JOINT INFORMATIONAL HEARING
OF THE

SENATE COMMITTEE ON HEALTH
AND
SENATE SUBCOMMITTEE ON AGING AND LONG-TERM CARE

Senator Deborah Ortiz and Senator Elaine Alquist, *Chairs*

NURSING HOME QUALITY IN THE 21ST CENTURY: STAFFING ADEQUACY AND COMPLAINT INVESTIGATION

Sunnyvale Senior Center
July 20, 2005

STAFF:
Nicole Vazquez, *Consultant*
Robert MacLaughlin, *Consultant*
Lynda Hancock, *Committee Assistant*
Stephanie Yang, *Intern*
Steven O'Mara, *Intern*

California Legislature
Senate Subcommittee on Aging and Long-Term Care
SENATOR ELAINE K. ALQUIST, CHAIR

MEMBERS
SAM AANESTAD
DAVE COX
SHEILA KUEHL
DEBORAH ORTIZ

CONSULTANT
ROBERT MacLAUGHLIN

COMMITTEE ASSISTANT
LYNDA HANCOCK

Nursing Home Quality in the 21st Century: Staffing Adequacy and Complaint Investigation

A joint informational hearing of the
Senate Committee on Health
and the
Senate Subcommittee on Aging and Long-Term Care
Senator Elaine K. Alquist presiding

Sunnyvale Senior Center
550 E. Remington Drive, Sunnyvale, CA
July 20, 2005
9:30 a.m. – 12:30 p.m.

Opening/Welcoming Remarks

- **Senator Elaine Alquist, Chairwoman, California State Senate Subcommittee on Aging and Long-Term Care**

(9:37-11:00)

Panel I:

Strengthening Accountability in Nursing Home Staffing Patterns

Building upon recent gains in nursing home resources, what strategies can be deployed to increase compliance with state staff ratio laws? What incentives exist in current law, how do they work, and how are newly implemented laws anticipated to work?

- **Charlene Harrington,** Associate Director of the UCSF John A. Hartford Center of Geriatric Nursing Excellence
  - A current assessment of the state's skilled nursing staffing patterns.
  - The affects of such staffing patterns on quality of care.
  - Ideal staffing levels, and current state mandates.

- **Beth Capell, Representative, Service Employees International Union State Council**
  - The history of improving wages, staffing and reforming the reimbursement system.

- **Willie Brennan, Chief, Rate Development Branch, Medical Care Services, Department of Health Services**
  - Current responsibilities of the Department of Health Services related to staffing levels, and the new requirements under AB 1629 (Chapter 875, Statutes of 2004).
  - Strategies DHS will employ to assure compliance with mandates of AB 1629, in conjunction with existing law.

- **Dave Helmsin, Legislative Advocate, California Association of Health Facilities**
  - An historical assessment of the nursing home industry's perspective on the realities of compliance efforts.

- **Alan Robison, Supervising Deputy Attorney General, Elder Abuse Prosecuting Unit, California Department of Justice**
  - The need for verifiable staffing data in elder neglect prosecutions involving nursing home operators.
  - Data needs of California's chief enforcement entity.

- **Robert Goldsborough, resident of a local nursing facility**
  - "Daily Life In an Understaffed Nursing Home"

Consumer Sounding Board: Informal opportunity for consumers to provide input and insight to testimony provided. Cards will be distributed at the hearing for individuals to submit requests to present during this portion of the hearing.

* * * * *

(11:00-12:30)

Panel II:

Status of the Complaint Investigation and Enforcement System

Actions needed to ensure that abuse and neglect complaints receive timely and thorough investigations. Current status enforcement practices, and efforts to ensure that California care standards and rights are fully enforced.

- **Willie Brennan, Chief, Rate Development Branch, Medical Care Services, Department of Health Services**
  - The Licensing and Certification Branch of the Department of Health Services: an assessment of the L&C role in assuring compliance with current and emerging state policies.

- **Patricia L. McGinnis, Executive Director, California Advocates for Nursing Home Reform**
    - Historical perspectives on the development of the existing complaint investigation system. Purpose and goals of California law and regulations, and the current state of California's complaint and abuse investigation systems.

- **Mark Reagan, Esq. California Association of Health Facilities**
    - Industry view of current enforcement practices and the challenges it poses for compliance efforts.

- **Beth Capell, Representative, Service Employees International Union State Council**
    - Contemporary enforcement challenges facing the state, the industry, and its effect on employees.

- **Linda Robinson, Long-term Care Ombudsman Coordinator, Santa Cruz County**
    - A description of current concerns about the complaint investigation system from the perspective of a local ombudsman coordinator.
    - The effects the current system has on the way the Long-term Care Ombudsman carries out its mandates, and role.

Consumer Sounding Board: Informal opportunity for consumers to provide input and insight to testimony provided. Cards will be distributed at the hearing for individuals to submit requests to present during this portion of the hearing.

Public Comment

Closing Remarks

Senator Elaine K. Alquist

13th Senate District

Representing the Heart of Silicon Valley

A policy maker for over 20 years, Senator Elaine K. Alquist (D-Santa Clara) is in her first Senate term representing the Heart of Silicon Valley in the 13th Senate District of Santa Clara County. The district covers 900,000 people living in the cities of San Jose, Sunnyvale, Santa Clara, Mountain View, and Gilroy.

As a new member of the Senate elected in November 2004, Senator Alquist is the first female Chair of the Senate Committee on Public Safety, where she is leading the fight to provide a prosperous, safe, and secure environment for all California families and businesses. She also chairs the Senate Subcommittee on Aging & Long Term Care and the Select Committee on Emerging Technologies and Economic Competitiveness; and serves on the Committees on Appropriations, Education, Health, Human Services, and Revenue & Taxation; the Subcommittee on Stem Cell Research Oversight; and the Select Committees on Defense & Aerospace Industry, Mobile & Manufactured Homes, and School Safety.

Elaine Kontominas Alquist grew up in St. Louis, MO, earned her bachelor's degree in mathematics from MacMurray College in Illinois, and her master's degree in Guidance and Counseling from Washington University in St. Louis.

Her love of children and public service led her to teach math and be a counselor in public schools. Senator Alquist moved to Santa Clara County in 1978. She immediately became involved in her sons' public schools, first as PTA President and then serving on the Board of Education of the Cupertino Union School District from 1983 through 1991, including two years as Board President. She continued her work advocating for education by serving on the California Postsecondary Education Commission.

A former small business owner and financial analyst at Stanford University, Senator Alquist became the first Greek-American woman elected to the California State Legislature when she was elected to represent the 22nd Assembly District in 1996. Recognized as a leader by her peers, she served as the Co-President of the incoming freshman Assembly class in her first term. Re-elected by huge margins in 1998 and 2000, she continued to represent the South Bay through 2002. In addition, Senator Alquist served as the Assembly's representative on both the Seismic Safety Commission and the Commission on the Status of Women.

A recognized leader on K-12 and higher education issues, Senator Alquist has helped implement the nation's toughest educational standards, expand professional development for teachers, increase per-pupil funding, and expand the Cal-Grant student aid program.

Making government work better is another passion of Senator Alquist's. As the Chair

of the Assembly Committee on Information Technology she blew the whistle on the disastrous Statewide Automated Child Support System (SACSS) and saved taxpayers millions of dollars.

A passionate advocate for seniors, she established the standing Committee on Aging and Long-term Care and served as its first chair, authoring a landmark law on Osteoporosis Prevention and HMO coverage of Hospice Care costs. She also secured permanent funding for Alzheimer's disease by creating a tax checkoff program.

A lifetime champion of victims of crime, Senator Alquist is using her position as the first woman to chair the Senate Committee on Public Safety to build on her groundbreaking legislation that made it easier for law enforcement to crack down on child molesters.

As a resident of the City of Santa Clara, Senator Alquist understands the transportation and housing challenges that she and the other residents of the 13th Senate District face. She was proud to have created the First-Time Homebuyers Down Payment Assistance Program and is working on solutions to ease traffic congestion and help more Californians buy their own homes.

Knowing that Silicon Valley is an economic engine for the entire state, Senator Alquist is also fighting to create jobs and revitalize our economy.

Senator Alquist is married to retired State Senator Al Alquist. Her family includes her sons Peter and Bryan White, daughter-in-law Anju Chowdhry White, granddaughter Jasmine, and grandson Logan.

<u>Contact Information</u>

Capitol Office
State Capitol, Room 4088
Sacramento, CA 95833
916-651-4013

District Office
100 Paseo de San Antonio, Ste 209
San Jose, CA 95113
408-286-8318

BACKGROUND

Verifying Nursing Home Staff: A Key to Quality
&
The state of California's Complaint Investigation and Enforcement System

July 20, 2005

I. *Verifying Nursing Home Staff: A Key to Quality*

The quality of a nursing home's care is directly related to the adequacy of its staff. Numerous studies have documented that insufficient or poorly trained staff endangers residents' health and safety. For example, a 2004 report by the Institute of Medicine found:

> The relationship between nurse staffing levels and patient outcomes in nursing homes has been shown in numerous studies...inadequate nurse staffing has been shown to be associated with malnutrition, starvation and dehydration in nursing homes.

In a 2004 report, the California Department of Justice reported a direct link between understaffing and elder abuse:

> There is no more accurate indication of failure or success in the delivery of care than that of staffing levels. This is best evidenced by the fact that every corporate neglect case prosecuted by the BMFEA has involved understaffing as one of the underlying problems.

Effective January 1, 2000, skilled nursing facilities in California were required to provide at least 3.2 hours of nursing care per resident each day. Under federal law, nursing homes must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Although Federal law does not prescribe a minimum-staffing ratio, a Congressionally ordered study recommended 4.1 hours of care per resident day.

Hundreds of California nursing homes do not meet California's minimum requirements and few meet the federal recommendations. In 2003, 31 percent of freestanding nursing facilities reported that they did not meet California's minimum requirements. Actual noncompliance is likely higher since California does not routinely audit the reported staffing data to determine its accuracy. Surprise inspections by the California Office of Attorney General, through its Operation Guardians program, found that 68 percent of inspected facilities did not meet California's minimum requirements.

The California Department of Health Services was required to develop regulations, taking effect by August 1, 2003, that prescribe staff to patient ratios for direct caregivers working in a skilled nursing facility. Two years after the deadline, the required regulations have not been published or taken effect.

California lacks a system to accurately document staffing levels and to enforce its minimum requirements. Nursing homes report some staffing data to the California Office of Statewide Health Planning and Development, but the information is not audited for accuracy nor is it available to consumers in a timely manner. The California Department of Health Services (DHS) collects limited staffing information during annual inspections, but it does not routinely verify the information. DHS does have the authority to cite and fine nursing homes for violating staffing requirements, but it has done so in only a handful of cases.

Federal officials report that the nursing home staffing data they collect is unreliable. In April 2004, the Secretary of the U.S. Department of Health and Human Services (HHS) stated that HHS has "serious reservations about the reliability of staffing data at the nursing home level." The HHS Office of Inspector General has completed a series of investigations in which it used payroll records to determine actual staffing levels at nursing homes around the county. It found that actual staffing levels were often lower, by as much as 36 percent, than the staffing levels self-reported by the nursing homes. As a result, HHS is developing staffing quality measures and is testing the use of auditable payroll data to accurately document nursing home staffing levels.

California's need to accurately document nursing home staffing levels is immediate. Its pending implementation of AB 1629 (2004) will establish a new Medi-Cal rate system for freestanding skilled nursing homes and boost Medi-Cal nursing home spending by about $2.7 billion through FY 07-08. The new rate system seeks to improve care by improving and individualizing Medi-Cal rates and by creating financial incentives to increase staff. California must establish reliable documentation and enforcement measures at the outset of this new system to help determine whether nursing home residents are benefiting from the substantial new payments through improved staffing and to hold nursing home operators accountable if they neglect the minimum staffing requirements or file false reports on their staffing levels.

II. *The state of California's Complaint Investigation and Enforcement System*

Federal Oversight: The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the federal agency responsible for overseeing nursing homes that participate in the Medicare and Medicaid (Medi-Cal) programs, for defining conditions of participation, and for imposing sanctions against those facilities that fail to meet the participation requirements.

California's Department of Health Services receives funding from CMS to conduct on-site surveys of those facilities participating in the Medicare and Medicaid (Medi-Cal) programs and to recommend sanctions against facilities that violate the laws. For these facilities, the state can recommend a variety of federal enforcement remedies, in addition to state sanctions. The federal remedies include directed plans of correction, directed in-service trainings, denial of payment for new admissions, federal civil monetary penalties, appointment of a temporary manager and termination of Medicare or Medicaid payments. Since over 80% of California nursing homes participate in Medicare and/or the Medicaid programs, most facilities are subject to federal, as well as, state sanctions.

Federal Deficiencies: Quality of care deficiencies identified during standard surveys or complaint investigations are classified according to their scope (i.e., the number of residents actually or potentially affected) and their severity. An A-level deficiency is the least serious and is isolated in scope, while an L-level deficiency is the most serious and is considered to be widespread in the nursing home. Although the number of federal deficiencies issued against California nursing homes increased from 13,557 in 2003 to 19,078 in 2004, the percentage of facilities cited for actual harm or immediate jeopardy has declined over 20%. According to a July 2003 GAO report on nursing home quality, California is among the states where the understatement of actual harm deficiencies is of serious concern.

Federal Sanctions: In 2003 and 2004, few federal sanctions were imposed, despite the more than 32,000 deficiencies issued.

Total Federal Remedies Imposed: 1995-2004

Year	Payment Denied	Civil Monetary Penalties	Total
1995	9	3	12
1996	40	22	62
1997	46	56	102
1998	63	167	230
1999	53	108	161
2000	71	74	145
2001	53	38	91
2002	13	18	31
2003	7	24	31
2004	24	32	56

The Role of DHS, Licensing & Certification: The Department of Health Services, Licensing and Certification Program (L&C) is responsible for licensing nursing homes for annual surveys, investigating complaints, and through its enforcement efforts, ensuring compliance with state and federal laws and regulations. The state has a wide variety of state and federal enforcement tools from which to choose. For facilities that do not participate in federal funding, state enforcement tools include a system of deficiencies, citations and penalties, bans on admissions, placing the facility in receivership, or even suspension or revocation of the facility's license. Because the state rarely utilizes the temporary manager or receivership option, the citation and civil monetary penalty system remains the primary state tool for state enforcement.

Citations: Assessment and Fines: Licensing staff has discretion to set the class of citation and the amount of penalty according to the severity of the violation and the impact on the resident. The calendar year of 2004 showed a marked decrease in the number of citations issued against nursing homes.

Total Penalties and Number of Citations issued 2001-2004:

2001:	991	$ 4,554,205

2002:	911	$ 4,375,589
2003:	906	$ 4,038,100
2004:	641	$ 2,740,550

State Deficiencies: The Department of Health Services, Licensing and Certification, can also issue deficiencies for violations of state laws, which, in many cases, are stronger than federal law or are in addition to federal laws. Because the Department has focused on federal law alone, the number of state deficiencies has decreased from 4,248 in 2003 to 992 in 2004.

Response To Consumer Complaints: L&C District Offices play the key role in enforcement efforts. Their capacity to respond to consumer complaints in a timely manner, to protect patients from neglect and abuse and to enforce the laws in a consistent manner has a direct impact on residents' lives.

The staffing crisis has led to a rising tide of complaints about bedsores, malnutrition, dehydration, infections and other lethal conditions caused by neglect. Between 2000 and 2003, the number of complaints against nursing facilities rose 38 percent. Thousands of additional concerns are being classified as "reported events" by the Department and deemed unworthy of investigation.

Existing law requires the Department to investigate life-threatening complaints within 24 hours and begin all other investigations within 10 working days. Yet, the Department does not investigate many complaints in a timely manner, if at all, due, according to the Department, to heavy budget cuts to its Licensing and Certification Division. Substantiation rates for complaints plunged from 41 percent in 2000 to 25 percent in 2003, demonstrating the futility of late, cursory investigations. Due to the broken complaint system, thousands of cases of elder neglect and abuse are simply falling through the cracks.

According to the July 2003 GAO report, California officials informed the GAO that the increase in the number of complaints requires an additional 32 surveyor positions.

Pilot Complaint Investigation Program: In early 2005, the Department, without prior legislative consent, embarked on a pilot program in two of its District Offices, Alameda and San Jose, to test a new complaint investigation protocol. Under this "pilot" program, evaluators are only examining compliance with federal requirements. They are not assessing compliance with numerous California laws. They are not issuing state deficiencies or citations. State enforcement remedies are not being used. There is no appeal process for consumers in the federal system, and the state appeals process, mandated by state law, is being denied to consumers. This means that hard fought state laws enacted to protect California's nursing home residents and to enhance the rights of residents are not being enforced.

Dedicated Complaint Response Units: SB 526 would require the Department to establish dedicated complaint response units in each District office to respond to complaints on a timely basis. Although the California State Auditor recommended Complaint Response Teams in each

District Office in 1994, this recommendation has not been pursued. Timely and comprehensive investigations of consumer complaints will do more in the long run to improve quality.

Partial List of Resources

Institute of Medicine, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, 165-166 (2004).

Bureau of Medi-Cal Fraud & Elder Abuse, California Department of Justice, 2004, *Operation Guardians 2001-02 and 2002-03 Results.*

U.S. Centers for Medicare and Medicaid Services, Prepared by ABT Associates Inc., 2001, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final.* Volumes I-III. Baltimore, MD: CMS.

Harrington, C., O'Meara, J., 2004, Report on California's Nursing Homes, Home Health Agencies, and Hospice Programs. Prepared for the California HealthCare Foundation.

Bureau of Medi-Cal Fraud & Elder Abuse, California Department of Justice, 2004, *Operation Guardians 2001-02 and 2002-03 Results.*

Letter from Secretary Tommy G. Thompson to Rep. Henry A. Waxman, April 21, 2004.

HHS Office of Inspector General, *Effect of Staffing on Quality of Care at Nursing Facilities -- Dublinair Health Care and Rehabilitation Center*, April 2004, A-04-04-04003.

Centers for Medicare and Medicaid Services, *Action Plan for Further Improvement of Nursing Home Quality*, December 2004.

Nursing Home Quality in the 21st Century: Staffing Adequacy and Complaint Investigation

A joint informational hearing of the
Senate Committee on Health
and the
Senate Subcommittee on Aging and Long-Term Care
Senator Elaine K. Alquist presiding

July 20, 2005

BACKGROUND ON AB 1629

Summary

In 2004, Assembly Bill 1629 (Frommer, Chapter 875, Statutes of 2004) created a quality assurance fee imposed on SNF providers beginning in 2004-05, with immediate COLA relief provided for SNFs in that same year. The bill called for DHS to design and implement a facility-specific ratesetting system by August 1, 2005, subject to federal approval and availability of federal funds, that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities. The legislation included a sunset of the entire system four years after enactment and included an increase in various reporting, review, evaluation, and audit activities to assure compliance with the law and to assess progress. Additionally, the bill included provisions that require SNFs to include in a resident's assessment whether the resident has indicated a preference to return to the community, with quarterly evaluation of the resident's discharge potential and the provision of information to the resident on options for home and community-based services.

A detailed breakdown of the components in AB 1629 is included in this document and the provisions of AB 1629 around reporting and accountability are summarized beginning on page 8.

Prior legislation

AB 1075 (Shelley, Chapter 684, Statutes of 2001) required DHS to develop regulations by August 1, 2003 to establish staff-to-patient rations with regard to direct caregivers working in SNFs. It also required DHS to implement a facility-specific ratesetting system by August 1, 2004, subject to federal approval and the availability of federal or other funds, that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities. The bill asked DHS to examine several alternative rate methodology models for a new Medi-Cal reimbursement system SNFs to include, but not be limited to, consideration of specified factors.

California's nursing homes

There are approximately 1,400 skilled nursing facilities in California. According to the California Healthcare Foundation's report "*Snapshot: Nursing Homes: A System in Crisis*" (2004), more than 110,000 individuals live in California's long-term care facilities. The majority of residents are 75 or older, female, and white. The majority of those who enter a nursing facility need care temporarily to recuperate or rehabilitate after an illness or hospital stay. Others

live there for the rest of their lives. Medicare pays for approved short-term care up to 100 days. After Medicare and private insurance benefits are exhausted, individuals and families must pay for nursing home care directly out of pocket. Once individuals spend down their assets, they may become eligible for Medi-Cal coverage, which paid more than half of the cost of care in freestanding facilities in 2002.

Purpose of AB 1629

California's Medi-Cal program pays for two thirds of nursing home care provided in California and pays for the care on a flat per day rate, regardless of the care needed or provided. The author and proponents state that the existing flat rate system has resulted in low wages, e.g. $9 per hour in Los Angeles, high turnover, over 100 percent in many cases, aging facilities, and minimal care.

In 2001, the Service Employees International Union (SEIU) sponsored AB 1075 to transform the rate system that was supported by many senior and consumer groups. In July 2003, SEIU submitted a revised proposal jointly with a group of nursing home providers who had joined with SEIU to form an Alliance to reform nursing homes. The proposal contained in AB 1629 was based on the actual cost of providing care and is intended to improve quality and accountability. Proponents stated that the new rate system was designed to pay for improved wages and staffing and is based on the actual cost of care. Due to the importance of wages and staffing to quality of care, labor costs can grow faster than non-labor costs. The new methodology is to reflect the sum of the actual cost of specified components and pass-through costs, subject to specific peer groups.

Cost Centers and Quality of Care

"Snapshot: Nursing Homes: A System in Crisis" asserts that high staff turnover among poorly paid personnel contributes to poor quality of care. In 2002, well over one-third of freestanding nursing homes did not meet the state mandated minimum nurse staffing level of 3.2 hours per resident. Ninety-three percent did not meet the 4.1 hour daily standard recommended in a recent report to CMS. More than two-thirds of the nursing staff in California nursing homes, the majority of them nursing assistants earning an average of $10.35 per hour), left their jobs in the year 2002. The annual turnover rates among nursing homes ranged from 5 percent to 304 percent. In 2002, freestanding, for-profit facilities had lower staffing levels, higher staff turnover rates, and more violations of health and safety regulations than nonprofit facilities.

A study entitled "Medicaid, Bed Constraint Policies, and Risk-Adjusted Pressure Ulcers" (Grabowski and Angelelli, *Health Services Research* 39:4, Part I, August 2004) made the principal finding that in the analysis of all U.S. markets, there was a positive relationship between the Medicaid payment rate and nursing home quality. The results from the analysis imply that a 10 percent increase in Medicaid payment was associated with a 1.5 percent decrease in the incidence of risk-adjusted pressure ulcers. Conversely, with a reduction in the Medicaid payment rate, the study would also expect greater physical restraints, daily pain, anti-psychotic drug use, catheters, feeding tubes, weight loss, hospitalizations, and other indicators of poor quality. Finally, there was a strong relationship between Medicaid payment and quality in high-Medicaid homes providing strong evidence that the level of Medicaid payment is especially important within resource poor facilities.

Proponents of AB 1629 stated that California's current reimbursement system does not support quality patient care. With every nursing home receiving a flat fee for each resident, there is no control over how much of the fee is paid for resident care costs, administration, or profit. This proposal creates a new system that bases Medi-Cal reimbursement on the actual costs of care, holds homes accountable for residents' quality of life, and provides a way for the state to tap into more federal Medicaid dollars to help fund the new system. This funding proposal fulfills the promise to protect residents and the disabled by dedicating funding to patient care, including wages, staffing, food, linens, and upgrading old facilities. In addition, it guarantees residents that a preference to return to the community will be considered in developing and implementing residents' care plans.

COMPONENTS OF AB 1629

Definitions.

- "Continuing care retirement community" (CCRC) as currently defined in existing law, as a facility were services promised in a continuing care contract are provided.

- "Exempt facility" as a SNF that is part of a CCRC, a SNF operated by the state or another public entity, or a SNF that is a distinct part of a facility that is licensed as a general acute care hospital.

- "Net revenue" as gross resident revenue for routine nursing services and ancillary services provided to all residents by a SNF, less Medicare revenue for routine and ancillary services including Medicare revenue for services provided to residents covered under a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation. "Net revenue" does not mean charitably contributions and bad debt.

- "Payer discounts and contractual allowances" means the difference between the facility's resident charges for routine or ancillary services and the actual amount paid.

- "Skilled nursing facility" means a licensed facility pursuant to existing law.

Quality Assurance Fee.

Imposes on SNFs each state fiscal year a uniform quality assurance fee (Q/A fee) per resident day, to be based upon the entire net revenue of all SNFs subject to the fee, except an exempt facility.

Reporting.

- Specifies a reporting requirement from facilities to DHS, showing the facility's total resident days for the preceding quarter and payments made, with a mechanism to ensure that underpayments and overpayments are reconciled in prospective quarters.

- Installs an annual reporting requirement due on or before August 31 of each year, specifying each facility's total resident days and total payments made for the preceding state fiscal year.

Fee Assessment.

- Requires that this assessment process become operative not later than 60 days from receipt of federal approval of the Q/A fee, unless later extended by DHS.

- Specifies that the Q/A fee shall be assessed per resident day shall be determined based on the aggregate net revenue of SNFs subject to the fee, in accordance with the methodology outlined in the request for federal approval and in regulations, provider bulletins, or other instructions.

Calculation of the Q/A fee.

- For the rate year 2004-05, the aggregate projected net revenue, for all facilities subject to the fee and based on prior rate year data, shall be multiplied by 2.7 percent, then divided by the projected total resident days of all providers subject to the fee. Authorizes the Director of DHS to increase the amount of the fee up to three percent of the aggregate projected net revenue if necessary to implement specified provisions.

- For the rate year 2005-06 and subsequent rate years through and including the 2007-08 rate year, the projected net revenue shall be based on the prior year's data and once determined for all facilities, shall be multiplied by six percent, then divided by the projected total resident days of all providers subject to the fee.

- Specifies a cap on the aggregate fees collected annually of six percent of the annual aggregate net revenue for licensed SNFs subject to the fee and permits DHS to make retrospective adjustments as necessary to the amounts calculated in order to assure that the Q/A fee for any fiscal year does not exceed this six percent.

- Specifies how facilities will pay fees assessed and receive increased rates retroactively under the circumstances of a delay in the approval of the quality assurance fee and methodology by the federal Centers for Medicare and Medicaid Services (CMS) in any rate year.

Further fee detail.

- Specifies the procedures by which DHS may deduct an unpaid assessment and interest owed from any Medi-Cal reimbursement payments for a facility that fails to pay all of part of the Q/A fee within the 60 days of the date that the payment is due. Specifies the action that DHS may take should all or part of the Q/A fee remain unpaid.

- Requires that, in accordance with the provisions of the Medicaid state plan, the payment of the Q/A fee shall be considered an allowable cost for Medi-Cal reimbursement purposes.

Adoption of regulations.

- Requires the Director of DHS to administer the Q/A fee article and permits the director to adopt regulations, including emergency regulations, as necessary to implement the article, outlining the purposes of implementation that these regulations may include. States that it is the intent of the Legislature that the regulations shall be adopted on or before July 31, 2007.

- Permits, as an alternative to regulations, the Director to implement the fee, in whole or in part, by means of a provider bulletin, or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2007.

Use of fee for additional reimbursement.

- Requires the Q/A fee to be deposited in the State Treasury. Requires that the funds assessed be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and to support facility quality improvement efforts in, licensed SNFs.

- Requires DHS to request approval from CMS to implement the Q/A fee and in making the request, to seek specific approval to exempt the facilities specified in the measure, including the submission of a request for waiver of the broad based, or statewideness, requirement, waiver of the uniform fee requirement, or both. Provides the Director the flexibility to alter the methodology of the fee and those facilities to which it would apply in order to meet requirements of federal law or regulation.

- Specifies the three continuing conditions under which the Q/A fee shall remain operative, including that CMS continue to allow the use of the provider assessment, that the reimbursement changes included in the measure are enacted and implemented on or before July 31, 2005 and remain in effect thereafter, and that the state has continued its maintenance of effort for the level of state funding of reimbursement for rate years 2005-06 through 2007-08 in an amount not less than the amount facilities would have received under the rate methodology in effect on July 31, 2004.

Federal approval.

- Makes the implementation of the Q/A fee contingent upon the state's receipt of federal approval from CMS and that legislation is enacted in the 2004 legislative session to make an appropriation from the General Fund and the Federal Trust Fund to fund a rate increase for SNFs for the 2004-05 rate year in an amount consistent with the Medi-Cal rates that facilities would have received under the rate methodology in effect as of July 31, 2004, plus the proportional costs as projected by Medi-Cal for new state or federal mandates.

Sunset.

- Sunsets the assessment or collection of the Q/A fee on July 31, 2008, makes the article inoperative on July 1, 2008, and repeals this law on January 1, 2009.

Return to the Community.

- Requires that at the time of admission, a SNF shall include in a resident's care assessment the resident's projected length of stay and the resident's discharge potential, and specifies the required components of the assessment.

- Includes provisions to facilitate a SNF resident's return to the community, when appropriate, including:

- Requiring the SNF to evaluate the resident's discharge potential at least quarterly or upon a significant change in the resident's medical condition.

- Requiring that, if return to the community is part of the care plan, the facility shall provide to the resident or responsible party and document in the care plan the information concerning services and resources in the community and specifies what the information may include.

Rate Reimbursement System.

Requires DHS to implement a facility-specific ratesetting system by August 1, 2004, subject to federal approval and availability of federal or other funds, that reflects the costs and staffing levels associated with quality of care for residents in hospital-based nursing facilities.

- Unfreezes the reimbursement rate for SNFs, exempting these facilities from the requirement in current law that Medi-Cal rates in effect on August 1, 2003 shall remain in effect through July 31, 2005.

- Enacts the Medi-Cal Long-Term Care Reimbursement Act and requires DHS to implement a facility-specific ratesetting system subject to federal approval and the availability of federal funds. Provides that the system shall be effective on August 1, 2005 and shall be implemented commencing on the first day of the month following federal approval.

- Permits DHS to contract as necessary, on a bid or nonbid basis, in implementing the new rate system and directs that the system shall be developed with all possible expedience.

- Permits DHS to obtain professional consulting services for the purposes of developing the new rate system and states that it is the intent of the Legislature that DHS be authorized to hire up to three full-time equivalents (FTEs) to support implementation and continuous operation of the system.

Methodology components (cost centers).

- Requires that the methodology shall be facility specific and reflect the sum of the projected cost of each cost category, passthrough costs, and operating allocation categorized as follows:

1. Labor costs, comprised of a direct resident care labor cost category, an indirect care labor cost category, and a labor-driven operating allocation cost category, as follows:

   a. Direct resident care labor cost category which shall include all labor costs related to routine nursing services including all nursing, social services, activities, and other direct care personnel. These costs shall be limited to the 90th percentile.

   b. Indirect care labor cost category which shall include all labor costs related to staff supporting the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, inservice education, and plant operations and maintenance. These costs shall be limited to the 90th percentile.

   c. Labor-driven operating allocation shall include an amount equal to eight percent of labor costs, minus expenditures for temporary staffing, which may be used to cover allowable Medi-Cal expenditures. In no instance shall the operating allocation exceed five percent of the facility's total Medi-Cal reimbursement rate.

2. Indirect care nonlabor costs limited to the 75th percentile.

3. Administrative costs limited to the 50th percentile.

4. Capital costs based on a fair rental value system (FRVS), that recognizes the value of the capital related assets necessary to care for Medi-Cal residents. The capital cost category includes mortgage principal and interest, leases, leasehold improvements, depreciation of real property, equipment, and other capital related expenses. The FRVS methodology shall be based on the formula developed by the department that assesses facility value based on age and condition and uses a recognized market interest factor.

5. Direct passthrough of proportional Medi-Cal costs for property taxes, facility license fees, new state and federal mandates, caregiver training costs, and liability insurance as projected based on the prior years' costs.

Rate floor.

- Establishes a rate floor for 2005-06 and 2006-07 rate years, including the Q/A fee in effect for these years, that shall not be less than the rate that the specific facility would have received under the rate in effect as of July 31, 2005.

Maximum annual rate increases.

- Specifies that General Fund moneys shall be utilized for increasing rates and that the following caps, subject to further adjustment, shall apply:

  a. For the 2005-06 rate year, the maximum annual increase in the weighted average Medi-Cal rate is capped at 8 percent of this rate for the 2004-05 year as adjusted for the cost of the Q/A fee for the 2005-06 year plus the costs of complying with new state or federal mandates.

b. Beginning with the 2006-07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

c. Beginning with the 2007-08 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5.5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

Federal approval.

- Requires DHS to seek approval of a Medicaid state plan amendment (SPA) for the new reimbursement methodology no later than February 1, 2005. Requires the SPA and any regulations or provider bulletins to be prepared in consultation with representatives of long-term care industry, organized labor, seniors, and consumers.

Adoption of regulations.

- Requires the Director to administer the new reimbursement system and permits the Director to adopt regulations, including emergency regulations, as necessary to implement the article, outlining the purposes of implementation that these regulations may include. States that it is the intent of the Legislature that the regulations shall be adopted on or before July 31, 2007.

Reporting and accountability.

Requires DHS to update each facility specific rate annually, specifying the sources of cost data, and requires DHS to adjust the updated rate in accordance with the results of facility specific audit and review findings.

- Requires DHS to conduct financial audits of facility and home office cost data as follows:

  a. The department shall audit facilities a minimum of once every three years to ensure accuracy of reported costs.

  b. It is the intent of the Legislature that the department develop and implement limited scope audits of key cost centers or categories to assure that the rate paid in the years between each full scope audit accurately reflects actual costs.

  c. For purposes of updating facility specific rates, the department shall adjust or reclassify costs reported consistent with applicable requirements of the Medicaid state plan

d. Overpayments to any facility shall be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations.

- Provides that compliance by each facility with state laws and regulations regarding staffing levels shall be documented annually either through facility cost reports, including supplemental reports, or through the annual licensing inspection process.

- Requires the Bureau of State Audits, by December 1, 2006, to conduct an accountability evaluation of DHS's progress toward implementing a facility-specific reimbursement system, including a review of data to ensure that the new system is appropriately reimbursing facilities within specified cost categories and a review of the fiscal impact of the new system on the General Fund.

- Provides that no later than January 1, 2007, to the extent information is available for the three years immediately preceding the implementation of this article, the DHS shall provide baseline information in a report to the Legislature on all of the following:

  a. The number and percent of freestanding skilled nursing facilities that complied with minimum staffing requirements.

  b. The staffing levels prior to the implementation of this article.

  c. The staffing retention rates prior to the implementation of this article.

  d. The numbers and percentage of freestanding skilled nursing facilities with findings of immediate jeopardy, substandard quality of care, or actual harm, as determined by the certification survey of each freestanding skilled nursing facility conducted prior to the implementation of this article.

  e. The number of freestanding skilled nursing facilities that received state citations and the number and class of citations issued during calendar year 2004.

  f. The average wage and benefits for employees prior to the implementation of this article.

- Requires that not later than January 1, 2008, the department shall provide a report to the Legislature that does both of the following:

  a. Compares the information required in the baseline evaluation to that same information two years after the implementation of the bill.

  b. Reports on the extent to which residents who had expressed a preference to return to the community were able to return to the community.

- Requires capital investment and improvement expenditures included in the FRVS formula to be documented in cost reports or supplemental reports required by the department.

Sunset.

- Makes the article inoperative on July 31, 2008, and repeals this law on January 1, 2009. Conditions the reimbursement system's operation upon the implementation of the Q/A fee.

Contingencies.

- States that if a final judicial or federal administrative finding is made that federal financial participation is not available because the methodology is invalid, unlawful, or contrary to existing federal law or regulation, the Q/A fee and/or the provider reimbursement system become inoperative.

Appropriations.

- $106,781,000 from both the State Treasury and the Federal Trust Fund, for a total of $213,562,000, to the department for expenditure to fund an increase to the 2004-05 skilled nursing facility Medi-Cal reimbursement rate consistent with the existing rate methodology in the Medicaid state plan.

- $2,000,000 for the 2004-05 fiscal year and $1,000,000 for the 2005-06 fiscal year to the department from the General Fund for expenditure for purposes of expeditiously implementing the ratesetting system that would be required under this bill.

- $350,000 for both the 2004-05 fiscal year and the 2005-06 fiscal year to the department from the General Fund for expenditure for purposes of funding the implementation of the bill.

- $200,000 for the 2005-06 fiscal year to the Bureau of State Audits from the General Fund for purposes of implementing the bill.

AMENDED IN SENATE APRIL 14, 2005

AMENDED IN SENATE APRIL 11, 2005

SENATE BILL No. 526

Introduced by Senator Alquist

February 18, 2005

An act to amend Sections 1324.25, 1420, 1424, and 1599.1 of, and to repeal Section 1419 of, the Health and Safety Code, and to amend Sections 14124.10 and 14126.023 of the Welfare and Institutions Code, relating to long-term health care facilities.

LEGISLATIVE COUNSEL'S DIGEST

SB 526, as amended, Alquist. Long-term health care.

Existing law provides for the licensure and regulation by the State Department of Health Services of health care facilities, including long-term health care facilities.

Existing law establishes procedures to be followed when the department receives a written or oral complaint about a long-term health care facility.

Existing law requires the department to establish a centralized consumer response unit within the Licensing and Certification Division of the department to respond to consumer inquiries and complaints.

This bill would repeal this provision. The bill would, instead, require, by January 1, 2007, the department to establish and operate a dedicated complaint response unit in each district office of the Licensing and Certification Division of the department to respond to consumer inquiries and complaints. The bill would require the department to submit a report to the Legislature, on or before January 1, 2006, about the necessary workforce and projected costs associated

with the dedicated complaint response units. The bill would make other changes to the complaint procedures.

Existing law provides for the imposition of a quality assurance fee on each skilled nursing facility, with some exemptions, to be administered by the director and deposited in the State Treasury. Existing law requires that funds assessed pursuant to these provisions be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and support facility quality improvement efforts in, licensed skilled nursing facilities. Existing law provides that these provisions are to be implemented as long as 2 conditions are met, including federal approval, specifies 4 circumstances under which these provisions would become inoperative, makes these provisions inoperative on July 1, 2008, and repeals them on January 1, 2009.

This bill would provide that the dedicated complaint response unit provisions provided under the bill shall only be implemented to the extent that the provisions imposing the quality assurance fee for skilled nursing facilities are implemented and operative. ~~The bill would provide that the quality assurance fee assessment shall be available to support the costs of implementing and operating the complaint response units established under the bill.~~

Existing law prescribe procedures for the issuance of a citation, classified according to the nature of the violation, and the imposition of a civil penalty against a long-term health care facility. Existing law provides that a Class "A" violation is a violation that the department determines presents either an imminent danger or substantial probability that death or serious harm to the patients or residents of the facility would result from the violation.

This bill would provide, instead, that a Class "A" violation is a violation that the department determines presents or involves, in addition to the situations presented, a nonconsensual sexual encounter between a patient or resident of the facility and any staff member currently employed by the same facility.

Existing law requires that written policies and procedures of a skilled nursing and intermediate care facility ensure that each patient admitted to the facility has prescribed rights.

This bill would add to these rights, among others, reasonable accommodation of individual needs and preferences, the right to choose an attending physician, the right to discharge oneself, bed hold options for hospitalized residents, and transfer and discharge rights.

Existing law prohibits a long-term health care facility that participates as a provider under the Medi-Cal program from discriminating against a Medi-Cal patient on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program.

This bill, instead, would prohibit discrimination under this provision against a Medi-Cal resident or prospective Medi-Cal resident.

This bill would prohibit each skilled nursing facility, with exceptions, from discriminating, on the basis of source of payment, against a current or prospective Medi-Cal beneficiary who seeks admission. The bill would require that all applicants for admission be admitted in the order in which they first request admission, with exceptions, and would establish additional requirements of a skilled nursing facility to provide certain notice, provide receipts of requests seeking admission, and maintain a dated list of applications. The bill would authorize the department to decrease the daily Medi-Cal reimbursement rate to a long-term health care facility for one year for a violation of this provision.

Existing law requires the department to establish the minimum number of equivalent nursing hours per patient required in skilled nursing and intermediate care facilities.

Existing law provides for the Medi-Cal program, which is administered by the department and under which qualified low-income persons receive health care benefits. Existing law provides for a Medi-Cal long-term care reimbursement methodology, that includes a facility-specific ratesetting system. Existing law provides for a labor-driven operating allocation under the methodology.

This bill would provide that the labor-driven operating allocation shall not be paid to facilities that, on an annual basis, fail to comply with the minimum staffing hours per patient required in skilled nursing and intermediate care facilities. The bill would require a skilled nursing facility to submit electronic payroll records to the department on a quarterly basis to document labor costs. The bill would require the department, on or before July 1, 2006, to devise and implement a uniform system for collecting and evaluating payroll data. The bill would require the administrator of the facility to sign and certify the accuracy of the payroll records~~, under penalty of perjury. Because this requirement would expand the scope of the~~

~~crime of perjury, this bill would impose a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~yes~~ *no*.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Over 14,000 oral and written complaints are filed each year with the Licensing and Certification Division of the State Department of Health Services.

(2) Currently, the department is required to respond to all complaints within statutory timelines with an onsite investigation to determine if the complaint is substantiated.

(3) As a result of the high volume of complaints, the lack of coordinated efforts among district offices of the Licensing and Certification Division of the department, and the lack of adequate staff, complaints are frequently not resolved within statutory timelines, resulting in violation of state laws, consumer dissatisfaction and frustration, and an estimated 73 percent of complaints being found to be unsubstantiated as a result of inadequate investigations.

(b) The Legislature also finds and declares both of the following:

(1) That the State Department of Health Services is required to inspect and investigate long-term health care facilities for compliance with state and federal laws and regulations pursuant to, at a minimum, Section 1423 of the Health and Safety Code.

(2) That changes made by this act to Section 1599.1 of the Health and Safety Code and Section 14124.10 of the Welfare and Institutions Code incorporate into state law requirements set forth under federal law, which the department already has a

responsibility to enforce and these changes should not result in additional enforcement costs.

SEC. 2. Section 1324.25 of the Health and Safety Code is amended to read:

1324.25. The funds assessed pursuant to this article shall be available to enhance federal financial participation in the Medi-Cal program, to provide additional reimbursement to, and to support facility quality improvement efforts in, licensed skilled ~~nursing facilities, and to support the costs of implementing and operating the complaint response units established under subdivision (a) of Section 1420.~~ *nursing facilities.*

SEC. 3. Section 1419 of the Health and Safety Code is repealed.

SEC. 4. Section 1420 of the Health and Safety Code is amended to read:

1420. (a) (1) By January 1, 2007, the department shall establish and operate a dedicated complaint response unit in each district office of the Licensing and Certification Division of the department to respond to consumer inquiries and complaints. Each complaint unit shall include a sufficient number of appropriately trained and qualified staff necessary to ensure thorough investigation of complaints and facility reports of suspected abuse, neglect, and unusual occurrence within the timelines established under this section.

(2) Not later than January 1, 2006, the department shall provide a report to the Legislature that includes a review of the appropriate workforce necessary to implement the dedicated complaint response units and the projected costs of implementation.

(3) The department shall demonstrate good faith efforts to comply with the requirements of this section, including hiring any additional staff necessary. The department shall develop a plan for full compliance by January 1, 2007.

(4) The requirements of this subdivision shall only be implemented to the extent that Article 7.6 (commencing with Section 1324.20) of Chapter 2 is implemented and operative.

(5) Nothing in this section shall preclude the department from taking any and all enforcement actions available under state and federal law.

(b) (1) Upon receipt of a written or oral complaint, the department shall assign an inspector to make a preliminary review of the complaint and shall notify the complainant within two working days of the receipt of the complaint of the name of the inspector. Unless the department determines that the complaint is willfully intended to harass a licensee or is without any reasonable basis, it shall make an onsite inspection or investigation within 10 working days of the receipt of the complaint. In any case in which the complaint involves a threat of imminent danger of death or serious bodily harm, the department shall make an onsite inspection or investigation within 24 hours of the receipt of the complaint. In any event, the complainant shall be promptly informed, in no case later than 10 working days of receipt of the complaint, of the department's proposed course of action and of the opportunity to accompany the inspector on the inspection or investigation of the facility. Upon the request of either the complainant or the department, the complainant or his or her representative, or both, may be allowed to accompany the inspector to the site of the alleged violations during his or her tour of the facility, unless the inspector determines that the privacy of any patient would be violated thereby.

(2) When conducting an onsite inspection or investigation pursuant to this section, the department shall collect and evaluate all available evidence and may issue a citation based upon, but not limited to, all of the following:

(A) Observed conditions.

(B) Statements of witnesses.

(C) Facility records.

(3) A final determination as a result of the inspection or investigation shall be completed within 90 days of receipt of the complaint by the department.

(4) Within 10 working days of the completion of the complaint investigation, the department shall notify the complainant and licensee in writing of the department's determination as a result of the inspection or investigation.

(c) Upon being notified of the department's determination as a result of the inspection or investigation, a complainant who is dissatisfied with the state department's determination, regarding a matter which would pose a threat to the health, safety, security,

welfare, or rights of a resident, shall be notified by the department of the right to an informal conference, as set forth in this section. The complainant may, within 15 business days after receipt of the notice, notify the director in writing of his or her request for an informal conference. The informal conference shall be held with the designee of the director for the county in which the long-term health care facility which is the subject of the complaint is located. The long-term health care facility may participate as a party in this informal conference. The director's designee shall notify the complainant and licensee of his or her determination within 10 working days after the informal conference and shall apprise the complainant and licensee in writing of the appeal rights provided in subdivision (d).

(d) If the complainant is dissatisfied with the determination of the director's designee in the county in which the facility is located, the complainant may, within 15 days after receipt of this determination, notify in writing the Deputy Director of the Licensing and Certification Division of the department, who shall assign the request to a representative of the Complainant Appeals Unit for review of the facts that led to both determinations. As a part of the Complainant Appeals Unit's independent investigation, and at the request of the complainant, the representative shall interview the complainant in the district office where the complaint was initially referred. Based upon this review, the Deputy Director of the Licensing and Certification Division of the department shall make his or her own determination and notify the complainant and the facility within 30 days.

(e) Any citation issued as a result of a conference or review provided for in subdivision (c) or (d) shall be issued and served upon the facility within three working days of the final determination, unless the licensee agrees in writing to an extension of this time. Service shall be effected either personally or by registered or certified mail. A copy of the citation shall also be sent to each complainant by registered or certified mail.

(f) A miniexit conference shall be held with the administrator or his or her representative upon leaving the facility at the completion of the investigation to inform him or her of the status of the investigation. The department shall also state the items of noncompliance and compliance found as a result of a complaint

and those items found to be in compliance, provided the disclosure maintains the anonymity of the complainant. In any matter in which there is a reasonable probability that the identity of the complainant will not remain anonymous, the department shall also notify the facility that it is unlawful to discriminate or seek retaliation against a resident, employee, or complainant.

(g) For purposes of this section, "complaint" means any oral or written notice to the department, other than a report from the facility of an alleged violation of applicable requirements of state or federal law or any alleged facts that might constitute such a violation.

SEC. 5. Section 1424 of the Health and Safety Code is amended to read:

1424. Citations issued pursuant to this chapter shall be classified according to the nature of the violation and shall indicate the classification on the face thereof.

(a) In determining the amount of the civil penalty, all relevant facts shall be considered including, but not limited to, the following:

(1) The probability and severity of the risk that the violation presents to the patient's or resident's mental and physical condition.

(2) The patient's or resident's medical condition.

(3) The patient's or resident's mental condition and his or her history of mental disability or disorder.

(4) The good faith efforts exercised by the facility to prevent the violation from occurring.

(5) The licensee's history of compliance with regulations.

(b) Relevant facts considered by the department in determining the amount of the civil penalty shall be documented by the department on an attachment to the citation and available in the public record. This requirement shall not preclude the department or a facility from introducing facts not listed on the citation to support or challenge the amount of the civil penalty in any proceeding set forth in Section 1428.

(c) (1) Class "AA" violations are violations that meet the criteria for a class "A" violation and that the department determines to have been a direct proximate cause of death of a patient or resident of a long-term health care facility. Except as provided in Section 1424.5, a class "AA" citation is subject to a

civil penalty in the amount of not less than five thousand dollars ($5,000) and not exceeding twenty-five thousand dollars ($25,000) for each citation. In any action to enforce a citation issued under this subdivision, the department shall prove all of the following:

(A) The violation was a direct proximate cause of death of a patient or resident.

(B) The death resulted from an occurrence of a nature that the regulation was designed to prevent.

(C) The patient or resident suffering the death was among the class of persons for whose protection the regulation was adopted.

(2) If the department meets the burden of proof required under paragraph (1), the licensee shall have the burden of proving that the licensee did what might reasonably be expected of a long-term health care facility licensee, acting under similar circumstances, to comply with the regulation. If the licensee sustains this burden, then the citation shall be dismissed.

(3) Except as provided in Section 1424.5, for each class "AA" citation within a 12-month period that has become final, the department shall consider the suspension or revocation of the facility's license in accordance with Section 1294. For a third or subsequent class "AA" citation in a facility within that 12-month period that has been sustained following a citation review conference, the department shall commence action to suspend or revoke the facility's license in accordance with Section 1294.

(d) (1) Class "A" violations are violations that the department determines present or involve any of the following:

(A) Imminent danger that death or serious harm to the patients or residents of the long-term health care facility would result therefrom.

(B) Substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom.

(C) A nonconsenual sexual encounter between a patient or resident of the long-term health care facility and any staff member currently employed by the same facility.

(2) A physical condition or one or more practices, means, methods, or operations in use in a long-term health care facility may constitute a class "A" violation.

(3) The condition or practice constituting a class "A" violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the department, is required for correction. Except as provided in Section 1424.5, a class "A" citation is subject to a civil penalty in an amount not less than one thousand dollars ($1,000) and not exceeding ten thousand dollars ($10,000) for each and every citation.

(4) If the department establishes that a violation occurred, the licensee shall have the burden of proving that the licensee did what might reasonably be expected of a long-term health care facility licensee, acting under similar circumstances, to comply with the regulation. If the licensee sustains this burden, then the citation shall be dismissed.

(e) (1) Class "B" violations are violations that the department determines have a direct or immediate relationship to the health, safety, or security of long-term health care facility patients or residents, other than class "AA" or "A" violations. Unless otherwise determined by the department to be a class "A" violation pursuant to this chapter and rules and regulations adopted pursuant thereto, any violation of a patient's rights as set forth in Sections 72527 and 73523 of Title 22 of the California Code of Regulations, that is determined by the department to cause or under circumstances likely to cause significant humiliation, indignity, anxiety, or other emotional trauma to a patient is a class "B" violation. A class "B" citation is subject to a civil penalty in an amount not less than one hundred dollars ($100) and not exceeding one thousand dollars ($1,000) for each and every citation. A class "B" citation shall specify the time within which the violation is required to be corrected. If the department establishes that a violation occurred, the licensee shall have the burden of proving that the licensee did what might reasonably be expected of a long-term health care facility licensee, acting under similar circumstances, to comply with the regulation. If the licensee sustains this burden, then the citation shall be dismissed.

(2) In the event of any citation under this paragraph, if the department establishes that a violation occurred, the licensee shall have the burden of proving that the licensee did what might reasonably be expected of a long-term health care facility licensee, acting under similar circumstances, to comply with the

regulation. If the licensee sustains this burden, then the citation shall be dismissed.

(f) (1) Any willful material falsification or willful material omission in the health record of a patient of a long-term health care facility is a violation.

(2) "Willful material falsification," as used in this section, means any entry in the patient health care record pertaining to the administration of medication, or treatments ordered for the patient, or pertaining to services for the prevention or treatment of decubitus ulcers or contractures, or pertaining to tests and measurements of vital signs, or notations of input and output of fluids, that was made with the knowledge that the records falsely reflect the condition of the resident or the care or services provided.

(3) "Willful material omission," as used in this section, means the willful failure to record any untoward event that has affected the health, safety, or security of the specific patient, and that was omitted with the knowledge that the records falsely reflect the condition of the resident or the care or services provided.

(g) Except as provided in subdivision (a) of Section 1425.5, a violation of subdivision (f) may result in a civil penalty not to exceed ten thousand dollars ($10,000), as specified in paragraphs (1) to (3), inclusive.

(1) The willful material falsification or willful material omission is subject to a civil penalty of not less than two thousand five hundred dollars ($2,500) or more than ten thousand dollars ($10,000) in instances where the health care record is relied upon by a health care professional to the detriment of a patient by affecting the administration of medications or treatments, the issuance of orders, or the development of plans of care. In all other cases, violations of this subdivision are subject to a civil penalty not exceeding two thousand five hundred dollars ($2,500).

(2) (A) Where the penalty assessed is one thousand dollars ($1,000) or less, the violation shall be issued and enforced, except as provided in this subdivision, in the same manner as a class "B" violation, and shall include the right of appeal as specified in Section 1428. Where the assessed penalty is in excess of one thousand dollars ($1,000), or for skilled nursing facilities or intermediate care facilities as specified in paragraphs

(1) and (2) of subdivision (a) of Section 1418, in excess of two thousand dollars ($2,000), the violation shall be issued and enforced, except as provided in this subdivision, in the same manner as a class "A" violation, and shall include the right of appeal as specified in Section 1428.

(B) Nothing in this section shall be construed as a change in previous law enacted by Chapter 11 of the Statutes of 1985 relative to this paragraph, but merely as a clarification of existing law.

(3) Nothing in this subdivision shall preclude the department from issuing a class "A" or class "B" citation for any violation that meets the requirements for that citation, regardless of whether the violation also constitutes a violation of this subdivision. However, no single act, omission, or occurrence may be cited both as a class "A" or class "B" violation and as a violation of this subdivision.

(h) Where the licensee has failed to post the notices as required by Section 9718 of the Welfare and Institutions Code in the manner required under Section 1422.6, the department shall assess the licensee a civil penalty in the amount of one hundred dollars ($100) for each day the failure to post the notices continues. Where the total penalty assessed is less than two thousand dollars ($2,000), the violation shall be issued and enforced in the same manner as a class "B" violation, and shall include the right of appeal as specified in Section 1428. Where the assessed penalty is equal to or in excess of two thousand dollars ($2,000), the violation shall be issued and enforced in the same manner as a class "A" violation and shall include the right of appeal as specified in Section 1428. Any fines collected pursuant to this subdivision shall be used to fund the costs incurred by the California Department of Aging in producing and posting the posters.

(i) The director shall prescribe procedures for the issuance of a notice of violation with respect to violations having only a minimal relationship to patient safety or health.

(j) The department shall provide a copy of all citations issued under this section to the affected residents whose treatment was the basis for the issuance of the citation, to the affected residents' designated family member or representative of each of the

residents, and to the complainant if the citation was issued as a result of a complaint.

(k) Nothing in this section is intended to change existing statutory or regulatory requirements governing the ability of a licensee to contest a citation pursuant to Section 1428.

(*l*) The department shall ensure that district office activities performed under Sections 1419 to 1424, inclusive, are consistent with the requirements of these sections and all applicable laws and regulations. To ensure the integrity of these activities, the department shall establish a statewide process for the collection of postsurvey evaluations from affected facilities.

SEC. 6. Section 1599.1 of the Health and Safety Code is amended to read:

1599.1. Written policies regarding the rights of residents shall be established and shall be made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. Those policies and procedures shall ensure that each resident admitted to the facility has the following rights and is notified of the following facility obligations, in addition to those specified by regulation:

(a) The facility shall employ an adequate number of qualified personnel to carry out all of the functions of the facility.

(b) Each resident shall show evidence of good personal hygiene, be given care to prevent bedsores, and measures shall be used to prevent and reduce incontinence for each patient.

(c) The facility shall provide food of the quality and quantity to meet the residents' needs in accordance with physicians' orders.

(d) The facility shall provide an activity program staffed and equipped to meet the needs and interests of each resident and to encourage self-care and resumption of normal activities. Residents shall be encouraged to participate in activities suited to their individual needs.

(e) The facility shall be clean, sanitary, and in good repair at all times.

(f) A nurses' call system shall be maintained in operating order in all nursing units and provide visible and audible signal communication between nursing personnel and residents. Extension cords to each resident's bed shall be readily accessible to residents at all times.

(g) Consistent with federal law, each resident shall have the right to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health and safety of the individual or other residents would be endangered, and to receive notice before the room or a roommate of the resident in the facility is changed. A resident shall have all of the following rights:

(1) To choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care.

(2) To interact with members of the community both inside and outside of the facility.

(3) To make choices about aspects of his or her life in the facility that are significant to the resident.

(h) Consistent with federal law, each resident shall have the right to choose a personal attending physician and other health care providers. For purposes of this subdivision, an "attending physician" means the physician chosen by the resident or resident's representative to be responsible for the medical treatment of the resident in the facility. If a resident does not have a personal attending physician, the facility shall assist the resident in obtaining one.

(i) A resident shall have the right to discharge himself or herself from the facility. The exercise of this right is subject to Section 1599.3, which establishes when a resident's rights devolve to an authorized representative.

(j) Each resident shall have the right to receive long-term health care services in the most integrated setting appropriate. Pursuant to Section 1418.81, the facility shall provide assessment and discharge planning services that are designed to help residents return home or to home-like settings.

(k) (1) If a facility has a significant beneficial interest in an ancillary health service provider or if a facility knows that an ancillary health service provider has a significant beneficial interest in the facility, as provided by subdivision (a) of Section 1323, or if the facility has a significant beneficial interest in another facility, as provided by subdivision (c) of Section 1323, the facility shall disclose that interest in writing to the resident, or his or her representative, and advise the resident, or his or her representative, that the resident may choose to have another ancillary health service provider, or facility, as the case may be,

provide any supplies or services ordered by a member of the medical staff of the facility.

(2) A facility is not required to make any disclosures required by this subdivision to any resident, or his or her representative, if the resident is enrolled in an organization or entity that provides or arranges for the provision of health care services in exchange for a prepaid capitation payment or premium.

(*l*) (1) A resident of a long-term health care facility who is hospitalized in an acute care hospital has all of the following rights:

(A) To receive written notice at the time of hospitalization explaining his or her right to return to the facility.

(B) To have his or her bed held for up to seven days by giving notice to the facility within 24 hours after being informed of the right to have the bed held, if the resident desires to have his or her bed held.

(C) To be readmitted to the first available bed in a semiprivate room at the facility if, at the time of readmission, the resident requires the services provided by the facility and the hospitalization exceeds the seven-day bed hold period or the resident did not exercise the bed hold option.

(2) Except as provided in Section 51535.1 of Title 22 of the California Code of Regulations, any resident who exercises the bed hold option shall be liable to pay reasonable charges, not to exceed the resident's daily rate for care in the facility.

(3) If a resident asserts his or her rights to readmission pursuant to bed hold provisions or readmission rights of either state or federal law and the facility refuses to readmit him or her, the resident may appeal the facility's refusal.

(4) The refusal of the facility as described in this subdivision shall be treated as if it were an involuntary transfer under federal law and the rights and procedures that apply to appeals of transfers and discharges of nursing facility residents shall apply to the resident's appeal under this subdivision.

(5) If the resident appeals pursuant to this subdivision, and the resident is eligible under the Medi-Cal program, the resident shall remain in the hospital and the hospital may be reimbursed at the administrative day rate, pending the final determination of the hearing officer, unless the resident agrees to placement in another facility.

(6) If the resident appeals pursuant to this subdivision, and the resident is not eligible under the Medi-Cal program, the resident shall remain in the hospital if other payment is available, pending the final determination of the hearing officer, unless the resident agrees to placement in another facility.

(7) If the resident is not eligible for participation in the Medi-Cal program and has no other source of payment, the hearing and final determination shall be made within 48 hours.

(m) (1) Consistent with federal law, each resident shall have all of the transfer and discharge rights described in this subdivision.

(2) For purposes of this subdivision, the following definitions shall apply:

(A) "Facility" means a skilled nursing facility or intermediate care facility, as defined in Section 1250.

(B) "Certified entity" means a Medi-Cal program certified facility, a Medicare Program certified facility, or a Medicare Program certified distinct part.

(C) "Discharge" means movement from a facility to a noninstitutional setting when the discharging facility ceases to be legally responsible for the care of the resident.

(D) "Transfer" means movement from a facility or certified entity to another institution when the legal responsibility for the care of the resident changes from the transferring facility to the receiving institution. A transfer includes movement of a resident from a bed in a certified entity to a bed in an entity that is certified as a different provider or to a bed that is not certified for the Medi-Cal program or the Medicare Program.

(3) The facility shall permit each resident to remain in the facility and not transfer or discharge the resident from the facility, unless one of the following circumstances exist:

(A) The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility.

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility.

(C) The safety of individuals in the facility is endangered.

(D) The health of individuals in the facility would otherwise be endangered.

(E) The resident has failed, after reasonable and appropriate notice, to pay or have paid in his or her behalf, in the case of the Medi-Cal program or the Medicare Program, for a stay at the facility. As specified in Section 14124.7 of the Welfare and Institutions Code, a Medi-Cal certified facility may not discharge a resident who converts to coverage under the Medi-Cal program after admission or who has a Medi-Cal application pending.

(F) The facility ceases to operate.

(4) When the facility transfers or discharges a resident under any of the circumstances set forth in subparagraphs (A) to (E), inclusive, of paragraph (3), the resident's clinical record shall be documented. When transfer or discharge is necessary under subparagraph (A) or (B) of paragraph (3), the documentation shall be made by the resident's physician. When transfer or discharge is necessary under subparagraph (D) of paragraph (3), the documentation shall be made by a physician.

(5) The resident shall have the right to appeal a proposed or completed transfer or discharge. The appeal shall include the right to an informal hearing conducted by the department's administrative hearings and appeals unit prior to the proposed date of transfer or discharge. If the resident files the appeal within 10 days of receipt of the notice described in paragraph (6), the resident shall have the right to remain in the facility until a written determination is made on the appeal.

(6) Before a facility transfers or discharges a resident, the facility shall do all of the following:

(A) Notify the resident and, if known, a family member or legal representative of the resident, of the transfer or discharge and the reasons for the transfer or discharge in writing and in language and a manner the resident, family member, or legal representative understands.

(B) Record the reasons in the resident's clinical record.

(C) Include in the notice the items described in paragraph (8).

(D) Send a copy of the notice to the district office of the department's Licensing and Certification Division and to the local office of the State Long-Term Care Ombudsman.

(7) (A) Except as provided in subparagraph (B), the notice of transfer or discharge required under paragraph (6) shall be made by the facility at least 30 days before the resident is transferred or discharged.

(B) Notice may be made as soon as practicable before transfer or discharge when any of the following conditions exist:

(i) The safety of individuals in the facility would be endangered under subparagraph (C) of paragraph (3).

(ii) The health of individuals in the facility would be endangered under subparagraph (D) of paragraph (3).

(iii) The resident's health improves sufficiently to allow a more immediate transfer or discharge and thus transfer or discharge is authorized under subparagraph (B) of paragraph (3).

(iv) An immediate transfer or discharge is required by the resident's urgent medical needs and thus transfer or discharge is authorized under subparagraph (A) of paragraph (3).

(v) The resident has not resided in the facility for 30 days.

(8) The written notice required under paragraph (6) shall include all of the following:

(A) The reason for transfer or discharge.

(B) The effective date of transfer or discharge.

(C) The location to which the resident will be transferred or discharged.

(D) The following statements:

(i) That the resident has the right to appeal the action to the State Department of Health Services and the name, address, and telephone number of the district office of the Licensing and Certification Division of the department.

(ii) That the facility must permit the resident to remain until an appeal determination is issued if the appeal is filed within 10 days of receipt of the notice.

(iii) That the resident may represent himself or herself or use legal counsel or a relative, friend, or other spokesperson at any appeal hearing.

(iv) That the resident or resident's representative shall be allowed to review, prior to and during the appeal hearing, the resident's medical records and documents to be used by the facility at any appeal hearing.

(v) That the resident may bring witnesses to any appeal hearing.

(E) The name, address, and telephone number of the local office of the State Long-Term Care Ombudsman.

(F) For nursing facility residents with developmental disabilities or who are mentally ill, the name, address, and

telephone number of the protection and advocacy agency described in subdivision (i) of Section 4900 of the Welfare and Institutions Code.

(9) The department shall rescind a proposed transfer or discharge when the notice required in paragraph (6) does not meet the requirements set forth in paragraph (8). A facility that issues an invalid notice or fails to meet the requirements of subparagraph (D) of paragraph (6) is subject to a class B citation.

(10) A facility shall provide sufficient advance preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility by performing all of the following:

(A) Taking timely steps to protect the resident from unnecessary and avoidable anxiety and trauma related to the transfer or discharge.

(B) Actively involving the resident and the resident's family in the selection of any new residence or facility.

(C) Ensuring that necessary care and services, including appropriate transportation to a new residence or facility, are available upon transfer or discharge.

(D) Helping prepare the resident for the move to a new residence or facility by appropriate methods, including trial visits.

(E) Thoroughly informing staff at the receiving residence or facility about the resident's needs, strengths, routines, relationships, and preferences.

(n) The costs to comply with this section shall be allowable for Medi-Cal reimbursement purposes, but shall not be considered a new state mandate under Section 14126.023 of the Welfare and Institutions Code.

SEC. 7. Section 14124.10 of the Welfare and Institutions Code is amended to read:

14124.10. (a) No licensed long-term health care facility participating as a provider under the Medi-Cal program shall discriminate against a Medi-Cal resident or prospective Medi-Cal resident on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program. Nothing in this section shall be construed to prohibit a facility from charging private-pay residents for services required to be provided to Medi-Cal

residents or for services that are in addition to those required under the Medi-Cal program.

(b) For purposes of this section, the following definitions shall apply:

(1) "Skilled nursing facility" means a licensed facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code.

(2) "Exempt facility" means a skilled nursing facility that is part of a continuing care retirement community as defined in Section 1771 or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.

