NEW AND CONTINUING IMPEDIMENTS TO IMPROVING THE QUALITY OF LIFE AND THE QUALITY OF CARE IN CALIFORNIA'S NURSING HOMES

A Report
of the
Commission on California State Government
Organization and Economy

Prepared By

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May, 1987

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Dear Governor and Members of the Legislature:

In 1982, the Little Hoover Commission conducted surprise visits and received shocking testimony that confirmed absolutely horrifying conditions in far too many nursing homes in California. These findings prompted our Commission to appoint a Blue Ribbon Advisory Committee chaired by Lieutenant Governor Leo McCarthy and comprised of individuals representing all major interested parties to review the conditions in California's nursing homes and develop broad-based recommendations for reform.

Based upon the work of the Blue Ribbon Advisory Committee, the Little Hoover Commission issued a report in 1983, entitled "The Bureaucracy of Care." After completing this report, the Commission and the Advisory Committee translated more than 75 percent of the report's recommendations into a package of legislation that was signed into law in March 1985. This package of legislation is known as the Nursing Home Patients Protection Act (NHPPA) of 1985.

At the time that the NHPPA was enacted, the Little Hoover Commission pledged that it would follow up on and monitor the implementation of these reforms. To do this, the Commission held two public hearings, one in January 1986 and the other in February 1987. In addition, the Commission reconvened its Blue Ribbon Advisory Committee in October 1986 to review the impact of the NHPPA on the quality of care in the State's approximately 1,200 nursing homes that serve more than 105,000 residents.

Our study showed there have been some improvements in nursing home conditions in California since the passage of the NHPPA. For example, the Department of Health Services' Licensing and Certification Division has better-defined and stepped up its role in surveying and enforcing nursing home conditions and enforcing regulations. In addition, the State has taken positive action to crack down on clearly substandard nursing home facilities through its enhanced enforcement efforts.

(This letterhead not printed at taxpayer's expense)

However, our high expectations for the impact of the reforms contained in the NHPPA to remedy the substandard conditions and abuse and neglect in nursing homes have not been fully realized. During the course of the study, our Commission analyzed a variety of major issue areas including: enforcement of nursing home regulations; theft and loss in nursing homes; admissions contracts; consumer information services; voluntary decertification of facilities from the Medi-Cal program; and the training and monitoring of nursing home personnel. Among the findings in our study are the following:

- A loophole exists in current law which allows nursing homes to decertify from the Medi-Cal program, evict their Medi-Cal patients, and then seek recertification in the Medi-Cal program at a later date once the facilities have increased their census with additional private paying residents who are more profitable. In fact, as of December 1986, 26 facilities have decertified from the Medi-Cal program causing the forced eviction of more than 550 Medi-Cal residents. This occurred even though some of these residents had paid facilities upwards of $100,000 of their own money for care prior to converting to Medi-Cal. These residents understood at the time of their admission that the facility would allow them to remain once they exhausted their private pay funds and converted to Medi-Cal.

- Poor care has directly resulted in the deaths of 79 patients in nursing homes in the past two years. This includes instances of patients dying from blood poisoning due to untreated bed sores, from beatings received while under the care of a nursing home, and from malnutrition and dehydration as well as the lack of proper medical treatment.

- There is a growing number of complaints regarding the quality of care provided in nursing homes. In 1986, the State Ombudsman program received approximately 32,000 complaints, or nearly one complaint for every three nursing home residents.

- The theft and loss of patients' property and valuables is a prevalent problem in the nursing home industry. Our Commission was appalled by the indignities that some patients are subjected to because of this problem, including the theft of dentures, clothing, eyeglasses, hearing aids, and rings.

- There is no mechanism in place to monitor the professional performance of key nursing home staff that are largely responsible for ensuring the quality of care in nursing homes, including facility administrators and directors of nursing. As a result, professionals with substandard performance are not tracked and few administrators or directors of nursing ever have their licenses reviewed, suspended, or revoked.

- The training of nurses aides, who provide the predominance of the hands-on care in nursing homes, is not standardized and turnover rates of 90 percent per year or more are not uncommon

in California's nursing homes partially due to the lack of career opportunities.

- The Department of Health Services' Licensing and Certification Division's effectiveness as an enforcement agency is greatly impaired by the low rate of citation assessments actually collected. For example, as of early 1987, the Division has collected only 8.4 percent of the $5.3 million in fines assessed in 1985 after the enactment of the NHPPA. However, $2.1 million of the $5.3 million is uncollectable under current law. Thus, of the amount collectable, the Division has collected 34 percent.

Clearly, these problems indicate that there are still impediments in ensuring that the residents of nursing homes, who the Commission has referred to as society's "forgotten people," are treated with consideration, respect, and full recognition of their dignity and individuality, and live in a safe and secure environment. Towards this end, the Commission's report makes a series of recommendations, including:

1. The Governor and the Legislature should enact an urgency statute to stop the forced eviction of Medi-Cal residents from facilities that are decertifying from the Medi-Cal program. This legislation should also insure that present private pay residents who may later convert to Medi-Cal are allowed to remain in the facility.

2. The Governor and the Legislature should require the Board of Examiners of Nursing Home Administrators and the Board of Registered Nurses to track and monitor the performance of facility administrators and directors of nursing, respectively.

3. The Department of Health Services and the Attorney General's Office should more vigorously pursue the collection of assessments for the violation of nursing home regulations.

4. The Governor and the Legislature should enact legislation to reduce the period of time that facilities have to contest "B" citations, which now may take up to five years.

5. The Governor and the Legislature should enact legislation that requires nursing homes to work actively and cooperatively with the Department of Health Services, local law enforcement agencies, and concerned consumer groups to develop theft and loss prevention programs.

6. The Governor and the Legislature should enact legislation that requires the fingerprinting of all nursing home employees who provide care or have access to residents.

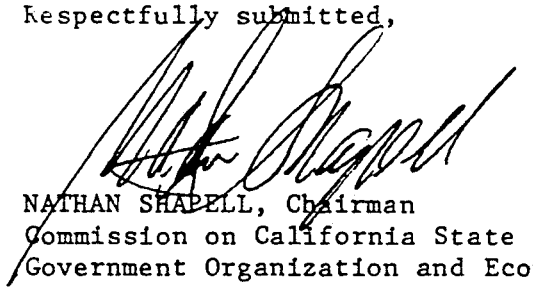
7. The Governor and the Legislature should require changes be made in the content of nursing home admission agreements and make them available to the public.

8. The Governor and the Legislature should establish a goal for improving the training, performance, and retention of Certified Nurse Assistants.

The Commission would like to commend the efforts of the Nursing Home Study Advisory Committee whose hard work, candor, and insight have contributed greatly to the quality of this report. When the Commission first embarked on its review of nursing homes in 1982, we knew it would be a long and difficult process to achieve meaningful reform. This study indicates that we have made some progress, but we still have a long way to go. The Advisory Committee and the Commission want you to know that we have reaffirmed our commitment to see this process through to a satisfactory conclusion. We call upon you to join us in this effort.

Respectfully submitted,

LEO McCARTHY, Lt. Governor
Chairman, Nursing Home Study
Advisory Committee



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MAY 1987

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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" #	"AA" Assessed	"A" #	"A" Assessed	"B" #	"B" 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 (this year)	%Collected (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 suprise 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 actitives (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 cicumstances 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 recievership 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 addtional 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 specificed 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 implemention 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 adminstrators 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 apppoint 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 suprising 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 effectivness 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. Not withstanding 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 Commitee 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 physicans 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.

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 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.

The Commission held a follow-up hearing in January, 1986, to assess the implementation of NHPPA. That hearing made it clear to the Commission that there are continuing problems in quality of care in many of the State's long-term care facilities. This being the case, the Commission reconvened the blue-ribbon Nursing Home Advisory Committee, chaired by Lieutenant Governor McCarthy, in the Fall of 1986. The Advisory Committee met several times between October, 1986 and April, 1987 to address issues directly related to the quality of life and quality of care in California nursing homes. A Public Hearing concerning many of these matters was held in February, 1987.

This Report reflects the important contributions of members of the Advisory Committee, as well as the concerns presented by those persons who testified at the Public Hearing. 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.

A number of important issues regarding quality of care either were not addressed in the 1985 legislation, or they have arisen since the reform legislation was enacted. These issues may be thought of collectively as impediments to continued progress toward the overall goal of providing a system of excellent long-term care. Much remains to be done in order to remove the significant number of impediments to quality of care and quality of life for the residents in California nursing homes.

Long-term care in California should serve as a national model. The State has the largest nursing home industry in the country: more than 1,200 facilities containing almost 107,000 beds, 94-98% of which are occupied on any given day. There are a number of reasons that make it timely and appropriate that the Commission continue its assessment of "the bureacracy of care": the continued rapid growth of the elderly population; the continuing strong demand for institutional long-term care services; the complex and far-reaching changes taking place in the regulatory environment; and, finally, the ways by which these services are delivered and paid for. All of these issues are of concern to those involved with the present and future of institutional long-term care in California.

If California nursing home care and regulation were to serve as a national model, that system should be characterized by excellent care rendered in a humane and cost effective manner. Regulatory oversight should be provided by committed and well-trained professional civil servants and fair sanctions should be applied fairly and speedily to those facilities and operators which do not provide excellent services. Residents of long-term care facilities, their families and loved ones, as well as the invaluable volunteer Ombudsmen visiting these residents, should feel increasing confidence in the commitment and ability of facilities and their staffs to provide frail and vulnerable elders with dignified and professional care. All-too-often, many of these preconditions for appropriate, needed, and expected professional care are absent for many residents in a significant number of facilities across the state.

The Commission fully realizes the importance of the fiscal issues surrounding long-term care in California. The expenditures for long-term care incurred by the State, through the Medi-Cal program, are of continual concern to budget planners and the public. The belief of the nursing home industry, and others, that in many instances the Medi-Cal reimbursement rates are too low is an argument that the Commission has listened to carefully throughout our history of concern with nursing homes in California. The Commission has also heard the continued concern of nursing home residents (and of their loved ones) of the fiscal impoverishment that many of them, sooner or later, have experienced as a consequence of their stay in a nursing home.

This Report does not specifically attend to reimbursement issues---neither the formulas and methods presently in use nor the

rates that come from them. This is not because we do not think them important, but rather because this topic deserves a careful investigation of its own. That analysis is presently being conducted by the Auditor General's Office which has recently contracted for a major assessment of the long-term care reimbursement system in California. The final report is due from the Auditor General's office in October of 1987.

The Commission believes that the Auditor General's reimbursement study may prove to be an essential tool for better understanding how the long-term care system in California presently operates, and how it could operate better. This, in turn, should also further aid our understanding of the impediments to quality of care and quality of life for nursing home residents which are described in the present study.

In the chapters that follow, we address some of the central issues which need remediation in order to decrease or remove a number of those impediments to improved quality of life and quality of care for the present and future residents of California's long-term care system.

In the remainder of Part One, the goals of this Study are described, as are the methods used to gather the background information, in order to derive the findings and recommendations made here.

Part Two is concerned with the process of monitoring and enforcement in long-term care: the citation and assessment process; the present system for collecting (or not collecting) fines; the Department of Health Services Licensing and Certification Division's (DHS/LCD) special surveys, called the Enhanced Enforcement Effort (EEE); the growing concern with litigation delays which impede the overall enforcement effort; and finally, the changes that should be made in the receivership procedure to render it a more effective enforcement tool.

Part Three addresses the endemic issue of loss and theft of nursing home residents' property and also issues relating to patient abuse. This latter area is addressed by an Advisory Council of the Attorney General's Bureau of Medi-Cal Fraud (BMCF) which met concurrently with the Commission's Nursing Home Advisory Committee. The text of the BMCF's Advisory Council's Report is included as the Appendix of this Report.

Part Four is concerned with three issues which continue to make it most difficult for long-term residents, their families and others to be fully and fairly informed as to the nature of the system: the practice of voluntary decertification from the Medi-Cal program which resulted in the eviction of more than 550 Medi-Cal residents in the past three years; admission agreements which are too-often either illegal or misleading; and the developments regarding the implementation of a Consumer Information Service within DHS/LCD.

Part Five is concerned with the preparation and ongoing professional training of key personnel in long-term care: administrators, directors of nursing, and the persons who provide the vast majority of the "hands on" care, the aides.

In Part Six, we present a number of issues which the Commission believes need further analysis. These issues are important enough so that findings and recommendations have been developed; but, in each case, the amount of information needed is not yet adequate to make legislative or regulatory recommendations.

These issues include: (i) the new centralized procedures for Citation Review Conferences (CRCs); (ii) the formula used to calculate minimum staffing requirements in long-term care facilities, specifically the "doubling factor" used to calculate registered nurse and licensed vocational nurse hours; (iii) the critical role often not being played by physicians in providing long-term care; (iv) the possibility that the acuity level of patients may be increasing, in part due to releases of Medicare patients from hospitals "quicker and sicker" under the DRG system of Medicare payments to hospitals ; (v) the vexing relationship between quality of care and the paperwork required to monitor it; and (vi) the need for continued improvement in communication between the long-term care system and the interested public.

CHAPTER TWO

Goals of this Study

As we noted above, 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. It is also assumed, however, that the tasks associated with improving quality of life and quality of care in nursing homes were not completely resolved by the passage of NHPPA. A number of issues either remain to be addressed or have arisen since the reform legislation was enacted. The issues which will be addressed in this study thus represent impediments to continued progress toward the overall goal of providing a system of excellent long-term care.

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. This study makes a series of legislative and regulatory recommendations in order to diminish or remove impediments to providing quality care.

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

1. To assess the central components of the NHPPA legislation to see if and how they are being implemented by public regulatory agencies and nursing homes.

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. Some of those issues now need to be examined. These issues include:

(a) Regulatory and implementation issues that may have been unforeseen in NHPPA. These difficulites are some of NHPPAs side-effects. Such side-effects are often perceived by some actors as negative. An example in this area is the problem of the presently legal eviction of nursing home residents when a facility decides to voluntarily decertify from further participation in the Medi-Cal program.

(b) New issues which have arisen even in the relatively short time since the Commission study was written (1982-1983) and since the NHPPA legislation was enacted (March, 1985) which are

now inserting new forces into the long-term care environment. Some believe that these new forces will, sooner rather than later, pose new, potentially large problems of their own for long-term care services and regulation. An example in this area is the demise of the Certificate of Need (CON) legislation in California and the subsequent government de-regulation of the construction of new long-term care beds. The absence of CON authority at the state level may well mean that signficant growth, and possibly some competition, could take place in the near future. What this may mean for the state's resources, and for the state's elders seeking long-term care services will need to be carefully assessed.

(c) Finally, issues which were either not initially addressed by the Commission's earlier study or, if they were, did not become part of NHPPA. Examples in this area include staffing needs that have arisen as a consequence of increased enforcement activities undertaken at LCD, and the creation of the "AA" citations in the NHPPA legislation. There appears to be a disturbing and counter-productive pattern of long delays developing in the enforcement system that occurs between the assessment of fines associated with citations and their resolution and/or collection.

The Context of California's Long-Term Care Enterprise

The environment in which long-term care policy and regulation is undertaken in California is complex. Professional interest groups represent the best interests of the nursing home industry with the legislature and state and federal agencies. Regulatory and oversight agencies such as the Department of Health Services (DHS), Licensing and Certification Division (LCD), as well as the Attorney General's (AG's) and the Ombudsman Program of the Department of Aging also heavily influence this environment.

To a more limited (and less visible) extent, the long-term care environment continues to be influenced by concerns reflected by some nursing home staff members, by the media, and finally, by consumer or advocacy groups. While none of these actors are as consistently powerful a force as those mentioned above, nonetheless their work has often influenced the entire California nursing home reform effort over the past decade.

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.

Quantitative Data: A key issue that has faced all prior investigations of the California long-term care system is the paucity or unavailability of quantitative data. These circumstances have previously been noted in earlier studies undertaken by the Commission as well as by the Auditor General, and, most recently, in the 1985 national study of long-term care conducted by the Institute of Medicine (cf. IMPROVING THE QUALITY OF CARE IN NURSING HOMES published by the Institute of Medicine in Washington, D.C. in 1986).

Careful attention has been given to the data that are available from the Office of Statewide Health Planning and Development (OSHPD) which, in addition to its own material, has inherited the long-term care industry data files of the California Health Facilities Commission. Most of the enforcement and citation data that are used in this Report come from LCD and, to a far lesser extent, from the Office of the Attorney General (AG). Often there are incompatibilities and gaps in the data.

The proprietary nursing home trade association, the California Association of Health Facilities (CAHF), maintains its own database, and some of that information has been used by Association members in their presentations to the Advisory Committee. CAHF's database at one time was probably as good or better than much of the unorganized data collected by LCD. The new LCD/DHS management information system, ACLAIMS, is going on-line at present. This system gives LCD the potential for far greater monitoring and reporting information than has been the case in the past.

Advisory Committee: The Commission's work which resulted in THE BUREAUCRACY OF CARE could not have been as thorough as it was had it not been for the presence of a balanced Advisory Committee which was actively chaired by the Lieutenant Governor. The Advisory Committee was invaluable both in raising issues that it felt must be part of the final report's recommendations, and in making vital connections to the range of constituencies that needed to be involved: several agencies, professional associations, and interest-groups.

The reconstituted Nursing Home Advisory Committee contributing to this Report has served the same vital purpose: it has been a real working body, which often met in sub-groups to prepare several

position papers that have been used in preparation of the findings and recommendations found here. Membership on the Advisory Committee overlapped with the Commission's 1984 Advisory Committee. The Committee for the present Study was updated both to reflect changes in personnel in some key places (e.g., the Deputy Director of DHS who is responsible for the administration of LCD, as well as representatives of the Attorney General's office). The Advisory Committee was not asked to reach agreement or consensus on issues when that was not possible. Far more important to the Commission was the balanced presentation of the views of government, consumers, and the industry, sometimes agreeing, sometimes disagreeing, as they thoughtfully assessed a number of issues vital to improved quality of care and quality of life in nursing homes.

Key Actor Information: As with THE BUREAUCRACY OF CARE, this Report also includes information gained from a combination of interviews with key actors in the long-term care system. Some of these key actors have been members of the Advisory Committee and a number of them have not. In all cases, we sought to supplement information that came from the quantitative data and the Advisory Committee with the expertise of others knowledgeable about the California long-term care system. These persons have ranged from academic researchers to individual ombudsmen, to past and present employees of long-term care faciltities, to family members of residents.

Other Sources of Information: Public Hearings: The Commission has been well served in the past by public hearings which have encouraged consumers and a variety of professionals to bring forward their experiences and concerns: this was also the case with the public hearing held in February, 1987, in connection with this inquiry. These Hearings have served to highlight the particularly human issues that underlie nursing home regulation and quality of care issues. The Commission's Nursing Home Public Hearings have always included testimony from nursing home residents or family members who relate tragic and heart-rending stories concerning their experiences with nursing homes. For example, several persons testified at the February, 1987 Public Hearing concerning the human consequences of a transfer of a loved one necessitated by a facility which voluntarily decertified from Medi-Cal, making residents move against their will.

Given that the level of complaints about nursing home care gives no evidence of materially decreasing, and may well be increasing, what occurs at the public hearing is very important. It materially aids the Commissioners and the public in knowing just how different, and sometimes how vastly different, the perceptions are of the providers and the consumers of long-term care services. The public hearing highlights, with human voices, the perceptions of individuals who feel "caught" in the system. It offers the perceptions of those persons who are charged with government oversight for the system, or those persons who administer the individual long-term care facilities which, collectively, are the system. Hearing these different voices is critical in

ascertaining what impediments are in the present system which may be responsible for the gap between the intent of NHPPA and the actual delivery or receipt of long-term care services.

CHAPTER FOUR

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

Background

Quality of care in nursing homes is very difficult to measure and evaluate, even though many persons believe that it is relatively easy to recognize. Given this difficulty, quality of care is assessed negatively; that is, assessments of deficiencies and citations serve as proxy indicators for the absence of required standards of care.

This process is bound to be imperfect, and must, in the case of long-term care, rely on the judgment of the professional training and skill of the surveyors of LCD as they inspect nursing homes. The results of these inspections, or surveys, always fail to give positive recognition for good or high quality care. There are, at present, few mechanisms which can inform government and consumers that a particular facility performs its difficult tasks well.

Until we have access to standardized and reliable measures of quality of care and until we devise ways to communicate that good care is being given in a particular facility, we will probably continue to rely on negative indicators which can tell interested parties that problems of varying severity have been found in a facility. Those problems, reflected in the citation record of a facility, must be used by all parties interested in judging the overall quality of care that is provided in that nursing home.

As the following Table shows, 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.

Citations Issued

	"AA"		"A"		"B"	
Year	#	Assessed	#	Assessed	#	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 1985 to 1986 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.

A 50% sample of all citations for the first three quarters of 1986 drawn from LCD data by the California Association of Health Facilities (CAHF) shows that 55% of the citations issued were in the area of patient care; 9% were in the medications area; and 10% concerned patients'rights. Thus, almost 75% of the citations issued directly affect the health or welfare of residents. The remaining citations were given for physical plant concerns and related areas.

