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THE MEDICAL CARE OF CALIFORNIA'S

NURSING HOME RESIDENTS:

INADEQUATE CARE, INADEQUATE OVERSIGHT

FEBRUARY 1989

The Little Hoover Commission's
Report on the Medical Care of California's
Nursing Home Residents:
Inadequate Care, Inadequate Oversight

February 1989

This report prepared pursuant to contract No. GOE-7007 for \$27,200.00.

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February 8, 1989

The Honorable George Deukmejian
Governor of California

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

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

The Honorable Kenneth L. Maddy
Senate Minority Floor Leader

The Honorable Ross Johnson
Assembly Minority Floor Leader

Dear Governor and Members of the Legislature:

When someone is elderly, frail and friendless, the State must be particularly vigilant in shielding that person from harm and neglect. Yet many of the 115,000 persons who are spending their final days in California's nursing homes face poor medical care--or none at all--and there is no one in charge of protecting them.

The Little Hoover Commission thoroughly scrutinized the State's nursing homes and the overall care they provided in 1983 and again in 1987. Each time the Commission urged many changes to improve conditions in these facilities.

But the one element that the Commission felt was never fully explored is the standard of medical care provided to residents of nursing homes. Because of the many complaints and the numerous allegations of neglect that our Commission has heard over the years, we decided to deepen our probing of nursing homes by concentrating on medical care in the attached report.

What we found was appalling. Some doctors may "visit" 30 to 50 patients in an hour by glancing through charts and signing medication orders. Patients may be over-medicated or suffer for weeks from adverse reactions to combinations of drugs before a doctor responds to their changed condition. Family members may make repeated calls to doctors, only to be ignored or to have their concerns brushed off as trivial.

Sometimes only when the conditions sink to the life-threatening point and the patient is moved to a hospital does adequate medical care finally enter the picture.

But if the conditions that we found are appalling the bureaucratic response to them is even more so.

The Licensing and Certification Division of the Department of Health Services has no tracking mechanism for medical care complaints, has no coordinated recordkeeping for such cases and has no guidelines for what constitutes proper medical care. In addition, even if medical care in nursing homes were to become a top priority for the division, they lack sufficient personnel and expertise to make a difference.

The Board of Medical Quality Assurance also has been singularly inactive in this area, having neither adopted standards of care for nursing homes nor instituted a fine and citation system for those who fail to provide adequate care.

If the State has failed the elderly, is there anyone else watching over the needs of this very vulnerable population who often are trapped and helpless? It doesn't appear so.

Individual doctors and individual nursing homes may be making heroic efforts and providing exemplary service. But, by and large, that is not the case. Doctors who feel they are overloaded with patients and under-reimbursed by Medi-Cal may either make only cursory efforts or refuse to treat nursing home patients at all. Nursing home operators currently are engaged in efforts to eliminate citations and fines that they face when necessary medical care isn't provided. They want to be off the hook if, despite what they feel are conscientious efforts, no medical help arrives.

It is fair to say that the primary focus of none of these agencies or industries at the moment is the best possible care of the nursing home resident.

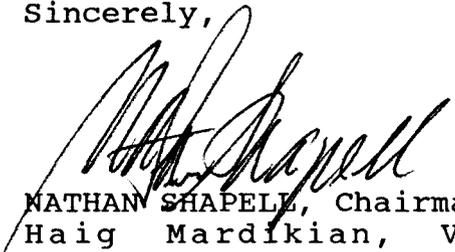
The Little Hoover Commission has determined that steps can and must be taken to not only create a responsive monitoring system to encourage good medical care in nursing homes but also to increase the numbers of doctors trained in geriatrics and willing to specialize in treating the elderly. These recommendations involve the nursing homes themselves, the State agencies that clearly should be involved in the issue, and the medical profession.

Among our chief recommendations:

1. Nursing homes should be required to set up peer review of doctors who provide medical care in their facilities. In addition, medical directors of nursing homes should be limited to handling only up to 400 beds or four facilities.
2. Both the Licensing and Certification Division and the Board of Medical Quality Assurance must develop better mechanisms to track cases and coordinate records. Also, the division should convene an ad hoc committee to create standard-of-care guidelines and the board should set up a fine and citation system that reflects those guidelines.
3. All doctors who treat more than five patients in nursing homes within six months should be required to complete continuing education courses in geriatrics and chronic care. In addition, the State should establish a fund that would be used to attract doctors into the geriatrics field to increase the availability of medical care to the elderly.

Nursing homes should not become an end-of-the-line dumping ground for people. The Commission urges you to safeguard these vulnerable people by instituting the recommended changes and forcing both the bureaucracy and industry to focus on the needs of the patients.

Sincerely,



NATHAN SHAPELL, Chairman
 Haig Mardikian, Vice
 Chairman
 Senator Alfred Alquist
 Mary Ann Chalker
 Albert Gersten
 Richard Gulbranson
 Senator Milton Marks
 Assemblywoman Gwen Moore
 George Paras
 Abraham Spiegel
 Barbara Stone
 Richard Terzian
 Assemblyman Phillip Wyman

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nursing home patients.

Recommendation 1. A formal system of physician peer review should be established as a requirement for licensure and operation of all nursing homes. 30

Finding 2. There has been little attempt made to develop guidelines for standards of medical practice in nursing homes. 32

Recommendation 2. An ad hoc Committee should be convened to develop guidelines and standards of practice for medical care in nursing homes. 34

Finding 3. For a number of people in nursing homes effective contact with their physician is extremely difficult to either establish or maintain. 36

Recommendation 3. Patient neglect, or de facto patient abandonment and mistreatment, should be clearly defined in law and substantial penalties for such conduct prescribed. 38

Finding 4. Despite the fact that the Board of Medical Quality Assurance has the authority to issue citations and fines, this has not been done. 39

Recommendation 4. The Board of Medical Quality Assurance should establish regulations for the issuance of citations and fines for poor patient care of nursing home residents. 41

Finding 5. To a certain extent, the Board of Medical Quality Assurance has been hampered in its oversight activities by restrictive guidelines and enabling legislation and regulations. 43

Recommendation 5. Investigators from the Board of Medical Quality Assurance should be granted a waiver of confidentiality for medical records for investigatory purposes. 44

Finding 6. There is a lack of coordination between the Licensing and Certification Division and the Board of Medical Quality Assurance. 44

Finding 10. There is an insufficient number of physicians who work effectively in long term care settings. 54

Recommendation 10. The Board of Medical Quality Assurance in cooperation with the University of California, the California Association of Medical Directors and the California Medical Association should develop additional training and continuing education in geriatric medicine. 55

Finding 11. Although there may be a substantial over-supply of physicians in the United States, it is unlikely that this will, of itself, guide physicians to work in geriatric medicine in long term care settings. 56

Recommendation 11. Every effort should be made to increase the number of physicians with skills in gerontology and geriatrics. The Legislature should establish a California Health Services Corps to partially fund physician education for those willing to specialize in geriatrics at the University of California medical schools. 56

Finding 12. Given the shortages in available physicians to work in long term care settings, the use of physician extenders has not been adequately explored. 58

Recommendation 12. Programs which enhance the role of physician extenders (both Physician Assistants and Geriatric Nurse-Practitioners) need to be further developed. Medi-Cal requirements should be modified to permit direct payment for services provided by licensed Physician Assistants, Geriatric Nurse Practitioners and other qualified Nurse Practitioners. 59

Finding 13. The position of Medical Director of a long term care facility is a critically important one. 59

Recommendation 13. Medical Directors contracted by any California long term care facility after September 1, 1989 should be required to have completed a 60

shortage has resulted in nursing homes having to depend on nursing registry services.

Recommendation 18. Standards for the operation of nursing home registries should be quickly and cooperatively developed. 70

EXECUTIVE SUMMARY

CHAPTER I

Inadequate Care, Inadequate Oversight: The Medical Care of California's Nursing Home Residents

Introduction

In the past decade, the Little Hoover Commission has shown continued concern with the quality of life of California's elderly population in general, and its nursing home population in particular. In a 1983 Commission report entitled THE BUREAUCRACY OF CARE, the Commission extensively studied conditions in California nursing homes and made a series of recommendations which led to the enactment of the Nursing Home Patients' Protection Act (NHPPA) of 1985.

In late 1987, the Commission agreed to conduct an inquiry into the subject of the quality of the medical care and its oversight provided to California nursing home residents. The Nursing Home Advisory Committee utilized in the prior two Commission studies was reconstituted, additional members were added to reflect the specific medical concerns of the inquiry, and a series of Advisory Committee and Sub-Committee Working Group meetings were held throughout 1988 in order to address these concerns.

In the Spring and Summer of 1988, the Commission held two Public Hearings (one in Los Angeles, the second in Sacramento) where a

number of interested parties were able to provide testimony concerning their personal or professional experience with regard to medical care in nursing homes.

Background

The provision of medical care to the more than 115,000 residents of California's nursing homes is a complex subject about which far too little is known. This lack of knowledge stems, in some large part, from the fact that this subject has been not a major concern for any single state agency or professional organization. Thus, there is a real paucity of quantitative data concerning the quality of the medical care provided---or not provided---to the institutionalized elderly in California. Neither state government regulatory and oversight agencies, nor the nursing home industry, nor the physician community itself, have made a major and sustained effort to improve the medical care provided to these most frail and vulnerable citizens.

Much of the medical care provided to nursing home residents appears to be sub-standard compared to that received in acute care hospitals. As one physician who testified at the Commission's Public Hearing on this subject described it, the medical care found in nursing homes is "shoddy." These sub-standard conditions are all the more deplorable because they appear to be the accepted norm in many nursing homes.

The Role of Physicians in Long Term Care

Substandard medical care can lead to a variety of undesirable psychosocial and medical consequences, which, in the worst instances, may be life-threatening. Poor medical care for long term care residents appears to have at least two central characteristics: the inattention of the physician to the changing medical needs of the long term care resident and the unavailability of long term care physicians.

Many persons concerned with reimbursement and regulatory issues in the long term care environment believe that virtually any further regulatory activity which is recommended with regard to either nursing homes and/or physicians who work in nursing homes will be counter-productive and result in additional physicians refusing to work in nursing homes. Ultimately, the Commission rejects this view. The Commission believes that concerns with funding and provider reimbursement cannot be considered independently from the needs to improve the quality of institutional and medical care for nursing home residents.

Problem Prevalence and the Paucity of Data: Information from State Agencies Regarding Medical Care of Nursing Home Residents

The quality and quantity of the data that are available from state agencies concerning the medical care of California nursing home residents is miniscule. The overall paucity or absence of such data is, in itself, one distressing indicator of the low

priority which this issue has had for both the Licensing and Certification Division of the Department of Health Services and, especially, for the Board of Medical Quality Assurance of the Department of Consumer Affairs.

The Role Of the Licensing and Certification Division of the State Department of Health Services In the Medical Care of Nursing Home Residents in California

Licensing and Certification Division surveyors visit long term care facilities at least annually. Consequently, they are the best trained and most experienced "eyes and ears" who regularly visit long term care facilities. Clearly these professionals, along with the professional staff and volunteers working with the Ombudsman Program, can and should be used to aid in the determination of whether adequate standards of medical care are being provided for the facility's residents. To a large extent, this is not the case.