(c) A skilled nursing facility certified for participation in the Medi-Cal program that is not an exempt facility shall not discriminate on the basis of source of payment against a current or prospective Medi-Cal beneficiary who seeks admission. Except as otherwise provided by law or as specified in subdivision (d), all applicants for admission shall be admitted in the order in which they first request admission. Each skilled nursing facility shall do all of the following:

(1) Provide a copy of the notice described in paragraph (4) to each person who requests information about admission.

(2) Provide to each person seeking admission a receipt recording the date and time of the request.

(3) Maintain a dated list of applications that shall be available at all times to any applicant, his or her legal representative, and authorized personnel from the department. If a skilled nursing facility desires to remove the name of an applicant who is unresponsive to facility telephone calls and letters from its waiting list, the skilled nursing facility may, no sooner than 90 days after initial placement of the person's name on the waiting list, inquire by letter to that applicant and any one person if designated by that applicant whether the applicant desires continuation of his or her name on the waiting list. If the applicant does not respond and an additional 30 days passes, the facility may remove the applicant's name from its waiting list. A skilled nursing facility may annually send a waiting list placement continuation letter to each person who has been on the waiting list for at least 90 days to inquire as to whether that person desires continuation of his or her name on the waiting list if that letter is also sent to any one person designated by the

applicant. If an applicant to whom the letter was sent does not respond and at least 30 days passes, the facility may remove the person's name from its waiting list.

(4) Post in a conspicuous place a notice in plain language informing persons seeking admission that the facility is prohibited from discriminating against applicants for admission on the basis of their current or future Medi-Cal eligibility. The notice shall advise persons seeking admission about the facility's application procedures and describe the complaint options and remedies available under this section. The notice shall also list the name, address, and telephone number of the local office of the State Long-Term Care Ombudsman.

(d) Notwithstanding the requirements of subdivision (c), a skilled nursing facility may disregard its waiting list to admit an applicant whose spouse is a current resident of the facility or to admit a person who lives within a retirement community located on the same campus as the skilled nursing facility. Residents of the skilled nursing facility who are hospitalized or away from the facility on authorized leaves shall not be subject to the waiting list and shall be readmitted in accordance with state and federal laws, including the rights provided under subdivision (h) of Section 1599.1 of the Health and Safety Code.

(e) Upon the receipt of a complaint concerning a violation of this section, the department shall conduct an investigation into the complaint in accordance with Section 1420 of the Health and Safety Code.

(f) The department may decrease the daily Medi-Cal reimbursement rate to a long-term health care facility for one year for a violation of this section. The per diem rate shall be reduced by one-quarter of 1 percent for an initial violation of this section and 1 percent for each additional violation.

(g) The costs to comply with this section shall be allowable for Medi-Cal reimbursement purposes, but shall not be considered a new state mandate under Section 14126.023.

SEC. 8. Section 14126.023 of the Welfare and Institutions Code is amended to read:

14126.023. (a) The methodology developed pursuant to this article shall be facility specific and reflect the sum of the projected cost of each cost category and passthrough costs, as follows:

(1) Labor costs limited as specified in subdivision (c).
(2) Indirect care nonlabor costs limited to the 75th percentile.
(3) Administrative costs limited to the 50th percentile.
(4) Capital costs based on a fair rental value system (FRVS) limited as specified in subdivision (d).
(5) Direct passthrough of proportional Medi-Cal costs for property taxes, facility license fees, new state and federal mandates, caregiver training costs, and liability insurance projected on the prior year's costs.

(b) The percentiles in paragraphs (1) through (3) of subdivision (a) shall be based on annualized costs divided by total resident days and computed on a specific geographic peer group basis. Costs within a specific cost category shall not be shifted to any other cost category.

(c) The labor costs category shall be comprised of a direct resident care labor cost category, an indirect care labor cost category, and a labor-driven operating allocation cost category, as follows:

(1) Direct resident care labor cost category which shall include all labor costs related to routine nursing services including all nursing, social services, activities, and other direct care personnel. These costs shall be limited to the 90th percentile.

(2) Indirect care labor cost category which shall include all labor costs related to staff supporting the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, inservice education, and plant operations and maintenance. These costs shall be limited to the 90th percentile.

(3) Labor-driven operating allocation shall include an amount equal to 8 percent of labor costs, minus expenditures for temporary staffing, which may be used to cover allowable Medi-Cal expenditures. In no instance shall the operating allocation exceed 5 percent of the facility's total Medi-Cal reimbursement rate. The labor-driven operating allocation shall not be paid to facilities that, on an annual basis, fail to comply with the minimum staffing requirements established pursuant to Section 1276.5 of the Health and Safety Code.

(d) The capital cost category shall be based on a FRVS that recognizes the value of the capital related assets necessary to care for Medi-Cal residents. The capital cost category includes

mortgage principal and interest, leases, leasehold improvements, depreciation of real property, equipment, and other capital related expenses. The FRVS methodology shall be based on the formula developed by the department that assesses facility value based on age and condition and uses a recognized market interest factor. Capital investment and improvement expenditures included in the FRVS formula shall be documented in cost reports or supplemental reports required by the department. The capital costs based on FRVS shall be limited as follows:

(1) For the 2005–06 rate year, the capital cost category for all facilities in the aggregate shall not exceed the department's estimated value for this cost category for the 2004–05 rate year.

(2) For the 2006–07 rate year and subsequent rate years, the maximum annual increase for the capital cost category for all facilities in the aggregate shall not exceed 8 percent of the prior rate year's FRVS cost component.

(3) If the total capital costs for all facilities in the aggregate for the 2005–06 rate year exceeds the value of the capital costs for all facilities in the aggregate for the 2004–05 rate year, or if that capital cost category for all facilities in the aggregate for the 2006–07 rate year or any rate year thereafter exceeds 8 percent of the prior rate year's value, the department shall reduce the capital cost category for all facilities in equal proportion in order to comply with paragraphs (1) and (2).

(e) For the 2005–06 and 2006–07 rate years, the facility specific Medi-Cal reimbursement rate calculated under this article shall not be less than the Medi-Cal rate that the specific facility would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005–06 and 2006–07, respectively.

(f) The department shall update each facility specific rate calculated under this methodology annually. The update process shall be prescribed in the Medicaid state plan, regulations, and the provider bulletins or similar instructions described in Section 14126.027, and shall be adjusted in accordance with the results of facility specific audit and review findings in accordance with subdivisions (h) and (i).

(g) The department shall establish rates pursuant to this article on the basis of facility cost data reported in the integrated

long-term care disclosure and Medi-Cal cost report required by Section 128730 of the Health and Safety Code for the most recent reporting period available, and cost data reported in other facility financial disclosure reports or supplemental information required by the department in order to implement this article.

(h) The department shall conduct financial audits of facility and home office cost data as follows:

(1) The department shall audit facilities a minimum of once every three years to ensure accuracy of reported costs. Audits shall examine the accuracy of payroll records described in subdivision (*l*). Fraudulently reported labor costs shall be subject to all of the following:

(A) Referral to the Franchise Tax Board and Internal Revenue Service for investigation.

(B) Recovery of overpayments through a retroactive adjustment of the facility specific reimbursement rate.

(C) Assessment of a penalty equal to 200 percent of the fraudulently reported direct care staffing hours times the average hourly wage of the direct care staff at the time the fraudulent activity occurred.

(2) It is the intent of the Legislature that the department develop and implement limited scope audits of key cost centers or categories to assure that the rate paid in the years between each full scope audit required in paragraph (1) accurately reflects actual costs.

(3) For purposes of updating facility specific rates, the department shall adjust or reclassify costs reported consistent with applicable requirements of the Medicaid state plan as required by Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations.

(4) Overpayments to any facility shall be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations.

(i) (1) On an annual basis, the department shall use the results of audits performed pursuant to subdivision (h), the results of any federal audits, and facility cost reports, including supplemental reports of actual costs incurred in specific cost centers or categories as required by the department, to determine any difference between reported costs used to calculate a facility's rate and audited facility expenditures in the rate year.

(2) If the department determines that there is a difference between reported costs and audited facility expenditures pursuant to paragraph (1), the department shall adjust a facility's reimbursement prospectively over the intervening years between audits by an amount that reflects the difference, consistent with the methodology specified in this article.

(j) For nursing facilities that obtain an audit appeal decision that results in revision of the facility's allowable costs, the facility shall be entitled to seek a retroactive adjustment in its facility specific reimbursement rate.

(k) Compliance by each facility with state laws and regulations regarding staffing levels shall be documented annually either through facility cost reports, including supplemental reports, or through the annual licensing inspection process specified in Section 1422 of the Health and Safety Code.

(*l*) For purposes of documenting labor costs described in subdivision (c), a skilled nursing facility shall submit electronic payroll records to the department on a quarterly basis. ~~Under penalty of perjury, the~~ *The* administrator of the facility shall sign and certify the accuracy of the payroll records. On or before July 1, 2006, the department shall devise and implement a uniform system for collecting and evaluating payroll data.

~~SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

O

SENATE HEALTH
COMMITTEE ANALYSIS
Senator Deborah V. Ortiz, Chair

BILL NO:	**SB 526**	**S**
AUTHOR:	**Alquist**	**B**
AMENDED:	**April 14, 2005**	
HEARING DATE:	**April 20, 2005**	**5**
FISCAL:	**Appropriations**	**2**
		6

CONSULTANT:
Vazquez / ak

SUBJECT

Long-term health care

SUMMARY

This measure would require the State Department of Health Services to establish dedicated complaint response units in each district office of the Licensing and Certification Division of the Department of Health Services (DHS) by January 1, 2007 following a study of unanticipated costs, require DHS to issue a Class "A" citation when a nursing home resident is sexually assaulted by an employee of the facility, add to the list of resident rights for long-term health care facilities, including changes to requirements regarding transfer and discharge of patients, create requirements for skilled nursing facilities for the admission of patients covered by the Medi-Cal program, and require nursing home operators to document labor costs by submitting payroll records to DHS on a quarterly basis.

ABSTRACT

Existing law:

1. Provides for the licensure and regulation by the State Department of Health Services (DHS) of health care facilities, including long-term health care facilities.

2. Establishes procedures to be followed when DHS receives a written or oral complaint about a long-term health care facility.

3. Requires DHS to establish a centralized consumer response unit within the Licensing and Certification Division of DHS (Licensing and Certification)to respond to consumer inquiries and complaints.

4. Provides for the imposition of a quality assurance fee on each skilled nursing facility (SNF), with some exemptions.

Continued---

5. Requires that funds assessed pursuant to these provisions be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and support facility quality improvement efforts in, licensed SNFs. Provides that these provisions are to be implemented as long as two conditions are met, including federal approval, specifies four circumstances under which these provisions would become inoperative, makes these provisions inoperative on July 1, 2008, and repeals them on January 1, 2009.

6. Prescribes procedures for the issuance of a citation, classified according to the nature of the violation, and the imposition of a civil penalty against a long-term health care facility and provides that a Class "A" violation is a violation that DHS determines presents either an imminent danger or substantial probability that death or serious harm to the patients or residents of the facility would result from the violation.

7. Requires that written policies and procedures of a skilled nursing and intermediate care facility ensure that each patient admitted to the facility has prescribed rights.

8. Prohibits a long-term health care facility that participates as a provider in Medi-Cal from discriminating against a Medi-Cal patient on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under Medi-Cal.

9. Requires DHS to establish the minimum number of equivalent nursing hours per patient (3.2) required in skilled nursing and intermediate care facilities.

10. Provides for a Medi-Cal long-term care reimbursement methodology, that includes a facility-specific ratesetting system and provides for a labor-driven operating allocation under the methodology.

11. Requires DHS to audit facilities a minimum of once every three years to ensure accuracy of reported costs.

This bill:

1. Makes various findings and declarations, including:
   a. Over 14,000 oral and written complaints are filed each year with Licensing and Certification.
   b. Currently, DHS is required to respond to all complaints within statutory timelines with an onsite investigation to determine if the complaint is substantiated.
   c. Complaints are frequently not resolved within statutory timelines, resulting in violation of state laws, consumer dissatisfaction and frustration, and an estimated 73 percent of complaints being found to be unsubstantiated as a result of inadequate investigations.
   d. DHS is required to inspect and investigate long-term health care facilities for compliance with state and federal laws and regulations.

2. Repeals the existing requirement that DHS to establish a centralized consumer response unit within Licensing and Certification to respond to consumer inquiries and complaints and instead, requires, by January 1, 2007, DHS to establish and operate a

Continued---

dedicated complaint response unit in each district office of Licensing and Certification to respond to consumer inquiries and complaints.

3. Requires DHS to submit a report to the Legislature, on or before January 1, 2006, about the necessary workforce and projected costs associated with the dedicated complaint response units. The bill would make other changes to the complaint procedures.

4. Provides that the dedicated complaint response unit provisions provided under the bill shall only be implemented to the extent that the provisions imposing the quality assurance fee for SNFs are implemented and operative.

5. Provides that a Class "A" violation is a violation that DHS determines presents or involves, in addition to the situations presented, a nonconsensual sexual encounter between a patient or resident of the facility and any staff member currently employed by the same facility.

6. Adds to the prescribed rights for residents of a skilled nursing and intermediate care facility, among others, reasonable accommodation of individual needs and preferences, the right to choose an attending physician, the right to discharge oneself, bed hold options for hospitalized residents, and transfer and discharge rights.

7. Prohibits each SNF, with exceptions, from discriminating, on the basis of source of payment, against a current or prospective Medi-Cal beneficiary who seeks admission.

8. Requires that all applicants for admission be admitted in the order in which they first request admission, with exceptions, and would establish additional requirements of a SNF to provide certain notice, provide receipts of requests seeking admission, and maintain a dated list of applications.

9. Authorizes DHS to decrease the daily Medi-Cal reimbursement rate to a long-term health care facility for one year for a violation of waiting list requirements imposed by the measure.

10. Provides that the labor-driven operating allocation shall not be paid to facilities that, on an annual basis, fail to comply with the minimum staffing hours per patient required in skilled nursing and intermediate care facilities.

11. Prescribes that the audits required under existing law examine the accuracy of payroll records and that fraudulently reported labor costs shall be subject to referral to the Franchise Tax Board and Internal Revenue Service for investigation, recovery of overpayment through a retroactive rate adjustment, and assessment of a penalty equal to 200 percent of the fraudulently reported direct care staffing hours times the average hourly wage of the direct care staff.

12. Requires a SNF to submit electronic payroll records to DHS on a quarterly basis to document labor costs and requires DHS, on or before July 1, 2006, to devise and

Continued---

implement a uniform system for collecting and evaluating payroll data and requires the administrator of the facility to sign and certify the accuracy of the payroll records.

FISCAL IMPACT

Unknown.

BACKGROUND AND DISCUSSION

California's nursing homes

There are approximately 1,400 skilled nursing facilities (SNFs) in California. According to the California Healthcare Foundation's report "*Snapshot: Nursing Homes: A System in Crisis*" (2004), more than 110,000 individuals live in California's long-term care facilities. The majority of residents are 75 or older, female, and white. The majority of those who enter a nursing facility need care temporarily to recuperate or rehabilitate after an illness or hospital stay. Others live there for the rest of their lives. Medicare pays for approved short-term care up to 100 days. After Medicare and private insurance benefits are exhausted, individuals and families must pay for nursing home care directly out of pocket. Once individuals spend down their assets, they may become eligible for Medi-Cal coverage, which paid more than half of the cost of care in freestanding facilities in 2002.

Purpose of the bill

The sponsor states that California nursing home residents are often the victims of a culture of neglect. Many skilled nursing patients live in aging, understaffed facilities where institutionalized neglect is causing an epidemic of bedsores, malnutrition, dehydration and other lethal conditions for which regulators have no answer. Licensing and Certification has taken large cuts in recent years, whittling away its inspection resources, while complaints have skyrocketed, estimated at about 14,000 complaints in 2004.

Numerous academic and government-sponsored reports have concluded that understaffing is the single most important factor in substandard nursing home care. Far too many nursing homes violate California's minimum staffing standards and don't come close to safe staffing standards recommended by a federal study. Surprise inspections by the Attorney General's Operation Guardians found that two of every three nursing homes did not meet minimum staffing requirements. The sponsors contend that SB 526 would help change this culture of neglect by strengthening accountability with staffing standards. It would give operators stronger incentives to comply with staffing requirements and provide regulators with the information they need to accurately measure compliance. In so doing, SB 526 would improve care and save money.

The sponsor states that the measure would strengthen key residents' rights and give all residents equal rights, regardless of their payment source or the certification status of facilities. These changes would make residents' rights easier to understand and enforce. SB 526 also strengthens penalties against sexual abuse by caregivers and prohibits discrimination against Medi-Cal beneficiaries who are seeking care.

Continued---

Discussion of bill components
Due to the varied purposes of the bill and detailed reaction from opposition, the bill's components are presented below, with discussion beneath each heading on what the bill proposes, sponsor arguments on the need for the policy change, and reaction from opposition.

Opposition response and amendments. The California Association of Health Facilities (CAHF), a non-profit professional organization representing a majority of the state's licensed long-term health care facilities, has taken an "oppose unless amended" position on the measure and has proposed amendments which are discussed within each section listed below. An April 18, 2005 list of amendments proposed by CAHF is also attached to this analysis. These have come subsequent to a prior letter (dated March 18, 2005) containing similar amendment proposals and after a recent discussion among the stakeholders on this bill. The California Healthcare Association (CHA), representing California's 500 hospitals and health systems, many of which operate distinct-part nursing facilities, opposes the measure and iterates many of the concerns raised by CAHF.

1. **Establishment of dedicated complaint response units (Sections 2 and 3)**

   Policy proposal. The bill requires DHS to establish and operate the dedicated complaint response units by January 1, 2007, following a study of anticipated costs and workforce needs.

   Sponsor's rationale. The sponsor states that the staffing crisis has led to a rising tide of complaints about bedsores, malnutrition, dehydration, infections and other lethal conditions caused by neglect. Between 2000 and 2003, the number of complaints against nursing facilities rose 38 percent, and is predicted to exceed 14,000 complaints in 2004. Existing law requires DHS to investigate life threatening complaints within 24 hours and begin all other investigations within 10 working days. Yet, it does not investigate many complaints in a timely manner because of heavy budget cuts to Licensing and Certification. Substantiation rates for complaints plunged from 41 percent in 2000 to 25 percent in 2003, demonstrating the futility of late, cursory investigations. In a state of California's size, regional complaint units are an absolute necessity. Staffed appropriately, they will help ensure that abuse and neglect allegations are investigated in a timely manner.

   Opposition response. CAHF states that each Licensing and Certification district office already has dedicated staff to respond to consumer complaints about SNF care. The system has been plagued with inconsistent determinations based on where the complaint was filed, and which district office handled the investigation. The move to a centralized complaint unit was designed to increase consistency in enforcement determinations and help DHS maintain adequate staffing for this function. It also allows DHS to respond as efficiently and economically as possible. Unfortunately, the centralized system has never been fully operational and each district office continues to handle its own consumer complaints. The reasons the centralized complaint unit was created are still valid, including consistency, efficiency, and

Continued---

complaint prioritization. The DHS has received funding to operationalize this centralized unit, paid for by facilities through an increase in their license fees.

Proposed amendments. CAHF opposes the repeal of current law on the centralized complaint system. CAHF also suggests that the new provision be amended to make it clear that to the extent DHS incurs additional expenses for staff or other costs to implement this section, the additional costs shall be paid by funds in the citation penalty account and shall not be used to calculate license fees.

2. **Additional time for complaint investigation (Section 4)**

Policy proposal. The bill authorizes an additional ten business days, with current law allowing five business days, in which a complainant can request an informal conference from DHS after receiving the results of the DHS investigation.

Sponsor's rationale. The sponsor states that current law gives consumers just five business days to appeal the results of a DHS complaint investigation, although it is DHS practice to allow 15 days. SB 526 conforms the law to this practice. The sponsor states that five days is an unreasonably short period of time to consider an appeal and falls well short of timelines for provider appeals.

Opposition's response. CAHF states that the current five-day timeframe was adopted by the Legislature in 2001 to expedite completion of the complaint/investigation process. CAHF is opposed to any extension of the timeframe established in current law for DHS, patients, or providers alike. Resolving a complaint about care or services in the most timely manner is essential to protect the rights of the resident and the staff involved in the dispute, and to be able to locate witnesses and preserve evidence.

Proposed amendment. CAHF requests elimination of this change.

3. **Nonconsenual sexual encounter (Section 5)**

Policy proposal. The bill requires DHS to issue a Class "A" citation when a nursing home resident is sexually assaulted by an employee of the facility.

Background. Existing law establishes a citation system for nursing homes that utilizes three classes of citations. A Class "AA" citation, the most severe, is issued when a violation leads to the death of a resident. Penalties range from $25,000 to $100,000. Class "A" citations, the mid-level, are issued for violations that present imminent danger of death or serious physical harm to residents. Penalties range from $2,000 to $20,000. Class "B" citations, the least severe, are issued for violations that have an immediate relationship to resident health, safety or security. Penalties range from $100 to $1,000.

Sponsor's rationale. The sponsor states that the bill corrects a flaw in the current citation system that inappropriately results in sexual assaults of residents by caregivers often being cited at the lowest level, Class "B," with fines of no more than

Continued---

$1,000. It would require that substantiated sexual assaults committed by nursing home employees be cited at the Class "A" level, subjecting them to more suitable penalties. This treatment is appropriate given the psychological trauma and potential for serious long term physical health consequences that are associated with sexual assault.

Opposition's response. CAHF states that this provision of SB 526 is a broad departure from the current legal doctrine of "respondeat superior" which determines when an employer is vicariously liable for actions of an employee. The California Supreme Court has refused to hold health care facility employers liable for nonconsensual sexual assaults as long as the assault was not predictable or attributable to the nature of the employment. A LTC employer who has taken all of the appropriate precautions should not be held strictly liable for a random abhorrent act on the part of an employee. The employee should be prosecuted to the full extent of the law. The California Supreme Court has refused to hold health care facility employers liable for nonconsensual sexual assaults as long as the assault was not predictable or attributable to the nature of the employment.

Proposed amendment. CAHF requests elimination of this change.

4. **Residents' Rights: Individual preferences and choice of personal attending physician (Section 6)**

Policy proposal. The bill proposes to expand the bill of rights for residents of long-term health care facilities. In particular, it adds to the authority to exercise individual needs and preferences related to room selection, roommates, activities and plans of care, the right to choose a physician, the right to be readmitted after a hospital stay, the right to be free from illegal evictions, and the right to be discharged.

The bill also states that each resident shall have the right to receive care in the "most integrated setting" appropriate. Protection and Advocacy, Inc. (PAI) has provided the following definition of this term from the Americans with Disabilities Act: "Integrated settings. Good, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual."

Sponsor's rationale. The sponsor states that California's statutory Bill of Rights for nursing home residents is one of the weakest in the nation and is substantially supplemented by an outdated regulatory bill of rights that lacks some very important rights guaranteed by federal law. Many residents and their families are confused about their rights because the rights often vary depending on the payment source for their care or the certification status of their nursing home. The bill conforming specified rights to both federal law and interpretive guidelines and in so doing, it will ensure that all California nursing home residents will have the same rights in these critical areas, regardless of their source of payment. The sponsor contends that this will simplify and strengthen DHS's ability to enforce residents' rights. Additionally, in keeping with the Supreme Court Olmstead decision, the enhanced Bill of Rights

Continued---

declares that nursing home residents have the right to receive long-term care services in the most integrated setting appropriate.

The sponsor continues by noting that, by law, each nursing home resident is required to have an attending physician who is responsible for the overseeing his or her plan of care. The right to choose that physician is a most fundamental right and is already guaranteed by federal law for residents of certified facilities. In situations where physician availability is very limited, residents in those areas may be unable to exercise the right to choose a physician and SB 526 allows residents to exercise choice only to the extent they can find and retain a physician willing to serve in this capacity.

Opposition's response. CAHF states that federal law addresses individual resident's rights and balances them against needs of other residents, staff, and facility operations, as follows:
A resident has the right to:

1. Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.
2. Receive notice before the resident's room or roommate in the facility is changed.

CAHF states that while the goal of having every resident be able to designate an attending physician of their choice is laudable, this provision of SB 526 creates an unrealistic right in certain geographic locations where it is extremely difficult, if not impossible, to find a medical doctor willing to accept a Medi-Cal patient. By statutorily requiring this, SB 526 would create additional penalties and causes of action for resident's rights violations for circumstances beyond the control of the facility.

The Legislature has recognized that both the facility and the resident's attending physician need reasonable notice in order to adequately assist a resident who wants a voluntarily discharge. Current law requires facilities to conduct discharge planning for each resident, which implies that reasonable notice be given; the same notice should apply to resident-initiated discharges.

SB 526's reference to "integrated care" suggests that the facility should be providing undefined "community-based" services. Although this may be appropriate for a alternative care type settings where such services are specifically funded, CAHF states that it is not appropriate for a SNF and would not be a covered service, currently paid for Medi-Cal.

Proposed amendments. CAHF requests the following amendments to this section of the bill:

- Adopt the language in federal law related to residents' rights specified above;
- Require consistency of rights with the patient care plan;
- Recognize designated levels of care within the facility in regard to the provision of residents' rights;

Continued---

- In regards to the attending physician provision, make the requirement subject to the availability of positions in the community;
- In regards to the provision allowing a resident to discharge himself or herself, specify a notification to the facility.
- Define "integrated setting" and provide reimbursement for additional facility costs as appropriate.

5. **Residents' Rights: Bed hold and transfer and discharge (Section 6)**

Policy proposal. SB 526 consolidates language contained in multiple federal rights and interpretive guidelines regarding the duration of a bed hold and transfer and discharge specifications.

Sponsor's rationale. SB 526's simply stated right requires a nursing home that is evicting a resident to plan a safe discharge that takes into account the preferences of the resident and is based in current federal law and interpretive guidelines.

Opposition's response. CAHF states that this section of the bill codifies the federal regulations governing transfer and discharge of a resident, but goes beyond federal law to add additional requirements. The bill creates new definitions for the federal terms "sufficient advance preparation" and "orientation". These definitions create new mandates for a facility to provide services such as:

1. Taking a resident who is being discharged to another location on a "trial visit" of the new placement.
2. Taking timely steps to protect the resident from unnecessary and avoidable anxiety and trauma related to the transfer/discharge.
3. Thoroughly informing staff at the receiving residence or facility about the resident's needs, strengths, routines, relationships, and preferences.

CAHF contends that the new mandates create a level of services that are not paid for by the Medicare or Medicaid program and would require dedicated facility staff. CAHF also opposes the new penalty associated with the written notice requirement included in the bill.

Proposed amendments. CAHF requests amendments to clarify new requirements and provide reimbursement for additional facility costs as appropriate and/or amend to direct DHS to provide additional policy guidance in this area.

6. **Admission of Medi-Cal patients and waiting lists (Section 7)**

Policy proposal. The bill prohibits SNFs from discriminating against applicants who are or will be on Medi-Cal, establishes waiting list procedures, and sets penalties for facilities that violate this section.

Sponsor's rationale. The sponsor states that Medi-Cal certified nursing homes discriminate against applicants who are on Medi-Cal or who may soon qualify, preferring to admit higher-paying private pay residents. Medi-Cal beneficiaries pay a great price due to the pervasive discrimination. They are often relegated to

Continued—

substandard nursing homes, sometimes far from home, if they are able to find a nursing home at all.

Hospitals and other health care facilities certified by Medi-Cal are not allowed to discriminate against Medi-Cal beneficiaries. Medi-Cal should ensure that certified nursing homes treat applicants on Medi-Cal fairly. The bill addresses the problem by outlawing discrimination against prospective Medi-Cal residents by removing the perceived ambiguity in existing law. The sponsor contends that the bill creates an admissions application and waiting list process that does the following:

1. Creates a "first-come/first-served" system for applicants for admission to SNF facilities;
2. Requires facilities to provide a notice and receipt to all applicants;
3. Requires facilities to maintain a waiting list in order to keep names of applicants for 90-days;
4. Requires facilities to contact applicants on the waiting list to allow an applicant to continue to be listed on the waiting list;
5. Prohibits a facility from removing someone from the list until a letter is mailed to the applicant and no response has been received for 30-days; and
6. Creates penalties equal to reducing the per diem facility rate by one-quarter of 1 percent for an initial violation and by 1 percent for each additional violation.

Opposition's response. CAHF states that the language would deny facilities the ability to evaluate existing case load and acuity levels to determine if the facility is capable of accepting a specific applicant and continue to maintain quality services for the existing caseload, particularly if the facility has a high number of bed-bound residents or residents with heavy care needs. It will deny facilities the right to specialize in services for a particular ethnic group, type of disease, etc. The "first-come/first served" policy will interrupt the delicate balance between payer sources that facilities must maintain to ensure the ability to provide appropriate care for the patients they admit.

This provision would also require a dedicated staff person in each facility to manage the new process, which would result in a further diversion of resources away from patient care. The administrative burden, the labor-intensive paperwork trail, the disruption to caseload determinations, and the heavy penalties that facilities are bound to under the language in SB 526 are disproportionate to benefits that an individual could gain for mere access to a 90-day waiting list for skilled nursing services.

Proposed amendment. CAHF requests that this language be eliminated entirely.

7. **Labor-Driven Operating Allocation and Nursing Requirement (Section 8)**

Policy proposal. The bill states that the labor-driven operating allocation will not be paid to facilities that, on an annual basis, fail to comply with the minimum staffing requirements established in law of 3.2 nursing hours per patient day. The labor-driven operating allocation was included as a component of the newly enacted nursing home rate-setting system, which is currently under implementation according

Continued---

to AB 1629 passed in 2004 (described under the "Prior legislation" section of this analysis).

Sponsor's rationale. The sponsor states that California nursing home residents are suffering from an enduring staffing crisis. Five years after a January 2000 legislative deadline to provide at least 3.2 hours of nursing care per resident each day, hundreds of California nursing homes routinely endanger their residents by ignoring this standard. The bill would improve staffing performance, without increasing the minimum staffing requirements, by establishing a system to enforce the existing standards.

Opposition's response. CAHF contends that this provision does not recognize California's severe caregiver shortage, which has worsened in the wake of acute hospital staffing rations. The staffing crisis cannot be solved by merely mandating more penalties, without offering other solutions, such as encouraging the development of additional training capacity, meaningful career ladder programs, incentives for providers to maintain caregiver training programs, hire wages, etc. The proposed penalty would deprive those facilities most in need of the resources required to attract and retain a stable workforce.

Proposed amendment. CAHF requests that this language be eliminated entirely.

8. **Payroll Records and Reporting (Section 8)**

Policy proposal. This set of provisions create new audits and electronic filing of facility payroll data and new penalties, including referral to the Franchise Tax Board and IRS, recovery of overpayments through a retroactive rate adjustment, and an assessment of a penalty equal to 200 % of the fraudulently reported staff hours times the average hourly staff wage. The bill also requires electronic reporting of payroll records on a quarterly basis and on or before July 1, 2006, requires DHS to devise and implement a uniform system for collecting and evaluating payroll data.

Sponsor's rationale. The sponsor states that the requirement for SNFs to submit electronic payroll data on a quarterly basis gives DHS the most accurate data available to ascertain staffing levels and costs. The bill would deter fraudulent reporting of staffing costs by establishing stronger penalties.

A reliable, uniform staffing information system will allow DHS to improve its audit, enforcement and public reporting duties, leading to cost savings through the improved detection of understaffing and inflated cost reports. The bill places virtually no new burden on operators, who already report payroll data to the Franchise Tax Board and the IRS and also report additional staffing information to DHS. Consolidating reported staffing data might reduce reporting costs.

Opposition's response. CAHF contends that these provisions have no relationship to improving the overall quality of facility care. Current law has provisions for making referrals to investigate potential provider fraud and abuse. These laws have been significantly strengthened in the past two years. In addition to their audit program,

Continued---

DHS is currently gearing up to be able to audit SNFs payroll data as required by AB 1629 and has already mailed supplemental schedules for providers to return by April 2005. Licensing and Certification has also been required to review staffing compliance more precisely and the State Auditor is required to conduct a review of the entire process.

This bill mandates a costly new electronic reporting system that is more prescriptive than what is currently necessary for DHS to monitor providers. It also mandates penalties which are excessive when added to current recovery and penalty provisions.

Proposed amendment. CAHF requests that this language be eliminated entirely.

Prior legislation

AB 1629 (Frommer, Chapter 875, Statues of 2004) provided for the imposition of a quality assurance fee on each skilled nursing facility, to be administered by DHS and provided that the funds assessed be made available to draw down a federal match in the Medi-Cal program or to provide additional reimbursement to, and support facility quality improvement efforts in, SNFs. The bill required a facility to include in a resident's care assessment the resident's projected length of stay and the resident's discharge potential, facilitating their return to the community. The bill enacted the Medi-Cal Long-Term Reimbursement Act and required DHS to develop and implement a cost-based reimbursement rate methodology by August 1, 2005 that utilizes cost components as a basis for facility-specific reimbursement rates.

AB 1075 (Shelley, Chapter 684, Statutes of 2001) required DHS to develop regulations by August 1, 2003 to establish staff-to-patient rations with regard to direct caregivers working in SNFs. It also required DHS to implement a facility-specific ratesetting system by August 1, 2004, subject to federal approval and the availability of federal or other funds, which reflects the costs and staffing levels associated with quality of care for residents in nursing facilities. The bill asked DHS to examine several alternative rate methodology models for a new Medi-Cal reimbursement system SNFs to include, but not be limited to, consideration of specified factors.

COMMENTS AND QUESTIONS

1. **Tie to new rate-setting system.** The bill currently penalizes facilities that fail to comply with the staffing requirements in law by withholding the labor-driven operating allocation. The bill also would exempt new costs associated with some of the changes from being considered "costs" under the new rate-setting system.

   Given the delicate administrative and federal approval structure of the new rate-setting system, and the belief by its supporters that the allocation works as an incentive for the investment in labor by facilities, should this area of law and the provision of the operating allocation, dependent on staffing compliance, be modified by this bill? Is there a way to create enforcement of the minimum staffing requirement, perhaps by strengthening the role of Licensing and Certification on compliance review and the issuance of penalties, which could act as an alternative to the change proposed by this measure?

Continued—

2. **Totality of changes and operational impact.** The industry has weighed in with feedback and proposed amendments to nearly all of the components in the bill. It is unclear whether the sponsor and author can accept any of the amendments currently being proposed by CAHF where there is concern that the additional requirements will create new mandates for facilities, might be duplicative of current practices for facilities, or create new liability and citation risks for facilities. Can the author accept any amendments proposed by the opposition?

3. **Restriction to federal law on resident's rights issues.** The author and sponsors have chosen to codify existing federal law and language from interpretive guidance in the establishment of new rights and rules for patients governing a range of issues from individual needs and preferences to transfer and discharge services. This language would allow these new rights to broadly apply to all residents, in some cases the language being identical to that found in federal law and at other points in the bill, the language is from interpretive guidance and/or is newly crafted. Should the language be aligned exclusively with federal law to allow for a more incremental approach for these changes in residents' rights in facilities?

POSITIONS

Support:
AARP California (co-sponsor)
Bet Tzedek Legal Services (co-sponsor)
California Advocates for Nursing Home Reform (co-sponsor)
National Senior Citizens Law Center (co-sponsor)
Alzheimer's Association, California Council
California Association of Public Authorities for In-Home Supportive Services
California Church IMPACT
Californians for Disability Rights, Inc.
California Long Term Care Ombudsman Association
California Medical Association
Consumer Attorneys of California
Piedmont Gardens Next Generation
Protection and Advocacy, Inc.
San Pablo Senior Center, City of San Pablo
St. Mary's Center
22 Individuals

Oppose:
Anaheim Crest Nursing Center
Artesia Christian Home
California Association of Health Facilities *(unless amended)*
California Association of Homes & Services for the Aging
California Hospital Association
Chaparral House
Harbor Villa Care Center
Palm Village Retirement Community

Continued---

Retirement Housing Foundation
SunBridge Harbor View Rehabilitation Center
TSW Management Group, Inc.
Tyler & Wilson
Approximately 2,668 Individuals

-- END --

Continued---

STATE CAPITOL
P.O. BOX 942849
SACRAMENTO, CA 94249-0043
(916) 319-2043
(916) 319-2143 FAX

DISTRICT OFFICE
. BRAND BLVD., SUITE 403
GLENDALE, CA 91203
(818) 240-6330
(818) 240-4632 FAX

WEBSITE
http://www.assembly.ca.gov/frommer/

Assembly
California Legislature

DARIO FROMMER
ASSEMBLYMAN, FORTY-THIRD DISTRICT
MAJORITY LEADER

COMMITTEES
GOVERNMENTAL ORGANIZATION
HEALTH
INSURANCE
WATER, PARKS & WILDLIFE

CHAIR
SELECT COMMITTEE ON
SMALL BUSINESS
SELECT COMMITTEE ON
RUNAWAY PRODUCTION

Assembly Bill 1629

Nursing Home Quality Care Act

BACKGROUND

California Nursing Home Care is Underfunded

Medi-Cal pays for more than 2/3 of all nursing home residents, yet this program is not adequately funded. On average, Medi-Cal reimburses only $118 per resident per day, which is $14 less than the average cost of providing care per day. In Los Angeles County, reimbursement averages at $107 per resident per day.

Inadequate funding makes it difficult to maintain adequate staffing, improve aging facilities or to develop a stable workforce to care for seniors and people with disabilities who rely on nursing home care. Low pay for nursing home caregivers, averaging $10.13 an hour ($8.90 an hour in Los Angeles), has created turnover rates as high as 100% in more than a quarter of the state's nursing homes.

Acknowledging the need for care, lawmakers passed AB 1075 (Shelley) in 2001 that promised to fix the problem of underfunding in California by August 1, 2004. Assembly Bill 1629 delivers on that promise by implementing real reforms that change the way Medi-Cal funds nursing homes to improve accountability and quality of nursing home care.

WHAT THE BILL DOES

- Implements a "quality assurance fee" paid by nursing homes that would enable the state to tap into millions of available federal Medicaid dollars to support the new funding system.

- The fee, 6% of a nursing home's net revenue minus Medicare reimbursement, is expected to raise an estimated $250 million, which will then be matched with $250 million in Medicaid funds.

    - At least 23 other states have similarly tapped Medicaid dollars this way.
    - This additional funding is expected to raise Medi-Cal reimbursement rates for all nursing homes. Rates are expected to increase 5.7% on average for long-term care providers in 2004-05.

- Changes the way Medi-Cal funds will be disbursed, tying the amount of funding to staffing levels and quality of care.

    - Encourages more spending on direct patient care by placing caps on administrative costs, direct patient care labor costs and capitol improvement costs at different levels. For example, the cap for direct patient labor care costs is higher than the cap for administrative costs, giving an incentive to spend more on direct care and maintain more cost-effective administration.
    - Improves accountability and quality of care because money allocated for one cost can not be spent in another. For example, money that is supposed to be spent on direct labor costs can not be spent on capitol improvement costs or overhead. Facilities will only be reimbursed for the cost of care that is actually provided to residents.

SUPPORT

Congress of California Seniors, Gray Panthers, Older Women's League, California Senior Legislature, Service Employees International Union, California Association of Health Facilities.

NEWS RELEASE

DARIO FROMMER

Assembly Majority Leader

FOR IMMEDIATE RELEASE

CONTACT: Karen S. Kim
(916) 319-2043

NURSING HOME OPERATORS, PATIENTS AND CAREGIVERS URGE PASSAGE OF BIPARTISAN LEGISLATION TO REFORM NURSING HOME QUALITY OF CARE

(SACRAMENTO, CA) – Assembly Majority Leader Dario Frommer (D-Glendale) and Assemblyman Tony Strickland (R-Thousand Oaks) today introduced legislation to improve the quality of ailing nursing home care in California, proposing dramatic reforms to the state's system of funding such facilities and allowing the state to tap into $250 million of additional federal Medicaid funds, money habitually left on the table in the past.

"These reforms respond to the crisis gripping California's nursing homes by rewarding those who provide the quality of care our loved ones deserve," Frommer said. "Today we are bringing legislators from both sides of the aisle, caregivers, patient advocates and nursing operators together to finally make some serious reforms to a system that doesn't work."

Nursing homes currently receive a flat fee for care of each Medi-Cal resident, regardless of how much care a resident needs. Frommer's *Nursing Home Quality Care Act* (AB 1629) will instead hold nursing homes accountable for better quality of care by tying increased funding to higher staffing, direct resident services and better pay and benefits for caregivers.

Assembly Bill 1629 will also provide for a way to pay for these improvements without costing taxpayers more money. Already, some of the state's largest providers who care for Medi-Cal patients have agreed to pay a "quality assurance fee" that would enable the state to tap millions of federal Medicaid matching dollars for nursing home care to support the new funding system. At least 23 other states have adopted similar systems.

"Every year, California walks away from millions in federal matching dollars for nursing home care," Frommer said. "Those are dollars we're taking directly away from nursing home patients who are suffering from poor quality care because of a faulty system. We owe it to these seniors to take care of them better."

In 2001, lawmakers passed AB 1075 (Shelley), promising to fix underfunding by transforming the Medi-Cal rate system by August 1, 2004. Assembly Bill 1629 fulfills that promise by providing a true

-more-

620 North Brand Boulevard, Suite 403
Glendale, CA 91203
(818) 240-6330
FAX (818) 240-4632

Forty-third Assembly District
www. assembly.ca.gov/frommer
assemblymember.frommer@assembly.ca.gov

State Capitol
Sacramento, CA 95814
(916) 319-2043
FAX (916) 319-2143

Representing Glendale, Burbank, Silver Lake, Los Feliz, Atwater Village, Toluca Lake, North Hollywood and Valley Village

reform plan for nursing home care in California and laying the foundation for a new system of funding nursing homes that encourages high quality staff, facilities and care.

Several member organizations of the coalition California United for Nursing Home Care, including: California Association of Health Facilities, Gray Panthers, Older Women's League, Congress of California Seniors, Service Employees International Union and California Alliance for Retired Americans stood in support of the legislation at a press conference in Sacramento today.

"Changes in our long term care system are long overdue, and AB 1629 is the culmination of years of work by nursing home operators, caregivers and senior advocates to fix a badly broken system," said Hank Lacayo, state president of Congress of California Seniors. "Thousands of residents who look to us as their voice are counting on us to pass this bill and help them live and age with dignity."

Today, residents and caregivers at more than 100 nursing homes from Eureka to San Diego will hold "crisis drills" simultaneously to protest underfunding. Residents and caregivers will file out of their facilities, sounding alarms as they call upon legislators to pass AB 1629. In Sacramento, residents of Emerald Gardens, 6821 24th Street, began their crisis drill at 11 a.m.

###

Nursing Home Residents' Rights

Courtesy of the California Advocates for Nursing Home Reform

Grievances

The resident has the right to:

Exercise rights, voice grievances, and recommend changes in policies and services to facility staff and/or outside representatives of the resident's choice, free from restraint, interference, coercion, discrimination or reprisal. *(42 C.F.R. §483.10(f)(1))*
Prompt efforts by the facility to resolve grievances the resident may have, including those having to do with other residents. *(42 C.F.R. §483.10(f)(2))*

Admission Agreements

The resident has rights about the content of admission agreement contracts, which are signed at the time the resident enters the nursing home:

The contract may not require that the resident pay with private funds (i.e. with funds that are not Medicare or Medi-Cal) for a specified period of time. *(Cal. Health & Safety Code §1599.69(a))*
The contract may not require, at the time of admission, the resident to give notice that he or she intends to convert to Medi-Cal status. *(Health & Safety Code §1599.69(b))*
The contract may not require the resident to promise not to apply for Medicare or Medi-Cal benefits. *(42 C.F.R. §483.12(d)(1)(i-ii))*
The contract may not require a third-party guarantee of payment as a condition of admission or expedited admission. *(42 C.F.R. §483.12(d)(2); Cal. Welfare & Institutions Code §14110.8(b))*

In addition, a resident has the right to have his or her security deposit returned:

When the resident converts to Medi-Cal. *(Cal. Health & Safety Code §1599.70(b); Cal. Welfare & Institutions Code 14110.8(d))*

Medical Condition and Treatment

The resident has the right to:

Be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care. *(42 C.F.R. §483.10(b)(3)*)

Be fully informed in advance about care and treatment and of any changes in care or treatment that may affect the resident. *(42 C.F.R. §483.10(d)(2))*
Participate in planning care and treatment or changes in care or treatment unless adjudged incompetent or otherwise found to be incapacitated under State law. *(42 C.F.R. §483.10(d)(3))*
Self-administer medications unless doing so would be dangerous.*(42 C.F.R. §483.10(n))*
Choose a personal attending physician. *(42 C.F.R. §483.10(d)(1))*
To consent to or refuse any treatment or procedure or participation in experimental research.*(42 C.F.R. §483.10(b)(4))*
To receive all information that is material to his or her decision concerning whether to accept or refuse any proposed treatment or procedure. *(42 C.F.R. §483.10(b)(8))*

Protection of Resident Funds

The resident has the right to:

Manage his or her financial affairs. The facility may not require residents to deposit their personal funds with the facility although a resident can if he or she so desires.*(42 C.F.R. §483.10(c)(1))*
Have funds entrusted to the facility held separately from the funds of the facility and from those of other residents, and have an accurate accounting of those funds. Funds over $50 must be held in an interest-bearing account. *(42 C.F.R. §483.10(c)(3))*
Be informed when the amount in the resident's account, if managed by the facility, reaches $200 less than the $2000 Medi-Cal resource limit and, if increased, may cause the resident to be disqualified from Medi-Cal. *(42 C.F.R. §483.10(c)(5))*

Transfer and Discharge

The resident has the right to be transferred or discharged only if:

He or she has recovered to the point of not needing nursing home care.*(42 C.F.R. §483.12(a)(2)(ii))*
It is necessary for the resident's welfare and her/his needs cannot be met in the facility. *(42 C.F.R. §483.12(a)(2)(i))*
The health or safety of others is endangered. *(42 C.F.R. §483.12(a)(2)(iii) and (iv))*
He or she has failed to pay for care.*(42 C.F.R. §483.12(a)(2)(v))*
The facility ceases to operate. *(42 C.F.R. §483.12(a)(2)(vi))*

Other rights regarding transfer or discharge from a nursing home:

A nursing home must give both the resident and a family member or legal representative advance notice of the transfer or discharge as soon as practicable or reasonable, or in some cases, at least 30 days in advance. *(42 C.F.R. §483.10(b)(11)(D), §483.12(a)(4), (5); Title 22, Cal. Code of Regulations §72527(a)(5))*

A nursing home that participates in the Medi-Cal program may not transfer or seek to evict a resident when he or she changes from private pay or Medicare to Medi-Cal, or while the Medi-Cal application is pending. *(42 C.F.R. §483.12(c)(1); Cal. Welfare & Institutions Code §14124.7(a))*

The nursing home must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. *(42 C.F.R. §483.12(a)(7); Cal. Health & Safety Code §1599.78)*

The nursing home must produce a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living arrangement. *(42 C.F.R. §483.20(l)(3))*

The resident has a right to a 7-day bedhold and immediate readmission when transferred to a general acute care hospital, if he or she continues to pay for the nursing home bed. *(42 C.F.R. §483.12(b); Cal. Health & Safety Code § 1599.79; Title 22, Cal. Code of Regulations, §72520(a))*

After a hospitalization, the resident has the right to be readmitted to the nursing home's first available bed, if the nursing home fails to give written notice of the resident's right to a 7-day bedhold. *(Cal. Health & Safety Code §1599.79; Title 22, Cal. Code of Regulations, §72520(c))*

After a hospitalization, a resident who is a Medi-Cal recipient has the right to the nursing home's first available bed even if he or she is absent from the nursing home for more than 7 days. *(42 C.F.R. 483.12(b)(3))*

Chemical & Physical Restraints & Abuse

The resident has the right to:

Be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. *(42 C.F.R. §483.13(b))*

Be free from any physical or chemical restraints—either psychotherapeutic or antipsychotic drugs—imposed for purposes of patient discipline or staff convenience which are not required to treat the resident's medical symptoms, except in an emergency which threatens to bring immediate injury to the resident or others.*(42 C.F.R. §483.13(a))*

Be given the necessary information to be able to refuse or accept the use of psychotherapeutic drugs, physical restraints, or the prolonged use of a device that may lead to the inability to regain use of normal bodily functions, which will allow the resident to give informed consent about the use of these methods. *(Title 22, Cal. Code of Regulations §72528(c))*

Based on a comprehensive assessment of a resident, the facility must ensure that:

Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition. *(42 C.F.R. §483.25(l)(2)(i))*

Residents who use antipsychotic drugs receive gradual dose reductions or behavioral programming in an effort to discontinue these drugs, unless clinically contraindicated. *(42 C.F.R. §483.25(l)(2)(ii))*
The facility must ensure that each resident's drug regimen is free from unnecessary drugs. *(42 C.F.R. §483.25(l)(1))*

Resident Records

The resident has the right to:

Personal privacy and confidentiality of his or her personal and clinical records. *(42 C.F.R. §483.10(e))*
Review all records pertaining to the resident upon oral or written request within 24 hours, and to purchase photocopies of these records with two days advance notice. *(42 C.F.R. §483.10(b)(2))*
Approve or refuse release of records to any individual or agency outside the facility except when transferred or required by law. *(42 C.F.R. §483.10(e)(2) and (3))*

Dignity and Privacy

The resident has the right to be treated with consideration, respect and full recognition of dignity and individuality *(42 C.F.R. §483.15(a))*. This includes the right to:

privacy during treatment and personal care; *(42 C.F.R. §483.10(e)(1))*
receive and make phone calls in private; *(42 C.F.R. §483.10(k))*
send and receive mail unopened;
(42 C.F.R. §483.10(i)(1))
associate privately with persons of resident's choice, inside or outside the facility. *(42 C.F.R. §483.15(b)(2))*

Free Choice and Participation

The resident has the right to:

Refuse to perform services for the facility. *(42 C.F.R. §483.10(h)(1))*
Choose activities and schedules consistent with his or her interests and care plan and to receive services with reasonable accommodation of individual needs and preferences. *(42 C.F.R. §483.15(b)(1) and (e)(1))*
Participate in resident groups and in activities of social, religious and community groups. *(42 C.F.R. §483.15(c)(1) and (d))*
Communicate with persons of one's choice inside or outside of the facility. *(42 C.F.R. §483.10)*
Retain and use personal clothing and possessions as space permits if it doesn't infringe upon the rights or health and safety of other residents. *(42 C.F.R. §483.10(l))*

Access and Visitation

The resident has the right and the facility must provide—subject to the resident's right to deny or withdraw consent at any time—immediate access to any resident by:

Immediate family or other relatives of the resident. *(42 C.F.R. §483.10(j)(1)(vii))*
Others who are visiting with the consent of the resident, subject to reasonable restrictions. *(42 C.F.R. §483.10(j)(1)(viii))*
The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal or other services to the resident. *(42 C.F.R. §483.10(j)(2))*
If a resident is married, he or she and their spouse must be assured privacy and to be able to share a room if both are residents in the facility and both agree to the do so. *(42 C.F.R. §483.10(e)(1) and (m))*

Resident & Family Councils

Resident Councils

A resident has the right to organize and participate in resident groups in the facility. *(42 C.F.R. §483.15(c)(1))*
The facility must provide a resident group with private space. *(42 C.F.R. §483.15(c)(3))*
Staff or visitors may attend meetings at the group's invitation. *(42 C.F.R. §483.15(c)(4))*
The facility must provide a designated staff person responsible for providing assistance and responding to written requests from the resident council. *(42 C.F.R. §483.15(c)(5))*
The nursing home must listen to the views, and act upon the grievances and recommendations of a resident council, concerning policies affecting resident care and life in the facility. *(42 C.F.R. §483.15(c)(6))*

Family Councils

A resident's family has the right to meet in the facility with families of other residents. A nursing home may not prohibit the formation of a family council. *(42 C.F.R. §483.15(c)(2))*
A family council may be made up of family members, friends, or representatives of residents. *(Cal. Health & Safety Code §1418.4(b))*
The family council must be allowed to meet in a common meeting room of the nursing home at least once a month, and to meet in private without nursing home staff present. *(42 C.F.R. §483.15(c)(3); Cal. Health & Safety Code §1418.4(a), (c))*
Staff or visitors may attend family council meetings, at the group's invitation. *(42 C.F.R. §483.15(c)(4); Cal. Health & Safety Code §1418.4(e))*
The nursing home is required to consider the views, and act upon the grievances and recommendations of a family council, concerning proposed policy and operational decisions affecting resident care and life in the facility. *(42 C.F.R. §483.15(c)(6); Cal. Health & Safety Code §1418.4(g))*
The nursing home is required to respond within 10 working days to written requests or concerns of the family council. *(Cal. Health & Safety Code §1418.4(h))*

SENATE OFFICE OF RESEARCH

Donald Moulds, Director

July 14, 2005

MEMORANDUM

TO: Senator Elaine Alquist
Attn: Robert McLaughlin

FROM: Laurel Mildred

SUBJECT: Data on Oversight of Skilled Nursing Facilities

You requested assistance in analyzing the drop in Department of Health Services (DHS) citations in skilled nursing facilities (SNFs) between 2000 and 2004, including the number of field inspectors tasked with oversight of SNFs and the impacts of the DHS policy to shift primary enforcement attention from issuing state deficiencies to issuing federal deficiencies.

In response, we requested data from DHS on the number of full-time equivalent licensing staff who work on oversight of skilled nursing facilities. We learned that field evaluators are not dedicated to one type of facility, but that each of them inspects different facility types. DHS was able to provide the total number of field evaluators in its Licensing and Certification Program, as well as the number of hours spent in SNF inspections and the percentage of the total inspection hours that were dedicated to SNF inspections.

For purposes of comparison we have included Table 1, which was provided by the California Advocates for Nursing Home Reform and was based on information from DHS.

Table 2 represents the new data on field evaluators and the amount of time they spent inspecting SNFs, provided to us by DHS.

TABLE 1
Total Number of Citations and Deficiencies by Year

	2000	2001	2002	2003	2004	Thru 3/15/05
Number of Surveys	1,088	1,158	1,182	1,236	1,230	118
Number of Citations	595	452	495	433	275	30
Number of Fines	350	401	460	390	274	30
AA	3	2	0	3	3	4
A	42	31	34	37	47	2
B	305	368	426	350	224	24
Penalty Amount	$2,423,179	$3,363,796	$3,295,949	$2,970,408	$1,911,588	$765,550
Number of State Deficiencies	3,731	4,283	4,551	4,291	993	0
Number of Federal Deficiencies	14,220	15,130	14,072	13,557	19,078	1580

Source: California Advocates for Nursing Home Reform from data provided by the California Department of Health Services

TABLE 2
Staffing and Total Hours of Inspection for Skilled Nursing Facilities within DHS Licensing and Certification

	99/00	00/01	01/02	02/03	03/04
Total Number of Field Evaluator Positions Budgeted	451.5	546	516	531	478
Total Number of Field Evaluator Positions Filled	467	557	476	483	443
Total Hours of SNF Inspections	319,609	305,989	357,893	247,428	252,688
% of Total Inspection Hours Spent in SNF's	38.7%	35.88%	36.62%	30.10%	29.65%

Source: California Department of Health Services

Note on Methodology: According to the Department, the total number of hours of inspection are compiled on the basis of fiscal year (for example, 99/00) whereas the number of inspectors is based on a point-in-time count on June 30 of each year.

As we discussed, the issue of the enforcement of federal versus state deficiencies represents a shift in policy that DHS would be best-suited to explain. To assist you, we have prepared a number of questions that could be posed to DHS to help the Legislature understand the impacts of this policy decision. These questions could be posed at the hearing. A draft letter to DHS Director Sandra Shewry is attached to focus the department's explanation and facilitate a better understanding of the matter.

Please feel free to contact me at 651-1500 if I can be of further assistance.

LAM:gd
Attachment

California Legislature
Senate Subcommittee on Aging and Long-Term Care
SENATOR ELAINE K. ALQUIST, CHAIR

MEMBERS
SAM AANESTAD
DAVE COX
SHEILA KUEHL
DEBORAH ORTIZ

CONSULTANT
ROBERT MacLAUGHLIN

COMMITTEE ASSISTANT
LYNDA HANCOCK

July 14, 2005

Director Sandra Shewry
California Department of Health Services
1501 Capitol Avenue
Sacramento, CA 95820

Dear Director Shewry:

As you know, I am holding a hearing of the Senate Subcommittee on Aging and Long Term Care on nursing home quality on Wednesday, July 20, 2005, in Sunnyvale. The Department of Health Services has been requested to testify at the hearing.

In the course of preparing for the hearing, my staff has identified an important and urgent issue. -While researching the Department's records on nursing home oversight activity between 2000 and 2004, they identified a marked trend of a decline in state deficiencies issued while there was a concurrent increase in federal deficiencies. I have heard that this trend represents a shift in state policy.

Given this shift in Department policy and what it might mean for nursing home quality of care in California, I would appreciate it if the DHS representative at next week's hearing is prepared to address the following questions.

1. Please describe the types of violations that would be issued as Type AA, A, or Type B citations.

2. According to data provided by DHS, there were 426 Type B citations issued in 2002, but only 224 citations issued in 2004, a 48 percent reduction in two years. Please explain the specific reasons why substantially fewer Type B citations were issued in 2004.

1020 N Street, Room 545 • Sacramento, CA 95814 • Tel (916) 651-1541 • Fax (916) 323-5179

However, there were only 993 state deficiencies issued during 2004. Can you explain the specific reasons for the difference?

5. Please describe the difference between violations that constitute "state deficiencies" and "federal deficiencies." Do they represent the same type of violations? What violations are covered under state deficiencies that are not covered under federal deficiencies? Similarly, what violations are covered under federal deficiencies that are not covered under state deficiencies?

6. What are the relative impacts of issuing state versus federal deficiencies on the following:

- Total amount of fines assessed
- Total amount of fines actually paid
- Rate of return of fines to the DHS state licensing program
- Quality of care

7. Under what statutory or regulatory authority has DHS effected a policy change to emphasize federal rather than state deficiencies? Was the Legislature notified of this change in policy?

8. In summary, exactly why have the number of deficiencies issued to skilled nursing facilities changed?

In addition to verbal testimony at the hearing, I would appreciate it if DHS would provide a written response to these questions at the hearing also.

I recognize that we are asking for a quick turn around, but given the nature of the hearing, I believe it is imperative that the Department be prepared to provide the data requested and address the policy questions I have identified.

If you or your staff have any questions, please contact Robert MacLaughlin at the Senate Subcommittee on Aging and Long Term Care at 916/651-1541. Thank you for your assistance in this matter.

Sincerely,

Elaine Alquist

Elaine Alquist, Chair
Senate Subcommittee on Aging and Long Term Care

Panel I

CHARLENE HARRINGON, PH.D., RN, FAAN

Charlene Harrington, Ph.D., RN, FAAN, is Professor of Sociology and Nursing in the Department of Social and Behavioral Sciences, School of Nursing, University of California, San Francisco. After receiving her doctoral degree in sociology and higher education at the University of California Berkeley, she was appointed deputy director of the California Licensing and Certification program, where she was instrumental in strengthening the regulation of nursing homes and hospitals in California. She joined the UCSF faculty in 1980, and has focused her teaching and research on long term care, nursing homes, managed care, and home and community services.

Dr. Harrington served on the Institute of Medicine (IOM) Committee on Nursing Home Regulation whose l986 report led to the passage of the Nursing Home Reform Act of l987, and she was elected to the IOM in 1996. Since 1980, she has published numerous papers on nursing home reimbursement, supply, staffing, utilization and expenditures that have contributed to public policies at national and state levels. She was the principal investigator on a project that developed a Nursing Home Consumer Information System (Agency for Health Care Policy and Research from 1995-2000), used to develop the Medicare Nursing Home Compare website in 1999. Her team of researchers designed a model California consumer information system website for nursing homes funded by the California Health Care Foundation (launched in October 2002) that she continues to maintain and expand. Since 1994, she has been collecting and analyzing trend data on Medicaid home and community based service programs and policies. In 2003, she became the principal investigator of a five-year $4.5 million national Center for Personal Assistance Services funded by the National Institute on Disability and Rehabilitation Research. She is Associate Director of the John A. Hartford Center for Geriatric Nursing Excellence and Director of the new doctoral program in nursing and health policy at UCSF. She has served on several IOM committees and has testified before the US Senate Special Committee on Aging, and has written more than 200 articles and chapters and co-edited five books while lecturing widely in the U.S. and the U.K.

BETH CAPELL
SEIU Representative

Beth Capell, Ph.D., is the owner and principal of Capell & Assoc., a lobbying firm, representing consumer organizations and labor unions on health care issues. Her clients include Health Access, a consumer coalition of more than 200 organizations and sponsor of the HMO Patient Bill of Rights; the Service Employees International Union, the largest union in California; and other public interest organizations.

She is currently working on universal access, hospital charity care, hospital ratios, prescription drug prices and HMO regulation. She has also worked on nursing home issues as well as other health care issues.

Beth Capell has worked in Sacramento since 1977, in the legislature, in state legislative campaigns, in ballot initiative campaigns, in the administration, and since 1983, as a lobbyist and strategist. From 1986 to 1995, she represented the California Nurses Association, first as legislative advocate and later as Director of Government Relations. Her doctorate is in political science from the University of California, Berkeley.

WILLIAM V. BRENNAN, CHIEF
Rate Development Branch, Medi-Cal Policy Division
Department of Health Services, Sacramento

Mr. Brennan is Chief of the Rate Development Branch of the Medi-Cal Policy Division of the Department of Health Services in Sacramento. He manages the Rate Development Branch, which establishes the provider payment schedule for covered services, conducts rate studies and develops long-term care rates. Within the Branch are the Hospital Finance, Provider Rate, and Waiver Analysis sections. The Hospital Finance Section is responsible for the Department's $2 billion Disproportionate Share Program, the establishment of the Medi-Cal reimbursement rates for non-contract hospitals. The Provider Rate Section is responsible for complex and sensitive rate-setting studies, which involves statistical analyses, grouping methodologies, and reimbursement modeling. The Waiver Analysis Section serves as the State's Single State Agency to the Centers for Medicare and Medicaid Services (CMS) for 11 Medicaid waivers with regard to development.

DAVE HELMSIN
Legislative Advocate
California Association of Health Facilities

Dave Helmsin is a Sacramento lobbyist who specializes in health care issues. Dave started his career in health care policy with the California Health and Human Services Agency. He then spent seven years as Program Director for the California Association of Health Facilities, where he was responsible for a variety of long-term care financing, public advocacy and government relations programs. Dave formed his own lobbying firm in 1992 and, along with his Washington D.C.-based partner, represented long-term care providers at both the state and federal level. In 2001, he founded Capitol Advocacy, where he continues to advocate for long-term care providers in California.

Dave has been part of the debate on long-term care issues for more than 20 years and has had a hand in virtually all related legislation adopted in California during that timeframe. As a member of the first panel, Dave will discuss facility compliance with current staffing levels and what can be done to encourage higher staffing levels in California. On the second panel, Dave will offer a provider perspective on the current process for complaint investigation and how performance in this area can also be improved.

ALAN ROBISON
Supervising Deputy Attorney General
Elder Abuse Prosecution Unit

Alan B. Robison is the supervising deputy attorney general for the California Attorney General's Elder Abuse Prosecution Unit. He was the lead criminal prosecutor in the Beverly Enterprises, Inc., Sun Healthcare Group, Inc., and Pleasant Care Corporation corporate prosecution cases. Prior to joining the Attorney General office, he was a California deputy district attorney for 12 years, specializing in the prosecution of adult sexual assault and child physical abuse/molest cases. He obtained his undergraduate degree from the University of California, Santa Barbara, and his law degree from the University of California, Davis.

CHARLES W. RABORN, JR.
Investigative Auditor

Charles Raborn is an Investigative Auditor for the California Attorney General's Bureau of Medi-Cal Fraud and Elder Abuse. He has served in the Bureau's Civil Prosecution Unit, the Medi-Cal Fraud Prosecution Unit and presently serves in the Elder Abuse Prosecution Unit. With more than 24 years of combined federal and state service, Charles has held professional positions in both the audit and criminal investigation fields, including service as a Statistician and a Special Agent. Possessing several certifications, Charles is a graduate of, and is certified to instruct for, the Robert Presley Institute of Criminal Investigation. He is active in both the audit and investigative disciplines, and is a member of many professional associations which include the American Society for Law Enforcement Training, the California Financial Crimes Investigators Association, the Association of Government Accountants, and the International Association of Financial Crimes Investigators. Charles presently serves as Executive Director for the Association of Certified Fraud Specialists, an educational non-profit corporation that specializes in educating, and certifying, anti-fraud professionals.

Panel II

PATRICIA L. M^{C}GINNIS
Executive Director
California Advocates for Nursing Home Reform

Patricia L. McGinnis is the co-founder and Executive Director of California Advocates for Nursing Home Reform, a statewide consumer advocacy organization formed in 1983.

Ms. McGinnis received her J.D. from Golden Gate University School of Law in 1977. She has been involved with nursing home reform issues for over 25 years and has written and lectured extensively on elder abuse and long-term care issues.

Nursing Home Quality in the 21st Century:
Staffing Adequacy and Complaint Investigation
Joint Informational Hearing of the Senate Committee on Health and the Senate Subcommittee on Aging and Long Term Care

July 20, 2005

Testimony submitted by
Patricia L. McGinnis, Executive Director
California Advocates for Nursing Home Reform

Senator Alquist, Committee members, I would like to thank you for the opportunity to address the problems with California's complaint response and enforcement system. My name is Pat McGinnis, and I am the Executive Director of California Advocates for Nursing Home Reform. Our organization has been monitoring the problems with California's nursing homes and addressing consumer concerns for over 23 years.

California's enforcement system for nursing homes, under the auspices of the Department of Health Services' Licensing and Certification Unit, has a long and checkered history. Numerous studies, reports and reviews since the 1970s have found inadequacies in enforcement and failure to respond to consumer complaints.

California's Little Hoover Commission examined the State's oversight of nursing homes in 1983, 1987, 1989 and 1991. In every case, the Little Hoover Commission issued reports critical of the Department's nursing home oversight and enforcement activities and issued recommendations for reform.