Increased citation activity took place as a consequence of several factors. The most important factor is the strong enforcement philosophy adopted by the Director of the Department of Health Services and his Deputy, who is in charge of the Division of Licensing and Certification (LCD), the State agency which conducts surveys and issues citations.

It is also important to note that the number of complaints received by LCD about conditions in nursing homes has also continually risen since the passage of the NHPPA legislation. As the following Table shows, this increase was most dramatic in 1983-1984, the years in which the Commission was conducting its study which led to the NHPPA legislation of 1985.

Nursing Homes Complaints Received By LCD

Year	Complaints Received	Increase from Prior Year
1982	1,383	N.A.
1983	2,863	107%
1984	3,738	31%
1985	4,267	14%
1986	5,029	15%

Source: LCD, February, 1987

Total complaints received by LCD have increased from 1982 to 1986

by 365%. Mr. Jack Toney, Deputy Director of DHS for LCD, mainly attributes the increase in complaints to the activities and publicity that have been a part of the Commission's on-going inquiries into conditions in California nursing homes.

Complaints can and do lead to citations. CAHF data indicate that, based on a 50% sample of all citations and complaints for the first three quarters of 1986, 41% (383 of the 921 citations in the sample) of the citations were generated from complaints. In addition, the increase in complaints are an indicator that more people are aware that they can complain. The level of concern, as measured by the sheer increase in volume of complaints, indicates that there are large numbers of persons who are both displeased with nursing home conditions and are resourceful enough to know where and how they can complain about these conditions.

A 1985 LCD survey of complaints received for health facilities in general (including hospitals) showed that complaints were generated from the following sources: 5% from patients, 5% from ombudsmen, 30% from families, and 13% from facility employees. This same survey also found that all "anonymous" complaints (and unusual occurrences which were treated as complaints) accounted for the remaining 47% of the total complaints received. As the nursing home industry trade association noted in an analysis of these figures: "This group of anonymous complaints are being generated from sources which are undoubtedly very close to the day to day operations of facilities."

Prior to the NHPPA legislation there were two forms of citations that LCD gave: "B" citations (for an offense which has a direct or immediate relationship to the health, safety or security of the patient), and "A" citations (for an offense when a patient has been placed in imminent danger or substantial probability existed of serious harm or death). The NHPPA legislation created a third category, the "AA" citation, for offenses resulting in a patient death as a direct and proximate result of the violation of a regulation. (Another citation, called a deficiency or "C" violation, has no fines assessed and is given for conditions which have only a minimal relationship to patient safety or health.)

Under the NHPPA legislation, maximum fines were increased from $250 to $1,000 for "B" citations, and from $5,000 to $10,000 for "A" citations. The maximum fine for the newly-created "AA" citation was set at $25,000.

In 1985, the first year in which "AA" citations were mandated, LCD issued 32 "AA" citations and assessed fines of $777,000 for them. Assessments for "A" citations held steady in 1983 and 1984 (190 citations assessed $1.0 million and 197 citations assessed $1.1 million). In 1985, however, there were 318 "A" citations issued and fines assessed in the amount of $3.1 million. A similar pattern took place with "B" citations: 967 citations were issued in 1983 with $288,025 assessed; in 1984 1,074 "B" citations were issued, with $307,150 assessed; and in 1985 these numbers had

increased to 1,612 citations issued and more than $1.3 million dollars in fines assessed.

The nursing home industry has complained that the increased enforcement efforts of LCD have also resulted in steadily increasing average assessments on fines. The California Association of Health Facilities presented the Commission with data which indicate that, for the first three quarters of 1986, 624 of 921 violations examined, or 68%, were assessed at the maximum. These figures also reveal that some 38% of violations were not assessed at the maximum, thus leaving the possibility that the average fine is not the maximum.

From the totals given above for the numbers of citations given and fines assessed in 1985 and 1986, we can see that in 1985 the average assessment on an"AA" citation was $24,271, and in 1986 it declined fully 29% to $17,438. In 1985 the average assessment for "A" violations was $9,976 and, in 1986 it also declined, in this case 22% to $7,805. In 1985 the average assessment for a"B" violation was $862, in 1986 it declined 12% to $772. The average fine in 1986 represented 69% of the maximum allowable for "AA" citations; for"A" citations in 1986 the average fine was 78% of the maximum allowable, and for "B" violations in 1986 it was 77% of the maximum allowable.

There has been a decline in average fines assessed which ranges from 12% of"B" violation assessments to a 29% decline in "AA" violation assessments over the two-year period, 1985-1986, since NHPPA was enacted.

However, the NHPPA legislation required that DHS/LCD, in determining the amount of civil penalties to be assessed with each citation, take into consideration a number of factors, including such good faith efforts as had been undertaken by the facility to prevent the occurrence in question, as well as the facility's prior history of compliance with regulations. Whereas in 1985 it appears LCD assessed most ciations at the maximum, in 1986 it appears that closer regard is being given to the assessment criteria specified in NHPPA.

In addition to the growth in the number of citations issued and the amount of fines assessed, there were new penalties assessed under the 1985 NHPPA legislation, concerning patient or facility records. In 1985, 11 violations for Willful and Material Omission (WMO) of records were issued resulting in $37,500 in fines assessed and 16 violations were issued for Willful Material Falsification (WMF), resulting in $50,750 in fines assessed. In the first six months of 1986 there were 10 WMO violations issued (assessed $35,000) and 16 WMF violations issued (assessed $51,200). In addition, there were 3 violations issued for retaliation, which was also made illegal by NHPPA. These 3 violations were assessed a total of $21,000. WMF, WMO and retaliation violations for the first half of 1986 totaled 29 and were assessed at $90,200. It appears the numbers of violations

and the fines assessed in these areas will substantially exceed the 1985 totals.

In the past, nursing home advocacy groups had complained of what they alleged was a too-close relationship between the nursing home industry and DHS/LCD. Indeed, a steady number of former LCD surveyors have gone to work for the industry. It has been suggested that there should be an interval of time during which former California LCD employees could not go to work in the long-term care profession. In our 1983 Report, The Bureaucracy of Care, we suggested dealing with this issue in the same way, for example, as the Department of Defense. Department of Defense employees may not be employed by defense contractors doing business with the government for a specified period of time. Many consumer groups suggested that the relationship between the nursing home industry, and its trade associations, was "too close," and that one visible result of that alleged closeness was an enforcement policy that was not as active and strong as advocacy groups would have wished. Under the present administration of DHS and LCD, these complaints (if not the issues themselves) have been far less predominant than in the past.

While the LCD enforcement and its citation assessment process continues to be problematic, there is wide consensus that LCD's enforcement posture has changed. The results of this change are as would be expected: the nursing home industry feels that many citations are either too stringent and/or are given without sufficient justification. This view is part of a larger one which is integral to the industry's ideology that they are, and continue to be, over-regulated. Nursing home advocacy groups, on the other hand, have files of complaints which they have received where either LCD did not issue a violation, or where a "B" citation was given when an "A" should have been, or an "A" given when persons directly affected by the situation would have found a "AA" citation more appropriate. In addition, it is the opinion of many consumer advocates that there are still large numbers of offenses taking place in nursing homes that should receive citations, and further, many of the citations that are given are not stringent enough.

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. In line with NHPPA guidelines, in 1986 a number of factors appear to have been considered in determining assessments. This led to a decrease in average assessments from 1985 to 1986.

Calls for substantial deregulation of the industry, or, in particular, a diminuation in the enforcement efforts of LCD, are unwarranted. Conditions in long-term care in California require

ongoing regulation and monitoring. Those activities would be substantially diminished in their effectiveness under a different LCD enforcement posture.

4-2. In 1983 and 1984, 69% of facilities received no citations. In 1985, this figure decreased: 60% of nursing homes received no citations. In other words, 40% of the almost 1,200 facilities in the State (or 480 facilities) did receive some form of citation in 1985. In 1986 this 60-40 division continued essentially unchanged from 1985.

4-3. Approximately 11% of facilities account for a fully 40% of the citations issued, according to industry data. These figures lend some credence to the belief that there may be a "core" of facilities which are particularly troublesome. Given the fact that almost 75% of all citations are given in areas directly concerning resident health or rights, this "core" group of facilities requires special oversight.

Recommendations

4-1. LCD should continue its good faith efforts at fair enforcement practices. These practices should not be deterred. Virtually all policy studies of nursing home regulation, including the 1986 federal study conducted by the Institute of Medicine, conclude that more rather than less regulatory and oversight activity is appropriate and needed given conditions in many long-term care facilities.

4-2. Reporting of LCD numbers of citations issued, total fines assessed, and average fines assessed should be undertaken on an annual basis by both LCD and by this Commission 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 complainant 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 in order to improve performance and to assess on at least a semi-annual basis whether other sanctions should be considered in order to improve their performance record and their quality of care.

4-5. The listing of "core" facilities should be kept current and should be shared with the Ombudsman Program at the State and sub-State level, the trade association, other local and State agencies, and consumer groups which provide information and referral services for long-term care consumers.

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, a 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.

If citation activity increases and collection of assessments is only a relatively 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 activities are fairly pursued.

Only 8.4% ($449,635) of the $5,319,890 total assessed in penalties (representing 1,981 citations) in 1985 has been collected to date. If we presume that many of the fines assessed are (or should be) collected in the year following their assessment, the following Table shows that this is not taking place:

Assessments and Collections, 1983-1986

Year	Assessed	Collected	%Collected (this year)	%Collected (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 has increased only 25% in this same 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.

It is important to add at this point that there is another way of reading this data which does somewhat improve the picture in terms of percentage of fines collected. The figures given in the Table above are for all assessments. As we shall see in the remainder of this Chapter, fully $2.1 million of the $5.3 million in fines assessed in 1985 are uncollectable under present law. Further, as the data to be presented show, $1.1 million of the fines assessed, according to LCD, are collectable.

If we take these figures as another way of viewing the issue of assessments collected, overall collection rates will be substantially higher than the 8.4% we cite in the Table above for 1985. Using this alternative way of viewing the data, $5.3 million was assessed in 1985, however $2.1 million of that amount (which is almost 40%) is not collectable under current law. This leaves $3.2 million assessed which is collectable for 1985. LCD estimates that as much as $1.1 million of that which is collectable will, in fact, be collected (through penalties received in settlements, minimum penalties paid, full penalties paid, or assessments collected through off-sets to Medi-Cal).

We can thus recalculate the 1985 collection data differently than was done for the Table above: $3.2 million (of the total $5.3 million assessed) was collectable, and $1.1 million was collected. Viewed this way, the collection rate for 1985 is 34%, not the 8.4% shown in the Table above. It can be argued that both the 8.4% and the 34% collection percentages are accurate. However, either figure used alone reveals only part of the complex relationship between assessments and collections.

What else can be said of these collection rates? Viewed from the perspective of total fines assessed, the amount collected for 1985 is 8.4%. Viewed from the perspective of fines collected that were collectable, 34% was collected. Neither collection figure is high. Depending on which figure you use, either 66% of the fines assessed and collectable were not collected, or, worse, more than 91% of the total fines assessed were not collected. In either event, collection rates for 1985 were not what might have been expected. As the Table above shows, these rates did not materially change for 1986 assessment collections.

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.

Uncollectable Assessments

For 1985, $5,319,890 was assessed for citations. Almost 40% of these assessments are classified by LCD as "not collectable." The penalties not collectable and the percentage they represent of the total penalties assessed in 1985 are shown in the following Table:

1985 Citations LCD Classifies "Not Collectable"

Type	Amount	% of Total Assessments
Penalties Waived In Settlement	$ 208,625	4.0
Waived for Minimum Penalty Payment	$ 469,450	8.8
Returned/Closed by Attorney General	$ 62,500	1.0
Adjusted in Citation Review Conference	$ 283,000	5.4
Corrected "B" Citations	$1,108,440	20.8
TOTAL	$2,132,015	40.0

Source: LCD, February, 1987

More than $1.1 million, or 20.8% of the total assessed in 1985, are for "B" citations which were corrected and thus were not subject to fine under current law. These assessments are thus not collectable. While "B" citations may be appealed, and some 35% are, most "B" citations stand with no assessment if an approved plan of correction is submitted to LCD. This set of circumstances applies to the first "B" citation given for violation of a particular regulation. (The process, which takes place if a facility receives a second "B" citation for the violation of the same regulation within 12 months or a third "B" citation for the same section which can lead to a trebling of the assessment on the second "B" citation, is described in detail in Chapter Seven when we address the issue of litigation and litigation delays). Given the relative ease with which plans of correction for first "B" citations can be developed by facilities, and will be accepted by LCD, most first "B" citations are "on paper" only, and are not collectable.

In 1982 the Auditor General recommended against the practice of removing assessments for all corrected first "B" citations. Further study of that recommendation was urged in this Commission's 1983 study of nursing homes. 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.

Given that the number of "B" citations issued and fines assessed for them were only slightly lower in 1986 than in 1985, we can expect essentially these same circumstances to continue with the "B" citations in 1986: approximately $1 million in assessed fines for first-time "B" violations will be uncollectable in 1986. As the Lieutenant Governor stated to the Advisory Committee: "We made a mistake in not imposing a fine that sticks on "B" citations."

Collectable Assesments

For 1985, penalties collectable and their percentage of the total assessed in that year are shown in the following Table:

Collectable Assessments, 1985

Type	Amount	% of Total
Penalties Settled	$ 578,375	11.0
Minimum Penalties Paid	$ 168,750	3.2
Full Penalties Paid	$ 279,175	5.2
Medi-Cal Offset	$ 83,600	1.6
TOTAL	$1,109,900	21.0

Source: LCD, February, 1987

The remaining 39% of the total penalties assessed in 1985, $2,077,975 million, are pending adjudication. Given that LCD must forward these cases to the Office of the Attorney General (AG) within one year, none of the 1985 cases remain in LCD as of February, 1987; they have all been forwarded to the AG and thus are classified by LCD as "pending adjudication."

Many of these cases involve citations and assessments for major violations resulting in "AA" or "A" citations. In addition, a substantial number of these key cases often involve more than one of these serious citations. Under current law, the AG may take up to twelve months from the date that a citation is issued or from

the date of a CRC decision to file an action in Superior Court. During this time all rights of due process must be accorded to the facility and business continues at the particular facilty while the case is being litigated.

Given the magnitude of some of these penalties, the seriousness of the offenses that brought about the citations and assessments, and the length of time that it takes the AG to bring action, it is usually in the best interest of the facility to litigate. There are two additional reasons to litigate. First, the cost of litigation is a part of the "cost of doing business" and thus an allowable cost for Medi-Cal cost reports and in the calculation of the Medi-Cal reimbursement rate. There is little or no reason not to secure counsel in these circumstances. Second, and more importantly, the longer a case is delayed, the more "stale" it becomes, and the more likely that there may be a settlement resulting in a reduced penalty. Thus, it is usually in the best interest of a facility to litigate--delays almost always work in their favor.

As we noted above, only 5.2% or $279,175 of the more than $5.3 million in penalties assessed in 1985 were paid in full. The remainder of the cases in the "collectable" category, 15.2% of the grand total assessed in 1985, were in fact collected only after some form of arrangement whereby either there was an acceptable minimum payment, fines were collected through a Medi-Cal offset or there was a settlement. In short, virtually all these "collectable" fines, with the possible exception of that small group that was paid in full, involved some labor to make the fines "collectable" by LCD, or, in some small number of cases, by the AG.

The final category of fines assessed in 1985 that are listed as "collectable" is the $2,077,975 that is "pending adjudication." These pending cases with their assessments represent the single largest percentage category of the 1985 citations, fully 39% of the total. We shall have more to say about this group of citations and assessments in the Chapter Seven which is devoted to litigation delays.

Findings

5-1. The integrity of the LCD enforcement effort is greatly impaired by the low rate of citation assessments actually collected. The enforcement effort is rendered without deterrent strength if, in fact, the collection rate for citations cannot be significantly improved. The number of citations issued and the amount of assessments for these citations both expanded significantly with the passage of NHPPA. There is data that indicate that the collection rate for these assessments has dropped rapidly with the passage of NHPPA. For 1985, only 8.4% of the total fines assessed were collected.

Given the fact that some assessments are not collectable (e.g., first-time "B" citations), we need also to present the collection rate on those assessments which are collectable under present law. In 1985 the collection rate for those assessments which are collectable was 34%. For 1986, between 11.8% and 12.3% of the total fines assessed were collected. These collection rates are unacceptable. If continued, they could reduce the entire enforcement process to 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. The net result of this litigation activity, to date, has been to materially slow the process of citation appeal, disposition, and, when possible, collection. The nursing home industry has little, if anything, to lose, and much to gain by seeking to appeal citations which allows for having the opportunity to see fines reduced or settled, as well as having the opportunity to forestall any payments until such adjudication takes place. For example, in 1985, after the passage of NHPPA, more than one-third of "B" citations given in the remaining 10 months of that year were contested.

5-3. The second largest group of 1985 citations is the $1.1 million in assessments, for first-time "B" citations: they represent 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 the Auditor General recommended that all "B" citations become subject to assessment rather than their semi-automatic assessment dismissal.

Recommendations

5-1. LCD and the Office of the AG should assure that the citation assessment collection rate improves significantly. This will mean the provision of adequate resources to make certain that cases leave LCD for the AG's office in a timely fashion, as well as the development of cooperative strategies between these two offices to make certain that the number of cases pending adjudication can be promptly handled. The alternative to this would be a continuation of litigation delays and of low collection rates which leave at least 66% of collectable assessments uncollected. Neither of these situations are acceptable.

5-2. Legislation should be enacted so that assessments would not be waived for those first-time "B" citations issued in the areas

of patient care, nursing services, medications, and patients' rights. Correspondingly, if a "B" citation in any of these areas is upheld in a Citation Review Conference, the penalty shall not be waived or dismissed. Assessments for all other first-time "B" violations would continue to be waived upon submission of an acceptable plan of correction to LCD.

CHAPTER SIX

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

Background

In May of 1985, DHS insituted a new program specifically for special inspections of facilities which were believed to be particularly deficient in rendering care. These special inspections are different from the annual surveys conducted by LCD, and they are often occasioned by the history of complaints that have come to LCD regarding a facility. This program is called the Enhanced Enforcement Effort (EEE).

EEE reviews are roughly three times more labor intensive than a routine LCD survey. A routine survey involves two persons working eight hours daily for five days, and thus takes 80 hours of time. In contrast, an EEE review takes 240 hours: it utilizes six persons working eight hours per day for five days.

In 1985, 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. EEE surveys were begun in May, 1985; the 1985 EEE surveys represent eight months. The following Table provides EEE outcome data for this period:

LCD EEE Activity: May-December,1985 and 1986

Action/Activity	1985	1986	%Change
EEE Surveys Performed	27	16	-41
"AA" Citations Issued in EEEs	6	5	-17
"A" Citations Issued in EEEs	37	41	10
"B" Citations Issued in EEEs	162	117	-28
WMO/WMF Violations in EEEs	1	10	1,000
TOTAL FINES ASSESSED in EEEs	$813,150	$957,549	15
TOTAL LCD ASSESSMENTS (CITATIONS + VIOLATIONS)	$5,101,550	$5,408,140	6
EEE PENALTIES AS PERCENT OF TOTAL LCD PENALTIES ASSESSED	15.0%	18.7%	3.7%

Source: LCD, February, 1987

These data reveal that the number of "AA" and "B" citations issued during EEE surveys fell from 1985 to 1986, and that there was a small increase in "A" citations. The major results of the 1986 EEE effort were 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.

These data can be seen more closely with the aid of the yearly incidence and assessment figures for these two particular violations:

YEAR	#	WMO ASSESSMENT	#	WMF ASSESSMENT
1985	11	$37,500	20	$50,750
1986	16	$42,200	47	$225,350

Source: LCD, February, 1987

WMF violations increased 235% and assessments for these violations increased 444%. Ten of the total 53 WMO/WMF violations were issued in the course of EEE surveys in 1986; only 1 of the 31 WMF/WMO violations were discovered in the course of EEE surveys in 1985. This finding doubtlessly reflects more aggressive attention being paid by LCD surveyors to conditions that would lead to violations being given for WMF or WMO conditions. This would appear to be especially true during the 1986 EEE undertakings.

The nursing home industry has voiced some displeasure at the EEE undertaking. They believe that there are inadequate criteria developed by which LCD selects facilities for an EEE survey. This belief appears to be a variation of the industry's allegations concerning the overall "subjective" behavior of many surveyors. The industry is concerned about the potential for EEE surveys to be exercised in a harrassing manner.

On the other hand, the consumer community found the EEE provisions of NHPPA to be one way in which LCD could stretch its resources to pay in-depth attention to a limited number of facilities where they had reason to believe that such a labor and time intensive special survey would do the most good. Not surprisingly, many in the industry would like to see EEE diminished or abandoned and many in the consumer or advocate community applaud LCD's EEE efforts but find them too limited.

LCD proposes to conduct some 24 EEE inspections yearly. LCD estimates that approximately 5% of the 1,236 nursing homes in California should receive an EEE inspection. This would mean that there should be about 62 EEE inspections yearly and LCD presently has the resources to conduct 24. This leaves some 38 facilities which LCD believes should have EEE inspections not receiving them.

In other words, LCD resources allow them to inspect only 39% of those facilities which they believe should receive EEE attention.

