

17-2. Data have been presented by the industry for maintaining the doubling factor, and by consumer groups for abandoning it. It is not known whether the data presented in the industry example

can be generalized across most facilities. While we know that doubling could be used for more effective staffing in some settings, we do not know if it is used for this reason.

### Recommendations

17-1. The study of the long-term care reimbursement mechanisms in use in the State, presently being undertaken by an outside contractor for the Auditor General's office, should consider the costs and benefits of the doubling factor.

2. If the Auditor General's study does not address the doubling factor question as recommended above, the study should be undertaken by OSHPD with results reported no later than December 31, 1987. The results of this study should serve as the basis for regulatory and legislative changes as soon thereafter as possible.

## CHAPTER EIGHTEEN

### Physicians: A Vital And Often Missing Component Of Long-Term Care And Caring

#### Background

The Commission did not seek the testimony of physicians concerned with long-term care in California for either its 1985 assessment or for the current Study. This decision did not mean that the Advisory Committee believed that the issue of the multiple relationships between physicians and long-term care patients was satisfactory.

On the contrary, virtually the entire Advisory Committee, which represented several government agencies, the nursing home industry, the Senior Legislature, the Ombudsman Program and consumer groups felt that the issues concerning physicians presence in, and treatment of, the elderly in nursing homes was critically important and that it should be a major focus for an inquiry which the Commission should conduct as soon as possible.

The major issue that concerned virtually all members of the Advisory Committee was the ongoing difficulty in securing physicians to work with nursing home patients. The feelings expressed from the Advisory Committee concerning this subject arose were variable degrees of resentment, anger, and frustration.

While it is acknowledged that there are nursing home patients who do receive good, timely, and humane care from physicians, and that there are doubtlessly a cadre of physicians committed to providing

these services, nonetheless the view of almost all persons concerned with long-term care in California (and in other states as well) is that these excellent physicians are far from the majority.

### Findings

18-1. The role of physicians who care for nursing home patients needs to be comprehensively evaluated. The professional association of physicians who work in long-term care is the California Association of Medical Directors (CAMD). Any inquiry the Commission conducts regarding physician presence and care in nursing homes would need to begin with understanding better the role and activities of this group, and, of course, of the larger professional association, the California Medical Association.

18-2. The perception of virtually all of those involved with the Commission's Advisory Committee, as well as many who have testified at its Public Hearings in 1983, 1986, and 1987, is that there is something lacking with regard to the way in which physician services are rendered to long-term care patients.

### Recommendations

18-1. The Commission should soon undertake a major study to understand the role of the physician in long-term care facilities.

18-2. The existing statutes, including the Elder Abuse law (Penal Code Section 368 (a)), should be used to investigate and prosecute if appropriate, those physicians who are themselves derelict in their responsibilities for and care of nursing home residents.

18-3. DHS/LCD should secure a Memorandum of Understanding with the Board of Medical Quality Assurance concerning the need for vastly increased cooperation in the oversight of physician services for nursing home patients.

18-4. The forthcoming Auditor General's reimbursement study of long-term care services in California needs to be aware of the perception by many physicians that reimbursement rates for Medi-Cal patients in nursing homes are very inadequate.

18-5. Failing consideration of this issue in the Auditor General's study, DHS, in consultation with interested non-governmental agencies and professional groups, should assess the magnitude of this problem and suggest solutions to it.

## CHAPTER NINETEEN

### DRGS And Long-Term Care: Do New Nursing Home Residents Require More Care?

#### Background

There is a good deal of fragmented and as yet preliminary evidence that the prospective diagnosis-based method of reimbursement that was begun by Medicare in 1984, called Diagnostically Related Groups (or DRGs), has had one unintended side-effect---the release of persons "quicker and sicker" from the hospital. In some of these cases, hospital-based discharge planners seek nursing home beds for these persons.

The use of DRGs in acute care has raised a number of important questions for the long-term care system. These are questions for which there is little hard data to answer them at this time.

In 1982 legislation was enacted which required that DHS develop a sub-acute care program. At the present time the State's program is designed to apply to approximately 300 high-acuity patients statewide. When DRGs began to be used in 1984 it became clear that hospital length-of-stays would decline. What was not so clear is where many of these people would go and what their health status would be at the time of their discharge from the hospital.

Clearly changes in the overall health status and acuity of the entering long-term care patient population will have important, if presently-undetermined, effects on the long-term care system.

#### Findings

19-1. The system of reimbursement known as DRGs is doubtlessly having an effect on nursing homes. That effect could mean some unknown number of new patients having significantly higher levels of care needs. There are no good data presently available on the scope of this problem.

19-2. The relationship between DRGs and Medi-Cal hospital "administrative days" is not known. If Medi-Cal patients are being readied for dismissal from hospitals sooner under DRGs, and if they need a nursing home bed, DRGs may be making the finding of those beds even more difficult than it has been in the past. If a long-term care bed cannot be found, the hospital keeps the person on "administrative days" which are paid for by Medi-Cal. The costs to Medi-Cal for such days are substantial and may be increasing because of DRGs.

19-3. The California subacute program, enacted in 1982, will provide care for only some 300 persons statewide.

