Progress Report on the Little Hoover Commission Recommendations for Long-Term Care

July 2006

This document is a compilation of information gathered from a variety of sources regarding California's efforts to improve long-term care. It cites legislative, administrative, and regulatory actions taken that meet or partially meet the recommendations of the 1996 Little Hoover Commission report on long-term care in California.

In addition, we have included an estimation of the progress that has been made in the last ten years, and have assigned a status to each recommendation of either implemented, substantial progress, some progress, or not implemented. This judgment was based on interviews with representatives from each of the different subject areas of the report: State Structure, Community Care, Skilled Nursing Care, and Residential Care. The status assigned is entirely subjective.

It is important to note that not all of the recommendations were universally embraced by long-term care stakeholders as laudable goals for the state. For example, there are those who championed a "single point of entry" as alluded to in Recommendation 1-B, while others felt equally as strongly that the alternative concept of "no wrong door" was preferable. Consequently, for this particular recommendation, the status of "not implemented" might be seen as a lack of progress by some, while others might view it as a success.

However, it is clear that the state has taken an incremental approach to improving services for seniors and persons with disabilities and the documentation shows the state's consistent efforts over the last ten years to improve services. Over the ten years, the ratio of spending for home and community-based services (HCBS) versus institutional care been reversed. Ten years ago, total spending for skilled nursing facilities exceeded HCBS. In 2005-06, spending for HCBS exceeded that for skilled nursing care. This change in spending was achieved largely without an overall strategy or plan on the state's part to aggressively divert consumers from skilled nursing facilities.

State Structure

Finding 1: The present state structure for long-term care oversight is not conducive to a coordinated continuum of care and fails to focus state efforts on consumer-centered, least-restrictive, best-value services.

Recommendation 1-A: *The Governor and the Legislature should consolidate the multiple departments that provide or oversee long-term care services into a single department.*

Efforts to date: Not implemented.

• AB 452 (chaptered in 1999)	Established a Long Term Care Council within the Health and Human Services Agency as an interdepartmental, interagency council to coordinate long-term care policy development.
• Agency White Paper (2004)	In response to CPR, the Health and Human Services Agency released a white paper that recommended creating the Division of Adult and Community Living responsible for policy and budget development and program planning for home, community, and institutional long-term care programs.
• AB 2014 (currently being considered)	Creates a single consolidated department for services for seniors and persons with disabilities.

Recommendation 1-B: *The Governor and the Legislature should mandate that the new state department establish an effective one-stop service for consumers to obtain information, preliminary assessment of needs and referral to appropriate options.*

Efforts to date: Some progress.

• AB 1339 (failed passage in 1999)	Created a single assessment tool for evaluating the long-term care needs of older persons and persons with disabilities and established the Area Agencies on Aging as the single point of entry to long-term care services for older persons and persons with disabilities.
• SB 953 (chaptered in 2002)	Directed the Health and Human Services Agency to develop a coordinated system of care through Care Navigation and Cal Care Net, a self-directed statewide Internet-based application that links local information systems.
• Real Choice Systems Change grant (2002)	Federal grant that established two Aging and Disability Resource Centers to provide a one-stop approach to the services provided and simplify the eligibility and assessment processes.

Recommendation 1-C: *The Governor and the Legislature should require departments involved in long-term care to pursue federal waivers and options that will infuse flexibility into programs and funding.*

Efforts to date: Some progress

• AB 499 (chaptered in 2000)	Required DHS to develop a Medi-Cal assisted living benefit federal waiver program to test the provision of assisted living services as an alternative to receiving services in a nursing facility. Serves 500 to 1,000 persons residing in residential care facilities or publicly funded housing projects.
• IHSS - Personal Care Services Waiver (2004)	1115 Medicaid demonstration waiver that made virtually all IHSS, including the "residual program" beneficiaries eligible for federal funding.

Recommendation 1-D: *The Governor and the Legislature should adopt a multi-pronged strategy for coping with the expected rising demand for and cost of long-term care services.*

Efforts to date: Some progress

• SB 910 (chaptered in 1999)	Required the Health and Human Services Agency to develop a statewide strategic plan based on the findings, recommendations, and demographic projections developed by UC.

Recommendation 1-E: *The Governor and the Legislature should ensure that the State's policies are consumer-focused by establishing an advisory committee that can have a persuasive voice in policy formation, program implementation and quality assurance.*

Efforts to date: Substantial Progress

• SB 910	California Commission on Aging charged with tracking progress on the state's strategic plan.
• Olmstead Advisory Committee established (2004)	The Olmstead Advisory Committee informs the Administration's understanding of the current system of care and establishes priorities regarding diversion, transition, and data collection.