The fact that there are a significant number of EEE surveys conducted where neither "A" nor "AA" citations were issued seems to indicate that EEE surveyors do not believe that they must find violations and issue large assessments in each and every 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 number of EEE surveys decreased 40% from 1985 to 1986; however total EEE assessments increased 15% in this period. The LCD EEE undertaking appeared to shift focus somewhat in 1986, at least in terms of citations issued and violations assessed. The relatively small number of EEE surveys conducted in 1986 resulted in assessments that amounted to 18.7% of the total LCD assessments for the year. This represented a 3.7% increase over 1985 totals.

There is no real way of measuring the effect of EEE surveys in general, or of one EEE survey in particular, on the quality of care in either that specific facility or in long-term care facilities Statewide. EEE surveys are yet another impetus to for facilities in remain in good operating order, to offer good care, and to be aware that such intensive surveys are always possible. Furthermore, facility operators know that the likelihood of an EEE survey increases should there be an increase in the quantity and seriousness of complaints about a facility.

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 an EEE inspection. They are actually able to conduct 24 EEE inspections per year, which is less than 2% of the State's facilities.

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. The professional judgment of appropriate LCD staff should not be required to develop specific guidelines for EEE surveys. To do so would be an open invitation to legal challenges from the industry to whatever wording was developed for such surveys. 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. In addition, LCD should continue EEE efforts in those facilities where they have reason to believe WMO or WMF conditions may exist.

6-3. LCD should receive additional resources for additional specialized regional office staff to conduct EEE inspections in 5% of the State's facilities 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.

While such cooperation has always been necessary, the need for it became even more pressing with the passage of the NHPPA legislation in March of 1985. From that date to the present, the volume of enforcement activities undertaken both by LCD and by the Health, Education and Welfare section of the Civil Division of the AG's office has steadily increased.

One unanticipated side-effect of the NHPPA legislation, and the enforcement efforts of LCD which followed the legislation, has been the significant increase in the use of lawyers both for individual nursing homes (where legal fees are an "allowable cost of doing business" and are therefore included in the calculations used in the Medi-Cal cost reports submitted to the State to determine Medi-Cal reimbursement rates), and for the State, namely the AG's office.

The undertaking of these litigation activities, both in terms of preparation and in terms of actual court time, can often be a slow and expensive process for all concerned. To cite only one example: the AG's office estimates that attorney costs for a member of their staff will be $72.70 per hour for 1987-1988. AG lawyers are estimated to work 1,820 hours per year for a total annual cost of almost $132,000. Attorney hourly rates in the private sector, where overhead and salaries are often higher and where the profit motive operates, would often be expected to exceed the AG's estimates for use of its own legal staff.

Mr. Charlton Holland, Assistant Attorney General in charge of the Health, Education and Welfare section of the Civil Division of the AG's office, provided the Commission with data which show that the total number of hours worked by his office on nursing home matters has increased 98% from 3,290 attorney hours in 1984-1985 to 6,524 hours estimated for fiscal year 1986-1987. Paralegal hours have increased 26% over this same period from 5,125 to 6,914. Clearly, there has been a significant workload increase, and it is likely

to continue as the AG's office works on citations and appeals from NHPPA's second year, 1986.

The cost of the AG's legal services for nursing home litigation continues to grow. It seems fair and reasonable that these costs be distributed as they are in many other legal actions. As such, we believe that court costs should be paid by the prevailing party in all nursing home litigation. Furthermore, when facilities lose an adjudication, we believe that the court costs, including attorney fees, should not be considered a "cost of doing business" for purposes of Medi-Cal reimbursement. Rather, the court costs (in the event that a facility does not prevail), should come from facility profits (or, in the case of non-profit facilities, from facility surplus).

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 been either prepared by LCD for AG action, have been sent to the AG's office, or have been filed in court by the AG, but no resolution has yet been reached. At the present time, <u>delays in the resolution of these cases represents the single most important impediment in the overall enforcement process</u>.

Mr. Holland testified at the Commission's initial NHPPA follow-up public hearing in January of 1986 and again, at the public hearing conducted in conjunction with this inquiry, in February, 1987. In his most recent testimony Mr. Holland outlined how the AG's office works with DHS/LCD in regard to nursing home enforcement matters:

> The Legislature has left the ultimate decision whether the issuance of a citation was valid and what penalty should be assessed to the judiciary. A facility has the right to an informal review of the issuance of the citation by a [Citation Review] Conference with the Department [of Health Services/LCD]. This conference is not required. In the event the facility wishes to challenge the issuance of the citation or the proposed assessment, in the instance of "A" or "AA" citations, the facility is required to notify the Department [LCD] within a short period that it wishes to have the matter decided by a court. If the citation is a "B", the facility is required within a short period of time to file a complaint in court to challenge the issuance of the citation or the proposed assessment.

The AG first becomes involved with a citation when the Department forwards the file of a "AA" of "A" citation for enforcement or forwards a complaint served on the Department by a facility to challenge a "B" citation.

Mr. Holland provided the data in the following Table concerning the large increase in cases that have taken place as a consequence of NHPPA and the LCD monitoring efforts, including the Enhanced Enforcement Effort:

Cases Received By the AG from DHS/LCD

Year	"AA" Citations	"A" Citations	"B" Citations	WMO/ WMF
1984	N.A.	66	268	N.A.
1985	12	107	60 +(24)*	9
1986**	23	153	69 +(122)*	11
1987***	32	376	374	unknwn

* Prior to NHPPA, "B" citations were only filed by LCD with the AG. AG policy at that time was not to attend to these complaints unless they were attached to another "A" citation, or could be used in building an administrative case against a facility. With the passage of NHPPA in March, 1985, "B" citations had to be appealed by the facility itself.

For 1985 and 1986 "B" citations, the first number given here is for those complaints sent directly from LCD. The second number, given in parenthesis after the plus (+) sign, is the number of complaints brought by facilities. Mr. Holland estimates that a single complaint, on the average, contains 2.5 "B" citations, the range being from 1 to more than 20 "B" citations wrapped together in a single complaint. Thus the total number of "B" complaints in 1985 would be 60 from LCD plus 24 from facilities (with an average of 2.5 citations for each of the 24, or a total from facilities of 60) and thus a "B" total in 1985 of 60+60 or 120. For 1986, the "B" total would be 69 from LCD plus 122 complaints from facilities (with an average of 2.5 citations per complaint) for a total of 374. It is these larger "B" figures, namely 120 for 1985 and 374 for 1986, which better reflect AG workload coming from nursing home enforcement activities. Given the potential for doubling of "B" citations, it may well be that the 374 "B" citations that Mr. Holland estimated would be appealed in 1987 could turn out to be a significantly low estimate.

** Through December 15, 1986; Mr. Holland did not have the complete 1986 figures in late March of 1987.

***These 1987 estimates were prepared in March of 1987 by Mr. Holland. Actual citations received as of late March, 1987 by the AG were: 8 "AA", 94 "A", and the presumption is made that the number of "B" citations challenged by facilities in complaints to LCD/AG will remain the same as in 1986, that is 374.

The 1987 estimates are projections from the actual numbers received in the first quarter of 1987. As noted directly above, there is reason to believe that at least the "B" citation challenges could be significantly highly than the 374 figure that Mr. Holland used.

LCD issued 32 "AA" citations in 1985; 24 of them had been received in the AG's office as of December,1986. Seven of these "AA" citations issued in 1985, which had reached the AG's office by mid-December of 1986, have been settled for $231,250 with $43,750 of the original assessment waived, resulting in a collection rate of 84%.

The AG's office received 107 "A" citations from LCD in 1985, some of which may have been issued by LCD in 1984 or even before. LCD issued 318 "A" citations in 1985, however the AG's office had received only 155 of them by mid-December of 1986. The remainder of the 1985-issued "A" citations, 163 in number, either were settled within the purview of LCD (in a CRC, for example) or the complaint had not yet been forwarded to the AG by LCD.

There have been, however, a large number of these 1985-issued "A" citations that have arrived in the AG's office in the first quarter of 1987. Thirty of the 155 "A" citations that were issued in 1985 and received by the AG by mid-1986 were settled. These 30 cases bore a total of $560,500 in original assessments. These cases have been settled for $420,125 and the remaining $140,375 from the original assessments was waived in settlement; the collection rate on these 30 "A" citations is 75%.

The AG's office has completed action on 37 citations (7 "AA"s and 30 "A"s) which were issued in 1985 and which were referred to the AG's offices by mid-December of 1986. They have collected a total of $651,375 on them, and waived in settlement $184,125 as a part of these actions. For the cases closed to date, the overall collection rate is 72%. What remains, of course, is the remaining 1985 cases, which total more than $2.07 million in original assessments.

Mr. Holland testified at the public hearing in February, 1987 that the collection rates on the remaining 1985 cases will probably <u>not</u> continue at present levels: "Frankly I would doubt it. I think that settled cases [that is, those which were settled quickly and relatively early] tend to be the ones where the facilities are deplorable. The ones [which are remaining and in need of adjudication] feel less vulnerable and they do not settle. They force us to go to trial." In these instances, of course, the length of time taken to prepare the cases, both at LCD and for trial by the AG, will be substanial,and the effort will be more costly than some of the earlier settled cases. In addition, Mr. Holland believes that there is a significant amount of statutory vagueness with regard to "AA" and "A" violations. This vagueness makes these prosecutions more difficult and time consuming for the AG's office.

In addition, there have been instances of "A" citations issued in 1985 by LCD which have not as yet been received by the AG. Reasons for these delays include the difficulty in gathering expert testimony in a timely manner and other delays in issuing decisions from a CRC.

In order to speed the process of seeking adjudication for "AA" and "A" citations, members of the Advisory Committee proposed regulatory changes which would require that LCD fully prepare and move all "AA" and "A" citations to the AG's office within 45 days of the issuance of the citation or within 45 days of a CRC. At the present time LCD may take up to one year to move these cases to the AG. The Advisory Committee was assured by the Director of the LCD Regional Office for Los Angeles County that such a deadline for getting cases to the AG could be met. He stated that,in his office (which has responsibility for one-third of all nursing homes in the State) there is presently "no backlog in moving cases to the AG." Other LCD Regional Offices should be able to move cases to the AG in a similar manner. Given that the "AA" cases are ones where a death has resulted, faster movement of these cases in particular may provide some small amount of comfort for families and loved ones, rather than increasing their grieving through bureaucratic delays and inaction.

There are two additional issues concerning preparation of these cases which have to do more with LCD than with the AG's office. First, complete and careful preparation of a case must be undertaken by LCD, and especially its medical staff in regard to "A" and "AA" citations, before they are forwarded to the AG's office. The AG's office believes this is often not done and thus either the AG must return the case to LCD for further information or the AG must notify LCD that the AG will not prosecute the case because the materials presented are not strong enough to warrant pursuing the case. Second, in the view of the AG's office there is little pre-screening of cases undertaken at LCD prior to their submission to the AG's office. This means, again, that cases must be returned to LCD from the AG requesting further information. Lacking such information, the AG's office notifies LCD that it cannot move forward on the case. The longer <u>any</u> of these serious cases remain dormant, the more likely it becomes that the case and its evidence will grow stale and more difficult to undertake. The AG's office should not be faced with the prospect of dismissal of any of these cases because of the inability to prepare them for effective prosecution.

<u>The Issue of the "Lost" "B" Citations</u>

In the discussion above concerning actions currently being taken on the 1985-issued citations, it should be noted that <u>no</u> action has been taken on any of the 374 "B" citations in the AG's office.

Present law assesses no fine for the first "B" citation given in a twelve-month period, a collectable assessment for the second "B" citation of that same regulation given in that same twelve-month period, and a trebled assessment if a third "B" citation is issued for the same regulation within the same twelve months.

Of the 374 "B" citations that have come to the AG's office in 1985, 65 (17% of the total) are first "B" citations (not collectable) being appealed; 7 (3%) are second "B" citations (collectable); and 53 (14%) are for a third citation and are trebled and collectable.

The status of the remaining 249 (or fully 66%) "B" citations is "unknown." The AG's office is not aware of whether the "B" citations involve a first, second, or third citation, and thus is unaware of whether the citation is uncollectable, collectable, or collectable with trebling. More often than not, when "B" citations are sent to the AG from LCD there is no notification on the citation, or package of citations, as to whether this is the first, second, or third violation of the same regulation. The AG's office, at the present time, has no way of finding out this information other than by seeking it from LCD. While there has been a formal Memorandum of Understanding entered into between the AG and DHS which is to encourage mutual cooperation, clearly this is an area where better communication and sharing of information is needed.

We can speculate about the percentage distribution of the 249 "unknown" citations: if they are distributed in the same proportion as the 125 "known" "B" citations, it would mean that 52% of the 249 (or 130 citations) would be for first offenses, 6% of the 249 (or 15 citations) would be for second offenses, and the remaining 42% of the 249 (or 104 citations) would be collectable as trebled. If this extrapolation is accurate we then estimate that there would be, in addition to the 53 citations that are <u>known</u> to be trebled "B" citations, an additional 104 of those presently "unknown" that could also be trebled. This would mean that there could be 53 plus 104, or 157 of the 374 "B" citations which have been appealed to the AG's office in 1985 that could potentially be trebled and collectable. Thus, fully 42% of the "B" citations appealed to the AG's office are trebled. That is a large number of "B" citations in trebled status, and a significant amount of assessments due.

As Mr. Holland and others have noted, the present system virtually encourages facilities to file lawsuits against DHS to challenge even a first "B" citation, even though it has no fine imposed. This is so because a facility is seeking to protect itself against future citations that will carry assessments. Correspondingly, if a facility has received no second or third citation in twelve months, it would simply ignore the first "B" and also not move further with its original lawsuit.

The resources of the AG's staff are such that, as a matter of

policy, they have not moved to prosecute any first or second "B" citations in the past: the effort is too great and the consequences too small in terms of the increasingly large caseload the office has with the more serious citations and violations. The nursing home industry knows this, of course, and this renders the issuance of a "B" citation-- unless it becomes the basis of a second or third violation of the same regulation within a twelve-month period-- financially meaningless, and almost inconsequential from the point of view of many facilities.

However, we need to inquire as to what will happen with those citations which are now trebled. As AG resources increase, and the quality of the timely information that is received about these potentially trebled cases also increases, there would be every reason to suggest that these cases should receive the top priority of all the "B" citations in the AG's office. Not pursuing these trebled cases will send a clear signal to the nursing home industry, and their counsel, that trebling is not a serious concern from the point of view of the enforcement efforts of the AG.

The burden of challenge to these "B" citations lies with the facilities which, as a matter of law, are required to bring the case to trial within five years of the date the facility filed the legal complaint.

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 further diminish the value of all "B" citations, it would render much of the LCD enforcement effort somewhat empty, and, finally, it would not respect the mandate or the intent of the NHPPA legislation.

Changing the "B" Citation Enforcement Pattern

In Chapter Five, we noted that 20.8% (or more than $1.1 million) of the total 1985 citation assessments were for "B" first-time citations which are not collectable under present law. In Recommendation 5-2 of Chapter Five, we endorse legislation which would remove the waiver of fines for first-time "B" citations in the areas of patient care, nursing services, medications, and patients' rights.

The Commission believes that mechanisms should be implemented whereby LCD can bear primary legal responsibility for adjudicating "B" citations. This should be done in a two-step process:

(i) Present law should be amended to provide that "B" citations for regulatory violations in the areas of patient care, nursing services, medication, and patients' rights are due and

payable unless the licensee requests a CRC to be conducted by LCD's Independent Hearing Officers. Such a request must take place within 30 days of receiving the citation. The Independent Hearing Officers shall make conclusions of law and findings of fact.

(ii) The facility may, within 30 days of the Independent Hearing Officer's decision, file an appeal by writ of mandate to Superior Court. If a facility files to overturn the CRC decision, LCD shall prepare the complete record of the CRC for the Superior Court within 90 days. At this time the AG's office would join the proceedings on behalf of DHS/LCD.

Findings

7-1. As a consequence of NHPPA and the LCD EEE special surveys, the overall level of litigation activity undertaken by the AG with regard to nursing homes matters has increased dramatically. As the caseload has increased, the AG's office has increased the number of attorney hours spent on nursing home litigation by 98% in the past two years. Professionals in the AG's office have been most concerned with litigation arising largely from "AA" and "A" citations, and the other violations cited as a result of regular surveys, complaints, or EEE investigations.

7-2. The costs to the State for the overall nursing home enforcement effort are substantial and growing. DHS/LCD 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 1986-87 budgeted figure of $465,702. In addition to this AG allocation provided by LCD, LCD also expends DHS funds on various enforcement efforts, including Citation Review Conferences.

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" under the Medi-Cal program. 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. Thus the State can be said to be bearing most of the costs of the total enforcement effort: it pays for the State (LCD and AG) effort and, in addition, the State also indirectly is paying for some portion of the facility's legal costs through inclusion of these costs in the Medi-Cal cost formulas and reimbursement rates.

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. There are at least two important areas where this lack of coordination is proving detrimental to the overall enforcement effort:

(a) There is a need for adequate preparation of cases by LCD for the AG. LCD needs to improve its pre-screening of cases for the AG to assess their merit. If these actions are not taken in a coordinated fashion, the AG will often return the case to LCD for further information, or, lacking the availablity of that information, the AG's office must notify LCD that it will not prosecute a case, and that it must be dismissed.

(b) There is an additional difficulty with regard to those "B" citations which are collectable and eligible for trebling. Ordinarily the AG receives "B" citations with no notification of whether the citation case is the first, second, or third citation or whether more than one citation for the same violation has occurred within a twelve-month period and thus cen be trebled.

7-5. Basically "B" citations are "lost." At the present time facilities have 60 days to file a complaint in Municipal Court to contest a "B"citation either upon receipt of the citation or if they are dissatisfied with the results of a Citation Review Conference. Within three years of that date the facility may serve a summons on the Director of DHS stating their intent to appeal the citation or CRC decision. Within thirty days of the facility's serving the summons, the AG's office must file a response. The facility still has two years in which to bring the case to trial. If, after three years the facility has taken no further action, the citation remains and the assessment, if any, stands. This three-year period will not arise for those "B" citations that were issued and contested in 1985 until three years later, that is until 1988. If, however, a facility has served a summons on the Director of DHS, the maximum amount of time before the issue is resolved could be as long as five years. In those cases, if the citations were issued in 1985, resolution could come as late as 1990. The AG's office does not have the resources to pursue these "B" citations on its own and, except for those cases where there is not only trebling but also an "A" citation involved, the AG's office has had to give virtually all "B" citations last priority.

Recommendations

7-1. The AG's resources for nursing home litigation are inadequate. Neither the AG's office nor DHS/LCD anticipated 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, presuming enforcement activity levels hold at or near their present levels. To the extent the AG's office is understaffed, the entire enforcement effort is slowed and potentially seriously undermined.

7-2. The cost of a facility's legal services to contest citations is not known. Legal services associated with facilities seeking counsel for efforts to appeal citations or their assessments should be a line items on the Medi-Cal cost reports. Regulatory changes should be enacted so that court costs, including attorney fees, of nursing home litigation are paid by the prevailing party. In those cases where the facility does not prevail in court, and must pay all court costs, these costs should not be an allowable or reimburseable Medi-Cal expense for facilities.

Notwithstanding this proposed method of determining who pays for nursing home litigation, DHS should examine the present costs of litigation to Medi-Cal from facilities engaged in litigation, and make estimates of these costs for Medi-Cal nursing home expenses.

7-3. The AG's office should have on-line computerized knowledge of the status of citation and other nursing home litigation. 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. This system should be interactive; that is, the AG's office should be able to update that portion of ACLAIMS which would give the status of any and all citation cases which receive AG action. Further, this portion of the system should be used by the AG's office so that citizens who inquire about the status of a particular nursing home case in the AG's office could receive an informed and timely status report.

As long as the responsiblity for "B" citation appeals remains within the AG's office, immediate attention should be given to "flagging" those "B" violations which are eligible for collection and trebling. It is especially important that the AG give attention to these particular cases as opposed to the low priority that the AG's office presently accords first or second "B" violations. They should not be dismissed due to AG lack of resources.

7-4. Facilities may take as long as five years to bring "B" citations to trial. 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. A facility must serve a summons on the Director, within 60 days of the issuance

of a citation or whenever a CRC decision is issued and file a memorandum to set within six months from the date that DHS/LCD and the AG has responded to the facility's summons. If a facility has not acted within this period the citation is final; if it carried an assessment, it then becomes due and payable. The present five-year period unnessarily retards the judicial process and makes evidence needed for a fair hearing that much harder to gather or preserve.

7-5. The AG's office should make information about nursing home litigation available to the public. The AG's office should immediately organize citation cases so that they can be immediately connected with the ACLAIMS system, especially that portion of the system which deals with facility violations. In turn, the AG's office should add to the ACLAIMS system all serious violations and enforcement actitives (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 other interested parties, including, those who brought or are a party to the circumstances described in the case or complaint.

7-6. The AG's office has "A" violation cases from before NHPPA, and "A" and "AA" cases pending in court that are several years old. Regulations should be changed to require LCD to fully prepare all "A" and "AA" citation cases for the AG within 45 days of the issuance of the citation or 45 days from the issuance of the CRC decision regarding an "A" or "AA" citation. The one-year period that LCD sometimes takes to complete this process is counter-productive, and LCD should move these cases more quickly to the AG.