From January of 1986 through May of 1988, Licensing and Certification referred 131 cases to the Board of Medical Quality Assurance; of these cases, only 13 concerned long term care. While there may well be other cases that Licensing and Certification Division could have referred to the Board of Medical Quality Assurance, nine months after the Commission began its inquiry into this subject, Licensing and Certification still did not know how many other cases its Regional Offices may have referred directly to the Board of Medical Quality Assurance,

or how many of those cases may have concerned the provision of medical care services in long term care facilities.

The Role Of the Board of Medical Quality Assurance In the Medical Care of Nursing Home Residents in California

The Board of Medical Quality Assurance of the Department of Consumer Affairs is responsible for the licensing, oversight and regulation of physicians and other specified health care practitioners in California. There is often a perception by members of the public that the Board of Medical Quality Assurance and similar regulatory agencies are "captives" of the very professions they are empowered to oversee.

The Board should demonstrate, clearly and soon, that the medical care of the more than 115,000 nursing home residents in California is an integral part of the medical care system which it is charged with overseeing. Such concern must be demonstrated by a clear and present commitment that will significantly increase the resources of the Board with regard to long term care oversight and significantly increase the accessibility of the Board to the public. The Board needs to demonstrate to the medical care community that standards for the delivery of medical care in long term care facilities will be judged on stringent criteria for professional behavior which equal or exceed those found in other medical practice settings.

The Role Of the Nursing Home Industry In the Medical Care of Nursing Home Residents in California

Illustrative of the mixed feelings of dismay and dependence that the nursing home industry has with physicians is the nursing home industry's request that the citation and fine system now in place be changed so that nursing homes are not given citations or fines if they have made unsuccessful efforts to contact a physician. In these circumstances no action of any kind is taken by any oversight agency against a physician. The physician is essentially free of regulatory oversight and possible sanctions. The nursing home takes the responsibility, and may bear the cost of a citation or deficiency for the patient's change in health status even if the nursing home tried to secure the services of the physician.

The Commission does not recommend a change in this regulatory policy----nor does the Licensing and Certification Division support any such change. The ultimate responsibility of the long term care facility for the resident is to secure appropriate medical care in a timely fashion. Calling a sometimes non-responsive physician begins, but by no means exhausts or completes, the long term care facility's responsibility.

The present system is one in which physicians are essentially unaccountable for inadequate care. In long term care settings the lack of accountability encourages patient neglect or de facto abandonment. The present system does little or nothing to

encourage continuity of medical care. In such circumstances the profession of medicine is ill served, the long term care industry is justly frustrated, and, most importantly, nursing home residents and their loved ones become victims of what a U. S. Senate Committee on medical care in nursing homes called a "shunned responsibility." Such "shunning" is neither good policy, nor is it good care. Existing policy, while it may implicitly condemn such behaviors, does little or nothing explicitly to limit or sanction such behavior except in particularly egregious cases.

Toward A More Responsible Balance: Decreasing Burdensome Regulation on Physicians, Increasing The Quality of Medical Care, and Insuring Effective Oversight

Present regulations call for notification of physicians by nursing home staff when virtually any change in a long term care resident's condition occurs. For those physicians who have a large number of long term care patients, the process of dealing with these notifications, the broad number of which are trivial from the point of view of both appropriate medical management and prognosis can be enormous. Efforts should be made to decrease this burden.

Conclusion

The Commission has gathered reliable information from a variety of sources which strongly indicates that there is much room for

improvement with regard to both the quality of medical care services delivered to nursing home residents as well as to the oversight of those services by state agencies. It is clear that substantial and prompt changes in both the delivery of medical care and in the responsible monitoring of that care are needed.

Chapter II

Recommendations

Introduction

Neither organized medicine, nor the proprietary long term care providers nor the Board of Medical Quality Assurance, the agency most directly charged with the oversight of physician behavior have been strong advocates for improving the quality of either medical care or for improving the oversight of that care with regard to California's nursing home residents. Furthermore, the state agency charged with the oversight of nursing homes, the Licensing and Certification Division of the Department of Health Services, has expressed continued reluctance to acquire any additional responsibilities which would involve Division surveyors in any direct way with responsibilities for assessing the medical care in long term care facilities.

The Commission believes that there is a significant problem with the medical care provided, or not provided, to many nursing home residents.

The Commission's Findings and Recommendations with regard to the provision of medical care services, and the oversight of those services by state agencies, are divided into three categories:

- . Enforcement and the Regulatory Environment
- . Roles and Responsibilities of Health Care Providers
- . Medical Treatment and Other Policy Issues

A comprehensive series of regulatory, legislative, and administrative actions will be needed in order to improve the quality of medical care for California's nursing home residents, and in order to improve the quality of the state's oversight of that care.

Enforcement and the Regulatory Environment

Recommendation 1. A formal system of physician peer review should be established as a requirement for licensure and operation of all nursing homes in California (both Intermediate Care Facilities and Skilled Nursing Facilities).

Recommendation 2. An ad hoc Committee should be convened to develop guidelines and standards of practice for medical care in nursing homes.

Recommendation 3. Patient neglect, or de facto patient abandonment and mistreatment, should be clearly defined in law and substantial penalties for such conduct prescribed.

Recommendation 4. The Board of Medical Quality Assurance should establish regulations for the issuance of citations and fines for poor patient care of nursing home residents.

Recommendation 5. Investigators from the Board of Medical Quality Assurance should be granted a waiver of confidentiality for medical records for investigatory purposes.

Recommendation 6. Licensing and Certification should immediately coordinate and centralize all reports from its regional offices concerning medical care cases that are to be referred to the Board of Medical Quality Assurance.

Recommendation 7. Both the Licensing and Certification Division and the Board of Medical Quality Assurance should rapidly improve their management information and tracking systems.

Recommendation 8. An attachment to the current Admissions Agreement for every long term care facility in the state should be developed by the Board of Medical Quality Assurance and the Licensing and Certification Division describing how to access and follow-up with requests for information and complaint-filing procedures.

Recommendation 9. The Ombudsman Program should mandate as part of its training of all professional and volunteer staff a portion of their training curriculum to be devoted to describing in detail the procedures for filing requests for information or

complaints with the Board of Medical Quality Assurance and with the Licensing and Certification Division of the Department of Health Services.

Roles and Responsibilities of Health Care Providers

Recommendation 10. The Board of Medical Quality Assurance in cooperation with the University of California, the California Association of Medical Directors and the California Medical Association should develop additional training and continuing education in geriatric medicine.

Recommendation 11. Every effort should be made to increase the number of physicians with skills in gerontology and geriatrics. The Legislature should establish a California Health Services Corps to partially fund physician education for those willing to specialize in geriatrics at the University of California medical schools.

Recommendation 12. Programs which enhance the role of physician extenders, both Physician Assistants and Geriatric Nurse-practitioners, need to be further developed. Medi-Cal requirements should be modified to permit direct payment for services provided by licensed Physician Assistants, Geriatric Nurse Practitioners and other qualified Nurse Practitioners.

Recommendation 13. Medical Directors contracted by any California long term care facility after September 1, 1989 should be required to have completed a specified number of Continuing Medical Education hours in gerontology and geriatric medicine as a contractual condition of both initial and continued employment.

Recommendation 14. Title 22 of the California Administrative Code should be amended in order to significantly broaden the responsibilities of the Medical Director of any long term care facility.

Recommendation 15. No Medical Director should be responsible for more than four separate facilities or a total of 400 beds.

Medical Treatment and Other Policy Issues

Recommendation 16. Long term care facilities should establish institutional Ethics Committees.

Recommendation 17. Policy standards regarding the maintenance of mental health and the treatment of mental illness in nursing home patients need to be developed.

Recommendation 18. Standards for the operation of nursing registries which provide part-time nurses to long term care facilities should be quickly and cooperatively developed.

CHAPTER I

INADEQUATE CARE, INADEQUATE OVERSIGHT: THE MEDICAL CARE OF CALIFORNIA'S NURSING HOME RESIDENTS

Introduction

In the past decade, the Little Hoover Commission has shown continued concern with the quality of life of California's elderly population in general, and its nursing home population in particular. In a 1983 Commission report entitled THE BUREAUCRACY OF CARE, the Commission extensively studied conditions in California nursing homes and made a series of recommendations which led to the enactment of the Nursing Home Patients' Protection Act (NHPPA) of 1985.

In May of 1987, the Commission issued its most recent study of nursing homes. That report, entitled NEW AND CONTINUING IMPEDIMENTS TO IMPROVING THE QUALITY OF LIFE AND QUALITY OF CARE IN CALIFORNIA'S NURSING HOMES, provided a series of Findings and Recommendations to remediate several of the major problem areas that remained, or that had arisen, after the passage of the NHPPA legislation.

Neither the 1983 nor the 1987 Commission reports on nursing home care and oversight undertook an analysis of the complex issues and needs surrounding the provision of medical care services to California's nursing home residents. The Commission's Nursing

Home Study Advisory Committee, chaired by Lieutenant Governor Leo McCarthy, felt strongly that the quality of the medical care provided to nursing home residents was an important issue which needed a more detailed and specific assessment.

The Commission's 1987 report summarized the concerns of the Nursing Home Advisory Committee on the subject of the medical care of nursing home residents when it stated:

...virtually the entire [Nursing Home] Advisory Committee, which represented several government agencies, the nursing home industry, the Senior Legislature, the Ombudsman Program and consumer groups, felt that the issues concerning physicians' presence in, and treatment of, the elderly in nursing homes was critically important and that it should be a major focus for an inquiry which the Commission should conduct as soon as possible (p. 94).

In late 1987, the Commission agreed to conduct an inquiry into the subject of the quality of the medical care and its oversight provided to California nursing home residents. The Nursing Home Advisory Committee utilized in the prior two Commission studies was reconstituted, additional members were added to reflect the specifically medical concerns of the inquiry, and a series of Advisory Committee and Sub-Committee Working Group meetings were held throughout 1988 in order to address these concerns.

In the Spring and Summer of 1988, the Commission held two Public Hearings (one in Los Angeles, the second in Sacramento) where a number of interested parties were able to provide testimony

concerning their personal or professional experience with regard to medical care in nursing homes.

The results of this inquiry are presented in two major parts. The first chapter of this report provides an introduction and background material for understanding the issues involved in an assessment of the quality of medical care for the institutionalized elderly in California's nursing homes, as well as material concerning the quality of state government oversight of the physicians who provide that care. The second chapter contains detailed Findings and Recommendations. The Findings and Recommendations have been grouped into three areas: (A) Enforcement and the Regulatory Environment, (B) Roles and Responsibilities of Health Care Providers, and (C) Medical Treatment and Other Policy Issues.

This report contains material based upon independent research, the testimony at the Commission's two Public Hearings on this subject, and, of central importance, the significant contributions of the Commission's Nursing Home Advisory Committee and its constituent Working Groups.

Background

The Medical Care of Nursing Home Residents

The provision of medical care to the more than 115,000 residents

of California's nursing homes is a complex subject about which far too little is known. This lack of knowledge stems, in some large part, from the fact that this subject has been not a major concern for any single state agency or professional organization. Thus, there is a real paucity of quantitative data concerning the quality of the medical care provided---or not provided---to the institutionalized elderly in California. Neither state government regulatory and oversight agencies, nor the nursing home industry, nor the physician community itself, have made a major effort to improve the medical care provided to these most frail and vulnerable citizens.