In a scathing 1998 report submitted to the U.S. Senate Committee on Aging, the U.S. General Accounting Office found that oversight of California's nursing homes was inadequate to protect residents with serious care problems and, in fact, placed residents in danger of death or serious bodily harm.

Subsequent reports issued by the Special Investigations Division of the U.S. House of Representatives' Committee on Government Reform in 1999, 2000 and 2003 found that less than 3% of the nursing homes in Los Angeles were in full or substantial compliance with federal standards, and that only 6% of Bay Area facilities were in compliance. 19% of the facilities in Los Angeles and over 33% of Bay Area nursing homes had violations that caused actual harm to residents or placed them at risk of death or serious injury.

A July 2003 GAO study found that serious weaknesses in state survey, complaint and enforcement activities continue to exist is most states, including California. In fact, the GAO report noted that California was among those states that showed a marked decline in the issuance of serious deficiencies. The number of actual harm or serious jeopardy deficiencies issued against California nursing homes declined almost 20% in a one-year period. While it would be comforting to think that this decline could be attributed to better quality of care, the GAO study indicated that this decline was actually due to the understatement of actual harm deficiencies.

So how did the Department of Health Services respond to these critical reports and recommendations? I would suggest that the facts and statistics speak for themselves.

The Department of Health Services, Licensing and Certification Program (L&C) is responsible for licensing nursing homes, for completing annual surveys, investigating complaints and, through its enforcement efforts, ensuring compliance with state and federal laws and regulations. The state has a wide variety of state and federal enforcement tools to choose from. State enforcement tools include a system of deficiencies, citations and penalties, bans on admissions, placing the facility in receivership, or even suspension or revocation of the facility's license. For facilities that participate in the Medicare or Medicaid programs, the state can recommend a variety of federal enforcement remedies, in addition to state sanctions. The failure of the enforcement system is seen in the downward trends in citations, in the understatement of the scope and severity of deficiencies, and in the infrequent use of federal and state enforcement measures.

Citations: The Department issued fewer citations and assessed fewer civil monetary penalties in 2004 than in the history of the citation system in California. Only 484 citations with a total of $2,457,500 in civil monetary penalties were assessed against nursing facilities in 2004. With numerous opportunities for facilities to appeal, less than 50% of these fines will ever be collected.

Federal Deficiencies and Remedies: The Department can issue state or federal deficiencies against a facility, depending on the violation. Although the number of federal deficiencies has risen to over 19,078 in 2004 from 13, 557 in 2003, most of these deficiencies do not reflect the seriousness of the violations and, thus, few federal remedies are imposed. In fact, the number of federal remedies, including bans on admissions and federal civil monetary penalties has decreased dramatically over the past few years.

State Deficiencies: Having a menu of state and federal remedies helps ensure compliance with federal laws as well as compliance with many state laws unique to California. Unfortunately, the Department has decided that they will not longer enforce state laws pertaining to nursing homes. This is reflected in the sharp drop in the number of state deficiencies issued in 2004 - from over 4,000 state deficiencies in 2003 to less than a 1,000 in 2004 - and in the Department's decision to test a "pilot" project in the San Jose and Alameda County District Offices. Under this pilot project, state surveyors are only examining compliance with federal laws.

What this illegal change in protocol means for the nursing home consumer is that violations of state laws are not enforced; state deficiencies, citations, and penalties are not issued. Consumers are denied due process, and nursing home residents are denied the hard fought rights and protections under state law enacted by California legislators over the past twenty years.

California's Complaint Response System:

Perhaps nowhere is the failure of enforcement reflected more than in the response to consumer complaints. The timely and comprehensive investigation of consumer complaints is essential to any adequate enforcement system and can provide a far better picture of the overall care in a facility than one annual survey.

Under California law, the Department is required to make an onsite inspection or investigation within 10 working days of receipt of a complaint. Where the complaint involves imminent danger of death or serious bodily harm, the investigation must be within 24 hours of receipt of the complaint. The Department is required under law to notify the complainant within 2 working days of receipt of the complaint of the name of the inspector. The Department is required by law to notify the complainant "promptly" of the right to accompany the inspector on the investigation of the complaint. The complainant has a right to appeal the results of the complaint - both in the county where the facility is located and, if still dissatisfied, to the Deputy Director of Licensing and Certification.

In 2004, nearly 14,000 complaints were filed against nursing homes in California. As a result of the Department's failures, thousands of complainants did not receive timely notice of the status of their complaints; few received notice of their right to accompany the surveyor; and the majority of complaint investigations were delayed well beyond the 24 hour or 10 day timeline. As a result, 75% of the complaints were found to be "unsubstantiated." Evidence is missing, staff is gone, witnesses are unavailable, and even the resident is sometimes deceased by the time the Department completes its investigation.

In San Jose and Alameda District Offices, as well as in the rest of California, complainants are even denied the right to an appeal.

(See attached letter)

If the Department of Health Services is not issuing citations or collecting the fines; not issuing serious deficiencies or imposing federal remedies; not monitoring compliance with state laws; or not responding to or investigating complaints on a timely basis, then we have, in essence, no enforcement system in California.

SB 526: Dedicated Complaint Response Units

The concept of dedicated complaint response units as proposed by SB 526 in District Licensing and Certification offices is not a new one. It has been recommended by our organization in annual reports since 1990. In a 1994 critical review of the Licensing & Certification Division's complaint investigation system, California's State Auditor recommended Complaint Response Teams in each district office.

District Office staff is already charged with the obligation to investigate complaints in a timely manner. Staffing complaint teams to fit the complaint workload and training this staff to perform adequate investigations will benefit everyone in the long run.

California's DHS Licensing & Certification Division is the only consumer protection agency for nursing home residents with the power to enforce the law. When they fail in their mission, when they fail to respond to complaints, when they deny due process to complainants - they fail the residents of nursing homes in California and place their health and safety at risk.

It is unconscionable that the Department is using a staffing shortage as an excuse to deny the rights of residents and of consumers. Even if the Department had unlimited staffing and funding, without a fundamental structural change; without trained and dedicated complaint response units, the problems outlined today would continue to exist.

Thank you.

MARK E. REAGAN, ESQ.

Mr. Reagan is the managing partner in the San Francisco office of Hooper, Lundy and Bookman. Mr. Reagan has long been General Counsel to the California Association of Health Facilities; he also serves on the Legal Subcommittee for the American Health Care Association and the ethics committee of the American College of Medical Quality; and, he is a board member of the American Board of Medical Quality. Throughout his legal career, Mr. Reagan has represented long-term care facilities, hospitals, physician groups, trade associations, and other health-related entities in California. He provides his clients with policy analysis, counseling, litigation and trial and appellate work, before administrative agencies and the courts. He frequently testifies before the California State Legislature and is a nationally recognized speaker, instructor and author on health-related topics.

LINDA ROBINSON
Ombudsman Coordinator, Santa Cruz

Linda Robinson, MSW is the coordinator of the Long-Term Care Ombudsman program for Santa Cruz and San Benito Counties. Linda has worked with Ombudsman/Advocate, Inc., the Santa Cruz nonprofit that houses the LTC Ombudsman Program and Patient Rights Advocate Program, for eight years. Linda has been an advocate for older adults for the past twelve years and recently received the Dorothy Miller award for outstanding field instructor from the San Jose State University Department of Social Work. Linda has consistently been recognized by families, residents of long term care facilities and community agencies for her integrity and ethical commitment to rights protection and advocacy.

Background

CNA, Nurse Patient Ratio

Good Morning, Senator Alquist-my name is Robert Goldsborough. I have been a resident of long term care facilities in Santa Clara County for 15 years. I am currently a resident at Winchester Convalescent Hospital and president of the Residents' Council. Thank you for the opportunity to testify at this important hearing.

Patients at Long term health care facilities are being cheated out of the care that they need. Nurses and CNA's have too many patients.

What does it mean when your care attendant (certified nurse attendant) has too many residents? Especially high care maintenance patients, like myself. It means that they cut corners either with you or other Patients.

If the attendant takes time to do something for us, things that should be done, we are reminded that we are taking time from someone else. I'm constantly being reminded that "You're not the only patient ".

It means the attendants either do a complete job quickly, sometimes resulting in physical injury (like patients being thrown against the rails) or they eliminate tasks moving onto the next patient.

In my case it means that attendants are not careful with supersensitive patients who are in lots of pain. When you are experiencing chronic pain, the way you are handled can increase or reduced the pain. If you can't move, the way your body is arranged and the frequency with which you are turned affects your pain. And with increasing pain the longer the pain is allowed to last the more intense it gets and when you do get care: it is less effective in reducing that pain.

Failure to be turned not only increases pain but leads to bedsores and death. I had two bedsores several years ago. My lawyer and I needed to demand that the facility take proper care of me. Thank God I have a lawyer.

When attendants have too many patients to take care of, they stop caring for their patients. They don't have the time to be kind. They just need to get their work done, so they end up making their own priorities.

And just what takes priority? Paperwork, not resident cares. "If it's not on paper it hasn't been done" and in our experience what's on paper has nothing to do with the care we get. This is especially true of the care conference where they "decide with you and your family what care you need". After the conference, paperwork gets filed and nothing new gets done. After going through this charade a couple of times most patients get discouraged and stop going to them.

When the caregiver has too much work to do, they lie about what they did. They skip showers, they don't brush teeth, they don't shave beards, they never floss teeth and sometimes they don't get you up in time for your activities. In my case, staff told me I needed to drink more water and then they wouldn't give me water or rig up something so that I could drink at will even though I asked. Twice I was sent to the hospital when I was dehydrated and got a urinary tract infection because my urine was too concentrated. Obviously, I needed to take my life into my own hands and so I scouted different stores and jury-rigged my own contraption for water delivery both in my wheelchair and in my bed. What about patients, who can't do things for themselves, what are they to do?

After one of my urinary tract infections I was given a suprapubic catheter, which is a tube going straight into my abdomen. It is supposed to be cleaned every day and changed every month. When I went to the hospital to the emergency room and later to intensive care we found out that the end of the catheter tube was black, it hadn't been changed for six weeks.

If you need something done you have to beg or make demands and you soon gain the reputation as a difficult demanding patient. And God help you if you try to tell your caregiver how to do something or the most effective way to do something. And training caregivers is a never-ending process since there is such a high turnover, 83% on the average, sometimes as high as 200 to 300%. Many caregivers are immigrants, who speak little English, how do you communicate with them?

And what about patients who can't speak? What about patients who are incapable, comatose or just don't know what their rights are concerning patient care?

When there are not enough caregivers, residents just don't get care and caregivers get burnt out. Being a caregiver, a CNA or nurse, is a difficult hard job and they don't get paid enough. Most caregivers work a 16 hour day: either they work a double shift or eight hours at two facilities. Those caregivers who do care, work very hard. Some workers often skip their breaks and sometimes even their lunch. Hard-working caregivers are often chastised by other caregivers, "You're doing too much work" or "You're making me look bad".

Attention should be placed on not only how many caregivers there are but also on what they do. When patients are in the activity room, there should always be a certified nurse attendant assigned there to help. What if someone starts choking? The other residents don't have the ability to help. Though oftentimes we are the only ones available.

Something needs to be done about the conditions at convalescent hospitals. They shouldn't need to be a choice between documentation and providing factual care. We need adequate staffing, we need to make sure staff does the work that we need, and facilities need to be held accountable when they fail in their responsibility.

Senator Alquist, thank you so much for your untiring efforts to improve staffing accountability thereby improving the quality of our lives.

California's Nursing Home Complaint Statistics
Calendar Years 2000. 2001, 2002 & 2003

	2000	**2001**	**2002**	**2003**
Complaints	7,947	8,458	11,365	11,072
Reported Events	1,428	1,743	3,572	4,707
Total	9,375	10,201	14,937	15,779

	2000	**2001**	**2002**	**2003**
Closed Complaints	7,913	8,351	11,114	8,757
# Substantiated	3,215	3,156	3,142	2,231
Substantiation Rate	41%	38%	28%	25%

- Source: DHS ACLAIMS

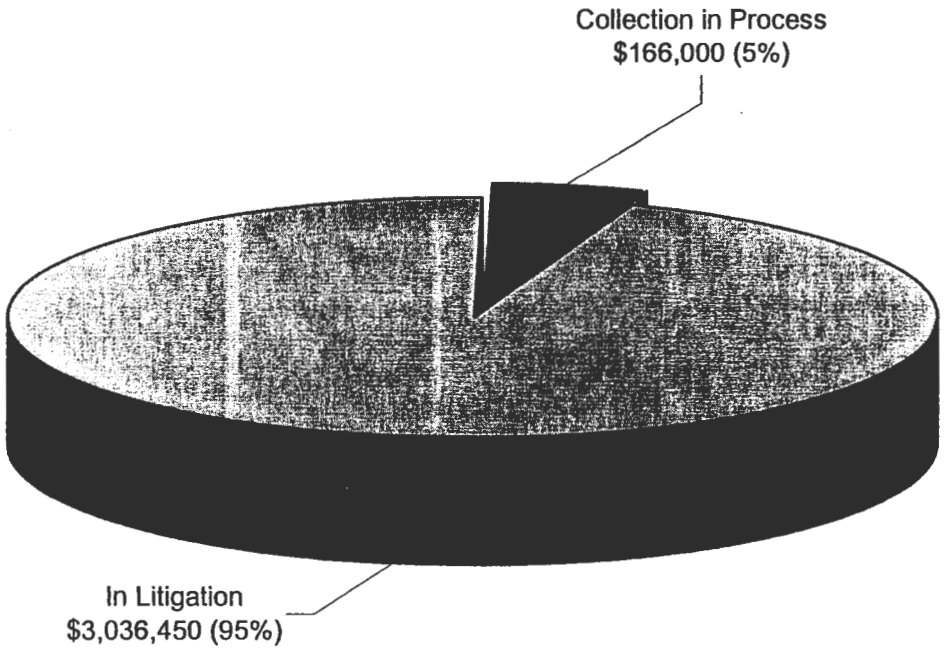
QUARTERLY CITATION REPORT

1st Quarter of Calendar Year 2005 for
Calendar Years 2002, 2003, 2004, 2005

Prepared by Licensing and Certification
Federal Grant, Budgets and Accounting Unit

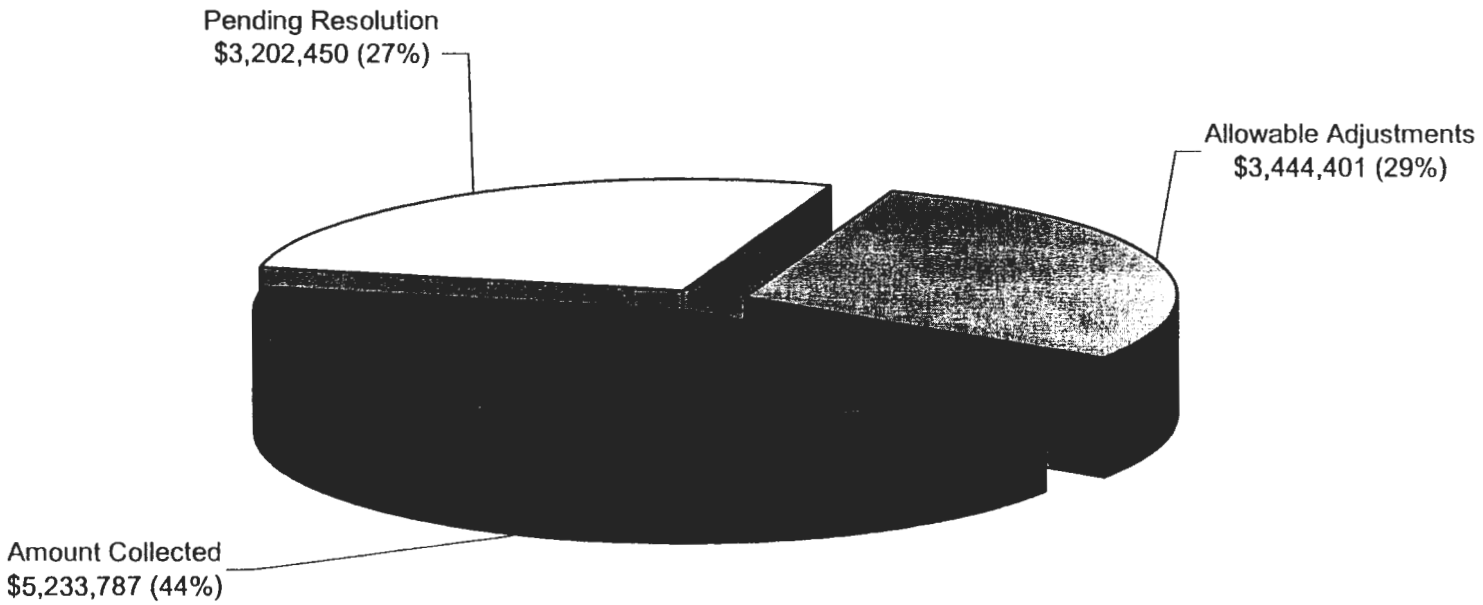
QUARTERLY CITATION REPORT SUMMARY 1ST QUARTER 2005
CALENDAR YEARS 2005, 2004, 2003, 2002

Total Amount Pending Resolution
$3,202,450



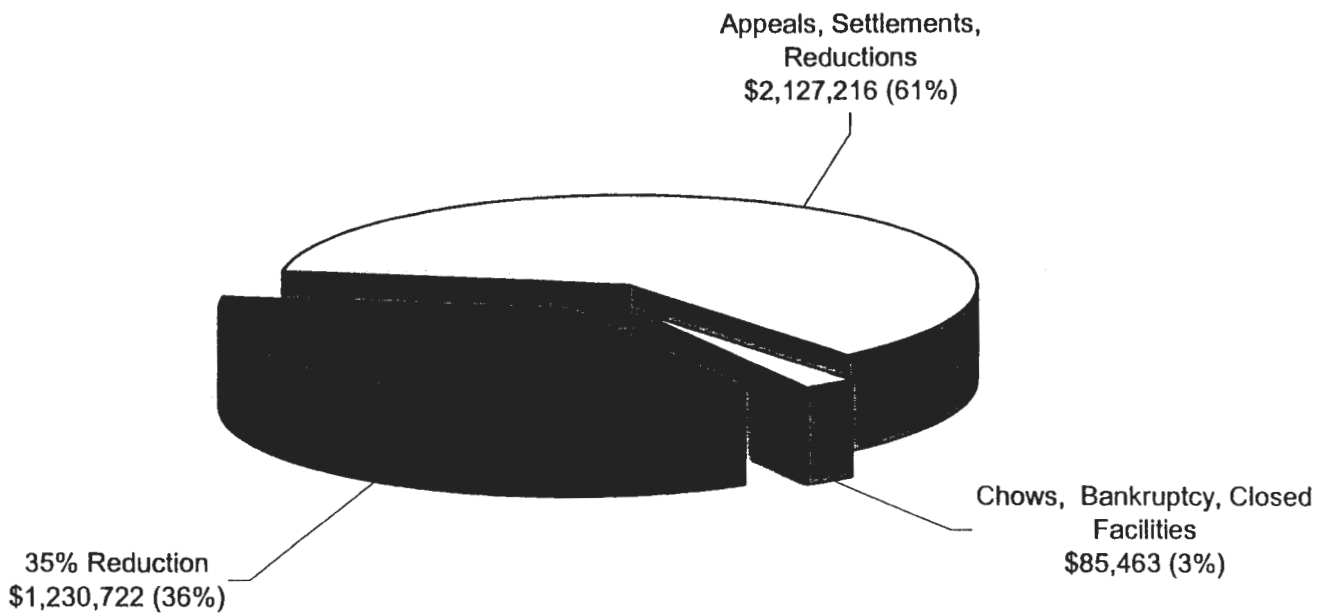
QUARTERLY CITATION REPORT SUMMARY 1ST QUARTER 2005
CALENDAR YEARS 2005, 2004, 2003, 2002

Total Amount Assessed
$11,880,638



QUARTERLY CITATION REPORT SUMMARY 1ST QUARTER 2005
CALENDAR YEARS 2005, 2004, 2003, 2002

Allowable Adjustments
$3,444,401



Calendar Year 2005

QUARTERLY CITATION REPORT
CALENDAR YEAR 2005
1ST QUARTER 2005

LICENSING AND CERTIFICATION
Centralized Citation Collection Unit

	footnote	ALL LONG-TERM CARE FACILITIES # of Citations	AMOUNT ASSESSED Subtotal	AMOUNT ASSESSED Total	%	# of Citations	NURSING FACILITIES (SNF/NF-ICF) # of Citations	AMOUNT ASSESSED Subtotal	AMOUNT ASSESSED Total	%	# of Citations	DEVELOPMENTALLY DISABLED & CLHF # of Citations	AMOUNT ASSESSED Subtotal	AMOUNT ASSESSED Total	%	# of Citations
I TOTAL AMOUNT ASSESSED				**$727,050**	**100%**	**130**			**$640,800**	**100%**	**88**			**$86,250**	**100%**	**42**
II ALLOWABLE ADJUSTMENTS	1			**$51,222**	**7%**	**63**			**$42,612**	**7%**	**40**			**$8,610**	**10%**	**23**
A. Reduction Amount for Citations Paid at 65% Discount Rate (in lieu of appeal)	2	23	$8,610		17%		0	$0		0%		23	$8,610		100%	
B. Amount Reduced in Appeal/or Settlements	3	40	$42,612		83%		40	$42,612		100%		0	$0		0%	
C. Allowable Adjustments Due to Change of Ownership(CHOW), Bankruptcy, Facility Closure	4	0	$0		0%		0	$0		0%		0	$0		0%	
III AMOUNT COLLECTED TO-DATE				**$100,328**	**14%**	**6**			**$83,488**	**13%**	**4**			**$16,840**	**20%**	**2**
IV TOTAL AMOUNT PENDING RESOLUTION				**$575,500**	**79%**	**61**			**$514,700**	**80%**	**44**			**$60,800**	**70%**	**17**
A. In Litigation	5	33	$487,000		85%		28	$448,100		87%		5	$38,900		64%	
B. Collection In Process	6	28	$88,500		15%		16	$66,600		13%		12	$21,900		36%	
C. Pending Resolution	7	0	$0		0%		0	$0		0%		0	$0		0%	

Report run date: April 2005 - ACL649

See Graphs I, II, III for LTCF's.

Footnotes:

1 "Allowable Adjustments" are divided into "A", "B","C".

2 "Reduction Amount for Citations Paid @ 65% Discount Rate": per H & S Code Section 1428.1, citations paid within 15 days are reduced by 35% (after 1/1/99).

3 "Amount Reduced in Appeals and /or Settlements".

4 None

5 "In Litigation" indicates citations in appeal (Citation Review Conference, Administrative Law Judge, Binding Arbitration, Court) or Bankruptcy court.

6 "Collection in Process" (Includes Medi-Cal offset, payment notices, settlement money pending, etc.)

7 "Pending Resolution" (Captures citations issued to State owned/operated facilities in which collection procedure is under review).

Calendar Year 2004

QUARTERLY CITATION REPORT
CALENDAR YEAR 2004
1ST QUARTER 2005

LICENSING AND CERTIFICATION
Centralized Citation Collection Unit

	footnote	ALL LONG-TERM CARE FACILITIES # of Citations	AMOUNT ASSESSED Subtotal	AMOUNT ASSESSED Total	%	# of Citations	NURSING FACILITIES (SNF/NF-ICF) # of Citations	AMOUNT ASSESSED Subtotal	AMOUNT ASSESSED Total	%	# of Citations	DEVELOPMENTALLY DISABLED & CLHF # of Citations	AMOUNT ASSESSED Subtotal	AMOUNT ASSESSED Total	%	# of Citations
I TOTAL AMOUNT ASSESSED				**$2,738,900**	**100%**	**654**			**$2,457,500**	**100%**	**484**			**$281,400**	**100%**	**170**
II ALLOWABLE ADJUSTMENTS	1			**$456,367**	**17%**	**410**			**$390,085**	**16%**	**284**			**$66,282**	**24%**	**126**
A. Reduction Amount for Citations Paid at 65% Discount Rate (in lieu of appeal)	3	389	$331,099		73%		271	$267,767		69%		118	$63,332		96%	
B. Amount Reduced in Appeal/or Settlements	4	14	$112,168		25%		7	$111,368		29%		7	$800		1%	
C. Allowable Adjustments Due to Change of Ownership(CHOW), Bankruptcy, Facility Closure	5	7	$13,100		2%		6	$10,950		2%		1	$2,150		3%	
III AMOUNT COLLECTED TO-DATE				**$801,883**	**29%**	**66**			**$666,915**	**27%**	**50**			**$134,968**	**48%**	**16**
IV TOTAL AMOUNT PENDING RESOLUTION				**$1,480,650**	**54%**	**178**			**$1,400,500**	**57%**	**150**			**$80,150**	**28%**	**28**
A. In Litigation	6	168	$1,407,950		95%		141	$1,328,300		95%		27	$79,650		99%	
B. Collection in Process	7	10	$72,700		5%		9	$72,200		5%		1	$500		1%	
C. Pending Resolution	8	0	$0		0%		0	$0		0%		0	$0		0%	

Report run date: May 2005 - ACL649

See Graphs I, II, III for LTCF's.

Footnotes:

1 "Allowable Adjustments" are divided into "A", "B","C".

2 "Reduction Amount for Citations Paid @ 65% Discount Rate": Per H&S Code Section 1428.1, citations paid within 15 business days are reduced by 35% (after 1/1/99) unless issued as a Class AA or Class A citation which can

3 "Amount Reduced in Appeals and /or Settlements"

4 "Allowable Adjustments Due to Change of Ownership, Bankruptcy, Facility Closure"
#
#
#
#

5 "In Litigation" indicates citations in appeal (Citration Review Conference, Administrative Law Judge, Binding Arbitration, Court) or Bankruptcy court.

6 "Collection in Process" (Includes Medi-Cal offset, payment notices, settlement money pending, etc.)

7 "Pending Resolution" (Captures citations issued to State owned/operated facilities in which collection procedure is under review)

Calendar Year 2003

QUARTERLY CITATION REPORT
CALENDAR YEAR 2003
1ST QUARTER 2005

LICENSING AND CERTIFICATION Centralized Citation Collection Unit	footnote	ALL LONG-TERM CARE FACILITIES					NURSING FACILITIES (SNF/NF-ICF)					DEVELOPMENTALLY DISABLED & CLHF				
		# of Citations	AMOUNT ASSESSED Subtotal	Total	%	# of Citations	# of Citations	AMOUNT ASSESSED Subtotal	Total	%	# of Citations	# of Citations	AMOUNT ASSESSED Subtotal	Total	%	# of Citations
I TOTAL AMOUNT ASSESSED				$4,039,100	100%	908			$3,633,300	100%	726			$405,800	100%	182
II ALLOWABLE ADJUSTMENTS	1			$1,379,530	34%	617			$1,264,222	35%	485			$115,308	28%	132
A. Reduction Amount for Citations Paid at 65% Discount Rate (in lieu of appeal)	2	416	$398,721		29%		295	$303,363		24%		121	$95,358		83%	
B. Amount Reduced in Appeal/or Settlements	3	187	$939,521		68%		178	$920,771		73%		9	$18,750		16%	
C. Allowable Adjustments Due to Change of Ownership(CHOW), Bankruptcy, Facility Closure	4	14	$41,288		3%		12	$40,088		17%		2	$1,200		1%	
III AMOUNT COLLECTED TO-DATE				$1,809,720	45%	138			$1,576,828	43%	113			$232,892	57%	25
IV TOTAL AMOUNT PENDING RESOLUTION				$849,850	21%	153			$792,250	22%	128			$57,600	14%	25
A. In Litigation	5	151	$845,050		99%		128	$792,250		100%		23	$52,800		92%	
B. Collection in Process	6	2	$4,800		1%		0	$0		0%		2	$4,800		8%	
C. Pending Resolution	7	0	$0		0%		0	$0		0%		0	$0		0%	

Report run date: May 2005 - ACL649

See Graphs I, II, III for LTCF's.

Footnotes:

1 "Allowable Adjustments" are divided into "A", "B","C".

2 "Reduction Amount for Citations Paid @ 65% Discount Rate": Per H&S Code Section 1428.1, citations paid within 15 business days after the issuance of the citation are reduced by 35% (after 1/1/99) unless issued as a

3 "Amount Reduced in Appeals and /or Settlements"

4 "Allowable Adjustments Due to Change of Ownership, Bankruptcy, Facility Closure."
#
#

5 "In Litigation" indicates citations in appeal (Citation Review Conference, Administrative Law Judge, Binding Arbitration, Superior Court) or

6 "Collection in Process" (Includes Medi-Cal offset, payment notices, settlement money pending, etc.)

7 "Pending Resolution" (Captures citations issued to State owned/operated facilities in which collection procedure is under review).

Calendar Year 2002

QUARTERLY CITATION REPORT
CALENDAR YEAR 2002
1ST QUARTER 2005

LICENSING AND CERTIFICATION Centralized Citation Collection Unit	footnote	ALL LONG-TERM CARE FACILITIES # of Citations	AMOUNT ASSESSED Subtotal	Total	%	# of Citations	NURSING FACILITIES (SNF/NF-ICF) # of Citations	AMOUNT ASSESSED Subtotal	Total	%	# of Citations	DEVELOPMENTALLY DISABLED & CLHF # of Citations	AMOUNT ASSESSED Subtotal	Total	%	# of Citations
I TOTAL AMOUNT ASSESSED				**$4,375,588**	**100%**	**916**			**$3,906,938**	**100%**	**732**			**$468,650**	**100%**	**184**
II ALLOWABLE ADJUSTMENTS	1			**$1,557,282**	**36%**	**655**			**$1,424,210**	**36%**	**517**			**$133,072**	**28%**	**138**
A. Reduction Amount for Citations Paid at 65% Discount Rate (in lieu of appeal)	2	489	$492,292		32%		364	$398,020		28%		125	$94,272		71%	
B. Amount Reduced in Appeal/or Settlements	3	152	$1,032,915		66%		140	$994,215		70%		12	$38,700		28%	
C. Allowable Adjustments Due to Change of Ownership(CHOW), Bankruptcy, Facility Closure	4	14	$32,075		2%		13	$31,975		2%		1	$100		1%	
III AMOUNT COLLECTED TO-DATE				**$2,521,856**	**58%**	**206**			**$2,188,278**	**56%**	**162**			**$333,578**	**71%**	**44**
IV TOTAL AMOUNT PENDING RESOLUTION				**$296,450**	**6%**	**55**			**$294,450**	**8%**	**53**			**$2,000**	**1%**	**2**
A. In Litigation	5	55	$296,450		100%		53	$294,450		100%		2	$2,000		100%	
B. Collection in Process	6	0	$0		0%		0	$0		0%		0	$0		0%	
C. Pending Resolution	7	0	$0		0%		0	$0		0%		0	$0		0%	

Report run date: April 2005 - ACL649

See Graphs I, II, III for LTCF's.

Footnotes:

1 "Allowable Adjustments" are divided into "A", "B","C".

2 "Reduction Amount for Citations Paid @ 65% Discount Rate": per H & S Code Section 1428.1, citations paid within 15 days are reduced by 35% (after 1/1/99).

3 "Amount Reduced in Appeals and /or Settlements"

4 5 SNFs Uncollectable facility closure in the amount of $28,100
4 SNFs Uncollectable bankruptcy in the amount of $2,925
4 SNFs Uncollectable Continuing Penalty in the amount of $950
1 DDH Uncollectable Continuing Penalty in the amount of $100

5 "In Litigation" indicates citations in appeal (Citation Review Conference, Administrative Law Judge, Binding Arbitration, Court) or Bankruptcy court.

6 "Collection in Process" (Includes Medi-Cal offset, payment notices, settlement money pending, etc.)

7 "Pending Resolution" (Captures citations issued to State owned/operated facilities in which collection procedure is under review).

Calendar Year 2005

QUARTERLY CITATION REPORT
CALENDAR YEAR 2005
1ST QUARTER 2005

LICENSING AND CERTIFICATION Centralized Citation Collection Unit	footnote	ALL LONG-TERM CARE FACILITIES					NURSING FACILITIES (SNF/NF-ICF)					DEVELOPMENTALLY DISABLED & CLHF				
		# of Citations	AMOUNT ASSESSED Subtotal	Total	%	# of Citations	# of Citations	AMOUNT ASSESSED Subtotal	Total	%	# of Citations	# of Citations	AMOUNT ASSESSED Subtotal	Total	%	# of Citations
I TOTAL AMOUNT ASSESSED				$727,050	100%	130			$640,800	100%	88			$86,250	100%	42
II ALLOWABLE ADJUSTMENTS	1			$51,222	7%	63			$42,612	7%	40			$8,610	10%	23
A. Reduction Amount for Citations Paid at 65% Discount Rate (in lieu of appeal)	2	23	$8,610		17%		0	$0		0%		23	$8,610		100%	
B. Amount Reduced in Appeal/or Settlements	3	40	$42,612		83%		40	$42,612		100%		0	$0		0%	
C. Allowable Adjustments Due to Change of Ownership(CHOW), Bankruptcy, Facility Closure	4	0	$0		0%		0	$0		0%		0	$0		0%	
III AMOUNT COLLECTED TO-DATE				$100,328	14%	6			$83,488	13%	4			$16,840	20%	2
IV TOTAL AMOUNT PENDING RESOLUTION				$575,500	79%	61			$514,700	80%	44			$60,800	70%	17
A. In Litigation	5	33	$487,000		85%		28	$448,100		87%		5	$38,900		64%	
B. Collection in Process	6	28	$88,500		15%		16	$66,600		13%		12	$21,900		36%	
C. Pending Resolution	7	0	$0		0%		0	$0		0%		0	$0		0%	

Report run date: April 2005 - ACL649

See Graphs I, II, III for LTCF's.

Footnotes:

1 "Allowable Adjustments" are divided into "A", "B","C".

2 "Reduction Amount for Citations Paid @ 65% Discount Rate": per H & S Code Section 1428.1, citations paid within 15 days are reduced by 35% (after 1/1/99).

3 "Amount Reduced in Appeals and /or Settlements".

4 None

5 "In Litigation" indicates citations in appeal (Citation Review Conference, Administrative Law Judge, Binding Arbitration, Court) or Bankruptcy court.

6 "Collection in Process" (Includes Medi-Cal offset, payment notices, settlement money pending, etc.)

7 "Pending Resolution" (Captures citations issued to State owned/operated facilities in which collection procedure is under review).

4-Year Summary

QUARTERLY CITATION COLLECTION REPORT

CALENDAR YEARS 2005, 2004, 2003, 2002

1ST QUARTER 2005

LONG-TERM CARE FACILITIES

		Calendar Year 2005				Calendar Year 2004				Calendar Year 2003				Calendar Year 2002			
		#of Citations	Total Amount Assessed	% of $ Assessed	# of Citations	#of Citations	Total Amount Assessed	% of $ Assessed	# of Citations	#of Citations	Total Amount Assessed	% of $ Assessed	# of Citations	#of Citations	Total Amount Assessed	% of $ Assessed	# of Citations
I	TOTAL AMOUNT ASSESSED		$727,050	100%	130		$2,738,900	100%	588		$4,039,100	100%	908		$4,375,588	100%	916
	footnote																
II	ALLOWABLE ADJUSTMENTS 1		$51,222	7%	63		$456,367	17%	410		$1,379,530	34%	617		$1,557,282	36%	655
	A. Reduction Amount for Citations Paid at 35% discount Rate (In Lieu of Appeal)..... 2	23	$8,610	17%		389	$331,099	73%		416	$398,721	29%		489	$492,292	32%	
	B. Amount Reduced in Appeal/or Settlements 3	40	$42,612	83%		14	$112,168	25%		187	$939,521	68%		152	$1,032,915	66%	
	C. Allowable Adjustments Due to Change of Ownership (CHOW), Bankruptcy , Facility Closure,... 4	0	$0	0%		7	$13,100	2%		14	$41,288	3%		14	$32,075	2%	
III	AMOUNT COLLECTED TO-DATE		$100,328	14%	6		$801,883	29%	0		$1,809,720	45%	138		$2,521,856	58%	206
IV	TOTAL AMOUNT PENDING RESOLUTION		$575,500	79%	61		$1,480,650	54%	178		$849,850	21%	153		$296,450	6%	55
	A. In Litigation..... 5	33	$487,000	85%		168	$1,407,950	95%		151	$845,050	99%		55	$296,450	100%	
	B. Collection in Process..... 6	28	$88,500	15%		10	$72,700	5%		2	$4,800	1%		0	$0	0%	
	C. Pending Resolution..... 7	0	$0	0%		0	$0	0%		0	$0	0%		0	$0	0%	

See Graphs I, II, III for LTCF's.

LICENSING AND CERTIFICATION, Federal Grant, Budgets and Accounting Unit

Footnotes:

1 "Allowable Adjustments" are divided into "A", "B","C"

2 "Reduction Amount for Citations Paid @ 65% Discount Rate": per H & S Code Section 1428.1(a), citations paid within 15 days are reduced by 35% if violation occurred after 1/1/1999.

3 "Amount Reduced in Appeals and /or Settlements".

4 Uncollectable due to Change of Ownership, Bankruptcy (discharged), Closure.

5 "In Litigation" indicates citations in appeal (Citation Review Conference, Administrative Law Judge, Binding Arbitration, Court) or Bankrupcty Court.

6 "Collection in Process" (Includes Medi-Cal Offset pending, payment demands pending response, settlement money pending, etc.).

7 "Pending Resolution" (Captures citations issued to State owned/operated facilities in which collection procedure is under review).

Nursing Home Conditions in Los Angeles County: Many Homes Fail to Meet Federal Standards for Adequate Care

---

Prepared for Rep. Henry A. Waxman

Minority Staff
Special Investigations Division
Committee on Government Reform
U.S. House of Representatives

February 4, 2003

Distributed by the National Citizens' Coalition for Nursing Home Reform
1424 16th Street, NW, Suite 202, Washington, DC 20036
Ph: (202) 332-2275 – Fax: (202) 332-2949 – e-mail: nccnhr@nccnhr.org

Table of Contents

EXECUTIVE SUMMARY

Many families are becoming increasingly concerned about the conditions in nursing homes. Federal law requires that nursing homes "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." But recent studies by the U.S. General Accounting Office and others have indicated that many nursing homes fail to meet federal health standards.

To address these growing concerns, Rep. Henry A. Waxman asked the Special Investigations Division of the minority staff of the Committee on Government Reform to investigate nursing home conditions in Los Angeles County. There are 419 nursing homes in Los Angeles County that accept residents covered by Medicaid or Medicare. These homes serve over 34,000 residents. This congressional report is a follow-up to a report on nursing home conditions that Rep. Waxman released in November 1999. The earlier report found that almost all nursing homes in Los Angeles County failed to meet federal health standards.

This report finds that there continue to be serious deficiencies in many of the nursing homes in Los Angeles County. A total of 382 of the 419 nursing homes (91%) in the county violated federal standards during recent state inspections. Moreover, 14 of the nursing homes had violations that caused actual harm to residents or worse.

A. Methodology

Under federal law, the U.S. Department of Health and Human Services contracts with the states to conduct annual inspections of nursing homes and to investigate nursing home complaints. These inspections assess whether nursing homes are meeting federal standards of care, such as preventing residents from developing pressure sores (commonly known as bed sores), providing sanitary living conditions, and protecting residents from accidents.

This report is based on an analysis of these state inspections. It examines the most recent annual inspections of nursing homes in Los Angeles County, which were conducted between April 2001 and October 2002. In addition, the report examines the results of any complaint investigations conducted during this time period.

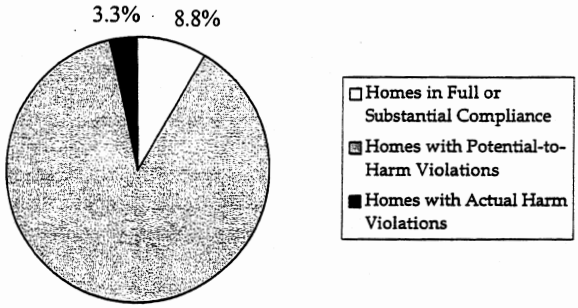
Because this report is based on recent state inspections, the results are representative of current nursing home conditions in the region as a whole. However, conditions in individual homes can change. New management or enforcement activities can bring rapid improvement; other changes can lead to sudden deterioration. For this reason, the report should be considered a representative "snapshot" of overall conditions in nursing homes in Los Angeles County, not an analysis of current conditions in any specific home. At any individual nursing home, conditions could be better – or worse – today than when the most recent inspection was conducted.

B. Findings

The vast majority of nursing homes in Los Angeles violated federal standards governing quality of care. State inspectors consider a nursing home to be in full compliance with federal health standards if no violations are detected during the annual inspection or a complaint investigation. They consider a nursing home to be in "substantial compliance" with federal standards if the violations at the facility do not have the potential to cause more than minimal harm. Of the 419 nursing homes in Los Angeles County, only 17 facilities were found to be in full compliance with the federal standards; another 20 facilities were in substantial compliance. The other 91% of nursing homes – 382 facilities – were cited for violations that had the potential to cause more than minimal harm to residents or worse. On average, each of these 382 noncompliant nursing homes had almost 11 violations of federal quality of care requirements.

Some nursing homes in Los Angeles County had violations that caused actual harm to residents. Fourteen facilities in Los Angeles County had a violation that caused actual harm to nursing home residents or placed residents at risk of death or serious injury (see Figure 1). These 14 nursing homes with actual harm violations or worse serve 1,185 residents and are estimated to receive over $16 million each year in federal and state funds.

Figure 1: Compliance Status of Nursing Homes in Los Angeles County



Most nursing homes in Los Angeles County did not provide adequate staffing. During recent annual inspections, most nursing homes in Los Angeles County – 320 of 419 facilities (76%) – did not meet the minimum staffing levels identified by HHS in a recent report to Congress. Moreover, 20% of the nursing homes did not meet even the more lenient nurse staffing standards required under California law. Nursing homes that met the HHS minimum staffing levels were over twice as likely to be in full or substantial compliance with federal health standards when compared with nursing homes that did not meet the HHS minimum.

I. GROWING CONCERNS ABOUT NURSING HOME CONDITIONS

Increasingly, Americans are facing difficult decisions about nursing homes. The decision to move a loved one into a nursing home raises very real questions about how the resident will be treated at the nursing home. Will the resident receive proper food and medical treatment? Will the resident be assisted by staff with basic daily activities, such as bathing and dressing? Will the resident be able to live out his or her life with dignity and compassion? These are all legitimate concerns – and they are becoming more common as America ages.

In 1966, there were 19 million Americans 65 years of age and older.[1] That figure has now risen to 35 million Americans, 12.4% of the population.[2] By 2030, the number of Americans aged 65 and older is expected to increase to 70.3 million, 20% of the population.[3]

This aging population will increase demands for long-term care. In 2000, there were 1.5 million people living in more than 17,000 nursing homes in the United States.[4] The Department of Health and Human Services (HHS) has estimated that 43% of all 65 year olds will use a nursing home at some point during their lives. Of those who do need the services of a nursing home, more than half will require stays of over one year, and over 20% will be in a nursing home for more than five years.[5] By 2050, the total number of nursing home residents is expected to quadruple from the current 1.5 million to 6.6 million.[6]

Most nursing homes are run by private, for-profit companies. Of the 17,023 nursing homes in the United States in 2000, over 11,000 (65%) were operated by for-profit companies.[7] During the 1990s, the nursing home industry witnessed a trend toward consolidation as large

---

[1]Centers for Medicare & Medicaid Services (CMS), *Medicare Enrollment: National Trends, 1966 - 2001* (available at http://cms.hhs.gov/statistics/enrollment/natltrends/hi_smi.asp).

[2]U.S. Census Bureau, *Profiles of General Demographic Characteristics: 2000 Census of Population and Housing, United States* (May 2001).

[3]U.S. Census Bureau, *Projections of the Total Resident Population by 5-Year Age Groups, and Sex with Special Age Categories: Middle Series, 2025 to 2045* (December 1999).

[4]American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook*, vii (2001).

[5]Health Care Financing Administration, Report to Congress, *Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System*, §1.1 (July 21, 1998).

[6]*Facts and Trends*, *supra* note 4, at vii.

[7]*Id.* at viii.

national chains bought up smaller chains and independent homes. As of December 2001, the six largest nursing home chains in the United States operated 2,040 facilities with over 243,000 beds.[8]

Through the Medicaid and Medicare programs, the federal government is the largest payer of nursing home care. Under the Medicaid program, a federal-state health care program for the needy, all nursing home and related expenses are covered for qualified individuals. Under the Medicare program, a federal program for the elderly and certain disabled persons, skilled nursing services are partially covered for up to 100 days. In 2003, it is projected that federal, state, and local governments will spend $67.9 billion on nursing home care, of which $53.8 billion will come from Medicaid payments ($34.3 billion from the federal government and $19.5 billion from state governments) and $11.5 billion from federal Medicare payments. Private expenditures for nursing home care are estimated to be $39.2 billion ($26.9 billion from residents and their families, $8 billion from private insurance policies, and $4.3 billion from other private funds).[9] The overwhelming majority of nursing homes in the United States receive funding through either the Medicaid program or the Medicare program, or both.

Under federal law, nursing homes that receive Medicaid or Medicare funds must meet federal standards of care. Prior to 1987, these standards were relatively weak: they focused on a facility's ability to provide adequate care, rather than on the level of care actually provided. In 1986, a landmark report by the Institute of Medicine found widespread abuses in nursing homes.[10] This report, coupled with national concern over substandard conditions, led Congress to pass comprehensive legislation in 1987 establishing new standards for nursing homes. This law requires nursing homes to "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[11]

Implementing regulations were promulgated by HHS in 1990 and 1995. The 1987 law

---

[8]Aventis Pharmaceuticals, *Managed Care Digest Series 2002* (available at http://www.managedcaredigest.com/edigests/inst2002/inst2002.shtml).

[9]All cost projections come from: CMS, *Nursing Home Care Expenditures Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1980 - 2011* (available at http://cms.hhs.gov/statistics/nhe/projections-2001/t14.asp).

[10]Committee on Nursing Home Regulation, Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (1986). The IOM report concluded: "[I]ndividuals who are admitted receive very inadequate – sometimes shockingly deficient – care that is likely to hasten the deterioration of their physical, mental, and emotional health. They are also likely to have their rights ignored or violated, and may even be subject to physical abuse." *Id.* at 2-3.

[11]42 U.S.C. §1396r(b)(2).

and the implementing regulations limit the use of physical and chemical restraints on nursing home residents. They require nursing homes to prevent pressure sores, which are painful wounds or bruises, caused by pressure or friction, that can become infected. They also establish other health standards for nursing homes, such as requiring that residents are properly cleaned and bathed, receive appropriate medical care, and are supervised to prevent falls and accidents. The regulatory requirements are codified at 42 C.F.R. Part 483.

Recently, investigators have begun to examine whether nursing homes are meeting the requirements of the 1987 law and its implementing regulations. The results have not been encouraging. Certain abusive practices documented by the Institute of Medicine in 1986, such as the improper use of physical restraints and antipsychotic drugs, have been reduced.[12] But health violations appear to be widespread. In a series of 1999 reports, the U.S. General Accounting Office (GAO), an investigative arm of Congress, found that "more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury";[13] that these incidents of actual harm "represented serious care issues . . . such as pressure sores, broken bones, severe weight loss, and death";[14] and that "[s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months."[15]

Other researchers have reached similar conclusions. In July 1998, Professor Charlene Harrington of the University of California-San Francisco, a leading nursing home expert, found that the current level of nursing home staffing is "completely inadequate to provide care and supervision."[16] In March 1999, the inspector general of HHS found an increasing number of serious deficiencies relating to the quality of resident care.[17] And in March 2002, HHS released a

---

[12]The percent of residents in physical restraints dropped from 38% in 1987 to 15% in 1998; the percent of residents being administered anti-psychotic drugs dropped from 33% to 16% during the same time period. Testimony of Michael Hash, Deputy Administrator of HCFA, before the Senate Special Committee on Aging (July 28, 1998).

[13]GAO, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, 3 (March 1999).

[14]GAO, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, 2 (June 1999).

[15]GAO, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, 2 (March 1999).

[16]Testimony of Charlene Harrington before the Senate Special Committee on Aging (July 28, 1998).

[17]HHS Office of Inspector General, *Nursing Home Survey and Certification: Deficiency Trends* (March 1999).

study that found that over 90% of nursing homes have staffing levels that are too low to provide adequate care.[18]

In light of the growing concern about nursing home conditions, Rep. Henry A. Waxman asked the Special Investigations Division of the minority staff of the Government Reform Committee to investigate the prevalence of health violations in nursing homes in Los Angeles County. Rep. Waxman represents the 30th Congressional District of California, which includes a portion of Los Angeles County. This report is a follow-up to a report on nursing home conditions that Rep. Waxman released in November 1999.

II. METHODOLOGY

To assess the compliance records and staffing levels in Los Angeles County nursing homes, this report analyzed three sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of nursing home inspections; and (2) the nursing home complaint database maintained by HHS, which contains the results of state complaint investigations.

A. Determination of Compliance Status

Data on the compliance status of nursing homes in Los Angeles County comes from the OSCAR database and the complaint database. These databases are compiled by the Centers for Medicare and Medicaid Services (CMS), a division of HHS.[19] CMS contracts with states to conduct annual inspections of nursing homes and to respond to nursing home complaints. During these inspections and investigations, the inspection team interviews a sample of residents, staff members, and family members. The inspection team also reviews a sample of clinical records. Violations of federal standards observed by the inspectors are cited by the inspection team, reported by the states to CMS, and compiled in the OSCAR and complaint databases.[20]

The OSCAR and complaint databases use a ranking system in order to identify the

---

[18]HHS Report to Congress, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report*, 1-6 (Winter 2001).

[19]Prior to 2001, CMS was known as the Health Care Financing Administration (HCFA).

[20]In addition to tracking the violations at each home, the OSCAR database compiles the following information about each home: the number of residents and beds; the type of ownership (*e.g.*, for-profit or nonprofit); whether the home accepts residents on Medicare and/or Medicaid; and the characteristics of the resident population (*e.g.*, number of incontinent residents, number of residents in restraints). To provide public access to this information, CMS maintains a website (http://www.medicare.gov/nhcompare/home.asp) where the public can obtain data about individual nursing homes.

violations that pose the greatest risk to residents. The rankings are based on the severity (degree of actual harm to residents) and the scope (the number of residents affected) of the violation. As shown in Table 1, each violation is given a letter rank, A to L, with A being the least serious (an isolated violation that poses minimal risks to residents) and L being the most serious (a widespread violation that causes or has the potential to cause death or serious injury). Homes with violations in categories A, B, or C are considered to be in "substantial compliance" with the law. Homes with violations in categories D, E, or F have the potential to cause "more than minimal harm" to residents. Homes with violations in categories G, H, or I are causing "actual harm" to residents. And homes with violations in categories J, K, or L are causing (or have the potential to cause) death or serious injury to residents.

Table 1: CMS's Scope and Severity Grid for Nursing Home Violations

Severity of Deficiency	Scope of Deficiency		
	Isolated	*Pattern of Harm*	*Widespread Harm*
Potential for Minimal Harm	A	B	C
Potential for More Than Minimal Harm	D	E	F
Actual Harm	G	H	I
Actual or Potential for Death/Serious Injury	J	K	L

To assess the compliance status of nursing homes in Los Angeles County, this report analyzed the OSCAR database to determine the results of the most recent annual inspections of each nursing home in the region. These inspections were conducted between April 2001 and October 2002. In addition, the report analyzed the complaint database to determine the results of any nursing home complaint investigations that were conducted during this same time period.

B. Determination of Staffing Levels

Data on the staffing levels in nursing homes in Los Angeles County also comes from the OSCAR database. During the annual inspections, the nursing homes provide the state inspectors with data on their staffing levels for the two weeks prior to the inspections. This information on staffing levels is then reported by the states to CMS and entered into the OSCAR database.[21]

---

[21] According to some experts, this data may overestimate the number of staff involved in resident care. Researchers have suggested that nursing homes may increase their staff during the period around the survey, meaning that reported staffing levels would be higher than the staffing levels found at the nursing homes during most periods of the year. Charlene Harrington, et al., *Nursing Home Staffing and Its Relationship to Deficiencies*, 17 (August 1999). HHS research also suggests that the OSCAR data may overestimate actual staffing levels in some instances. HHS compared the staffing data in the OSCAR database with the staffing data contained in "Medicare Cost Reports," which are audited cost statements that are prepared by nursing homes in order to receive Medicare payments. Although the HHS analysis found that in the aggregate average staffing levels in the OSCAR database and in the Medicare Cost Reports were similar,

The staffing data used in this report is the data gathered during the most recent annual inspections of nursing homes in Los Angeles County. These inspections were conducted between April 2001 and October 2002. The report compared these staffing levels to the minimum staffing level required under California law and the recommended staffing minimum identified by HHS.[22]

C. Interpretation of Results

The results presented in this report are representative of current conditions in nursing homes in Los Angeles County. In the case of any individual home, however, current conditions may differ from those documented in the most recent inspection report, especially if the report is more than a few months old. Nursing home conditions can change over time. New management or enforcement activities can rapidly improve conditions; other changes can lead to sudden deterioration. According to GAO, many nursing homes with serious deficiencies exhibit a "yo-yo pattern" of noncompliance and compliance: after a home is cited for deficiencies, it briefly comes into compliance to avoid fines or other sanctions, only to slip into noncompliance after the threat of sanctions is removed.[23]

For this reason, this report should be considered a representative "snapshot" of nursing home conditions in Los Angeles County. It is not intended to be – and should not be interpreted as – an analysis of current conditions in any individual nursing home.

The report also should not be used to compare violation rates in Los Angeles County nursing homes with violation rates in other states. Data regarding violation rates comes from state inspections that can vary considerably from state to state in their thoroughness and ability to detect violations. According to GAO, "[c]onsiderable inter-state variation still exists in the citation of serious deficiencies."[24]

---

the analysis also found that for homes with lower staffing levels, the staffing levels reported in the OSCAR database were higher than the staffing levels reported in the Medicare Cost Reports. This indicates that for homes with lower staffing levels, the OSCAR database could overestimate actual staffing levels. *See* HHS, *Report to Congress: Appropriateness of Minimum Nursing Staffing Ratios in Nursing Homes*, 8-7–8-8 (Spring 2000).

[22]HHS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report*, 1-6 (December 2001) (hereinafter "*Phase II Final Report*").

[23]GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 13, at 12-14.

[24]GAO, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, 16 (September 2000).

III. NURSING HOME CONDITIONS IN LOS ANGELES COUNTY

There are 419 nursing homes in Los Angeles County that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 42,288 beds that were occupied by 34,342 residents during the most recent round of annual inspections. The majority of these residents, 23,743, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 3,228 residents. A total of 340 – or 81% – of the nursing homes in Los Angeles County are private, for-profit nursing homes.

The results of this investigation indicate that the conditions in these nursing homes often fall substantially below federal standards. Many residents are not receiving the care that their families expect and that federal law requires.

A. Prevalence of Violations

Only 17 nursing homes in Los Angeles County were found by the state inspectors to be in full compliance with federal health requirements; another 20 facilities were found to be in substantial compliance. The other 382 nursing homes (91%) had at least one violation that had the potential to cause more than minimal harm to their residents. Fourteen of these facilities had violations that caused actual harm to residents or worse, including one nursing home that was cited for violations that had the potential to cause death or serious injury. Table 2 summarizes these results.

Table 2: Nursing Homes in Los Angeles County Had Numerous Violations that Placed Residents at Risk

Most Severe Violation Cited by Inspectors	Number of Homes	Percent of Homes	Number of Residents
Complete Compliance (No Violations)	17	4%	1,498
Substantial Compliance (Risk of Minimal Harm)	20	5%	1,088
Potential for More than Minimal Harm	368	88%	30,571
Actual Harm to Residents	13	3%	1,113
Actual or Potential Death/Serious Injury	1	2%	72

A total of 40 nursing homes were cited for 20 or more violations, 16 nursing homes were cited for 25 or more violations, and 6 nursing homes were cited for 30 or more violations. State inspectors found a total of 4,150 violations in the 382 facilities that were not in full or substantial compliance with federal requirements – an average of almost 11 violations per noncompliant home.

B. Prevalence of Violations Causing Actual Harm to Residents

According to GAO, some of the greatest safety concerns are posed by nursing homes with violations that cause actual harm to residents or have the potential to cause death or serious

injury. These are homes with violations ranked at the G-level or above. As shown in Table 2, 14 nursing homes in Los Angeles had violations that caused actual harm or worse; one facility was cited for violations that had the potential to cause death or serious injury. These 14 facilities serve 1,185 residents and are estimated to receive over $16 million in federal and state funds each year.

C. Potential for Underreporting of Violations

The report's analysis of the prevalence of nursing home violations was based in large part on the data reported to CMS in the OSCAR database. According to GAO, even though this database is "generally recognize[d] . . . as reliable," it may "understate the extent of deficiencies."[25] One problem, according to GAO, is that "homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations."[26] A second problem is that state inspectors often miss significant violations. A recent GAO report found that when federal inspectors inspect nursing homes after state inspectors, the federal inspectors find more serious care problems than the state inspectors in 70% of the nursing homes. The federal inspectors also find many more violations of federal health standards.[27] Consequently, the prevalence of violations causing potential or actual harm may be higher than what is reported in this study.

IV. NURSING HOME STAFFING IN LOS ANGELES COUNTY

A. Minimum Staffing Levels

Nursing homes cannot provide a high level of care unless they have enough well-trained staff to care for their residents. However, the staffing requirements under the 1987 federal nursing home law are minimal. In general, the law allows each nursing home to decide for itself how many hours of nursing care to provide to residents each day.

The 1987 federal law recognizes three types of nursing staff: registered nurses; licensed nurses; and nursing assistants. Different standards apply for each type of nursing staff:

- Registered nurses, who are often in a supervisory position, are nurses who have gone

---

[25]GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 13, at 30.

[26]GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, 4 (July 1998).

[27]*Nursing Homes: Sustained Efforts Are Essential*, *supra* note 24, at 43.

through two to four years of nursing education.[28] Under the 1987 law, all nursing homes must have a registered nurse on duty for at least eight hours per day.[29] This standard applies regardless of the size of the nursing home or the number of residents. The law does not specify a minimum registered nurse-to-resident ratio.

- Licensed professional nurses provide a level of care between the nursing assistant and the registered nurse. Licensed nurses generally undergo a 12 to 18 month period of training in basic bedside nursing in order to provide care under the supervision of a registered nurse.[30] Under the 1987 law, nursing homes must have a licensed nurse on duty 24 hours a day.[31] Again, this standard applies regardless of the size of the nursing home or the number of residents and does not specify a minimum licensed nurse-to-resident ratio.

- Nursing assistants provide the majority of care in most facilities. Federal law requires that nursing assistants receive a minimal amount of special training.[32] The law does not, however, contain any requirements regarding the level of staffing by nursing assistants. Rather, each nursing home is permitted to determine for itself how many hours of nursing assistant care it will provide residents each day.

There is a widespread consensus among nursing home experts that current federal staffing requirements need to be improved. To assess the need for new staffing standards, HHS released the final results of a ten-year study, entitled *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, in April 2002.[33] In order to determine whether minimum nursing home staffing ratios could be identified, researchers analyzed detailed staffing and resident data from over 5,000 nursing homes. The analysis examined the ratio of nursing assistants, licensed nurses, and registered nurses to nursing home residents, and assessed whether staffing ratios affected resident outcomes, such as the risk of hospitalization or the risk of developing pressure sores.

The report found there are minimum staffing levels below which nursing homes are at

---

[28]Institute of Medicine, *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?*, 69, 74-75 (1996) (hereinafter "IOM Report").

[29]42 U.S.C. § 1396r(b)(4)(c)(i).

[30]IOM Report, *supra* note 28, at 76.

[31]42 U.S.C. § 1396r(b)(4)(c)(i).

[32]The 1987 federal nursing home law requires that nursing assistants receive 75 hours of training and testing for competency within four months of employment. Nursing assistants must also receive 12 hours of additional training annually. IOM Report, *supra* note 28, at 157.

[33]*Phase II Final Report*, *supra* note 22.

substantially greater risk for quality of care problems. The report found that facilities that fell below these standards were significantly more likely to have high numbers of residents with problems such as urinary tract infections, respiratory infections, pressure sores, and unexpected weight loss.

Based on these findings, the HHS report identified minimum staffing levels necessary to provide adequate care for residents. For nursing homes that predominantly housed residents with long-term stays of 90 days or more, the staffing levels identified by HHS would require that each resident receive at least 4.1 hours of individual care per day, including at least 2.8 hours of individual care by nursing assistants and 1.3 hours of individual care by registered or licensed nurses, with at least 0.75 hours of care by registered nurses.[34] According to the HHS report, nursing homes that fail to meet these staffing levels for short- and long-term residents can have "markedly increased quality problems."[35]

In addition, California has a state law regulating nursing home staffing. The law, which took effect on January 1, 2000, requires that all residents in California nursing homes receive a minimum of 3.2 hours of care each day from a registered nurse, licensed vocational nurse, or certified nurse assistant.[36] This minimum staffing level is supposed to increase to 3.5 hours by 2004.[37]

B. Most Nursing Homes Failed to Meet the HHS Staffing Levels

The minimum staffing levels identified by HHS recommend that each nursing home resident receive a minimum of 4.1 hours of daily nursing care. In total, 320 of the 419 nursing homes (76%) failed to provide the recommended 4.1 hours of care to residents each day (see Figure 2). These nursing homes provide care for over 29,000 residents.

The HHS recommended staffing levels require a minimum of 2.8 hours of individual care each day by nursing assistants. In Los Angeles County, 343 of the 419 nursing homes (82%) failed to meet the recommended standard for nursing assistants.

---

[34] *Id.* at 1-6. The HHS report also identified minimum staffing levels for a nursing home with a mix of residents that are predominantly in the facility for short-term stays. The HHS report found that these nursing homes must have sufficient staff to provide each short-term resident at least 3.55 hours of individual care per day, including at least 1.15 hours of individual care by registered or licensed nurses, and at least 0.55 hours of care by registered nurses, in order to meet the minimum staffing level. *Id.*

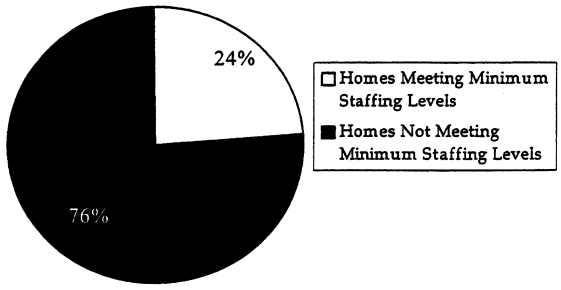
[35] *Id.* at 2-22.

[36] Cal. Welf. & Inst. Code §14110.7.

[37] Cal. Health & Safety Code §1276.7(b).

The HHS recommended staffing levels require a minimum of 1.3 hours of individual care each day by registered or licensed nurses. In Los Angeles County, 368 of the 419 nursing homes (88%) failed to meet the recommended standard for registered or licensed nurses.

Figure 2: 76% of Nursing Homes in Los Angles County Did Not Meet the HHS Minimum Staffing Levels



C. Many Nursing Homes Failed to Meet the California Staffing Requirement

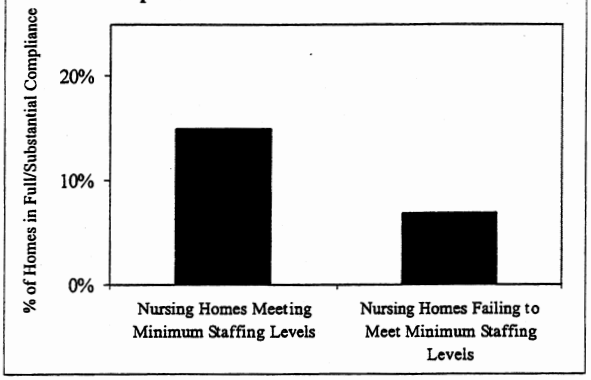
Under California law, all nursing homes in the state are required to provide a minimum of 3.2 hours of nursing care per day to each resident. However, 85 nursing homes in Los Angeles County (20%) failed to meet this state legal requirement. These facilities provide care for over 8,000 residents.

D. Inadequate Staffing Is Linked to Inadequate Care

There was a direct correlation between inadequate staffing and inadequate care. The nursing homes that did not meet the minimum staffing levels identified by HHS were more likely to be cited for violations of federal health standards than nursing homes that met the minimum staffing levels.