7-7. A joint AG-LCD Task Force should be convened with the intent of assigning priority to cases so that they can be handled expeditiously. This Task Force should review the status of all pending litigation in the AG's office, as well as the nature of the particular cases. The Task Force should also appoint senior AG management and senior LCD management (including personnel charged with maintaining the facility violation and CIS portions of ACLAIMS) to meet at least quarterly to assess the status of pending cases, seek increased resources for them if that becomes necessary, and make certain that the AG-LCD relationship is functioning effectively.

7-8. Representatives of the LCD staff who prepare cases for the AG should be coordinated more closely with representatives of the AG's office. If necessary, the AG's office should either conduct regular inservice trainings for LCD staff engaged in this preparatory activity or, if it is more efficient, should place a member of the AG's staff with LCD to serve as a resource. This arrangement is recommended both to decrease the number of cases that the AG has to return to LCD for further preparation, as well as to aid in such pre-screening activities whereby LCD staff could better learn what materials need to be included in a case for the

AG to move forward.

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 the the LCD Independent Hearing Officer. A facility could only overturn a CRC decision by filing a writ of mandate to 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, but place 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 is to make needed changes in operating the facility so that the quality of care is immediately improved and 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 no one: not the nursing home industry, and not various consumer groups. LCD representatives spoke of the Morro Bay case as a "judicial circus," and told the Advisory Committee that they would not use receivership again until or unless changes were made to make the process less cumbersome and more effective. Many members of the Advisory Committee believe the existing procedure is fundamentally flawed and in need of change.

Representatives of the proprietary nursing home industry summarized their position in regard to the use of receiverships in a working paper prepared for the Advisory Commitee in February, 1987:

> We [the California Association of Health Facilities] continue to endorse the concept of receivership to assist in the operation of a facility when it has been demonstrated in court that such action is desireable. That decision should be based on the facts that the licensee or owner is substantially out of compliance; [that] the licensee or owner has not demonstrated a turnaround potential to bring the facility into compliance and that patients are in imminent danger of death or serious physical harm

> We do not view receivership as a substitute for the various other mechanisms for ensuring facility compliance which are available to DHS. Rather, it is our position that receivership is an extraordinary remedy to be used only when attempts have been made to resolve the situation and there are no other alternatives available; but the circumstances are not so severe as to call for [license] revocation.

Consumer groups proposed for the Advisory Committee a number of changes in present receivership law and procedures which many members of the Committee believe will result in positive changes. These recommendations would result in substantial modifications to the procedures that were carried out in the Morro Bay case. It is important to note that, on a point-by-point basis, the proprietary nursing home industry opposes each of these recommendations as either unneeded, or as interfering in the operation of facilities.

Findings

8-1. Receivership as an "intermediate sanction" is a flawed enforcement tool. The single case of the use of the receivership provision of the law did not work in a timely or effective manner. Neither the nursing home industry, nor LCD, nor consumer groups were satisfied with the process used in this case.

8-2. The proprietary nursing home industry resists significant changes in the receivership process. Based upon a single experience, they believe that changes would "impair the ±checks and balance' role of the court and the licensee..."

8-3. LCD and Consumer groups believe that receivership could become a viable enforcement tool. For receiverships to be an effective and fair "intermediate sanction," modifications in existing procedures are needed.

Recommendations

8-1. Legislation should be enacted which would make the receivership process a more viable enforcement tool. Changes in existing receivership procedures which need to be included in such legislation include:

(a) requiring that the State, specifically DHS, establish uniform qualifications for a receiver. These qualifications should be developed by DHS/LCD in consultation with consumer groups and the nursing home industry;

(b) require that DHS establish and maintain a list of qualified receivers, soliciting suggestions for candidates from the nursing home industry as well as from consumer groups;

(c) the powers, duties, and authority of the receiver should be more clearly delineated under law. A successful receivership action must include clear authority for the receiver to carry out any and all such actions as he or she believes necessary to protect the health, saftey, rights, and welfare of the patients;

(d) patients or guardians should be permitted to petition for a receivership, and the use of an ex parte (emergency) order shall be allowed;

(e) provisions of the present law which allow the present owner or licensee to engage in operations of the facility during receivership may be continued; and

(f) the powers and duties of the receiver should be increased to include full control of a facility during the period of receivership. The present requirement that the receiver maintain a reasonable return on the licensee's investment should be modified so that the receiver is required to engage in "sound business practices" in order to strive to maintain the facility as a "going concern."

8-2. In addition to the Commission's support for the legislation described in Recommendation # 1 (a-f) above, we also recommend that DHS/LCD convene a Receivership Planning Group to examine the ways in which receivership might be better implemented. Membership in the Receivership Planning Group should include, at a minimum, representatives from those consumer groups who have recommendations for change in existing procedures, and represenatives of the nursing home industry. In addition, Receivership Planning Group membership should include DHS or AG counsel.

The Receivership Planning Group should begin meetings as soon as possible, toward the goal of producing a set of guidelines by September 1, 1987. These guidelines should serve to make receivership more effective and timely, and should be made available to the industry and consumer groups by LCD after they have been reviewed and accepted for use by DHS/LCD. This process of review and approval should be completed no later than December 1, 1987.

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. These complaints are often received by volunteer Ombudsman who may be the only regular visitor a person has in a facility, or, with less frequency, received by LCD, or, rarely, such complaints are received by local law enforcement authorities.

Virtually everyone agrees that there is a problem, albeit of unknown magnitude. Virtually everyone also agrees that programs and actions need to be taken to address this problem. Not surprisingly, what should be done about the problem is not something where consumer groups, the nursing home industry, and other interested parties are in full agreement.

The proprietary nursing home industry takes the position that they should not be held responsible or liable for theft which takes place in spite of their good faith efforts to prevent it, and if it is uncertain whether it was, in fact, a theft rather than a loss.

In meetings of the Commission's Nursing Home Advisory Committee, industry representatives showed their concern for this endemic problem and willingness to participate in the development of programs which would reduce both loss and theft of nursing home residents' possessions. It is the position of the industry that they can and will support the development of a listing of guidelines which should be met by facilities to prevent theft. The industry believes that when facilities have met these guidelines they should not be held responsible or liable for any theft that takes place thereafter.

Consumer groups and others disagree with this perspective. They believe more stringent programs need to be undertaken by individual facilities, that LCD should more seriously address the theft and loss issue, and that guidelines need to be developed which would be outcome-focused. These programs would be evaluated not only on a "plan of correction," or "inservice training," as useful as these may be, but,in addition, on whether theft and loss

in the facility is actually reduced.

Sometimes the events which have taken place are graphic enough so that there is no doubt that a theft has in fact occurred. There have been instances where residents have had their fingers bruised when cherished and often-valuable rings have been forceably removed, or in which necks and faces have been bruised when necklaces have been pulled off. There is, in all of these cases, a compounding of physical harm, the fear that the victim may have felt during and after the theft, and the emotional and financial loss of the item(s).

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 convenience items such as radios and televisions, even if the latter are chained down. In addition, protheses absolutely vital to the health and well-being of the resident, such as glasses, dentures, hearing aids, and other valuable health-related appliances are also among the items most often described as either "lost" or stolen. In the case of protheses, their disappearance materially reduces the basic functioning abilities of the person who, for example, no longer can see (without her glasses), or no longer can chew (without his dentures).

The great majority of these events are unreported, and undocumented. Ultimately these tragic events make residents, facility administrators and owners, and families frustrated, bitter, and angry. Residents are unlikely to report thefts because they fear retaliation (even though that is illegal under NHPPA) and because they often do not get a response from facility staff or administrators. More often than not local law enforcement agencies show no interest in such events, and will not take reports on these matters.

Facility administrators, well aware that activities such as these do real harm to any sense of professionalism they may be trying to engender in their staff, will often suggest that a "theft" is a "loss," often the "fault" of the resident or a family member. With most facilities paying aides close to minimum wages, and with aide turnover rates ranging between 75-130% per year in most facilities, it is assumed that some nursing home staff are engaged in theft. This is almost always very hard to prove, especially when the victim is either legally incompetent or frequently disoriented. Facilities often suggest that it is not staff engaged in thefts, but visitors who prey on residents by taking their belongings.

Many nursing home admission contracts de facto acknowledge this problem by containing clauses which released them from all liability from any theft of loss. That such clauses were illegal and unenforceable is not as important as the fact that very few actions were sought against facilities where thefts had taken place because the resident or family member understood from the

admission agreement that the facility was not liable for any lost or stolen articles. There is a pervasive belief among residents and families that thefts have to be tolerated as part of being able to remain in the facility and that complaints were either useless or counter-productive.

As we shall see in Chapter Twelve when we speak of admission agreements, many admission contracts for nursing homes continue to contain phrases which seek to release them from all liability for theft and loss if the items in question are not placed in safekeeping by the facility. This is difficult to do with a radio or television which is used every day. It seems almost foolish to do this with a new housecoat or similiar article of clothing. It is tragic that these steps would need to be taken with a wedding ring.

Legislation which would have increased the penalties for those convicted of stealing from nursing home residents has been proposed in the past, but has not been enacted. Usual policy is for facilities neither to replace or reimburse for such items.

Counsel for the proprietary nursing home industry trade association proposed to the Commission's Advisory Committee that <u>if</u> replacement or reimbursement were required, and that even <u>if</u> the facility were shown to be negligent or at fault, the facility should be able to call such expenditures "a cost of doing business" and that these replacement costs would thus be built into the Medi-Cal reimbursement calculations. Such a view attempts to "blame the victim," and, failing that, to bill the state for any expense that may be incurred for replacing or reimbursing stolen items. This proposal received no endorsement from any other members of the Commission's Advisory Committe.

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 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. <u>Theft and loss in nursing homes is endemic.</u> As LCD's Director, Mr. Jack Toney said in his testimony to the Commission at the Public Hearing, "theft and loss is one of the most insidious problems" with which those concerned with nursing homes must contend. Mr. Toney 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 the theft and loss of personal possessions."

9-2. There is presently little in regulation or legislation which deals with the issue of theft and loss in nursing homes in all its complexity. There are two existing regulations in this area. The first is concerned with the patient's right "... to retain and use personal clothing as space permits....," (Title 22, Section 72527 (A) (14). The second which relates to safeguards for patients' monies and valuables states that "... the facility shall make reasonable efforts to safeguard patients' property and valuables that are in the possession of the patient" (Section 72529 (D)).

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. 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 develop meaningful theft and loss programs. Facilities 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. They also need to be far more security conscious. Such efforts will have a far greater chance of succeeding if they actively involve patients, through their council, and family councils, in seeking their assistance in working to reduce both loss and theft.

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 facilities must take to protect patients' belongings.

The Commission is in full 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." As with LCD's policies presently in use with the Enhanced Enforcement Effort (EEE), the preparation by LCD of a listing of "specific actions" would not serve as an appropriate "solution" to this problem and, indeed, might hinder creative programs undertaken by the industry and others seeking such solutions.

9-3. Nursing homes should undertake comprehensive theft and loss programs which should include (but need not be limited to) the following components: (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 loss 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 shall be open to the public) and complete a missing item report within 48 hours of a report of any 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. Such notification shall also be in a form which also advises the resident of their legal remedies if they reasonably believe that a theft (with a replacement cost of $25 or more) has been committed, (f) report all thefts of replacement value of $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) make concerted efforts, either through individual facilities or through group arrangements, to purchase replacement value theft and loss insurance for residents' belongings if it can be purchased at a reasonable premium.

Sanctions should be instituted against any facility which knowingly retains an employee who has been convicted of theft. Failure to report loss or theft, in accord with the legislation and regulatory changes proposed above, shall be grounds for the issuance of the appropriate citation for each instance of failure to report.

If a persistent pattern of theft is present, facilities may hire an employee with the specific responsibility of finding out the person(s) responsible for the theft(s).

9-4. Absent the development of "reasonable efforts" by a facility to prevent loss and theft due to the negligence of the facility, "B" citations should be issued for each instance of theft and negligent loss. Such citation issuance shall be especially warranted in circumstances where there is both a pattern of thefts, as well as little evidence that the theft issue is being treated seriously. Inservice education of staff, for example, is necessary but not sufficient: there must be results or outcomes of programs which reduce theft in a facility. "Paper compliance" which provides a pro forma minimal theft and loss program will not exempt a facility from the appropriate citation for theft of residents' possessions, nor from such other

enforcement actions as may be taken by LCD or the AG's office.

9-5. A policy for replacing or reimbursing for lost or stolen articles needs to be implemented. 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 the facility did not have an adequate theft and loss program, as determined by DHS/LCD. Costs of such replacement or reimbursement, when it is determined that an adequate theft and loss program was not in place, shall be taken from the profits or surplus of the facility. Under such circumstances, costs for replacing or reimbursement for items lost or stolen shall not be an allowable Medi-Cal cost.

9-6. We concur with both of the following recommendations developed by the AG's Bureau of Medi-Cal Fraud (BMCF) Advisory Council on Nursing Home Abuse and Neglect: (i) 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, and (ii) that no facility may knowingly retain an employee who is convicted of stealing. Violation of either of these conditions shall result in the facility receiving an appropriate citation from LCD for each instance in which either of these conditions is violated. (We have included the full text of the BMCF Report in the Appendix. In regard to these two recommendations, see especially pages 6 and 7 of the BMCF Advisory Council Report.)

9-7. All prosthetic devices which are vital to everyday health and functioning (including, but not necessarily limited to, dentures, glasses, and hearing aids) shall be replaced in a timely and humane manner by the facility regardless of whether they have been "lost" or "stolen." Facilities shall provide the funds for such timely replacement for prosthetic devices.

The Commission believes that, given an adequate facility theft and loss program, and absent facility negligence, the facility should <u>not</u> have to bear the replacement cost of prostheses for Medi-Cal residents. Medi-Cal should reimburse facilities for providing timely replacement of "lost" or "stolen" prostheses. Medi-Cal regulations limiting the payment, for example, for the replacement of glasses to only once a year should be reviewed to provide for reimbursement to facilities which have purchased replacement glasses for residents and seek reimbursement from Medi-Cal for this expense.

The Commission believes reimbursement for replacement of prostheses is in the best interest of nursing home residents. The existing Medi-Cal regulations regarding such replacement must allow California's Medi-Cal nursing home residents the dignity and autonomy that comes with hearing aids, glasses, and dentures, and such other prosthetic devices which are so important for the maintenance of both functional ability and individual dignity.

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 and to investigate and prosecute such abuse and neglect. In Chapter Seven of this Report, we have discussed the role of the Health, Education and Welfare section of the Civil Division of the AG's office in nursing home enforcement.

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, and devising ways in which BMCF could work more closely with the Department of Aging, specifically the Ombudsman Program, and work more closely with DHS, specifically LCD in regard to nursing home oversight and enforcement.

At the first meeting of the Commission's Advisory Committee, representatives of BMCF stated that they had formed an Advisory Council to address these issues and others. The BMCF Advisory Council met separately from the Commission's Advisory Committee, though membership in the two groups overlapped somewhat. In writing of their effort, the BMCF Advisory Council noted:

> As a result of growing attention to crimes relating to nursing home abuse and neglect, it has been recognized that current criminal justice efforts must be improved.
>
> The Little Hoover Commission recently evaluated the impact of legislation passed in 1985 and 1986 designed to improve the quality of care in California nursing homes. As no significant improvements were found relative to the involvement of local law enforcement agencies in investigating and prosecuting crimes against nursing home patients, the Attorney General's office, through the BMCF, agreed to provide the Commission's [Nursing

> Home] Advisory Committee a report recommending measures to stimulate such involvement. (BMCF Advisory Council Report, page 1, emphasis added.)

The Commission welcomed the active cooperation of the BMCF within the Nursing Home Advisory Committee and is pleased to include in the Appendix the "Report of the BMCF's Advisory Council on Nursing Home Abuse and Neglect." The BMCF Report made recommendations in four areas: legislation, training, employee background checks, and theft reduction. These are summarized as follows:

> LEGISLATION: Through legislation, BMCF will establish procedures to collect statewide data on occurrences of nursing home abuse and neglect, and publish an annual statistical report. BMCF will also develop information based upon complaints reported to various regulatory agencies. These data would be used to identify patterns of crimes occurring in long-term care facilities, and also assist local agencies in current investigations.
>
> Additionally, BMCF will seek to amend existing statutes [in order to] clarify reporting responsibilities. This will result in referral of most Penal Code violations to local law enforcement agencies and referral of criminal neglect, discriminatory treatment, trust fund violations and Medi-Cal fraud violations to BMCF for investigation and prosecution.
>
> TRAINING: BMCF will provide training to assist law enforcement and prosecutorial staff in investigating and prosecuting offenses occurring in nursing homes. This training will focus on the special needs and sensitive issues typically involved in these cases.
>
> EMPLOYEE BACKGROUND CHECKS: The [BMCF Advisory] Council recommends support of legislation by Assemblyman Lloyd Connelly to require fingerprinting for background checks of applicants for employment in nursing homes.
>
> THEFT REDUCTION: The [BMCF] Council proposes guidelines for nursing homes to assist with reduction of theft and loss. (BMCF Advisory Council Report, pages 23.)

Representatives from the proprietary nursing home industry trade association attended the meetings of the BMCF Advisory Council and notified the Commission's Advisory Committee that they could not

support some of the recommendations of the BMFC Council, specifically the request that BMCF be included (along with local law enforcement agencies and the local Ombudsman Program, and, often, DHS/LCD as well) among those agencies which are notified in all instances of cases of criminal negligence. The industry would prefer that LCD first screen all citations and refer to BMCF only those citations in which they believe criminal negligence is involved.

The BMCF Report provides the following examples where BMCF could play and important oversight and enforcement role:

> ...where the failure to provide adequate care is so aggravated that it results in actual or potential death or great bodily harm to a patient. Recent actual examples include bathing a patient in scalding water; leaving a frail and weak patient unattended in a full bathtub where she drowned; leaving an immobile patient unattended on a sun terrace for several hours in temperatures of 105 degrees, so that she died of sunstroke; and feeding patients with faulty tube-feeders which caused them to aspirate food into their lungs, causing fatal pneumonia. (BMCF Report, page 5.)

The BMCF believes it should directly investigate such cases because:

> ...few, if any, local law enforcement agencies have the expertise to handle such cases, yet they are cases in which the civil penalties which licensing authorities [e.g., LCD] can impose are too lenient for the criminal degree of negligence which they manifest... These are crimes that most local law enforcement agencies lack the training, expertise and resources to pursue, while the BMCF has the ability and the jurisdiction to investigate them. The BMCF will coordinate criminal filings with local prosecutors (district attorneys or city attorneys). No new reporting requirements will be imposed on local authorities. (BMCF Report, page 5.)

The BMCF Advisory Council (the membership of which is listed as Attachment I of their Report) did not concur with the nursing home industry objection that including BMCF in the reporting of these matters would encumber the reporting process by only adding another reporting layer. Rather, the Council believed that their recommendations would <u>un</u>encumber largely untrained and often unresponsive local law enforcement agencies in these instances, and would, instead, bring to bear a cooperative effort coordinated

by the AG's BMCF which has both the expertise and resources which are often lacking at the local enforcement level.

Findings

10-1. Cooperation between the AG's BMCF will aid overall nursing home enforcement activities. 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 will aid the overall enforcement effort, not make it more cumbersome. 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 should be most helpful for the enforcement system and thus improve patient care conditions.

10-2. The proprietary nursing home industry is not in support of finger-printing nursing home employees. However, this procedure has the strong endorsement of various law enforcement agencies throughout the State. Such a requirement does exist in other settings where frail elders are cared for (community care facilities administered by the Department of Social Serives). This requirement does not exist for hospital employees.

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. The Task Force should be "standing," that is it should meet at least quarterly, and be a permanent part of the relationship between the AG (and specifically BMCF) and DHS (and specifically LCD and other divisions as appropriate).

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. BMCF cooperation will be potentially invaluable, but it must not replace the LCD primary responsibility.

BMCF may well be notified in addition to LCD (and other agencies) in regard to patient care concerns in long-term care, but under no circumstances shall BMCF alone be notified, and in no circumstances shall BMCF alone decide which other agencies shall be notified. All reporting requirements shall include, at least, notification of both LCD and other appropriate agencies such as BMCF.

10-3. Legislation should be enacted which requires the finger-printing 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 promptly made available to consumers.

10-5 The Commission supports legislation which would formally give BMCF authority to aid and assist in 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 elderly nursing home residents which forced their removal, and often traumatic relocation, from the facility that they 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.

A number of facilities in the past two years have made the decision to withdraw from participation in the Medi-Cal program itself. By removing the facility itself from participation in the entire Medi-Cal program, all Medi-Cal residents in the facility, present and future, must leave the facility when they exhaust their own resources and become eligible for Medi-Cal support. As the nursing home industry representatives and counsel repeated to the Advisory Committee and to the Commissioners and others in attendance at the Public Hearing: federal regulations regarding the Medicaid (Medi-Cal in California) program state that it is voluntary in regard to providers' participation. It is the legal right of a nursing home owner to say that, for whatever reason, they no longer wish to participate (that is, be certified for participation) in Medi-Cal.