While there is little data, there is no shortage of rhetoric regarding quality medical care for the institutionalized elderly. A patina of rhetoric about the need for high quality medical care for nursing home residents can be found in the official language of state agencies and of professional associations. The rhetoric of quality medical care is most certainly a major part of the reassurances that are offered by the owners and operators of nursing homes.

As we shall see in what follows, in all-too-many instances there appears to be a vast difference between the reassuring rhetoric and the harsh reality. Much of the medical care provided to nursing home residents appears to be sub-standard compared to that received by patients in acute care hospitals. As one physician who testified at the Commission's Public Hearing on this subject described it, the medical care found in nursing

homes is "shoddy." These sub-standard conditions are all the more deplorable because they appear to be the accepted norm for nursing home care in many facilities.

Concern over the quality of medical care provided--- or not provided--- to nursing home residents appeared, at first, to be an issue where one might expect there to be common interests and concerns between the health professional community (physicians and nurses working in long term care settings), nursing home residents, their families, and the nursing home industry itself. Each of these disparate groups often speak of seeking the best and most appropriate medical care services possible for nursing home residents.

Clearly, were these persons hospital patients rather than nursing home residents, or were they children rather than aged adults, the level of concern and the amount of data available to assess medical care issues would be vastly different. But the persons we are concerned with are not living in acute care hospitals---- most of their days are spent in the chronic care setting we call a nursing home.

The Role of Physicians in Long Term Care

The Commission's Nursing Home Advisory Committee, both in 1983 and again in 1987, heard a significant number of complaints concerning the medical care, or lack of it, that these most

vulnerable citizens receive. Information came to the Commission from both urban and rural nursing homes, from nursing home residents and their relatives, from the Ombudsman program, and, to a lesser extent, from the agency responsible for the oversight of the long term care facilities themselves, the Licensing and Certification Division of the Department of Health Services.

The Commission's 1987 report noted these common concerns with access to, and the provision of, medical care services for nursing home residents when it stated:

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

Multiple stories were told [by Advisory Committee members themselves, and by persons testifying at the Commission's Public Hearings] of the difficulty in securing medical staff to attend to the regular, much less the urgent, needs of patients... Moreover, several nursing home administrators, owners and directors of nursing expressed feelings of being 'captive;' that is, they are often very displeased with the professional performance of physicians. At the same time, [they]... believe that the current situation with regard to physicians is the best that they can do or get..(p.94).

Circumstances that seem substantially similar to those described above resulted in the United States Senate Sub-Committee on long term care titling its 1975 report on medical care for nursing home residents bluntly: Doctors in Nursing Homes: The Shunned

Responsibility. The studies that have been done since 1975 have found continued evidence of physicians' predisposition not to treat these patients utilizing the same standards of care that appear to be in place with other health care consumers, such as hospital patients.

The consequences of such attitudes by health professionals who care for nursing home residents can be poor care. It is not known whether this "shoddy care" is the norm for nursing home residents, but many members of the Commission's Nursing Home Advisory Committee, as well as several of the persons who provided testimony at the Commission's Public Hearings, believe that this may well be the case.

Such medical care, or lack of it, can, at worst, lead to a variety of undesirable psychosocial and medical consequences, which, in the worst instance, may be life-threatening. Poor medical care for long term care residents appears to have at least two central characteristics: the inattention of the physician to the changing medical needs of the long term care resident and the unavailability of long term care physicians and facilities.

From the physician's perspective there are often few positive rewards that come from serving nursing home residents. Most nursing home residents, especially the very frail and the very old, are not going to "get well." Further, there are few physicians who have much experience in treating this population,

and even fewer who have academic or professional training in geriatrics.

Physicians who were members of the Advisory Committee for this study, as well as the majority of their professional colleagues, find the present system of reimbursement and the limitations on treatment that will be reimbursed for Medi-Cal nursing home residents to be seriously inadequate. These professionals believe that one method to improve the quality of the medical care available to nursing home residents would include increasing significantly the Medi-Cal payment for seeing these patients as well as changing some of the treatment and patient visitation limitations now required by the regulations governing the Medi-Cal program.

Physician familiarity with or knowledge of nursing homes seems often to be remarkably similar to that of the general public. These facilities are seen as institutions of last resort in which little can be done, and where little is done medically until or unless an acute situation presents itself, at which time hospitalization may follow.

With few exceptions, medical education and subsequent professional training and certification deals very little with either gerontology or with geriatrics, even in the "primary care" specialities of internal medicine and family practice. With regard to mental health concerns, neither psychiatrists nor other mental health professionals are widely available for ongoing work

with this population. From the perspective of mental health services, the nursing home population is seriously underserved. This appears to be the case, at least in part, because many persons, health professionals included, believe that the vast majority of the changes in mental status that may be observed in nursing home patients are to be expected and that these changes in mental status and behavior are largely "untreatable."

The present circumstances with regard to the delivery of medical services to nursing home residents has not emerged recently, nor has it emerged in a vacuum. The activities of physicians with regard to nursing home patients represent a consistent belief in the disease model of care, and an ongoing belief that aging is, in itself, a "disease" that cannot be "cured." Thus, in the opinion of many health professionals, it is not "exciting" or "rewarding" to work with older patients because it does not involve working with patients who are "worthwhile" in terms of medical efforts.

Many persons concerned with reimbursement and regulatory issues in the long term care environment believe that virtually any further regulatory activity which is recommended with regard to either nursing homes and/or physicians who work in nursing homes will be counter-productive and result in additional physicians refusing to work in nursing homes. Ultimately, the Commission rejects this view.

The Commission believes that issues of reimbursement for

providers are of major importance; however, we reject the view that the central impediments to increasing the quality of medical care, or, indeed, the quality of long term care in general, are, first and foremost, increased payment to physicians, and, second, ridding long term care providers of what they perceive as burdensome regulatory oversight.

Virtually all of the evaluative and policy research that has been conducted in California, as well as nationally, for the past three decades has recommended substantial additional regulatory oversight for long term care. With regard to the issue of physician reimbursement, there is no intuitive reason to believe that were physicians to be reimbursed incrementally more for working with long term care residents that such an increment would, in turn, lead to improved quality of medical care for those nursing home residents.

A March, 1988 report from the state Auditor General to the Legislature was primarily concerned with considering the various options that are available to the state with regard to the financing of long term care. There is no question that that complex question should be an important part of the policy agenda. The Commission believes that concerns with funding and provider reimbursement cannot be considered independently from the real continuing needs to improve both the quality of institutional life and the quality of medical care for nursing home residents.

It is clear that an incremental increase in provider reimbursement would be costly to the state; it is less clear that the benefits associated with such increased costs would be soon visible. It is for these reasons, among others, that this study does not address in any detail the concerns of some providers for increased reimbursement and decreased regulation. While each of those issues are important, they are not central to the Findings and Recommendations which make up Chapter II of this report.

Even though many health policy analysts believe that there is an increasing over-supply of physicians, this does not appear to have resulted in significant changes in either attitudes toward this patient group or in availability of these professionals for evaluating and treating nursing home patients. These problems of physician attitude and availability are present in many nursing homes. They may be especially critical from the perspective of the state of California because more than 70,000 California nursing home residents have their physician and nursing home care fully paid for by the Medi-Cal program.

With the possible exception of that relatively small number of physicians who serve as Medical Directors of nursing homes, the physician marketplace continues to give low priority to the provision of geriatric services, especially those services needed by the frail institutionalized elderly. One author recently suggested that these circumstances lead us to a society where "it is our institutionalized elders who have become the new orphan class of the late 20th century." (Sheila Ballantyne, New York

Times Book Review, July 19, 1987, page 23). The nursing home literature calls this the problem of "the missing physician."

There is little evidence that present policies will, by themselves, result in either improved physician access or improved medical and mental health care for nursing home residents. There is too little caring and too little care being provided.

It needs to be remembered that there are a small but dedicated group of physicians and other health professionals who are providing good care to nursing home patients. It is also true that professional interest in this area has been slowly growing within medical education. There are some postgraduate physician training programs in geriatric medicine; there are some medical schools working with their clinical students and residents in collaborative arrangements with some long term care facilities such as the "teaching nursing home" projects; and there are some practitioners who are undertaking their own gerontological and geriatric educational activities as their patient population ages. However, it also needs to be remembered that these efforts can also be characterized as often late-in-coming, small in size, and undertaken with goodwill by competent and caring providers and educators who could use significant additional resources.

There are two state agencies, the Board of Medical Quality

Assurance of the Department of Consumer Affairs, and the Licensing and Certification Division of the Department of Health Services, whose direct purview includes concern with the medical care provided to long term care residents. We will address concerns within each of these agencies.

Problem Prevalence and the Paucity of Data: Information from State Agencies Regarding Medical Care of Nursing Home Residents

Any assessment of the work of these two agencies needs to be prefaced with more generic comments concerning the quality and quantity of the data that are available from state agencies concerning medical care of California nursing home residents. The overall paucity or absence of such data is, in itself, one distressing indicator of the low priority which this issue has had for both the Licensing and Certification Division and for the Board of Medical Quality Assurance.

While many important health and social policy issues suffer from a paucity of data to address and assess a particular issue, this is particularly evident with regard to the medical care of nursing home residents in California. There appears to be an inverse relationship between the prevalence of the problems associated with the delivery (or non-delivery) of medical care services in nursing homes and the presence of data to evaluate the problem quantitatively.

There is virtually no quantitative data available from either the

Board of Medical Quality Assurance or from the Licensing and Certification Division concerning physician performance and behavior in nursing homes. The data that are available are extremely limited, and thus of only marginal usefulness (not only for the Commission, but, it should be added, for the agencies themselves).

The absence of such data is the result of a combination of factors. First, there is a sustained inattention to this area by both the Licensing and Certification Division and by the Board of Medical Quality Assurance. Second, the Licensing and Certification Division mandate does not include any requirement that they provide oversight with regard to the professional behavior of the physicians who see long term care patients. Given these factors, it is not surprising that neither agency has much data on the subject of the medical care services provided in long term care settings. What data are available are often inconsistent and of limited use. Timely and accurate information concerning physician behavior and such complaints as may exist with regard to long term care residents treatment, or lack of treatment, needs to be vastly improved by both the Licensing and Certification Division and the Board of Medical Quality Assurance.

The Role Of the Licensing and Certification Division of the State Department of Health Services In the Medical Care of Nursing Home Residents in California

For the past five years the Licensing and Certification Division has been developing an automated management information system (called ACCLAIMS). The system remains inadequate in terms of being able either to serve as a Consumer Information System or to provide data concerning referrals of cases by Licensing and Certification to the Board of Medical Quality Assurance. Even though the Deputy Director for the Licensing and Certification Division has made a commitment to assign a staff member to coordinate their referrals to the Board of Medical Quality Assurance, this, in itself, is a necessary but far from sufficient step.

Licensing and Certification Division surveyors visit long term care facilities at least annually. Consequently, they are the best trained and most experienced "eyes and ears" who regularly visit long term care facilities. Clearly these professionals, along with the professional staff and volunteers working with the Ombudsman Program, can and should be used to aid in the determination of whether adequate standards of medical care are being provided for the facility's residents. To a large extent this is not the case.