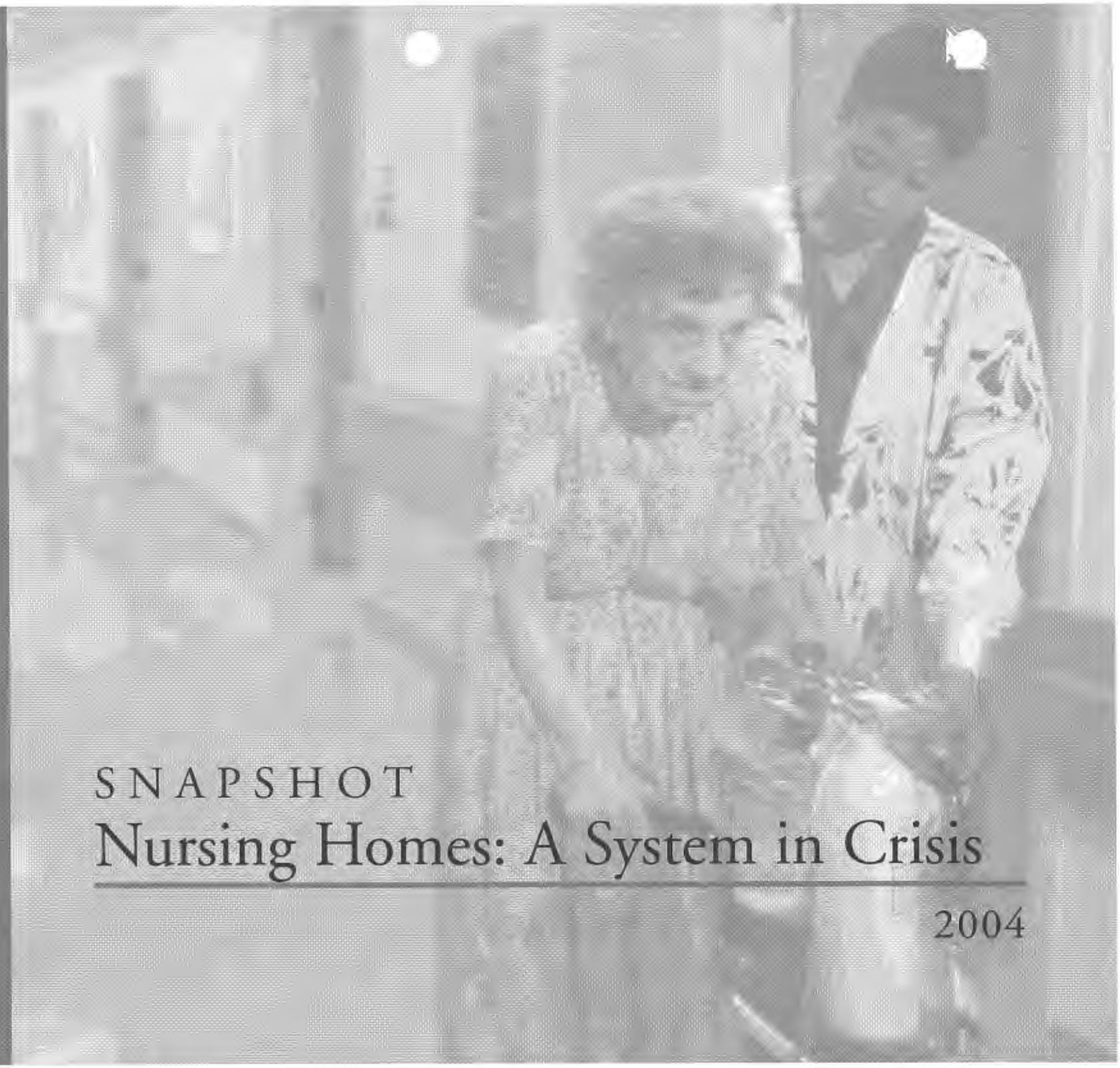
There are 99 nursing homes in Los Angeles County that met the minimum staffing levels identified by HHS. Fifteen of these facilities that met the minimum staffing levels (15%) were in full or substantial compliance with federal standards. In contrast, only 22 of the 320 facilities (6.9%) that failed to meet the HHS minimum staffing levels were in full or substantial compliance with federal standards. The nursing homes that satisfied the HHS minimum staffing level were over twice as likely to be in compliance with federal health standards than nursing homes that did not meet the HHS minimum (see Figure 3).

Figure 3: Nursing Homes That Meet HHS Staffing Levels Are More Likely to be in Compliance with Federal Health Standards



V. CONCLUSION

The 1987 nursing home law was intended to stop abuses in nursing homes by establishing stringent federal standards of care. Although the law and its implementing regulations require appropriate standards of care, compliance by the nursing homes in Los Angeles County has been poor. This report reviewed the OSCAR and complaint databases, as well as nurse staffing data. The same conclusion emerges from both analyses: many nursing homes in Los Angeles County are failing to provide the care that the law requires and that families expect.



California HealthCare Foundation

SNAPSHOT
Nursing Homes: A System in Crisis

2004

A Crisis in Care

The number of Californians age 65 and over is projected to double in the next decade. Many of the facilities slated to provide long-term care for these individuals already operate with deficits in staff and operating budgets. High staff turnover among poorly paid personnel contributes to poor quality of care.

Serious problems in California's nursing homes include:

- Only a small percentage meet the standards recommended for good nursing care.
- Many show clinical signs of poor care: high percentages of residents who lose weight, are left in bed all or most of the time, and are placed in physical restraints.
- Most do not meet government compliance standards for care and safety during routine inspections—and a number have had serious violations of both state and federal regulations.

With an ample number of beds available, however, Californians do have choices and can often find a bed in a facility that provides good quality care. This snapshot examines the current state of California's long-term care facilities* as they face growing demands and diminishing resources.

*Unless otherwise indicated, long-term care facilities refer to all hospital-based and freestanding institutions, including skilled nursing and intermediate care facilities.

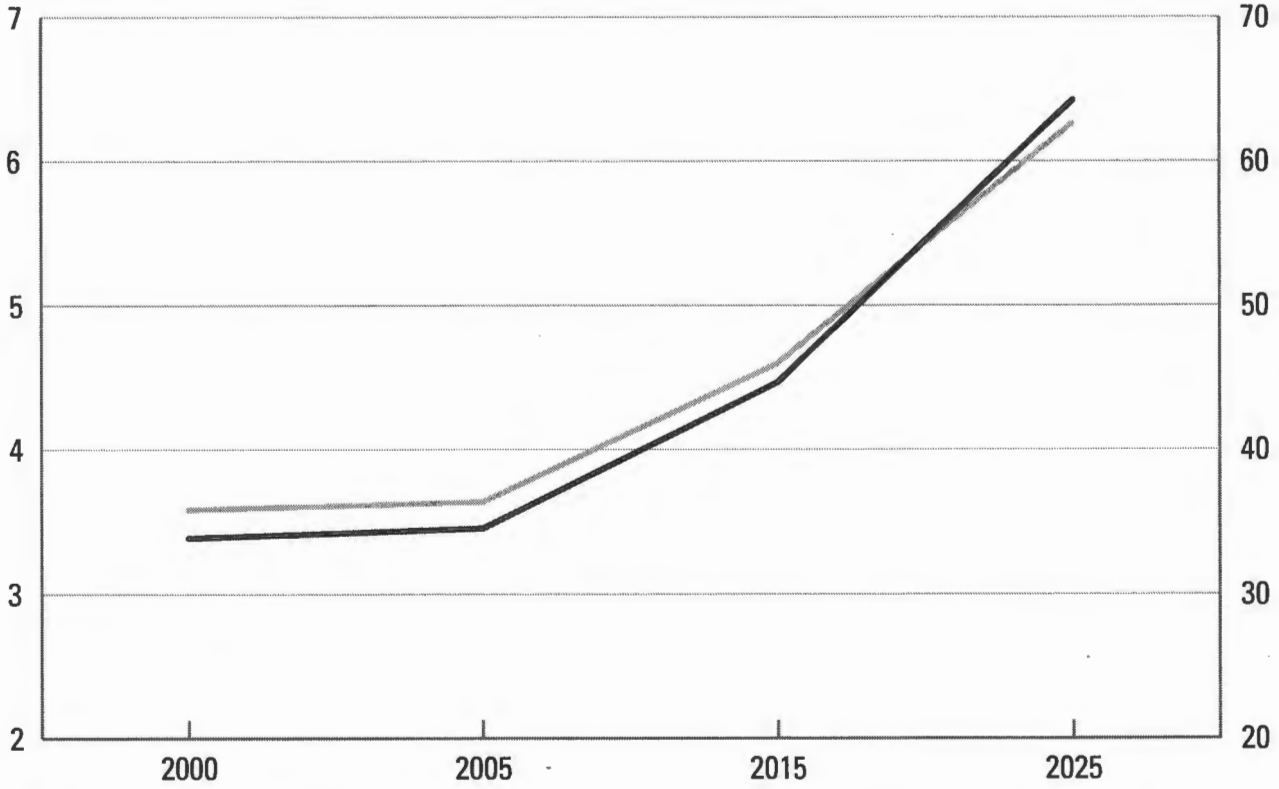
Nursing Homes:
A System in Crisis

CONTENTS

California's Population Is Aging

Californians
Age 65 and Older (millions)

U.S. Residents
Age 65 and Older (millions)



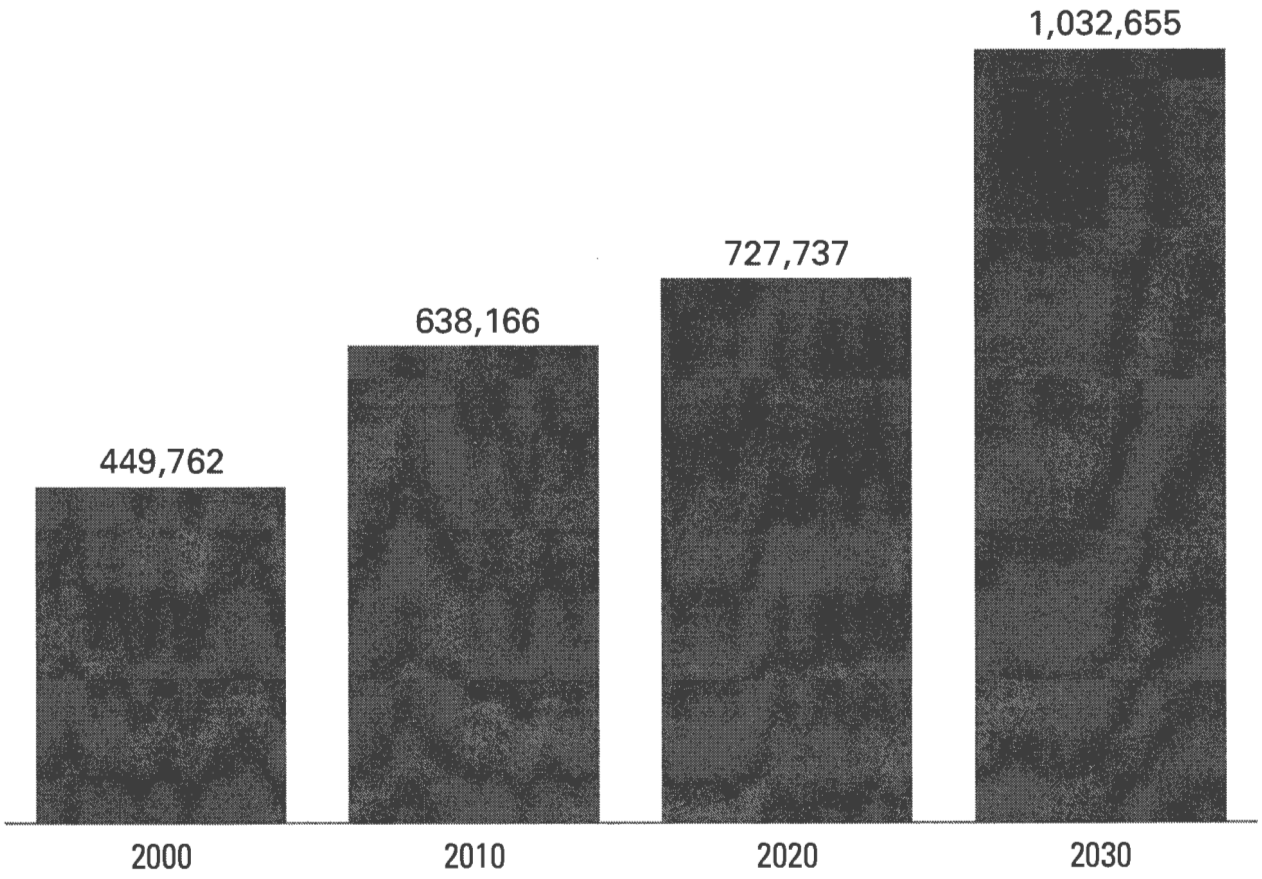
CA	3.387	3.454	4.465	6.424
U.S.	35.835	36.370	45.959	62.641

Source: U.S. Census Bureau, 2003: State Population Projections and Population Projections Program, Population Division.

As the population ages, the demand for long-term care services will increase. The number of California residents age 65 and over is projected to **nearly double** by 2025—a larger growth rate than any other state or the United States overall (75 percent).

More Frail Elderly, More Care Needed

Californians, Age 85 and Older

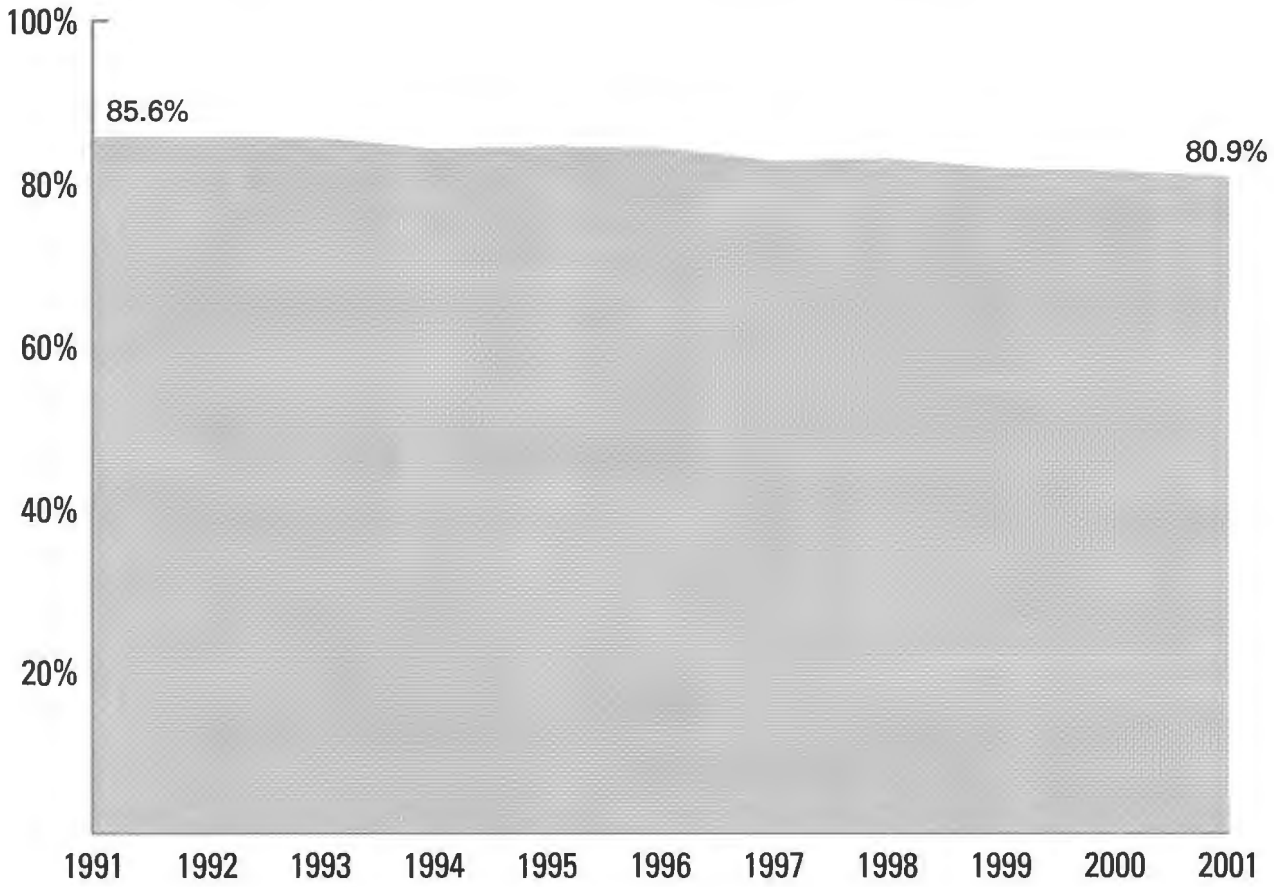


Source: California State Department of Finance, Demographic Research Unit. CDC Life Expectancy. www.cdc.gov/nchs/data/hus/tables/2003/03hus027.pdf

Americans are living longer. In 2001, the life expectancy was 77.2 years, compared to 75.5 just ten years earlier. The number of California residents age 85 and older—those who are most likely to need long-term care at home or in nursing homes—is likely to more than double by the year 2030, when the bulk of baby boomers will come of advanced age.

No Shortage of Space

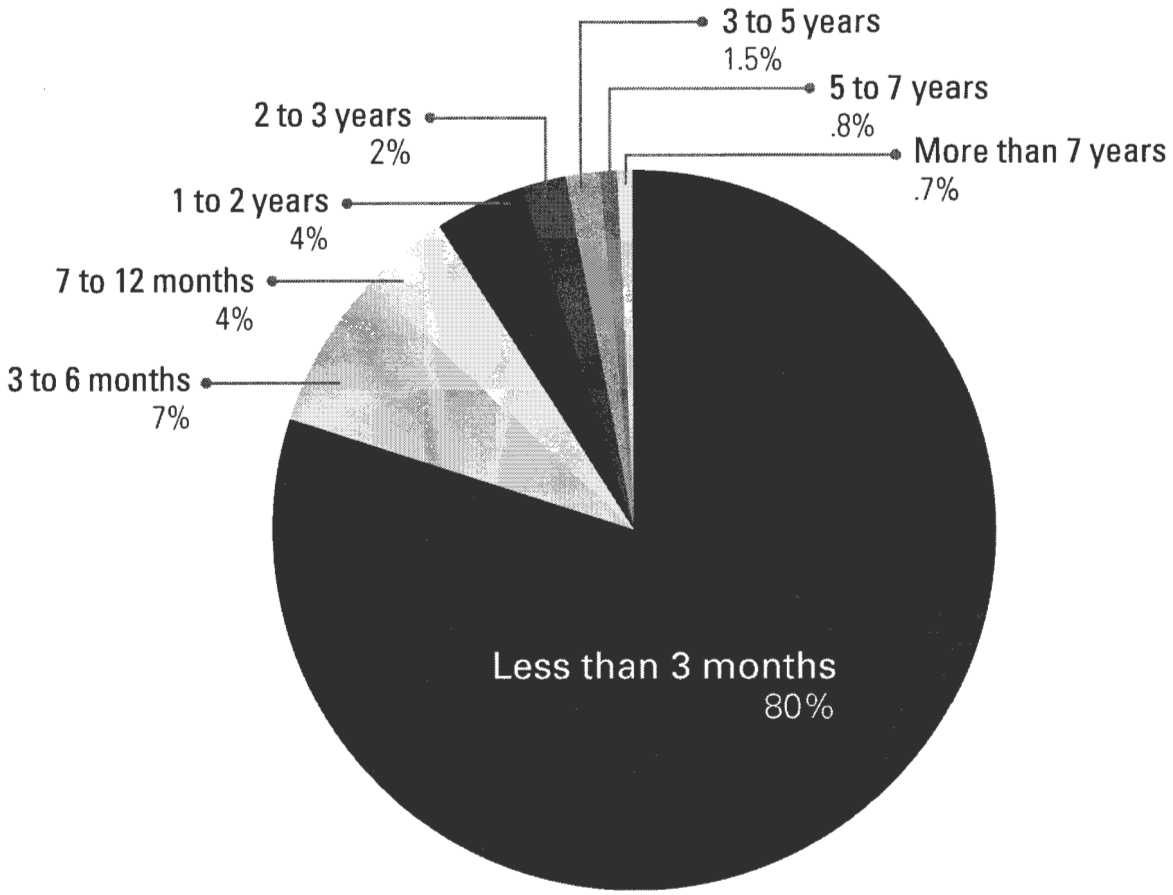
Bed Occupancy Rates in California Long-term Care Facilities



Source: California Office of Statewide Health Planning and Development (OSHPD): *California Long-Term Care Services Statewide Trends, 1991 to 2000 and 1992 to 2001.*

How Long They Stay

Length of Stay in California Nursing Homes, 2001



The majority of those who enter a nursing facility need care temporarily to recuperate or rehabilitate after an illness or hospital stay. Others live there for the rest of their lives.

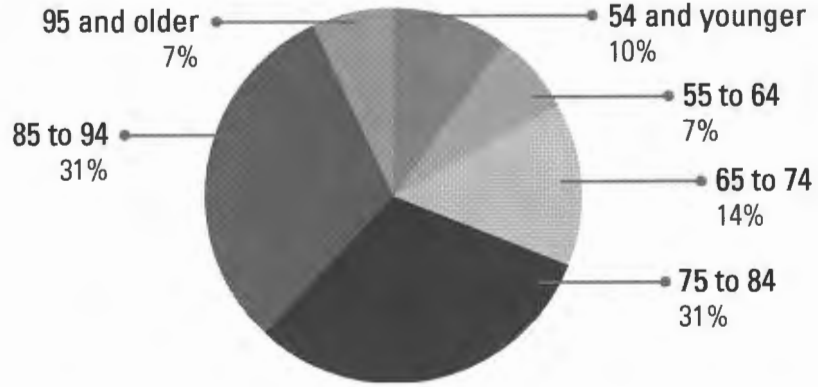
Source: State of California, Health Care Quality and Analysis Division: *Annual Utilization Reports of Hospitals and LTC Facilities, 1992-2001.*

A Look at the Residents

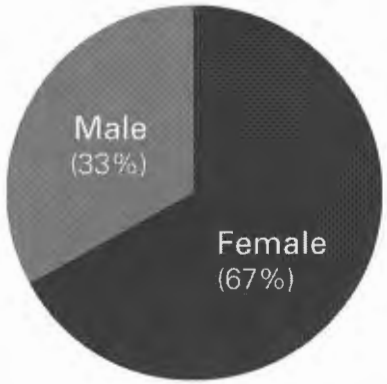
More than 110,000 individuals live in California's long-term care facilities. The majority of residents are 75 or older, female, and white.

Residents of California Long-term Care Facilities, 2001

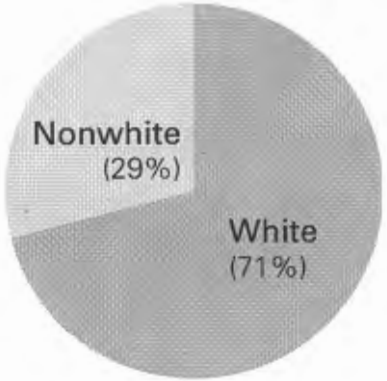
by Age



by Gender



by Ethnicity



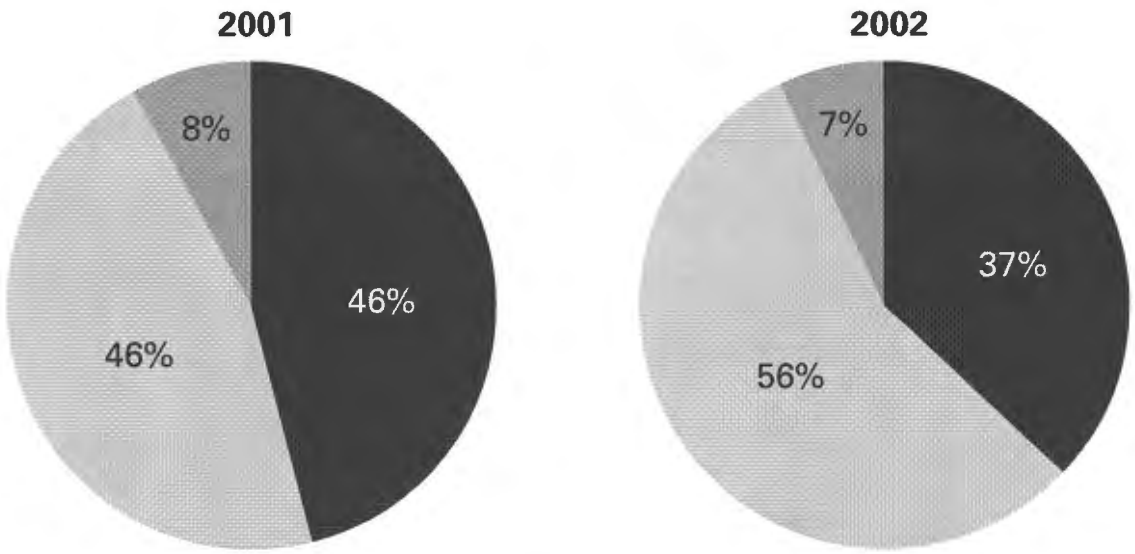
Source: California Office of Statewide Health Planning and Development (OSHPD): *California Long-Term Care Services Statewide Trends, 1992–2001.*

Nursing Care

Hours of Nursing per Resident per Day in California

Staffing Levels

- Recommended: 4.1 hours or more
- State Mandated: 3.2 hours or more
- Below State Mandate: Less than 3.2 hours

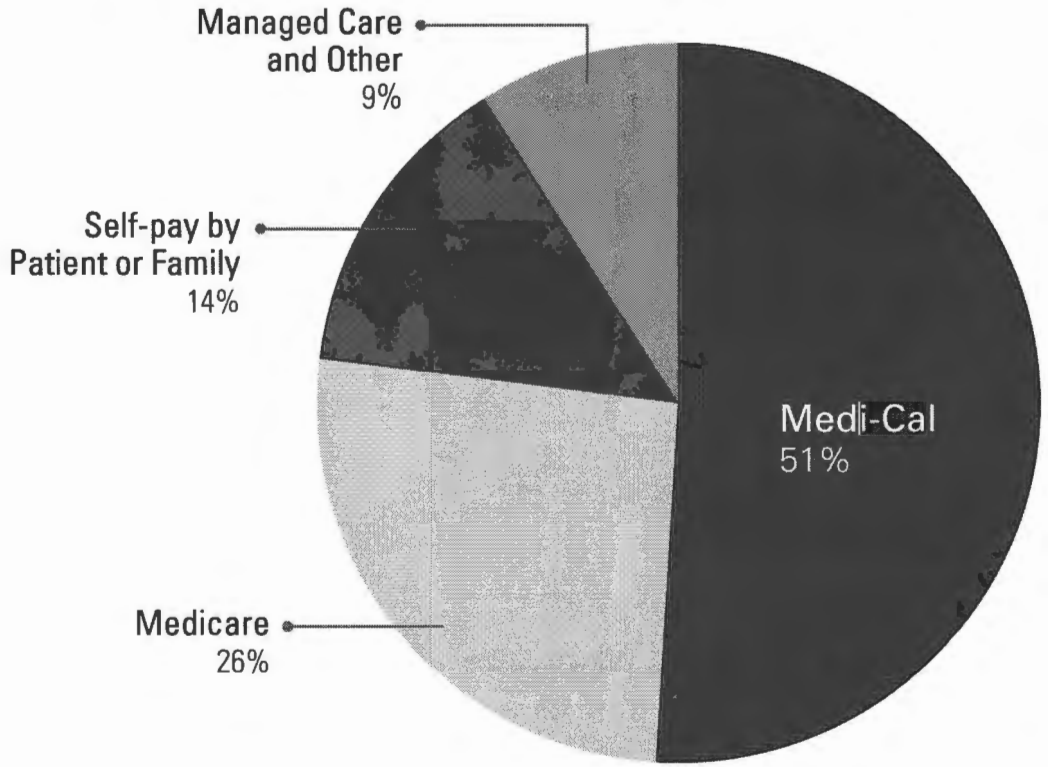


In 2002, well over **one-third** of freestanding nursing homes did not meet the state mandated minimum nurse staffing level of 3.2 hours per resident. **Ninety-three percent** did not meet the 4.1 hour daily standard recommended in a recent report to Centers for Medicare and Medicaid Services.

Sources: University of California School of Nursing, *Annual Report for California Nursing Home Search,* San Francisco, CA. 2003; Office of Statewide Health Planning and Development, 2003: *Long-Term Care Annual Financial Data for 2001 and 2002;* U.S. Centers for Medicare and Medicaid Services: *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress,* 2001.

Who Pays for Nursing Home Care

2002 Total Expenditures* in California: $6.6 billion



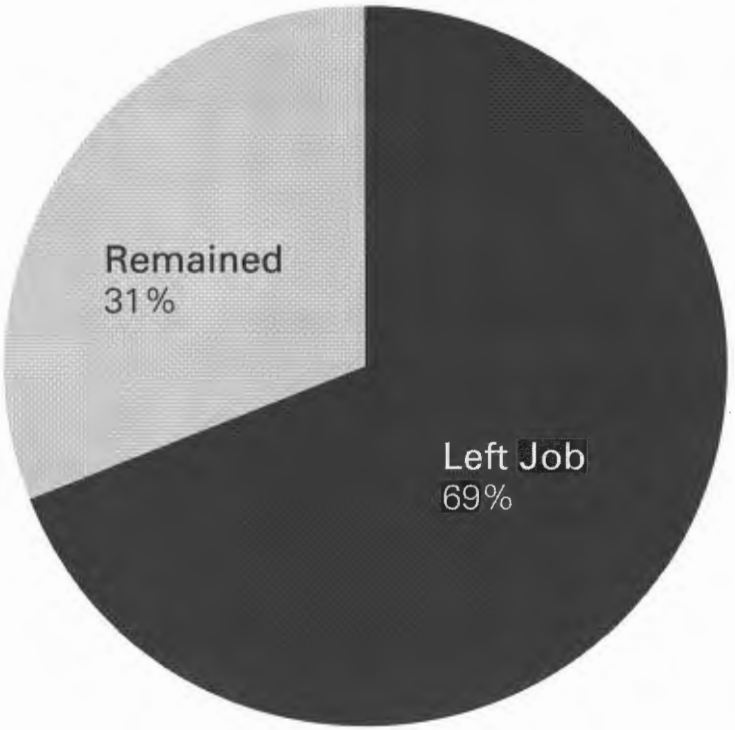
*California nursing home population was comprised of 179 hospital-based and 1,238 freestanding (non-hospital-based) homes.

Source: State of California, Office of Statewide Health Planning and Development, 2003: *LTC Annual Financial Data, 1/1/02 to 12/31/02 and Hospital Financial Data, 1/1/2002 to 6/30/2002.*

Medicare will only pay for approved short-term care up to 100 days. After Medicare and private insurance benefits are used, individuals and their families must pay for nursing home care directly out-of-pocket—almost **$1 billion** in 2002. Once individuals spend their income and assets, they may become eligible for Medi-Cal coverage, which paid more than half of the cost of care in freestanding facilities in 2002.

Staff Turnover

California Nursing Staff Who Left Their Job, 2002



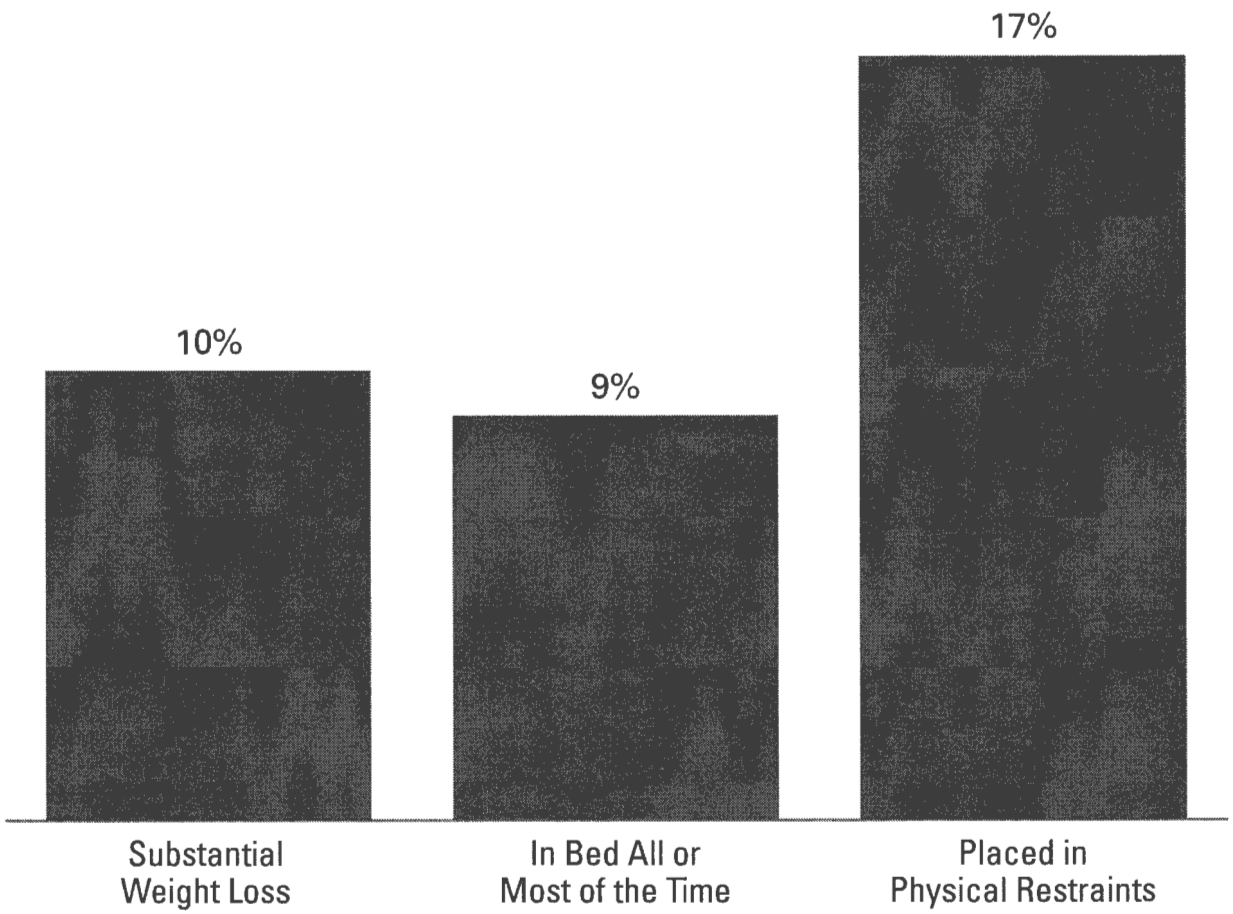
More than **two-thirds** of the nursing staff in California freestanding nursing homes (the majority of them nursing assistants earning an average of $10.35 per hour), left their jobs in the year 2002. The annual turnover rates among nursing homes ranged from **5 percent to 304 percent.**

Sources: Office of Statewide Health Planning and Development, 2003; Long Term Care Financial Data, 2002; and Harrington, C. & Swan, J.H., 2003: *Nursing Home Staffing, Turnover, and Case Mix. Medical Care Research and Review.*

Quality of Care

Weight loss, time spent in bed, and use of physical restraints commonly indicate poor quality of care for residents in nursing homes.

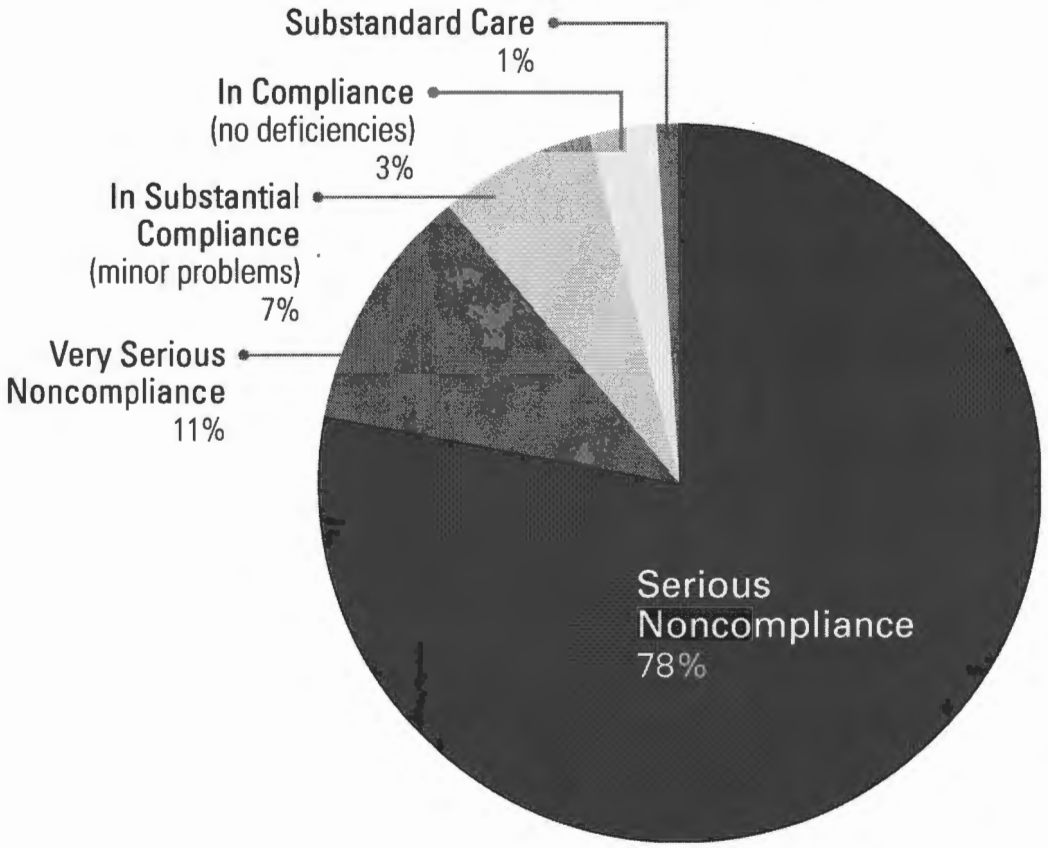
Problems with Residents in California Nursing Homes, 2002



Source: University of California School of Nursing, *Annual Report for California Nursing Home Search,* San Francisco, CA. 2003.

Violations of Federal Regulations

Federal Inspection Findings of California Nursing Facilities, 2002



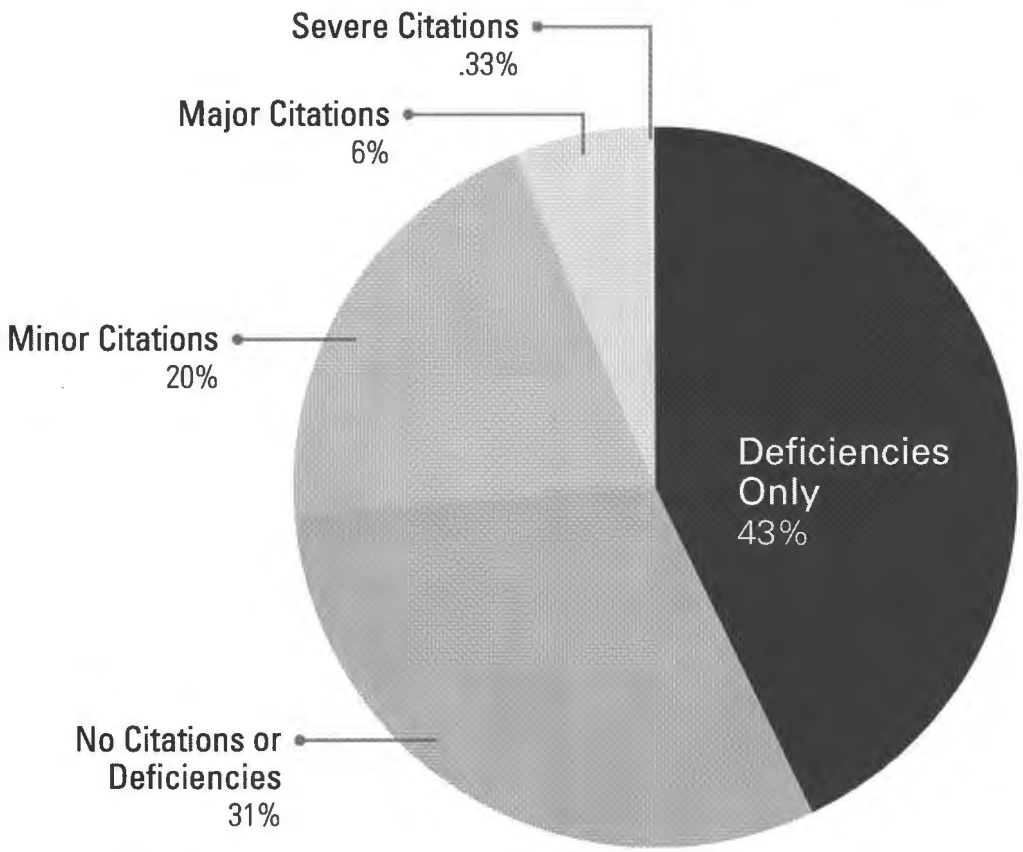
Seventy-eight percent of all California nursing homes surveyed in 2002 did not comply with federal care and safety regulations during mandatory inspections and another **12 percent** were cited for very serious quality of care problems.*

*12 percent combines "Substandard Care" and "Very Serious Noncompliance."

Source: University of California School of Nursing, *Annual Report for California Nursing Home Search,* San Francisco, CA. 2003.

Violations of State Regulations

State Inspection Findings of California Nursing Facilities, 2002

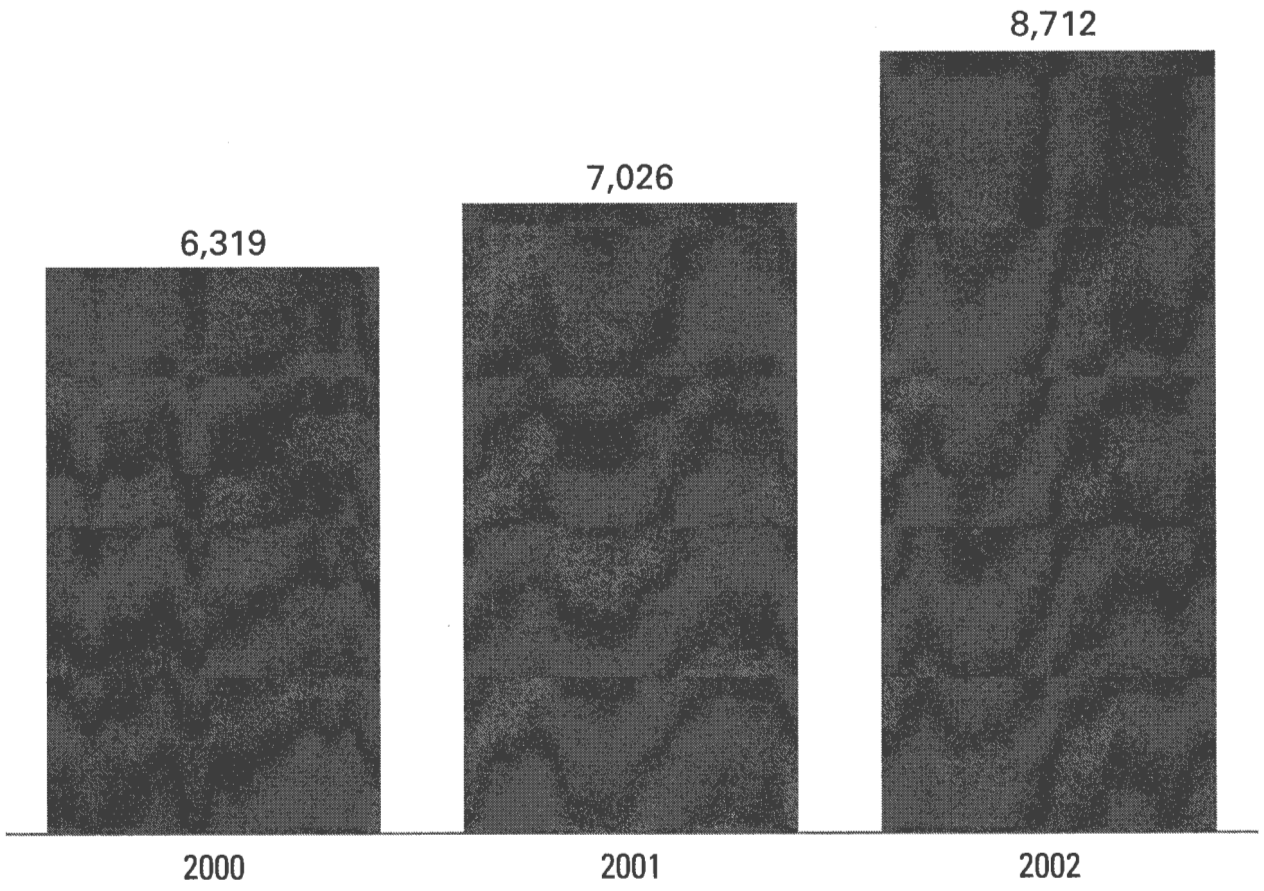


The state has separate standards that nursing homes must meet. Nursing homes are issued state deficiencies as warnings to correct minor problems and given citations as fines for more serious violations. **Fewer than one-third** of the facilities in California were free of these state sanctions in 2002.

Source: University of California School of Nursing, *Annual Report for California Nursing Home Search,* San Francisco, CA. 2003.

Complaints Filed

Number of Complaints Filed Against California Nursing Homes

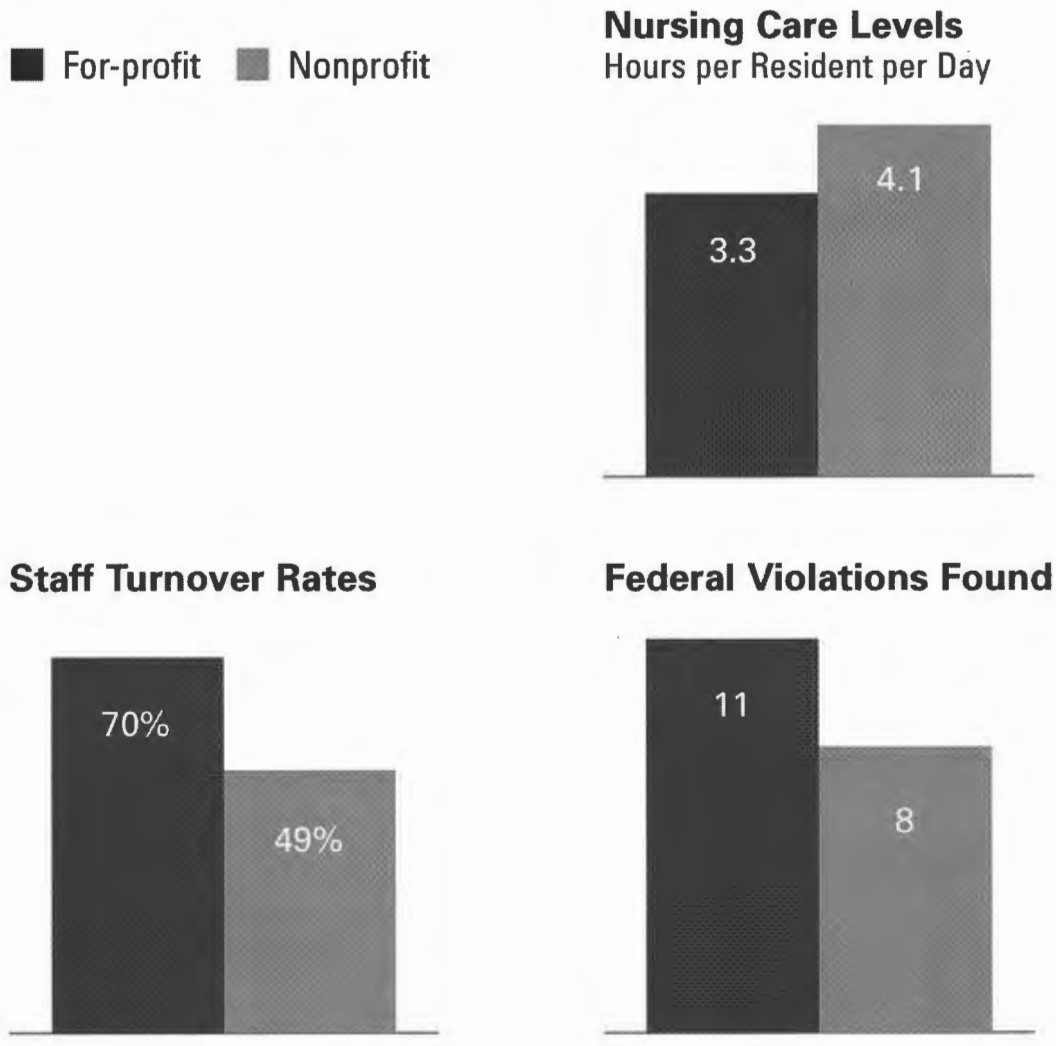


*Includes complaints submitted to the California Department of Health Services Licensing and Certification program by residents, their families, staff, and ombudsman.

Source: University of California School of Nursing, *Annual Report for California Nursing Home Search,* San Francisco, CA. 2003.

The number of complaints against nursing homes filed by those who saw or suspected substandard care or abuse increased **38 percent** from 2000 to 2002.*

For-profit vs. Nonprofit Performance



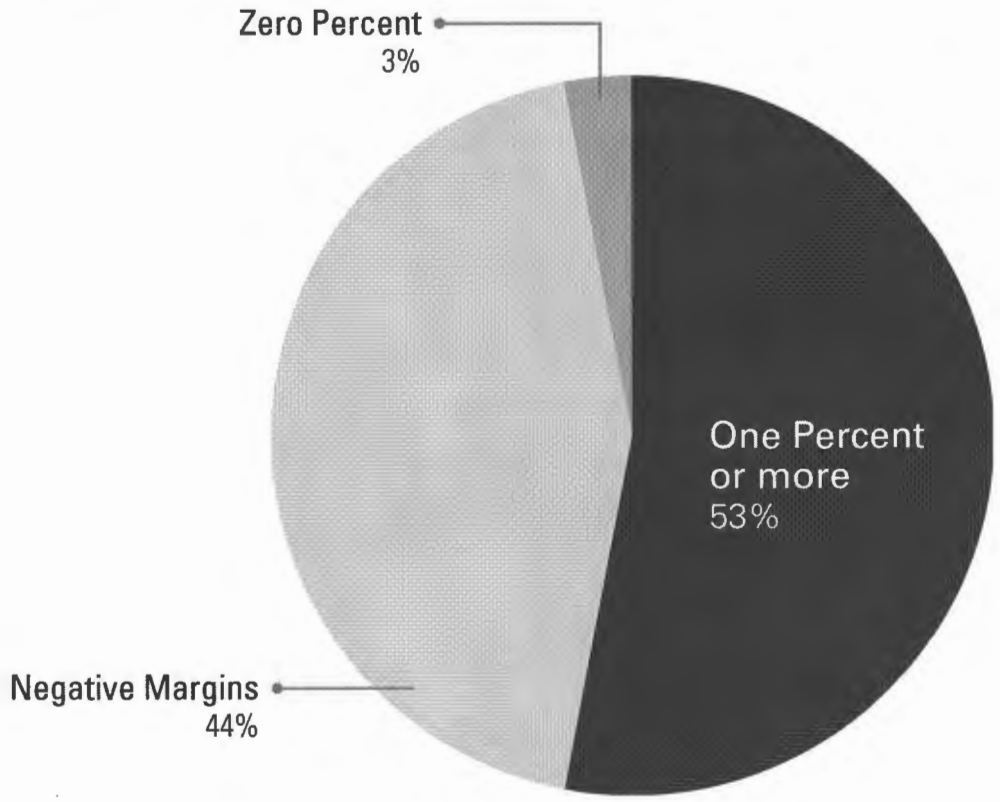
Source: University of California School of Nursing, *Annual Report for California Nursing Home Search,* San Francisco, CA. 2003.

About **78 percent** of the nursing homes in the state are owned by for-profit organizations, while **18 percent** are nonprofit and **4 percent** are operated by a government entity such as the city or county.

In 2002, freestanding, for-profit facilities had lower staffing levels, higher staff turnover rates, and more violations of health and safety regulations than nonprofit facilities.

Financial State

Profit Margins for Freestanding California Nursing Homes, 2002



Between 1999 and 2002, 160 California nursing homes filed for bankruptcy, indicating financial instability and signaling possible closure. **Nearly half** of the state's nursing homes reported negative or zero profit margins in 2002.

Source: University of California School of Nursing, *Annual Report for California Nursing Home Search,* San Francisco, CA. 2003.

Profitability of Nursing Homes Receiving Medi-Cal

Profitability (Net Income Margin)	**Share of Nursing Homes** 2001	2002	Change
Better than 0%	66%	58%	−12%
0% to less than −5%	17%	22%	+29%
−5% to less than −15%	12%	15%	+25%
−15% to less than −25%	3%	3%	0%
−25% and worse	2%	3%	+50%

Among freestanding nursing homes that receive Medi-Cal reimbursement, the proportion of those that broke even or lost money grew by an average of **26 percent.**

Note: Numbers may not add up to 100 because of rounding.
Source: OSHPD LTC Financial Data for 2001 and 2002.

Additional Resources

California HealthCare Foundation www.chcf.org/topics/index.cfm?topic=CL110

A compendium of information and resources is available here.

Additional relevant articles by Barbara Kate Repa are archived at www.chcf.org. To find them, enter "repa" at the search prompt.

- *Nursing Home Inspections: The Data Behind the Ratings*
- *Troubled Budget Times Hit Nursing Homes Hard*

California Nursing Home Search www.calnhs.org

This free, comprehensive consumer Web site provides ratings of California long-term care facilities on key quality measures. It also includes information on staffing levels, clinical quality measures, complaints and deficiencies, financial measures and ownership, as well as a number of helpful resources such as paying for care.

Charlene Harrington, Ph.D. and Janis O'Meara, M.P.A. *Annual Report for California Nursing Home Search.* University of California School of Nursing, San Francisco, CA. 2003. http://nurseweb.ucsf.edu/www/images/calnhs-rpt-03.pdf

CONTACT US

California HealthCare Foundation
476 Ninth Street
Oakland, CA 94607
t: 510.238.1040
f: 510.238.1388

GAO

Report to Congressional Committees

November 2002

SKILLED NURSING FACILITIES

Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase

GAO

Accountability * Integrity * Reliability

GAO-03-176

Contents

Tables

Abbreviations

AAHSA	American Association of Homes and Services for the Aging
AHCA	American Health Care Association
AHA	American Hospital Association
BBA	Balanced Budget Act of 1997
BLS	Bureau of Labor Statistics
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CMS	Centers for Medicare & Medicaid Services
CNA	certified nurse aide
FTE	full-time equivalent
HCFA	Health Care Financing Administration
LPN	licensed practical nurse
LVN	licensed vocational nurse
OSCAR	Online Survey Certification and Reporting System
PPS	prospective payment system
RN	registered nurse
RUG	resource utilization group
SNF	skilled nursing facility

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

November 13, 2002

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable William M. Thomas
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

The nation's 15,000 skilled nursing facilities (SNF) play an essential role in our health care system, providing Medicare-covered skilled nursing and rehabilitative care each year for 1.4 million Medicare patients who have recently been discharged from acute care hospitals. In recent years, many analysts and other observers, including members of the Congress, have expressed concern about the level of nursing staff in SNFs and the impact of inadequate staffing on the quality of care. In 2000, the Congress responded to these concerns with a temporary increase in Medicare payment intended to encourage SNFs to increase their nursing staff.

Medicare pays SNFs through a prospective payment system (PPS) in which they receive a fixed amount for each day that a patient receives care. This daily payment rate varies according to a patient's expected needs for care, and is the sum of nursing, therapy, and routine cost components.[1] The Congress, through the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA),[2] increased the nursing component of the PPS SNF rate by 16.66 percent, effective April 1, 2001. This raised the overall SNF payment rates by 4 to 12 percent,

[1]The nursing component includes costs related not only to nursing but to medical social services and nontherapy ancillary services, such as drugs, laboratory tests, and imaging. The therapy component includes costs related to occupational, physical, and speech therapy. The routine cost component includes costs for capital, maintenance, and food.

[2]Pub. L. No. 106-554, App. F, § 312(a), 114 Stat. 2763, 2763A-498.

depending on the patient's expected care needs. However, the law did not require facilities to spend this additional money on nursing staff. This was not the only recent legislative change to SNF payments. A year earlier, payment rates for certain types of patients had been increased by 20 percent, and for fiscal years 2001 and 2002, overall rates were boosted by 4 percent.[3] The nursing component increase expired on October 1, 2002, and the Congress is considering whether to reinstate it.

BIPA directed us to assess the impact of the increase in the nursing component on SNF nurse staffing ratios. The law also required that we recommend whether the increased payments should continue.[4] Specifically, this report examines whether nurse staffing ratios[5]—overall and for categories of SNFs, such as for-profit and not-for-profit facilities—rose after April 1, 2001, when the payment increase took effect.

To address this issue, we used data from the Online Survey Certification and Reporting System (OSCAR),[6] maintained by the Centers for Medicare & Medicaid Services (CMS),[7] to assess nurse staffing ratios. We examined all SNFs that at the time of our analysis had OSCAR data on staffing levels available both before and after the payment increase. There were slightly over 6,500 SNFs—over one-third of all SNFs—for which these data were available. We tested for differences between these 6,500 and the 13,454 SNFs that were surveyed in calendar year 2000. We found no statistically significant differences in terms of type of facility, size, ownership, and the share of SNF patients paid for by Medicare. However, we found statistically significant differences between these two groups of SNFs in terms of the distribution by state. (See app. I, table 6.) To improve the

[3]Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, App. F, § 101, 113 Stat. 1501, 1501A-324.

[4]BIPA § 312(b).

[5]A nurse staffing ratio is defined as nursing hours per patient per day. Nursing staff include registered nurses, licensed practical nurses, and aides. In this report, "staffing" refers to these nursing staff.

[6]OSCAR stores data collected during annual inspections or surveys of SNFs conducted by state agencies under contract to CMS. OSCAR is the only uniform data source that contains data on both patients and nursing staff.

[7]CMS administers the Medicare program. On July 1, 2001, the Secretary of Health and Human Services changed the name of the Health Care Financing Administration (HCFA) to CMS. In this report, we will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

accuracy of the OSCAR data, we identified over 500 SNFs in our sample that had apparent data entry or other data reporting errors,[8] compared those data to source documents, and made corrections where appropriate. For 179 of these cases, we contacted facilities to resolve data issues. These verification and correction procedures resulted in useable data for about 5,000 SNFs. For each facility, we compared the 2001[9] nurse staffing ratio to the staffing ratio in 2000. We were not able to incorporate data reported after January 2002, in order to accommodate the schedule set by BIPA. To supplement this analysis, we also examined staffing ratio changes from 1999 to 2000. In addition to analyzing these data, we interviewed representatives of three industry associations, CMS officials, and several independent researchers. Although OSCAR data allowed us to compare staffing ratios before and after the 16.66 percent payment increase took effect, our analysis was limited in several ways. OSCAR data pertain to a limited period—2 weeks for staffing and 1 day for the number of patients. Further, staffing cannot be examined separately for Medicare patients, who represent about 11 percent of total SNF patients; Medicaid patients, who represent over 66 percent of total SNF patients; or patients whose care is paid for by other sources, who represent about 23 percent of total SNF patients. For more details on our data and methods, see appendix I. We performed our work from November 2001 through October 2002 in accordance with generally accepted government auditing standards.

Results in Brief

Our analysis of available data shows that, in the aggregate, SNFs' nurse staffing ratios changed little after the increase in the nursing component of the Medicare payment rate took effect. Overall, SNFs' average nursing time increased by 1.9 minutes per patient day, relative to their average in 2000 of about 3 and one-half hours of nursing time per patient day. There was a small shift in the mix of nursing time that SNFs provided, with slightly less registered nurse (RN) time coupled with slightly more licensed practical nurse (LPN) and nurse aide time. For most types of

[8]CMS officials have stated that OSCAR data are accurate in the aggregate—that is, at national and state levels—but have indicated that data on some individual facilities may not be accurate. We report OSCAR data only at national and state levels. See HCFA, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase I* (Baltimore, Md.: July 2000).

[9]Our 2001 OSCAR data include May through December 2001, after the payment increase took effect. As a result, we only reviewed data for an 8-month period after the payment increase was implemented. We were not able to review data for a later period when facilities might have used the payment increase differently.

SNFs, increases in staffing ratios were small. Further, we found that the share of SNF patients covered by Medicare was not a factor in whether facilities increased their nursing time. Similarly, SNFs that had total revenues considerably in excess of costs before the added payments took effect did not increase their staffing substantially more than others. Although facilities with relatively low staffing ratios in 2000 increased their staffing ratios in 2001, highly staffed SNFs decreased their staffing ratios. We observed a similar pattern of staffing changes between 1999 and 2000, before the increased nursing component payment was implemented. This indicates that the nursing component payment increase was likely not a factor in the added nursing time among lower-staffed facilities. However, unlike most facilities, SNFs in four states increased their staffing by 15 to 27 minutes per patient day; three of these states—Arkansas, North Dakota, and Oklahoma—had made Medicaid payment or policy changes aimed at raising or maintaining facilities' nursing staff.

Our analysis of available data on SNF nursing staff indicates that, in the aggregate, SNFs did not have significantly higher nursing staff time after the increase to the nursing component of Medicare's payment. We believe that the Congress should consider our finding that increasing the Medicare payment rate was not effective in raising nurse staffing as it determines whether to reinstate the increase to the nursing component of the Medicare SNF rate.

In written comments on a draft of this report, CMS stated that our findings are consistent with its expectations as well as its understanding of other research in this area. Industry representatives provided oral comments in response to a draft of this report. Saying that our statements were too strong given the limitations of the study, they objected to our conclusions and matter for congressional consideration in the draft report. In conducting our study, we recognized the limitations of the data and the analyses we could perform and, when possible, performed tests to determine whether they affected our results. Taking account of these tests as well as the consistency of our results, we determined that the evidence was sufficient to conclude that the increased payment did not result in higher nursing staff time. However, we modified our conclusions to reiterate the limitations of our study. We rephrased the matter for congressional consideration to reflect the fact that the increase has lapsed since we drafted this report.

Background

Medicare covers SNF care for beneficiaries who need daily skilled nursing care or therapy for conditions related to a hospital stay of at least 3 consecutive calendar days, if the hospital discharge occurred within a specific period—generally, no more than 30 days—prior to admission to the SNF. For qualified beneficiaries, Medicare will pay for medically necessary SNF services, including room and board; nursing care; and ancillary services, such as drugs, laboratory tests, and physical therapy, for up to 100 days per spell of illness.[10] In 2002, beneficiaries are responsible for a $101.50 daily copayment after the 20th day of SNF care, regardless of the cost of services received.

Eighty-eight percent of SNFs are freestanding—that is, not attached to a hospital. The remainder are hospital-based.[11] SNFs differ by type of ownership: 66 percent of SNFs are for-profit entities, 28 percent of SNFs are not-for-profit, and a small fraction of SNFs—about 5 percent—are government-owned.[12] About three-fifths of SNFs are owned or operated by chains—corporations operating multiple facilities.

To be a SNF, a facility must meet federal standards to participate in the Medicare program.[13] SNFs provide skilled care to Medicare patients and usually also provide care to Medicaid and private pay patients. Medicare pays for a relatively small portion of patients cared for in SNFs—about 11 percent. Over 66 percent of SNF patients have their care paid for by Medicaid, and another 23 percent have their care paid for by other sources or pay for the care themselves.

Medicare Payment for SNF Care

In the Balanced Budget Act of 1997 (BBA), the Congress established the PPS for SNFs.[14] Under the PPS, SNFs receive a daily payment that covers almost all services provided to Medicare beneficiaries during a SNF stay,

[10]A spell of illness is a period that begins when a Medicare beneficiary is admitted to a hospital and ends when a beneficiary has not been an inpatient of a hospital or SNF for 60 consecutive days. A beneficiary may have more than one spell of illness per year that is covered by Medicare.

[11]CMS considers a facility to be hospital-based if it is "under the administrative control of a hospital."

[12]Government-owned facilities are operated primarily by counties or cities.

[13]State agencies, under contract to CMS, conduct initial and follow-up visits to assess compliance with federal standards—Medicare's and Medicaid's conditions of participation.

[14]Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414.

which is adjusted for geographic differences in labor costs and differences in the resource needs of patients. Adjustments for resource needs are based on a patient classification system that assigns each patient to 1 of 44 payment groups, known as resource utilization groups (RUG).[15] For each group, the daily payment rate is the sum of the payments for three components: (1) the nursing component, which includes costs related to nursing as well as to medical social services and nontherapy ancillary services, (2) the therapy component, which includes costs related to occupational, physical, and speech therapy, and (3) the routine cost component, which includes costs for capital, maintenance, and food. The routine cost component is the same for all patient groups, while the nursing and therapy components vary according to the expected needs of each group. Before the 16.66 percent increase provided by BIPA took effect, the nursing component varied from 26 percent to 74 percent of the daily payment rate, depending on the patient's RUG.[16] In 2001, Medicare expenditures on SNF care were $13.3 billion. The 16.66 percent increase in the nursing component raised Medicare payments about $1 billion annually—about 8 percent of Medicare's total annual spending on SNF care.

The increase in the nursing component is one of several temporary changes made to the PPS payment rates since the PPS was implemented in 1998. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) raised the daily payment rates by 20 percent for 15 high-cost RUGs beginning in April 2000.[17] BBRA also increased the daily rate for all RUGs by 4 percent for fiscal years 2001 and 2002.[18] BIPA upped the daily payment rates by 6.7 percent for 14 RUGs, effective April 2001.[19] This increase was budget neutral; that is, it modified BBRA's 20 percent increase for 15 RUGs by taking the funds directed at 3 rehabilitation RUGs

[15]These groups are based on patient clinical condition, functional status, and use or expected use of certain types of services. Each RUG describes patients with similar care needs and has a corresponding payment rate.

[16]These figures are for facilities in urban areas. For facilities in rural areas, the nursing component ranged from 23 percent to 72 percent of the total rate.

[17]Pub. L. No. 106-113, App. F, § 101, 113 Stat. 1501, 1501A-324.

[18]The 4 percent increase is based on the PPS daily rates that would have been in effect for those years without the 20 percent temporary increase for the 15 high-cost RUGs noted above.

[19]BIPA § 314.

and applying those funds to all 14 rehabilitation RUGs.[20] Two of these temporary payment changes, the 20 percent and 6.7 percent increases, will remain in effect until CMS refines the RUG system. CMS has announced that, although it is examining possible refinements, the system will not be changed for the 2003 payment year.[21]

SNF Staffing

In providing care to their patients, SNFs employ over 850,000 licensed nurses and nurse aides nationwide.[22] Licensed nurses include RNs and LPNs.[23] RNs generally manage patients' nursing care and perform more complex procedures, such as starting intravenous fluids. LPNs provide routine bedside care, such as taking vital signs and supervising nurse aides. Aides generally have more contact with patients than other members of the SNF staff. Their responsibilities may include assisting individuals with eating, dressing, bathing, and toileting, under the supervision of licensed nursing and medical staff.