Why would a nursing home seek to voluntarily decertify, and no longer seek to participate in the Medi-Cal program? Why would a facility remove all present Medi-Cal residents, accept no future Medi-Cal residents, and eventually cause to move to another facility any present private-pay resident of the decertified facility just as soon as he or she almost-inevitably "spends down" his or her resources and becomes Medi-Cal eligible?

Mr. Gary Devoir, adminstrator of the Camarillo Convalescent Hospital, began voluntary decertification action in October, 1986. He was interviewed in the Ventura County Star Free Press on January 20, 1987. Mr. Devoir gave the following explanation for why the 29 residents of the facility who were then receiving Medi-Cal would have to seek another home: "We're out there to make money just like Bullock's or May Company or any other business in Ventura County."

Mr. Devoir testified before the Commssion at our February 18, 1987 Public Hearing. In his prepared testimony Mr. Devoir provided additional information regarding the decision to voluntarily decertify from the Medi-Cal program the facility he administers and which his parents own:

> The decision to withdraw from the Medi-Cal program was only made after we determined that it would be extremely difficult to compete with other facilities if we continued to participate in the Medi-Cal program. The State of California has made a policy decision that there should be competition in the nursing home field. The State refused to support the continuation of the Certificate of Need program, thus opening the door for anyone to build skilled nursing facilities without going through any need determination. It is our decision that unless we become a [all] private facility we will be unable to offer the quality of service that will be necessary to compete with the new facilities that will be built and which will be seeking private [paying] patients.
>
> ...
>
> It appears to us at Camarillo Convalescent Hospital that we have the right to decide what type of facility we want to be. There are large numbers of private [pay] patients who have a desire to be in a certain type of facility that provides quality care. We think it is reasonable and responsible for us to want to take care of those patients. We have made a business decision...

Mr. Devoir in his testimony also told the Commissioners that the transfer of 26 of the 29 Medi-Cal residents had been carefully and uneventfully completed and that "follow-up" on these involuntarily transferred residents had been conducted and that "they are all doing fine."

At the 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."

Several persons familiar with this case, as well as other cases which have taken place in the past two years, told the Commission that such involuntary transfers, far from being uneventful, are traumatic and have resulted in a variety of difficult emotional, financial, and health problems both for the residents who must be moved, and for loved ones who have been involved in this wholly unexpected and trying process.

One family member testified that her grandfather had a written contract and he was told that he would be kept in the facility when his private funds were exhausted and he converted to Medi-Cal. In speaking of the anger, frustration, and fear that she felt when trying to relocate her grandfather she said: "I didn't know what I was looking for. I spent days on the telephone [with the facility, with other facilities, and then with a number of State agencies] getting the run-around." Prior to his eviction, the grandfather had expended more than $75,000 as a private pay resident before he converted to Medi-Cal. He and his family were then told that he would have to move insofar as the facility was decertifying from the Medi-Cal program.

The Commission heard testimony regarding several cases which had a common theme: residents who had spent between $50,000 and $100,000 of their personal funds over the years as private pay patients in a facility were told to go elsewhere because the facilty had chosen to decertify. Virtually all of these people and their loved ones had fully expected that when they entered the nursing home they could and would remain there. The expenditure of large amounts of personal funds, the period of time that a person had been a resident in the facility, the fact that many were told when they entered the facility that they could stay in that facility throughout the remainder of their lives---none of these powerful factors were considered at all in these decertification situations. Ombudsmen and other professionals confirmed to the Commission that many of these legally-evicted residents suffered and that they could not be truthfully described as "doing fine."

The Extent of Voluntary Decertification Activities

There are 1,236 skilled nursing facilities (SNFs) at present in California. Of these SNFs, 1,154 (93%) are presently certified for participation in the Medi-Cal program, and 82 SNFs (7%) are not certified for Medi-Cal participation. 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.

It is important to note here that the average Medi-Cal census in California long-term care facilities is about 70%. The reasons that these 26 decertifying facilities had only an average of 29% Medi-Cal census was probably because the owners began paring their admission of Medi-Cal patients before they formally announced their plan to decertify. Another possible explanation, related to the first is that some of these 26 facilities were among those in the State that have been participants in the Medi-Cal program but who had kept their Medi-Cal census rates relatively low. Perhaps some of these facilities with a low Medi-Cal census decided that they would prefer to operate without Medi-Cal altogether.

It is also important to bear in mind that the estimated 544 Medi-Cal residents of these 26 decertified facilities was the figure given at the time of decertification. We must presume that there would be a significantly larger number of residents, over and above the initial 544, who would, in the future, become Medi-Cal eligible. Given the fact that, at that time, they would be residing in a facility that was no longer certified for Medi-Cal, they too would be asked to transfer at that time.

If we make the conservative estimate that 50% of the remaining (and presently private-pay) residents would exhaust their funds before they left the facility (due to dismissal, death, or for another reason), this would add to the 544 immediately affected residents another 670 prospective Medi-Cal patients who would, in the future, also have to leave these facilities. Thus these 26 voluntary decertifications have resulted in 1,885 beds becoming available only for private pay residents, and, in addition, the immediate eviction of some 544 persons at the time of decertification and potentially required moves for an estimated 670 additional persons in the future. That "future" would come for these persons just as soon as they become poor enough to no longer be able to reside in what had been their home up to that point in time.

The total number of persons thus transferred in these 26 decertification actions could be at least 544 immediately and 670 in the future, for a total of 1,214. This estimate is conservative and, over the long term, would probably turn out to be low. Another way of viewing these circumstances would be to look at the average number of persons who would have to move, sooner or later, from each of these 26 facilities. Each of these 26 facilities, on the average, would have had to evict 21 Medi-Cal residents immediately upon their decertification and, on the average, another 25 residents when they became Medi-Cal eligible. Thus, the total number of decertification-related transfers would average 46 persons in each of these 26 facilities, although there

would doubtlessly be some variation between facilities.

The nursing home industry is acutely aware of the fact that, effective in January of 1987, California no longer has a Certificate of Need (CON) program for use in seeking approval for the addition of new beds. No one---not the nursing home industry, and not the Office of State-wide Health Planning and Development (OSHPD), and not the DHS, to name only three of the most vitally interested parties in this policy change---knows what the absence of such a regulatory mechanism will mean. The nursing home industry, which fought hard and unsuccessfully to stop the demise of the CON program, believes that the absence of a State CON program will mean the coming of "competition" within the industry for those private pay patients who generate most profit (or, in the case of non-profit nursing homes, what is technically called "surplus").

Some estimate that this deregulation will result in a significant increase in the marketing and construction of proprietary long-term care facilities which will voluntarily not certify for Medi-Cal. This would mean that the number of beds not available for Medi-Cal residents would continue to increase, and that the Medi-Cal bed supply, relative to total SNF beds, would decline. There is preliminary data from OSHPD that indicate that a (presently unknown) number of new facilities plan on going exactly this route: these new facilities will be in search of "gray gold," the well-to-do elderly who can pay premium prices for nursing home care.

Some nursing home industry representatives believe that, absent local community resistance from local governmental units such as Boards of Adjustments or Zoning Boards, there may be between 5,000 and 20,000 new beds constructed in California within the next two years. These projections are said to vary because of considerations such as changing developments in the federal and perhaps the State tax laws, as well as other variables including interest rates, lease arrangements, etc. What the consequences of such growth will be for the nursing home industry, and for patients both at present and in the future, are matters of speculation and concern. There does not appear to be any consensus on these matters at the present time.

Voluntary Decertification Followed By Requests to Recertify: A Revolving Door?

The voluntary decertification actions discussed above omit one possibility: 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 only those residents who convert to Medi-Cal.

The discussions of this possibility were, until quite recently, based on speculation, insofar as LCD had not received any requests for a recertification after a facility had voluntarily decertified. In late March of 1987, however, an indication of the problems that this might bring did arise. Camarillo Convalescent Hospital, the facility whose administrator testified at the Commission's Public Hearing a month earlier, asked that LCD not finally approve its request for decertification and permit it to continue its participation in Medi-Cal. While not quite a recertification request, this case is instructive.

All but one of the Medi-Cal residents had been removed from the Camarillo facility when the request for de-facto recertification was received by LCD. The LCD response to this particular request, coming as it did near the end of the decertification process which had not been completed, was to require Camarillo to notify all of its former Medi-Cal residents that had been transferred that they could come back. It is not known at this date how many of the former residents are able or willing to return, that is to move again. While we can applaud LCD's request, and the possible "return home" that it might offer these already once-dislocated residents, this case illustrates the complexities and the human suffering that can be involved not only in voluntary decertification actions, but, in addition, some of the consequences that may arise when and if recertification requests are made.

In late April, 1987 the Commission became aware of another situation which involves a voluntary decertification followed by a request for recertification. In April, 1985, El Encanto nursing home a non-profit 248 bed facility located in the City of Industry, was granted permission by LCD to voluntarily decertify. The facility had given as its reason for decertification the fact that it wished to remodel and upgrade a number of its beds so that it could participate in the new Medi-Cal sub-acute program. The decertification involved the removal of 78 Medi-Cal patients. Sixteen months later, in September, 1986, the facility was granted Medi-Cal recertification: the remodeling was complete, however El Encanto found the reimbursement rates that the sub-acute program was to offer inadequate for its needs, and thus sought, and was granted, recertification as a skilled nursing facility. Apparently some attempt was made, as in the Camarillo case described above, to see if any of the 78 Medi-Cal patients who had been removed from the facility sought to return.

In the El Canto case, an LCD regional office administrator, and apparently not with the direct knowledge of the Director of either LCD or DHS, took the following actions: voluntary decertification

was approved, and the request for recertification was also approved. No local or central LCD action was taken to mandate either attempting to bring back the evicted residents who might wish to return, nor did LCD mandate any arrangement whereby the facility would remain in the Medi-Cal program.

The LCD Sacramento office apparently became aware of this case after it was brought to their attention by the staff of the Lieutenant Governor at the Commission's final Advisory Committee meeting on April 20, 1987. LCD seems to have lacked both administrative oversight in this case, as well as timely information from its regional office concerning the events that took place between the voluntary decertification in April, 1985 and approval for recertification that was granted in September, 1986.

LCD examined the records of the 26 facilities which had voluntarily decertified in the 1984-1986 period and concluded that all but one or two of these facilities had decertified because they sought to become all private-pay facilities, that is they were dissatisfied with the reimbursement rates they were receiving for their Medi-Cal residents, and believed that they could do better as non-participants in the Medi-Cal program.

The "one or two" facilities that did give an explicit reason in their voluntary decertification notification to DHS/LCD indicated that they sought to change the level or type of care that they were providing. Whether in fact they made these changes or, as in the case of El Encanto, they made the changes but then did not changes levels of care to be provided, is not known. In any event, the outcome in all 26 cases was the same for the Medi-Cal residents: they were forced to leave.

Voluntary Decertification and Recertification in the Future

While no one knows just how much new construction will take place in the California nursing home industry, these new beds will be built without the constraints that CON exercised. Given this, there could be significant and rapid growth in the long-term care industry in the State, whether by investor-owned chains or by individual facilities, or, as is most likely, by both. Some large percentage of that growth will, at least initially, be seeking to market services where they are most profitable. This being the case, it may well be that the 26 facilities that have voluntarily decertified in the past three years may be the beginning of a trend which could have most significant consequences for California's present and future nursing home Medi-Cal population.

If some number of the newly-constructed facilities do not plan to seek certification for Medi-Cal at all, and some number of existing facilities undertake voluntary decertification, the finding of a Medi-Cal bed for a loved one---already extremely

difficult in virtually all of the major urban areas of the state---might move from "difficult" to nearly impossible. Such de facto social policy would have grave consequences for elders and their loved ones.

Findings

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

11-2. At least 550 Medi-Cal residents have been evicted as a result of voluntary decertifications. The 26 voluntary decertification actions which occurred from 1984-1986---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 if there is no legislative intervention.

As competition for private pay patients increases, and as some new facilities are built which do not certify for participation in the Medi-Cal program, more facilities may undertake voluntary decertification. This forecast, if accurate, portends a further exacerbation of a multi-tiered system of care: private expensive care for the well-to-do which will be available more or less upon demand, in contrast to Medi-Cal patients, who will have ever-increasing difficulty finding a nursing home bed, especially near the area where they or their loved ones live.

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: they must be Medi-Cal certified to operate (that is to be licensed) in California. This requirement for Medi-Cal certification should be extended to all nursing homes in California.

(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 notice is provided to all residents that they will be able to remain in the facility whether or not the facility is a participant in the Medi-Cal program, 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.

A long-term care facility may only finally voluntarily decertify from the Medi-Cal program when all residents (both Medi-Cal and private pay) residing in the facility at the time of the filing of the intent to decertify are no longer residents in the facility. Voluntary decertification shall not be permitted if any of these original residents were present, given the fact that they might well need to convert to Medi-Cal and thus be evicted.

11-2. Any facility which does voluntarily decertify in accordance with the requirements specificed in recommendation 11-1(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. Final approval to recertify, even if the five-year Medi-Cal contract requirement is met, resides with the Director of the DHS. Applications for recertification shall include a review of the facility's citation and performance record by the Director.

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 admission contract contains an array of basic information about the facility, as well as about the facility's expectations and requirements of its residents: ideally, both the business of care, and the philosophy of the caring provided by the facility should be found within the tone, language, and content of the agreement.

The nursing home agreement is a prerequisite to admission to a facility. It is a legal contract that defines the relationships that will be expected to exist between the facility and its residents. In 1986, the California Law Center on Long Term Care (CALC), in cooperation with the Institute of Health and Aging of the University of California San Francisco Medical Center, undertook a project, sponsored by the Retirement Research Foundation, which assessed admission agreements in a probability sample of California nursing homes.

The final report of the CALC project, entitled Autonomy of Nursing Home Residents: A Study of California Admission Agreements was published in September, 1986. This report drew a sample of 200 nursing homes (stratifying on the the three most common forms of operation: proprietary chain, proprietary non-chain, and nonprofit). This study was provided by CALC to all members of the Commission's Nursing Home Advisory Committee in January, 1987.

Given that CAHF, the proprietary trade association of nursing homes, had developed its own "model" nursing home agreement in 1985, CALC asked for and received comments on a draft of its study prior to publication from the association's counsel, and these lengthy comments were taken into consideration in writing the final CALC report. The CALC report served the Advisory Committee well in several discussions and analyses assessing the current status of admission agreements. The Commission's findings and recommendations which follow here are based on those discussions; they reflect the often diverse points of views of the Advisory Commitee.

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%. Given this fact, persons seeking a nursing home placement are usually not making their decisions with much freedom of choice. Beds that are located near loved ones, especially Medi-Cal beds, are difficult if not impossible to locate. Waiting lists are common in many facilities and discharge planners often try to find a bed in many facilities without success.

Given these market constraints, many consumers feel that there is little or no genuine opportunity to exercise choice. The CALC report provides further information about the context in which many nursing home placement decisions are made:

> The nursing home market is an unusual consumer setting in many respects. Most persons who use nursing homes are suffering from chronic mental and/or physical disorders. They are usually dependent in at least some of the routine activities of daily living, and they are likely to be very old, unmarried, and female. They are a particularly vulnerable population.
>
> Further, the choice of a nursing home is often made in an atmosphere of stress and crisis in response to a new illness, disability level, or loss of a caregiver or spouse. (page B-1)

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.

The CALC study found that many nursing homes, especially the larger chains, use a strandardized admission agreement which contains many clauses which represent what is known as an "adhesion contract." The CALC report notes that adhesion contracts are characterized by the presence of three conditions:

> (1) The contract is written entirely by a party with superior bargaining power;
>
> (2) it is offered on a "take it or leave it" basis;
>
> (3.) the weaker party is without the opportunity to bargain. (page B-2)

Adhesion contracts are not automatically unenforceable: they must

be shown to be unfair and unreasonable. The CALC study found many contracts which, they believed, could be characterized as adhesion contracts either in whole or in part. One example of such a circumstance would be the presence of language in many admission contracts concerning residents' personal property. The proprietary trade association "model" 1985 admission agreement states the following in regard to a patient's personal property:

> The Patient understands that the facility cannot be responsible for safeguarding the personal property of the Patient and agrees to store all valuable personal property in the Facility's safe or other secured storage areas as the Facility may provide. The Facility will not be responsible for bridgework, false teeth, dental plates, eyeglasses, hearing aids or other similiar items which remain in the Patient's possession. The facility will not be liable for either damages to or loss of personal property except as required by law. (California Association of Health Facilities Paitent Admission Agreement, 1985, page 6)

The CALC study found such language as that used in the "model" agreement quoted above to be the norm:

> A common provision in an admission agreement is one addressing a resident's right to personal property. Virtually all of the facilities in our sample include such a provision in the form of a waiver of liability. All of the agreements include a waiver of liability for all property in the resident's possession. Additionally, over three-fourths [of the facilities in the sample] include in the waiver provision important health-related property (e.g., eyeglasses, dentures). (page 10)

The fact that blanket waivers are probably unenforceable, and may well constitute illegal adhesion contracts, has not often deterred their use. Similiar limitations or exclusions of liability can often be found in admission contracts in regard to acts or omissions pursuant to doctors' orders. A small percentage of the facilities in the CALC study also included contractual language that also released the facility from all liability for harm to a patient that was caused by another patient.

Multiple additional problems have been discovered in the CALC study and by consumer groups over the years that have included, but are not limited to: descriptions of the basic daily rate which are confusing and often refer to state and federal regulations; unlawful clauses (e.g., statements that residents must purchase drugs exclusively from the facility's pharmacy or

clauses stating that laundry is not included in the daily rate of the facility when, in this latter case, this may only be true for private-pay residents); admission contracts that are not only difficult for the non-lawyer to understand but are, in addition, difficult for the frail elder to see given that they are often printed in quite small type; and clauses that give blanket consent to treatment for any illness to any physician.

In virtually all of these instances, and in others as well, what is being asked for in these admission agreements is not only a diminishing of personal autonomy quite above and beyond what may be needed in a chronic care facility, but a serious diminishing of the freedom of choice and sense of autonomy that is so basic to any person, and perhaps especially so to the frail and institutionalized elderly population in nursing homes.

Counsel for the proprietary nursing home industry summarized the situation well when he advised CALC, in a letter written July 24, 1986, that "Many nursing homes have not yet revised their admission agreements to come into conformity with legislation and regulations that have been passed in the last few years." In the view of the Commission, this situation, and some of the effects that it has had on long-term care residents in California, urgently needs to be rectified.

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, such persons first look at an admission agreement to a nursing home is during the admission process itself. Rarely are such agreements available for inspection prior to an admission, or outside of a facility. Yet it is this basic document which will govern, in large measure, the relationship that a resident has with the facility.

12-2. At present there is 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. Existing consumer protection laws have, too often, not served as a sufficient incentive for many facilities to conform their admission agreements to existing federal and State regulations and law.

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. Copies of such

agreements should be available (at minimal printing cost, if necessary) to interested consumer groups, State and sub-State Ombudsman Programs, and senior information and referral centers. DHS/LCD should also be provided copies of admission agreements, as well as with such amendments which are made to them by facilities.

12-2. Legislation should be enacted that:

(a) Consolidates the disparate legal requirements that must be a formal part of the admission process. The legislation will bring those several requirements together both in law and in the facility's admission agreement. The requirements that are to be so consolidated shall include, but not be limited to: whether the facility participates in the Medi-Cal program, a statement concerning the prohibition on duration of stay agreements (either written or oral), notice of the Patient's Bill of Rights, a statement which must in conformance with existing law on bed-hold policies, and a statement which requires a 30-day notice be given prior to increasing the daily rate of the facility.

(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. Appropriate citations should be issued for facilities that use clauses in their admission contracts that they know, or should know, are contrary to law, misleading, or unenforceable. LCD does not have the responsibility to approve the contents of an admission agreement upon receipt of it and providing LCD with such an agreement shall not imply DHS approval of any admission agreement in whole or in part.

(c) Regulates the print size of the admission agreement so that documents can be easily read and, further, requires a good faith attempt be made by the facility to obtain the signature of competent new residents on the admission agreement signifying that he or she has read and understood the agreement.

(d) Requires an easily understood description of the facility's charges for: the basic daily rate, services and supplies, including those that are optional, and separation of charges for Medi-Cal and private-pay patients where differences exist. This requirement shall also include that the facility shall inform the resident, in the form of a written itemized monthly statement, of charges incurred. This statement shall be provided to the resident if competent, or to his or her representative if the resident is legally or functionally not capable of understanding the statement.

(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. This notification shall include the right of the patient to have the names, addresses and telphone numbers for making an inquiry or complaint with the following agencies or groups: LCD, the AG, the state or sub-state long-term care Ombudsman Program, local legal services programs, and the trade association to which the facility belongs.

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

(h) Describes patients' rights, including, but not limited to, rights to privacy of confidential medical records, as well as the need to secure permission of the resident to be photographed.

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

Persons in need of services who lack timely and adequate information often make poor choices. Where information is difficult to obtain, is limited in quantity, or is of poor quality, the stage is set for fundamentally diminishing the capacity for informed choices, and thus for severely limiting autonomous actions. Nowhere do we feel more threatened by the loss of autonomy than in our fearful concerns about the health of ourselves and our loved ones. These concerns are often exacerbated for the frail elderly in need of long-term care services and for their families whose fiscal and physical resources are frequently limited. The search for a nursing home often happens with little or no prior planning, and with little or no planning time. Often elders, their families, and even professional discharge planners or information and referral (I&R) services which try to aid them, begin and end their search for an appropriate new home for the frail elderly suffering from what Kenneth Arrow calls "informational inequality."