From January of 1986 through May of 1988 Licensing and Certification referred 131 cases to the Board of Medical Quality

Assurance; of these cases only 13 concerned long term care. While there may well be other cases that Licensing and Certification Division could have referred to the Board of Medical Quality Assurance, nine months after the Commission began its inquiry into this subject, Licensing and Certification still did not know how many other cases its Regional Offices may have referred directly to the Board of Medical Quality Assurance, or how many of those cases may have concerned the provision of medical care services in long term care facilities.

Senior Licensing and Certification Division personnel have told the Commission that they lack the personnel to examine in any depth the circumstances which occasioned the sending of these 13 long term care citation cases to the Board of Medical Quality Assurance. We do not know, for example, what types of physician behavior were alleged in these cases. What is remarkable is the relatively small number of cases Licensing and Certification Division has sent to the Board of Medical Quality Assurance, and, in addition, the lack of information that Licensing and Certification Division has about those cases.

The Director of the Licensing and Certification Division is now putting in place and developing a mechanism whereby the Central Office will be able to "track" such cases. The Licensing and Certification Division believes that, in some real sense, this is not "their" issue, insofar as oversight of facilities and their employees, at both acute care hospitals and long term care

facilities throughout the state, is a major task for which personnel are lacking.

The Role Of the Board of Medical Quality Assurance In the Medical Care of Nursing Home Residents in California

The Board of Medical Quality Assurance of the Department of Consumer Affairs is responsible for the licensing, oversight and regulation of physicians and other specified health care practitioners in California. The Board is composed of 19 members, appointed by either the Governor, Speaker of the Assembly, or the Senate President pro tem. Of the 19 appointed members of the Board, 12 are physicians, and 7 are non-physician "public members." This arrangement follows the standard pattern for most professional regulatory agencies in California: a majority of the appointed Board members (the "regulators") are members of the profession regulated. The remainder of the Board is leavened with a small number of members who are not members of the regulated profession, but who are often professionals in their own right. As such, there is often a perception by members of the public that the Board of Medical Quality Assurance and similar regulatory agencies are "captives" of the very professions they are empowered to oversee.

The Board of Medical Quality Assurance in Fiscal Year 1988-1989 has an operating budget of \$15.3 million, and a total of 181 full time equivalent staff members. Of these resources, the great

majority (\$8.7 million of the Board's annual budget, and 94 of the permanent full time equivalent staff) are allocated to the Division of Medical Quality, the Board's oversight and enforcement arm. The Division employs 52 investigators and supervising investigators, who are warranted peace officers, and an additional 36 non-warranted enforcement paraprofessionals and support staff, and six licensed staff physicians to review and investigate alleged cases of physician misconduct. This staffing level has remained relatively constant since 1980, in spite of numerous attempts by the Board of Medical Quality Assurance to increase the number of persons on its enforcement staff.

During this same period (from 1980 to the present), the number of complaints received by the Board of Medical Quality Assurance regarding alleged physician misconduct has increased almost 35%, from 3,492 to 4,685. The number of investigations of physicians opened by the Board of Medical Quality Assurance from 1980 to 1988 has increased eight percent, from 1,767 to 1,913. The number of cases referred to the office of the Attorney General for prosecution for 1980 is not available, but in Fiscal Year 1987-1988, 138 cases were referred for review and possible prosecution.

This activity has resulted in an increasing caseload for the Board's investigative staff. Currently each member of the Board of Medical Quality Assurance's investigative staff has an average of 30 to 40 open cases at any given time. This figure contrasts with an average of four or five open cases carried by

investigators at the Department of Justice doing similar work. In addition, as of December of 1988, the Board of Medical Quality Assurance had approximately 700 cases on which investigations had been opened, but which were not being immediately pursued.

As a result of this increase in the investigative staff workload, a lack of a commensurate increase in staff or resources, and a perception by many Board members and staff that "there is just too much work," the Board has taken a series of steps to address this problem. There has been an increased use of paraprofessionals rather than warranted peace officers doing initial complaint screening and review. There have also been several structural changes in case management and processing. The most important action to date relating to the quality of medical care in nursing homes has been the Board's system of assigning priorities to cases for investigation.

Several years ago Board members and staff made the decision to divide complaints into two categories: those cases which immediately threatened the life or presented a grave threat to the well-being of a patient, and those cases which posed a less immediate threat of bodily harm. Cases with an immediate potential of death or grave bodily harm were given priority for investigation, and less immediately harmful cases were to be investigated as time and resources permitted, but not on an urgency basis.

Since many of the complaints of poor medical care that originate in nursing homes do not allege the potential for immediate death or grave physical harm, or the resident has already died, they are relegated to the lower priority investigative group. As such, these complaints may not be investigated in a timely or thorough manner. This can result, as several witnesses at the Commission's public hearings testified, in cases which are closed, or never opened, because the evidence is outdated or no longer available, or because the acts alleged have occurred so far in the past that no immediate purpose would be served by the Board of Medical Quality Assurance pursuing an investigation of the allegations.

There may be a real lack of understanding by the general public regarding the role and responsibilities of the Board of Medical Quality Assurance due, in part, to the difficulty the public has in contacting the Board. This is illustrated by the fact that the Assembly Office of Research, in a report entitled No Such Listing: Consumer Access to the Board of Medical Quality Assurance, issued in July of 1988, found that the Board of Medical Quality Assurance appeared in only 33 of 172 Pacific Bell directories in California, and in no Yellow Page directories, though the cost of so doing would be one-time fee \$7.00 for each phone number listed and a \$1.00 monthly charge. After publication of the Assembly Office of Research Report, the Board subsequently took action to increase its visibility by increasing the number of public telephone directories where it is listed.

Several of the witnesses at the Commission's public hearings stated that their complaints to the Board of Medical Quality Assurance concerning the medical care of their loved ones in long term care facilities were not responded to in a timely manner. When the response was forthcoming, the witnesses found the process and correspondence to be highly bureaucratic and insensitive. In one case involving a complainant whose spouse had died in a nursing home, the Board of Medical Quality Assurance eventually responded to the complaint with a telegram-like form letter stating that her complaint was "unfounded," and nothing further.

In a meeting held in the Fall of 1988 to discuss the ways in which the Board of Medical Quality Assurance could become more knowledgeable, active and cooperative with regard to long term care, the Board's senior staff developed a series of recommendations for consideration by members of the Board.

Absent more direct involvement from the Department of Health Services (that is by the Licensing and Certification Division), and even with further training and case-finding that might originate with the Ombudsman Program, the Commission strongly recommends a series of actions that will result in more aggressive oversight by the Board of Medical Quality Assurance.

There would be significant political, logistical, and organizational difficulties if the responsibility for the

oversight of medical care of long term care residents were transferred from the Department of Consumer Affairs, and more specifically from the Board of Medical Quality Assurance, to another department or agency. The Commission is not proposing such a step. However, the fact that such a Recommendation was carefully considered by the Commission's Nursing Home Advisory Committee should clearly illustrate the level of the Commission's concern with the Board's lack of cooperation, coordination, and concern with regard to the medical care of long term care residents.

The Board must demonstrate, clearly and soon, that the medical care of the more than 115,000 nursing home residents in California is an integral part of the medical care system which it is charged with overseeing. Such concern must be demonstrated by a clear and present commitment that will significantly increase the proportion of available resources of the Board with regard to long term care oversight, and significantly increase the accessibility of the Board to the public. The Board needs to demonstrate to the medical care community that standards of care in long term care demand and will be judged on stringent criteria for professional behavior which equal or exceed that found in other practice settings.

The Role Of the Nursing Home Industry In the Medical Care of Nursing Home Residents in California

The proprietary nursing home industry makes up the vast majority

of the operators of long term care facilities. As we noted above, it was hoped that the nursing home industry would see common goals between itself and the Commission's interest in improving the quality of medical care services in long term care settings. However, the nursing home industry has a decidedly mixed relationship with physicians with regard to the medical care of residents in their facilities.

On the one hand, many facility administrators and most Directors of Nursing in long term care facilities are quick to admit that having good physicians and a respected Medical Director for a facility is crucial not only for the overall sense of medical care provided residents, but also in terms of timely physician back-up. Often, however, these conditions are not found and many long term care owners feel that they are "held hostage" by a medical care community where few physicians have any interest in serving their residents. They feel that they must maintain good relations with physicians, even if they provide what appears to be inconsistent or substandard care.

Illustrative of the mixed feelings of dismay and dependence that the nursing home industry has with physicians is the nursing home industry's request that the present citation and fine system now in place be changed so that nursing homes are not given citations or fines if they have made unsuccessful efforts to contact a physician. At the present time, when such circumstances do occur, no action of any kind is taken by any oversight agency with regard to the physician. The physician is essentially free of

regulatory oversight and possible sanctions, while the nursing home takes the responsibility, and may bear the cost of a citation (with accompanying fine) or deficiency for the patient's change in health status even if the nursing home tried to secure the services of the physician.

The Commission does not recommend a change in this regulatory policy----nor does the Licensing and Certification Division support any such change. The ultimate responsibility of the long term care facility for the resident is to secure appropriate medical care, when needed, in a timely fashion. Calling a sometimes non-responsive physician begins, but by no means exhausts or completes, the long term care facility's responsibility.

At the same time, the Commission does believe that some criteria should be put in place whereby physician accountability to those nursing home patients in their care should be increased. If the medical care that is being provided to a long term care resident is deficient, and if that deficiency is due in whole or in part to the non-accessibility and neglect of that resident's physician, sanctions against the physician should also be available.

The present system is one in which physicians are essentially unaccountable for inadequate care. In long term care settings the lack of accountability encourages patient neglect or de facto abandonment. The present system does little or nothing to

encourage continuity of medical care. In such circumstances the profession of medicine is ill served, the long term care industry is justly frustrated, and, most importantly, the nursing home residents and their loved ones become victims of what a U. S. Senate Committee on medical care in nursing homes called a "shunned responsibility." Such "shunning" is neither good policy, nor is it good care. Existing policy, while it may implicitly condemn such behaviors, does little or nothing explicitly to limit or sanction such behavior except in particularly egregious cases.

Toward A More Responsible Balance: Decreasing Burdensome Regulation on Physicians, Increasing The Quality of Medical Care, and Insuring Effective Oversight

Present regulations call for notification of physicians by nursing home staff when virtually any change in a long term care resident's condition occurs. Most physicians, trained on an acute-care model, and used to working in hospitals where notification by nurses only takes place when major changes occur, believe themselves to be the victim of a regulatory system which has inappropriately equated "notification" with "proper [or legally required] care." For those physicians who have a large number of long term care patients, the process of dealing with these notifications, the broad number of which are trivial from the point of view of both appropriate medical management and prognosis can be enormous. Efforts should be made to decrease

this burden.

In addition, a mechanism needs to be devised whereby "good patient care" does not largely become "paper compliance" by long term care personnel and by long term care physicians. Efforts to reduce burdensome and unnecessary procedures must take place within an environment of continued rigorous oversight.

Conclusion

The Commission has gathered reliable information from a variety of sources which strongly indicates that there is much room for improvement with regard to both the quality of medical care services delivered to nursing home residents as well as to the oversight of those services by state agencies. It is clear that substantial and prompt changes in both the delivery of medical care and in the responsible monitoring of that care are needed.