Several studies have shown that nursing staff levels are linked to quality of care.[24] The Social Security Act, which established and governs the Medicare program, requires that SNFs have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient, as determined by patient assessments and individual plans of care.[25] More specifically, SNFs must have an RN on duty for at least 8 consecutive hours a day for 7 days per week, and must have 24 hours of licensed nurse

[20]The remaining 12 RUGs retained the 20 percent increase.

[21]BIPA requires that CMS submit a report to the Congress on possible alternatives to the current RUG patient classification system by January 1, 2005. BIPA § 311(e).

[22]This figure represents the number of full-time equivalents.

[23]In some parts of the United States, LPNs are known as licensed vocational nurses (LVN).

[24]See U.S. General Accounting Office, *Nursing Homes: Quality of Care More Related to Staffing than Spending*, GAO-02-431R (Washington, D.C.: June 13, 2002); Centers for Medicare & Medicaid Services, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report* (Baltimore, Md.: December 2001); U.S. Department of Health and Human Services, *Quality of Care in Nursing Homes: An Overview*, Office of Inspector General (Washington, D.C.: March 1999); and Institute of Medicine, *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* (Washington, D.C.: National Academy Press, 1996).

[25]42 U.S.C. § 1395i-3(b) (2000).

coverage per day.[26] SNFs also must designate an RN to serve as the director of nursing on a full-time basis, and must designate a licensed nurse to serve as a charge nurse on each tour of duty.[27]

SNF staffing varies by type of facility and by state. Hospital-based SNFs tend to have higher staffing ratios than other SNFs. In 2001, hospital-based SNFs provided 5.5 hours of nursing time per patient day, compared with 3.1 hours among freestanding SNFs. Hospital-based SNFs also rely more heavily on licensed nursing staff than do freestanding facilities, which rely more on nurse aides. Staffing also differs by state—from 2 hours and 54 minutes per patient day in South Dakota in 2000 to 4 hours and 58 minutes per patient day in Alaska.

Many states have established their own nursing staff requirements for state licensure, which vary considerably. Some states require a minimum number of nursing hours per patient per day, while others require a minimum number of nursing staff relative to patients. Some states' requirements apply only to licensed nurses, while others apply to nurse aides as well. Some states also require an RN to be present 24 hours per day, 7 days per week. As of 1999, 37 states had nursing staff requirements that differed from federal requirements. Since 1998, many states have raised their minimum staffing requirements or have implemented other changes aimed at increasing staffing in nursing homes, such as increasing workers' wages or raising reimbursement rates for providers whose staffing exceeds minimum requirements.

While states have set minimum requirements for nursing staff, there are indications of an emerging shortage of nursing staff, particularly RNs, in a variety of health care settings.[28] The unemployment rate for RNs in 2000 was about 1 percent—very low by historical standards. As a result, SNFs must compete with other providers, such as hospitals, for a limited supply of nursing staff. According to associations representing the industry,

[26]42 C.F.R. § 483.30 (2001).

[27]The Department of Health and Human Services may waive the requirement that a SNF provide the services of an RN for 8 hours a day, 7 days a week, including a director of nursing, in certain circumstances. However, according to CMS, few facilities have those requirements waived.

[28]See U.S. General Accounting Office, *Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors*, GAO-01-944 (Washington, D.C.: July 10, 2001), and Centers for Medicare & Medicaid Services, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report*, ch. 4.

nursing homes have had difficulty recruiting and retaining staff. The American Health Care Association (AHCA)[29] reported vacancy rates for nursing staff in nursing homes for 2001 ranging from 11.9 percent for aides to 18.5 percent for staff RNs.[30] Labor shortages are generally expected to result in increased compensation—wages and benefits—as employers seek to recruit new workers and retain existing staff. Our analysis of Bureau of Labor Statistics (BLS) data shows that, from 1999 to 2000, average wages for nurses and aides employed by the nursing home industry increased by 6.3 percent, compared to 2.9 percent among workers in private industry and state and local government.[31] Industry officials, citing a survey they commissioned, told us that wages have risen more rapidly since 2000.[32]

SNF Staffing Changed Little after Payment Increase Took Effect

In general, SNF staffing changed little after April 1, 2001, when the increase in the nursing component of the PPS payment took effect. There was no substantial change in SNFs' overall staffing ratios, though their mix of nursing hours shifted somewhat: SNFs provided slightly less RN time and slightly more LPN and nurse aide time in 2001. For most categories of SNFs—such as freestanding SNFs and SNFs not owned by chains—increases in staffing ratios were small. Although SNFs with relatively low staffing ratios in 2000 increased their staffing ratios in 2001, SNFs with relatively high staffing ratios decreased their staffing. Our analysis indicates that the nursing component payment increase was unlikely to have been a factor in these staffing changes. Unlike most facilities nationwide, SNFs in four states increased their staffing by 15 or more minutes per patient day, following payment or policy changes in three of the states aimed at increasing or maintaining SNF nursing staff.

[29]AHCA represents for-profit and not-for-profit nursing facilities.

[30]American Health Care Association, *Results of the 2001 AHCA Nursing Position Vacancy and Turnover Survey* (Washington, D.C.: Feb. 7, 2002).

[31]These figures are based on data from BLS's Occupational Employment Statistics and National Compensation Survey for 1999 and 2000. BLS's 2001 Occupational Employment Statistics were not available at the time of our analysis.

[32]The 2001 Nursing Facility Compensation Survey, sponsored by AHCA and the Alliance for Quality Nursing Home Care, was conducted by Muse and Associates and Buck Consultants.

SNF Staffing Changed Little after Payment Increase, Though Mix of Staffing Shifted Somewhat

No substantial change in SNFs' overall staffing ratios occurred after the nursing component payment was increased. Between 2000 and 2001,[33] SNFs' average amount of nursing time changed little, remaining slightly under 3 and one-half hours per patient day.[34] Although there was an increase of 1.9 minutes per patient day, it was not statistically significant.[35] (See table 1.) According to our calculations, this change was less than the estimated average increase, across all SNF patients, of about 10 minutes per patient day that could have resulted if SNFs had devoted the entire nursing component increase to more nursing time.[36]

There was a small shift in the mix of nursing time that SNFs provided. On average, RN time decreased by 1.7 minutes per patient day. This was coupled with slight increases in LPN and nurse aide time, which rose by 0.7 and 2.9 minutes per patient day, respectively.

[33]The 2001 data are from May through December 2001, after the increased nursing component payment took effect.

[34]These staffing ratios, and the ratios presented throughout this report, are based on SNFs' overall direct care nursing staff and the total number of patients; they are, therefore, facilitywide staffing ratios, rather than ratios specific to Medicare patients.

[35]That is, the change was too small to be statistically distinguished from zero. Since we were only able to review data for a limited period after the payment increase was implemented, we compared SNFs' staffing ratio changes over time to test whether this affected our results. When we compared the change in staffing ratios among facilities surveyed soon after the payment increase to those surveyed later in 2001, we found no significant difference. This suggests that our results were not affected by examining staffing soon after the payment change. SNFs responded similarly to the increase regardless of how much time had elapsed since its implementation.

[36]The estimates ranged from 9.4 to 10.1 minutes, depending on whether we assumed relatively large—10 percent—or small—3 percent—increases in wage rates from 2000 to 2001.

Table 1: Average SNF Staffing Time by Type of Nurse, 2000 and 2001

	Average nursing time per patient day		
Nursing staff	Calendar year 2000	May - December 2001	Change in minutes[a]
RNs	30.0 minutes	28.3 minutes	-1.7 minutes
LPNs[b]	42.9 minutes	43.6 minutes	0.7 minutes
Aides[c]	2 hours, 10.0 minutes	2 hours, 12.9 minutes	2.9 minutes
Total	3 hours, 22.9 minutes	3 hours, 24.8 minutes	1.9 minutes

Note: Data include freestanding and hospital-based SNFs.

[a]For each category of nursing staff, the change in minutes was significant at the .05 level. The total change in nursing time, however, was not significant.

[b]LPNs are also known as LVNs.

[c]Aides include certified nurse aides, nurse aides in training, and medication aides/technicians.

Source: GAO analysis of CMS's OSCAR data.

For most categories of SNFs, changes in staffing ratios were small. For example, freestanding facilities, which account for about 90 percent of SNFs nationwide, increased their nursing time by 2.1 minutes per patient day on average. Nonchain SNFs had an increase of 3.9 minutes per patient day. Hospital-based facilities and those owned by chains had nominal changes in nursing time. The changes in staffing for for-profit, not-for-profit, and government-owned facilities also were small. (See app. II.)

The share of a SNF's patients who were covered by Medicare was not a factor in whether facilities increased their nursing time. SNFs that relied more on Medicare would have received a larger increase in revenue due to the nursing component change, and might have been better able than others to raise staffing ratios. However, we found that freestanding SNFs in which Medicare paid for a relatively large share of patients[37] increased their nursing time by 1.3 minutes per patient day—less than SNFs with

[37]For this analysis, we consider patients to be Medicare-covered if they are receiving Medicare-covered SNF care. Although a SNF may have a large number of patients who are Medicare beneficiaries, not all such patients necessarily receive Medicare-covered SNF care. For example, patients receiving long-term custodial care could be eligible for Medicare-covered services, but their SNF stays would not be paid for by Medicare.

somewhat smaller shares of Medicare patients, and not substantially more than SNFs with the smallest share of Medicare patients.[38] (See table 2.)

Table 2: Average Change in Nursing Time between 2000 and 2001 for Freestanding SNFs, Grouped by Medicare Patient Share

Medicare patient share in 2000 (percentage)[a]	Change in minutes of nursing time per patient day[b]
Less than 3.8	0.8 minutes
3.8 to 7.1	3.6 minutes
7.2 to 11.4	2.9 minutes
11.5 and higher	1.3 minutes

Note: The 2001 data are from May through December 2001, after the nursing component payment increase took effect.

[a]The four groups of SNFs are roughly equal in size.

[b]Between any two groups of SNFs (rows), there were no statistically significant differences in the change in minutes. For the two middle groups of SNFs, the change in minutes between 2000 and 2001 was significant at the .05 level.

Source: GAO analysis of CMS's OSCAR data.

Similarly, SNFs' financial status was not an important factor affecting changes in nursing time. Although SNFs with higher total margins in 2000[39]—that is, those with revenues substantially in excess of costs—might have been best able to afford increases in nursing staff, those with the highest total margins did not raise their staffing substantially more than others. Changes in nursing time were minimal, regardless of SNFs' financial status in 2000. For SNFs in the three groups with the highest margins, increases were about 3 to 4 minutes per day, compared to 2 minutes per day for those with the lowest margins. (See table 3.)

[38]The average staffing levels in 2000 were similar for the groups with the highest and lowest Medicare patient shares—3 hours, 11 minutes of nursing time per patient day for the highest group, and 3 hours, 8 minutes for the lowest group.

[39]A margin is the difference between revenues and costs, divided by revenues, and expressed as a percentage.

Table 3: Average Change in Nursing Time between 2000 and 2001 for Freestanding SNFs, Grouped by Total Margin

Total margins in 2000 (range)[a]	Change in minutes of nursing time per patient day[b]
Less than -3.4	2.1 minutes
-3.4 to 2.2	2.9 minutes
2.3 to 7.4	4.2 minutes
7.5 and higher	3.7 minutes

Note: The 2001 data are from May through December 2001, after the nursing component payment increase took effect.

[a]Total margins are expressed as percentages and are based on a SNF's cost reporting year, which corresponds to its fiscal year that begins during the federal fiscal year. The four groups of SNFs are roughly equal in size.

[b]Between any two groups of SNFs (rows), there were no statistically significant differences in the change in minutes. For each group of SNFs, however, the change in minutes between 2000 and 2001 was significant at the .05 level, except for the lowest group (with total margins less than –3.4 percent).

Source: GAO analysis of CMS's OSCAR data and 2000 Medicare cost reports.

Lower-Staffed SNFs Added More Nursing Time, but the Increased Medicare Nursing Payment Likely Was Not the Cause

SNFs with relatively low initial staffing ratios—which may have had the greatest need for more staff—increased their staffing ratios substantially, while SNFs that initially were more highly staffed had a comparable decrease in staffing. Among freestanding SNFs that had the lowest staffing ratios in 2000, staffing time increased by 18.9 minutes per patient day.[40] (See table 4.) Nearly all of the increase—over 15 minutes—was due to an increase in nurse aide time. LPN time increased by 3.2 minutes and RN time by 11 seconds on average. Among facilities with the highest staffing ratios in 2000, staffing decreased by 17.7 minutes.[41] For these SNFs, as for those with the lowest staffing ratios, most of the overall change occurred among nurse aides: aide time decreased by over 10 minutes in 2001, while LPN and RN time decreased by 2.7 and 4.6 minutes, respectively.

Despite the staffing increases among lower-staffed facilities, our analysis indicates that these staffing changes may not have resulted from the nursing component payment increase. We found that similar staffing changes occurred between 1999 and 2000—prior to the nursing component increase. Low-staffed facilities increased their staffing by 15.2

[40]When we looked at median changes in staffing rather than average changes, we found that these SNFs had a median increase of 13.6 minutes of nursing time.

[41]These SNFs had a median decrease of 11 minutes.

minutes per patient day in 2000, while high-staffed facilities decreased their staffing by 19.8 minutes.[42] The changes that occurred during the two periods were similar, suggesting that the payment increase probably did not cause the change in the latter period.

Table 4: Average Change in Nursing Time between 2000 and 2001 for Freestanding SNFs, Grouped by 2000 Staffing Ratios[a]

Staffing ratio in 2000 (range)[a]	Change in minutes of nursing time per patient day[b]
Less than 2 hours, 42 minutes	18.9 minutes
2 hours, 42 minutes to 3 hours, 1 minute	7.6 minutes
3 hours, 2 minutes to 3 hours, 25 minutes	0.9 minutes
3 hours, 26 minutes and higher	- 17.7 minutes

Note: The 2001 data are from May through December 2001, after the nursing component payment increase took effect.

[a]The four groups of SNFs are roughly equal in size.

[b]Between any two groups of SNFs (rows) the differences in the changes in minutes were statistically significant. For each group of SNFs, except the group with 3 hours, 2 minutes to 3 hours, 25 minutes of nursing time, the change in minutes was significant at the .05 level.

Source: GAO analysis of CMS's OSCAR data.

In Several States, Staffing Ratios Rose Substantially

Unlike most facilities nationwide, SNFs in four states—Arkansas, Nebraska, North Dakota, and Oklahoma—increased their staffing by 15 to 27 minutes per patient day, on average.[43] These increases could be related to state policies: according to state officials, three of the states had made Medicaid payment or policy changes aimed at increasing or maintaining facilities' nursing staff. North Dakota authorized a payment rate increase, effective July 2001, that could be used for staff pay raises or improved benefits. Oklahoma increased its minimum requirements for staffing ratios in both September 2000 and September 2001, provided added funds to offset the costs of those increases, and raised the minimum wage for nursing staff such as RNs, LPNs, and aides. Arkansas switched to a full

[42]This pattern appears to reflect a common statistical phenomenon in which high and low values tend to move closer to the average over time.

[43]Our sample included 30 percent of the facilities in Arkansas, 38 percent of the facilities in Nebraska, 62 percent of the facilities in North Dakota, and 16 percent of the facilities in Oklahoma. SNFs in four other states had staffing increases of 15 minutes or more, but those changes were not statistically significant.

cost-based reimbursement system for Medicaid services in January 2001, in part to provide facilities with stronger incentives to increase staffing; the state had previously relied on minimum nurse staffing ratios. In Nebraska, no new state policies specific to nursing staff in SNFs were put in place during 2000 or 2001.

Conclusions

The change to the nursing component of the SNF PPS payment rate was one of several increases to the rates since the PPS was implemented in 1998. This temporary increase, enacted in the context of payment and workforce uncertainty, was intended to encourage SNFs to increase their nursing staff, although they were not required to spend the added payments on staff. In our analysis of the best available data, we did not find a significant overall increase in nurse staffing ratios following the change in the nursing component of the Medicare payment rate. Although the payment change could have paid for about 10 added minutes of nursing time per patient day for all SNF patients, we found that on average SNFs increased their staffing ratios by less than 2 minutes per patient day. Nurse staffing ratios fell in some SNFs during this period and increased in others by roughly an equal amount—the same pattern that occurred before the payment increase took effect. Our analysis—overall and for different types of SNFs—shows that increasing the nursing component of the Medicare payment rate was not effective in raising nurse staffing.

Matter for Congressional Consideration

Our analysis of available data on SNF nursing staff indicates that, in the aggregate, SNFs did not have significantly higher nursing staff time after the increase to the nursing component of Medicare's payment. We believe that the Congress should consider our finding that increasing the Medicare payment rate was not effective in raising nurse staffing as it determines whether to reinstate the increase to the nursing component of the Medicare SNF rate.

Agency Comments and Our Evaluation

We received written comments on a draft of this report from CMS and oral comments from representatives of the American Association of Homes and Services for the Aging (AAHSA), which represents not-for-profit nursing facilities; AHCA, which represents for-profit and not-for-profit nursing facilities; and the American Hospital Association (AHA), which represents hospitals.

CMS

CMS said that our findings are consistent with its expectations as well as its understanding of other research in this area. CMS also stated that our

report is a useful contribution to the ongoing examination of SNF care under the PPS. CMS's comments appear in appendix III.

Industry Associations

Representatives from the three associations who reviewed the draft report shared several concerns. First, indicating that our statements were too strong given the limitations of the study, they objected to the report's conclusions and matter for congressional consideration. Second, they noted that the draft should have included information about the context in which SNFs were operating at the time of the Medicare payment increase, specifically, the nursing shortage and SNF staff recruitment and retention difficulties. Finally, they noted that SNFs could have used the increased Medicare payments to raise wages or improve benefits rather than hire additional nursing staff.

The industry representatives expressed several concerns about the limitations of our data and analysis. The AAHSA representatives noted that, for individual SNFs, the accuracy of OSCAR is questionable; they agreed, however, that the average staffing ratios we reported for different types of SNFs looked reasonable and were consistent with their expectations. The AHA representatives said that, while OSCAR data are adequate for examining staffing ratios, we should nonetheless have used other sources of nurse staffing data—such as payroll records and Medicaid cost reports—before making such a strong statement to the Congress. The AHCA representatives noted that, due to the limitations of OSCAR data, our analyses of staffing ratios reflect staffing for all SNF patients rather than staffing specifically for SNF patients whose stays are covered by Medicare. They stressed that the small increase in staffing for patients overall could have represented a much larger increase for Medicare-covered SNF patients. In addition, representatives from both AHCA and AHA were concerned that our period of study after the payment increase—May through December 2001—was too short to determine whether SNFs were responding to the added payments. They also cited delays in SNFs being paid under the increased rates as an explanation for our findings. The AHCA representatives further noted that the lack of change in staffing was not surprising, given the short period, and that the payment increase was temporary, applied to only one payer, and affected only about 10 to 12 percent of SNFs' business. AAHSA representatives noted that, to be meaningful, staffing ratios must be adjusted for acuity—the severity of patients' conditions.

Representatives from all three groups also stated that the report lacked sufficient information on contextual factors that could have affected SNF

staffing ratios during our period of study. They said that we should have provided information on the nursing shortage as well as on SNF staff recruitment and retention difficulties. They further stated that SNFs' difficulties in recruiting and retaining staff could explain why we found little change in nurse staffing ratios. The AAHSA representatives were concerned that the report omitted information on the economic slowdown's effect on state budgets and Medicaid payment rates, which could have discouraged SNFs from hiring during the period of the increased nursing component. Finally, both AAHSA and AHA representatives commented that the report gave too little attention to state minimum staffing requirements, indicating that SNFs would be more responsive to those requirements than to the Medicare payment increase. The AAHSA representatives noted that facilities may have increased their nursing staff to meet state minimum staffing requirements prior to the Medicare increase. The AHA representatives stated that we may not have found staffing increases because, when states require a minimum level of staff, facilities tend to staff only to that minimum. They also commented that state requirements may have had a greater effect on staffing than the nursing component increase, which was temporary and had only been in effect for a limited time.

Representatives from all three groups noted that facilities could have opted to raise wages, improve benefits, or take other steps to recruit or retain staff, rather than hire additional nurses or aides. AHA added that we did not consider whether, prior to the rate increase, nurse staffing was adequate; if it was, SNFs may have chosen to spend the added Medicare payments on retention rather than on hiring. In addition, AASHA and AHCA representatives noted that we did not address what would happen to nursing staff and margins if the payment increase were not in place. The AAHSA representatives stated that, without the increase, staffing might have decreased. AHCA representatives noted that we should have considered the implications for SNF margins of not continuing the payment increase.

Our Response

As noted throughout the draft report, in conducting our study we considered the limitations of the data and the analyses we could perform. We therefore tested whether these limitations affected our results. Taking account of those tests and the consistency of our findings across categories of SNFs, we determined that the available evidence was sufficient to conclude that the increased payment did not result in higher nursing staff time. Our evidence consistently shows that staffing ratios changed little after the nursing component payment increase was

implemented. However, we modified our conclusions to reiterate the limitations of our study.

Regarding the representatives' specific concerns about the limitations of our data and analysis:

- In the draft report, we detailed our efforts to correct OSCAR data errors. We have no evidence that OSCAR data are biased in the aggregate or that errors in OSCAR data would have understated the change in nurse staffing ratios.
- In the draft report we noted that neither payroll records nor Medicaid cost reports were feasible sources of staffing data for this study. We have no reason to think that our results would have been different if we had used those data sources because a HCFA study found that those other sources yielded comparable aggregate staffing levels to those in OSCAR.[44] We believe that the data from OSCAR were appropriate for examining staffing ratio changes because OSCAR is the only nationally uniform data source that allowed us to compare staffing ratios before and after the payment increase.
- In the draft report, we stated that while nurse staffing ratios apply to all SNF patients and not just Medicare patients, we found no relationship between changes in staffing ratios and the percentage of a SNF's patients paid for by Medicare. Specifically, staffing increases were no larger in SNFs with a greater percentage of Medicare patients than in those with a smaller percentage of Medicare patients.
- The staffing changes in SNFs surveyed in the months just after the payment increase was implemented differed little from staffing changes of those SNFs surveyed later in 2001. Because we found no relationship between SNFs' staffing ratio changes and the amount of time that had passed since the payment increase (which ranged from 1 to 9 months), we believe that our period of study was sufficiently long to determine whether SNFs were responding to the payment increase. We have added information on this analysis to the report.
- We agree that adjusting for patients' acuity is particularly important for comparing staffing among different facilities; however, acuity averaged over all facilities varies little over short periods.[45] Moreover, unless

[44]See HCFA, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase I.* HCFA's analysis was based in part on data from a special survey of payroll records from facilities in Ohio.

[45]See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2001).

patients' acuity declined after the nursing component increase—and we have no evidence that it did—adjusting for acuity would not have affected our finding that nursing staff time changed little.

Regarding representatives' concerns that we did not include sufficient information on external factors affecting SNFs:

- We added information to the report on issues related to the nursing workforce.
- Hiring difficulties would not have prevented SNFs from expanding the hours of their existing nursing staff or using temporary nurses and aides from staffing agencies—which would have been reflected in staffing ratios.
- With respect to the possible influence of a weak economy on Medicaid payments and SNF staffing levels, we noted in the draft report that the pattern of nursing staff changes from 2000 to 2001 was similar to the pattern from 1999 to 2000—a period when the economy was considerably stronger.
- If SNFs increased nursing staff in response to new state requirements during 2001, our study would have attributed these increases to the Medicare payment change.

Regarding the representatives' statements about alternate ways SNFs could have used the increased Medicare payments:

- To the extent that SNFs used the added Medicare payments for higher wages or benefits, they may have reduced staff vacancies, which in turn may have resulted in higher staffing ratios. However, we found little change in nurse staffing ratios after the Medicare payment increase.

Regarding the representatives' statements about the adequacy of SNF staffing:

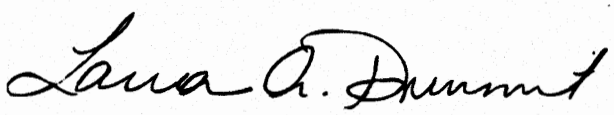
- Because staffing adequacy was not within the scope of our study, we did not consider whether staffing was adequate prior to the rate increase, or whether this influenced SNFs' hiring decisions. The Congress directed CMS to address this issue, which it did in two reports. The first report, published in 2000, suggested that staffing might not be adequate in a significant number of SNFs. This was reaffirmed in CMS's recent report.[46]

[46]See HCFA, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase I* and CMS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report.*

CMS, AAHSA, AHCA, and AHA also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Administrator of CMS, interested congressional committees, and other interested parties. We will also provide copies to others upon request. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staffs have any questions, please call me at (202) 512-7114. Other GAO contacts and staff acknowledgments are listed in appendix IV.



Laura A. Dummit
Director, Health Care—Medicare Payment Issues

Appendix I: Data Source and Data Verification Methods for Nurse Staffing Ratio Analysis

This appendix describes the selection of the data source for our analysis, the characteristics of that data source, and procedures used to verify data accuracy and make adjustments.

Data Sources Considered

To assess the impact on nurse staffing ratios of the April 1, 2001, increase in the nursing component of the SNF payment, we needed a nationally uniform data source that included the number of patients and the number of nursing staff (full-time equivalents (FTE)) or nursing hours, for two periods—before April 1, 2001, to establish a baseline, and after April 1, 2001. We considered several sources of nursing staff data, including SNF payroll data, Medicaid cost reports, and CMS's OSCAR system.

We determined that payroll records could not be used for several reasons. CMS has collected and analyzed nursing home payroll data in several states and has found that it is difficult to ensure that the staffing data refer to hours worked (as required for an analysis of nurse staffing ratios) rather than hours paid, which includes time such as vacation and sick leave.[1] CMS also found that although current nursing home payroll records were usually available, older records were difficult to obtain; consequently, it is unlikely that we would have been able to get records prior to the rate increase. Finally, payroll records do not include information on the number of patients and would have had to be supplemented with other data.

Similarly, Medicaid cost reports were not an appropriate source of data. While these reports by SNFs to state Medicaid agencies contain data on both patients and nursing staff, Medicaid cost reports do not permit a comparison of staffing ratios before and after the 16.66 percent increase in the nursing component because these reports cover a 12-month period that cannot be subdivided. Furthermore, these reports do not contain nationally uniform staffing data because the categories and definitions differ from state to state. Finally, the 2001 reports were not available in time for our analysis.

OSCAR is the only uniform data source that contains data on both patients and nursing staff. Moreover, OSCAR data are collected at least every 15

[1]See CMS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report* (Baltimore, Md.: December 2001).

months, allowing us to compare staffing ratios before and after the 16.66 percent increase in the nursing component.

OSCAR Data

The states and the federal government share responsibility for monitoring compliance with federal standards in the nation's roughly 15,000 SNFs. To be certified for participation in Medicare, Medicaid, or both, a SNF must have had an initial survey as well as subsequent, periodic surveys to establish compliance. On average, SNFs are surveyed every 12 to 15 months by state agencies under contract to CMS. In a standard survey,[2] a team of state surveyors spends several days at the SNF, conducting a broad review of care and services to ensure that the facility complies with federal standards and meets the assessed needs of the patients. Data on facility characteristics, patient characteristics, and staffing levels are collected on standard forms. These forms are filled out by each facility at the beginning of the survey and are certified by the facility as being accurate. After the survey is completed, the state agency enters the data from these forms into OSCAR, which stores data from the most current and previous three surveys.

Although OSCAR was the most suitable data source available for our analysis, it has several limitations. First, OSCAR provides a 2-week snapshot of staffing and a 1 day snapshot of patients at the time of the survey, so it may not accurately depict the facility's staffing and number of patients over a longer period. Second, staffing is reported across the entire facility, while the number of patients are reported only for Medicare- and Medicaid-certified beds. OSCAR, like other data sources, does not distinguish between staffing for Medicare patients and staffing for other patient groups. Finally, the Health Care Financing Administration (HCFA) reported that OSCAR data are unreliable at the individual SNF level.[3] However, the agency's recent analysis has concluded that the OSCAR-based staffing measures appear "reasonably accurate" at the aggregate level (e.g., across states). Neither CMS nor the states attempt to verify the accuracy of the staffing data regularly.

[2]In addition to the standard survey, state agencies conduct other surveys including complaint surveys.

[3]See HCFA, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase I* (Baltimore, Md.: July 2000).

Limitations to Our Analysis

In addition to limitations inherent in OSCAR data, our analysis was limited in several ways. First, our sample included only SNFs for which OSCAR data were available both before and after the 16.66 percent increase in the nursing component took effect. Second, our analysis of staffing ratios after the increase took effect was limited to data collected from May through December 2001. As a result, we only reviewed data for 8 months after the payment increase was implemented, although our results do not appear to be affected by any seasonal trends in staffing.[4] We were not able to review data for a later period when facilities might have used the payment increase differently.[5] Finally, due to data entry lags, when we drew our sample in January 2002, OSCAR did not include data from some facilities surveyed from May through December 2001.[6]

Creation of the Sample

To determine the change in nurse staffing ratios, we selected all facilities surveyed from May through December 2001 that also had a survey during 2000, which could serve as the comparison. This sample contained OSCAR data for 6,522 facilities. (See table 5.) Although not a statistical sample that can be projected to all SNFs using statistical principles, the sample is unlikely to be biased because it was selected on the basis of survey month. Our sampling procedure, in which selection depended solely on the time of survey, was unlikely to yield a sample with characteristics that differ substantially from those of the entire population of SNFs. We found no significant differences between these 6,522 SNFs and the 13,454 SNFs that were surveyed in calendar year 2000, in terms of various characteristics—the proportion that are hospital-based, the proportion that are for-profit, the share of a facility's patients that are paid for by Medicare, and the

[4]To test whether our results reflected any seasonal trends in staffing, we examined the change in nurse staffing ratios among facilities surveyed from May through December of both 2000 and 2001. We found that these facilities had a small change in their nurse staffing ratios that was similar to the change among facilities that were surveyed at any time during calendar year 2000 and from May to December 2001.

[5]Although the payment increase began with services furnished on or after April 1, 2001, according to CMS, facilities would not have begun to receive the added payments until May 1, 2001, because of the time it takes to process claims. We compared the change in staffing ratios among facilities surveyed in May and June 2001 to those surveyed in July and August 2001 and found no significant difference. This suggests that the results were not affected by examining staffing soon after the payment change.

[6]We compared the change in staffing ratios among SNFs surveyed from May through August 2001 to the change among those surveyed later in the year—the period for which state agencies had not yet entered all survey data into OSCAR—and found no significant difference.

capacity of the facilities. However, our sample was not distributed across states like the population of SNFs. (See table 6.) This may be because state agencies differ in the amount of time required to complete entry of survey data into OSCAR. In addition, we excluded from our sample 449 SNFs that, based on their 2000 Medicare claims data, had received payments from Medicare that were not determined under the PPS. The resulting sample had 6,073 facilities—over one-third of all SNFs.

Table 5: Creation of Our Sample of SNFs

	Number of SNFs
Total SNFs in 2000 OSCAR file (no duplicates)	13,454
Total SNFs in 2001 OSCAR file	14,760
SNFs surveyed from May 2001 through December 2001	6,775
SNFs also with survey in calendar year 2000	6,522
SNFs that had received Medicare payments not determined under the PPS	-449
Original sample	6,073

Source: GAO analysis of CMS's OSCAR data and Medicare claims data.

Table 6: Distribution of SNFs across States (In Percentages)

	All SNFs with OSCAR data in calendar year 2000 (n=13,454)	Sample SNFs* (n=6,522)
Alabama	1.34	1.84
Alaska	0.10	0.08
Arizona	0.99	0.86
Arkansas	1.40	1.15
California	7.50	7.65
Colorado	1.32	1.27
Connecticut	1.77	2.02
Delaware	0.27	0.28
District of Columbia	0.13	0.11
Florida	5.01	5.24
Georgia	2.19	2.81
Hawaii	0.27	0.25
Idaho	0.54	0.69
Illinois	4.60	4.35
Indiana	3.43	3.77
Iowa	2.00	2.18
Kansas	1.86	1.59

	All SNFs with OSCAR data in calendar year 2000 (n=13,454)	Sample SNFs[a] (n=6,522)
Kentucky	2.01	2.13
Louisiana	1.79	1.79
Maine	0.85	0.95
Maryland	1.68	0.61
Massachusetts	3.20	2.59
Michigan	2.80	3.51
Minnesota	2.75	2.81
Mississippi	0.97	1.18
Missouri	3.26	2.61
Montana	0.65	0.58
Nebraska	1.05	1.23
Nevada	0.33	0.21
New Hampshire	0.38	0.32
New Jersey	2.42	1.98
New Mexico	0.46	0.43
New York	4.39	3.31
North Carolina	2.83	3.13
North Dakota	0.63	0.81
Ohio	5.72	5.80
Oklahoma	1.46	0.52
Oregon	0.88	1.07
Pennsylvania	5.34	5.78
Rhode Island	0.62	0.64
South Carolina	1.22	1.29
South Dakota	0.64	0.66
Tennessee	1.84	1.98
Texas	7.20	7.41
Utah	0.57	0.74
Vermont	0.28	0.31
Virginia	1.61	1.72
Washington	1.86	2.12
West Virginia	0.81	0.37
Wisconsin	2.53	3.01
Wyoming	0.24	0.26

Note: These percentages do not add to 100 because we did not include the small percentage of SNFs located in Puerto Rico, Guam, and the United States Virgin Islands.

[a]The sample includes all SNFs with OSCAR data for both calendar year 2000 and May to December 2001.

Source: GAO analysis of CMS's OSCAR data.

Validating and Correcting OSCAR Data

To assess the accuracy of the OSCAR data in our sample, we applied decision rules developed by CMS for its study of minimum nurse staffing ratios to identify facilities with data that appeared to represent data entry or other reporting errors.[7] In addition, we identified facilities in our sample that had changes in their nurse staffing ratios greater than 100 percent, but that did not report 100 percent changes in both total patients and total beds. Using these rules, we identified 570 facilities for review. For 536 of these facilities, we obtained the original forms completed by SNF staff and used for entering data into OSCAR, from the state survey agencies. We compared the data on the forms to the OSCAR entries and identified 159 facilities with data entry errors. For these facilities, we corrected the data, although 12 continued to be outliers and were excluded. For 179 facilities, we telephoned the SNF to verify its data; 65 facilities confirmed that OSCAR correctly reported their data. Based on the information gathered in these calls, we were able to correct the data for an additional 47 facilities. We also excluded 35 facilities for which we could not correct the data. In addition, we excluded 915 SNFs with more total beds than certified beds because they may have inaccurate staffing ratios.[8] Other facilities were excluded because we did not receive their forms, we were unable to call the SNFs, or we did not receive replies from them. After these exclusions, our final sample contained 4,981 SNFs. (See table 7.)

[7]These rules identified facilities that reported more patients than beds, 12 or more hours of nursing time per patient day, less than 30 minutes of nursing time per patient day, and any hours coded as "999"—which could indicate reporting error. Other researchers who use OSCAR data have developed similar decision rules. Although we also initially used a CMS rule to identify facilities that had no staff registered nurse (RN) hours but 60 or more beds, we did not exclude facilities based on this rule because we later determined it was not a good indicator of problem data. After reviewing the federal SNF staffing regulations and discussing these requirements with a number of SNFs, we determined that a SNF could have 60 or more beds and have no RNs except for administrative staff. 42 C.F.R . § 483.23 (2001).

[8]Facilities are instructed to report only patients in certified beds. As a result, the number of patients reported in OSCAR for these facilities may not truly reflect the number of patients who received care from nursing staff.

Table 7: Exclusions from the Sample

	Number of SNFs
Original sample	6,073
Facilities with edited data that were still identified as outliers	12
Facilities for which we could not correct the data	35
Facilities that had closed	3
Facilities with more total beds than certified beds	915[a]
Facilities for which we did not receive forms	34
Facilities that we were unable to call	81
Facilities that did not reply	12
Final sample	4,981

[a]These SNFs were excluded because they may have inaccurate staffing ratios. Facilities are instructed to report only patients in certified beds. As a result, the number of patients reported in OSCAR for these facilities may not reflect the number of patients who received care from nursing staff.

Source: GAO analysis of CMS's OSCAR data.

Nurse Staffing Ratios

We calculated nurse staffing ratios—hours per patient day—for each facility by dividing the total nursing hours[9] by the estimated number of patient days.[10] We calculated nurse staffing ratios for all nursing staff as well as for each category of staff: RNs, LPNs, and aides. We also calculated the change in these ratios for each facility in our sample. We analyzed these changes in nurse staffing ratios overall and for several categories of SNFs, including for-profit, not-for-profit, and government-owned facilities. We also analyzed these changes based on each facility's prior year staffing ratio. Finally, we supplemented the staffing data with cost and payment data from Medicare cost reports for 2000 and related the changes in nurse staffing ratios to each SNF's total margin—a measure of its financial status. We tested whether staffing ratio changes from 2000 to 2001 were statistically significant—that is, statistically distinguishable from zero. In

[9]Total nursing hours includes the number of full-time, part-time, and contract RN, licensed practical nurse (LPN), certified nurse aide (CNA), CNA-in-training, and medication technician hours reported in OSCAR for a 2-week period. Nursing hours do not include RN directors of nursing or nurses with administrative duties. In addition, nursing hours reflect the amount of time that nursing staff were at work, but do not necessarily reflect the time they spent with patients. For example, they may spend a portion of their day in training or on breaks.

[10]We estimated patient days by multiplying by 14 the number of patients reported in OSCAR for 1 day.

addition, for the analyses of SNFs' prior year staffing and their financial status, we tested whether, between any two groups of SNFs, the difference in their staffing ratio changes was statistically significant.

Appendix II: Average Change in Nursing Staff Time between 2000 and 2001, Grouped by Category of SNF

Category	Average nursing time per patient day		Change in minutes
	Calendar year 2000	May-December 2001	
Hospital-based	5 hours, 32.1 minutes	5 hours, 32.0 minutes	-0.1 minutes
Freestanding	3 hours, 6.7 minutes	3 hours, 8.9 minutes	2.1 minutes
For-profit	3 hours, 8.3 minutes	3 hours, 9.5 minutes	1.3 minutes
Not-for-profit	3 hours, 51.9 minutes	3 hours, 54.6 minutes	2.7 minutes
Government	3 hours, 53.8 minutes	3 hours, 58.9 minutes	5.0 minutes
Chain	3 hours, 14.9 minutes	3 hours, 15.4 minutes	0.5 minutes
Nonchain	3 hours, 34.7 minutes	3 hours, 38.6 minutes	3.9 minutes

Note: For freestanding and nonchain SNFs, the change in minutes between 2000 and 2001 was significant at the .05 level. Due to rounding, the reported change in minutes does not always match the 2000 and 2001 figures exactly.

Source: GAO analysis of CMS's OSCAR data.

Appendix III: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 25 2002

TO: Laura A. Dummit
Director, Health Care—Medicare Payment Issues
General Accounting Office

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Report, "*Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little After Medicare Payment Increase*" GAO-02-1051

As requested, we have reviewed the above-captioned report, which GAO developed in response to Section 312 of the Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554, Appendix F). The BIPA legislation provided for a temporary, 16.66 percent increase in the nursing component of the case-mix adjusted payment rates for skilled nursing facilities (SNFs), from April 1, 2001, through September 30, 2002. It also directed GAO to study the payment increase impact on nurse staffing ratios in SNFs, and to submit its findings to the Congress, including a recommendation on whether the payment increase should be continued.

The report finds that there was no significant overall increase in nurse staffing ratios after the payment increase went into effect. It attributes the modest staffing changes that did occur mainly to other factors, such as payment or policy changes in individual state Medicaid programs aimed at increasing nurse staffing. Accordingly, GAO recommends that the Congress consider permitting the payment increase to expire.

We believe that the report represents a useful contribution to the ongoing examination of SNF care under the prospective payment system, and we appreciate receiving the opportunity to review it. The GAO's findings in this report are consistent with our expectations, as well as our understanding of other findings in this area.

Appendix IV: GAO Contacts and Staff Acknowledgments

GAO Contacts

Jonathan Ratner, (202) 512-7107
Phyllis Thorburn, (202) 512-7012

Acknowledgments

Major contributors to this report were Robin Burke, Jessica Farb, and Dae Park.

Related GAO Products

Skilled Nursing Facilities: Providers Have Responded to New Payment System By Changing Practices. GAO-02-841. Washington, D.C.: August 23, 2002.

Nursing Homes: Quality of Care More Related to Staffing than Spending. GAO-02-431R. Washington, D.C.: June 13, 2002.

Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities. GAO-02-279. Washington, D.C.: February 15, 2002.

Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors. GAO-01-944. *Washington, D.C.: July 10, 2001.*

Nursing Homes: Success of Quality Initiatives Requires Sustained Federal and State Commitment. GAO/T-HEHS-00-209. Washington, D.C.: September 28, 2000.

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives. GAO/HEHS-00-197. Washington, D.C.: September 28, 2000.

GAO's Mission

The General Accounting Office, the investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through the Internet. GAO's Web site (www.gao.gov) contains abstracts and full-text files of current reports and testimony and an expanding archive of older products. The Web site features a search engine to help you locate documents using key words and phrases. You can print these documents in their entirety, including charts and other graphics.

Each day, GAO issues a list of newly released reports, testimony, and correspondence. GAO posts this list, known as "Today's Reports," on its Web site daily. The list contains links to the full-text document files. To have GAO e-mail this list to you every afternoon, go to www.gao.gov and select "Subscribe to daily E-mail alert for newly released products" under the GAO Reports heading.

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are $2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. General Accounting Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

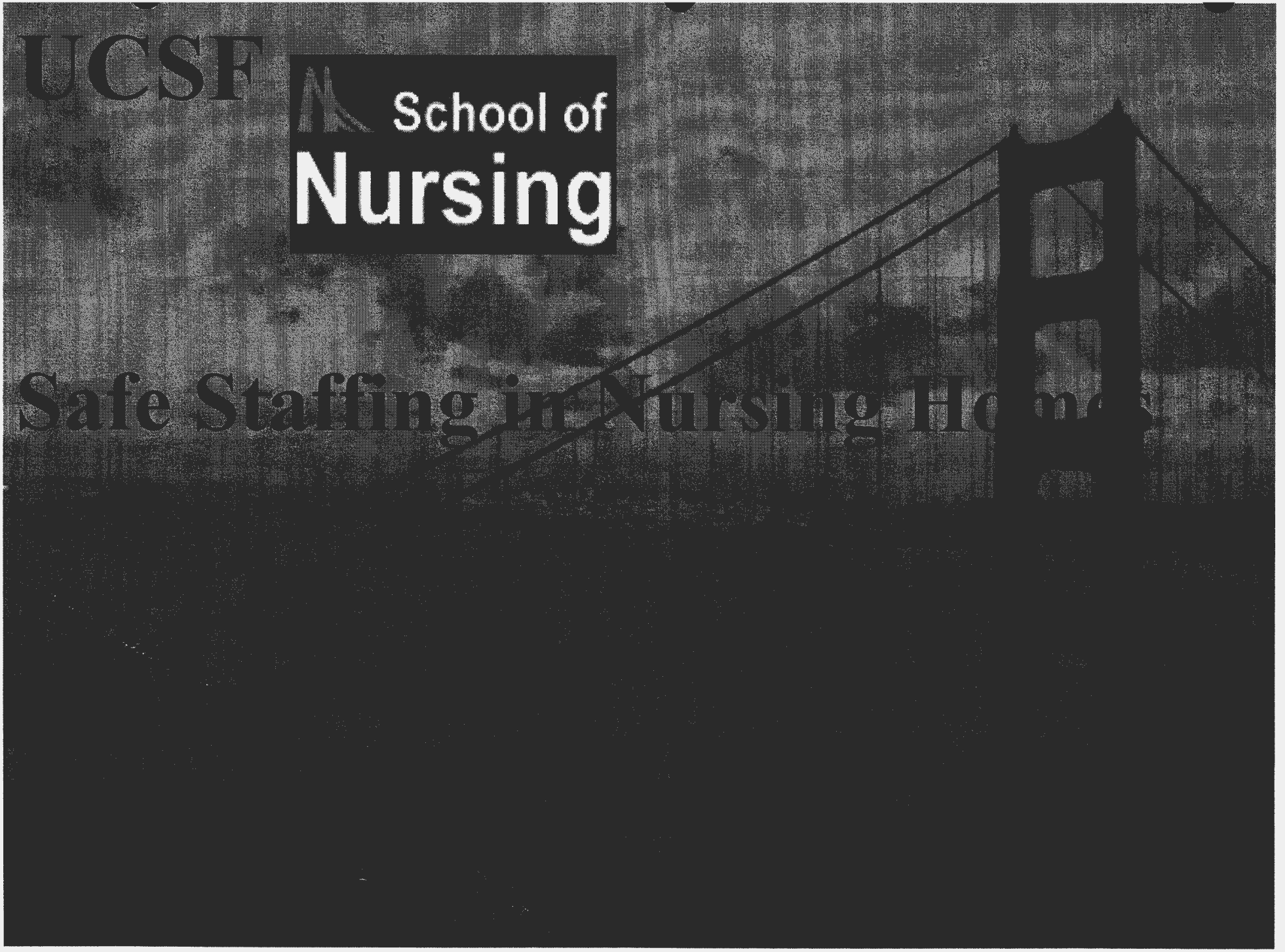
To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Public Affairs

Jeff Nelligan, managing director, NelliganJ@gao.gov (202) 512-4800
U.S. General Accounting Office, 441 G Street NW, Room 7149
Washington, D.C. 20548


UCSF
School of
Nursing
Safe Staffing in Nursing Ho

NURSING HOME RESEARCH STUDIES: SHOW A POSITIVE RELATIONSHIP BETWEEN NURSING HOURS & QUALITY

- Linn et al. 1977
- Fottler et al. 1981
- Nyman l988
- Kayser-Jones l989
- Monroe l990
- Gustafson et al 1990
- Spector/Takada 1991
- Cherry 1991
- Braun, 1991
- Johnson-Pawlson 1993
- Cohen/Spector 1994
- Kayser-Jones 1997
- Harrington et al 1999
- IOM 2001
- IOM 2003

Includes RNs, LVNs, and Nursing Assistants

MORE NURSES IN NURSING HOMES

- **Reduce mortality**
- **Improve functional ability**
- **Improve nutritional status**
- **Reduce behavioral problems**
- **Improve quality of life**
- **Reduce restraint use**
- **Reduce deficiencies**
  - **IOM Reports 1996, 2001, 2003**

CMS Staffing Study, 2001

- **Dr. Schnelle's Simulation Model**
  - **2.8 to 3.2 NA hprd is a conservative minimum level just to carry out 5 basic care activities (1 to 7-8 residents in day/evening, 1 to 12 night)**
  - **2.8 for low, 3.0 average, 3.2 high casemix**

CMS 2001. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Final Report.

CMS 2001 STAFFING STUDY

Lower Staffing Resulted In:

Short Stay Residents

- Congestive heart failure
- Electrolyte imbalance
- Respiratory infection
- Urinary tract infections
- Sepsis

Long Stay Residents

- Less functional improvement
- Pressure sores
- Weight Loss

CMS 2001. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Final Report.

CMS 2001 STAFFING STUDY

Staffing levels below

- **2.8 NA hprd (1:8 ratio)**
- **1.3 licensed hprd (1:18 ratio) <u>including .75 RN hprd</u>**
- **4.1 hprd total**
- **have substantial probably of jeopardizing the health and safety of residents – shows a threshold**

Excludes the Director of Nursing

CMS 2001. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Final Report.

California Nursing Home Study 2001

- Study of 34 nursing homes and 887 residents
- Sample included nursing homes in
  - top 10% (4.1 hrpd) on staffing
  - top 25% on staffing & clinical indicators
  - bottom 25% on staffing & clinical indicators
- Seven Standard Protocols/measured for 3 days

Schnelle et al, HSR, 2004

Poor Care in Most CA Homes

- Weight loss problems
  - Only 4 to 7 minutes of assistance
  - Verbal interactions only 28%of time
  - False charting on food intake
- Incontinence – only toileted 1.8 times in 12 hrs
- Residents turned every 5-6 hours
- Bedfast –left in bed most of the day (>22 hrs)
- Walking assistance – only 1 time a day
- Untreated pain most of the time
- Untreated depression

Schnelle et al., HSR, 2004

California Nursing Home Study

- **Quality Indicators**
  - **Nurse Staffing**
  - **Weight Loss**
  - **Restraints**
  - **Bedfast**
  - **Pain**
  - **Pressure Ulcers**
  - **Incontinence**
  - **Depression**
  - **Physical activities**

- **Staffing is the best quality indicator on 13 of 16 process measures of care**
- **Staffing is the best predictor of processes of care**

Schnelle et al, HSR, 2004

CA Nurse Staffing Study, 2001

- Facilities with 4.1+ hprd had better nursing care processes:
  - Feeding assistance
  - Helping residents out of bed
  - Incontinence care
- Confirmed that there is a staffing threshold (4.1 hprd) before differences in care processes can be identified

Schnelle et al, 2004. Health Services Research

NY Times 2-18-02 #1

9 in 10 Nursing Homes Lack Adequate Staff, Study Finds

By ROBERT PEAR

WASHINGTON, Feb. 17 — More than 90 percent of the nation's nursing homes have too few workers to take proper care of patients, a new federal study has found.

But the Bush administration, citing the costs involved, says it has no plans to set minimum staffing levels for nursing homes, hoping instead that the problem will be resolved through market forces and more efficient use of existing nurses and nurse's aides.

The report, ordered by Congress and prepared by the Department of Health and Human Services, concludes that "it is not currently feasible" for the federal government to require that homes achieve a minimum ratio of nursing staff to pa-

Congress in a few weeks, found "strong and compelling" evidence that nursing homes with a low ratio of nursing personnel to patients were more likely to provide substandard care.

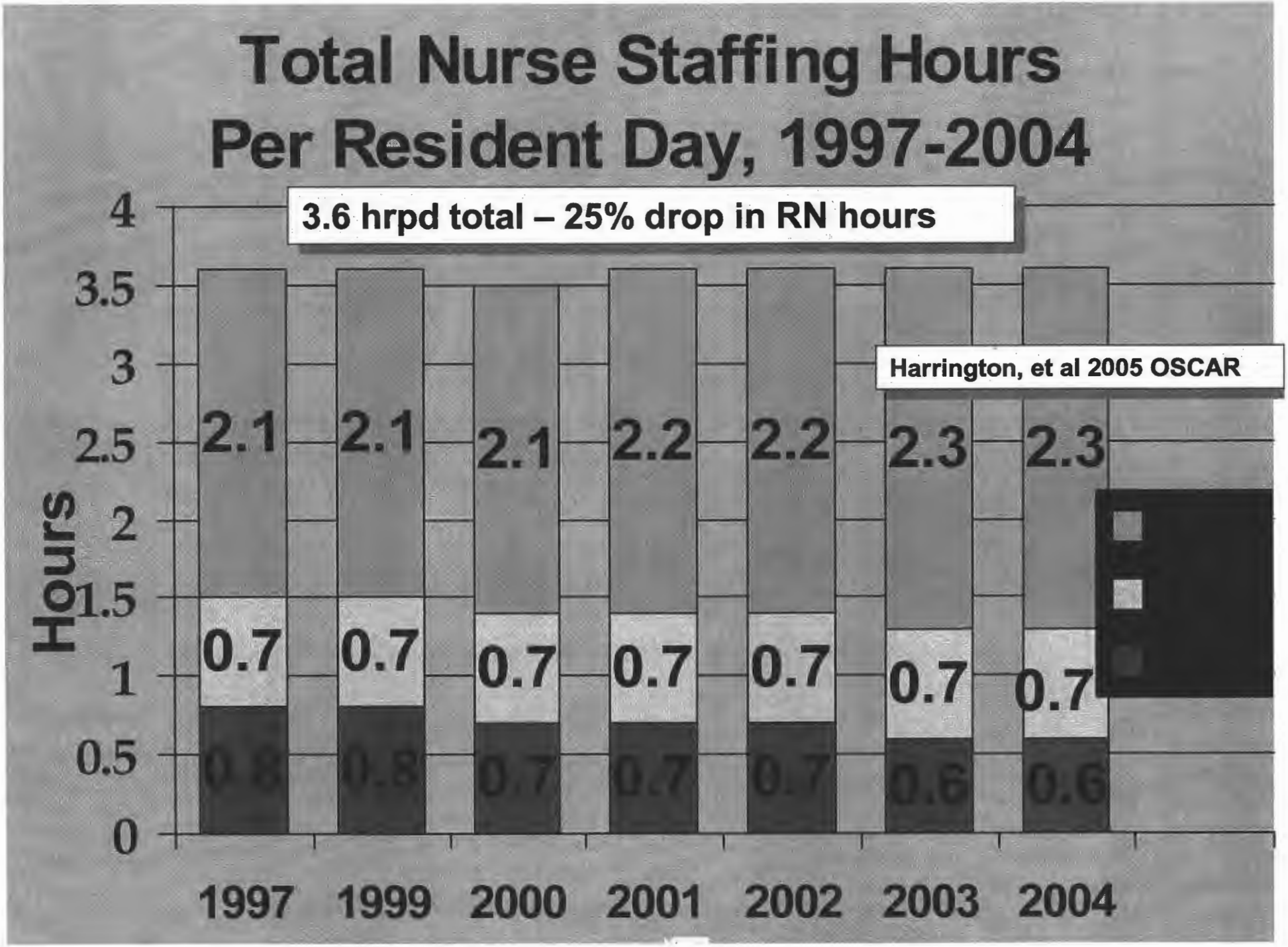
Patients in these homes were more likely to experience bedsores, malnutrition, weight loss, dehydration, pneumonia and serious bloodborne infections, the report said.

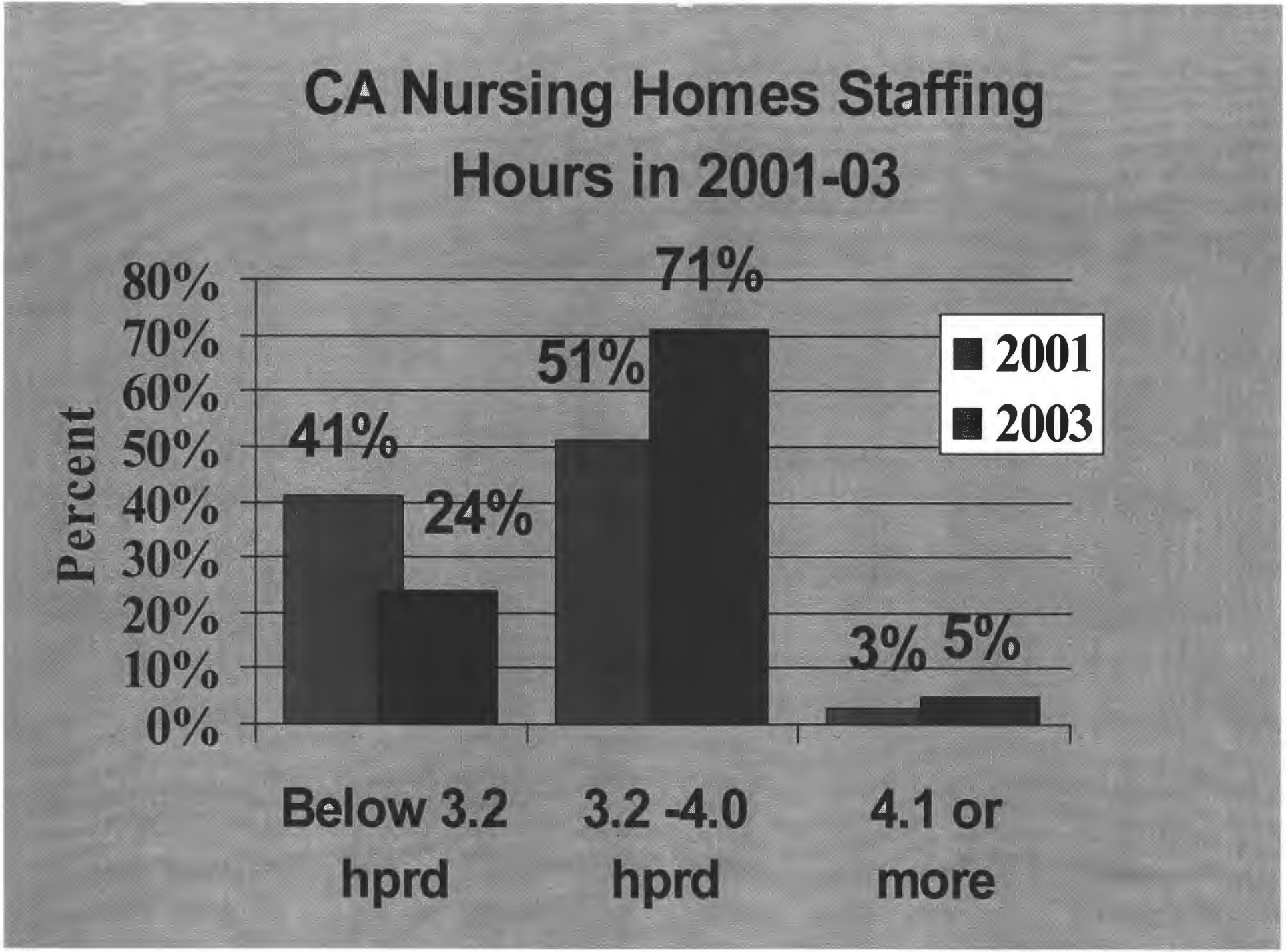
Its conclusions about the prevalence of staffing problems were borne out in interviews around the country with relatives of nursing home residents.