Policy planners working to enchance services for the elderly are aware of the need for more and better information. The Older Americans Act, for example, mandates the development and maintenance of I&R systems and networks. Using programs and software developed initially for handling large collections of information such as that needed by libraries, I&R providers hope these new systems can make information more accessible for consumers.

Many I&R systems are increasingly elegant examples of beneficent technological power: they wish to provide a means to reduce the pervasive "informational inequality" for frail elders who, often with relative suddenness, find that they need long-term care. As a central component of "the aging enterprise," I&R systems themselves are not neutral instruments: they reflect the choices of system designers, and many of the larger systems also reflect the views of the providers of services themselves as to what information they wish to see included and excluded from public access.

I&R systems have become an active sub-component of government as well as public and private social service agencies. The need is palpable. To cite only one representative example: the San Francisco United Way office receives some 3,000 I&R requests monthly. In addition, the Eldercare office of the San Francisco Department of Public Health receives 1,500 calls monthly requesting I&R services specifically for elders. In both cases

the number of I&R requests is steadily increasing.

To set the context for this growing demand for information: there are some 5,000 social service and health programs offered in the five county San Francisco Bay Area. About 500 of these provide programs or services primarily for the elderly. These programs produce some 65 separate I&R directories of varying completeness. Utilizing I&R software where local modums access a central mainframe computer, the Bay Area I&R System (BAIRS) will eventually replace the 65 different directories with one master directory, and several sub-directories, including one specifically for the elderly. The computerized directories will be capable of being updated, that is electronically "rewritten," as often as is wished. The technology is now available to make current information quickly accessible and available to a wide range of persons in need.

I&R efforts are also taking place at the State level. CAIRS, the California Alliance for I&R Services, is working with the State Department of Aging to improve its existing system. DHS/LCD is now actively developing its nursing home system which is largely designed as a management information system. This system will also be able to provide potential consumers with some baseline quantitative information (but not referrals) on the 1,200 nursing homes in the State. Similiar developments are taking place in a number of states, counties, and urban areas, often with little or no coordination with, or knowledge of, other I&R efforts.

Often information that is available from these I&R systems is largely quantitative. Narrative or descriptive evaluative information about a facility is usually not included in larger I&R systems. Information regarding some indicators of quality of a facility or service are usually not present with a few exceptions which do attempt to provide some quality of care indicators, e.g., a citation history listing the number and type of survey violations in nursing homes.

I&R systems may have questionable use with regard to some particular services in the long-term care continuum. This set of circumstances arises, for example, when information about nursing home bed availability may yield no viable referrals. For example, for a Medicaid-eligible person in need of "heavy [institutional] care," often a local I&R system cannot refer this person to <u>any</u> long term care facility in the area because there may not be any beds available or there are long waiting lists.

Thus, even well-informed professionals, such as some hospital discharge planners, may be able to access information but offer no referrals at all, referrals only to distant facilities, or referrals to facilities which the discharge planner knows have openings <u>because</u> of the poor quality of the facility. If getting access to informational services is difficult, and it certainly is for most persons, it needs to be added that <u>having</u> information does not mean being able to effectively translate it to a useable

form and to actually make use of it.

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. At that time, LCD proposed an automated Licensing and Monitoring System (LAMS). In 1983, with federal encouragement and support, LCD began work on an expansion of LAMS, now renamed the Automated Certification and Licensure Information and Management System (ACLAIMS) to reflect the inclusion of certification activities in the system.

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, this Commission was 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 would 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) which would rectify this serious omission in the design of the ACLAIMS system at that point in time.

In testimony given at the Commission's NHPPA follow-up hearing conducted in January, 1986, Mr. Jack Toney, Director of LCD noted that the new LCD system, with the again-modified name Automated Certification and Licensing Administrative Information Management System (and still called ACLAIMS), was virtually complete and was being prepared for field testing. It was also noted in the January, 1986 hearing that a subsystem of ACLAIMS was to be designed in 1986 to serve as the NHPPA-mandated Consumer Information System.

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--- such as the Department of Aging, and specifically the Ombudsman Program, representatives of consumer and advocacy groups, and representatives of the nursing home industry--- to insure that the CIS is as responsive as possible to their somewhat different needs.

The LCD ACLAIMS CIS should be examined in light of existing long-term care I&R systems, such as the Nursing Home Information and

Referral Service operated since 1976 by the Los Angeles County Health Department. The Los Angeles office operates under contract to DHS and serves as the LCD regional office for Los Angeles County, where fully one-third of the State's nursing homes are located. In addition to the Los Angeles system, the Commission's Advisory Committee was shown profile information for a comprehensive and detailed consumer information and referral system designed and operated by the Bay Area Advocates for Nursing Home Reform which provides I&R services concerning all the long-term care facilities in the San Francisco Bay Area.

The ACLAIMS CIS, as it hopefully develops into a State-wide tool which can be easily understood and widely used, can profit from the history of the two systems now in place in San Francisco and Los Angeles. Neither of these "local" systems has the level of resources or the technological expertise that has gone into ACLAIMS. However, each of these sytems contains components that should be a part of the State-wide ACLAIMS CIS.

The Los Angeles I&R system basically provides information on facility type, some citation history data, and the type of patients that the facility will take. The system also contains a very valuable additional element: if the performance of a facility has been poor based upon previously published criteria, that facility is placed on a "do not refer" list, and this status information remains part of the system until substantial evidence of remediation has been observed.

The LCD Los Angeles regional office can be viewed as a prototype in terms of the complaints that were received from nursing home industry representatives who questioned the criteria used for placing a facility on the "do not refer" list. Initially, the system was constructed with the cooperation of the nursing home industry. For the past several years the proprietary trade association has opposed its operation, partly because of the system's de facto ranking system whereby facilities can be put on a "do not refer" listing for poor performance. Performance is judged, in large measure, by the number and type of citations and violations a facility may have received relative to a county-wide average.

The I&R system designed by the Bay Area Advocates for Nursing Home Reform (BANHR), a relatively small private non-profit group, was funded by limited foundation grants. Baseline information for the system was gathered from individual facilities--- most of which were interested in and cooperative with the undertaking--- and from a very time-consuming review of each individual Bay Area facility's file in the regional LCD office. In addition, the BANHR system contains significantly more narrative and descriptive material than does either the one in use in Los Angeles or the proposed ACLAIMS CIS. The addition of this narrative material doubtlessly enhances the value of the system from the point of view of the consumer seeking to make an informed choice about a facility, a choice that consists of more than "just the numbers."

Findings

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

13-2. The new LCD CIS must be accessible and informative. 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, professionals and non-professionals alike; it must contain facility profiles which are as detailed and informative as possible and include a full and current history of citations, violations, and deficiences, as well as complaint and special incident information.

13-3. The nursing home industry has requested LCD to exclude some information from the CIS specifically the record of all citations and violations which were "without merit." The industry believes that the public profile of a facility presented in ACLAIMS is inaccurate if the record of all citations and violations "without merit" are not deleted from the ACLAIMS facility profile. Consumer groups and representatives of the Ombudsman Program argue that all information should be retained in the CIS and the larger ACLAIMS system insofar as it informs interested parties of all actions taken in regard to a facility, including the original citation issuance and assessment, successful or unsuccesful appeal of the citation, and the final settlement or assessment. Both the Bay Area Advocates for Nursing Home Reform system providing information about facilities in the San Francisco area, as well as the system used by the Los Angeles Department of Health include all citation information, and clearly note the status of the citation, including the original assessment, whether it was appealed, settled, dismissed, or sustained, and, if so, in what amount.

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 an Advisory Group, including representatives of other agencies working on State-wide I&R systems and problems, representatives of the Ombudsman Program, the AG's office, the nursing home industry, as well as advocacy and consumer groups. This CIS Advisory Group should meet regularly with LCD's senior staff to assist in the initial implemention 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. The only LCD enforcement data which should be deleted would be that which had been entered in error, in which case corrections should be timely, and noted on the record that a particular piece of information was removed because it was in error.

13-4. Every effort should be made to have the CIS include 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. An outstanding example of such statements can be found in the I&R system maintained by the Bay Area Advocates for Nursing Home Reform.

Persons seeking information about a facility should not have to rely only on often difficult to understand regulatory language which is expressed in bureaucratic slang unknown to most consumers. Variations of such a system are in place in Illinois and other states, and the LCD CIS Advisory Committee should avail itself of those ranking or comparability systems in use elsewhere as prototypes for California use.

13-5 LCD should include its information from its Non-Compliance Index in the CIS portion of ACLAIMS. Further, LCD, following the lead established by the LCD operation in Los Angeles County, should devise a system whereby it can enhance information available to consumers. This "enhancement" process should include a mechanism whereby information about a facility is regularly added to the ACLAIMS consumer information system by the State and sub-state Ombudsman Program representatives.

The LCD CIS should include some basic "findings" about a facility, somewhat like that which is presently done by the Los Angeles system, or simliar to information provided by the Better Business Bureau. An example of such a "finding" would be that as of a certain date, a facility did or did not meet current "standards," however such "standards" may be operationally defined by DHS/LCD. The implementation of this Recommendation does not place LCD in the position of developing and maintaining a rating or comparability system. Such "findings" would aid consumer choices.

CHAPTER FOURTEEN

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

Background

The three critical management positions for the operation of a nursing home are that of the owner, the administrator, and the director of nursing. Sometimes one or more of these positions may be filled by one person, as in a facility operated by an owner-administrator, or an owner-director of nursing. While these senior managers typically engage in little or no hands-on care for residents, they are responsible for creating and maintaining standards for the quality of care to be delivered. It is these key personnel who articulate by their words, actions, policies and procedures the management philosophy of the facility to residents, employees, and to government agencies in charge of monitoring, oversight, and enforcement. Finally, it is these people who represent the facility to the public.

Most visible among these three positions, at least to the public, is the facility administrator. 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.

Often the Boards hear only of the most extreme cases, and even then the investigation and resolution of such cases takes a long period of time. Often the staff and thus the investigatory resources of the Board are minimal. In addition, the due process rights of the accused must be protected.

For directors of nursing services, and for long-term care administrators, there is no way of knowing if these senior management professionals have worked in one (or more than one) facility where the most serious patient care violations have occurred. If, for example, a facility has received one (or more) "A" or "AA" citations and/or where there is evidence of a pattern of poor care being delivered reflected in both citations and surveys, this information is not available in the record of the administrator or the director of nursing.

Furthermore, there is no way of knowing whether an administrator has been responsible for a facility that has been given a Temporary Suspension Order (TSO) or has been closed (that is, has

had its license to operate revoked or had its participation in the Medicare or Medicaid (known as Medi-Cal in California) programs withdrawn or "involuntarily decertified." At the present time, there is no "tracking" of the performance records or employment history of these senior personnel in any long-term care facility: they could, under virtually all circumstances, simply "move on" to another facility.

Nursing home administrators are licensed in California by the Board of Examiners for Nursing Home Administrators (BENHA). Some critics believe that the Board is ineffective in its minimal regulatory activities with administrators, that its professional staff (consisting of one retired nursing home administrator and a small support staff) is, at best, inadequate to the challenges and needs of the large and complex long-term care profession in California.

Many also believe that the Board lacks the authority or ability or resources to thoroughly investigate cases of alleged improper or unprofessional conduct. The Commission evidenced concern with the effectiveness of BENHA both in its 1983 report, The Bureaucracy of Care and at the NHPPA follow-up hearing held in January, 1986.

Senior administrative personnel at LCD/DHS have stated candidly that they have little or no contact with either BENHA or the BRN; nor, for that matter, do such contacts concerning professional conduct take place in any organized way with the Board of Medical Quality Assurance (BMQA) which licenses the State's physicians, including those (few) who work with long-term care patients. For each of these Boards, LCD has found what some consumers also perceive: complaints to the Boards are often not processed, or are not processed in a timely manner.

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, the BRN, 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 adminstrators 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.

Often continuing education hours are offered which feature such "bottom line" concerns as marketing techniques for maximizing the private pay census of a facility or methods for understanding the surveyor-regulatory apparatus. While these latter issues may have their place, it is questionable whether they should be at the center of the preparation and continuing education of long-term care administrators. Many concerned with long-term care, including many long-term care administrators who would like to see the profession bettered, feel that the Board does little more than routinely approve virtually all continuing education offerings that are brought to it for approval.

The fact that the rate of nursing home administrators license revocations appears to be somewhat higher than that of nurses and physicians in California, and may be higher than in some other states, is not at issue. The central issue for policy and regulatory oversight is whether the quality of care would be improved in long-term care facilities in the State if new mechanisms were in place so that those administrators who were responsible for facilties where there were significant instances of poor care would themselves be subject to careful and timely reevaluation of their ability to continue to practice.

At its February, 1987 Public Hearing, the Commission heard testimony concerning nursing home administrator oversight from Assemblyman Terry Friedman who had served as a member of the BENHA from 1979 to 1985. In 1984-1985, Mr. Friedman was Chair of the BENHA Disciplinary Committee. Many of the observations made in this section confirm his experience, and several of the Findings and Recommendations which follow are based, in part, on his suggestions as well as discussions held in several Commission Advisory Committee meetings which discussed the subject of accountability and improved performance of senior administrative personnel in nursing homes.

Findings

14-1. Evidence from the hearings held in January, 1986, showed that few administrators have their licenses reviewed, suspended, or removed. This is due, in part, to the fact that BENHA lacks its own investigative staff. BENHA, like all of the 30 Boards located within the Department of Consumer Affairs, must utilize the investigators from the Division of Investigation of the Department of Consumer Affairs. (These investigators work for, among others, the Board of Accountancy, the Board of Automotive Repair, the Board of Veterinary Medicine, and the Board of Vocational Nurses and Psychiatric Technicians.) This means that should BENHA seek to undertake an investigation, more often than not this involves waiting for an availalbe investigator. BENHA presently has only three staff members which is doubtlessly part of the reason why there is very poor coordination of licensure issues between the Board, the AG's office, DHS/LCD, and the

Department of Aging's Ombudsman program.

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 where much of the information concerning facilities and their administrators is developed and, in large measure, kept.

14-3. There is much that needs improvement in the area of intial training and 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 of many of the present offerings which emphasize mostly the business aspects of long-term care---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. BENHA and the BRN should be authorized additional funds for additional staff whose major responsibility is investigatory. These investigatory units should coordinate their activities with DHS/LCD and with the AG's office.

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 (including, but not necessarily limited to, facility license revocation action, involuntary decertification proceedings, or the receipt of "A" or "AA" citations). BENHA shall begin a preliminary fact-finding inquiry, undertaken in cooperation with LCD, at that time to determine what role and responsibility, if any, the administrator had in regard to these significant actions.

Should the results of this preliminary inquiry show that there is reason to believe that the administrator could have or should have prevented the circumstances which led to any of these "significant actions," the Board shall then initiate a formal inquiry to consider disciplinary action with regard to the license of the administrator. When considering disciplinary actions for administrators directly responsible for facility sanctions, BENHA should also consider the past performance record of the

administrator as well as the past performance record(s) of the facility or facilities where the administrator has been employed. If, at some subsequent time, the significant enforcement action is dismissed, the administrator's record shall show that no BENHA action was instituted, and the reason why no disciplinary action was taken.

In the event the license review consequent to the citation or violations mentioned above show unprofessional conduct and the licensee loses or has his or her license suspended, this information should be transmitted to the two trade associations in California, the AG's office, LCD (for inclusion in its ACLAIMS file information) and, in addition, licensing authorities in other states. In the event the license review shows the administrator was not at fault, his or her BENHA file should clearly show that the investigation revealed no fault.

(b) Each holder of a license shall be responsible for notification of both BENHA and DHS/LCD within 30 days of their place of employment and this requirement shall remain in force whenever an administrator moves to a new position. Failure to report will be subject to a $500 fine for the administrator and, should the circumstances warrant, an appropriate citation for the facility where he or she is employed. This reporting requirement shall also apply to any administrator who is dismissed, or voluntarily leaves his or her 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 shall consider an additional survey of the facility. Such additional surveys shall be optional and shall be based upon the recommendation of both the results of the prior BENHA investigation(s), as well as upon the recommendation of the Director of LCD.

14-3. BENHA should appoint an Advisory Committee to assist the Board in a comprehensive review of the content and quality the CE courses brought to it for approval. This Advisory Commitee, which should serve without salary and should meet at least quarterly, would additionally be charged with recommending to BENHA ways in which the entire course approval process can be revised and substantially upgraded, including the qualifications of the instructors providing such CE efforts. The curriculum revision process should be premised on the fact that BENHA should require that a minimum of 10 of the required 40 administrator CE hours be in gerontology.

The Advisory Committee shall include in its membership (but need not be limited to) representatives from: the Ombudsman Program, higher education faculty who specialize in the fields of gerontology as well as health services administration, representatives of the higher education community who work in

"extension" or CE program planning and development, the California Senior Legislature, and Department of Education, representatives of the Board of Registered Nurses, and the California Medical Association, the California Association of Medical Directors, and consumer groups as well as representatives from the nursing home industry.

14-4. Each of the Recommendations above shall 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, working with the AG's office when approppriate.

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 certificates to approximately 240,000 persons. At the present time, DHS grants about 2,000 CNA certificates monthly. There are approximately 120,000 CNAs 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, which is approximately $182 weekly, or some $784 monthly, for a total of $9,400 per year (if one assumes that holidays and vacation are paid, which is not always true). The NHPPA legislation included a "wage pass-through" provision to make certain that some of the additional monies inserted in the NHPPA legislation would go directly, in the form of wage increases, to these employees. Legislation mandating wage pass-throughs for subsequent cost of living adjustments was vetoed by the Governor in 1986.

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%, and much of this turnover is comprised of aides who do not stay in their positions very long. The overall average turnover rate in all nursing homes in the state in 1985 was almost 91%: most of those people who "turned over" were aides who left their jobs thus creating positions that needed to be filled, often more than once in any given year. 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.

In summary, many CNAs find their jobs are unsatisfying and low-paying and people 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." It is no wonder that it is difficult for many nursing homes to hire aides, and difficult for most nursing homes to keep them.

Changes in aides'responsibilities and job descriptions have been few; most legislative efforts, including NHPPA in 1985, have consisted of trying to pay these employees more than a minimum wage.

The following Table presents data showing the changes in wage rates, and several related pieces of information, which describes, in part, the position of aides in long-term care facilities.

Facility Profiles: Selected Dimensions, Calendar 1981-1985

Year	Turn-over %	Aides wages $	LVN +RN	Aides %	Dbl. hrs. %	Act. hrs.	#	Medi-Cal nursing days%
85	90.7	4.56	23.9	71.6	3.35	2.63	1,206	71.8
84	82.0	4.31	23.5	71.9	3.22	2.54	1,197	72.1
83	77.2	4.23	22.8	72.2	3.23	2.55	1,186	74.1
82	88.5	4.15	22.5	72.8	3.22	2.55	1,188	76.4
81	100.0	4.01	22.2	72.4	3.23	2.57	1,012	77.1

Source: Office of Statewide Health Planning and Development, January, 1987

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.

The nurse aide program is currently the responsibility of DHS/LCD. A subcommittee of the Commission's Advisory Commitee described the DHS/LCD activities with regard to aide training and certification this way: "The Department [of Health Services, LCD] is totally preoccupied with training program approval and the issuance of certifications. DHS is presently incapable of the program oversight and individual certification and performance/renewal activities required to ensure quality and availability of trained staff." The Advisory Committee concluded that there are a number of areas in which the CNA program could and should be substantially improved.

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. CNA training is highly variable in quality. The training provided CNAs is not standardized 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 to materially improve the training, performance, and retention of CNAs. Toward this end the following issues need to 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 (known commonly as the LVN Board). The Board should apppoint a balanced and representative Advisory Committee to aid in the administration of the CNA program, and specifically to aid in the development of standard guidelines to be used in statewide training and certification of aides.

Certification programs should be conducted by institutions of higher education, or, when this is not possible, by the adult education office of a city or county school district. 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. The only exception to this requirement should be that a facility which has no institution of higher education in or near the community in which it is located. These facilities may petition the Board to be the offerer of the approved certification program, although in such cases there should be co-sponsorship (offering aid with curriculum development and teaching) of a faculty member from an institution of higher education or adult education.

The Board should include, but need not be limited to, health professionals with expertise in training of long-term care employees, representatives from higher education, LVN and RN representatives, and representatives of the nursing home industry, including at least one practicing administrator. The Board should also have representation from CNAs themselves. Board members should serve without compensation, with the exception of the LVN, RN, and CNA representatives, who will be paid per diem equivalent

to their earnings for time spent on Advisory Committee business.

(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 so that training funds for the career ladder effort may be secured, at least in part, from those sources. Implementation of this plan should include provisions for both professional recognition and wage increases for participants. These programs should begin as soon as the Board and the Advisory Committee should have completed their study of this area, but in no event should such career ladder programs commence later than December 1, 1988.