The Findings and Recommendations which follow are premised upon the organizational and political environment which has been described in this Chapter. The overall goal of the Commission's Recommendations is significant improvement in the quality of the medical care provided California's nursing home residents and in the governmental oversight of the physicians who are entrusted with that care.

CHAPTER II

FINDINGS AND RECOMMENDATIONS

Introduction

From the point of view of long term care residents, their loved ones, and of many members of the Nursing Home Advisory Committee who have worked with the Commission on this inquiry, a careful review of the quality of medical care available in California nursing homes presents a quandary. Based upon material gathered by the large and balanced Advisory Committee, testimony at the public hearings, and a series of conversations with many persons throughout the state (including but not limited to many long-term consumers and many dedicated government employees of oversight and licensing agencies), the Commission believes that there is a significant and real problem with the medical care provided, or not provided, to many nursing home residents. At the same time, however, the Commission also recognizes that while there is a large amount of narrative testimony and other forms of "evidence" which support this view, nonetheless there are few "hard" numbers available. These circumstances are addressed in some detail in Findings and Recommendations which follow. The format of this Chapter divides these Findings and Recommendations into three categories:

- . Enforcement and the Regulatory Environment
- . Roles and Responsibilities of Health Care Providers
- . Medical Treatment and Other Policy Issues

These three categories, which were also used by the Commission's Nursing Home Advisory Committee and its Working Groups, are interdependent. In what follows, it is important to bear in mind that the Findings and Recommendations are not rank-ordered, either within or between these categories.

Some of the Findings and Recommendations are of substantially different length and detail than others. This has been done where it was felt that more detail would be useful in the legislative and regulatory processes needed to implement that Recommendation. However, the length of a particular Recommendation does not reflect its relative importance.

A comprehensive series of regulatory, legislative, and administrative actions will be needed in order to improve the quality of medical care for California's nursing home residents, and in order to improve the quality of the state's oversight of that care.

Enforcement and the Regulatory Environment

Finding 1. There is no regular formal procedure or process to regularly and systematically review and evaluate the quality of medical care provided to nursing home patients.

Utilization Review Committees and the development of Quality Assurance efforts in nursing homes notwithstanding, the quality of medical care provided for nursing home residents is not

regularly subject to review and evaluation. The practice and process of peer review is standard practice within acute care hospitals. Even given the significant differences between acute care facilities and chronic care settings, a modified version of peer review could and should be implemented within long term care facilities.

Medical treatment in long term care settings is, at present, not assessed except in those (comparatively few) cases when a surveyor from the Licensing and Certification Division of the Department of Health Services makes a referral to the the Board of Medical Quality Assurance based on observations made during a visit to a facility. Absent a formal complaint alleging a pattern of simple negligence or an act of gross negligence, the Board of Medical Quality Assurance cannot engage in any type of formal oversight of the medical practice or standards of care in nursing homes.

The quality of the medical care provided in nursing homes is not regularly subject to assessment, either internal or external. With regard to "external" review, state agencies are rarely involved with issues surrounding the provision of medical care services in nursing homes. Neither the Licensing and Certification Division of the Department of Health Services, whose surveyors may be in a given long term facility only once a year, nor the the Board of Medical Quality Assurance, whose investigators are rarely in long term care facilities at all,

provide consistent observation of the quality of care provided in long term care facilities.

Professional etiquette, medical and community politics and a host of other factors make it highly unlikely that a state agency will be involved in assessing the quality of care provided to a nursing home resident as long as that care remains within a rather broad acceptable arena of physician professional behavior. Only in extreme or egregious circumstances, will state regulatory agencies become involved.

If substandard is the norm in too many nursing homes, then processes and procedures need to be developed in order to shift the norm from "substandard" to "professionally acceptable."

One way in which this issue has been addressed with some success in acute care hospitals is through the creation of Peer Review Committees which provide regular and meaningful assessment of physicians. Even given the substantial differences between the operation of Peer Review organizations in acute care settings and those proposed for nursing homes, much can be learned from the procedures and the politics of implementation of Peer Review organizations as they have been utilized in hospital settings.

Recommendation 1. A formal system of physician peer review should be established as a requirement for licensure and operation of all nursing homes in California (both Intermediate Care Facilities and Skilled Nursing Facilities).

All physicians with patients in a nursing home should be subject to periodic review by the peer review system. The purpose of a peer review system would be to develop a process and a mechanism for improving the quality of medical care in nursing homes. The peer review system will have as its central purpose the review of the care being given to the residents of a long term care facility.

In those circumstances when a Peer Review Committee determines that the standard of care is not being met, the Committee shall have a series of options, ranging from withdrawal of privileges to practice in a particular facility up to and including referring cases of inadequate care to the Board of Medical Quality Assurance for their review and action.

The Peer Review Committee must include (but need not be limited to) the following health care professionals: the Medical Director of the facility, acting as chair of the Peer Review Committee, the director of nursing, the facility administrator, and a representative group of physicians made up and selected from those who have patients at that particular facility.

The Peer Review Committee shall meet at regularly specified intervals, but no less than every 90 days throughout the year. The Peer Review Committee shall systematically review all cases of patient care within the facility (regardless of source of payment for the patient's care).

Finding 2. There has been little attempt made to develop guidelines for standards of medical practice in nursing homes.

With the noteworthy exception of the dedicated efforts of some conscientious individual physicians and professional associations, there has been little attempt made to develop guidelines for standards of medical practice in nursing homes. While there are multiple state and federal regulations regarding the nursing home and its employees, there is a comparative dearth of guidance provided concerning the acceptable standards for medical care. Given the poor (or "shoddy") care that is prevalent in many nursing homes, it is clear that further specification and direction is needed.

When guidelines to physician care in nursing homes have been independently developed, their effect has been severely limited because of their "advisory only" status. For example, in 1982-1983, the Medical Quality Review Committee of Alameda and Contra Costa Counties, which is an advisory body to the Board of Medical Quality Assurance, developed guidelines for the medical care to be provided to nursing home patients. These guidelines were reprinted by the Board of Medical Quality Assurance with the prefatory comment that "We [BMQA] have printed them not as general standards or regulations but merely as information." (Department of Consumer Affairs, Board of Medical Quality Assurance, Action Report, Number 23, April, 1983, page 4, emphasis in original). The use of the word "merely," as well as

the emphasis that the guidelines are to be considered "information," greatly lessens their application and effectiveness.

Interestingly, these guidelines were cited by the Board of Medical Quality Assurance in correspondence to the Commission as evidence of the Board's commitment to the quality of medical care in nursing homes. The Alameda and Contra Costa County guidelines are a start toward thoughtful and reasonable minimum performance standards for some aspects of the medical care of nursing home residents, as for example the statement on physician response time:

It is the standard of practice for physicians who care for patients in skilled nursing facilities to be available to respond to any medical problem that might arise. In the event that the treating physician is out of town, a specific alternative physician must be designated to receive calls.

The physician's response time should not go beyond two hours from the time that the facility has initiated a call for the physician. A call from the facility should always be answered. A call from family members may be answered depending on the physician's judgment.

Action Report, op cit., p 4

While there are both federal and state regulations regarding medical care in nursing homes, key issues such as the necessity for a physician to physically see (and examine) the patient are not explicitly addressed. Nursing home residents often suffer the effects of poly-pharmacy drug reactions. Problems surrounding

the over-use, or inappropriate use, of medication with nursing home patients have been documented by both the research community as well as the state and federal governments. These medication abuses are particularly troublesome in that they often include the medically and ethically questionable practice of prescribing psychoactive medications which are given to the resident on an "as needed" (PRN) basis.

In addition to issues surrounding the prescribing and use of medication, there are other serious concerns. There are, for example, those changes in health status which must be promptly diagnosed and treated to prevent an overall worsening of the patient's condition, for example treatment to prevent the development or worsening of decubitus ulcers. Examples such as these are all-too-common in California nursing homes and point out the need to develop minimum standards of practice for physicians responsible for the care of nursing home patients and to require that those standards be met.

Recommendation 2. An ad hoc Committee should be convened to develop guidelines and standards of practice for medical care in nursing homes. The ad hoc committee should develop guidelines that include, but must not be limited to, development of criteria for the establishment of baseline acceptable minimal standards of care. This committee shall also establish the conditions under which a physician can be found negligent in the provision of care.

These guidelines should address both process and substantive issues and should be used by the facility Peer Review Committees. The ad hoc committee shall include representatives from the Licensing and Certification Division of the Department of Health Services, the Board of Medical Quality Assurance, the nursing home industry, the California Association of Medical Directors, the California Medical Association, consumer advocate groups, representatives from the Attorney General's office, the Ombudsman Program, the Department of Aging, as well as public representatives (e.g., from the Senior Legislature). In addition, the ad hoc committee should seek the cooperation of other health professionals and regulatory agencies working in long term care, most importantly the licensees and representatives of the Board of Registered Nurses and the Board of Pharmacy.

The ad hoc committee shall be convened by the Licensing and Certification Division immediately and shall meet on an urgency basis to develop the initial version of these guidelines. Completion of the initial version of the guidelines, subject to emendation and modification after field testing, should take place no later than September, 1989. It is expected that these guidelines will be substantially more explicit than existing state and federal regulations. It is further expected that these guidelines will set minimum required standards of practice for physicians who provide care for nursing home residents.

The ad hoc committee should also begin a process whereby, with

the aid of the Board of Pharmacy, a system could be designed and implemented to monitor multiple drug prescriptions for persons in long term care facilities. The goal of such a system would be to inform both physicians and the nursing staff of a long term care facility of the possible iatrogenic or nosocomial effects of poly-pharmacy. In instances where there appears to be a pattern of over-prescribing which results in substandard care, this information should be relayed in a timely, confidential, and routine matter to the appropriate investigatory officials within the Board of Medical Quality Assurance.

Finding 3. For a number people in nursing homes effective contact with their physician is extremely difficult to either establish or maintain.

The Commission heard testimony from a number of persons stating that effective contact with their physician was extremely difficult to either establish, or, once established, to maintain. Often complaints were heard concerning physicians who "visited" nursing home residents without actually ever seeing them. When such "visits" take place with a number of patients, the "gang visit" phenomena takes place with the result that a physician may bill for having "seen" all of his or her patients in a nursing home but may have physically seen or examined few or none of these patients.

While there are instances where physicians follow their patients

from out-patient or hospitalized status to nursing homes, this is not the norm. What more typically happens is that new nursing home residents must not only adjust to these new surroundings but also to a new physician, probably someone that they have never seen before.

In cases where physician follow-up is done, the goal of continuity of effective care is easier to reach. However, such continuity is the exception rather than the rule. Often the treating physician in the nursing home may have never seen the resident prior to his or her arrival in the facility. In too many cases this means that physician visits to patients will conform only to the legal minimum standards.