Anna M. Spinella, 67, of Tampa, Fla., said she had friends and relatives at nursing homes that were

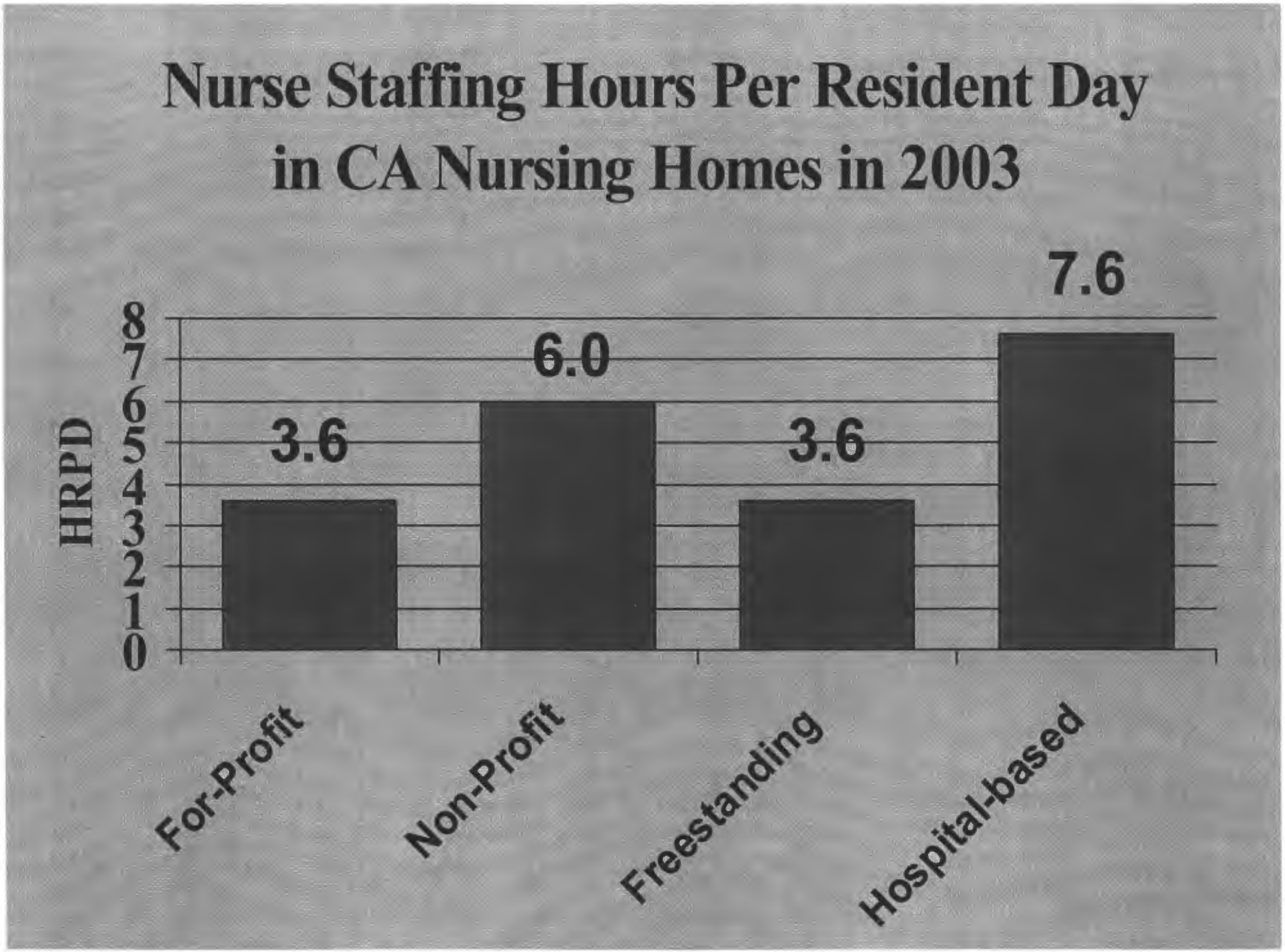
STAFFING REQUIREMENTS ARE TOO LOW

- Federal standards -- 1 RN 8 hours a day 7 days a week and 1 licensed nurse 24 hours a day
- California minimum standard of 3.2 hours a day is too low to protect the health and safety of residents
- Standards need to be 4.1 hours per resident day adjusted for casemix


Total Nurse Staffing Hours Per Resident Day, 1997-2004
3.6 hrpd total – 25% drop in RN hours
Harrington, et al 2005 OSCAR
Hours
4
3.5
3
2.5
2
1.5
1
0.5
0
2.1
2.1
2.1
2.2
2.2
2.3
2.3
0.7
0.7
0.7
0.7
0.7
0.7
0.7
0.8
0.8
0.7
0.7
0.7
0.6
0.6
1997
1999
2000
2001
2002
2003
2004


CA Nursing Homes Staffing Hours in 2001-03
Percent
80%
70%
60%
50%
40%
30%
20%
10%
0%
41%
24%
51%
71%
3%
5%
2001
2003
Below 3.2 hprd
3.2 -4.0 hprd
4.1 or more

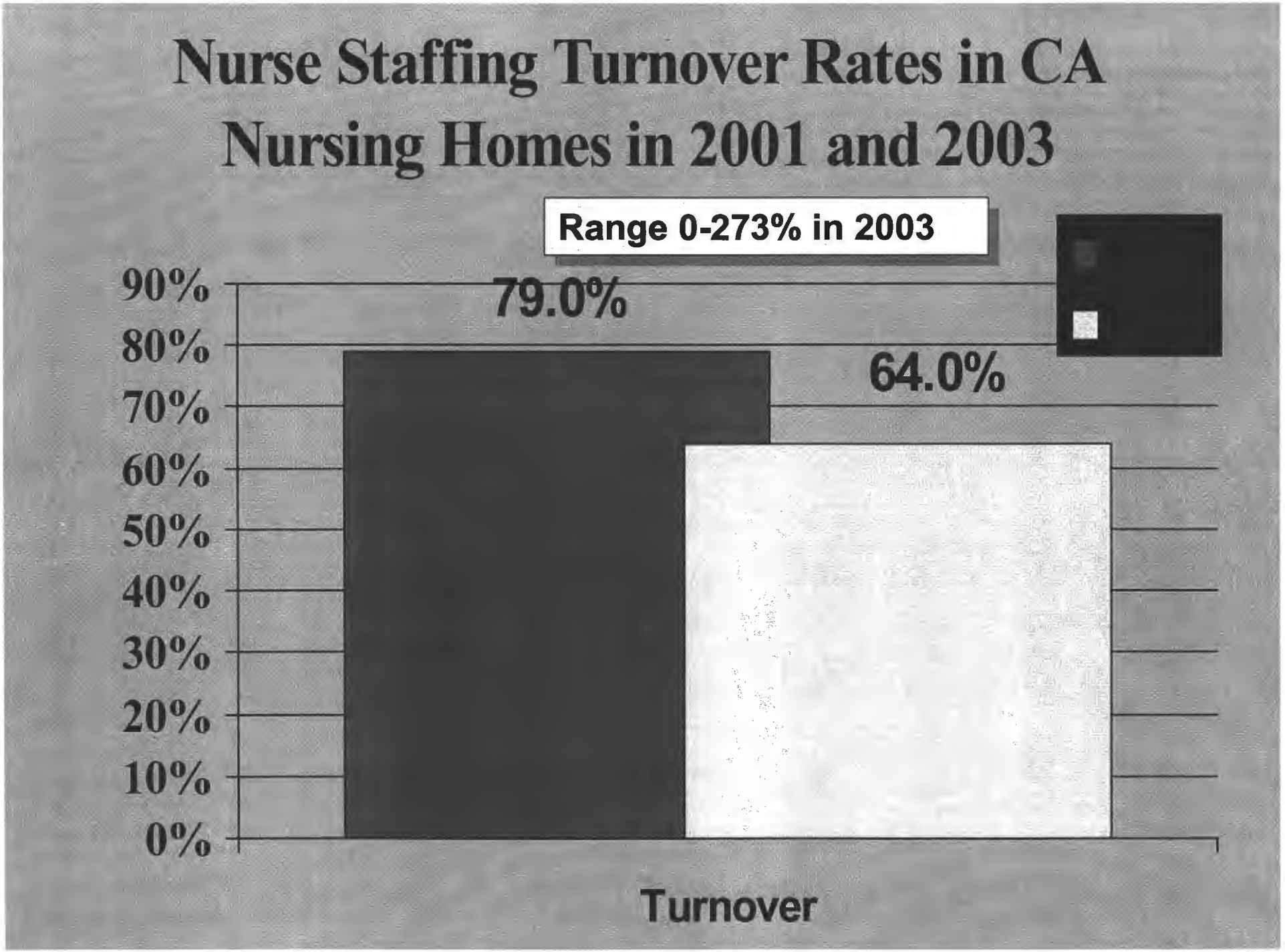
Nurse Staffing Hours Per Resident Day in CA Nursing Homes in 2003



Staffing Data

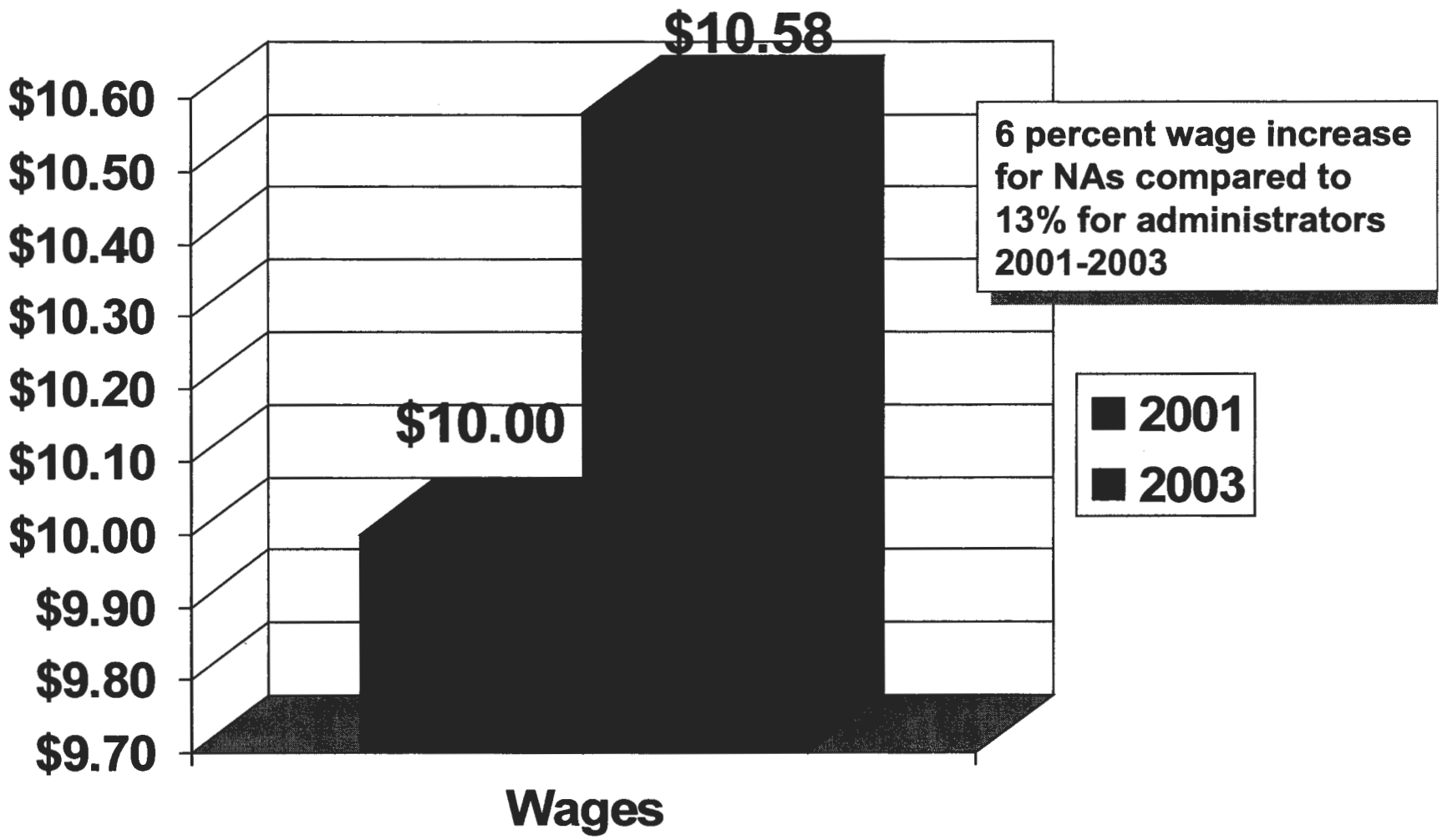
- Facilities tend to over report staffing – data are often incomplete and incorrect
- Little auditing of staffing data is done by the state
- Accurate quarterly staffing data are needed
- Facilities should be given citations for low staffing and inaccurate data

Nurse Staffing Turnover Rates in CA Nursing Homes in 2001 and 2003



Low Nursing Home Wages for Nursing Assistants

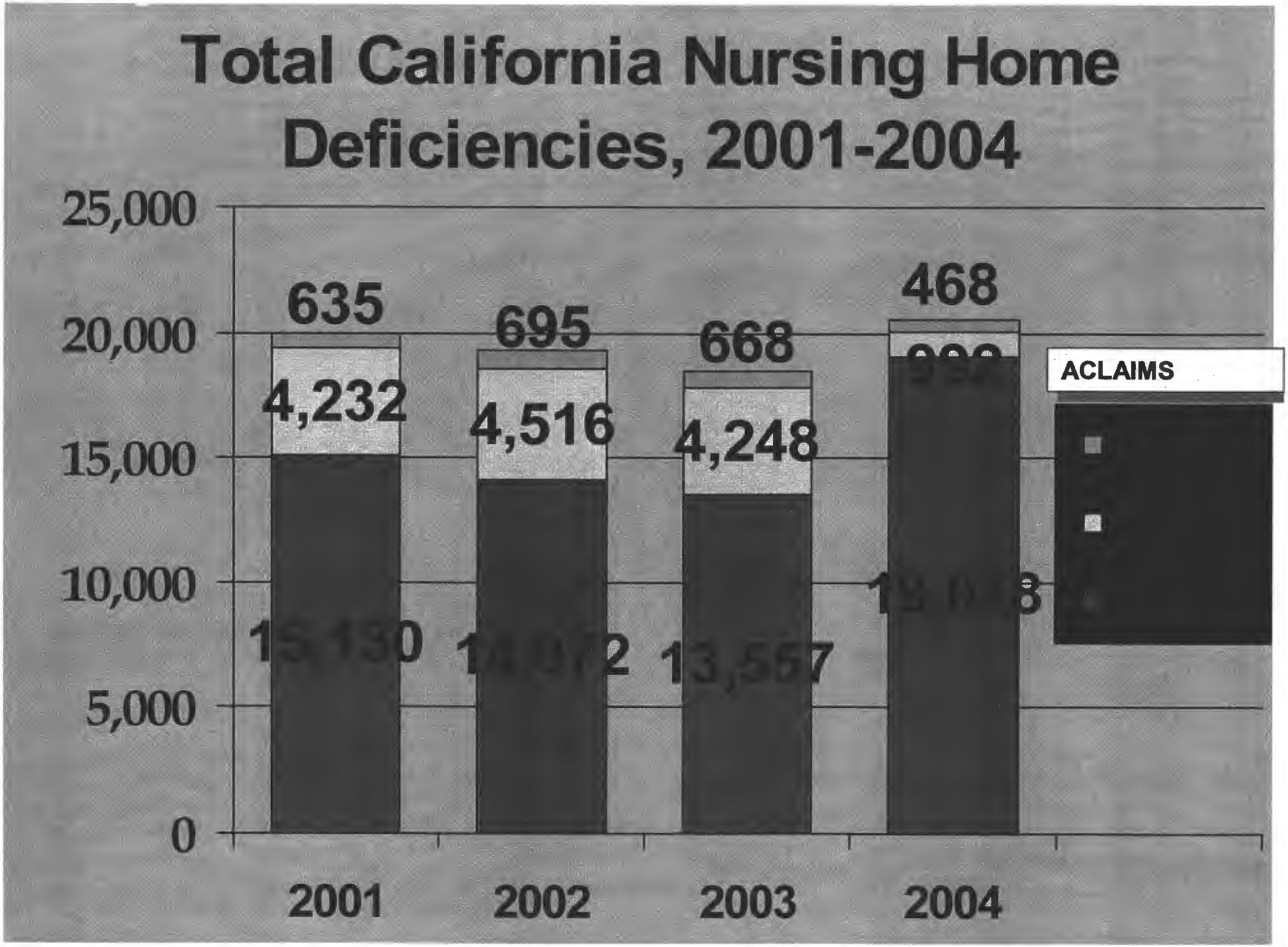
Wages 15% below hospital wages



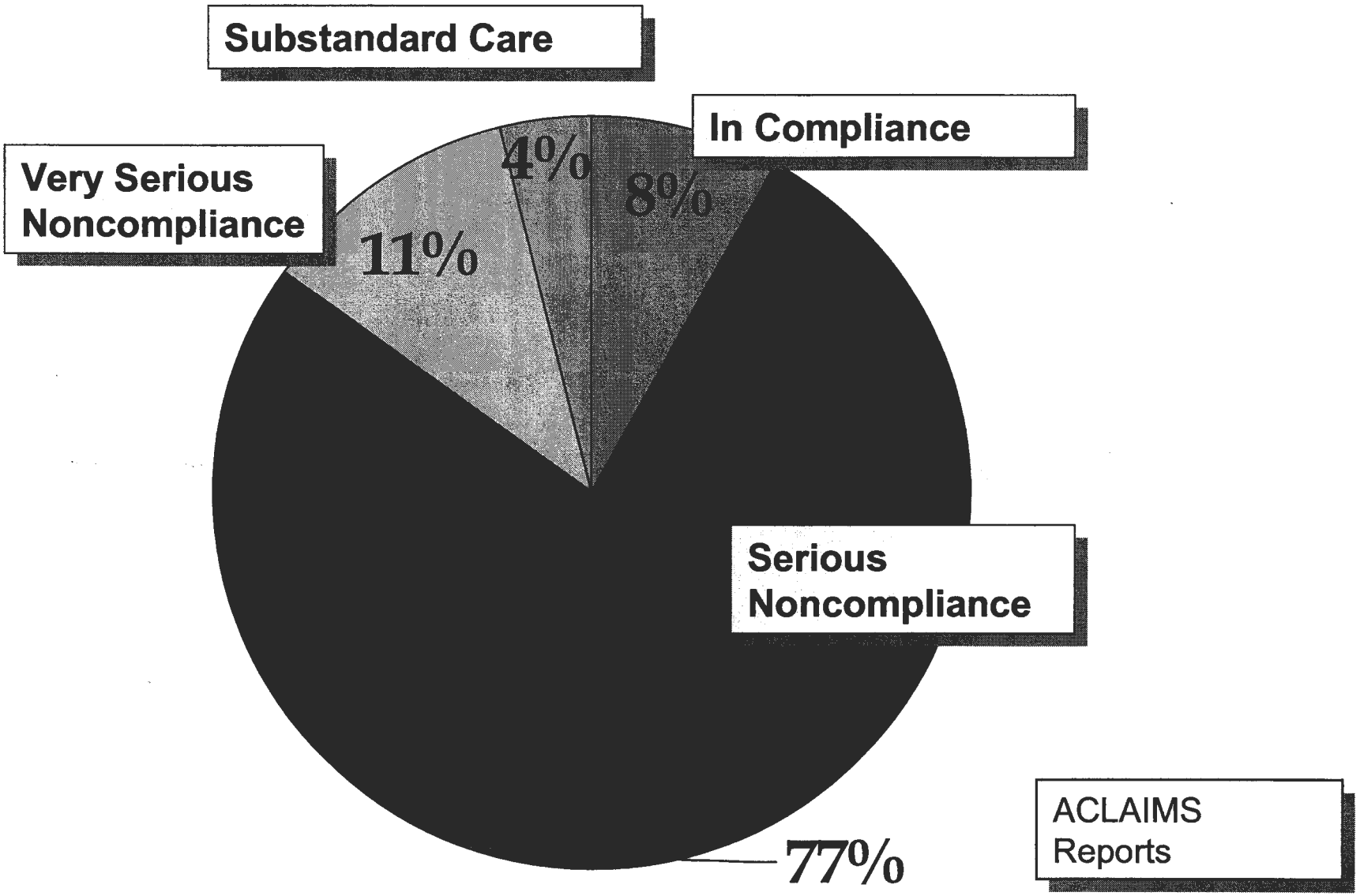
Predictors of Nurse Home Staffing

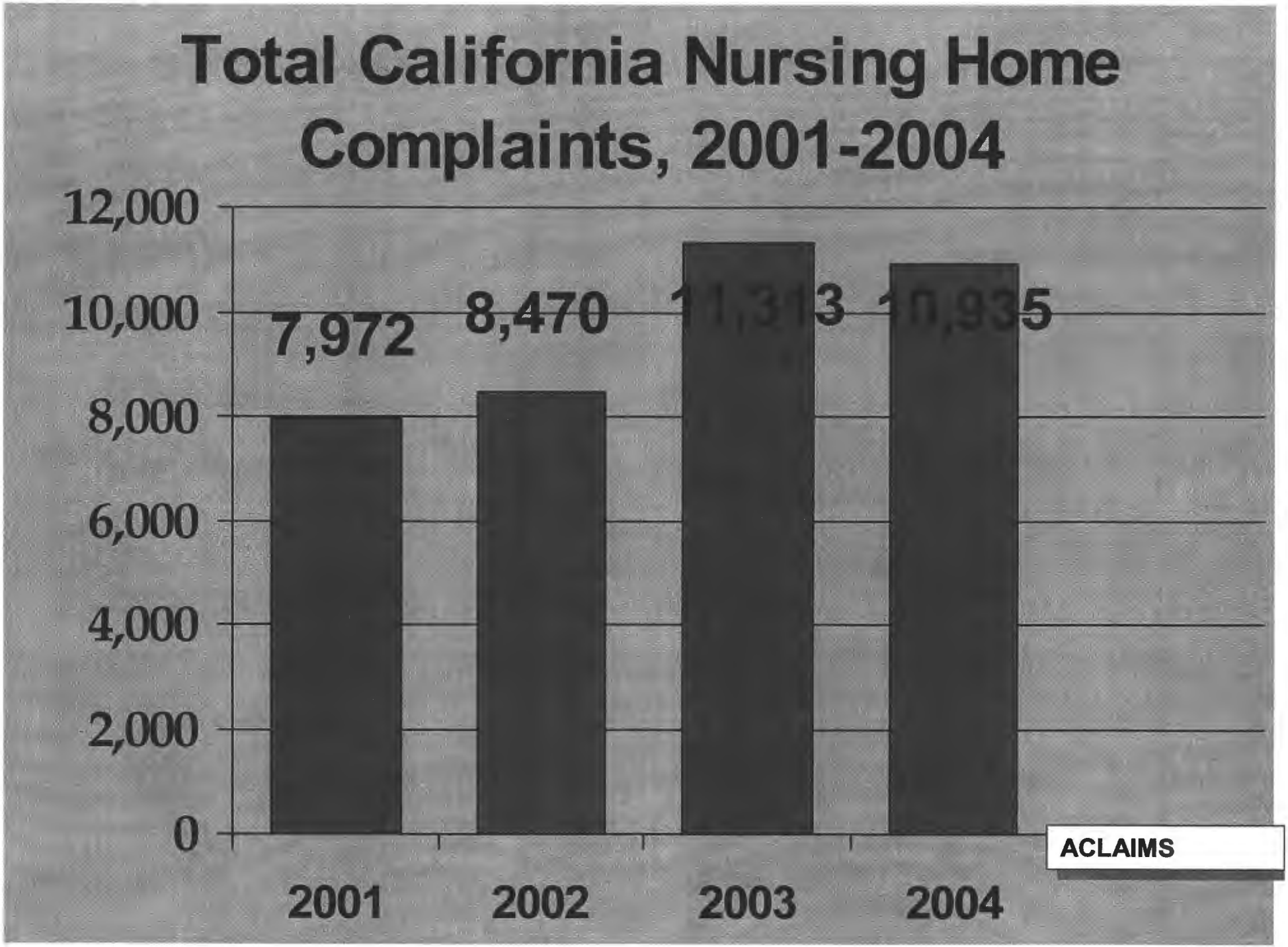
- Predictors of Low Staffing
  - –Low wages for NAs
  - –High turnover
- Predictors of Low Turnover
  - –High staffing

Harrington and Swan, 2003.


Total California Nursing Home Deficiencies, 2001-2004
25,000
20,000
15,000
10,000
5,000
0
635
695
668
468
4,232
4,516
4,248
13,557
2001
2002
2003
2004
ACLAIMS

Violations of Federal Regulations 2003-2005

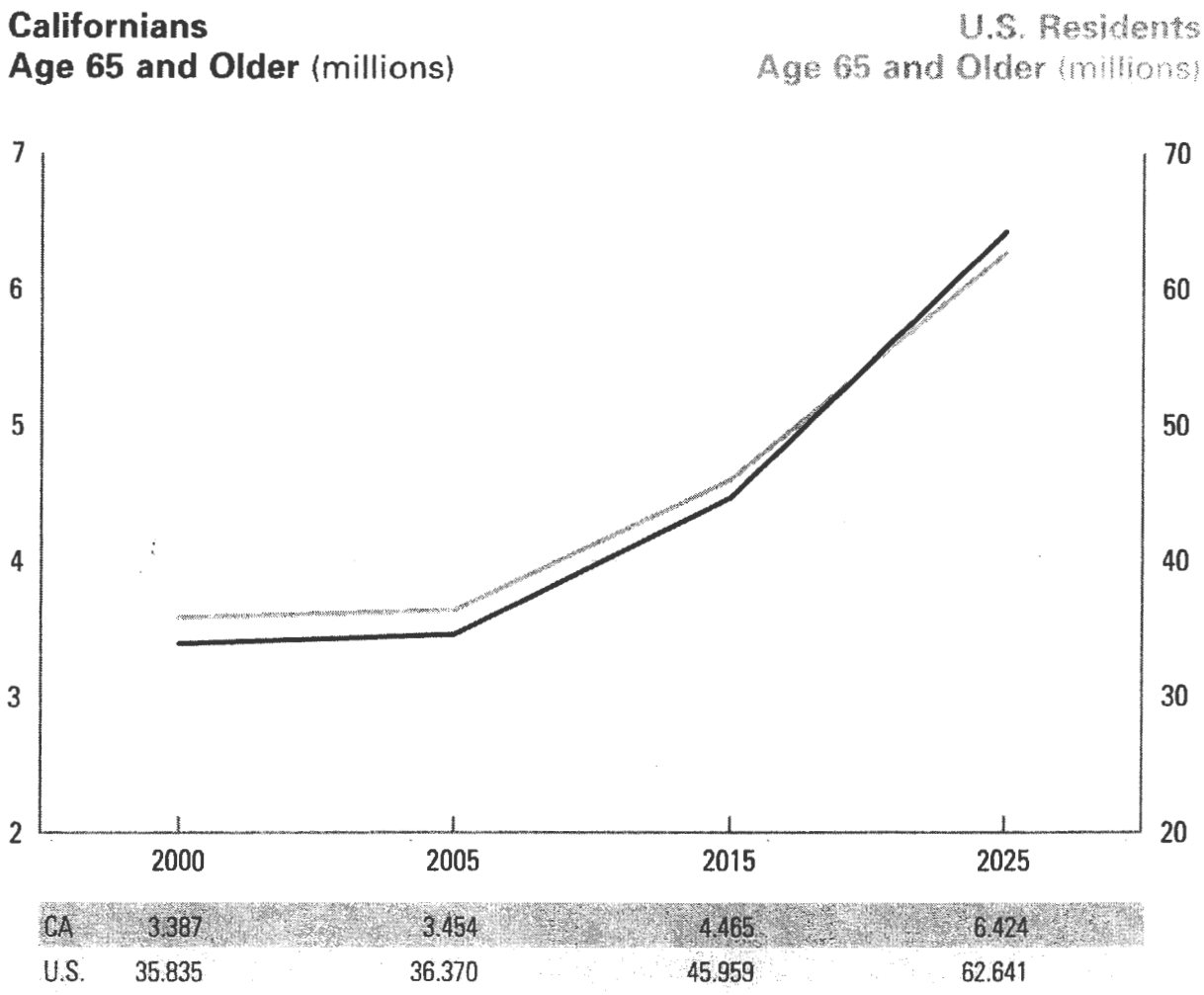



Total California Nursing Home Complaints, 2001-2004
12,000
10,000
8,000
6,000
4,000
2,000
0
7,972
8,470
11,313
10,935
2001
2002
2003
2004
ACLAIMS

Staffing

- Staffing is the best predictor of quality
- Staffing is dramatically below the levels needed to protect health and safety
- Deficiencies and complaints are high
- Only 8% of CA nursing homes meet federal standards
- Nursing homes can make money by keeping staffing levels low
- State standards should specify 4.1 hprd as a minimum and be adjusted for resident casemix

California's Population Is Aging

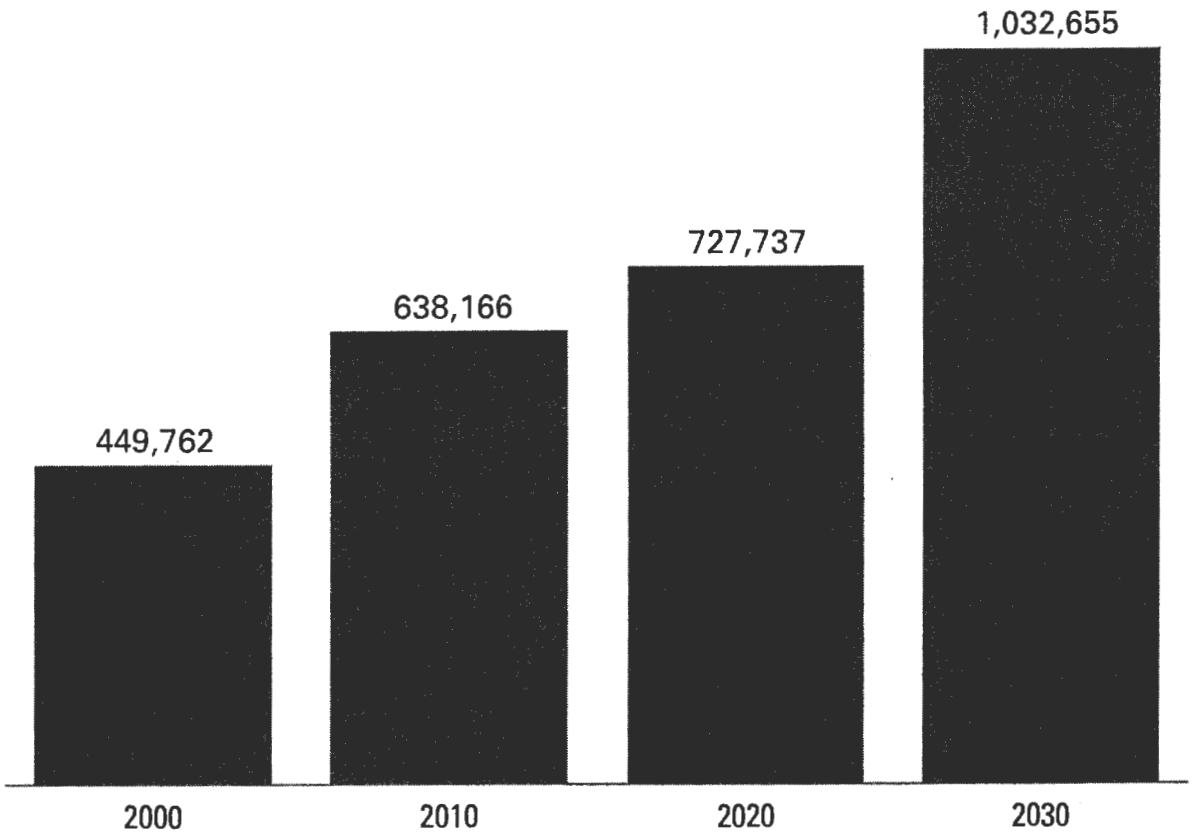


Source: U.S. Census Bureau, 2003: State Population Projections and Population Projections Program, Population Division.

As the population ages, the demand for long-term care services will increase. The number of California residents age 65 and over is projected to **nearly double** by 2025—a larger growth rate than any other state or the United States overall (75 percent).

More Frail Elderly, More Care Needed

Californians, Age 85 and Older

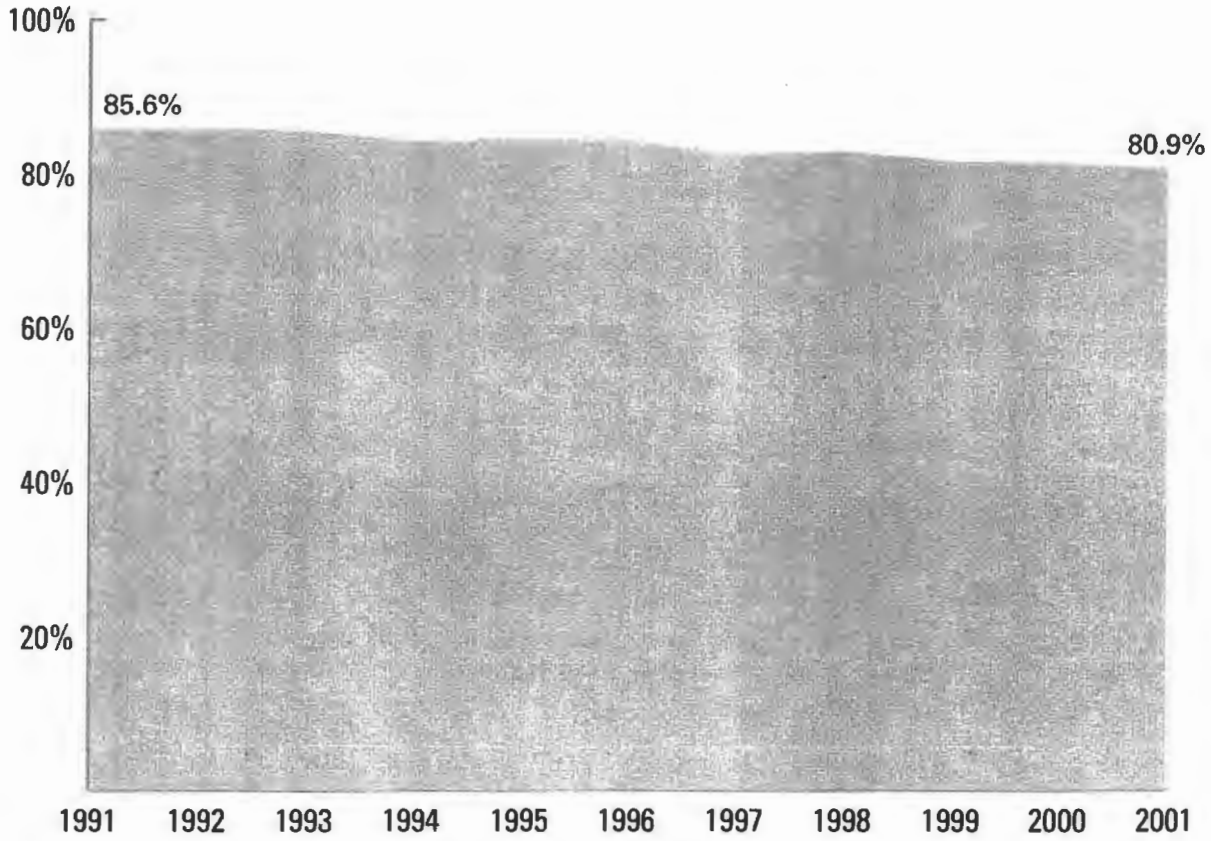


Source: California State Department of Finance, Demographic Research Unit. CDC Life Expectancy. www.cdc.gov/nchs/data/hus/tables/2003/03hus027.pdf

Americans are living longer. In 2001, the life expectancy was 77.2 years, compared to 75.5 just ten years earlier. The number of California residents age 85 and older—those who are most likely to need long-term care at home or in nursing homes—is likely to more than double by the year 2030, when the bulk of baby boomers will come of advanced age.

No Shortage of Space

Bed Occupancy Rates in California Long-term Care Facilities



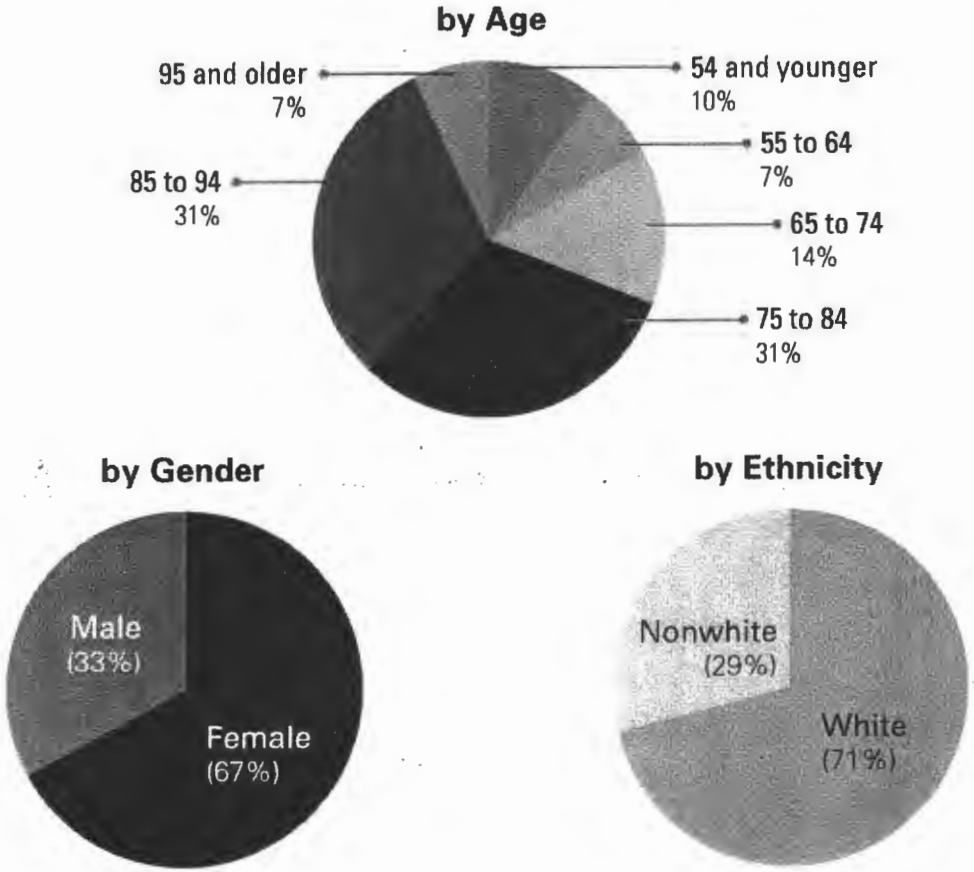
Source: California Office of Statewide Health Planning and Development (OSHPD): *California Long-Term Care Services Statewide Trends, 1991 to 2000 and 1992 to 2001.*

Despite the growth of the aging population, fewer beds in the state's 1,400 skilled nursing facilities are being used because more older Californians are able to live independently or receive care at home. The increased vacancy rate in nursing homes gives consumers greater choice in most areas of the state.

A Look at the Residents

More than 110,000 individuals live in California's long-term care facilities. The majority of residents are 75 or older, female, and white.

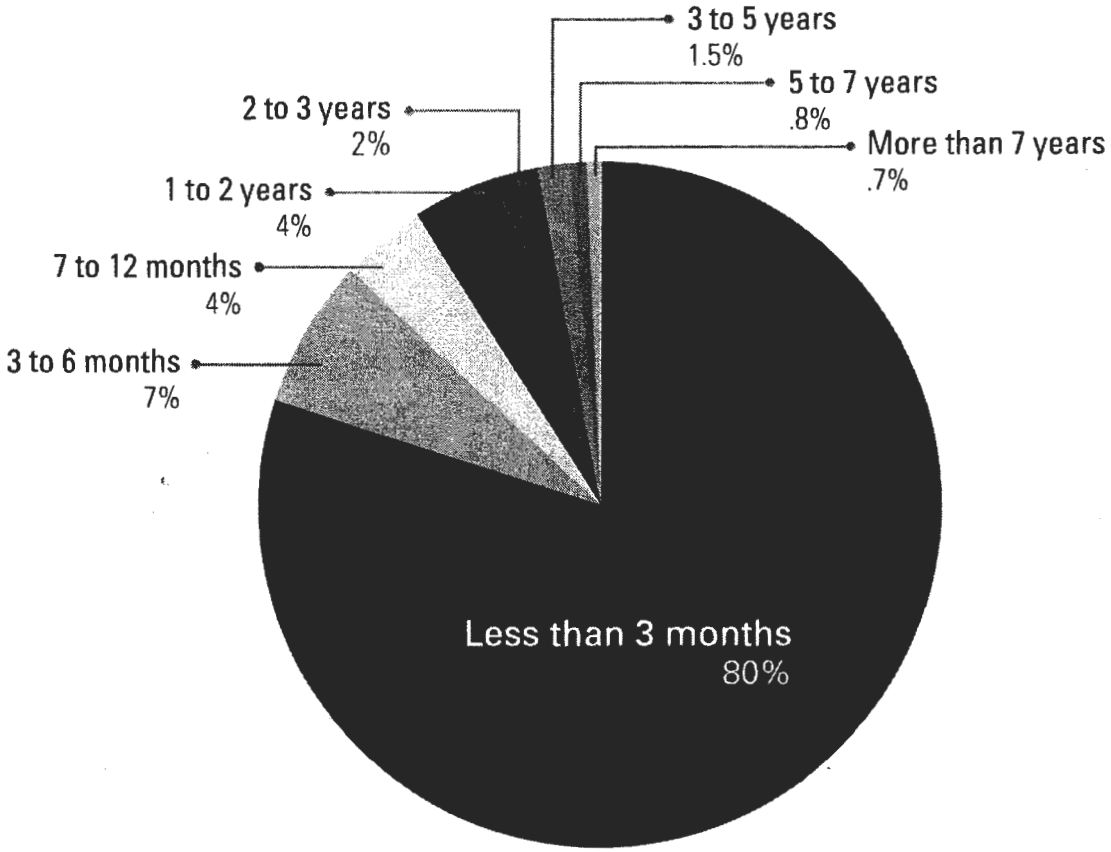
Residents of California Long-term Care Facilities, 2001



Source: California Office of Statewide Health Planning and Development (OSHPD): *California Long-Term Care Services Statewide Trends, 1992–2001.*

How Long They Stay

Length of Stay in California Nursing Homes, 2001

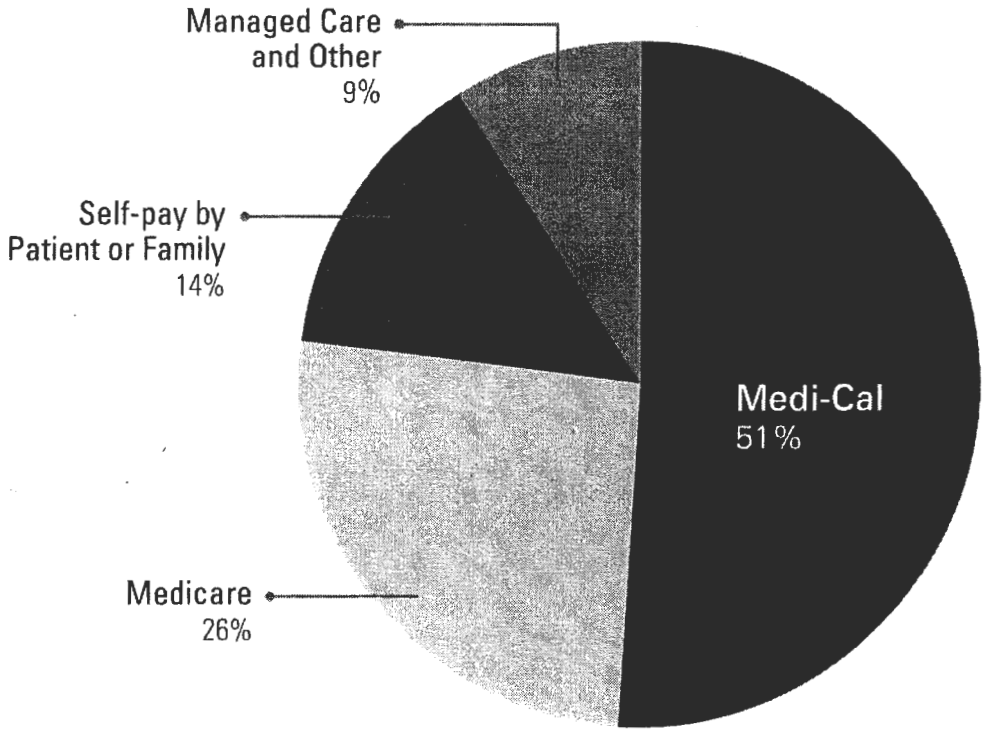


Source: State of California, Health Care Quality and Analysis Division: *Annual Utilization Reports of Hospitals and LTC Facilities, 1992-2001.*

The majority of those who enter a nursing facility need care temporarily to recuperate or rehabilitate after an illness or hospital stay. Others live there for the rest of their lives.

Who Pays for Nursing Home Care

2002 Total Expenditures* in California: $6.6 billion



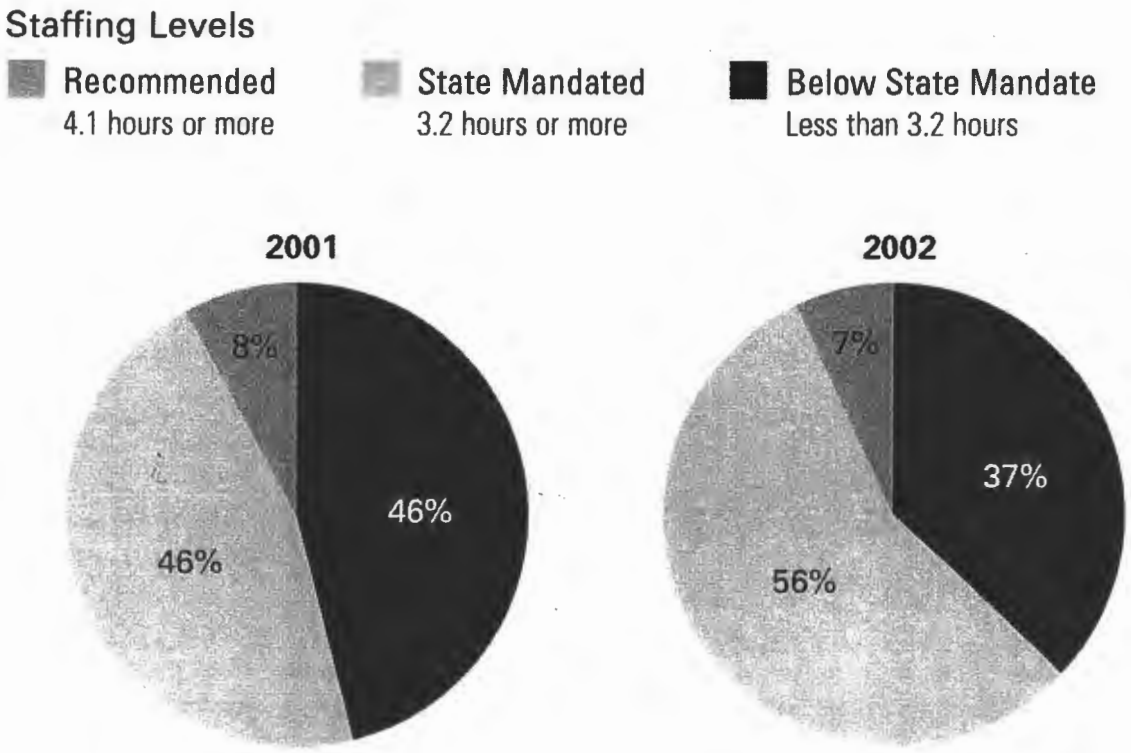
*California nursing home population was comprised of 179 hospital-based and 1,238 freestanding (non-hospital-based) homes.

Source: State of California, Office of Statewide Health Planning and Development, 2003: *LTC Annual Financial Data, 1/1/02 to 12/31/02 and Hospital Financial Data, 1/1/2002 to 6/30/2002.*

Medicare will only pay for approved short-term care up to 100 days. After Medicare and private insurance benefits are used, individuals and their families must pay for nursing home care directly out-of-pocket—almost **$1 billion** in 2002. Once individuals spend their income and assets, they may become eligible for Medi-Cal coverage, which paid more than half of the cost of care in freestanding facilities in 2002.

Nursing Care

Hours of Nursing per Resident per Day in California

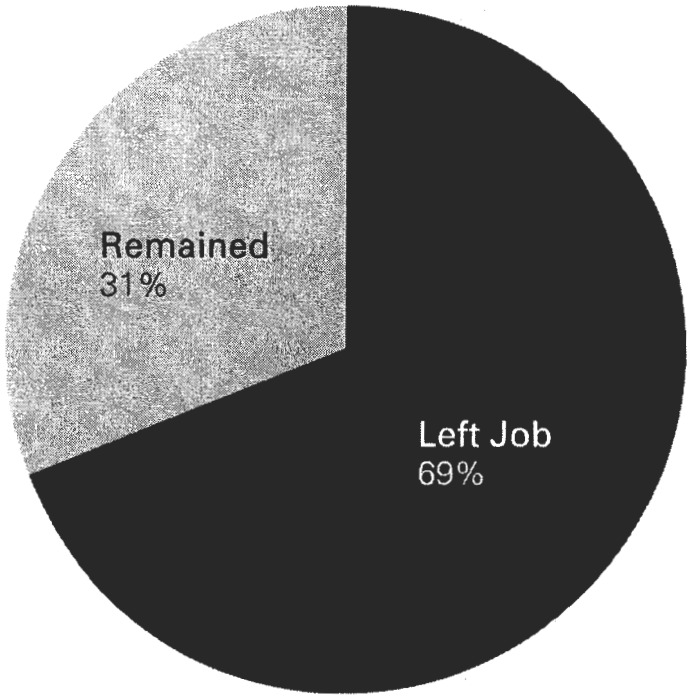


Sources: University of California School of Nursing, *Annual Report for California Nursing Home Search*, San Francisco, CA. 2003; Office of Statewide Health Planning and Development, 2003: *Long-Term Care Annual Financial Data for 2001 and 2002;* U.S. Centers for Medicare and Medicaid Services: *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress,* 2001.

In 2002, well over **one-third** of freestanding nursing homes did not meet the state mandated minimum nurse staffing level of 3.2 hours per resident. **Ninety-three percent** did not meet the 4.1 hour daily standard recommended in a recent report to Centers for Medicare and Medicaid Services.

Staff Turnover

California Nursing Staff Who Left Their Job, 2002

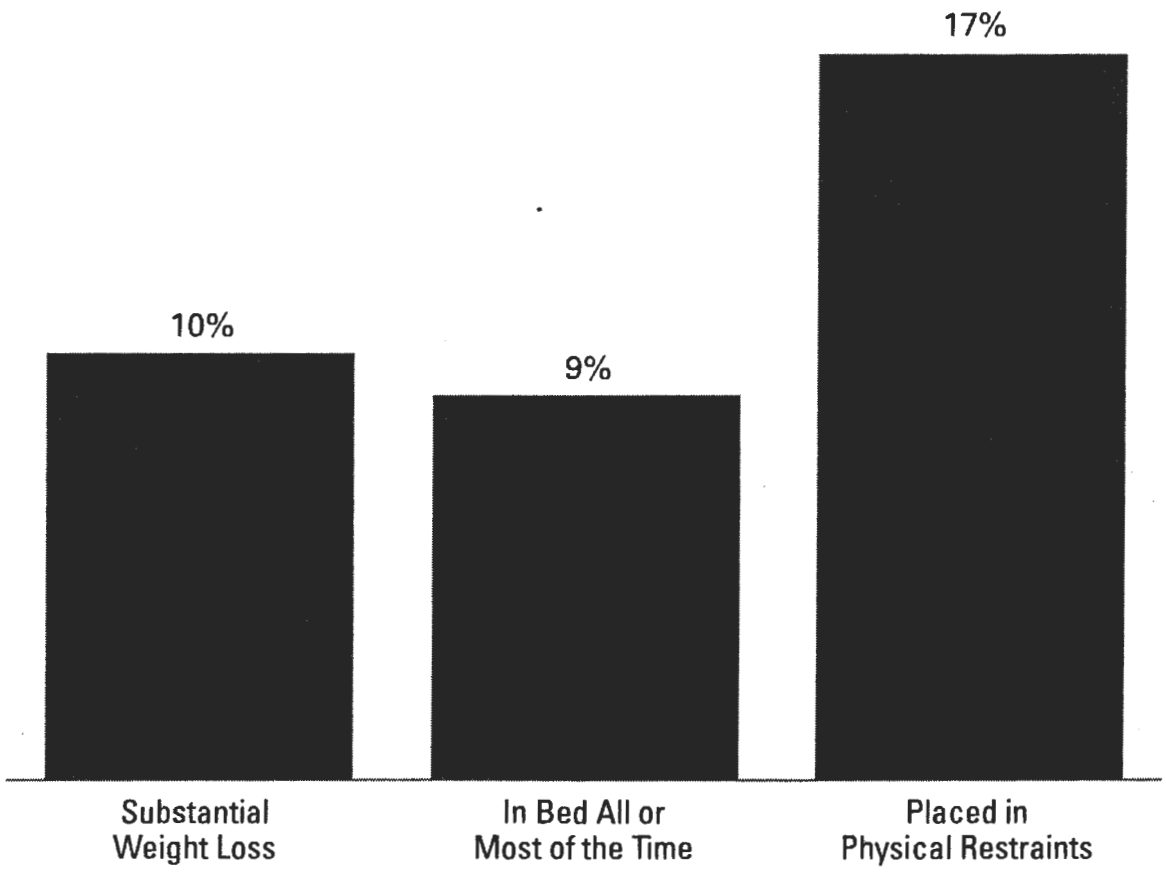


More than **two-thirds** of the nursing staff in California freestanding nursing homes (the majority of them nursing assistants earning an average of $10.35 per hour), left their jobs in the year 2002. The annual turnover rates among nursing homes ranged from **5 percent to 304 percent.**

Sources: Office of Statewide Health Planning and Development, 2003; Long Term Care Financial Data, 2002; and Harrington, C. & Swan, J.H., 2003: *Nursing Home Staffing, Turnover, and Case Mix. Medical Care Research and Review.*

Quality of Care

Problems with Residents in California Nursing Homes, 2002

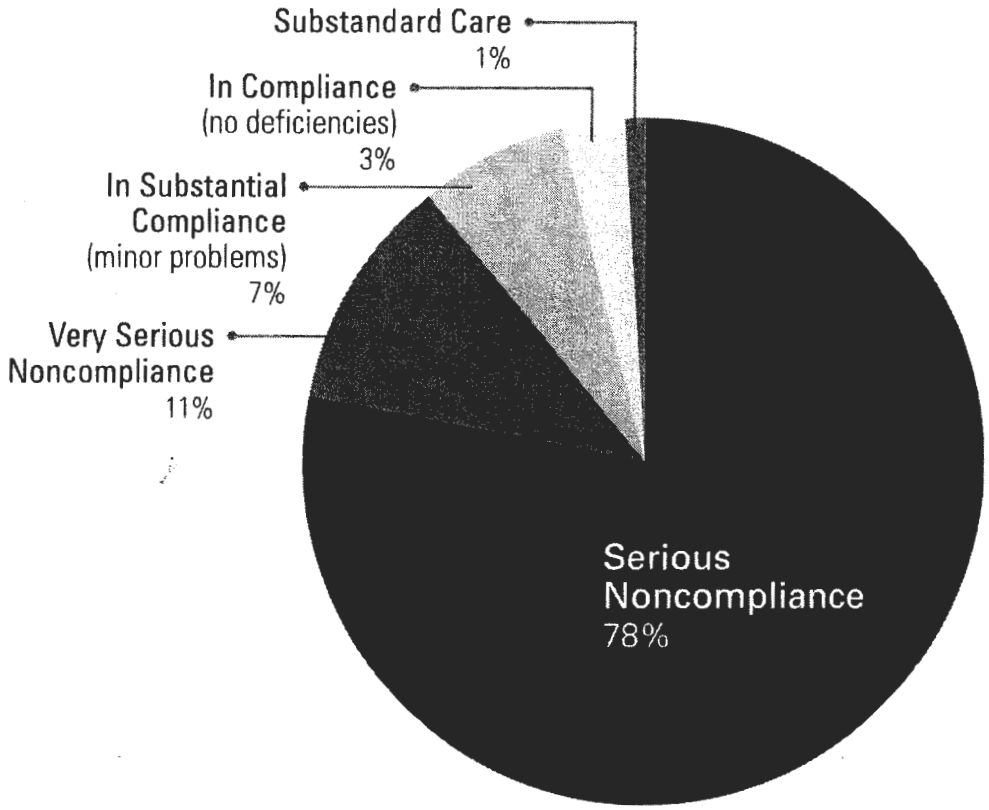


Weight loss, time spent in bed, and use of physical restraints commonly indicate poor quality of care for residents in nursing homes.

Source: University of California School of Nursing, *Annual Report for California Nursing Home Search*, San Francisco, CA. 2003.

Violations of Federal Regulations

Federal Inspection Findings of California Nursing Facilities, 2002



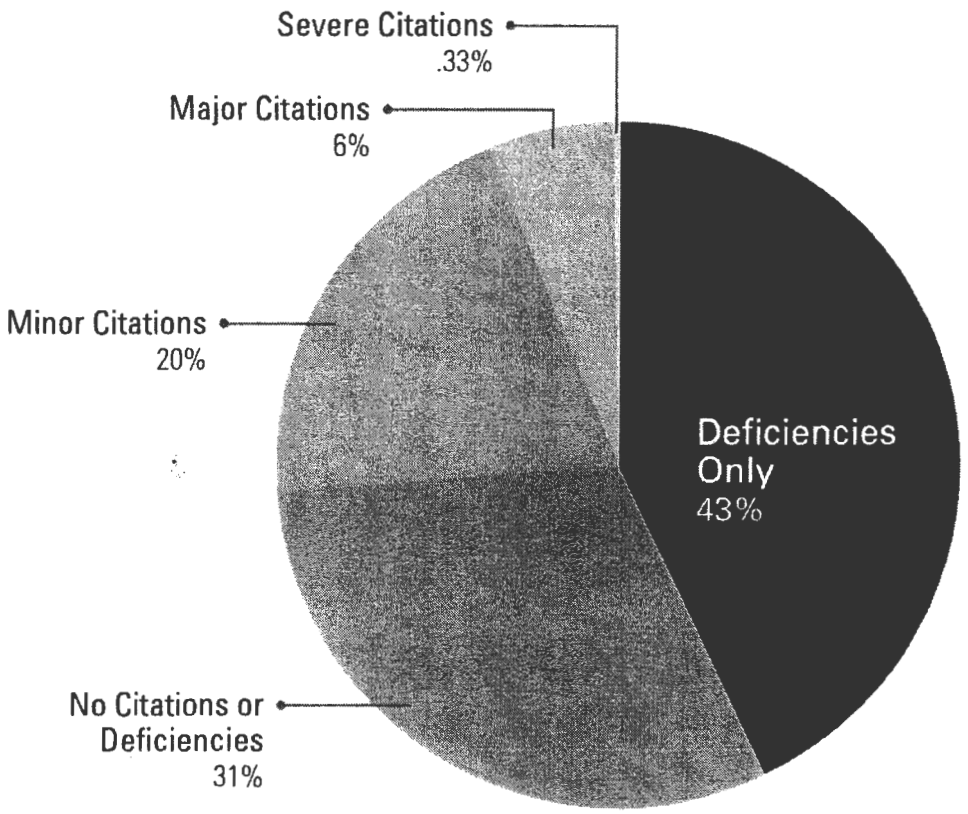
Seventy-eight percent of all California nursing homes surveyed in 2002 did not comply with federal care and safety regulations during mandatory inspections and another **12 percent** were cited for very serious quality of care problems.*

*12 percent combines "Substandard Care" and "Very Serious Noncompliance."

Source: University of California School of Nursing, *Annual Report for California Nursing Home Search*, San Francisco, CA. 2003.

Violations of State Regulations

State Inspection Findings of California Nursing Facilities, 2002

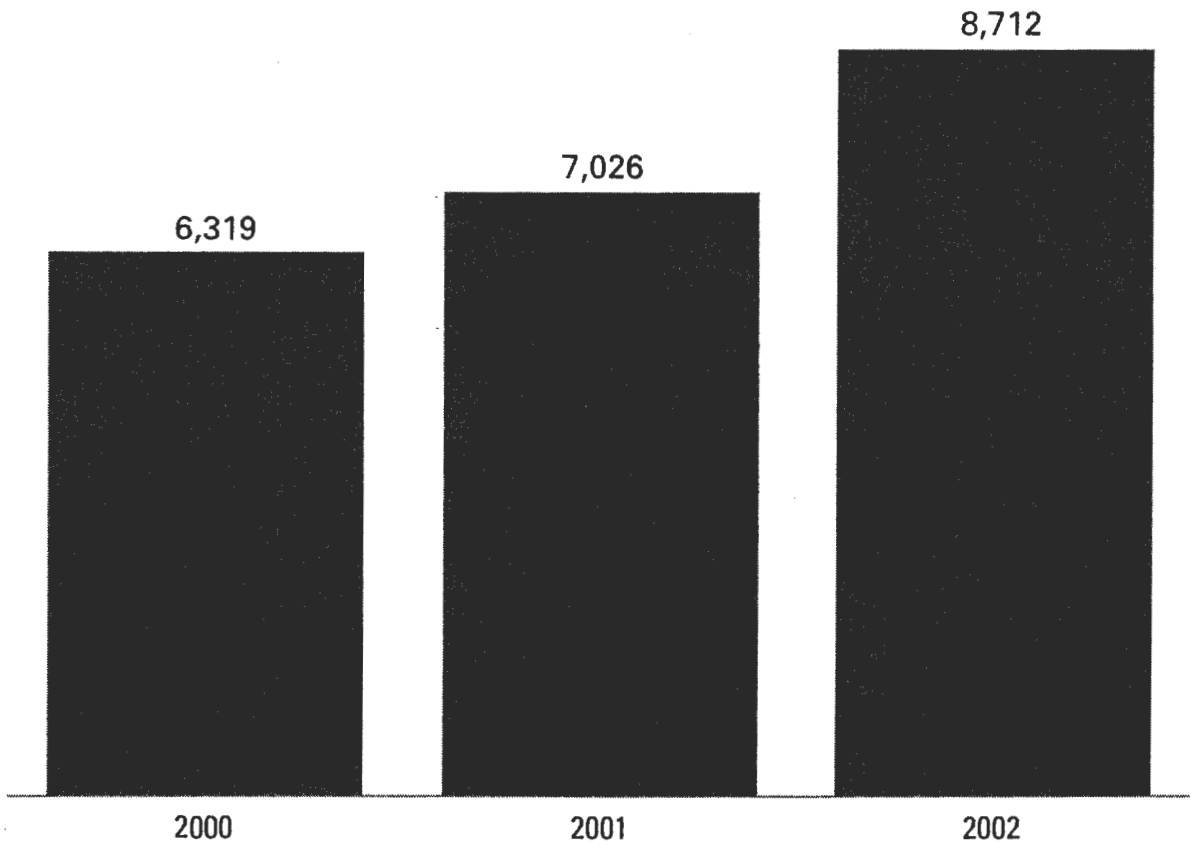


The state has separate standards that nursing homes must meet. Nursing homes are issued state deficiencies as warnings to correct minor problems and given citations as fines for more serious violations. **Fewer than one-third** of the facilities in California were free of these state sanctions in 2002.

Source: University of California School of Nursing, *Annual Report for California Nursing Home Search*, San Francisco, CA. 2003.

Complaints Filed

Number of Complaints Filed Against California Nursing Homes

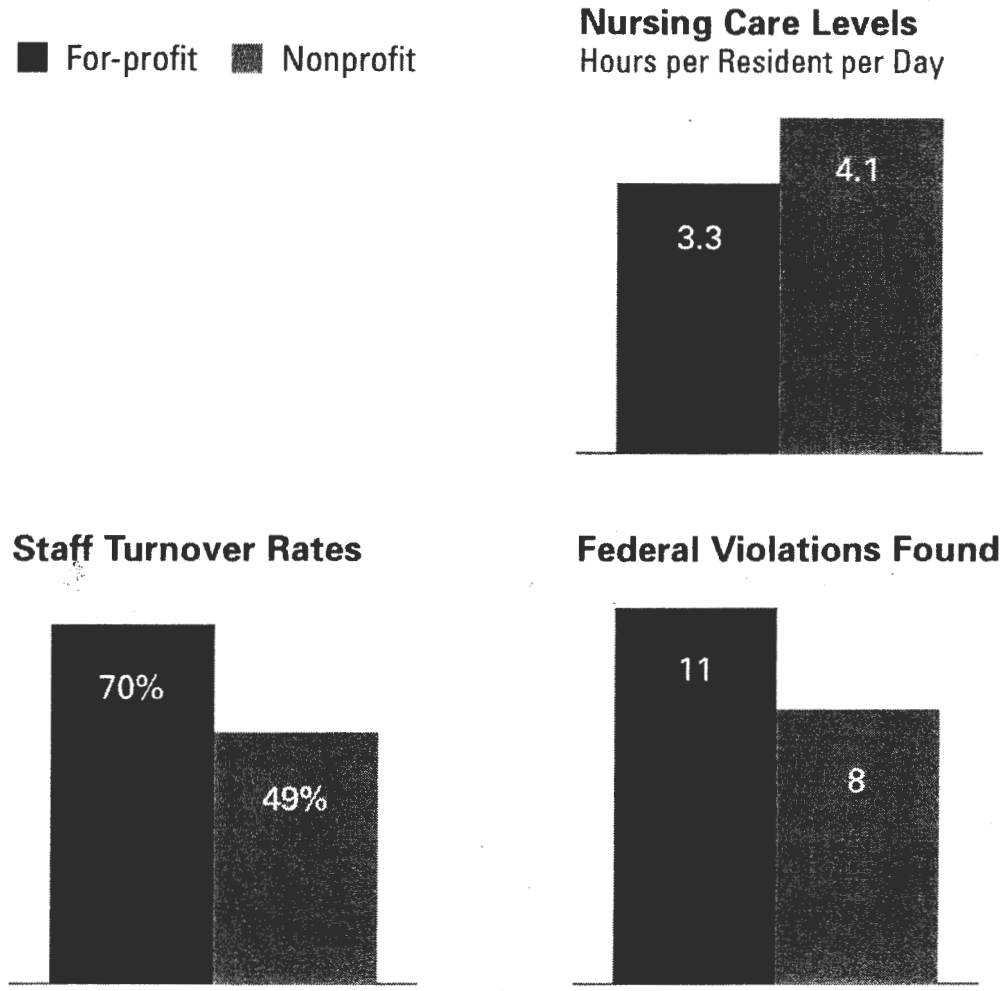


The number of complaints against nursing homes filed by those who saw or suspected substandard care or abuse increased **38 percent** from 2000 to 2002.*

*Includes complaints submitted to the California Department of Health Services Licensing and Certification program by residents, their families, staff, and ombudsman.

Source: University of California School of Nursing, *Annual Report for California Nursing Home Search*, San Francisco, CA. 2003.

For-profit vs. Nonprofit Performance



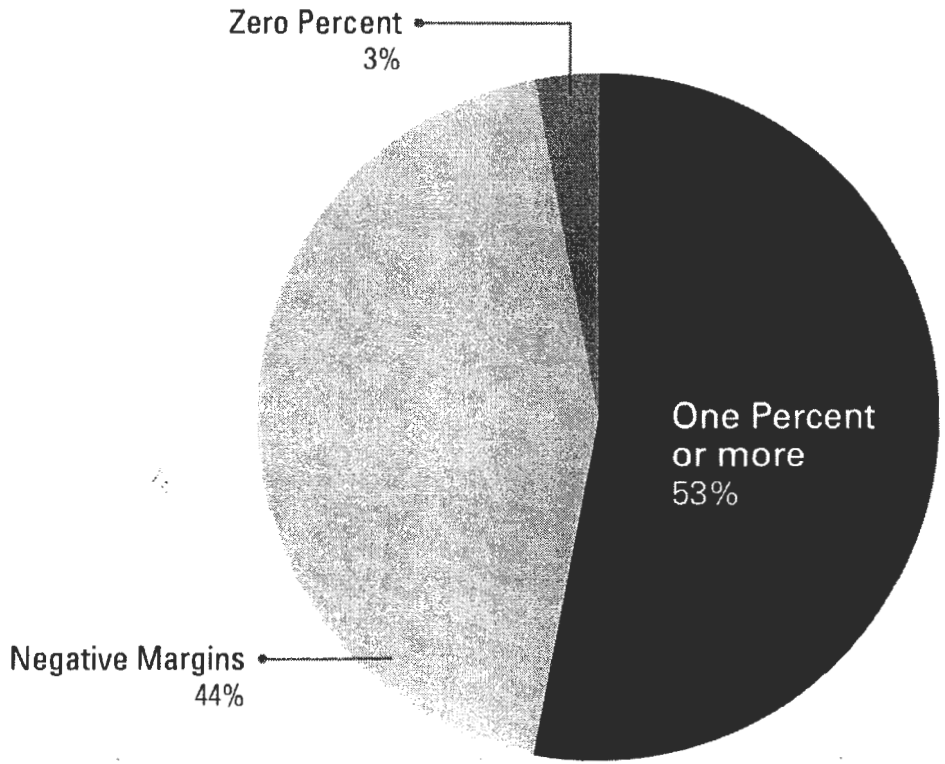
About **78 percent** of the nursing homes in the state are owned by for-profit organizations, while **18 percent** are nonprofit and **4 percent** are operated by a government entity such as the city or county.

In 2002, freestanding, for-profit facilities had lower staffing levels, higher staff turnover rates, and more violations of health and safety regulations than nonprofit facilities.

Source: University of California School of Nursing, *Annual Report for California Nursing Home Search*, San Francisco, CA. 2003.

Financial State

Profit Margins for Freestanding California Nursing Homes, 2002



Between 1999 and 2002, 160 California nursing homes filed for bankruptcy, indicating financial instability and signaling possible closure. **Nearly half** of the state's nursing homes reported negative or zero profit margins in 2002.

Source: University of California School of Nursing, *Annual Report for California Nursing Home Search*, San Francisco, CA. 2003.

Profitability of Nursing Homes Receiving Medi-Cal

Profitability (Net Income Margin)	**Share of Nursing Homes** 2001	2002	Change
Better than 0%	66%	58%	−12%
0% to less than −5%	17%	22%	+29%
−5% to less than −15%	12%	15%	+25%
−15% to less than −25%	3%	3%	0%
−25% and worse	2%	3%	+50%

Among freestanding nursing homes that receive Medi-Cal reimbursement, the proportion of those that broke even or lost money grew by an average of **26 percent.**

Note: Numbers may not add up to 100 because of rounding.
Source: OSHPD LTC Financial Data for 2001 and 2002.

Additional Resources

California HealthCare Foundation www.chcf.org/topics/index.cfm?topic=CL110

A compendium of information and resources is available here.

Additional relevant articles by Barbara Kate Repa are archived at www.chcf.org. To find them, enter "repa" at the search prompt.

- *Nursing Home Inspections: The Data Behind the Ratings*
- *Troubled Budget Times Hit Nursing Homes Hard*

California Nursing Home Search www.calnhs.org

This free, comprehensive consumer Web site provides ratings of California long-term care facilities on key quality measures. It also includes information on staffing levels, clinical quality measures, complaints and deficiencies, financial measures and ownership, as well as a number of helpful resources such as paying for care.

Charlene Harrington, Ph.D. and Janis O'Meara, M.P.A. *Annual Report for California Nursing Home Search.* University of California School of Nursing, San Francisco, CA. 2003. http://nurseweb.ucsf.edu/www/images/calnhs-rpt-03.pdf

CONTACT US

California HealthCare Foundation
476 Ninth Street
Oakland, CA 94607
t: 510.238.1040
f: 510.238.1388

Select Bibliography of Reports Related to Nursing Home Quality

Office of Inspector General, U.S. Department of Health and Human Services, April 2005. *Nursing Home Enforcement: The Use of Civil Monetary Penalties*, OEI-06-02-00720

Lipson, Debra J., April 2005. "Linking Payment to Long-Term Care Quality: Can Direct Care Staffing Measures Build the Foundation?," Institute for the Future of Aging Services, American Association of Homes and Services for the Aging.

Harrington, C., O'Meara, J., 2004. "Snapshot Nursing Homes: A System in Crisis." Prepared for the California HealthCare Foundation.

Harrington, C., O'Meara, J., 2004. "Report on California's Nursing Homes, Home Health Agencies, and Hospice Programs." Prepared for the California HealthCare Foundation.

Schnelle, J.F., Simmons, S.F., Harrington, C., Cadogan, M, Garcia, E., and Bates-Jensen, B., 2004. "Relationship of Nursing Home Staffing to Quality of Care." Health Services Research. 39 (2):225-250.

Harrington, C., Mullan, J. and Carrillo, H., 2004. "State Nursing Home Enforcement Systems." Journal of Health Politics, Policy and Law. 29 (1):43-73.

Harrington, C., 2003. "Issue Brief: California's Nursing Homes: A System in Trouble." Prepared for the California HealthCare Foundation.

U.S. General Accounting Office (GAO), July 2003. *Report to Congressional Requesters: Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*. GAO-03-561.

Harrington, C. and Swan, J.H., 2003. Nursing Home Staffing, Turnover, and Case Mix. *Medical Care Research and Review*, 60 (3):366-92.

U.S. General Accounting Office (GAO), 2002. *Nursing Home Expenditures and Quality*, GAO-02-431R.