### Recommendations

19-1. The Auditor General's current reimbursement study should, in its development of alternative reimbursement systems for the Medi-Cal nursing home program, pay careful attention to whatever effects of DRGs are known at present and incorporate those findings in their analyses, as well as such other major changes in the long-term care patient population as are projected.

19-2. DHS, in cooperation with OSHPD, should assemble comparative data on the nature and costs of administrative days paid by the State to hospitals for Medi-Cal patients seeking a long-term care bed. The results of this study should be made available to all relevant agencies.

19-3. The California subacute program represents a "third level of care" (in addition to skilled and intermediate) which should be evaluated in a timely and systematic manner.

19-4. This Commission should undertake an assessment of how DRGs impact long-term care, using the results of studies now being undertaken.

## CHAPTER TWENTY

### Are Reduced Paperwork and Acceptable Levels of Accountability Compatible Goals In Long-Term Care?

#### Background

Many long-term care professionals believe that the increasing amount of paperwork that they must contend with as a consequence of continued regulatory and monitoring requirements may actually decrease the quality of care, as less time of some professionals, especially licensed nursing personnel, is spent on clinical care, or on supervision of staff, and more time is spent on required "paperwork compliance." This belief is prevalent throughout the nursing home industry in the United States. In California, this same belief holds, and with more force since the passage of the NHPPA legislation. The overall issue of improved quality and the relationship between quality and paperwork should be examined.

The NHPPA legislation included a provision that authorized facilities to utilize quality assurance logs with the intent of improving the quality of care, and potentially even providing some

form of incentives for providing excellent care. Up to now facilities have been reluctant to establish or maintain these logs.

There is reason to believe that policies could be developed which would give recognition to this tension between the need for high levels of accountability and the need for decreasing paperwork as much as is possible. The problem has not been systematically addressed either by the nursing home industry, nor by the government, nor by the two working cooperatively.

### Findings

20-1. Increased accountability and increased paperwork appear to go together. To the extent that this has the unintended side-effect of reducing actual care-giving, this area deserves serious attention.

20-2. The creation of quality assurance programs, and the logs that are often part of such programs, cannot proceed without the assurance from DHS/LCD that such logs and programs will not be used punitively.

### Recommendations

20-1. A joint LCD nursing home industry Task Force should be created to address the related issues of how quality assurance programs might be created (and how quality assurance logs might be used), as well as how facilities, perhaps especially those with excellent records, might be less hampered by paperwork.

20-2. In the process of its work, the Task Force should also devise guidelines for a program which would give incentives to long-term care facilities for excellence.

## CHAPTER TWENTY-ONE

### Continuing To Improve Communications Concerning Long-Term Care

#### Background

In its 1983 report, the Commission described in some detail the difficulties that most consumers experienced in seeking information from LCD. Given the increasing number of complaints about long-term care services that LCD (as well as the Department of Aging in general and the Ombudsman Program particularly) are

receiving, it was expected that in the current Study this issue would, again, be a major concern.

While this area has improved a great deal since NHPPA, this is not to say that access is either rapid or easy for all consumers of long-term care services. At the Commission's February, 1987 Public Hearing a relative spoke of "getting the run-around" with the multiple telephone calls she made to State agencies, including LCD, concerning the eviction of her grandfather that was taking place as a consequence of a voluntary decertification of a facility. Consumer group files are full of letters, often angry and sometimes pleading, for action to be taken about a situation concerning a loved one who is a patient in a long-term care facility.

For these less-informed persons, the increased outreach efforts of LCD, combined with I&R systems operated by government and social and human service agencies, as well as cooperation from the nursing home industry, will be of some assistance. The advent of the Consumer Information System as part of LCD's ACLAIMS management information system should also be of aid.

### Findings

21-1. The administrative policies of LCD which encourage informal and regular communication with interested groups in long-term care matters is commendable.

21-2. It is not easy for the concerned or confused or vulnerable person to acquire information, or to make an inquiry of a complaint concerning a long-term care facility. LCD's outreach efforts are a fine beginning in this area, but the evidence suggests that a great many people seek to know more, and that some large number of persons still are frustrated and confused when it comes to trying to seek entry to, or interaction with, the long-term care system as symbolized by LCD.

21-3. The role and activities of the Ombudsman Program are crucial and they are severely underfunded given the tasks that they are charged with by the legislature.

21-4. While access to LCD has improved significantly since the passage of NHPPA for groups interested in long-term care policy and programs, it is not at all clear whether access has increased for citizens seeking either to get information or ask a question or make a complaint.

## Recommendations

21-1. The present administrative policy of LCD to hold regular informal meetings with consumer groups and representatives of the nursing home industry is very valuable and should be commended and maintained.

21-2. A joint Ombudsman-LCD-AG working group should be established immediately to design both data and information sharing techniques, and to also develop programs which will increase consumer knowledge of the system.

21-3. Additional funding should be provided for the Ombudsman Program so that they can have the resources necessary to meet the mandate of the legislature and the needs of the people they serve.

21-4. The outreach efforts of LCD should be continued and expanded, in active cooperation with the Department of Aging senior information and referral services as well as with the Ombudsman Program.