Related to the issue of the absence of continuity of care for many new nursing home residents is the subsequent problem of the developing over time a sustained and informed doctor-patient relationship for nursing home residents and their loved ones. This problem appears to stem from two different but related sources. First, many physicians with busy practices have few patients in nursing homes. For these practitioners, the time taken for a nursing home visit is incommensurate with the remuneration process. The Advisory Committee heard a number of physicians say it simply is not worth it to them to continue to provide care for their patients after they have been moved to a nursing home. Second, some practitioners do have a significant number of patients in a particular nursing home, and perhaps most

of their practices are with nursing home patients. In this instance the physicians may also be over-loaded but with a practice that is largely nursing home residents, perhaps several hundred in number, and scattered among several different nursing homes. In either case the outcome will almost certainly be distressingly similar from the point of view of the patient or loved one seeking to be seen by the physician.

There are long periods of time when communication is minimal, and in some of the more extreme cases, there is reason to believe that the physician has certainly neglected and perhaps de facto abandoned the patient. Given that each of these circumstances exist, and that they result in poor patient care as well as unprofessional conduct, there is cause for reassessing the minimally necessary connections that must exist between physicians and nursing home residents. The alternative to this would be to condone substandard care. The Commission opposes any standard of practice which finds such a "norm" either professionally customary or legally acceptable. It should be neither.

Recommendation 3. Patient neglect, or de facto patient abandonment and mistreatment, should be clearly defined in law and substantial penalties for such conduct prescribed.

Patient neglect should be defined to include, but not be limited to, those events which by either willful behavior or negligence cause or create a risk of serious physical or mental illness, or

death. Abandonment of a patient should include both deliberate and negligent failure to provide care. Depending on the gravity of the offense, penalties should include both substantial fines and, in most serious offenses, terms of imprisonment in either a county jail or the state prison system. Finally, conviction on any criminal count of patient neglect or abandonment should be immediate mandatory cause for disciplinary action against the convicted party's professional license or certificate.

While legislation is needed to mark the seriousness of nursing home cases of patient neglect, there is also a need for additional "intermediate sanctions" which might also address aberrant and unacceptable levels of care.

Finding 4. Despite the fact that the Board of Medical Quality Assurance has the legal authority to issue citations and fines, this has not been done.

The Board of Medical Quality Assurance has the responsibility to oversee and fairly sanction, when appropriate, the physicians licensed to practice in California. The Board, conscious of the need to protect the rights of due process, has a set of procedures by which it handles complaints concerning physicians. These procedures involve an array of actions that the Board may take, ranging from stipulated counseling to revocation of the license to practice medicine in the state.

Included in this array of disciplinary sanctions, but never used by the Board of Medical Quality Assurance, is the right to issue citations and fines (under the Business and Professions Code, Sections 125.9 and 125.95). While license revocation is a most severe step---it essentially removes the professional livelihood from the physician----the issuance of citations and fines as one of several intermediate enforcement tools is far less stringent.

Nursing homes are subject to citations and fines. Members of the Advisory Committee who represented the nursing home industry regularly pointed out that physicians who were often wholly or partially responsible for the poor care given a resident were rarely if ever sanctioned, while the facility would be issued a citation or fine in these instances.

The Commission is not prepared to take the position---urged by the nursing home industry---that cases of poor medical care should result in sanctions of some sort for the physician and no sanction for the nursing home. The final responsibility for that resident rests with the nursing home and the issuance of citations or fines to the facility by the Licensing and Certification Division is appropriate public policy.

What is inappropriate, however, is the absence of sanctions for any physicians working in long term care facilities who may have been largely responsible for the decrement in health status of a nursing home resident. Physicians who share in the care of such persons with the nursing home itself should also be subject to an

array of intermediate sanctions which are designed, in part, to show the seriousness with which the state regards poor quality medical care provided to nursing home residents.

Recommendation 4. The Board of Medical Quality Assurance should establish regulations for the issuance of citations and fines for poor patient care of nursing home residents.

Fines and citations should be used by the Board of Medical Quality Assurance in cases of isolated acts of negligence, and could, additionally, be used in tandem with other Board sanctions for other offenses such as repeated patterns of simple negligence or acts of gross negligence.

The issuance of fines and citations should be undertaken by the Board of Medical Quality Assurance and should include a system of appeals for such sanctions which will both protect the innocent as well as preserve the due process rights of those cited or fined. Unsuccessfully appealed fines and sanctions may not be waived: they are due in full, and made a part of the public record at the conclusion of any appeal process. Such models for regulation are already in effect for several other professional regulatory agencies in California, including the Board of Podiatric Medicine.

The Board of Medical Quality Assurance should immediately modify its Complaint Information Tracking System to specifically

identify and track such acts, and their resultant disposition, including the issuance of any sanctions, citations or fines. The Complaint Information Tracking System of the Board of Medical Quality Assurance should also provide information, in a timely manner, to other agencies with concern for the quality of the patient care received in nursing homes, specifically the Licensing and Certification Division of the Department of Health Services and the Office of the Attorney General.

Issuance of citations and fines by the Board of Medical Quality Assurance shall be a matter of public record through publication of the name, location, and license number of the physician. In addition, there shall also be printed as a matter of public record a description of the sanctions applied and the name(s) of the nursing home(s) in which the physician has patients. This information should be published, as are other sanction actions presently, in the Board of Medical Quality Assurance Action Report.

In addition, the Department of Consumer Affairs Phase II Case Tracking System should be modified so that it includes the necessary detailed information with respect to all quality peer counseling cases conducted under the aegis of any division of the Board of Medical Quality Assurance. The System should reflect both the source of the referral as well as include the results of the counseling. The System should be configured so that it can also track any physician who was required by the Board of Medical Quality Assurance to undertake any repeat counseling.

The Phase II Case Tracking System is to be begun in January of 1989 and completed by December of 1989. These recommended modifications to the System should be made as early in 1989 as is possible so that these vital data are available to the Board of Medical Quality Assurance and to other state oversight agencies (e.g., the Licensing and Certification Division and the office of the Attorney General) when appropriate.

Finding 5. To a certain extent, the Board of Medical Quality Assurance has been hampered in its oversight activities by restrictive guidelines and enabling legislation and regulations.

Guidelines and legislation sometimes quite carefully and quite explicitly curtail the investigative purview of the Board. Two examples of such restrictions that could and probably do have consequences for overseeing the quality of medical care in nursing homes were presented to the Commission by the Board. In each instance, the Commission believes that the investigatory work of the Board of Medical Quality Assurance would be substantially enhanced if these impediments to full and careful physician oversight were removed.

First, the waiver of confidentiality of medical records accorded some state offices for official business relating to Medi-Cal funded nursing home residents does not apply to the Board of Medical Quality Assurance's investigative staff. At present, Board investigative staff cannot investigate whether there may be a pattern of substandard care provided by a particular physician.

Second, the Board of Medical Quality Assurance cannot conduct a "blind" (names deleted) review of patient records in a long term care facility in order to evaluate a suspected pattern of poor care by a physician. Absent the authorization to be in a position to fully asses whether a pattern of poor or substandard care exists, the Board of Medical Quality Assurance is unnecessarily constrained in what it can review and thus what it can do with a complaint about a the care a physician provided.

Recommendation 5. Investigators from the Board of Medical Quality Assurance should be granted a waiver of confidentiality for medical records for investigatory purposes.

A waiver of confidentiality should extend beyond Medi-Cal funded nursing home patients and should include all patients in all long term care facilities in the state regardless of the source of their payment for long term care. Investigative staff from the Board of Medical Quality Assurance should, in addition, also be authorized to review all patient records in long term care facilities in instances where the Board of Medical Quality Assurance has reason to suspect that there may be a pattern of poor care being provided by a particular physician.

Finding 6. There is a lack of coordination between the Licensing and Certification Division and the the Board of Medical Quality Assurance.

In the instances of cases referred to the Board of Medical

Quality Assurance by either the Licensing and Certification Division's long term care surveyors or by the Ombudsman Program of the Department of Aging, the results of filing such complaints have been almost uniformly unsatisfactory from the point of view of virtually all personnel involved. This includes the agency staff member who files the complaint within their own program in order to have it prepared for the Board of Medical Quality Assurance, the patient who has allegedly received poor or substandard care, and the Board of Medical Quality Assurance itself after it has received the complaint and is charged with carrying on the investigation from that point forward.

Finally, when and if it is appropriate that the lawyers for the state become involved, the Office of the Attorney General has also expressed dissatisfaction with the timeliness of the entire process. This unfortunate state of affairs reflects the lack of coordination that has existed between the Licensing and Certification Division and the Board of Medical Quality Assurance, as well as the fact that neither agency has provided focused attention on physicians working with long term care residents.

Within the Licensing and Certification Division the process of preparing cases for the Board of Medical Quality Assurance is slow. This slowness is due in part to the time it takes to get material from the field to be properly prepared for referral. It is also a reflection of the fact, expressed to the Commission

Advisory Committee on several occasions, that the perception of many professional staff members of the Licensing and Certification Division was that preparing a case for review by the Board of Medical Quality Assurance is often time-consuming and usually fruitless because the Board of Medical Quality Assurance did not handle the case in a timely and appropriate manner. On the other hand, senior staff at the Board of Medical Quality Assurance have alleged that many of the referrals that they received from the Licensing and Certification Division were not adequately prepared and had to be sent back to the agency thus resulting in further delays.

In this bureaucratic quagmire the end result is always the same: it is the long term care patient who suffers due to an oversight system which is seriously fragmented and uncoordinated.

Recommendation 6. Licensing and Certification should immediately coordinate and centralize all reports from its regional offices concerning medical care cases that are to be referred to the Board of Medical Quality Assurance.

The inadequacy of the information concerning the medical care of the institutionalized elderly is deplorable and in need of immediate rectification.

Licensing and Certification should develop a "fast track procedure." Thus, when there is reason to believe that a case should be referred to the Board of Medical Quality Assurance, the

Board shall be given preliminary notification that such a case is being prepared. This preliminary notification shall take place no more than five working days after the Licensing and Certification Division's initial decision to send a case forward to the Board of Medical Quality Assurance.

Licensing and Certification should fully prepare all cases that it seeks to send to the Board of Medical Quality Assurance in no more than 45 days after the initial observation is made. Given the fact that Licensing and Certification staff are the most highly trained observers of long term care facilities, staff should be made aware that referrals the Board of Medical Quality Assurance can be made, that they will move forward quickly, and that there will be a channel for open and continuous communication established between Licensing and Certification and the Board of Medical Quality Assurance. This will assure that complaints that originate with Licensing and Certification Division employees are treated as presumptively in need of rapid attention, coming, as they do, from long term care professionals in the field.

A procedure to expedite case review and referral to the Board of Medical Quality Assurance must be developed by the Licensing and Certification Division, the Ombudsman Program, and the Department of Justice. This procedure shall be premised on the development of a coordinated case referral system which establishes a set of explicit priorities. Top priority both for case referral to the

Board of Medical Quality Assurance and for the Board's investigation of incoming complaints shall be based upon the frailty, age and seriousness of the medical condition of the case subjects. This would mean that if, for example, a complaint alleging poor care to a 85 year old nursing home resident who has suffered a serious decline in her health as a consequence of that poor care was made, such a case would be given very high priority by the Board of Medical Quality Assurance both for investigation and for resolution and findings.

Finding 7. The Licensing and Certification Division of the Department of Health Services does not have a centralized referral process for complaints about medical care in nursing homes.

The Licensing and Certification Division has begun the process of centralizing referrals that they make to the Board of Medical Quality Assurance. This centralization process should result in the Licensing and Certification Division being able to know what these referrals are, where they originated, and how long they have been either in the Division or at the Board of Medical Quality Assurance. The Licensing and Certification Division cannot do any of these basic things at the present.