(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 in gerontology. The clinical hours should be obtained under the supervision of the designated instructor of the certification program and this portion of the program should be conducted in the long-term care facility. Biannual recertification should be required and should include 24 hours of inservice training; a minimum of 12 of these hours should be in the area of current developments in gerontology and geriatrics. This training may be conducted at the facility, but preference should be given to recertification programs that are developed by the Board and the Advisory Committee and, as with initial certification programs, are offered by institutions of higher education or school district adult education programs.

(d) The Commission believes that aides should have completed their training prior to employment, and that this goal should be phased in as rapidly as possible. For the present time, howevever, the maximum time that an aide should have to enroll in a certification 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) Fees for certification should be set at $20 and for biannual renewal at $15, or at least at a level so that program is self-supporting. Adjustments to the fee schedule in the future should bear in mind the low-income status of CNAs. Fees should accrue to the Board and be used to significantly increase the content of training, certification, and in-service educational activities used for the recertification of CNAs and, as developed, other career ladder positions such as CNA-II.

(f) Training programs for aides should include instruction in English for non-English speaking participants. Such training should be in addition to any of the required class hours for certification. This recommendation was initially made by the Commission in 1983, and it is important that it be restated here.

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 suprising that there has also been an increase in CRC activity. The following Table shows that there has been an overall increase of 378% in CRCs between 1983 and 1985:

CRCs Held 1983-1985

Year	CRCS held	%Change over last year	#Citations reduced/ dissmissed in CRCs
1983	153	N.A.	127
1984	192	20	71
1985	579	302	148

Source: LCD, February, 1987

More information about the increased enforcement the CRC process and its outcomes can be seen in the LCD data in the following Table:

Citations Heard In CRCs

	1983		1984		1985		
	"A"	"B"	"A"	"B"	"AA"	"A"	"B"
Number Sustained	50	202	46	219	6	104	383
Number Dismissed	17	28	8	13	-	7	37
Number Reduced Level/ Penality	29	53	21	29	1*	46	58
TOTAL	96	283	75	261	7	157	478

*Citation reduced because it occurred before NHPPA became law.

Source: LCD, February, 1987

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. Testimony offered at the Commission's January, 1986 Public Hearing suggested that patterns of implementation of this new procedure have been uneven, and, in the view of some ombudsmen, the overall result has been little or no change from the ways in which CRCs have been operated in the past.

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.

The Table above provides data which show that the percentage of citations being sustained (that is, not "modified") for "A" citations was 52% in 1983, 61% in 1984, and 66% in 1985. Effectively none of the 7 "AA" citations issued in 1985 was modified; the one modification that did take place was due to an error. In regard to "B" citations, 71% were sustained in 1983, 84% in 1984, and 80% in 1985. DHS/LCD data for the first two quarters of 1986 show 71% of all citations taken to CRC were sustained, 9% were dismissed, and the remaining 20% had their penalty or level reduced.

Legislation was sponsored in 1985-1986 which was designed to rectify some of these perceived problems. The bill summary states that:

> This bill requires the DHS to establish an independent unit of trained CRC hearing officers to conduct CRCs. Hearing officers are to be directly responsible to the Deputy Director of LCD, and shall not be concurrently employed as [either] supervisors, district administrators or regional administrators with LCD. Specified training must be provided to members of the unit on conducting informal conferences, with emphasis on regulatory and legal aspects of long-term health care.

This bill was signed into law in late September of 1986, and LCD is now in the process of hiring three "Independent Hearing Officers" to work with this new centralized CRC process. LCD expects to begin the new process no later than July 1, 1987.

It is clearly not yet possible to know what the effects of the LCD CRC unit are going to be, both in terms of the centralization of the CRC process, and in terms of the rate of citations which are sustained or modified in the CRC process. While the increased level of citation activity surely will mean that the CRC unit will have a steadily increasing workload, it remains to be seen as to whether their actions are seen as "effective and objective" from the point of view not only of the nursing home industry, but also from other groups who have an interest in this matter.

As we noted above, the NHPPA legislation also allows consumers to be present at CRCs. No data have been gathered as to whether and how the CRC process can be said to have changed and in what ways due to any consumer presence during CRC activities. Several representatives of the ombudsman program who were members of the Commission's Nursing Home Advisory Committee, or who testified at the February, 1987 Public Hearing, expressed doubts that either many consumers would be able to work out the logistics of being able to participate in the CRC process, or would be otherwise inclined to do so. As with the new legislation creating the centralized CRC unit, it appears that this new procedure will require further analysis in order to assess its effectivenss.

Findings

16-1. The centralized LCD CRC unit is not yet in operation. The use of Independent Hearing Officers for CRCs is to begin around July 1, 1987. Not until some time after that date will there be any data to assess to see if, and in what ways, this new procedure will result in changes in the percentages of citations being sustained or modified in CRCs.

16-2. It is not known how or whether consumer presence at CRCs influences these proceedings. There is little data concerning the effectiveness of the procedure which allows consumers to attend CRCs. Whether such consumer participation is actually taking place and the ways in which it may affect the CRC process (and outcome) are not known.

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. The data should be broken down by citation type, and, when modifications are made, the type and amount of that modification should be described. This information should be part of the overall data that LCD collects, maintains, and disseminates regarding its monitoring and enforcement activities on the Consumer Information Service portion of the ACLAIMS system.

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. Results of that study should be made available to all interested parties by the the Deputy Director for LCD. The results of that study should serve as the basis for discussions as to what further modifications, if any, might be needed to effectively empower and inform consumers who are directly or indirectly parties to citations which facilities choose to appeal in the CRC setting.

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 recommends that the new procedures with regard to assessments for certain first-time "B" citations should be undertaken in administrative hearings conducted by LCD Independent Hearing Officers. The details of this proposal and the background for it 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 following recommendation:

> Change the formula for calculating nursing hours: To improve public as well as State knowledge about the actual number of nurses [and nursing hours being provided patients] in long-term care, the following changes should be made in the calculation of nursing hours per resident day: [i] the doubling factor should be removed...it is [artificially] inflated... (The Bureaucracy of Care, pages 252-253.)

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 utility or lack of it 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 unabated. Several discussions on this topic were held by the Advisory Committee for the present study.

The two points of view on the subject of the doubling factor are clear: consumer groups feel the doubling factor is misleading and does not aid quality of care; the nursing home industry feels the doubling factor provides needed flexibility in staffing and does allow for better professional care.

In a position paper prepared for the Advisory Committee in January, 1987, representatives of the nursing home industry state their position clearly:

> Doubling enables a facility to staff according to its individual patient population, encourages the hiring of more licensed staff necessary to care for higher acuity patients, promotes more skilled patient observation and supervision of CNA activities, and allows staffing adjustments to accommodate task variations between shifts. Accountability is enhanced by recognizing greater investment in more costly licensed staff... The doubling process is understandable to both providers and evaluators and it provides the least complicated monitoring mechanism (compared to ratios).

In support of this position, the industry presented a hypothetical example where they believe the advantages of doubling were shown:

The Value of the Doubling Factor: An Example Prepared by the California Association of Health Facilities

	Class	Hours	Rate	Total	Actual TOTAL HOURS	Doubled TOTAL HOURS
Facility #1	RN	.32	$10.50			
	LVN	.47	$ 8.50			
	CNA	1.79	$ 4.53			
				$19.47	2.58	3.37
Facility #2	RN	.01	$10.50			
	LVN	.40	$ 8.50			
	CNA	2.17	$ 4.53			
				$13.34	2.58	2.99

The industry's claim is that with identiical wage rates and identical actual hours of work performed, Facility #1 in the above example is able to provide better care because it makes better use of the doubled resources, namely LVN and RN hours. While the number of actual hours worked in both facilities in the example is the same, 2.58, nonetheless Facility #1 gets more licensed personnel for those same actual hours by using the doubling factor. It is worth noting, however, that even in this industry-developed example, Facility #2 is not at the State-mandated minimum hours per patient day, which is 3.0 even with the use of the doubling factor. With the same actual hours of care being given, Facility # 1 exceeds the 3.0 minimum with their total 3.37 hours.

It is not clear, however, whether there is a real difference between the profiles of these two facilities. They are, after all, giving identical hours of patient care, that is 2.58, if we do not consider the changes in the numbers that take place once the doubling factor is used. Several questions need to be asked,and answered, before we might know whether there are, in fact, real differences in the quality of care between these two facilities. Those questions would include: (i) what is the relationship between having more professional (e.g., licensed) staff working and quality of care?, and (ii) would Facility #1 in the example above continue to use more licensed personnel regardless of whether the doubling factor were permitted, required, optional, or eliminated?

Consumer groups believe the doubling factor is, at best, misleading, and, at worst, actually reduces the quality of care. Consumer groups prepared a working paper for the Advisory Committee in which they state their belief that the use of the doubling factor "disguises and distorts the true number of hours provided to patients; [that it also] creates a complicated monitoring mechanism which, in addition, is not understandable to consumers; [and that] it allows facilities to provide less hands-on patient care by hiring licensed staff to perform paperwork duties."

In support of this view Bay Area Advocates for Nursing Home Reform (BANHR) prepared the data in the following Table which they, and many others, believe illustrates "how the doubling factor has done little to contribute to patient care, but rather has contributed to a reduced level of care."

How The Doubling Factor Works To Prevent Quality of Care: Data Presented by the Bay Advocates for Nursing Home Reform

Nursing Hours	Statewide Nursing Home Average	
	1979-1980	March 1985-1986
Minimum Required	2.8+	3.0+
Nursing Hours/ Pt. Day	3.1+	3.2+
%RN Hours	6.9%	6.3%
%LVN Hours	14.7%	17.6%
%Aides	72.3%	71.8%
%Supervisors	2.9%	2.9%

+ Using the Doubling Factor

Consumer groups believe that this Table, which contains data gathered from the California Health Facilities Commission (for 1979-1980) and from the Office of Statewide Health Planning and

Development (for the NHPPA period March, 1985 through June, 1986), shows how little impact doubling has had over time. The use of doubling has not, they believe, resulted in an increase in RN time; rather, it has decreased from 6.9% to 6.3%, a 9% overall decline. Further, they note that the percentage of nurse supervisor hours has remained the same, the percentage of LVN has increased only 3% in the five-year period, and the percentage of aides has decreased from 72.3% to 71.8%. Given these changes, these groups argue that what is needed is "truth in numbers" and thus the doubling factor should be abandoned.

To make matters somewhat more confusing, the Commission asked the Office of Statewide Health Planning (OSHPD) to compile comprehensive data on California long-term care facilties for 1981-1985 (the last year for which it is available). These OSHPD data, presented in the Table below, differ from the BANHR data presented immediately above:

Facility Profiles: Selected Dimensions, Calendar 1981-1985

Year	Turn over %	Aides wages $	LVN +RN %	Aides %	Dbl. hrs. nursing	Act. hrs. nursing	# of homes	Medi-Cal days%
85	90.7	4.56	23.9	71.6	3.35	2.63	1,206	71.8
84	82.0	4.31	23.5	71.9	3.22	2.54	1,197	72.1
83	77.2	4.23	22.8	72.2	3.23	2.55	1,186	74.1
82	88.5	4.15	22.5	72.8	3.22	2.55	1,188	76.4
81	100.0	4.01	22.2	72.4	3.23	2.57	1,012	77.1

Source: Office of Statewide Health Planning and Development. Data compiled for the Commission during November, 1986-January, 1987.

These OSHPD data indicate that the percentage of LVNs and RNs (combined) is incrementally increasing in facilities and that the percentage of aides is very slightly decreasing. The data also show that the number of "nursing hours" per patient day, using the doubled figure, has increased from 3.23 in 1981 to 3.35 in 1985. These same hours, without the doubling factor used (that is, "actual" nursing hours) has slightly increased from 2.27 in 1981 to 2.63 in 1985. The NHPPA legislation mandated an increase in the minimum required nursing hours per patient day, using the doubling factor, from 2.8 to 3.0. The 3.0 requirement has been in use since March, 1985 and continues at present.

It is also worthy of note that employee turnover rates (which translate most often to aide turnover rates), fell from 100% in 1981 to 88.5% in 1982 and 77.2% 1983, and are now increasing again (and were 90.7% in the latest data available, which is for 1985). There does not appear to be any visible relationship between

turnover rates and nurse aide hourly wages, for these have incrementally increased from $4.01 in 1981 to $4.56 in 1985.

Given the thoughtful discussions of the Commission's Nursing Home Advisory Commitee both in 1982-1983, and for this study as well, and given our 1983 recommendation to abandon the doubling factor, why, then, have we chosen to include this topic in the section dealing with matters which need "further study and analysis"?

The answer to this question lies in what we do not know at this point in time. We do not know if the industry's example which shows the benefits of doubling does, in fact, represent what most facilities do. The data gathered by consumer groups would seem to indicate that they do not.

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.

To answer these and other related questions would require a careful analysis of a representative sample of facilities, using as much information as can be gathered statewide by OSHPD. The Commission did not have the resources to undertake such a study in this Report, but we feel that such an effort must be undertaken so that resolution of this important issue can move forward promptly.

Findings

17-1. The use of the doubling factor may decrease patient care. Speaking as the Chair of the Nursing Home Advisory Committee at its January, 1986 Public Hearing, Lieutenant Governor Leo McCarthy stated:

> As you know, 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, the actual patient care may have been diminished in some cases.... I don't know how often this is happening, but it bears further study by the Little Hoover Commission. Maybe we need to reintroduce the provision that we lost [in the legislation that was not enacted in 1985 that would have removed the doubling factor]. (emphasis in original)

17-2. Conflicting 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 a broad number of facilities. While we know that doubling might be used for using more licensed personnel in some settings, we do not know if it is actually used for this reason, and, if so, if that is the norm or the exception in facility staffing arrangements.

We also do not know whether the use of licensed personnel would drop if there was no incentive such as the doubling factor. Nor do we know, in the worst case scenario, what would happen in terms of the quality and quantity of hands-on patient care if the number of hours provided by licensed personnel now covered by the doubling factor were to drop? Would some facilities used fewer licensed personnel if the doubling factor were eleminated?

Recommendations

17-1. The study of the long-term care reimbursement mechanisms and formulas 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. Data concerning staffing patterns by facility type and changes that have taken place since the enactment of NHPPA should be analyized from OSHPD records.

Among the key questions that such an analysis needs to address are: what is the impact of the doubling factor on Medi-Cal costs, what is the actual benefit of the doubling factor in terms of staffing patterns in use at most facilities, and, most importantly, what are the direct and observable results, if any, of the various utilizations of the doubling factor in terms of patient outcomes--- that is, on quality of care?

The Auditor General's reimbursement study will be completed in the Fall of 1987, and its recommendations in regard to minimally acceptable staffing patterns in general, and the doubling factor in specific, should serve as the groundwork, along with the 1983 findings and recommendations of this Commission, for regulatory and legislative change as soon thereafter as possible.

17-2. If the Auditor General's study does not address the doubling factor question as recommended above, the study should be undertaken by OSHPD and the results reported to the Commission, the Nursing Home Advisory Committee, and other interested parties, no later than December 31, 1987. As in the recommendation above, the results of the OSHPD 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 The Bureaucracy of Care in 1983 or for the current Study. This omission was the product of a full agenda of other major issues that were determined to be more in need of urgent attention. This decision was not made because 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 physician's 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. Time and resources did not permit that inquiry as part of the current study, but it does seem important to reflect here some of the concerns of the Advisory Committee, and to suggest the dimensions of the problem as they see it.

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 Commitee concerning this subject were variable degrees of resentment, anger, and frustration. Multiple stories were told of the difficulty in securing medical staff to attend to the regular, much less the urgent, needs of patients and of having physicians make timely visits which are more than a quick pass-by of "their" patients in nursing homes. Moreover, several nursing home administrators, owners and directors of nursing expressed feelings of being "captive;" that is, they are often very displeased with the professional performance of physicians. At the same time, many long-term care professionals believe that the current situation with regard to physicians is the best that they can do or get for the residents of their facilities.

To these accounts are those added by ombudsmen, visitors, and family members who have spoken too often of the absence of medical care personnel, and the absence of caring from those personnel. Senior LCD officials stated that they regularly received little cooperation and long delays with inquiries and correspondence when

dealing with the Board of Medical Quality Assurance which has the responsibility for physician licensure and is the agency charged with inquiring into the professional conduct of these key health providers.

A singular example of the level of concern and frustration that was expressed by the Advisory Committee was reflected in the suggestion that physicians themselves be liable for investigation and prosecution under the Elder Abuse law of California, which states, in part:

> (a) Any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult...to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person of health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation such that his or her person is endangered, is punishable by imprisonment in the county jail not exceeding one year, or in the state prison for two, three, or four years. (California Penal Code, Section 368, emphasis added.)

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 many persons concerned with long-term care in California, and in other states as well, is that these excellent physicians are far from the majority.

Many physicians have little or no training in geriatrics, and they are not much interested in including nursing home patients in their practice. Given the paucity of training in geriatrics available in medical schools, as well as the belief that aging patients either are chronic complainers or do not improve rapidly from their conditions, it is possible to understand the reluctance of many physicians to treat nursing home patients. In addition, the relatively low Medi-Cal system of reimbursement for physician visits clearly makes this issue a public policy problem for all of us.

Findings

18-1. The role of physicians who care for nursing home patients needs to 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. Physicians are frequently missing from nursing home care. The perception of many of those involved with the 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 the way physician services are rendered to long-term care facilities and 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. The scope of that inquiry should be undertaken with the aid of the Nursing Home Advisory Committee, augmented by representatives of the California Association of Medical Directors and, as appropriate, the California Medical Association and the Board of Medical Quality Assurance.

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. The Attorney General's office should also be party to such an Understanding.

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. This belief may account for at least part of the lack of attention these patients receive, and the alternatives and costs for remediating this problem should be addressed by the Auditor General study.

18-5. Failing consideration of this issue in the Auditor General's study, DHS should, in consultation with interested non-governmental agencies and professional groups, assess the magnitude of this problem and suggest solutions to it. Such a study should be undertaken and completed in the shortest possible time so that regulatory and legislative changes may be undertaken on an urgency basis.

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), for acute care 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.

The use of DRGs has given further evidence, the nursing home industry believes, that the California method of prospective Medi-Cal reimbursement is not adequate to provide the care for these new nursing home residents. At the present time there are no data to suggest that quality of care is declining in nursing homes because of persons coming to nursing homes "quicker and sicker," although many nursing home providers believe that this is the case.

In 1982, legislation was enacted which required that DHS develop a sub-acute care program. Sub-acute care, as defined in current regulations, encompasses those patients requiring frequent medical visits, special medical equipment, 24-hour licensed nursing care, and daily administration of at least three different treatment procedures. 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.

One possible outcome of the implementation of the DRG system for hospitals is that heavier care patients (especially Medi-Cal patients) are having even more difficulty finding a nursing home willing to accept them when the hospital seeks to release them. If these patients are being readied for release "quicker and sicker," this may pose real problems in terms of finding long-term care beds for these people.

When nursing home beds cannot be found, a procedure called "administrative days" comes into play, whereby the hospital keeps the patient and is reimbursed by Medi-Cal during the time that the person no longer needs to be in a hospital, but must remain there

because a skilled nursing facility bed cannot be located. It is possible that one result of DRGs would be an increase in "administrative days," and thus an increase in Medi-Cal costs paid to hospitals for these days. There are no good data on this supposition at the present time, although many persons, both inside and outside the nursing home industry, believe that this is occurring.

Clearly this change in the long-term care patient population, if it exists in signficant numbers, will have important effects on the long-term care system. The nursing home industry believes that those effects, or at least some of them, are already quite visible in terms of the higher level of care that many patients need who are being released from a hospital to a nursing home. This, along with what the industry calls "a more aged and debilitated long-term care patient profile, and special patient populations such as Alzheimers and AIDS," makes all the more urgent, in their view, that the California system of reimbursing for long-term care be modified to reflect new conditions and new costs associated with them.

While there is no doubt of the importance of the DRG issue and its complicated relationships to the long-term care system, the Commission's Advisory Committee did not address this issue in detail in the present inquiry. This decision was made for the following reasons:

(a) The Auditor General's study of alternative reimbursement mechanisms for long-term care is being conducted at present and the data and recommendations from that study should be available in the Fall of 1987. Commission recommendations absent the findings and recommendations of the Auditor General's study would be premature and ill-advised.

(b) Hearings held at the State level by Senator Mello, and at the federal level by Senator Heinz, have only illustrated that there is a good deal of dislocation of sick persons taking place in some large measure because of DRGs. Whether and in what ways the federal government or the State should respond to these dislocations is being actively debated.

(c) Major research projects, often under contract to the federal government or undertaken by large foundations, are underway to provide accurate evaluative data concerning the effects on the health-care system of DRGs. One such study is being conducted by the Institute for Health and Aging of the University of California Medical Center. It is just reaching the data analysis stage at this time (April, 1987) and findings, conclusions and recommendations are not yet available.

Findings

19-1. The DRG reimbursement system is 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, or what its systemic effects are now and might be in the future.

19-2. The relationship between DRGs and hospital administrative days is not known. It is not known if (or how much) the State is paying for more administrative days in hospitals since the advent of DRGs. Nor is it known whether DRGs are making it even more difficult for heavy care, or Medi-Cal heavy care, patients to find a nursing home bed. Many persons familiar with long-term care believe that DRGs are contributing to both increased administrative days and to increased difficulty in finding nursing home beds, especially for heavy care Medi-Cal patients.