U.S. General Accounting Office (GAO), 2002. *Skilled Nursing Facilities; Available Data Show Average Nursing Home Staff Changed Little after Medicare Payment Increase*, GAO-03-176.

U.S. General Accounting Office (GAO), 2002. *Nursing Homes: More Can Be Done to Protect Residents from Abuse*, GAO-02-312.

House of Representatives, 106th Congress. (Comm. Print 2000). Report on Nursing Home Conditions in the San Francisco Bay Area III.A. Minority Staff of Special Investigations Division, Committee on Government Reform.

California Advocates for Nursing Home Reform (CANHR), 2003. *Much Ado About Nothing: Debunking the Myth of Frequent and Frivolous Elder Abuse Lawsuits Against California's Nursing Homes.*

Office of Statewide Health Planning and Department (OSHPD). (April 27, 2004). California Long Term Care Services Statewide Trends, 1992-2001. *Annual Utilization Reports of Hospitals and LTC Facilities 1992-2001.* State of California Healthcare Quality and Analysis Division, Healthcare Information Resource Center.

Hearing Transcript

Joint Informational Hearing of the Senate Committee on Health and Senate Subcommittee on Aging and Long-Term Care

Senator Deborah Ortiz & Senator Elaine Alquist, Chairs

Nursing Home Quality in the 21st Century: Staffing Adequacy and Complaint Investigation

July 20, 2005
Sunnyvale Senior Center
Sunnyvale, California

SENATOR ELAINE ALQUIST: _____State Assembly and I'm pleased to do that again. I happen to live about ten minutes from here in the City of Santa Clara ...(gap in tape)... represent my senior community. And in years past, I was a senior in training, but I'm going to be 61 in August. And so I've been a member of AARP for years, and I no longer just smile and get away with saying I'm a senior in training. I'm getting to be a senior myself. My dear husband, Al Alquist, will be 97 August 2. He just had a complete physical a couple of weeks ago, got the report two days ago and nothing wrong with him. He had a great blood test, great chest X-ray. He's in great health, good mind, good spirit.

Anyway, welcome. I'd like to make some opening comments before we go into the panels. I'm going to try very, very hard—not just try but hopefully do it—to see that we run on time. I think it's important to give everyone toward the end of the hearing the same kind of time that we give people in the beginning. And so I will ask both of the panelists, and then when we go to open comment at the end, for people to be very concise in their comments, no need to repeat what someone else has said. And if you go on too long, I will, in a very nice way, ask you to stop.

So good morning, I'm Senator Elaine Alquist. I chair the Senate Subcommittee on Aging and Long-Term Care. You may recall that I recreated the Committee on Aging and Long-Term Care in the Assembly when it was originally created in the Assembly by Senator, then Assemblyman, Henry Mello many years ago and had gone inactive a few years and then we recreated that. On the Senate side, the Committee on Aging and Long-Term Care is a subcommittee under the Health Committee, so that's how it works there.

I'd like to say I know there are many people here who work in nursing home quality care, and I will also take a moment right now just to mention a few of our electeds. Mayor Dean Chu is here from Sunnyvale; John Warren, the Recreation Superintendent for Sunnyvale; Mark Stivers, Deputy Chief of Public Safety of Sunnyvale; and Tori Ueda, representing Assemblymember Rebecca Cohn's office. I'm sure there will be others joining us later, but I will not take time in the middle of things to be mentioning people.

Unfortunately, some of the other members of the committee will not be able to be here. But at some point, we will be seeing Nicole Vasquez, Senator Deborah Ortiz's consultant to the Health Committee, as we are putting this meeting on with the Health Committee, and I am also a member of the Senate Health Committee.

I'd like to thank the Sunnyvale Senior Center, Pat Lord and all of those who have made it possible today.

As you can understand, I've always championed rights for the elderly. My father was born in 1906, my husband in 1908, my mother in 1912. Both my parents have passed on, and my husband is almost 97 years old. I've worked on issues when it comes to quality of care for the elderly, for seniors for many, many years. Back in 1999, I had signed into law--back then a controversial bill--that actually took me two years to get it to go through both houses of the Legislature and get signed into law. It was AB 893, and it was signed into law in 1999, and it gave $100,000 so that DHS would document violations of nursing homes on the internet. I just found out

yesterday that that really has not been done, so that's another piece to the puzzle of why we are here today.

Also back in 2001, I co-authored legislation which required a minimum staff standard that guarantees 3.2 hours of direct patient care, per patient, per day and joint authored AB 1731, signed into law in 2000, which increased the serious fines in nursing homes from $25,000 to $100,000 Class AA violations for resident deaths, increased fines from $2,000 to $20,000 for Class A violations for a resident's health and safety, and willful falsification of patient health care records. And currently, I am authoring SB 526, a two-year bill.

The reason I'm authoring SB 526 is that it is really important that there be great accountability in state government and in this particular area, and I know we have representatives from the nursing home industry here today with us, and I say welcome. It's also really important, that when it comes to nursing homes, that we know really what is going on, that we have documentation on what is going on, and that that documentation is available to anyone who wishes to see that.

Some people would say to me, *"Elaine, you know, why do you have your bill right now, SB 526?"* They would say, *"You know, AB 1629 by Assemblyman Frommer gives all this money to help nursing homes."* And I think it's good to make this a priority to take care of our elderly, but I don't believe there is the accountability in AB 1629. It's the kind of accountability, had I been in the legislature—that was the two years I was out of office. You know, we have term limits in California, and so I was out of office two years, between when I ended my term in 2002 in the Assembly and then I was elected to the State Senate.

So there are things with AB 1629, in terms of the accountability, that we still really don't know about. And what I do know is that we're going to spend over a three-year period about $3 billion for care in nursing homes that will affect 1,400 nursing homes—1,400 nursing homes—in the State of California, and shouldn't we know what's going on there? As an aside, I also

sit on the Oversight Committee on Stem Cell Research and the way that initiative was written, it said after two years, state legislators really couldn't change the law. Well, we've held oversight hearings on that, starting with saying, *"You know, you're taking state taxpayers' dollars and we need to know what's going on."* Well, the same thing goes for right here with AB 1629. We, the public—and I'm part of the public, just like you are—we need to understand what's going on, and we need to see that care for the elderly is improved because, as great a place as California is, I think we still need to make great strides in how we care for the elderly. And so that's my opening comment.

Okay. I'll go back to my notes now, now that I said what comes from my heart here. AB 1629, Frommer, improves reimbursement under the Medi-Cal program to reflect the costs of adding staff to enhance quality by creating a new per-bed fee expected to generate $800 million annually for the nursing home industry over the next three years. It provides mechanisms for these expenditures. The mechanism allows for capital and administrative costs, and there certainly are costs when it comes to nursing homes. I understand that. Nonetheless, an unfortunate ramification has developed because of the passage of AB 1629. It has divided groups of advocates that had traditionally been unified on nursing home policy. And it's not because of a difference in final objectives—we all have the same final objectives—it's simply on how to get there. There is one commonality in these objectives, and that is to assure our nursing home residents receive the care that they need.

AB 1629 is the law of the land and provides a framework within which we must continue our efforts to develop and improve better public policy.

As mentioned, some of these other things about why I am carrying my bill. I should add also that only a small percentage of the state's 1,400 nursing homes meet the standards recommended for good care. Many show clinical signs of poor care, such as high percentages of residents who lose weight, are left in bed a lot of times, or are placed in physical restraints.

Many do not meet government compliance standards for care and safety, and a number have serious violations of both state and federal regulations.

My SB 526 will address what I believe are some inadequacies in AB 1629. For example, nursing homes report some staffing data to the California Office of Statewide Health Planning and Development, but the information is not audited for accuracy, nor is it available to the consumer in a timely fashion.

Next, the California Department of Health Services, DHS, collects limited staffing information during annual inspections, but it does not routinely verify the information. DHS does have the authority to cite and fine nursing homes for violating staffing requirements, but it has done so only in a handful of cases. And I want you to know that DHS is here with us because what I say regarding the issue I say publicly, and I'm prepared for whatever I say publicly to be on the front page of the newspaper and for anyone, including DHS too.

I believe in the continuum of long-term care services, from community-based services, in-home care, to the skilled nursing home, for those who need better kind of care. I want to make it clear—and I think those who know me well will understand this—I am not here to beat up on nursing homes—I don't think I have ever really done that—but I am here to say, that whenever any one of us has a loved one in a nursing home, I want to know if that person is getting the best care possible and not because I'm a state senator but because I'm a human being, and I want that for all of us and I believe we should get there.

Our task today is to bring together—to begin a stakeholder process to establish more accountability for new funds that nursing homes receive under Medi-Cal established by AB 1629.

So financing for nursing homes has its baggage _____, and I just think we need financing for it, but I wanted the accountability built in, and I think they will go a long way to bringing some credibility to the issue of what we're

trying to accomplish. Clearly, the Legislature has spoken with the funding of 3.2 hours of direct-patient care per patient, per day.

And with that, I would like to say thank you to all of you for being here; thank you for all of your work in this area. And we will begin with our first panel with Charlene Harrington, Associate Director of the UCSF John A. Hartford Center for Geriatric Nursing Excellence. I've worked with Charlene a lot when I chaired the Committee on Aging in the Assembly.

Welcome, Charlene. We're pleased to have you with us.

And Beth Capell has arrived also, and that is really good also. So let's see, we have Charlene Harrington who will be speaking first—I know she needs to catch a plane—and then after that, we will have Beth Capell, representative for SEIU, who will speak to the history of improving wages, staffing, and reforming the reimbursement system. So with that, welcome.

Charlene, would you like to begin?

DR. CHARLENE HARRINGTON: Thank you very much.

I have been working on nursing home issues since back in 1975 under the Jerry Brown administration, and I wanted to start off by saying that, at that time, we were concerned that approximately one-third of the nursing homes in California were not up to the standards. And I have wanted to say that_____the people of California...

SENATOR ALQUIST: Let's move the microphone a little closer to you.

DR. HARRINGTON: ...as a researcher at the University of California, San Francisco. We haven't seen much improvement in the quality of nursing home care in California in 30 years. I would like to argue today, but it has to do with inadequate staffing that we have in our nursing homes. And many, many research studies have been done over the past 30 years to show that one of the most important things is to have adequate staffing and that these studies are all confirmatory on the importance of staffing.

Now there's so many benefits from good staffing. It reduces the mortality rates, it improves people's ability to walk, it improves nutritional

status, reduces behavioral problems, it reduces your strength. All kinds of problems are directly related to poor nursing care.

Now there was a very important study done in 2001 by Dr. Schneid at UCLA, and that study showed, that for direct care, you need at least 3.0 hours per resident, per day, just to carry out five activities of daily living: eating, dressing, bathing, and toileting. So we know you have to have at least 3.0. The other part of this study in 2001 showed, that if you don't have adequate staffing, so many terrible things can happen to residents. They can go into congestive heart failure, electrol (sic) imbalance, respiratory infections, end up in a hospital; they have pressure sores, weight loss, and so many serious problems. So what we know is that we need to have 4.1 hours per resident, per day, at a minimum. The research shows that less than that has substantial jeopardy to health and safety of residents.

We did a study here in California of 34 nursing homes and picked nursing homes that have the highest staffing and the lowest staffing and high and low quality clinical indicators. And what we found was that most of the nursing homes in this state have poor quality care. Weight loss was a serious problem. Residents only got four to seven minutes of healthy eating. Most of the time, no one even talked...

SENATOR ALQUIST: Four to seven minutes?

DR. HARRINGTON: Yes.

SENATOR ALQUIST: A day?

DR. HARRINGTON: A meal. They should have at least 30 minutes.

SENATOR ALQUIST: It usually takes longer than that.

DR. HARRINGTON: Yes. And we found that they weren't being talked to. And in 12 hours, they were only being taken to the toilet 1.8 times. They should go to the toilet every two hours.

Residents were not being turned every two hours. They were being allowed to go back to bed and stay in bed 22 hours out of the day. They got very little walking assistance. Many were in pain all day long, and many have depression.

So we know from the research study that staffing was the best measure of quality of all of the measures that we looked at. On 13 out of 15 indicators, staffing was the key compared to other indicators. We found that facilities that have 4.1 hours had better feeding assistance, better help with residents in helping stay out of bed and better incontinence care. So we also believe strongly that there is a threshold, and if a nursing home does not meet that threshold, it's going to have jeopardy to its residents. Now we know it's not just a California problem. Nationally, 9 out of 10 nursing homes do not have those 4.1 hours.

We also know that the federal standards are completely inadequate for staffing. But for California, 3.2 hours is inadequate. We need to get those grades up to 4.1. We need that as a goal, and we need to encourage facilities to begin to employ that right away.

Now nationally, the average staffing is 3.6 hours per resident, per day. What has happened is a very frightening situation. The registered nursing hours have dropped 25 percent nationally since the year 2000. And in California, the registered nursing hours are also dropping. So here we have been promoting better staffing in the last 10 years and actually seeing it going down in terms of hours.

Now what's the situation in California? It is very serious. We have improvements, but 24 percent of nursing homes in California do not even meet the 3.2 hours per resident, per day. Now how can that be, after all this time, that that law was implemented and that was ordered of the nursing homes are not complying? We're not forcing them to do the minimal, and we know that it's inadequate.

Now when you look at how many are meeting the 4.1 hours that they should be meeting, it's 5 percent in California, 5 percent. So that means that if you want your loved one in a nursing home, you're going to have to look very long and hard to find one of those 5 percent.

SENATOR ALQUIST: How does the public know how to find that information?

DR. HARRINGTON: Well, there are two websites, the CANHR website and the California Healthcare Foundation. It's called calnhs.org. Both those websites show the stuff and consumers should look for good staffing.

Now we also know that this whole piece tends to over-report in their staffing data. One more point I wanted to make is that one of the reasons that staffing is low is that most of our homes are for profit, and they're cutting corners on faculty, trying to keep it low so they can make money, and this is a problem because we need higher staffing.

Facilities tend to over-report their staffing data. The data are often incomplete and incorrect. And, as you mentioned, there's very little auditing going on. So we think that SB 526 would be a good step forward because it would require payroll data to be submitted on a quarterly basis. Right now, the nursing homes only turn in their cost-report data on an annual basis and one year late. So that means the data is two years old. So we need timely data that's audited.

Those facilities that have 3.2 under that, I really think they should have holds on their admissions until they get their staffing up, and we should have some serious penalties for that group and then try to move to legislation over time to get up to 4.1 hours.

Another serious problem is the high turnover rate. We know that two out of three nursing personnel leave every year. Their staffing is very unstable, and this lack of facility causes poor quality, it causes incontinuity in care problems, it makes errors, factoring errors if they don't know the resident, there's fatigue and poor morale, and even higher injury rates are all related to these high turnover rates.

SENATOR ALQUIST: What do you think accounts for that high turnover?

DR. HARRINGTON: Okay. The key to the turnover is the wages. The wages are simply too low. We need to get the wages up. In 2003, they were $10.58 an hour on average. What we saw was a major increase in the wages for administrators over a two-year period but only a 6 percent

increase in wages for nursing assistants. So the wages are a big problem and the lack of healthcare benefits for the workers. That would help stabilize the workforce.

The other problem is that their workloads are too heavy because if they have to take care of 12 to 15 patients instead of seven, which it should be, six or seven per nursing assistant. They just are exhausted, and the care is poor. So we must reduce these terrible rates, and we must reduce their workload.

Okay. Now what happens, because we have this poor staffing, is we have a high number of deficiencies. Over 20,000 deficiencies were issued in California this past year for poor quality of care. In terms of looking at the federal deficiencies...

SENATOR ALQUIST: Can you explain, Charlene, what a deficiency is and who gives the deficiency?

DR. HARRINGTON: Well, the state that's serving the agency gives the deficiency for a violation of either federal law or state law. I have a graph here that shows that.

SENATOR ALQUIST: When this is done, who gives the deficiency?

DR. HARRINGTON: The state Licensing.

SENATOR ALQUIST: They are under DHS?

DR. HARRINGTON: Under DHS.

SENATOR ALQUIST: Thank you.

DR. HARRINGTON: So they're giving out 20,000 of these a year. That is a huge number for California. And then, when we look at the federal compliance, we see that only 8 percent of the nursing homes in California are in compliance under the law; 77 percent have serious noncompliance; 11 percent have very serious noncompliance; and 4 percent are completely substandard. Now this ratio has been the same for years and years. We're not getting care performing facilities. And it's going to continue to look like that if we don't do something about it fast. Also, we have over 11,000

complaints a year in California nursing homes. Again, that's directly related to inadequate staffing and poorly trained staff.

So just in summary, staffing is the best prediction of quality of care, but staffing in California is dramatically below what it should be to protect the health and safety of the residents. And one-quarter of all the nursing homes do not even meet the low 3.2 standard that we have. This leads to high deficiencies and high complaints, and the nursing homes are unlikely to raise their staffing levels on their own because they're trying to increase their net income.

I think we've got to get tough on nursing homes and force them into compliance or take them out of business if they're not going to comply with the law. (Applause) So in summary, I'd just like to say I would like to my strong support for your work on Senate Bill 525 to help improve the quality of care.

SENATOR ALQUIST: Thank you for coming, and thank you for all the documentation. Thank you.

Next we have Beth Capell, SEIU, on history of improving wages, staffing, and reforming the reimbursement system.

MS. BETH CAPELL: Thank you, thank you for having us here today. We are pleased to be here, and I'd like to say we've also been pleased working with Charlene Harrington over the years; although having to read all the staffing studies was rather like doing homework assignments, but we do concur with everything she had to say about importance of improving staffing and wages in nursing homes.

I'm going to begin not quite as far back as Charlene since I haven't been at this quite as long as she has. But I want to begin in 1998 when SEIU made an effort to improve quality of care in nursing homes to improve wages, staffing, and our reimbursement system. For us, these three themes have guided our work since 1998—improving wages because it reduces turnover and improves quality of care, improving staffing because it improves the working conditions of our members; and improves all of the

residents' quality of care, and dramatically revising the reimbursement system that has been in place in California since Ronald Reagan was governor quite a long time ago.

And I just want to take us through some of the accomplishments that we've all managed since 1999 because I think, as I was preparing for this hearing, we forget all of the things that have actually been done over the last seven or eight years. And I also want to note that much of this was done through the budget process rather than through separate legislation, and so you have to track this both through budget action as well as legislative action.

In the 1999-2000 budget, it was the 5 percent wage pass through for direct care to staff. Plus, we increased staffing to 3.2 nursing hours per patient day and finally got rid of the odd requirement that capped licensed nursing hours were doubled which obviously made it hard to tell what 3.2 hours was. In 2000-2001 budget, there was a 7.5 percent wage pass through. Also in 2000, AB 1731 was passed which included substantial enforcement requirements, which I know others who will talk it more than I will, but also required that there be a study of how to accomplish reimbursement reform.

In 2000, we saw Governor Davis propose a substantial increase in the number of inspectors in nursing homes for licensing certification. We also again saw a proposal in 2001 to improve substantially wages, this time through an innovative program called the "WARP" where nursing homes were required to have a legally binding commitment to pay increases in wages because they had failed so often to pay for each pass through to the workers as was intended. And so the work, which included another 8 percent raise in wages, was designed to improve wages once again.

Over the course of those years, the wages for nurse's aides in Los Angeles moved from $7 an hour to over $9 an hour. That is a very substantial improvement in wages that should have begun to help stabilize the workforce. Unfortunately, in the years since, because the work never

_____ because we've had bad budget years and because there's been a lack of increase, we have not seen further improvements in wages. So the progress we have made was sort of salt on _____ and that is a matter of deep concern to this union.

In 2001, AB 1075 passed, and I want to take up the other theme of improving staffing. We had increased staffing in the 99-2000 budget by requiring 3.2 nursing hours per patient day. AB 1075 proposes the improved staffing in a different way.

Currently in nursing homes, we require a certain number of nursing hours per patient day. Nobody knows what a nursing hour per patient day is. I cannot walk into a nursing home as a family member and walk up to a staff person and say, "*Have you done your 3.2 hours of care per day*?" This is not how people think about their work. It's not how a family member understands it. When DHS or any other entity attempts to measure it, there are all sorts of complications with doing that which we're going to hear, I suspect, quite a lot about today and on other occasions.

We instead propose that we do for nursing homes what we have already done for hospitals, which is require a staff-to-resident ratio. Now many of us are familiar with this on the hospital side. We have had in 30 years in California, after the Brown administration again, a requirement in our intensive care units and our operating room that there be one nurse to two patients in our intensive care units. This is readily understood, easily enforced, minimum, that nurses understand and family members can understand. We propose that DHS do the same thing for nursing homes.

This law has never been in--this provision of AB 1075 has never been implemented. And as best as we can gage, DHS is currently making progress toward implementing it. And we would encourage you. You know, it's hard—we have 24 percent of nursing homes or some chunk of them not meeting the nursing hours per patient day. Part of the virtue of ratios is anyone of us can walk into a nursing home and say, "*Okay,*" you know, "*the nurse's aide is caring for my family member. You know, you're supposed to*

have eight patients today. How many have you got? You're supposed to have four on the night shift. You're supposed to have 10 or 12. How many do you have?" SEIU in July of 2003 made a concrete proposal--we worked with Dr. Jack Shelly who's tried to devise it on what those ratios should be. To the best of our knowledge, no further action has occurred. We'll have to provide the committee and anyone else a copy of that proposal which has language since July of 2003.

So, we continue to be committed to improving staffing.

SENATOR ALQUIST: You have about two minutes left.

MS. CAPELL: Thank you and we'll continue to work on that.

With respect to AB 1629, we tried to build in accountability from the beginning. There were a number of organizations that were involved in devising that. We're happy to provide the committee a copy of the original SEIU proposal as well as the revised proposal that we developed with a number of other organizations.

We have not only the systemic cost centers, including cost centers for labor; we have also full audits every three years, limited scope audits, which are added as a result for this every year for facilities so we make sure that we don't have multiple years going by. We have the rate adjusted downward if a facility fails to spend. For example, if a facility gets $130 a day for care and they're supposed to spend $70 on staffing and they already spend $50, the rate will be adjusted downward in the future year to account for that.

The measure also includes four different evaluations, one by the Bureau of State Audits, a baseline evaluation, a report by DHS, and a sunset evaluation. Senator Ortiz, your colleague, attempted to include another evaluation. We literally couldn't figure out how to schedule it in before the sunset occurred.

With respect to staffing compliance, AB 1629 adds for the first time in statute the plain requirement that this be examined by audits, also a plain requirement that it will be part of the annual licensing process, and you add

that to the OSHPD data with all these inadequacies and lack of auditing. This is more scrutiny of staffing than there was before. We support additional efforts to assure that adequate staffing is there, and we also would support going to 4.1 nursing hours per patient day and look forward to the opportunity to do that.

With respect to 1629, I want to go back to the basic premise of the existing reimbursement system that has been in existence 30 years. This flat-rate system has no accountability. In Los Angeles, where the rate is $107 a day, if you, Senator Alquist, staff well, pay good wages, have nice food, make sure the facility is clean and the sheets are changed, you get $107 a day. And if I run a facility where we pay minimum wage, dump staff at 3.2, cut the orange juice with water, and don't bother to keep the place especially clean, I'd have $107 a day. And guess who's making money? You're not. I am. All the incentives are wrong in the flat-rate system

AB 1629 creates a system based on accountability with incentives to improve staffing and wages and with many provisions that are designed to improve staffing and wages, and we're happy to discuss at any length, at any time, with you or anyone else who's interested.

SENATOR ALQUIST: Thank you very much.

Next we have Willie Brennan, chief, Rate Development Branch, Medical Services, Department of Health Services, DHS.

Also, there are green cards on your chairs. There are green cards on your chairs. If you have questions, you should fill them out. If you have concerns you want to share, you can fill out a card, and then raise your hand and give your card to Mike--Mike over here--or Kansen on the other side.

Welcome.

MR. WILLIAM V. BRENNAN: Thank you, Senator.

SENATOR ALQUIST: Each speaker has 10 minutes, so be sure and save time for whatever is really important at the end here.

MR. BRENNAN: The Department has testimony in the back of the room that's provided. Two things—a little background history on the rates

and also where we currently are with AB 1629. I work in the Department of Health Services in the Rate Development Branch. I'm responsible for implementing AB 1629.

I want to go back to—I did it again—but 2000 was the first time we actually started looking at a new rate methodology. AB 1731 required the Department to actually hire a consultant to go back and review what other states do in review of new methodology. Then in 2001, AB 1075 was chaptered again. It required the Department to go back with this consultant to look at other methodologies for changing the current rate methodology system. We worked with a number of stakeholder groups. We had three meetings backing 2002 dealing with a consultant in a number of consumer groups.

Then in 2004, AB 1629 required the Department to implement this new rate methodology. One is to go back and unfreeze the frozen rates we established on August 1, 2003. As a result, the budget _____. In 2003, it was the first time in history we actually had not given a rate increase.

Another component was to add the quality assurance fee for August 1, 2004. It's a 3 percent fee on all nursing dollars in the State of California. Then on August 1, 2005, it was 6 percent.

The third component was to require the Department to develop a new rate methodology that's specific to each facility. This rate change required the approval by the federal government. And currently, the COLA, cost-of-living increase, has been approved by the federal government, the quality assurance fee waiver has been approved by the federal government, and the Department is still waiting for final approval on specific rate methodology. We submitted information to the federal government about five months ago. We received questions, and we're currently waiting for final approval of the specific rate methodology.

One of the things the Department has done in developing the new rate methodology, we held a number of work groups. Work groups were on the

long-term care industry, organized labor, seniors and consumers. And from these work groups we actually are developing this new rate methodology. Within the next month, month to month and a half, we should have new rates for all facilities, a new specific rate, and we hope to have seamless approval, federal approval, over the next 30 to 40 days. Our new rate system should go into effect, hopefully, on August 1 of this year.

SENATOR ALQUIST: Thank you very much.

Next we have Dave Helmsin. The reason we don't have everybody at the table is that I quickly realized that we have four seats and we have more than four people on the panel and I did not want to have anyone out. And hence, they are coming up one at a time. They all know they are on the panel. Okay.

Dave, welcome. Mr. Helmsin is the legislative advocate for the California Association of Health Facilities. And you will provide us with an historical assessment of the nursing home industry's perspective on the realities of compliance efforts.

MR. DAVE HELMSIN: Thank you, Madam Chair, for the opportunity to participate and for your continued interest in this subject area which is obviously of great importance to all of us.

I'm going to not talk about the reimbursement system as much as staffing because I think that's really the issue we want to point today. And I would start out by stipulating that we agree with the fact that staff is the key ingredient to quality, is the best indicator, and so forth. I would be remiss, though, without at least saying that the staffing levels that exist today are not solely a function of provider discretion. We're also subject to a reimbursement system that has its shortcomings, as you've heard, as well as a workforce pool that has persistent shortages which creates a multiple problem.

But that being said, there are a number of facilities out there and I think 24 percent is probably a pretty good number, that are not meeting the 3.2. The average staffing in California is 3.4, so they're also a great number

that are above the 3.2. If staffing is the best indicator of quality, then I have some good news. We are increasing our staffing and are improving our quality. In fact, we've brought staffing from an average of 2.9 in 2000 to 3.4 in 2003. Now that's a half a body per year, which may not sound like much, but it is about almost an 8 percent increase each year which is far more than Medi-Cal has funded. This industry has consistently spent more on staffing, wages, and positions every year than Medi-Cal has provided. We're constantly trying to catch up in reimbursement.

That puts California, by the way, about 24th in the nation on overall staffing, so we're pretty much in the middle of the pack, which is not where any of us would like to be. There is a problem with the data. I agree that the data is flawed in a number of areas, although I think it's understated. So that's an area we need work on, but there are a number of factors—how you treat salaried employees, some of the temporary help, private nursing, and other things—that don't go into a calculation on the 3.2.

Noncompliance is not something we're proud of. It's something we work every day to avoid. But just to put it in some perspective: The average nursing facility has about 35 employees a day, direct-care employees. And if you've got one employee missing for the entire day, you drop a tenth of an hour on your staffing. If you're 100th of a tenth off of your staffing, you're still out of compliance with 3.2. So it's intolerable in terms of the standard. But as a practical matter, it's not out of line with what a normal business's vacancy rate is. Once again, we fight every day to get folks there.

We've heard that the enforcement is lax on the staffing. I'm not sure that we understand that. We think that the Licensing and Certification Division has a body of state law, federal law, and a good deal of policy that directs their oversight of staffing.

We've heard that their staffing, meaning L&C reductions, taken over the year, have compromised their ability to do their job, which we also don't

understand that. We fund L&C through license fees so the facilities know what we pay in fees every year.

SENATOR ALQUIST: You might describe "L&C" for those that don't know what it means.

MR. HELMSIN: I apologize. The Licensing and Certification Division of the Department of Health Services, which is, I would argue, probably the primary enforcement tool that we use in California.

SENATOR ALQUIST: And they're not here today?

MR. HELMSIN: The problem there is that, once again, L&C has a $90-million-a-year budget for long-term care oversight. They have over 600 positions involved in overseeing care in 1,200 freestanding nursing homes and then obviously the smaller community-based facilities. But it's not a resource problem there, and the resources have not been decreasing. We've seen our rates for license fees increase each year for the last four years. So I'm not sure that the vacancy factor can be blamed, if there is a problem. I'd also point out that 1629 that we've heard so much about added over nine positions to L&C to look specifically at staffing.

Right behind L&C, you've got the Audits and Investigation Division. We heard a little bit about what they do. Sixteen twenty-nine also added—excuse me—they redirected positions within the Department to accommodate the workload for 1629, and that was determined in the legislative discussions.

You've also got—I'm just talking kind of like oversight here. You've also got OSHPD in the loop. And OSHPD does not do audits, but they are the keepers of the data. They've got a sophisticated system for doing accuracy assessments. They do work with providers to make sure the data is accurate. And then when you get to the more serious levels, we've got the Department of Justice with its operation, Guardian. We've got the Office of the Inspector General. Those folks are out there routinely overseeing nursing homes.

Sixteen twenty-nine, as we've heard, added a couple of reports and some other oversight which I think will help address the problem. When

there is a problem, there is an absolute plethora of sanctions that can be applied. The Department can and does use both state and federal citation and deficiency systems, and the operations run everywhere from directed training to $10,000-a-day fines. So these are not lightweight sanctions at their disposal. The AG and OIG, of course, could file criminal charges.

So with all of this, you know, we're not happy to be here today talking about lingering dissatisfaction over the staffing problem, and we agree it's there. We think there's some things that we can do and that should be done, and I would start with data. I think we share in agreement with everybody that's looking at this that better data is a good thing, and we believe that the current data has got limitations in its timeliness, accuracy, and comprehensiveness. So what we would like to propose in that regard is, as a part of 1629, the implementation process, we have got some supplemental reports being developed. Now we can still impact those supplemental reports and should impact those to collect the kind of data we need for better staffing assessment. And I think we would agree, or at least our thinking is, that you could probably go to something that's verifiable against payroll, against other things you file, like your employment development, unemployment insurance, your federal taxes, and so forth. So we think we can create a very accountable level of data through those supplemental reports. We think it ought to be timely. We're not opposed to quarterly reporting if, in fact, we can get the reports designed in a way that they're electronically submittable. Then quarterly reporting may make sense. And we also think they should be comprehensive and that all the stakeholders should have a voice in designing the stuff that they collect.

SENATOR ALQUIST: I have a question.

MR. HELMSIN: Yes.

SENATOR ALQUIST: What policies or industry standards does your organization endorse or promote in order to encourage industry-wide compliance with state and federal laws?

MR. HELMSIN: We are the primary trainers of facilities and staff in California, and we dedicate a huge amount. We have a foundation that we fund, and numerous employees that provide training throughout the state regularly on all the requirements, including staffing, and we also worked with EDD, the Employment Development Department worked with Workforce Investment Boards, the Employment Training Panel, and others to get staff into this line of work and to try to urge the facilities who conduct most of the facility-based trainings where the staff get the training. So without us, there would be very little coming out in terms of workforce.

Back to 1629, just for a minute, we think that this is the first systemic attempt to address the staffing problem. We agree that it will realign the incentives so that you have providers who are incentivized to spend money on wages and staffing within some limits of restrictions, but it will take away the distance end of it as existed in so many years and has developed the type of behavior that people are criticizing.

I would point out—you know, we heard a little bit from Charlene on nonprofit versus profit. I mean the difference in those two entities is not just a name. They have different realities as well. And by the way, the profit, the most recent data for profits in the nursing homes in California, is 1.8 percent, which is lower than any other industry, any other health provider. You could do a lot of other things with your money that will pay far better than running a nursing home.

That being said, if you look at the patients in those facilities, you'd better be thankful we have for-profit nursing homes. They're taking care of your Medi-Cal patients, they're doing it for less money than the nonprofits, and they're actually doing it with less resources, unfortunately, as a function of the reimbursement system.

We think we ought to implement 1629, get the reports, get the oversight that's in place to manifest what the issues really are, and then we'll be in a better position to do policy changes. Until that time, we wouldn't be recommending any changes in the enforcement area. We think

we can reevaluate all the standards, the staffing levels, oversight, everything, with a much more informed decision making in that time.

I would say, though, that nothing in 1629 waived any of the current enforcement requirements for the 3.2, and the Department, I think, has resources in place. They've got the mechanisms and the sanctions, and nothing in this bill and nothing in this change will preclude them from doing what they need to in that area.

SENATOR ALQUIST: You have about a minute.

MR. HELMSIN: Quickly, to wrap up on the quest for higher staffing, I mean we hear 4.1 as an objective, and I'm not sure there's any provider out there that wouldn't like to have more staffing at his facility or her facility to take care of the patients. If we've got 1629 up and running and it does fix the Medi-Cal reimbursement problem to the extent that we think it will, that's a good step, but it's not everything. We have other payers—Medicare. We dodged a huge Medicare bullet which was going to cut nursing home significantly this year. We've also got a proposal out of the administration to move most of this to managed care, and managed care makes their money by not paying providers. So we have a problem that we need to protect rates in that transition and assuming we get it all right and you've still got the training capacity and the workforce shortages to deal with.

Just to put it in perspective on workforce, California ranks 49th in the nation on RNs per capita. It's no wonder we're dropping RNs in nursing homes. In fact, the 87 percent of the active nurses, RNs, are employed right now. And the BRN, the Board of Registered Nurses, estimates they need 100,000 or more to fill the gap over the next few years.

SENATOR ALQUIST: And in closing...

MR. HELMSIN: In closing, I would just say that we're happy to work with you and other stakeholders to improve the quality of nursing home care. That's our profession, that's what we do for a living, and we'd like to do it well. Thank you.

SENATOR ALQUIST: Thank you very much. Thank you for being here.

As the next speaker comes up, who is Alan Robison, as he comes up, I'd like to welcome the Vice Mayor of Sunnyvale, Ron Swegles and also, Nicole Vasquez from Senator Ortiz's office. Senator Ortiz is Chair of the Senate Health Committee on which I serve, and this hearing is a joint effort between the Senate Health Committee and then the Subcommittee on Aging and Long-Term Care, which I chair

I'd also like to thank the Sergeants. I personally really appreciate what you do in having us, in being able to hold these hearings in an orderly fashion, and thank you very much.

Okay. Mr. Robison is supervising Deputy Attorney General, Elder Abuse Prosecuting Unit, California Department of Justice. He will speak to the need for verifiable staffing data in elder neglect prosecutions involving nursing home operators and the data needs of California's chief enforcement entity.

Welcome.

MR. ALAN ROBISON: Thank you, Madam Chairman. With me as well is Charles Raborn who is one of our senior investigative auditors because he has actually been involved in the process of trying to calculate staffing and has some comments about the difficulty in trying to do it with the present data.

I should mention that the bureau we work for is the Bureau of Medi-Cal Fraud and Elder Abuse, and we investigate and prosecute patient abuse and neglect in the state's long-term care facilities. So we do have a lot of experience in this particular area. And what we would say is that the most important factor determining the care that the patients receive at the nursing homes is staffing. So we think that that is very critical or very pleased that you're having this hearing today looking at staffing.

I can actually give an example of a case where the poor staffing resulted in egregious neglect of the patients. It's a case that we prosecuted

both criminally and civilly against Beverly Healthcare Corporation which is the nation's number one nursing home chain. And at the time we were prosecuting them, they were the number two chain in the state of California. They own the Beverly La Cumbra facility in Santa Barbara, and the facts that occurred there took place in 2000. We convicted them in court on July 31, 2002. And because of the lack of staffing they had at the facility, and we took all the census records as well as the punch detail reports from the facility, and we looked at it for the year of 2000, to look at the staffing. And the first thing I can tell you is it took an enormous amount of time. Basically, you're looking at one auditor having to spend months in order to figure what the staffing was for one facility for one year.

What we concluded was, for the year of 2000, it was 2.7 for that year. In particular, in some of the critical months, May through July, it was 2.5. So what you had was scores of patients who were not getting turned, for instance, who were bed-fast patients, and they developed pressure ulcers.

SENATOR ALQUIST: I have a question. How do you reconcile the data, you know, 2.5, 3.2, 3.4, 2.7? How do you make sense of it? How do *you* make sense of that?

MR. ROBISON: It was difficult for our auditors. We basically followed the policy and procedure manual of the Department of Health Services L&C. And so we, for instance, gave credit to the MDS, or minimum data set operators. Even though they're not involved in patient care, we followed the L&C guidelines. We went ahead and gave them credit for that. But we had to actually look at the employee and try to determine what they did at the facility so we could see if they were seeing CNAs or LVNs, if they were involved in direct-patient care. Like I said, it's terribly time consuming in order to do that for one facility for one year, and what we found was that the short staffing led to these pressure ulcers.

One patient in particular was a woman named Laura Simmons who was 102. And starting in January 2000, she developed severe pressure ulcers on her buttocks region and her feet due to the poor nursing care. Her

condition worsened until by May of 2000 her right foot went gangrene. Finally, on July 23, 2000, maggots were discovered between and underneath the fourth and fifth toes on her right foot.

We have a description here of one LVN that had to deal with these maggots and the pressure ulcer. And this is a quote from her, when we went and interviewed her. She said: "When we entered the room, there were small flies everywhere like there were rotten fruit in the room. As they removed the bandage from Simmons' foot, flies flew out of the bandage in the wound. There were hundreds of them. The smell was terrible, like something dead. There were maggots on top of the foot, between the toes, on the bottom of the foot, and crawling in and out of the wound. The maggots were big and fat. I took a long Q-Tip and probed into a large golf-ball-sized bubble on the upper foot pad of the foot. I pushed on it to flatten it out. It broke open. It was full of maggots. I scraped the maggots off the foot and legs. The more I would dig into the foot, the more maggots came out."

Laura Simmons was transferred on July 28, 2000, to an acute-care hospital where she died on August 1 of 2000. We criminally convicted the corporation of elder abuse, 368(b)(1) for that. We also had a civil filing as well of unfair business practices. That's an example of where short staffing leads directly to abject neglect of the patients.

What we would suggest is, what we need to do is focus on how to efficiently enforce the staffing standards we have in California. And the way that you do that, you can't have one auditor spend months for one facility, just for one year. We need to make it simple to calculate the staffing. Right now, it is not simple to calculate whether or not the facility is in compliance with 3.2.

What we have been doing is looking at OSHPD reports in order to try to see compliance. And we would suggest that OSHPD report...

SENATOR ALQUIST: Would you say what OSHPD is for people?

MR. ROBISON: Oh, yes. Thank you very much.

When I say "OSHPD," I'm referring to the Office of Statewide Health Planning and Development, and the all the facilities every year have to file a report with them where they give a lot of staffing information. And that would be an efficient way of checking the staffing of the various 1,400 facilities in the state. And Charles Raborn will speak briefly about some problems that we've encountered with that. There's some information there that's not broken out, such as MDS hours.

One thing that we're particularly concerned about as well, in terms of the industry trying to reach 3.2, is the way they've been cutting back the RN hours. That's one way that they've been getting closer to 3.2 because the RNs, of course, cost more, and so you can cut RN hours and hire more CNAs. The problem is that you really need those RNs there at the facility, and we've tracked the decline. Just looking, for instance, going from 2001 to 2003, we've had to take OSHPD data and calculate it ourselves because it's not available. And we've seen that for large facilities, 100 beds or more, in 2001, it was 0.351 RN hours. And now in 2003, it's .335. So we're very concerned about the reduction of RN hours.

Now I'm going to turn it over to Mr. Raborn who's going to talk about his work trying to calculate 3.2.

MR. CHARLES W. RABORN, JR.: Madam Chairman, as Mr. Robison said, I'm an investigative auditor with the Bureau of Medi-Cal Fraud and Elder Abuse.

When I was attached to this unit, my task that was laid in front of me was for several cases, and it was essentially to evaluate the performance of some entities as to whether or not they had been able to both not only comply with injunctions that had been in place but also that they were in compliance with the mandated staffing levels. My first—and also what they were doing in performance to their peers in the industry.

One of the things that I did was I looked and tried to find where the 3.2 was officially issued in terms of reports, where these facilities are officially evaluated and where the 3.2 compliance numbers come from. Of

the ones that I was able to determine at Department of Health Services, OSHPD and so forth, OSHPD was the most reliable and the best source of data for my use. But when I tried to evaluate the 3.2, the data that OSHPD collects, the way the form that it collects the information and the form that presents it, has some inherent problems.

For example, the Department of Health Services has a memo that says that the MDS operators count towards direct care. That information is captured and recorded on the OSHPD report in the "Other" category or, I should say, the technicians and specialists, which that category does not count for direct care. So we're combining hours that count in a column that does not count for calculation purposes. It is also allowed that directors of nursing time counts towards direct care for facilities that are between sizes of one and 59 and they separate their time. But then again, we have part of the time that counts in the management and supervision line which traditionally does not count, and the part of it in the RN line which does count. And where I'm going with this is that it's extremely difficult to break this information out for one facility or, I should say, one corporation that we're looking at that has multiple facilities. And when you're trying to look at it in terms of...

SENATOR ALQUIST: Doesn't direct care mean direct care? (Laughter) They're supposed to spend their time on direct care. It doesn't mean administration. It doesn't mean training nurses. It doesn't mean—it just means direct care...

MR. RAYBORN: I would agree with you, Madam Senator, that that's exactly what it would mean. It would not mean doing paperwork...

SENATOR ALQUIST: But I wouldn't be surprised _____ definition. Well, we can talk more about that at some other time.

MR. RAYBORN: Okay. I would welcome the opportunity.

MR. ROBISON: I think we are in agreement that 3.2 should be looking at direct-patient care, not administrative. But the OSHPD report as currently construed doesn't just doesn't break it out. The other problem

here, which is really not a punishment, is to make the facilities fill out OSHPD reports accurately and timely or even to comply with 3.2. There's nothing specifically in the statute that requires 3.2 that spells out what happens if they don't comply with it. So that's another thing that we think that OSHPD should look at. Thank you very much.

SENATOR ALQUIST: Thank you very much.

Okay. Next we have Robert Goldsborough, resident of a local nursing facility. Welcome, Robert. Thank you for being here with us today.

MR. ROBERT GOLDSBOROUGH: Thank you so much. Good morning.

SENATOR ALQUIST: Good morning.

MR. GOLDSBOROUGH: My name is Robert Goldsborough, and I have been a resident of long-term facilities in Santa Clara County for 15 years. I am currently a resident at Winchester Convalescent Hospital and president of the Residents' Council there. Thank you for the opportunity to testify.

Patients at long-term healthcare facilities are being cheated out of the care that they need. Nurses and CNAs have too many patients.

What does it mean when your care attendant has too many residents, especially for high-care maintenance patients, like myself? It means that they cut corners either with me or with other patients. It means, if the attendant takes time to do something for us, things that should be done, we are being reminded that they are taking time from someone else. I'm constantly being reminded that "*You're not the only patient,*" and "*You think you're king.*"

It means the attendants either do a complete job quickly, sometimes resulting in physical injury, like patients being thrown against the rails, or they eliminate tasks moving onto the next patient.

In my case, it means that attendants are not careful with supersensitive patients who are in lots of pain. When you are experiencing chronic pain, the way you are handled can increase or reduce that pain. If you can't move the way your body is arranged and the frequency with which

you are turned affects that pain. And with increasing pain, the longer you experience the pain, the less—it gets more intense. And when they finally do get care and therapy, it's less effective. It takes a longer time for you to get back to feel less pain.

Failure to be turned not only increases pain but also leads to bedsores and death. I had two bedsores several years ago. My lawyer and I needed to demand that the facility take proper care of me. Thank God I have a lawyer. _____. Thank God for her.

When attendants have too many patients to take care of, they stop caring for their patients. They don't have the time to be kind. They just need to get their work done, and so they end up making their own priorities. And just what takes priority? Paperwork, not resident care.

There's a quote here: *"If it's not on paper, it hasn't been done."* In our experience, what's on paper has nothing do with the care we get. This is especially true of care conferences, which they're supposed to have every quarter for each patient. You go in and they're supposed to decide what your care is going to be.

SENATOR ALQUIST: And you have that every quarter?

MR. GOLDSBOROUGH: Yes. It's scheduled for every quarter, but most patients, after they go to two or three of those, they just get discouraged because what they write down on paper gets tucked away and filed to be saved for the licensing _____.

SENATOR ALQUIST: So you have no sign-off of whether the task was accomplished? No sign-off?

MR. GOLDSBOROUGH: Not for me. I haven't seen anything.

When the caregivers have too much work to do, they'll lie about what they did. They may only brush your teeth maybe once a day, at the most, sometimes five times a week. They never floss; sometimes they won't shave you; and sometimes they don't get you up in time for activities. Twice I was sent to the hospital because I was dehydrated. They kept telling me I should drink more water, and then they never came around to give me

water. So my urine became too concentrated. When I came back, I realized I had to take things into my own hands, and I went around to various stores and bought different parts and put them together and had my home-water delivery for my bed and my wheelchair. _____.

Also, the problem I had was, I had a suprapubic tube, which is a tube going directly into my abdomen. It needs to be cleaned every day and changed every month. I went to the hospital for six weeks and it was black at the end of it.

I think, if you need something done, you have to beg and make demands and you soon get the reputation as being a demanding patient. And God help you if you try to tell your student aides or nurses how to take care of you. There's been hundreds of deaths since I've been in this condition for 17 years _____, as if 150 hours can train for a caregiver is not enough to take care of a high-care patient like myself. And training caregivers is a never-ending task because of a high turnover rate, 82 percent and sometimes as high as 200 to 300 percent. Unfortunately, many caregivers are immigrants who don't speak English very well. It's really difficult to expect that they can care for me when I can't move my hands or point to things. And what about patients who can't speak? Patients who are comatose? And many patients just don't know what their rights are concerning patient care.

When there are not enough caregivers, residents don't get care and caregivers get burnt out. Being a caregiver, a nurse, or CNA is not an easy job, and they don't get paid enough. And many caregivers, they work a 16-hour double shift. Either they work double where they're at now, or they work at two different facilities, eight hours at each place. And I questioned almost everyone who's ever taken care of me and they're all like that.

Those caregivers who do care, work very hard. Some caregivers who work really hard are chastised by other caregivers, "*You're working too hard; you're making me look bad.*"

SENATOR ALQUIST: You have about one more minute.

MR. GOLDSBOROUGH: Attention should be placed on not only how many caregivers there are, but how good they are and what they do. Like we need to have someone always in the dining room because if a patient falls or is choking, then it's left up to other patients to go find a nurse some place. One time it took 15 minutes for that to happen.

Something needs to be done about the conditions at convalescent hospitals. They shouldn't need to be a choice between documentation to providing actual care. We need adequate staffing, we need to make sure staff does the work that we need, and facilities need to be held responsible when they don't.

Thank you very much, Senator Alquist, for your untiring efforts to improving the quality of our care.

SENATOR ALQUIST: God bless you, Robert.

MR. GOLDSBOROUGH: God bless you.

SENATOR ALQUIST: I'd like to take a moment here to say, too, before we have the Consumer Sound Board that I appreciate the work that people do to provide care providers. I know that is not easy. And what we think—one reason I'm holding this hearing and one reason I do the work in elder and senior and disability care that I do is that we need to see that people who provide the care are paid well. To me, that's a big issue because many of the things that happen—and we're going to be hearing about some of the things that happen—happen because there just aren't enough care providers in a facility or a home and that they're not paid as well as they should be, and Mr. Thompson is a friend of mine. And I just really believe that people who take care of those in great need need to be paid fairly. And it seems like, I look at what we did on IHSS this year, we had to fight tooth and nail just to see that—the Governor wanted to take IHSS to minimum wage that that did not occur, and that did not occur. We had to fight so hard for that, so hard. In a civilized society, which for the most part we are in California and America, for the most part, that should not have to be the case.

Next we have a part that is little new to me. It's called the "Consumer Sounding Board." If you will bear with me a little bit, as I find exactly how this is working. There are two people for this part, and Gary Passmore is first. And then we'll have Sherrie Matza. Gary, I know he's here.

Welcome. Hold on. One more minute. Okay.

And if you could take about a minute each, a couple minutes each, that would be great.

MR. GARY PASSMORE: Okay. Thank you, Senator. I'm Gary Passmore, Congress of California Seniors. Before I begin, le me wish your wonderful and esteemed husband, Al Alquist, a happy birthday about in about ten days; 97 is an inspiration for all. (Applause)

SENATOR ALQUIST: Yes, thank you.

MR. GARY PASSMORE: Senator, I posed your question that I'll get to in a second. I just would like to make an opening statement about it, and that is...

SENATOR ALQUIST: Actually, it sounds like there are only two people for this part; is that true? So you each may get three minutes.

MR. PASSMORE: Oh, okay. Thank you.

I think you heard from all of the panelists this morning, a very deep concern about care of patients that are in skilled nursing facilities in California and a widespread commitment that we make changes that improve that quality of care, and we appreciate your leadership in this effort.

Assembly Bill 1629 made a huge step in that regard last year. It committed what I consider to be enormous resources, especially in light of the constrained physical situation that the state faces. As I understand it, your bill, 526—and this hearing, this process, is designed to examine whether or not the accountability that exists right now under state law is adequate, that we can all be comfortable that those new resources and the resources that are already being spent are being monitored and we know what we're getting for our money, and I agree, absolutely. That should be one of our top priorities.

I think in that regard, what we need to do is ask ourselves whether or not we need new law—new safeguards, new standards—or whether what we have in place today is at least adequate for the present and what we to do is enforce the law that we have.

SENATOR ALQUIST: Right. And we need to look at both.

MR. PASSMORE: Exactly, exactly, and I think then we need to look at the resources that are required for the enforcement. I think in some larger way we've looked at the resources that might be required for better quality care in 1629. So I guess that would be an opening topic that I'd want to make.

The nature of my question that I forwarded has to do with this issue that came up with several speakers about how we track staffing, how we track staffing hours, or hours per patient day and so on. And I guess I'd like to hear from some of the other panelists who were here earlier, if we have time, from that fellow from SEIU, Mr. Helmsin. Charlene Harrington, I guess, has already left. But maybe, if we could follow up with her and ask her to get back to us something in writing about this issue, about the way we measure and how they might go about measuring the staffing and comparing that. The issue came up in the Attorney General's Office.

SENATOR ALQUIST: If it's all right, why don't we just ask them to come up in just a minute? Mr. Helmsin and Ms. Capell.

Is there someone else you wanted to see?

MR. PASSMORE: It was Charlene Harrington. I think she's left. We'll just forward and maybe can get some information.

SENATOR ALQUIST: If you could just each speak literally a minute to explain how you come up with the staffing.

MR. PASSMORE: Well, it has to do with how we track and measure the number of hours and the staffing and whether or not there are other ways to do this and better ways perhaps.

SENATOR ALQUIST: Okay. Two minutes each.

MS. CAPELL: With respect to the 3.2 nursing hours per-patient day, let me first again make clear that from SEIU's perspective, we think ratios are a smarter way to do this. Having said that and having said that we regret that that law has not been implemented which I will continue to say until it's been implemented, with respect to the nursing hours per-patient day, we concur that the OSHPD data is not as accurate, not as timely, and has the flaw of being self-reported, unaudited data. That having been said, it is one resource with respect to information about adequacy of staffing.

Secondly, AB 1629 requires that in the annual licensing survey for the first time—in the annual licensing survey—that DHS review the compliance with the 3.2. It also requires that audits look at that as well. DHS had been doing some of this on its own voluntarily; 1629 codifies that, and one would hope that they would comply with the law.

I think with that, I will...

MR. HELMSIN: I would only add that I don't believe that there is a problem of validating the staffing if you're on site and you're a reviewer or an auditor because you have access to all the payroll records, registries, sign-ins, everything. It's the facility's burden to convince you that they staffed appropriately. So I don't think it's a problem at that level. What I think is a problem—and what I've heard here and other times—is that it's not readily accessible to consumers as a useful tool for evaluating the facility and that the OSHPD data, while it's available, has some flaws.

SENATOR ALQUIST: That's not easily available on _____.

MR. HELMSIN: I believe it's translated to a couple of websites that we heard about. And it is actually—they do a pretty good job in arranging and providing the data they have. But I think we're all of one mind that the date, one could be refined a little bit because now we're focusing in more on staffing and, two, to the timeliness is the issue. By the time you get OSHPD data, it's a couple of years old. I think everybody would like to have a quicker reference for staffing assurances.

SENATOR ALQUIST: Thank you very much.

MR. PASSMORE: Thank you, Senator.

SENATOR ALQUIST: What we're going to do next is we have Sherrie Matza from the Alzheimer's Association. She would like to speak. Then I would also like to invite Donna DiMinico who's in the Long-Term Care Ombudsman Program for San Clara County. She's the program director. I'd like to ask Donna, if she's still here, to come up also.

So Sherrie could come up. Would you like to make some comments?

MS. SHERRIE MATZA: Yes. Thank you, and thank you for holding this hearing. My name is Sherrie Matza, and I'm involved because I took care of my mother for almost a decade in my own home who had Alzheimer's disease and then had to place her in a nursing home. So I'd like to comment on a couple of things that I heard here today.

One, I'd like to react to, the whole issue about staffing in a skilled nursing facility. And while I appreciate everything that everybody said, when you have a situation, you're already just meeting whatever that requirement is. And as you heard from one of the panelists, somebody just doesn't show up that day, well, that's too bad, but businesses have to deal with that every day. Businesses don't have to deal with that every day because they don't have to deal with the possibility of somebody choking because you don't have enough staff or somebody becoming dehydrated or even dying. It's not the same as somebody who's not there to take a trade in a brokerage house.

SENATOR ALQUIST: It's literally life and death.

MS. MATZA: It's life and death. Thank you for allowing me to react to that, and I'm sure that was jus t a comment, but I picked up on that.

You heard from a man who had daily experiences living in a skilled nursing facility. And here's somebody who can articulate his own needs. What about the person with Alzheimer's disease or another dementia who is so cognitively impaired or even has no cognitive ability at all? How are those needs...

SENATOR ALQUIST: Or who doesn't speak English.

MS. MATZA: Doesn't speak English, which is a very common occurrence for someone who is from a country with another language and maybe spoke English beautifully or certainly well enough to get along in this country when they were cognitively able to. But once they go into the despair of Alzheimer's disease, they could very possibly lose that second language, so that's an excellent point. So what happens to them?

I want to address the issue about consumer data as well. Being a consumer and thinking that I'm a relatively smart person, but I can make no sense of data. What I want as a consumer is I want the professionals who are in the field to be able to do the kind of research that I heard here today, to come up with what is that best standard. Tell us, tell the residents of California, what that is and tell us in simple terms how to find that.

I don't have a horror story to tell. My mother was in a good nursing home. But as one of the panelists said, how does that consumer know what those hours are? She's right. I saw that there was someone sitting with my mother. And I said, "W*ell, I can see the same person every day when I go."* The particular nursing home that I had my mother in had low turnover. I was extremely fortunate. Maybe they're one of that 5 percent up there that has the good staffing ratios. But I saw the same people every day and that made a difference. After five years in a nursing home when she died, it was her caregivers who hugged me and cried with me. So I can only say I hope that you continue your work. I think that this is vital, and I volunteer with the Alzheimer's Association, and I know that we will provide you with anything that you need.

SENATOR ALQUIST: Thank you and I want to thank you for coming forward because we need to hear the examples of good nursing homes and good care that is provided. Also, I think you made a great point, and that is—and I say this to my staff a lot when we deal with a lot of situations with constituents—I say, *"How do you know the right question to ask if you don't understand?"* How do you know? I think that for many of us, that's a big

issue, you now. How do you find the information on which nursing homes—because there are some doing a very good job that are meeting the ratios that don't have the documented violations. But how do most of us really know? And I believe the state—that we need to provide that information to the community?

MS. MATZA: Yes. I agree. I also think that—again, I appreciate all the work that the caregivers do, that the nursing home industry does in large part. But as with so many things, we're only as good as our weakest link. So that's why, from what you've heard from the man with Elder Abuse, we've got to pay attention very seriously to those issues.

SENATOR ALQUIST: Thank you very much.

Is Donna DiMinico here? If she'd like to come up just briefly. We want to thank you for what you're doing. Would take like to take just a minute to share with the group what you do?

MS. DONNA DiMINICO: Thank you, Senator. I'm the Program Director for the Santa Clara County Long-Term Care Ombudsman Program, and we do advocacy for the people in the nursing homes.

SENATOR ALQUIST: And do you have cards with you?

MS. DiMINICO: I do.

SENATOR ALQUIST: After we're through, do you want to step over by the door? Some people want to talk to you.

MS. DiMINICO: Thank you. And thank you for giving me a minute or two to speak to you on the staffing issue.

_____ residents did refer somewhat to _____. I think that training the staff is going to increase the numbers to make it adequate, means the staff needs to be adequately trained. And knowing that sometimes the language may only be a superficial barrier, I think that people do not understand how to care for a resident with different needs, different conditions—you know, I know that the investigator spoke of the Beverly La Cumbra facility. But it seems to me, that when the staff's trained to understand the importance of a pressure sore or what the possible outcomes

could be and being invited as ombudsman to deliver training to staff that they are _____ services or whatever, I think that when you bring people into a room—and it's unfortunate they do not speak the same language as the presenter, even as you're standing _____, we have to be able to train people in a way that they can do their job very well.

SENATOR ALQUIST: Do you have people who can explain, who can translate into different languages?

MS. DiMINICO: Some of the facilities are able to provide a translator, and we have a couple of people who speak other languages on their staff. But I think the facility's responsibility is to be able to do that training so that the individual staff members are able to understand. Having had a grandmother who lived to almost 102 and for the last five months of her life went to a nursing home and spoke clearly and did not need assistance to express her need, you know, when I'm sitting there and she's asking me to put the little salt packet on her tray, and what happens is, is the care plan says she's on a NAS, no added-salt diet, why is the salt packet on her tray? The staff who was packing the tray didn't understand that whole—you know, for her to go to _____ the salt was not a big thing. But that's just a minor, personal experience.

You know, I love my job, and I appreciate the work that the staff do in facilities. Three point two never speaks to consumers, that it be individuals talking about going to their care plan. My staff member, who's also here, said that at a care plan meeting, the social service person and the medical records person were the only staff people at the residence care plan. So something's wrong with some of the training and interaction...

SENATOR ALQUIST: _____. Is there anyone here who would like to talk with Donna? Feel free to step by the door.

MS. DiMINICO: Thank you.

SENATOR ALQUIST: Thank you very much.

We will now go to the second panel, Status of the Complaint Investigation and Enforcement System. And we will start with William

Brennan, Chief, Rate Development Branch, Medi-Cal Care Services, Department of Health Services, DHS, who will speak to the Licensing and Certification Branch of DHS, an assessment of the L&C role in assuring compliance with current and emerging state policies.

So I understand that you will be speaking for Licensing and Care?

MR. BRENNAN: That is correct, Senator. I represent the rate side for Medi-Cal program. We provide a _____ on all professionals on the L&C side _____.

SENATOR ALQUIST: Okay. So no one from L&C is here?

MR. BRENNAN: That's right.

SENATOR ALQUIST: So no one from L&C is here. I know that you spoke before. Did you want to make any comments...

MR. BRENNAN: We have written testimony that L&C has supplied.

SENATOR ALQUIST: There are packets on the table for anyone who would like to see it. I'm assuming that we have a copy also. Okay. And I know you're hearing this. You spoke earlier, so thank you.

Well, Patricia, that gives you a little more time.

MS. PATRICIA L. McGINNIS: Yes. I'll try to save my time for consumers because I know this is an extension of the morning where many, many consumers have...

SENATOR ALQUIST: And this is Patricia M^{c}GINNIS, Executive Director of California Advocates for Nursing Home Reform, who will speak to the historical perspectives of the development of existing complaint investigation systems, purpose and goals of California law and regulations, and the current state of California's complaint and abuse investigation system. Welcome.

MS. M^{c}GINNIS: Thank you, Senator Alquist, and the committee consultants. I really appreciate the work you put into this, and I thank you for the opportunity to address the problems of California's Complaint Response and Enforcement System.

Before I begin, I just want to say a couple of things, I guess, about AB 1629. I can't help it. I think that we have to remember, AB 1629, for those who are new here today, or new to this issue, it creates a new rate reimbursement system. And primarily, it's about money and money alone. Whether or not there will be additional staffing, whether there will be better wages, all those wonderful goals that we heard today will be realized, I hope, for the sake of residents. I hope the faith that the union members have put in this bill is realized, very, very much. It didn't happen in 2000 when the industry got all that extra money under the Aging with Dignity Act. So I think that it has to be remembered, SB 526 is about accountability. It's about ensuring what the promise of 1629 promised, ensuring that that is, in fact, delivered.

Anyway, having said that, I'm going to talk about the enforcement system and really put the focus on the Complaint Response Units as are proposed by SB 526. My organization, California Advocates for Nursing Home Reform, has been monitoring profits with California's nursing homes and addressing consumer concerns for almost 23 years—over 23 years now.

California's enforcement system for nursing homes, under the auspices of the Department of Health Services' Licensing and Certification Unit, has a long and checkered history. Numerous studies, reports, reviews since the 1970s have found inadequacies in enforcement and failure to respond to consumer complaints.

California's Little Hoover Commission examined the state's oversight of nursing homes in 1983, 1987, 1989, 1991, and probably even longer than that. In every case, the Little Hoover Commission issued reports critical of the Department's nursing home oversight and enforcement activities and issued recommendations for reform.

In a scathing 1998 report submitted by the U.S. Senate Committee on Aging—or submitted to the U.S. Senate Committee on Aging—the General Accounting Office found that oversight of California's nursing homes was

inadequate to protect residents with serious care problems and, in fact, placed residents in danger of death or serious bodily harm.

Subsequent reports issued by the Special Investigation Division of the U.S. Representatives' Committee on Government Reform in 1999, 2000, and 2003 found that less than 3 percent of the nursing homes in Los Angeles were at full or substantial compliance with federal standards, that only 6 percent of Bay Area facilities were in compliance, 19 percent of the facilities in Los Angeles and over 33 percent of the Bay Area nursing homes had violations that caused actual harm to residents or placed them at risk of death or serious injury.

Now I mention this because, remember, 2000, 2003, that's when the rates, the wages in Los Angeles facilities had also gone up as a result of Governor Davis's Aging with Dignity Act. So we can't necessarily equate better wages with better enforcement or better care. It's not necessarily so. If we don't have an enforcement system, the rights of the residents and the better care is not necessarily going to follow.

A July 2003 GAO study found that serious weaknesses in state survey, complaint, and enforcement activities continue to exist in most states, including California. In fact, the GAO report noted that California was among those states that showed a marked decline in the issuance of serious deficiencies. You will note Dr. Harrington this morning noted we had over 20,000 deficiencies issued in 2004. But what we really have to realize is that the majority of those deficiencies were understated, that they were not more serious deficiencies, that they did not pick up the real serious problems that we have in nursing homes. The number of actual harm or serious jeopardy deficiencies issued against California nursing homes declined almost 20 percent in a one-year period. While it would be comforting to think that this decline could be attributed to better quality of care—certainly we'd like to think that—the GAO study indicated that this decline was actually due to the understatement of actual harm deficiencies.

So how did the Department of Health Services respond to these critical reports and recommendations? I would suggest that the facts and the statistics speak for themselves.

The Department of Health Services' Licensing and Certification is responsible for licensing nursing homes, for completing annual surveys, for investigating complaints, and through its enforcement efforts to ensure compliance with state and federal laws and regulations. The state has a wide variety of state and federal remedies to choose from. State enforcement tools include a system of deficiencies, citation, penalties, bans on admission, placing the facility in receivership, or even suspension and revocation of the facility's license. For facilities that participate in the Medicare or Medicaid programs, federal programs, the state can recommend a variety of federal enforcement remedies as well, in addition to the state sanctions. The failure of our enforcement system in California can be seen very directly in the downward trends and citations in California and the understatement of the scope and severity of deficiencies, and at a very infrequent use of federal and state enforcement measures.

SENATOR ALQUIST: Can you speak to AB 892, which we worked on together, which was my bill to put documented violations of nursing homes on the internet?

MS. McGINNIS: Well, it hasn't happened. It's one of many, many things that hasn't happened in California.

SENATOR ALQUIST: And that requires DHS to do that.

MS. McGINNIS: That's correct. Now DHS has said that they're working toward it. We got a memo that they were going to have internet information available in March. Then we got, no, it's going to be delayed.

SENATOR ALQUIST: Since 1999 on this particular issue.

MS. McGINNIS: Well, they had quite an obligation since the early '80s to provide consumer information as well from their district offices. That hasn't happened either. What we did get is such blank material, it's

absolutely useless to consumers. So that's just one part of what's not being done in California.

If we look at citations, which is generally the most frequently used enforcement measure in California, the Department issued fewer citations and assessed fewer civil monetary penalties in 2004 than in the history of the citation system in California. Only 484 citations were issued against California nursing homes, and with numerous opportunities for facilities to appeal, probably less than 50 percent of the fines that are assessed would actually be collected.