Currently, the Board of Medical Quality Assurance does not identify or track cases that originate in long term care facilities. As such there is almost a complete absence of reliable data about such cases. In the absence of such data some

have wrongly concluded that there is no problem. The Commission takes the view that a significant part of the problem is the relative absence of data. Both the Licensing and Certification Division and the Board of Medical Quality Assurance have quite sophisticated computerized management information systems which could be used for case tracking. This has not been done to date.

Recommendation 7. Both the Licensing and Certification Division and the Board of Medical Quality Assurance should rapidly improve their management information and tracking systems.

The management information and tracking systems must identify, assign priorities to, and cooperatively and promptly undertake investigation and resolution of those cases that originate in long term care facilities. The technology and the skill for such an undertaking already exist within each agency. What is now required is the administrative cooperation of these two agencies to put such a system in place as rapidly as possible. Such cooperation may be symbolized by a Memorandum of Understanding between the two agencies; the fulfillment of such an understanding will take ongoing administrative support and inter-agency staff cooperation.

Work toward establishing this management and information system should also include other interested parties, including (but not limited to) representatives from the Ombudsman Program, the Department of Justice, the California Association of Medical

Directors, the California Medical Association, the Boards of Pharmacy and Registered Nursing, and representatives from consumer groups. This group shall constitute a Long Term Care Data and Information Sharing Task Force. The Task Force shall be co-chaired by senior administrators from the Board of Medical Quality Assurance and the Licensing and Certification Division. The Task Force should begin and complete its work as early in 1989 as is possible.

Finding 8. It is difficult for the ordinary citizen to determine where or how to complain about conditions or treatment in long term care facilities.

Throughout the period that the Little Hoover Commission has been concerned with the operation and oversight of nursing homes, the Commission has been repeatedly told how difficult it is for the ordinary citizen to know either where or how to complain about either conditions or treatment in a long term care facility. Even the official names of the agencies involved with long term care services are opaque to consumers.

It is concerns such as these that led to the Assembly Office of Research report concerning the inaccessibility of even a telephone number of the Board of Medical Quality Assurance. That inaccessibility is symbolized in the title of the Assembly Office of Research Report: No Such Listing, referred to in Chapter I of this study.

Most citizens, and perhaps especially those who are vulnerable--- because of fear, frailty, or illness--- suffer from "informational inequality" when it comes to understanding and working with the long term care system and the medical care system. Several of these persons spoke at the Commission's Public Hearings, both for this study and for the two prior studies the Commission has undertaken in the long term care arena in the recent past. Their sense of anger and frustration at not being able to either locate or get responsive replies from "the system" was palpable. The Commission has no reason to believe that their experience were atypical.

Recommendation 8. An attachment to the current Admissions Agreement for every long term care facility in the state should be developed by the Board of Medical Quality Assurance and the Licensing and Certification Division describing how to access and follow-up with requests for information and complaint-filing procedures.

This attachment to the Admissions Agreement should be provided to all current long term care residents and their families, as well as be included in the information given to all new residents and their families. The information should include, but need not be limited to, the name and telephone number of the facility's Medical Director and the telephone numbers (toll free, where available) of both the Department of Health Services Licensing and Certification Division and the Board of Medical Quality Assurance.

This information shall also be required to be prominently posted within each long term care facility within the state in the same visible and accessible area where the Patient's Bill of Rights and Ombudsman Program poster are prominently displayed.

Finding 9. There are an inadequate number of "eyes and ears" observing the care needs of the residents of long term care facilities.

There are many nursing home residents who are not visited with any regularity. There are, in addition, some nursing home residents whose physical state is so frail or whose mental state is agitated or confused so that they cannot engage in informed decision-making activities for themselves.

The state-federal Ombudsman Program provides, for some residents of some facilities, the sole link that they may have with persons from outside the facility who are not in the employ of the facility. The Ombudsman Program, and especially its dedicated volunteers, performs invaluable services, not the least of which is to reduce the vulnerability and the "informational inequality" that is often pervasive in long term care facilities.

The federal legislation that created the Ombudsman Program is premised on the fact that the fear of retaliation is very real for nursing home residents, as well as nursing home employees, who file complaints with regulatory agencies. The Ombudsman Program has as one of its major goals to place volunteer

Ombudsmen inside long term care facilities on a regular basis who can listen to concerns that might otherwise not be voiced. Ombudsman act as impartial negotiators for residents, families, nursing homes, medical personnel and various public and private agencies. However, the Program is primarily concerned with the rights of nursing home residents, and it has the responsibility of attempting to reduce the vulnerability, isolation, and fear that many long term care residents experience.

The Commission, in its two prior reports on conditions in nursing homes in California, has advocated that the Ombudsman Program be given continued recognition both for what it does, and given resources to expand and continue its vital services. In this report, it seems clear that the Ombudsman Program, again, could play an important role in bringing knowledge and assistance to long term care residents who may have concerns with the availability or the quality of the medical care provided to particular nursing home residents.

Recommendation 9. The Ombudsman Program should mandate that as part of its training of all professional and volunteer staff a portion of the training curriculum shall be devoted to describing in detail the procedures for filing requests for information or complaints with the Board of Medical Quality Assurance and with the Licensing and Certification Division of the Department of Health Services.

All volunteers and staff participants in the Ombudsman Program

should have the following information available as a part of their portfolio of materials that they take to the long term care facility that they visit: the names and telephone numbers of the regional as well as the headquarters office of the Licensing and Certification Division and the regional as well as the Sacramento telephone number of the Board of Medical Quality Assurance.

Roles and Responsibilities of Health Care Providers

Finding 10. There is an insufficient number of physicians who work effectively in long term care settings.

The issue of the supply of physicians who work well in long term care facilities needs to be addressed both in terms of the accentuated development of training programs for these professionals as well as continuing educational efforts for providers now in practice who need to enhance their geriatric skills.

The issue of physician availability becomes particularly crucial in cases where timely consultation is necessary because of a deterioration in the condition of a resident that requires, at a minimum, physician consultation and telephoned changes to modify medical orders. In other cases, the physician is needed for prompt treatment in the long term care facility. Finally, there are those cases where the physician needs to determine if it is necessary to transfer the resident from the nursing home to a hospital because of an acute condition or incident.

Recommendation 10. The Board of Medical Quality Assurance in cooperation with the University of California, the California Association of Medical Directors and the California Medical Association should develop additional training and continuing education in geriatric medicine.

Continuing education hours in chronic care and geriatric medicine should be required by the Board of Medical Quality Assurance for any physician whose patient load includes more than five nursing home residents during any six month period.

The number of hours of clinical and pre-clinical training devoted to gerontology and geriatrics should be increased in all California medical schools as well as in all rotating internships. Further, the Governor and the Legislature should insure that the University of California has sufficient funding to increase the number of primary care residency programs, such as those in family practice and internal medicine. These programs should have a significant number of training hours where physicians-in-training would work directly with long term care patients both in hospital and long term care settings.

These efforts should be undertaken in cooperation not only with the California Association of Medical Directors and the California Medical Association but also in concert with other relevant consumer and professional organizations including, but not necessarily limited to, the nursing home trade associations, and the Licensing and Certification Division's Advisory Council

for long term care matters, and the Board of Medical Quality Assurance.

Finding 11. Although there may be a substantial over-supply of physicians in the United States, it is unlikely that this will, of itself, guide physicians to work in geriatric medicine in long term care settings.

There is some consensus that we are entering a period when there may be a substantial over-supply of physicians in the United States. However, it is highly unlikely that this over-supply will, alone, guide physicians to work in the long term care arena. Without some form of government intervention, it seems highly likely that the over-supply of physicians will result in an increased maldistribution of physicians. If this supposition is correct, there will be an ongoing shortage of committed and well-trained physicians willing and able to work with long term care residents. Present training programs which are aimed to remediate this problem are often very well intentioned, but they are usually quite small in both size and impact.

Recommendation 11. Every effort should be made to increase the number of physicians with skills in gerontology and geriatrics. The Legislature should establish a California Health Services Corps to partially fund physician education for those willing to specialize in geriatrics at the University of California medical schools.

Toward the end of increasing the supply of physicians trained in gerontology and geriatrics the state should design and fund (with federal assistance, if available, and independently if such federal support is not forthcoming) programs for both medical students as well as medical interns and residents which would lead to an increased number of qualified medical personnel working with long term care patients.

The legislature should establish a California Health Services Corps to partially fund physician education for those willing to specialize in geriatrics at the University of California medical schools. This program would award scholarships to students who would agree to have a significant percentage of their practice with patients in community-based or institutional long term care settings. This program could be modeled, at least in part, on the federal National Health Service Corps.

In addition to the training and education of additional physicians to work with the elderly, it is important to note the very real discrimination that takes place in the delivery of health care services in California and America. That discrimination is based, in some large measure, on ability to pay for the use of the health and medical care system. Physicians should be encouraged to contribute pro bono services both to training programs and to providing needed care to indigent nursing home patients. Such services would be in the finest tradition of providing care for the needy and the isolated of our society.

Finding 12. Given the shortages in available physicians to work in long term care settings, the use of physician extenders has not been adequately explored.

No matter what actions are taken to increase the number of physician providers for long term care residents it appears that the need will far outstrip the supply for some time to come. This is only one of the reasons for utilizing physician extenders within both institutional and community based long term care programs. The difficulties in securing the services of physicians to work in the long term care arena, or, for those that do, to get to long term care facilities in a timely manner, could be reduced with the addition of qualified additional personnel working under the general supervision of a physician.

The need for more and better qualified medical care for nursing home residents is clear. It is also clear that, at least in the short term, it will not be available. This being the case, alternative arrangements which provide options for increased presence of health care providers for long term care residents need to be encouraged.

The recommendation for the development of these programs (which follows below) is not meant in any way to detract from the central emphasis of this report: the serious problems and serious needs with regard to the provision of quality physician services and the oversight of those services by appropriate state agencies for nursing home residents.

Recommendation 12. Programs which enhance the role of physician extenders (both Physician Assistants and Geriatric Nurse-Practitioners) need to be further developed. Medi-Cal requirements should be modified to permit direct payment for services provided by licensed Physician Assistants, Geriatric Nurse-Practitioners and other qualified Nurse Practitioners.

Direct access to medical care for the institutionalized elderly must be substantially improved. One way to accomplish this is to reassess prior state efforts with Geriatric Nurse-Practitioners in order to make better use of these professionals and to encourage further development of training programs for them and for Physician Assistants who have a geriatric speciality.

Models for the employment, reimbursement, and mobile deployment of these professionals need to be developed, assessed, and made available---beginning in and especially for those areas where long term care facilities and their residents are medically underserved. At least one way to accomplish this would be to modify the Medi-Cal requirements in order to both permit and encourage direct payment for services provided by Physician Assistants, Geriatric Nurse Practitioners and other qualified Nurse Practitioners.

Finding 13. The position of Medical Director of a long term care facility is a critically important one.

The Medical Director of a long term care facility is, or at least

should be, both the model of accessible and high quality medical care that is to be provided to the residents, as well as the back-up for other physicians with patients in the facility.