19-3 The California subacute program, enacted in 1982, will provide care for some 300 persons statewide. The ways in which this program will impact the existing long-term care system are not known.

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. The consequences of DRGs should be incorporated in their analyses, as should 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 cost of administrative days paid by the State over the past five years for those patients in need of nursing home beds. Analysis of the relationship between such changes in the number of administrative days and decreased lengths of stay in hospitals attributed to DRGs need to be undertaken. The results of this study should be made available to relevant State government agencies inside and outside of DHS.

19-3. The California subacute program represents a "third level of care" (in addition to skilled and intermediate care) which should be evaluated in a timely and systematic manner. Such an evaluation will be difficult given the very small number of beds in the program, and thus the evaluation should use both quantitative as well as qualitative evaluation tools in conducting the assessment.

19-4. This Commission should undertake an assessment of how DRGs impact long-term care, using the results of the Auditor General's study, the University of California's Institute of Health and Aging forthcoming study results, and other such data as may be available. Such an assessment by the Commission working cooperatively with DHS should be undertaken as soon as possible, so that regulatory and legislative recommendations may be made in a timely manner.

CHAPTER TWENTY

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

Background

The nursing home industry strongly believes that it is over-regulated. It further believes that one of the major negative effects of this over-regulation is steadily increasing levels of "paper accountability," that is, increases in paperwork. This paperwork, they believe, contributes little if anything to the quality of care of nursing home residents. Put more strongly, 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. Members of the Commission's Advisory Committee representing the industry spoke on how they view much of the increased enforcement effort of LCD and much of the increased litigation activity that has come with that enforcement effort as resulting in time and energy taken away from supervision and administration and given, instead, to doing paperwork.

There was little discussion of these matters at the Advisory Committee. This was not because these concerns were not seen to be genuine----although perhaps not quite in the same terms as the industry perception of it summarized above---but because there were issues which demanded the Committee's more immediate attention. Nonetheless, it seems important to note here that the overall issue of improved quality and the relationship between quality and paperwork should be examined.

The suggestion was made that one way to improve quality of care, and potentially even provide some form of incentives for providing excellent care, would be for facilities to create and maintain quality assurance logs. Current law (Health and Safety Code, Section 1424.1) describes the quality assurance log procedurce for use in nursing homes, however LCD does not presently require facilities to engage in this practice.

The suggestion that quality assurance log use be implemented was viewed as problematic at the present time because: (i) there is a

need to develop mechanisms with DHS/LCD to assure that such a log could be used in a non-punitive way, that is, that the quality assurance log is seen as a place to develop issues for self-correction rather than a place to list possible occurrences which might lead to enforcement activities, and (ii) ironically enough, the creation of such a log, especially if it were not seen as a really valuable undertaking, could be seen as yet another example of more paperwork. Each of these issues is serious and, because of them, the Commission believes they need to be addressed so that the logs may become an effective quality assurance tool.

It is important to bear in mind, as mentioned earlier, that virtually all studies of long-term care done in the past five years, both in California by the Auditor General and by this Commission, as well as the recent study conducted by the Institute of Medicine at the federal level, conclude that more rather than less accountability is needed in long-term care.

Substantial deregulation of the industry would not be in the best interest of either State or federal policy, nor would it be in the best interest of present and future consumers of long-term care services. The actions of more than 26 California nursing homes which "dumped" Medi-Cal residents through the process of voluntary decertification (described in detail in Chapter Eleven), and the presence of much misleading or illegal information in admission contracts (described in detail in Chapter Twelve), provide ample evidence of the need for continued legislative, regulatory, and Commission oversight of the nursing home industry in California.

Nonetheless, 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 possible. The problem has not been systematically addressed either by the nursing home industry, nor by the government, nor by the two working cooperatively. Among the few things that are done at present by government is DHS/LCD making public the list of facilities that have not received citations. Current law (Health and Safety Code, Section 1430.5) requires that such facilities receive positive publicity, and LCD attempts to provide that information.

Findings

20-1. There is a positive relationship between increased accountability and increased paperwork. The extent to which this may have the unintended side-effect of reducing actual care-giving deserves serious attention.

20-2. Using quality assurance logs is not easy at the present time. 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 in enforcement efforts.

Recommendations

20-1. "Paper compliance" does no one any real good: those requiring the paper, those made to complete the paper, and those whose needs are not fully attended to because the paperwork has been granted some priority status. 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. These incentive programs should concentrate on the development of ways in which superior facilities can have some of their regulatory (and thus paperwork) burdens reduced in ways which do not endanger the health, care, safety or rights of the residents.

CHAPTER TWENTY-ONE

Continuing To Improve Communications Concerning Long-Term Care

Background

In its 1983 report, the Commission expressed the difficulty 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.

At the Commission's first Advisory Committee meeting there was agreement from virtually all the consumer representatives present that communication and accessibility to DHS/LCD senior staff had significantly improved under the administration of the present Deputy Director for LCD. It was further agreed that the series of informal meetings which Mr. Toney has regularly held with the consumer and advocate community have been useful for all concerned and that there was no need to suggest or mandate meetings because they were already taking place.

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.

The more agile consumers "scatter" such letters to any and all places where they think they may get assistance: members of the legislature, the Ombudsman Program, the AG's office, the office of Lieutenant Governor McCarthy, and DHS. With proper staff work, and often after some delay, most of these complaints find their way to LCD. There the complaint-resolution and inquiry process starts. Not infrequently, a complaint serves as the basis for an investigation and subsequent citation.

The presence of an 800 toll-free number is making access easier, and that process should continue to be facilitated by information supplied by LCD from the Consumer Information Service portion of its ACLAIMS management information system which is now largely in place.

For the consumer less likely to call or write much less visit an LCD regional office, there is still much that stands between him or her and having the knowledge to cause change in the long-term care system. These consumers who we assume make up the bulk of the California population are not sure where to go even to find out where to get advice concerning inquiries about long-term care. They are still largely ignorant of the resources that are there to aid them.

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. Such meetings have proved to be important places for exchanging information, sensing new problem areas, and for LCD to get consultation for its multiple clienteles.

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

21-3. The invaluable role of the Ombudsman Program is crucial in the area of maintaining and improving communication. The services of the Ombudsman Program are severely lacking in funding given the tasks that they have been given by the legislature and given the fine work that they do in nursing homes throughout the State.

21-4. Citizen access to LCD remains difficult for many. 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. LCD's outreach efforts in this regard are a valuable first step.

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 also to develop programs which will increase consumer knowledge of the system. Toward this end the working group should invite persons from consumer groups, the senior legislature, and I&R systems for seniors to address it and describe the types of problems which need addressed.

21-3. Additional funding should be provided the Ombudsman Program so that they have the resources necessary to meet the mandates of the legislature.

21-4. The outreach efforts of LCD should be continued and expanded in active cooperation with the Department of Aging's senior information and referral services as well as with the Ombudsman Program. These are "natural" places that LCD should, as a matter of course, send information. These agencies and programs receive large numbers of inquiries concerning long-term care. They need to be able to provide people with information about the roles and activities of DHS/LCD (as well as those of the Department of Aging, and, information concerning remedies that are available through the AG's office) in the California long-term care system.

APPENDIX I

NURSING HOME STUDY ADVISORY COMMITTEE

Hon. Leo McCarthy, Chairman
Lieutenant Governor
State of California

Assemblyman Phil Isenberg
The State Assembly

Senator Henry Mello, Chairman
Senate Committee on Aging

Assemblyman Phillip Wyman
The State Assembly

Mr. Haig Mardikian
Commissioner

Mrs. Jean Kindy Walker
Commissioner

Ms. Donna Ambrogi
California Law Center on
Long-Term Care

Ms. Susan Frauens
Deputy City Attorney
Representing James K. Hahn
City Attorney of Los Angeles

Mrs. Margaret Helton, Chair
Health Committee
Commission on Aging

Ms. Mary Hinchliff, President
CLTCOA

Mr. Charlton Holland
Assistant Attorney General
Health Education and Welfare
Section of the Civil Division

Ms. Maura Kealey
SEIU

Mr. Darryl Kelch
California Association of Homes
for the Aging

Mr. Ron Kurtz
Executive Director
California Association of
Health Facilities

Mr. Roderick W. Leonard
Representing Ira Reiner
Los Angeles County District
Attorney
Nursing Home and Dependent
Care Section

Mr. Ralph Lopez
Department of Health Services

Ms. Pat McGinnis
Bay Area Advocates on Nursing
Home Reform

Mrs. Ethelyn Mehren
California Seniors Coalition

Ms. Millie Paul

Mrs. Esther Rains
State LTC Ombudsman
Department of Aging

Mr. Jack Scheidegger
Acting Chief
Bureau of Medi-Cal Fraud
Attorney General's Office

Mr. Jack Toney
Deputy Director
Licensing and Certification
Department of Health Services

Commission Staff

Mr. Robert T. O'Neill
Executive Director
Commission on Organization
and Economy

Ms. Sherry Hankins

Contract Consultant

Mr. Stephen R. Blum, Ph.D.

A P P E N D I X II

REPORT OF THE ATTORNEY GENERAL'S BUREAU OF MEDI-CAL FRAUD'S ADVISORY COUNCIL ON NURSING HOME ABUSE AND NEGLECT

REPORT OF
THE BUREAU OF MEDI-CAL FRAUD'S ADVISORY COUNCIL ON NURSING HOME ABUSE AND NEGLECT

Purpose

The purpose of the Advisory Council was to make recommendations on ways to improve Law Enforcement's ability to investigate, prosecute, report, and measure patient abuse and neglect in California.

The Council members are experts in the field of patient abuse and neglect, representing law enforcement, prosecutions, and long-term care Ombudsman.

Background

As a result of growing attention to crimes relating to nursing home abuse and neglect, it has been recognized that current criminal justice efforts must be improved.

The Little Hoover Commission recently evaluated the impact of legislation passed in 1985 and 1986 designed to improve the quality of care in California's nursing homes. As no significant improvements were found relative to the involvement of local law enforcement agencies in investigating and prosecuting crimes against nursing home patients, the Attorney General's office, through the Bureau of Medi-Cal Fraud (BMCF), agreed to provide to the Commission's Advisory Committee a report recommending measures to stimulate such involvement. BMCF has jurisdiction under federal law to receive complaints of patient abuse and neglect in health facilities which receive Medicaid (Medi-Cal) funds and to investigate and prosecute such abuse and neglect. [1]

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[1] The jurisdiction of the Bureau of Medi-Cal Fraud is set forth in the Social Security Act, section 1903, 42 U.S. Code section 1396b(q), subdivisions (3) and (4), as follows:

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this subchapter.

(4) The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this subchapter, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other state agencies for action.

The BMCF Advisory Council was formed to receive input from the criminal justice community and address this issue from a statewide perspective. Membership on the Council was composed of law enforcement, prosecutorial and regulatory agencies, as well as long-term care ombudsmen (see Attachment I). Meetings were held on January 7 in San Francisco, on January 21 in Los Angeles and on February 19 in Sacramento.

Problem Areas

The council found that law enforcement efforts to date were ineffective, largely due to the following:

1. Perceived insufficient involvement by local law enforcement.

2. Lack of training and/or expertise in investigation and prosecution techniques unique to the nursing home environment.

3. Inappropriate statutory language concerning referral of medically oriented complaints to criminal justice agencies.

4. Lack of clarity relative to reporting procedures, both locally and at the state level.

5. Unavailability of statistical data and other information on the nature and scope of nursing home abuse or neglect cases.

6. Insufficient screening procedures for nursing home employee applicants.

7. Inadequate procedures and safeguards at nursing home facilities to prevent theft from patients.

Recommendations

I. LEGISLATION

Through legislation, BMCF will establish procedures to collect statewide data on occurrences of nursing home abuse and neglect, and publish an annual statistical report. BMCF will also develop information based upon complaints reported to various regulatory agencies. These data would be used to identify patterns of crimes occuring in long-term care facilities, and also assist local agencies in current investigations.

Additionally, BMCF will seek to amend existing statutes to clarify reporting responsibilities. This will result in referral of most Penal Code violations to local law enforcement agencies and referral of criminal neglect, discriminatory treatment, trust fund violations and Medi-Cal fraud violations to BMCF for investigation and prosecution.

II. TRAINING

BMCF will provide training to assist law enforcement and prosecutorial staff in investigating and prosecuting offenses occuring in nursing homes. This training will focus on the special needs and sensitive issues typically involved in these cases.

III. EMPLOYEE BACKGROUND CHECKS

The Council recommends support for legislation by Assemblyman Lloyd Connelly to require fingerprinting for background checks of applicants for employment in nursing homes.

IV. THEFT REDUCTION

The council proposes guidelines for nursing homes to assist with reduction of theft and loss.

Discussion of Recommendations

I. LEGISLATION

Council members agreed that development of a comprehensive statewide information base of allegations, investigations and prosecution of nursing home cases would be valuable. Although reporting procedures are currently in place (for example, instances of abuse and neglect are now reported to Department of Social Services by adult protective services and State Long-Term Care Ombudsmen), there is no system-wide report incorporating Department of Health Services, Department of Social Services, and Ombudsmen complaints. Department of Social Services data are to be included because of the importance of information on abuse of elders beyond the scope of nursing homes.

It was recommended that BMCF establish a statewide information gathering system, both for collection of statistical data and development of specific case information relating to complaints and investigations. This data will be published in an annual report, made available to the Governor, the Legislature, local jurisdictions, and other interested parties. Case data information would be available to local jurisdictions to assist them in identifying patterns of abusive or neglectful conduct. The information would also be used by BMCF to identify potential targets or areas for further investigation.

Reporting of these data to BMCF would also address a key concern identified by law enforcement representatives and ombudsman coordinators that allegations of criminal charges are seldom referred to the law enforcement agency. By analysis of data received from the various sources, i.e., ombudsman coordinators, police agencies, licensing agencies, and adult protective services agencies, BMCF can determine whether the proper response by the criminal justice system has occurred. It is also hoped that by reviewing the published data, agencies will be stimulated to fulfill their reporting responsibilities.

Current statutory reporting requirements relating to abuse and neglect of elders and dependent adults are set forth in W & I Code section 15630(a) and (b) and section 15631. Instances of physical abuse must be reported to a local law enforcement agency or to the county coordinator for the Long-Term Care Ombudsman if the incident occurred in a long-term care facility. They must be reported to a local law enforcement agency or the county adult protective services agency if they occurred anywhere other than in a long-term care facility. Any report of physical abuse received by a county coordinator for the Long-Term Care Ombudsman or by an adult protective services agency must be immediately referred to a local law enforcement agency.

Section 15630(b) of the W & I Code, however, contains a provision regarding permissive reporting to local law enforcement agencies which the council feels is inappropriate in terms of local law enforcement's response. To rectify this, certain types of allegations would be referred directly to BMCF for investigation and prosecution.

Under this proposal, the statutory language would distinguish reporting procedures as follows:

- Homicide, assaultive abuse and theft cases will be reported immediately to a local law enforcement agency or to the county Ombudsman coordinator or adult protective services agency (with reciprocal referrals by telephone and follow-up in writing within 36 hours), as currently required by W & I Code section 15630(a).

  Physical or assaultive abuse will usually constitute a crime as defined in such Penal Code sections as 240 (assault), 242 (battery), 243.4 (sexual battery), or 261 (rape). These violations are entirely appropriate for local law enforcement agencies to handle.

- Allegations of criminal neglect, Medi-Cal fraud and discrimination against Medi-Cal beneficiaries will be reported immediately to the county ombudsman coordinator and the Licening and Certification Division of the Department of Health Services (LCD) according to current requirements. These agencies would then report the cases immediately to the nearest regional office of BMCF. The new requirement for ombudsman coordinator and LCD to report to BMCF should not impose a significant burden inasmuch as it will be carried out at local or regional levels.

- Nursing home neglect cases of less serious magnitude will be reported to the county ombudsman coordinator and LCD for administrative action. Poor-quality-of-care cases involve violations of regulations set forth in Title 22 of the California Administrative Code, addressing the lack of attention to patients' personal hygiene, unclean rooms, soiled bed-linens, insufficient recreational opportunities, failure to follow prescribed treatment plans or to administer medications in a

timely way. These problems are appropriately handled by LCD, which imposes civil penalties--fines and, in severe cases, license revocations.

- Cases of neglect and other-than-physical abuse occurring elsewhere than in nursing homes will be reported immediately to the county ombudsman coordinator if occurring in a long-term care facility (or residential care facility for the elderly), and to the county adult protective services agency if occurring anywhere else. When their investigation reveals evidence that a crime has been committed, these agencies will then refer the case to the appropriate law enforcement agency.

Between these types of cases, however, is a another type where the failure to provide adequate care is so aggravated that it results in actual or potential death or great bodily harm to a patient. Recent actual examples include bathing a patient in scalding water; leaving a frail and weak patient unattended in a full bathtub where she drowned; leaving an immobile patient unattended on a sun terrace for several hours in temperatures of 105 ^{o} , so that she died of sunstroke; and feeding patients with faulty tube-feeders which caused them to aspirate food into their lungs, causing fatal pneumonia. Many cases of this type require lengthy and detailed investigations and call for medical judgments about what actually caused the harm to patients and what would have been appropriate care for particular patients. Few, if any, local law enforcement agencies have the expertise to handle such cases, yet they are cases in which the civil penalties which licensing authorities can impose are too lenient for the criminal degree of negligence which they manifest.

The Council recommends that nursing home cases involving criminal negligence should ordinarily be investigated by the Bureau of Medi-Cal Fraud, unless a local law enforcement agency expresses a compelling interest in the case. The prosecution of such cases can be carried out either by local prosecutors or BMCF, that decision to be based on consultation between BMCF and the district attorney or city attorney.

From the perspective of local law enforcement agencies, the above proposal has the benefit of directing to the Bureau of Medi-Cal Fraud (and away from police and sheriffs' departments) allegations of criminal neglect, Medi-Cal fraud and discrimination against Medi-Cal beneficiaries. These are crimes that most local law enforcement agencies lack the training, expertise and resources to pursue, while the BMCF has the ability and the jurisdiction to investigate them. The BMCF will coordinate criminal filings with local prosecutors (district attorneys or city attorneys). No new reporting requirements will be imposed on local authorities.

II. TRAINING

The Council unanimously recommended that BMCF develop a training program for local agencies on investigating and prosecuting crimes

against the elderly, particularly in the nursing home context. Few local agencies, with the exception of Los Angeles County have personnel trained to deal with the unique problems associated with the investigation and prosecution of these crimes. Therefore, training should be made available, on an optional basis, to agencies which request it.

III. EMPLOYEE BACKGROUND CHECKS

Council members felt that a major cause of crimes against elders and dependent adults confined to nursing homes may be the absence of thorough screening procedures to prevent the hiring by nursing homes of persons with criminal records. While no statistical data are available to support this theory, the impression held by most Council members is that a significant number of nursing home employees do have criminal backgrounds and that such employees are responsible for many of the instances of abuse of, and theft from, patients in those facilities. Fingerprinting prospective employees to determine possible criminal history will prevent unsuitable individuals getting jobs in those facilities.

IV. THEFT REDUCTION

Because of specific concerns expressed by the Little Hoover Commission, the Council discussed the problem of theft and loss of patients' personal property. There was consensus that no new legislation is required to address this problem since Penal Code section 368(c) clearly makes theft from an elder or dependent adult a felony or misdemeanor, depending on the value of what is stolen. Reduction of theft and loss is more likely to result from implementation of reporting requirements and enactment of a fingerprinting (criminal record check) requirement for applicants for nursing home jobs. In addition, each facility should utilize procedures designed to prevent theft and loss, and to identify and terminate any employees who steal patients' property.

The Council recommends that the Licensing and Certification Division, Department of Health Services, issue regulations or guidelines requiring long-term health care facilities to institute and maintain programs to protect patients' property from theft and loss. Elements of those programs should include, at minimum, the following:

1. Each facility must maintain a theft and loss log describing the item(s), recording the date and time of the theft or loss, the shift, and the employees then on duty.

2. Each facility must send a written "missing-item" report to LCD within 48 hours of receiving a complaint that an item is missing, provide a copy of that report to the resident or the resident's family or representative, and enter a copy of the report in the resident's records.

3. Each facility must ensure that a missing-item report is filed with the local law-enforcement agency within 48 hours of the facility receiving a complaint that an item is missing. If such a report is filed by the resident, the resident's family or the resident's representative, the facility need not file a duplicate report.

4. Each facility must train all employees in the facility's theft and loss prevention program.

5. No facility may knowingly hire or retain any employee who has been convicted of a crime of theft within a period of five years preceding his or her date of hire.

6. No facility may knowingly retain an employee who steals a patient's property.

Conclusion

This Advisory Council afforded BMCF with a unique opportunity to draw from the collective expertise of its members in developing an integrated approach to improving the criminal justice system response to crimes committed in nursing homes. While not a panacea, identification and discussion of the issues with recommendations should provide great improvement in reporting, understanding and dealing with problems confronting our elderly in long-term care facilities.

ATTACHMENT I

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Others Who Attended One or More of the Council's Three Meetings

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