Another measure, of course, is the federal deficiencies and remedies. The Department has told us over the last year, *"Well, the reason why you're not seeing so many state remedies and state citations and state deficiencies is because we're really focusing on federal deficiencies."* And in fact, we've seen that sharp increase. We've seen a number of federal deficiencies go up from 13,000 something to 19,000 something, and they can issue these deficiencies by scope and severity, depending on the violation. So although the number of federal deficiencies has risen to almost 19,078 in 2004, most of these deficiencies do not reflect the seriousness of the violations. And then because of that, few federal remedies are imposed. So despite what the Department of Health Services said, according to the data that we receive from the Centers for Better Care and Medicaid Services from CMS, the number of federal remedies, including bans on admission and federal civil monetary penalties, has decreased dramatically over the past couple of years.

State deficiencies, another measure. Having a menu of state and federal remedies helps ensure compliance with federal laws as well as compliance with many state laws in California. Unfortunately, the Department has decided that they will no longer enforce state laws pertaining to nursing homes. This is reflected...

SENATOR ALQUIST: Did you want to say that again?

MS. McGINNIS: The Department of Health Services has decided that they will no longer enforce state laws pertaining to nursing homes. I will explain; we have this on paper. We know a little bit more now than we did six months ago when we tried to figure out why the number of state deficiencies dropping so dramatically. And in fact, we had over 4,000 state deficiencies in 2003, and there are a fewer than a thousand in 2004. There's been a sharp decrease. Why is this? Well, the Department's decision to test pilot a project in the San Jose and Alameda County district offices under this pilot project, state surveyors are only examining compliance with federal laws and not with state laws.

What this illegal—and we say it's illegal because they have no legal basis for doing this—there's no legal authority for the Department of Health Services to take this arbitrary action to avoid compliance to federal laws. We're enforcing federal laws—state laws.

SENATOR ALQUIST: Do you have that in writing?

MS. McGINNIS: Yes. I'm going to read actually in a minute, and let me explain what they've done. The violations of state laws are no longer enforced in these district offices. State deficiencies, citations, and penalties are not issued. Consumers are now being denied due process. Nursing home residents are denied the hard-fought rights and protections that under state law that have been enacted by California's legislators over the last 20 years. As you well know, we've worked with Senator Mello on tons of bills and with Senator Vasconcellos, with you when you were Assemblywoman Alquist and now as a senator to get many important rights and protections for residents in California. All those have gone by the wayside as the Department has decided that they are no longer going to enforce that.

In fact, in the San Jose and Alameda district offices, complainants are even denied the right to appeal. Let me read the letter, and this is one we've been getting over the last—well, actually, since October 2004. This is in response to a complaint asking for an appeal. The only due process rights the complainants have in California is the right to appeal when they are

dissatisfied with the outcome of an investigation of a complaint. That's it. You don't have any other appeal rights under California law. So this particular person filed for an appeal:

"Dear Ms. Hanna, I am in receipt of your correspondence dated February 22, 2005, requesting the San Jose district office, California Department of Health Services, to consider your letter as an appeal to December 30, 2004, complaint investigation findings. Your request is denied. At this time, this office is following the federal complaint investigation procedure which does not include an appeals process. The Licensing and Certification Division will develop a policy regarding..."

SENATOR ALQUIST: This is in America, right?

MS. McGINNIS: Anyway, I've attached a copy of this because it's just one example of hundreds, thousands that have been sent out in response to claims in California and that I think illustrate some of the problems that we've had with the enforcement system in California, particularly over the past couple of years.

Now I want to talk about California's Complaint Response System because this is very key of SB 526, too, of why we think that dedicated Complaint Response Units are particularly relevant. Perhaps nowhere is the failure of enforcement reflected more than...

SENATOR ALQUIST: I want to mention too, the reason I'm giving Ms. McGinnis a little more time here is that she's only on the agenda once, and we do have Ms. Capell twice, and we do have representatives from the California Association of Health Facilities twice. So I'm, therefore, giving you a few more minutes.

MS. McGINNIS: Thank you and I won't be much longer.

But under California law, the Department's required to make an onsite discussion or investigation within ten working days of receipt of a complaint. When a complaint involves eminent danger of death or serious bodily harm, the investigation must be within 24 hours of receipt of this complaint. The Department is required under law to notify the complainant within two

working days of receipt of the complaint of the name of the inspector. The Department is required to notify the complainant promptly of the right to accompany the inspector on the investigation. The complainant has a right to appeal as the results of the complaint, both in the county where the complaint was filed; and then if they're still not satisfied with that, with the way that the complaint was investigated and the result, then they can file with the deputy director's level, to Licensing and Certification.

In 2004, nearly 14,000 complaints were filed against nursing homes in California. As a result of the Department's failures, thousands of complainants had not received timely notice of the status of their complaint, few receive notice of their right to accompany the surveyor, and the majority of complaint investigations were delayed well beyond the 24-hour or ten-day timeline. As a result, 75 percent of the complaints were found to be unsubstantiated. Now think about that. This is just in the last couple of years. We've gone down to 41 percent unsubstantiated to 25 percent.

Seventy-five percent of the complaints, 14,000 complaints were found to be unsubstantiated, not because they didn't happen; but because, by the time the surveyors get out there, the evidence is missing, the staff is gone, witnesses are unavailable, and even the resident is sometimes deceased by the time the Department completes its investigation. (Coughing) You'll have to excuse me. I'm so sorry. I might have to come back and finish up in a minute. I apologize. This has been a tough morning; I've got to tell you.

SENATOR ALQUIST: Would you like to come back?

MS. McGINNIS: No. I can do it now. I apologize.

If the Department of Health Services is not issuing citations or collecting the fines, not issuing serious deficiencies or imposing federal remedies, not monitoring compliance with state laws, or not responding to or investigating complaints on a timely basis, then we have, in essence, no enforcement system in California.

The concept of dedicated Complaint Response Units as proposed by SB 526 in the district Licensing and Certification offices is not a new one. It has been recommended by our organization in annual reports since 1990. And in 1994, critical review of Licensing and Certification, California State Auditor recommended Complaint Response Teams in each district office.

The district office staff is already charged with the obligation to investigate complaints in a timely manner. Staffing complaint teams to fit the complaint workload and training the staff to perform adequate investigations will benefit everyone in the long run.

California's Department of Health Services' Licensing and Certification branch is the only consumer protection agency in California. When they fail in their job, they fail the residents of nursing homes in California. They fail people like Robert Goldsborough. They fail all of the folks that we do this work for in California. And the fact that they aren't here today to talk about what they plan to do to beef up this system, to protect the residents of nursing homes in California, is, I think, unconscionable. Thank you. (Applause)

SENATOR ALQUIST: It is noted by me that the chief of the Department of L&C is not here with us today and that there was only written testimony. It was noted by me, and I'm sure it is noted by you.

Okay. Mark Reagan, California Association of Health Facilities, who will speak to the industry view of current enforcement practices and the challenges it poses for compliance efforts. Welcome.

MR. MARK REAGAN: Thank you very much. Appreciate the time to be able to testify.

I wanted to start first with talking about when the term *"complaint"* is used to put a big word *"tale"* on it because it's important to understand how and why, what we call complaints, has changed over the past couple of years and then talk about what we've seen in terms of trend lines. When we talk about complaints, we're just not talking about the very many avenues that consumers have, either through the Long-Term Care Ombudsman's Office

through the Department of Health Services, to raise issues that they have with the care that they receive. We're also talking about facility requirements and individual caregiver requirements to make self-reports under certain circumstances. And one of the things, that if you look over the last few years—and this is particularly important when you talk about the rate of substantiated complaints—that you see the rate of substantiated complaints go down as there has been far more emphasis on facility and caregiver self-reporting.

So, for example, where beginning in approximately 2002, where there was an increased emphasis, largely from the Office of the Attorney General, to make sure that facilities and caregivers understood their responsibilities to report issues that were brought to their attention in some way, shape, or form, we had an increase of complaints that we really hadn't seen before—and so if you were to—and not surprisingly—because there is not a great deal of clarity, if at all, about when the facility must report or the caregiver must report the rates of substantiation of the facility and the caregiver self-reports already for lower rates.

SENATOR ALQUIST: Did you say there is clarity about the reporting...

MR. REAGAN: Yes. With respect to facility and caregiver reporting, the standards, or at least what's written in the law, is that the caregiver of the facility is to report either what is alleged or is suspected to be abuse or neglect in some fashion. But the Department of Health Services has never issued regulations, though they said that they would, approximately two and a half or more years ago, clarifying for the caregiver and for the facility what it means.

For example, if you have a patient with a high level of dementia report to you that there is something that you know is impossible to have happened, such as a 60-foot giant in their room, that necessarily still produces a report that we call a complaint. When we look at rates of substantiation, the rates of substantiation of consumer complaints, those

that are made by the patient and by the resident, by their family, are, in fact, substantiated at the same rate approximately that we have seen in the past. So what we have really seen is this significant self-reporting increase and those particular complaints as their styled not producing allegations that are in fact substantiated.

SENATOR ALQUIST: How does that fit with what we just heard from Ms. McGinnis? I'm really puzzled. I don't understand because what I'm hearing—she read something in writing that, for example, San Jose and the Alameda offices, that they're basically not taking, that there's no appeal process on complaint.

MR. REAGAN: I see that as a different issue. What I was speaking to was when she talked about the issue of the percentage of complaints that were substantiated. It's because how you count complaints has increased by virtue of facility reports.

Now I saw what Ms. McGinnis referred to, and she is correct that there is a pilot process out there in a number of counties where the Department of Health Services has decided, for whatever reason, to use the complaint investigation and enforcement remedies that it is required to comply with by virtue of federal law and not apply apparently that provision of state law that allows the complainant—this is the consumer, that if they don't like the results of the complaint, i.e., that it wasn't substantiated, that under state law, they do have that right of appeal. So it would seem to me that there is nothing—and I personally would disagree with Mr. Quintaro's conclusion because, even if a complaint investigation is being done using the federal enforcement process, there's not a reason why the complainant should not have the right to appeal that under state law. So I don't understand that particular clarification of Mr. Quintaro.

SENATOR ALQUIST: Well, I would love to hear from the DHS director because it sounds to me like DHS is breaking state law and not allowing by not having a complaint appeals process.

MR. REAGAN: Let me try to put some additional meat on what I wanted to talk about with respect to the number of complaints. We've heard the number of 11,000, of 14,000 complaints. As has been stated here, we're talking about 1,200 to 1,400 facilities. More than half of those complaints, as the Department's statistics would show, were self-reports. So basically what we're talking about is we're talking about eight to ten complaints completely per facility, per year, half of those, less than half of those, from consumers. And then those that are made by the consumer, they are substantiated in about the same rates that we saw prior to the self-reporting system.

SENATOR ALQUIST: When you say only about half are made by the consumer, when I hear the word *"complaint,"* I really want to say this is a human being who's having a real problem in a nursing home.

MR. REAGAN: I completely agree. And what I'm trying to distinguish...

SENATOR ALQUIST: It's a real person. It's just not just a piece of paper. It's a real human not being turned over or not given water, or what have you. So where I want to go with this is that half of these complaints are coming from the nursing home residents. On the other half, who are they coming from and what are they about?

MR. REAGAN: The rest of them come from...

SENATOR ALQUIST: The other half.

MR. REAGAN: ...the caregiver and facility reporting requirements that the DHS has never done regulations clarifying their requirements. And as a result, with uncertainty about when something actually rises to the level of suspected or alleged neglect or abuse, there is an over-reporting of those issues by the caregiver because, if they don't, then they face criminal sanctions from Mr. Robison's office which has been very aggressive in that regard. So we can have a clearer process with respect to the actual number of complaints by having more focus and clarity on the portion of them that come from the facility themselves as compared to the patient who is the

human being. And in fact, when the human being reports, more often those are substantiated. And so looking at the statistics, we can truly see that distinction, okay?

So from the consumer standpoint, what we're really talking about is a consumer, the patient, the person who lives and is turned in the facility, is making a complaint, on average, once every three months; or every facility has one complaint from a consumer once every three months. And that is—I think when we throw numbers of 14,000 or 11,000 complaints, people have to realize we are talking half of that information coming from actual facility self-reports and then looking at what that means for 1,400 facilities.

SENATOR ALQUIST: I would say too that we really don't know exactly what percentage is coming from these homes and that that's one of the things that we really need to figure out.

MR. REAGAN: I have been looking at that parsed information over the past week.

SENATOR ALQUIST: It's very parsed.

MR. REAGAN: But we can tell from the DHS claims system the source of the report, whether it came from the consumer or the facility or caregiver. So to us, having clear policy and guidance associated with facility and caregiver self-reports, as well as to have obviously improvement in field training in terms of investigation of the complaints.

SENATOR ALQUIST: _____.

MR. REAGAN: Yes. I guess what's important for me to say as I wrap up is that I hear a lot of old statistics about lots of scathing reports. Now the system's not perfect, but staffing is more than a third higher since 1999. Turnover, as we've seen from Charlene Harrington's slides, are lower. We have seven of nine areas that the federal government looks at for quality of life, and quality of care has improved in California and is over the national average.

There are good things happening in the long-term care system. And somewhere, there has to be some recognition of that as well as we all move together to try to improve care.

SENATOR ALQUIST: Right. We need to work on this together, and certainly I appreciate that we have the nursing home facilities. But what I would say, as a good Greek grandmother, as a yiayiá, is that we're not there and it's not quite good enough yet. We have a lot to do in terms of DHS. We don't have the kind of regulations that are clear until we all know what the numbers really mean and who's reporting and what all the figures mean. And it's more than that, how it affects real human beings in these institutions, whether it would be my father who was in a nursing home for a period of time in Missouri or a relative of yours anyone else who is here. You know, we want to know that all our nursing homes provide adequate quality of care and that a complainant is a human being.

And in terms of staffing, it has improved. And I know because, when I was in the Assembly, we worked hard to change some of the ratios, so we had to work so hard to do that. And I do believe many nursing homes do a great job, but I'm just saying it's not anywhere close to 100 percent. Maybe it's 30 percent; maybe it's 60 percent. I don't know that we really know. And what I'm saying is, we need to have the kind of accountability and have that information open to the public. I'm hearing kind of a recurring theme in terms of different people and different groups wanting to do a good job. I don't question that. I just think that the regulations from DHS are such that we really don't know what's going on and that information needs to be easily accessible to all of us—to the little old ladies, to the little old man who has to think about putting a loved one in a facility or has to into one for herself or himself. This needs to be a common language that we can all understand, and that's why we're here today.

MR. REAGAN: Thank you.

SENATOR ALQUIST: I appreciate what you do. Thank you.

Okay. Next we have Ms. Capell who is going to, this time, speak to contemporary enforcement challenges facing the state, the industry, and its effect on employment.

MS. CAPELL: Thank you, Senator Alquist, for the opportunity to speak again on this important issue. I want to begin by thanking you for acknowledging the work that our workers do and to acknowledge that we have a number of them who have joined us today and that we appreciate, you know, that it's important. We think it's always important to have the people who do the work represented in these conversations.

SENATOR ALQUIST: Well, I really appreciate what they do. Thank you very much. (Applause)

MS. CAPELL: I'm going to speak on behalf, and I also want to acknowledge, that by improving wages and staffing, we firmly believe it improves quality of care. And you've spent time with our workers and you know how much that is true.

I'm going to now speak on behalf of another group of workers that we represent—the nurses who do the inspections and licensing surveys on behalf of the State of California—because SEIU also represents those nurses through Local 1000 and also through Local 660 in Los Angeles County, and that I, in my role as a representatives of nurses, have been meeting with them and talking with them.

I want to point you to one of your very helpful charts on staffing and total hours of inspection for skilled nursing facilities and look at the total number of field evaluator positions filled between '99-2000 is 467; 2000-2001 goes up to 557. And then in '03-'04 is at 443 and we believe has continued to drop. And I want to tell you from our nurse's perspective what the reality of that is in terms of doing enforcement, in terms of doing inspections, in terms of responding to complaints. Where they report to us—and these are the working nurses, not the people who do the budgets or manage all of this—they report to us that where the field offices used to have 25 to 27 full-time equivalents for surveys and for enforcement, there

are now 16 to 18, and this seems to be quite consistent about the field offices. Where they used to have three or four staff for every survey, they now have one or two, and they have the same number of nursing home student staff in the same amount of time. So literally, they are doing the same number of surveys every year with half as many staff. I'm shocked by what that means in terms of enforcement.

In terms of complaint responses, the reports we have from our nurses vary. They try very hard to meet the deadlines for the ones that are urgent, and they think they do a pretty good job of that, although never as good a job as Ms. McGinnis would want or they would want to do if they have the staff to respond.

In terms of non-urgent complaints, some field offices in the nurses' field, is they're reporting on these reasonably timely, in others, that's not true. They have long, they reported long backlogs. And it seems to be, as we pick up the reports from our working nurses, uneven. What is consistent—and this seems to be true no matter, in what way they're dealing with nursing homes, what is consistent is the turnover is high and morale is low because the working conditions are bad; the wages are inadequate. And that's as true for the nurses who inspect and surveyed these facilities as it is for the workers who work in them. It was exactly the same story again.

And as I've gone back and tried to track individual nurse health facility—they're called HFENs, Health Facility Evaluator Nurses, the turnover is really quite astonishing. And this is not, I would say, characteristic of nursing. As you know, I represented nurses now since 1986, almost 20 years. Many nurses have stable careers, stay in the, literally, the same shift at the same hospital for years and years and years. To have this kind of turmoil in state service, which is more usually characterized by stability, is a sign to us of a really troubled area and something that we're very committed to try to fix on behalf of the residents of the nursing homes and of the nurses who—these nurses went into this in order to improve quality of care in nursing homes. They're dismayed by what they find, the reality of it.

They report as well that they are disheartened that in the last few years there has been more intensive scrutiny of the complaints that they—that when they write up complaints, that when they write up licensing surveys—and I haven't gotten all the technical terms perfect, and I apologize for that, but when they would write them up, when they write up a nursing home, that they more often have their work rewritten, re-reviewed, rechecked and that where it used to be that a nurse evaluator could simply write up a citation, talk to her manager about it, and they were done, now there are multiple levels of review someplace else, that they don't have any way of reaching or understanding. And their recommendations are, from their perspective, too often changed.

SENATOR ALQUIST: So are there recommendations filtered?

MS. CAPELL: We're in the process of evaluating exactly what's transpiring and attempting to, in the interest of our nurses, who, after all, are licensed as registered nurses and are putting their license on the line every time they sign a survey of evaluating the options that are available.

We recognize that this is merely information in this conversation, and it's something that we bring to you in an attempt to pursue as we move forward about the context of our collective bargaining relationship with the Schwarzenegger administration which has been resistant to providing adequate wages or adequate staffing in these areas and also within the policy arena as we move forward in next year's budget process. But we would say to you, the reality on the ground is pretty bad from our nurses' perspective, and so we look forward to working with you and the Budget Subcommittees on these issues as we move forward.

Thank you.

SENATOR ALQUIST: Thank you very much.

Next we have Linda Robinson, Long-Term Care Ombudsman Coordinator from Santa Cruz County, who will speak to the description of current concerns about the complaint investigation system from the perspective of a local ombudsman coordinator, the effects of the current

system, the effects the current system has on the way the long-term care ombudsman carries out its mandates and role. Welcome.

MS. LINDA ROBINSON: Thank you very much, and thanks for letting me speak today about these issues.

My name is Linda Robinson. I'm the coordinator for Santa Cruz and San Benito County Long-Term Care Ombudsmen Program. Can you hear me okay?

SENATOR ALQUIST: I can't. Can you hear in the back? Bring the mike a little closer and speak a little louder.

MS. ROBINSON: I'm the coordinator—is that better?—of Santa Cruz and San Benito County Ombudsman Program. I've been an ombudsman for eight years, and I work for Ombudsman/Advocate, Incorporated. It's a nonprofit agency that has the Ombudsman Program and Patient Rights Advocate Program.

The statements I'm going to make today represent the experiences of our program, Santa Cruz/San Benito County Ombudsman Program only. The Long-Term Care Ombudsman Program is federally and state mandated. We advocate for residents living in skilled nursing and residential care facilities. We receive and investigate and resolve complaints on their behalf. We identify systemic problems. We maintain an active presence in the facilities. We work to protect the rights of the residents and to ensure they have the highest quality of life and care possible. Ombudsman acts as a voice for residents, which is why I'm here today. There are many residents and family members who are unable to come to this hearing today. I and several others of us are here to speak on their behalf, if they get a chance. I think it would also be nice to hear more consumers if the opportunity presents itself.

Ombudsmen do not have enforcement capabilities. We rely on the Department of Health Services' Licensing and Certification to enforce the regulations and find sanctions to enforce compliance. As an ombudsman in Santa Cruz and San Benito County, we see what works, I see what works

and doesn't work on a daily basis and we're in a prime position to identify the gaps in the system.

Some of the problems we have identified with the licensing investigative process are: timeliness, thoroughness, and effectiveness. Unsubstantiated complaints or no sanctions lead to repeated violations. Residents are continually at risk, the quality of their lives and their care is threatened. It's frustrating for ombudsmen when they report residents' rights violations, and they're repeatedly unsubstantiated by Licensing. For example, we had an active case in our county. I was told by the licensing evaluator that maggots are sometimes used in care treatment. Please keep in mind while I'm speaking that every complaint involves a person, like you said earlier, who's affected in some way. Their quality of life is affected, their care is compromised, and they're very vulnerable.

There were a couple of presenters here talking about numbers of complaints, and you've heard a lot of numbers thrown around.

SENATOR ALQUIST: Would you comment on that, please.

MS. ROBINSON: Yes. My comment is, those are complaints that have been reported to the Department of Health Services. Ombudsman—I wish I had the numbers of how many thousands of complaints ombudsmen around the state address, receive and investigate, that we don't report because we've resolved them at the local level, at the facility level. So again...

SENATOR ALQUIST: How do you resolve them at the local level?

MS. ROBINSON: We resolved them by working with the staff, you know, taking the resident's complaint to the staff for resolution, possibly to other agencies.

SENATOR ALQUIST: So many times, it is resolved at the local level?

MS. ROBINSON: Many times it is.

SENATOR ALQUIST: That's good.

MS. ROBINSON: And often it's a communication problem that we just need to clarify some things.

The other thing, I want to make one more comment really quick about the complaints is the speaker from—covering health facilities—talked about the increased number of complaints that are coming from staff and facilities.

SENATOR ALQUIST: I have questions about that.

MS. ROBINSON: The answer to that is that's because that's the state law, the Welfare and Institutions Code that says *"...facility staff are all mandated reporters of elder abuse..."* and you have adult abuse. So they're required by state law to report any allegation, any suspicion of abuse occurring in their facilities. That's what those reports are about.

SENATOR ALQUIST: I do a lot in the elder abuse area. So what happens if staff reports a problem with elder abuse to DHS, to Licensing and Care? I mean one thing I'm hearing is that there isn't a follow up now? Would you like to comment on that?

MS. ROBINSON: Well, yes. If the case is severe, which they're only investigating the most severe cases right now, call them Priority 1, so that he has been injured or there's a threat, an immediate threat to their lives or in danger, they will come out and investigate it, you know, soon. But any other complaints are held for weeks or months, and it could be resident-to-resident altercations. There could be abuse where there haven't been any injuries.

SENATOR ALQUIST: So would you give an example of that abuse where there hasn't been an injury and it's taking a long time for DHS or L&C to come out? What kind of situation would that be? Would you explain it to us?

MS. ROBINSON: It would be something like maybe a resident was—well, we had a resident who had been pushed out of his bed by a staff person and he fell and hit the trash can and said that he had some injuries. Well, it took a really long time for them to come out to investigate. I'm thinking close to, about three weeks. But by then, that person's injury has been healed. But the ombudsman was there—we were there. We were there the day we got the report. We cross-report with Licensing as part of

our mandate. But we were there. I ensured I was the one who worked on the case and ensured that the guy got medical attention. In a lot of cases, this is what is happening, is Licensing may not be out there in a timely manner, but the ombudsmen are out there. And we are resolving to try to get these complaints resolved.

It's the times when the complaints aren't being resolved, and the systemic problems in these facilities go on and on, that we really need Licensing to step in and start inputting some enforcement to these facilities so that they will start complying. That's a little bit about the complaint process, but I'd like to talk more about how it affects how we do our work and how it affects the residents.

A lot of times, also, when these complaints aren't investigated in a timely manner, the facilities aren't cited. We're finding they're not being cited. The evidence is gone, you know, some things that Pat spoke about. You have residents who forget about particulars of the incident. If it's weeks or months later, they're going to forget what time it occurred, who was involved. And when an evaluator may ask him what happened and they give a different story than they gave the facility administrator, then they'll say, well, you know, their report is really not—they're not giving the same report each time and so we can't substantiate it. Or often, when the complaints have already been resolved, they're not substantiated. So they may have been resolved for one person, but it's probably affecting a number of other people in that facility. When it's unsubstantiated, then there's nothing there to hold the facilities accountable for correcting their actions.

Residents have told Ombudsmen that nobody believes them when their complaints aren't substantiated. And so even after they told the staff, the ombudsman, and Licensing about their complaints, when they weren't investigated in a timely manner, these residents feel dismissed. And I ask, is this the quality that we value? Is this the message that we want to send to residents? Like, what was the intent of the law? An Act to ensure the safety of the residents.

Just to let you know, for most residents, it's really a big step for them to file a complaint. They're afraid of retaliation. Residents have told me that they were treated differently by staff or that their call light wasn't answered after they filed their complaint. Some of them are afraid to file a complaint; they're afraid to let the ombudsman know about their complaint. So when they do file one, they're taking a big risk. They have a lot of fear, and I just wonder if fear is the kind of thing that we accept, it is acceptable to us, what we would want for our family members and people we care about.

One family member waited till the death of his wife to file a complaint after he had tried to settle his complaint with the facility staff. He filed it with the Department of Health Services after his wife died. He waited three months for that complaint to be investigated. And his complaint had to do with care issues, medication issues, and responding to his wife's call light in time. And he keeps calling and saying, *"When are they going to investigate my complaint?"* And I say to him, *"I'll check. I'll let you know."* And, really, what he wants is some closure. He wants to hear from them.

When I told him I was coming today, he wanted me to tell you that, he said, "I want to see it changed. People don't know what they're getting into, and I wouldn't have put my wife into a nursing home that does those things."

We hear so many stories from residents about abuse and disrespect and violations, all kinds of problems. We do a thorough investigation. When we do forward it to Licensing, we hope for and we expect some action. But how do we as applicants go to these residents and say, *"I don't believe your complaint is going to be investigated by Licensing?"*

SENATOR ALQUIST: It sounds like you don't have any power to make the change.

MS. ROBINSON: We don't. I mean we work so hard at it. A couple of our nursing homes that have about a third of our complaints come from two nursing homes. We're in there three to four times a week, and we work really hard at trying to address the systemic problems that are occurring.

We say, *"Look, try this, try that."* We do a lot of follow-up with them. Those are times when we really need Licensing to step in. And when they're unable to address and enforce change of the systemic problem, then we see the system is broken and the system really needs to be looked at.

SENATOR ALQUIST: Well, I'm most disappointed that Licensing from DHS did not show up. Everyone else did, and I appreciate everyone who did show up. It's very obvious that they did not; they should have been here to hear us and to answer some of these questions and to tell us how they're going to fix some of these things.

MS. ROBINSON: Certainly, it would have been nice. Do I have time to give you more examples?

SENATOR ALQUIST: One minute because we're _____.

MS. ROBINSON: Just to give you an idea of some things that weren't substantiated, physical abuse to residents by staff persons, Licensing didn't substantiate that it was abuse. That person kept working there. The facility staff told me that they rely on Licensing's findings to decide whether or not to fire employees. That person kept working. And just last week, I got two more reports of physical abuse by that same staff person. Now that is not helping residents feel safe. That's another problem. We had a number of resident abuses within a facility.

SENATOR ALQUIST: I know we have some good nursing homes, but I also need to say no resident in a nursing home should have to fear for her or his life...

MS. ROBINSON: No. They shouldn't, they shouldn't. And before the time where we need Licensing to step in, you asked me for an example of what they do with abuse responding, resident-to-resident altercations. It occurs all the time. They're not going to come in right away. We had a resident who had pushed a couple of residents or hit them, and Licensing is not going to come in and do much about that in a timely manner. But what happened at this one nursing home, on the third occasion, this resident pushed someone who broke a hip and died from complications. So you have

the regulatory agency not stepping in and telling the facility that you need to protect your residents from this one resident. And then we have a facility not self-correcting their problems, not taking the initiative to keep their residents safe, and those two things combined led to a really tragic end for this one resident.

I'd like to talk a minute about the pilot project because our county has been affected by that pilot project, which I discovered back in October—I'm not very sure when it started.

What we found, the problems with the pilot project, is...

SENATOR ALQUIST: If you could please explain the pilot project for everyone.

MS. ROBINSON: Oh, the pilot project is....

SENATOR ALQUIST: We have a little more time.

MS. ROBINSON: Okay. So the Department of Health Services' Licensing and Certification—I think back in September or October it started, but a pilot project in the state of California in four—I think it's affecting at least four counties. But it's the San Jose and Alameda district office; our counties—Santa Cruz and San Benito—are under that office. So when they look at complaints that we file or anyone files, instead of looking at California law, they're looking at the federal regulatory system. They're looking at federal laws. So in a sense, they're really disregarding California law. And in that law, we have the elder, dependent adult abuse, where facilities have to file abuse and there's a fine if you don't. We also have the staffing ratio law in California law. So you've got a couple that are disregarded as well as a lot of residents' rights that may be stronger in state law.

The other thing that's happening is there's no citations being issued. But these citations, you get some financial incentive for nursing facilities to correct the problems. So that's not happening. The appeal rights were a big thing. Pat talked about that. We filed two appeals on behalf of residents in our county, and we were told, *"You no longer have appeal rights. We deny it."* And I thought, well, how in the world can they deny somebody's right to

due process? So those folks were not able to appeal. And anyone else in these counties lost that appeal right from October 2004 until I was recently told by the district office, that as of June 1, the appeal rights were reinstated. Now I'm not sure if...

SENATOR ALQUIST: Are they reinstated?

MS. ROBINSON: I don't know. I was told that. I haven't seen anything in writing.

SENATOR ALQUIST: Is it something we need to look into?

MS. ROBINSON: It would be something to look into. So having been in one of these programs affected by this pilot project or part of this pilot project, I would like to say that it may be abandoned right now, in this current form, it needs to be re-looked at because I was told also that it's going to roll out statewide or it may roll out statewide. Now these problems really need to be looked at before it does go out statewide. All laws, regardless of their origin, should be utilized in ensuring compliance.

I'd like to say that we support your bill. We think that it's wonderful to look at straightening residents' rights and establishing the Dedicated Response Unit within the district office. Hopefully, it will result in more timely investigation. There's always going to be a need for skilled nursing facilities, but the system that's currently in place to regulate and evaluate the care level needs to be re-examined and re-evaluated to see if it's meeting the needs and that it is guaranteeing a quality level of care. We need to question whether the minimum standards need to be raised. We're all aware of the budget cuts and the constraints that Licensing has been operating under. We, too, have had a lot of cuts, but the mandate of the minimum standards that are established under law that were motivated by need, need to be upheld, and that means doesn't exist today.

SENATOR ALQUIST: I wanted to thank you so much.

MS. ROBINSON: You're welcome.

SENATOR ALQUIST: While you are up there, I wanted to mention _____ checking with my consultants who helped me on my legislation. On

residential care facilities, now it's once every five years for them to come in and inspect? I had a bill this year to change that from once every five years, announced, to once every other year, unannounced. It got held in committee, but I do promise you to carry that again because the analogy kind of is, I can clean my house once every five years, but you don't know how it's going to look the other 364 days. So I think it should be common sense to say that every single day the facility—and as I said several times, there are some that are very, very good. But like anything in life, we need to keep looking at the ones who are not doing a good job. And, certainly that includes DHS's role in this, which I think is major in terms of what they are not providing.

And in terms of this pilot project, when you said the pilot project _____ stay at the state level, I wasn't going to say it out loud, but I will say it, you know, *"Over my dead body."* (Laughter) But I also know that this is a process and it's simple majority, so maybe it would be over my dead body. (Laughter) There's so many things that we'll be working on.

And I want to thank you for your courage in coming forward and sharing all of this with us because the goal is not to hear some of these very sad stories just to make them feel bad. The goal is to hear what's going on. I basically believe people want to do good in life. I guess that's what you call an *"optimist,"* and I think we need to have the kind of structure and infrastructure that puts out what our expectations really are, state what the expectations are, and then have a process to see that we follow that because certainly, in a person's elder years, it should be a time—one of my neighbors—I have several elderly neighbors, and one of them came up to me recently and said, *"You know, Elaine. It's not the golden years; it's the rusted years."* Right across the street and one over in Santa Clara. And I'm thinking certainly, whether people are in their own homes or whether they're in facilities, they should not live in fear. We should not live in fear. And I believe that if we talk about this, then we can come up with ways for changing laws. So thank you very much.

MS. ROBINSON: You're welcome. (Applause)

SENATOR ALQUIST: We have four people now who will speak under this section called "Consumer Sounding Board," and they wish to come up—Julie Fudge, Patricia Bryant, Suzanne Swift, and Kathleen Johnson. And this is an informal opportunity for consumers to provide input and insight to testimony that was provided. And if you would each like to take a minute or two, we would really appreciate that. We'll start with Julie, Julie Fudge.

MS. JULIE FUDGE: Thank you. I'm not quite sure I can get it done in one or two minutes, but I'll do my very best _____, and I want to thank you for your caring and for your talking about fear. So many of the residents don't make complaints formally with DHS because they are afraid. Shall I get a little closer? Okay. Is that better?

I was my mother's primary caregiver for almost six years while she was in a skilled nursing facility in this area, which I will not name, not to protect the facility but show that the problems are widespread.

Since I usually spent 20 or more hours a week in this facility, I saw and heard many things which alarmed and dismayed me. However, the brief time I have available to me, I will limit my comments to these areas, the amount of time it took for my problem and complaint to be investigated, the quality and nature of the complaint process, and how those might be improved to be effective and just. When I learned that the state survey of the facility was ending on May 14, 2004, the ombudsman and I met with a team, including a preceptor in training from San Diego, to share the egregiously neglectful care which hastened my mother's death when the facility and an LVN did not monitor my mother's oxygen level when it dropped to 66 percent, which is about 30 percent below what it should be.

One of the team, who I knew from previous surveys and who had refused to meet with family members of previous years, tried to placate me. But the preceptor in training wanted to hear my story. I shared the essence of it, and she was so upset, that she called the Licensing administrator at

DHS from the airport to urge this case to be investigated, even before I filed a complaint.

On May 17, 2004, I filed a written complaint with State Licensing giving many details. On May 19 I received my letter with them which officially started the complaint process. The letter stated that L&C must certify the violation through direct observation, interviews, or review of documented report and, *"Once the investigation is complete, you'll be notified of the findings."*

Soon, I requested an investigator, other than the one on the survey team, and the one assigned said she was so far behind, she was working on a 1999 complaint. Four and a half months passed with no word of an investigation being conducted. So I called the ombudsman who suggested I might want to call CAHNR. I learned that California Health and Safety Code states that *"an onsite inspection must be done within 10 days of receipt of a complaint."* I just learned today, however, that I should have been able to go there with the investigator, and I didn't know that until I learned it in this hearing.

On September 28, 2004, I sent a letter to the district administrator in Daly City advising her of this and urging her to comply. I never received a response to my letter.

On October 25, I called the ombudsman for advice, and she told me that the director of nursing of the facility had told her that the investigator had been there.

SENATOR ALQUIST: Always do a cc to your state legislator.

MS. FUDGE: You know, I had done that _____, I'll talk more about that later _____. But you're not my representative.

SENATOR ALQUIST: I meant from the point of view, too, of getting people to respond to you since you were also...

MS. FUDGE: I've had difficulty getting them to respond, too. In November, when I talked to the investigator, I told her that I had copies of the charts from the time in question in case she wanted to compare them to

the ones she was shown. She did not. She said she was typing the report, but she had no idea when I would receive it, because it had to go to her supervisor for his signature first.

On February 3, the investigator called and said the LVN denied everything I had reported, and that she "gave her every opportunity to come clean," but she didn't. The LVN told her that she had taken my mother's oxygen saturation level earlier but hadn't charted it. The ombudsman told me that the rule is, if they didn't chart it, it didn't happen. Yet the investigator said that since it was just the LVN's word against mine...

SENATOR ALQUIST: It's been four minutes. If you can close, please.

MS. FUDGE: She said that you have to have an independent, competent witness to substantiate a complaint, and on that basis, because there are generally in a nursing home no independent, competent witnesses. They're either staff or they're people that you know, or there are residents who are not competent to testify.

So 10 months after the complaint on March 21, the complaint—I got *"the complaint could not be substantiated"* with no information about what had been found and no written record of the information the investigator had shared with me on the phone.

Since facilities do not want to receive citations and possible finds, it is not in their interest to urge staff to tell the truth. It is not in the staff's self-interest to be honest when they've made a mistake because it could result in losing their job and their license. And since the rules are such that most complaints can't be substantiated without their cooperation, it's a wonder that citations are issued at all. But when citations do carry a fine, the record shows that rarely are they ever collected. Obviously.

SENATOR ALQUIST: Thank you. Thank you very much.

MS. FUDGE: Thank you.

SENATOR ALQUIST: What I'm trying to do, so you all understand it, is, just talk to us and tell us what occurred, but I want to be able to have all of

you have enough time to speak because then after that, I'd like to be able to take time for public testimony for anyone who wishes to speak. Knowing we will not be able to do everyone. And with everything, we still need to be done by 12:30, so we can try and do it that way. That's the only reason I keep saying—there are so many good witnesses that I want everybody to have a chance to speak. So, thank you very much.

MS. FUDGE: You are welcome.

SENATOR ALQUIST: Okay. Patricia Bryant.

MS. PATRICIA BRYANT: Hello. Thank you. I appreciate this opportunity. I'm going to try and very briefly outline my complaint process. A skilled nursing facility in Los Gatos. My mother is 85 years old—was 85 years old. She had advanced dementia. She was wheel-chair bound, but she has no physical health illness whatever. She's healthier than me and you.

What happened—I was her conservator. I've always hired someone to spend about—because chronically understaffed, things weren't—she was not getting the one-to-one attention ___ gets, okay? So I've always hired for about two to three hours a day for four-and-a-half years, she was in a nursing facility, I've hired people, as my mom's conservator, to spend this time with her. In addition, I was spending anywhere from one to three hours a day with my mother. I was all over the place. I know everything that goes on in a nursing home and worse.

What happened is in March 2004, they changed charge nurses, what they call LVNs. Unbeknownst to me, my mother's Kaiser, Dr. Chin—she visits the facility—it's her designated facility to take care of. Unbeknownst to us, this charge nurse outwardly falsified my mother's medical record. She would write—she was not following the prescriptions. If she chose to, she would do anywhere from three to 15 hours after they were supposed to be administered and back into medical records. All this came to a head when my mother was in the process of dying in this facility. So all this period of time, she was falsifying the records. And this led to, she got overdosed on

her psychotropics, she had a stroke, she lost her ability to speak, and she was partially paralyzed. So she declined in six months under this one nurse's care.

In addition to that, she was abusing the laxatives, and my mother got the infamous *"toxic wound."* The doctor came out on three separate occasions during this period of time to train and specifically give a very direct order how to treat this wound and to heal it. The nurse absolutely refused to follow the doctor's orders.

This went on. And then finally Labor Day 2004 came up, and everybody was gone. This nurse was in charge of the whole facility. My mother was put on a catheter as one last-ditch effort to get this woman to heal because we're talking grafting flesh, which is what happens a lot at nursing homes. Wound care is rampant. These nurses do not have the education, time, or the concern to treat wounds, period. My mother is out, so they put her on a catheter. Sure enough, she had—she developed within two days or so a urinary tract infection. The doctor was never notified. That led to her contracting at the facility e-coli, a very virulent strain. By the time my mother went to the emergency ward, the doctor was never notified all this period of time.

By the time my mother ended up in the emergency ward and got diagnosed and they tested for the virus or bacteria, it was too late. My mother was so damn healthy. I spent 23 hours a day for seven days a week next to her watching her die because her body was so physically healthy, and it was too late to save her with any kind of antibiotics.

So what happens here? Oh, Labor Day, this all came to a peak. This is just before my mother went into emergency. Dr. Chin comes to visit the facility because of my communications over the holiday. She comes to visit and talks to the director of nursing. That director of nursing is fired. I come in again and talk to the facility administrator. He resigns. All of this is in anticipation of what's going to happen when I file my complaint to DHS and with CANHR and the ombudsman, I filed my complaint. This was in the

middle of September my mother died. I filed my complaint on October 11. I got—on November 3 DHS finally sent me a letter acknowledging it and assigning a number. I spoke to their supervisor. She said that my case was a very low priority.

You would not believe the documentation. I have very detailed, factual, historical documentation. I have the support of my doctor who will come and testify. So DHS told me my case is low priority; they'll get around to it. So finally, at the very end of December, the investigating RN goes out to the facility. I repeatedly asked her to speak with me, to look at the evidence that I have of all these, you know prescription failures and treatments and everything else that defines this nurse. Did not do that. She went ahead, went by the book, and just did all this, whatever. She spent 15 minutes on a phone call with Dr. Chin, okay? That was Dr. Chin corroborating my story.

Then in April, the DHS gives me their findings. They find the lowest level deficiency, something or other, a Level D, basically a slap on the wrist. Then back in May, I, obviously, again with CANHR's support, I asked to have an appeal hearing. I got a letter from Quintero stating that they were going to decline, okay? At this point in time, that charge nurse is still at the facility. I'm working with DHS, the Licensing Board, one other agency—it slipped my mind right now. I'm personally targeting this nurse, and she wants to open up a care facility under her license in Santa Cruz County and/or Los Gatos. So I'm after her.

I was hoping that this DHS complaint finding would help to get this nurse out of play and not to open up more facilities under her license. And right now, I have an assigned officer from the Hayward office, so I'm doing everything I can. It's kind of like sit back and wait; we're not obligated to give you any information, whatever. I'm very vigilant. You can tell I'm very adamant, very organized. I have a lot of documentation. I have a lot of support. Nothing came of this. My mother's dead.

SENATOR ALQUIST: Thank you. I'm so sorry for her.

MS. BRYANT: So am I.

SENATOR ALQUIST: To hear all of this.

MS. BRYANT: And you know what? I'm not the only one. You saw the vigilance. Think of all the residents who don't have someone like me on the premises.

SENATOR ALQUIST: My father was put in a nursing home in Missouri, and it was in a rural area, and the doctor was just very much on contract. The doctor prescribed Haldol without even seeing my father. My father was probably 93 at the time.

MS. BRYANT: I call it *"Helldel."*

SENATOR ALQUIST: Yes, without even seeing him. And, you know, I was calling every day from California and then flying out when I could, and it had horrible effects on him which eventually, I think, had something to do with his death. And my way of dealing with it after that was to pass legislation in California that says when doctors prescribe psychotropics in nursing homes in California that within a 48-hour period, the family needed to be notified, that 95 percent of the cases were patients wanted their family to be notified. If a patient says, *"No, I don't need to be notified,"* nobody was notified. But the other 95 percent, they were notified, and that was my way of dealing with the grief and what had occurred. Thank you.

Suzanne Swift.

MS. SUZANNE SWIFT: I'm Suzanne Swift, and my mother was a resident in a nursing home, skilled nursing home, for six-and-a-half years. My experience will be brief but it takes a little bit of a different turn on the process of complaints.

My mother fell and broke her shoulder. She was admitted to a skilled nursing facility. She was in mid-stage Alzheimer's disease at the time, but totally ambulatory and no other health problems at all.

Before I placed her in this facility, she needed to attend physical therapy after she broke her shoulder. I did much of my own research. I talked to CANHR, I talked to the local ombudsman, I spoke with her doctor,

and I spoke with the Alzheimer's Association to get referrals. I finally found a facility I thought would be okay. None of these resources turned up any information of any complaints against this facility, okay?

My mother was in the facility. Within 10 days of her being in the facility, in spite of the fact that I was with her every day, four to five hours a day, she developed Stage 2 cubitus ulcers within 10 days. I immediately researched and found another home for my mother. I went down to her home, pulled her out of this facility, hired nurses for her care. And the moment that I removed her from the facility, I filed a complaint with DHS. DHS—I was luckier. They did come out a couple of years ago. They did come out. I went with them. I knew my rights; I had done my research. I went with them for the investigation. They did substantiate my complaint. They decided to give the facility a Class A citation, okay? The facility appealed it. I went to the appeal hearing. The citation upheld, okay? Two months later, the facility does it again to the State Attorney General's Office. I was not notified of this appeal. The appeal was plea bargained down to a B-class citation.

I was told when I called the district manager for DHS, he said to me, *"Well, we don't have the money or the resources to prosecute these complaints, so we couldn't send anybody to defend it. We did fine them."* However, they never collected the fine. My mother did end up in a wonderful nursing home. It's one of the 5 percent. I can guarantee that. However, my problem with this whole situation is, once they did find on the complaint, there was no clout; there was no enforcement from the agency to make this nursing home pay or even correct their action. What I found out later on through subsequent inquiries that they had many complaints against this nursing home. But I consider myself an informed consumer. I could not, and nobody else could either, find out what this nursing home and the egregious treatment it had given. There's no documentation. It has all been swept away. And that, I think, is just abominable.

SENATOR ALQUIST: Thank you.

Kathleen Johnson.

MS. KATHLEEN JOHNSON: I don't have an example, or I have many examples. But from what I've heard today, I want to spend my time responding and offering some suggestions.

I am a former certified ombudsman. I'm now the director of the agency for which Linda Robinson works. And I'm here on behalf of residents, not only in Santa Cruz and San Benito Counties, but obviously residents throughout the state. And there have been a few things that have been brought out by various presenters that I think need to be addressed. I'd like to talk about the idea of accountability within a facility, and there have been instances that have been given about the way staff provides care or doesn't provide care, the training, the staffing level. And there's one very important thing, I think, that needs to be addressed, and that is, that the quality of care and the manner in which care is given does not have to relate to the number of staff, but comes directly and is set by the administrator and the department heads at that facility. The qualifications, the testing, and the standards that need to be looked at to become an administrator and what is required of that, and who holds that person accountable needs to be addressed. That is something that every facility can do *without* increasing the cost. We know that the facilities—many of them feel that they're not getting enough profit.

The second thing is the evaluators, who I'm glad that Beth Capell spoke to this in that in her example of the evaluator, she continually referred to them as nurses. And this is another problem on the other side, and that is, that with evaluators going in working for the Department of Health Services and going into a facility that is a medical provision or a medical provider, what we have is a coalition of cultures. The question is, is the evaluator going in as a nurse, or is it her education as a nurse that should make her a better, more aware evaluator?

The licensing issue of losing a license, the idea of—and we've heard evaluators say this—we've looked at the charts, what the doctor has ordered

isn't anything that we even want to address or bring into account because we don't have any influence over the doctor's orders. And staff, when they say, *"The doctor ordered it—we were just following doctor's orders"*—they buy it. So the question is and the need is the standard of training and the accountability and consistency from evaluator to evaluator and the recognition that they are in a role of evaluator, not in a role of a practicing nurse.

SENATOR ALQUIST: How would they look at it differently then?

MS. JOHNSON: When an evaluator goes in, they have a set of regulations that they're following. In our experience and in my previous experience as an ombudsman, evaluators would say, *"Well, the doctor ordered this"* or we see it in the chart and it says, and this is what is in the chart and this is who—and it's initialed that this was done.

SENATOR ALQUIST: So, it's the process.

MS. JOHNSON: So it's actually objectivity, and it's the difference between the culture of being a nurse and that whole atmosphere that says you don't question doctor's orders, and this is what we do as nursing staff; this is what we follow. That culture, versus going in and looking at the regulations and everybody is equal and even, and the regulations are to be enforced...

SENATOR ALQUIST: Which is the process.

MS. JOHNSON: It is part of the process, yes. In addition to that, the facility, all the regulations are set up for facility operation and compliance. And as such, the regulations require that each facility have a medical director, that attending physicians be a part of the facility, that they need to have the availability of psychiatric services. All of these requirements are requirements under the regulations, but the enforcement agency, Department of Health Services, has absolutely no authority to regulate those requirements. So an attending physician is out of bounds for Department of Health Services; the medical director, out of bounds for the Department of Health Services; psychiatric providers, out of bounds for the Department of

Health Services. When there are concerns and complaints by residents about the doctor's care, about the attending physician that they don't recognize and they've been in the facility for a year, about a medical director who is the medical director for a facility and is also the attending physician for about 85 percent of the residents in that facility and there are problems with—and the residents are complaining about the physician, and the physician is in fact the medical director, so there's no way to go. There's no oversight by Department of Health Services?

SENATOR ALQUIST: How do we make it in bound?

MS. JOHNSON: What I believe is that the regulations require that these individuals or these roles be filled within a facility setting. Then anyone and everyone operating within a facility setting is under the purview of Department of Health Services. Their behavior, the manner in which they do their jobs, are within the realm of the facility. And if a facility is going to be held accountable, the administrator is going to be held accountable for deficiencies and violations, then the people who potentially are initiating those violations need to be accountable as well under the Department of Health Services.

SENATOR ALQUIST: Thank you very much.

I want to thank all of you for being here. Kathleen, we appreciate that kind of insight—it's very helpful—and to Julie and Patricia and Suzanne speaking as her daughter.

Both my parents have passed on. I really relate to what you have to say, and God bless you and _____ we all appreciate that.

MS. JOHNSON: I'd just like to say one thing, that an ombudsman told me, *"You're not protected. You're just supposed to think you're protected."* And I'm really hoping that the Senate Bill will give us some real protection. Thank you.

SENATOR ALQUIST: What we're going to do now—and I'm not quite happy where I thought we would be, but it's close enough, I guess. I'd like to take eight or nine minutes for any public comment. The way we will work

this is, if you would like to come to the table and state your name and take just a minute to share any thought you would like to share.

MR. PRESCOTT COLE: Thank you, maybe just for a moment. My name is Prescott Cole, staff attorney for CANHR, California Nursing Home Reform.

I want to just address this one issue that...

SENATOR ALQUIST: I want to say muchas gracias. I know we have AARP and also the El Centro Latino chapter of AARP, and I know people are leaving and I just want to say *"thank you"* right away. (Applause)

MR. COLE: It's a matter about understanding the reports that come in, complaints from staffing. And it's put out here that complaints have increased because the facilities _____.

There are two different statutes to understand here. One is the Welfare and Institution Code.

SENATOR ALQUIST: And you did say your name and that you're from CANHR...

MR. COLE: Prescott Cole. Again, 15630 was designed to make the mandated reporter report all abuse. But in that statute, it's a very complicated formula to really make it so the mandatory reporter doesn't really have to make a report. They don't have to make a report if it's a four-part puzzle that the individual making the report is under doctor's care, if the care plan is being properly put out there, and if the injury is a direct result of the care plan, improperly administered, and if they don't have reason to believe that there was abuse of a client.

Now the Attorney General's Office has been very aggressive over the last couple of years with training mainly for the reporters. So we would hope that the mandated reporter would get by that four-part, little puzzle they have to do to make more reports. Now when you split out here that facilities have to report abused alleged, or suspected abuse...

SENATOR ALQUIST: Excuse me. If you all could take any private conversations out into the hallway... This is still part of the hearing, and we

still would really like to hear from anyone who would like to come forward, but we'd like to be able to hear them. Thank you.

MR. COLE: And this is the last point, that facilities have second reporting requirements, second from the mandated reporter. So when it's pointed out here that all reports of the facility, it's not true, it has to be parsed out. The only way to determine if these reports are extra reports coming in from those statute, from the Health and Safety Code, which is 1488.91, it's only up to _____. You'll never know unless the Department of Health Services' Licensing and Certification tells us what part of facilities are reporting and what part of the mandated reporters who are coming in, the people who are doing the care, are they reporting? And if they are reporting and reporting under these restrictive formulas, so you can bet that those reports are really well thought out. Thank you.

SENATOR ALQUIST: Thank you, Prescott. We can talk more about that also. Thank you.

And did you just quickly want to come up and just say your name and the point you would like to make?

MS. KATHRYN MANENTO: My name is Kathryn Manento. I'm an AARP member, Milpitas Senior Advisory Commissioner, and I do health surveys—I mean national survey—for five years, and it is really an honor and privilege for me, Senator. I'm nervous because...

SENATOR ALQUIST: Don't be.

MS. MANENTO: ...to actually see someone who's actually listening and caring, just makes me want to cry.

I'm very concerned about the balanced budget for California and that every Californian has the right to live with respect and decency. I'm concerned for the growing losses in nursing homes. And as the last lady spoke, we're saying nursing, but it is the whole gander—administration, doctors—and she also left out X-rays.

I had family members that were taken far better care at home and died in nursing homes. _____.com on the internet is such a horror story. My

own situation is so frightening, that after my thyroid was removed and I was in Superior Court without a lawyer against Amtrak, the judge whispered to me she didn't know how I made it to her chambers without a lawyer. I don't know.

I'm so happy to hear that you have legislation to increase inspections unannounced. I worked in a place and I know what management can do with announced inspections, and that was _____. It's like foster homes. I _____ through in-home care was bringing down costs and overhead for the state. For those of us who need more care, eight-hour shifts would be applied while in-home care are already, is well-established in elder abuse. Many cities have organized and are working independent of government funding, sharing questions with us about, questions to ask doctors, learning to read side effects of medication, teaching healthy food, encouraging exercise.

SENATOR ALQUIST: I also have a bill on adverse drug reactions to get medical personnel to report adverse drug reactions.

I want to thank you very much. We're going to close down in five minutes. I would love for everybody else to speak also.

MS. MANENTO: I do want to thank you. But most of all, when innovative, visionary, proactive men and women like yourselves are in office, with the Constitution, the Bill of Rights, and the dignity of America shines in America and around the world, and our children are pressed towards excellence with gratitude. Thank you.

SENATOR ALQUIST: Thank you for your beautiful comments. Thank you.

MR. PAUL TUTWILER: Senator Alquist, you're great.

My name is Paul Tutwiler, and I am a long-term care ombudsman from Santa Cruz County. I've been an ombudsman for seven-and-a-half years, volunteer ombudsman, and it's a retirement activity. I have been involved in nursing homes for 55 years. I remember the old days. I won't talk about

them now, things have changed; mostly for the better. Nevertheless, there is one particular issue I'm concerned about.

In my seven-and-a-half years' experience, I would say the greatest single problem, the greatest single source of complaints, substantiated complaints, by the way, is shortage of staff, the nursing shortage. And so I'm concerned with that issue. And I do sympathize with the fine people that I know who own and operate nursing homes. It's a hard job, and people work very hard in it. But realistically, I think that the most stringent means of accountability are needed. It's a real world.

So there is a provision in SB 526 that hasn't been really been mentioned about the electronic monitoring payroll. And while it's a simple thing, it is, I think, a realistic way of trying to approach the goal of accountability *now*. There will be studies how to do it better, but we want to do it now.

SENATOR ALQUIST: Thank you, Mr. Tutwiler. Are you related to Phyllis?

MR. TUTWILER: No. (Pause) Probably. (Laughter)

MS. TAMARA RASPBERRY: Senator, my name is Tamara Raspberry, and I am here on behalf of the Service Employees International Union, representing several thousand CNAs in nursing homes. So we thank you for the opportunity that we could finally could hear from those who work in the homes every day and taking their day off to come here and express to you some of their thoughts.

MS. NANCY EVANS: Hello, Senator. Thank you for hearing us today. My name is Nancy Evans, and I've been a CNA for 24 years, and I'm out of Concord, California. I've worked for hospitals; I've worked for private industry. But the nursing home is my heart, and I heard the lady and the gentleman that was in the wheelchair talk about the fear.

If I hear one of my residents say—you know what? If I say something, something's going to happen, I tell them, you tell me. For every one that says that I fear, I'm your spokesperson. I'm going to go out and

tell them how you fear because I got into this industry to help people. But due to the staffing that's been going downhill over the years—and I call it the *"AKA"* domino effect because staffing leads into other things from falls to, well, we can't take care of our patient. And I feel bad when I can't complete my job, you know. And I tell them, is that you're here in between these walls. But I hear your cries, and I want to take your cries out because we work really hard; we work really hard.

SENATOR ALQUIST: I had a wonderful CNA to taking care of my father, and I appreciate what you do.

MS. EVANS: And DHS needs to do their job because we have called upon them many, many times, and they don't want to do anything. They respond—I just heard a response that we got back in a letter. They find nothing. They find nothing adequate back about it, just like that lady said, and they're wrong; they're wrong. We're working it. They hide a lot of stuff, and we're there to see it. But I said, *"God sees all, and he's going to uncover."*

But I thank you for your help, and we need help with our staffing. Thank you.

SENATOR ALQUIST: Thank you.

If the other two ladies could just be very brief.

MS. KRISTINA SMAL: My name is Kristina Smal. I'm from Woodland, California, and I'm a CNA in a nursing home. And pretty much the staffing issues are a huge issue. I'm 21 years old, and I have a huge heart. But right now, I'd never see my grandpa go into a nursing home. If staffing issues were fixed, we could give them the quality of life that they've worked their whole life for.

SENATOR ALQUIST: I think there are some things that we can do to make the situation better. And there are some things that haven't been done that help make it worse. Thank you.

MS. RUTH SEGARRA: My name is Ruth Segarra. I work in the Jewish Home for the Aged. I've been there for 23 years.

SENATOR ALQUIST: Would you pull the mike closer to you?

MS. SEGARRA: Okay. My name is Ruth Segarra. This is my first time I'm talking for a public hearing.

UNIDENTIFIED SPEAKER: I can't hear you.

MS. SEGARRA: My name is Ruth Segarra. I'm a licensed vocational nurse in the Jewish Home for the Aged, one of the better nursing homes in California. We have problems with staffing. I've been a union activist in this facility. In my own particular nursing station, I am the only charge nurse with one CNA.

Through the years, the residents' health has declined, and I have been asking our assistant director of nurses, everybody from the bottom to the top to the CEO, to the Jewish Home lawyer, that this particular nursing station needs staffing. So we have several head injuries because I have asked all the heads that we need staff there. Falls could be prevented if we have adequate staffing in our units.

SENATOR ALQUIST: Thank you.

MS. SEGARRA: Thank you.

MS. DELORES C. CARLSON: My name is Delores Carlson. I'm an AARP member in Campbell, and that's where I found out you were having a meeting, so I'm thankful for that. I also have a mother in a nursing home. This is my first experience ever in a nursing home, and I really was very green. I had no idea what was going on _____ anything before anything else.

Basically, you're hearing all of these things. I also volunteer in nursing homes, and there are questions I have. I have no guidelines. I don't know what to look for most of the time_____ visitors program which _____ new program five years old.

Thank you for the information. But there are so many questions _____ nursing home. How much can you expect _____? There are some questions like you have, like, if I note _____ off day and find there's no staff around, and they said they were in the process of changing, shifting.

So there were just one or two people. And I thought shouldn't there be something in the interim.

SENATOR ALQUIST: This speaks to something we were taking about earlier, and how do you really find out, how do you really know what you really have? How does 3.2 hours per person, per patient day, how does that translate into the real world of _____?

MS. CARLSON: Well, there's a gap between shifts. I don't know why.

SENATOR ALQUIST: That's why we should quantify some of this. I'm going to be—we need to move forward.

MS. CARLSON: I have just one more _____.

SENATOR ALQUIST: One more.

MS. CARLSON: Okay. How do I find out where the 5 percent of the highest class of nursing homes are? My effort is for the future and for referring people.

SENATOR ALQUIST: Speak with Prescott Cole right here. Eventually, we're going to see that all of this information is on the website. It is not now, and my bill from 1999, which became law, said that documented violations of nursing homes were you to be posted on the internet. And $100,000 was given to that purpose, here at 2005, that still has not been done. So we are working on a solution. There are people you can speak to. Eventually though, sooner or later, you can see that there is a website where you can go to and you get answers to your question. So thank you very much.

I'm going to have to move forward. We have two more _____. One is standing up, and that would be Nancy Rutherford.

MS. NANCY RUTHERFORD: Yes, Senator Alquist. My name is Nancy Rutherford, and I've been an LVN 39 years. My family owned a very—they should model their nursing homes — it was Whitcomb, Irene Whitcomb in Palo Alto. They are now deceased, but she was on the premises. The reason they're having these problems, administrators come in these suits and everything, and they are not doing their job. When I go in, I'm it. I

come from a registry or I've been employed by them. You know, I'm in charge of these people. I don't know them. I'm very good at assessment skills, and you can assess the needs that staffing ratios are low. They have nurses' aides working 16 hours because those poor souls cannot meet their bills in the Bay Area. You know, I thank God that there is going to be a day of reckoning.

Who's ever running these, these are corporations. They are warehousing our elderly people. One of them I've worked in had people from a foreign country sleeping in bunk beds in a room. They bring them in. They don't speak English to these people. I mean I think it's appalling. I've worked for Kaiser 21 years _____ Burlingame 60 years where I grew up. I think my nursing skills are good. They just offered me two jobs in two nursing homes. One is at $19.50 an hour. I'm in charge of the whole ball of wax, then another one—oh, she wanted me to do 30 patients. You're it. I mean you're in charge of the medical, the nursing assistants. It's very hard. I recently went to get a childcare license. I cannot do it any more.

SENATOR ALQUIST: What is the main thing you would like for us to know?

MS. RUTHERFORD: They need to lobby. There is a law written. One to 87 patients, one person in assisted living. That is ludicrous. Those people have to go to the bathroom. They need to lobby and get these laws changed. From the licensing down, public health, these agencies need to be responsible. They are not responsible.

SENATOR ALQUIST: Thank you.

MS. RUTHERFORD: Thank you.

MS. RUTH GAY: Thank you, Senator. My name is Ruth Gay, and I'm with the Alzheimer's Association.

I'll be very brief. The thing that I wanted to say is when I heard from DHS those issues around all the reporting that goes on in the different segments and the issue that they do get reports that are hard to _____.

One of the things that I just want to say, is that working with families, and I've worked with many, many families who are moving, whether or not to report a case _____. What I find in the work that I do with people with Alzheimer's disease and their family members that are very reluctant to report. They're very fearful of reporting. You heard from some of the speakers here how they moved their mother when they file a complaint. Many people do not have the resources to do that. _____ Medi-Cal, it would be very difficult to move them from a facility _____.

So what I want to say is that they may be getting 14,000 reports a year, but that, I think, it's probably only a portion of what could have they do have where families try to move out of the facility, try to move out on their own, because they're fearful of retribution or they're fearful of _____. Thank you.

MS. ROSEMARY McCARTHY: I'm Rosemary McCarthy. My mother's been in a facility—several facilities—in Santa Clara County over the last several years.

I want to reiterate what so many people have said. I never met Mr. Goldsborough before, but I understood and I've seen that happen so often. Of course, the only difference is he was able to speak for himself.

I ended up spending the entire night with my mother because I was so concerned about her. I could not leave. The entire staff slept the entire night long. All those people that were working, I knew from working the day shift, they were good workers during the day, the night they were able to sleep. So one thing, I know we have limits on how many hours a trucker is allowed to work during the week. We need some sort of limits. These people pick up the extra shifts because they want the money. And the certain facilities have rules, so they go pick up another shift at another facility.

I have many other things to say, but I want to stick to that one because I didn't really hear them talk about that. Thank you.

SENATOR ALQUIST: Well, I want to thank all of you for being here, and particularly also those of you who are still here at ten minutes until 1:00 when we started at 9:30.

I think it's clear that there is a lot going on that is negatively affecting the positive quality of care in nursing homes. I think we've heard testimony that speaks to the Department of Health Services, and at many levels, one being how they're starting an appeals process, some of these pilot projects, including Alameda and San Jose, to other issues including not paying people what they need to be paid in order to do good work.

One reason I held this hearing was to talk about some of the accountability issues that we heard about today. And to do that, in regard to Mr. Frommer's bill, which was AB 1629, and why I carry my bill now, my Senate Bill, to deal with some of the issues. I was not in the Legislature during the two-year period when the Frommer bill became law. And quite bluntly, it allocates approximately $3 million over a three-year period of time affecting 1,400 nursing homes.

I'm not saying that we shouldn't see that we have money going into nursing homes, but what I'm definitely saying is that there are problems that need to be dealt with and we don't even really know what's really going on because DHS is not even looking into all of these issues.

I know that we need to see that staff of nursing homes, the staff is paid better. I know that nursing homes are faced with many constraints. But what I truly understand is that no one who's in a nursing home should live in fear of their life or their safety or their quality of care. And time upon time, witness upon witness, we have heard about how people have been afraid to come forward with complaints while their spouse or another loved one was in the nursing home. So, I think this has been a very good hearing.

It's one thing in hearings to look at problems. It's another thing to deal with the issues. And I do promise you I will for my constituents in Santa Clara County and those in the, really, in the entire state of California, that I will continue as chair of the Subcommittee on Aging to deal with these

specific issues to find out what DHS is doing. And just like my bill in 1999 required DHS to post document violations of nursing homes on the website, we will see that that is done very quickly. I know what it is like to have an elderly person that you love, and you certainly want to put them in a place where you believe, where you trust, *where you trust*, that they are going to get good care.

I believe that people want to do good, and I know we have many representatives from various entities dealing with this issue, and I do believe that we will be able to come together and deal with it and, when necessary, to have the course of law, the rule of law, to deal with situations where the elderly are not protected.

California—and this is my closing comment—California needs to be a place where it is a good place for seniors and the elderly to grow old. Thank you. (Applause)

---o0o---

1329-S
Additional copies of this publication may be purchased for $13.00 per copy
(includes shipping and handling) **plus current California sales tax**.

Senate Publications & Flags
1020 N Street, Room B-53
Sacramento, CA 95814
(916) 651-1538

Make checks payable to SENATE RULES COMMITTEE.
Please include Senate Publication Number 1329-S when ordering.