In many cases these key medical personnel are not trained either in geriatrics, nor do they have a sense of the medical and administrative functions of the Medical Director. While the California Association of Medical Directors attempts to provide this type of training, their active membership is quite small. Most Medical Directors of California long term care facilities do not choose to belong to this professional and educational organization.

Recommendation 13. Medical Directors contracted by any California long term care facility after September 1, 1989 should be required to have completed a specified number of Continuing Medical Education hours in gerontology and geriatric medicine as a contractual condition of initial and continued employment.

Educational training in gerontology and in geriatric medicine should be required for any physician serving as Medical Director of a long term care facility. The Board of Medical Quality Assurance, in cooperation with the California Medical Association and the California Association of Medical Directors, and a committee of gerontologists and geriatric specialists from the University of California should oversee the approval of the curriculum for these continuing education efforts.

The Board of Medical Quality Assurance should continue, and materially strengthen, its practice of active partnership with the research, practitioner and academic communities in the design of continuing education physicians. Special attention should be given to the rapid development of additional continuing education programs of the highest quality in the areas of gerontology and geriatric medicine.

Finding 14. The role of the Medical Director needs to be expanded in terms of the training and experience that he or she must have in order to provide medical leadership for the facility.

While there are a number of regulations in place at both the federal and state levels with regard to the position of Medical Director of a long term care facility, a number of key issues are absent from the regulations at present. The present regulatory language does not, for example, explicitly assign the Medical Director a role in the planning processes of the long term care facility and of its staff. Clearly both physical considerations within the facility, as well as staffing levels, can and do have an impact on medical care, and it is therefore reasonable to expect that the Medical Director would be included in planning that related to either of these two issues. However, this has not traditionally been the case with the exception of those cases where the Medical Director held full or partial ownership of the facility.

The Medical Director's role must include involvement in those management and administrative areas of long term care which relate to the quality of the medical care the residents of that facility can expect to receive. This is rarely the case at present: more often than not Medical Directors who are part-time contractors working for a nursing home or nursing homes and the extent of their involvement with administrative issues, even when they directly relate to patient care, is minimal at best.

Recommendation 14. Title 22 of the California Code of Administrative Regulations should be amended in order to significantly broaden the responsibilities of the Medical Director of any long term care facility.

In addition to the expansion of the educational requirements for the position of Medical Director (described in Recommendation 13 above), additions need to be made to Section 72305 (Physician Services: Medical Director) of Title 22 of the California Code of Administrative Regulations.

Title 22 should be amended to include the following additional requirements and specifications for the Medical Director of any long term care facility in California: the Medical Director shall be jointly responsible with the long term care facility's administration for jointly planning the resource allocations necessary for providing adequate resident care; the Medical Director shall be Chairperson of the Peer Review organization at

the facility; the Medical Director shall be responsible for assuring that each medical practitioner at the facility has a current and clear license to practice; and, the Medical Director shall serve as a consultant to the Director of Nursing with regard to the development and implementation of matters relating to patient care services.

The Medical Director shall also be responsible for monitoring other physicians in the facility to ensure that each resident is evaluated by his or her physician at least every 30 days, unless there is an approved alternative schedule in place.

There is existing regulatory language with regard to the need for a nursing home administrator to be actively involved with the operation and management of a facility:

The administrator shall have sufficient freedom from other responsibilities and shall be on the premises of the skilled nursing facility a sufficient number of hours to permit adequate attention to the management and administration of the facility. The Department [of Health Services] may require that the administrator spend additional hours in the facility whenever the Department determines through a written evaluation that such additional hours are needed to provide adequate administrative management.

California Code of Administrative Regulations,
Title 22, Section 72513 (b)

Similar regulatory language needs to be developed to insure a continuous cooperative relationship between the administrator of a long term care facility and the Medical Director of that

nursing home.

Finding 15. The number of patients and nursing homes that a Medical Director can be responsible for is unlimited.

It is not uncommon for some physicians to serve as Medical Director of more than one long term care facility. Given that these physicians often have devoted much of their practice to work with long term care facilities and their residents, this practice may well be beneficial. Such benefits, however, decrease quite severely when a physician is serving as the Medical Director of seven or eight or nine different long term care facilities.

In the course of its work during 1988, the Commission became aware of several physicians who fit in this category. In such circumstances, regardless of the energy and professional preparedness that the physician has, it would be nearly impossible to hold this large number of simultaneous administrative responsibilities, much less to also provide quality direct medical care to several of the residents in several of these facilities. Members of the Commission's Advisory Committee felt strongly that no one physician could provide good care under such circumstances.

Recommendation 15. No Medical Director should be responsible for more than four separate facilities or a total of 400 beds.

Precedent for limiting the number of facilities and beds exists within present regulatory language with regard to nursing home administrators, and similar language needs to be developed for long term care facility Medical Directors. The present regulatory language reads, in part:

Each skilled nursing facility shall employ or otherwise provide an administrator to carry out the policies of the licensee. The administrator shall be responsible for the administration and management of only one skilled nursing facility unless all of the following conditions are met:

(1) If other skilled nursing facilities for which the administrator is responsible are in the same geographic area, and within one hour travel time of each other, and are operated by the same governing body.

(2) The administrator shall not be responsible for more than three facilities or a total of no more than 200 beds.

California Code of Administrative Regulations,
Title 22, Section 72513 (a) (1) and (2)

In those cases where a Medical Director either has an ownership interest in a facility or is responsible for the care of 25 percent or more of the patients in a single facility, limitations on the maximum number of facilities a physician may serve as Medical Director shall be determined by a joint committee made up of, but not limited to, representatives from the Ombudsman Program, the the Board of Medical Quality Assurance, the Licensing and Certification Division, the appropriate nursing home trade association, and representatives from the facility's family council and/or a community representative. This committee will be chaired by the representative of the Licensing and

Certification Division.

Medical Treatment and Other Policy Issues

Finding 16. California long term care facilities are the home for a large number of persons who present some of the major bioethical discussion, decisions, and dilemmas of our time.

Decisions concerning the best interest of a patient----including such major issues as those concerned with the withholding of treatment, the discontinuance of feeding and hydration, and about resuscitation--- are all very much part of the complex discussions, litigation, and new regulations and statues which have rapidly assumed a major role in biomedicine and social policy generally. Long term care residents and their families and representatives are often at the center of these considerations. For example, The Department of Health Services published, on August 7, 1987, "Guidelines Regarding Withdrawal or Withholding of Life-Sustaining Procedure(s) in Long Term Care Facilities." Appendix A of that document includes the California Medical Association's statement on "Withholding or Withdrawing Life-Sustaining Treatment: Ethical Guidelines for Decision Making in Long Term Care Facilities," which reads, in part:

(7.) It is recommended that every long-term care facility have access to bioethical consultation. When concerned parties have disagreements that cannot be resolved regarding treatment options, consultation with a broadly based, interdisciplinary bioethics

committee or other appropriate source should be sought. If a facility is unable to support its own bioethics committee, such committees formed by local hospitals or established under the auspices of the county medical society might serve as resources for the facility. In every instance, those who provide bioethical consultation should be familiar with both the specific medical setting and with community standards, and should have as their primary concern the patient's best interests. (page 2)

Committee on Evolving Trends in Society Affecting Life and Committee on Long Term Care Review

Recommendation 16. Long term care facilities should establish either regional or institutional Ethics Committees.

Long term care Ethics Committees would address issues including, but not limited to, treatment termination, resuscitation, and the discontinuance or withdrawal of feeding and hydration. The Ethics Committee should be established following guidelines established by the ad hoc standards of practice committee described in Recommendation 2 above.

The development and maintenance of these Ethics Committees should be based on guidelines developed cooperatively by the nursing home trade associations, the Licensing and Certification Division and the the Board of Medical Quality Assurance. These three groups should move promptly to facilitate bioethics education, consultation and training to aid in the design, creation, and operation of the Ethics Committees. The Ethics Committees should be staffed by facility physicians, nurses, social workers and administrators. They should also have have community

representation, as well as representation from the Ombudsman program. The creation of Ethics Committees which serve more than one facility in a limited geographic area is encouraged.

The organization and implementation of nursing home Institutional Ethics Committees should be undertaken on an urgency basis, given the rapid changes in the medical, judicial and regulatory environments all of which may have direct impact on both the wishes and the best interests of nursing home residents and their loved ones.

Finding 17. Many residents of nursing homes are receiving too many psychoactive drugs.

Nursing home residents often suffer the effects of poly-pharmacy drug reactions. Problems surrounding the over-use, or inappropriate use, of medication with nursing home patients have been documented by both the research community as well as the state and federal governments. These medication abuses are particularly troublesome in that they often include the medically and ethically highly suspect practice of prescribing psychoactive medications which are given to the resident on an "as needed" (or "PRN") basis.

Too many residents of too many nursing homes are receiving too many psychoactive drugs. The over-prescribing, and over-utilization of these medications has been cited time and again in

both the policy and the research literature. In some sense this is an accurate reflection of the medical inattention or "shoddy care" which too many nursing home residents receive. The use of such medications, often by staff on an "as needed" basis, serves to chemically mask behavior problems that make the nursing home staff uncomfortable.

While there is no doubt that some forms of severe dementia do require appropriate medical management which may include carefully titrated medications in order to bring some comfort to the patient, this phenomena alone does not explain the heavy and often inappropriate use of drugs (replete with side-effects of the psychoactive drug or from poly-pharmacy drug interactions) that occurs with many nursing home residents.

Recommendation 17. Policy standards regarding the maintenance of mental health and the treatment of mental illness in nursing home patients need to be developed.

Specific procedures for utilization of mental health professionals with nursing home patients procedures must describe the diagnoses that must be present in order to utilize psychoactive medications and what limits should be placed upon the use of such medications both over time and on a "as needed" (or "PRN") basis. These standards shall be a part of the overall standards of care to be developed by the ad hoc committee described in Recommendation 2 above.

Finding 18. The severe and ongoing nursing shortage has resulted in nursing homes having to depend on nursing registries to secure the services of part-time nurses.

Improvement in the quality of medical care within long term care facilities is not dependent on the physician or physician extenders alone. The registered nurses in long term care facilities are key members of the health care team, and are a crucial link between the medical care provider and the resident. The severe and ongoing nursing shortage, as well as the wage differential that is common between acute care facilities and long term care facilities, has resulted in more and more nursing homes having to regularly depend on nursing registry services to provide them with needed (part-time, temporary) nurses.

These registry services are temporary employment services which often provide nurses to long term care facilities. Often these nurses are unfamiliar with geriatric populations and with the state and federal regulations which govern the care of such residents. The nursing registry services themselves are not presently regulated. There are no standards for ensuring that these temporary employees are either licensed and that they are familiar with geriatric nursing.

Recommendation 18. Standards for the operation of nursing registries which provide part-time nurses to long term care facilities should be quickly and cooperatively developed.

The Commission supports actions which will lead to standards for nursing registries. These standards should be developed cooperatively with the Bureau of Registered Nurses and the Licensing and Certification Division of the Department of Health Services, in consultation, as required, with other professional licensing bureaus or boards and professional associations.

Every effort should be made to insure that the part-time temporary nurses that are used in long term care settings are, in fact, knowledgeable about geriatric care and also have a minimal familiarity with the state and federal regulations that relate to nurses who work in long term care facilities.