Recommendation 1-F: *The Governor and the Legislature should develop a program for quality assurance and control that is outcome-based and consumer-oriented rather than prescriptive and process-oriented.*

✓ Any structural reform should be accompanied by efforts to minimize conflicting roles. Complaint investigations could be shifted to either the Attorney General's Office or the Department of Consumer Affairs. Similarly, the ombudsman program could be housed in these departments. Such a change, if implemented, should be monitored for several years and then assessed for effectiveness.

Efforts to date: Some progress

- AG's Elder Abuse Unit established (1999) — Although the Ombudsman program was not transferred to the AG's office, an Elder Abuse unit was established to use the AG's civil, administrative, and criminal enforcement powers to bring poorly performing care facilities into compliance. Operation Guardian is designed to bring increased accountability to those who abuse California's elderly population.

✓ Increasing the resources available to the ombudsman program, which is stretched too thin over many important duties, would allow increased training and more effective outreach to identify a larger pool of volunteers. Added funding could be diverted from fines collected for violations of regulations.

Efforts to date: Substantial progress

- Ombudsman Program funding (2003) — A significant infusion of funds (currently $1.75 million) was made available from civil monetary penalties collected from skilled nursing facilities. Funding provided twice-a-year training for Ombudsman coordinators. More than 1,000 new volunteers have been recruited in the last three years.

Community Care

Finding 2: The State's policies and programs do little to encourage the use of community-based services, and too small an effort is made to protect people from premature deterioration that can result in costly institutional placements.

Efforts to date: Substantial progress

- 2006 Spending — According to the Legislative Analyst's Office, most long-term care spending is for home and community-based services. Estimated expenditures for 2005-06 are:
  - Home and community based services: $8.4 billion
  - Institutional care: $5.3 billion

  Approximately 375,000 individuals rely on the IHSS program for assistance, in contrast to less than 100,000 relying on institutional care. The nursing home caseload has remained relatively flat, with only about a 1 percent increase in caseload annually.

Recommendation 2-A: *The Governor and the Legislature should revamp the present highly segmented licensing structure for long-term care service providers to allow a more seamless delivery of service, to allow aging in place whenever possible and to emphasize social models over medical models.*

Efforts to date: Some progress

- AB 1040 (chaptered in 1995) — Required the Department of Health Services to establish up to five Long Term Care Integration pilot programs to integrate the delivery and funding of institutional and home and community based long term care services. To date no pilots have been established.
- AB 43 (vetoed in 2003) — Would have established Chronic Care Integration program and made various modifications to the original AB 1040 statute.
- AB 1671 (failed passage in 2004) — Established the Cal Care Options Program that would have integrated Medicare and Medi-Cal funding streams to provide medical care and long-term care services.
- ALTCI projects (2005 Governor's Budget proposal) — Proposed implementation of acute and long term care integration in three counties to serve dually eligible and Medi-Cal only seniors and persons with disabilities. The bill failed passage due unresolved issues with the IHSS program.
- Access Plus and Access Plus Community — Establishes two integration pilot projects to improve the coordination of care for seniors and persons with disabilities. Access Plus (voluntary enrollment) would test the integration of health services

Choices (Governor's Budget Proposal 2006)	with institutional long-term care services and ADHC in Sacramento and San Diego. Access Plus Community Choices (mandatory enrollment) would enroll seniors and persons with disabilities in Special Needs Plans in two counties (Contra Costa and Orange).

Recommendation 2-B: *The Governor and the Legislature should designate a point person to develop funding streams and provide technical support for adult day care and adult day health care programs.*

Efforts to date: Not implemented

• Moratorium on licensure of ADHCs (2004)	As a result of explosive growth in the ADHC program, the Governor's Budget proposed: (1) a moratorium of new licensure; (2) the program be converted from a Medicaid optional state plan benefit to one operating under a federal waiver; and (3) requiring separate TARs for transportation services and therapy services (unbundling). To date, only the moratorium has been enacted.

Recommendation 2-C: *The Governor and the Legislature should increase funding for family caregiver respite and support services.*

Efforts to date: Substantial progress

• Increased federal funding for caregiving (2002)	Two programs to support caregiving operate in California: 1. The Family Caregiver Support Program administered by the Department of Aging and the 33 AAAs. The budget for this program is $36 million. 2. Caregiver Resource Centers administered by the Department of Mental Health operate through the network of eleven Caregiver Resource Centers statewide. The budget for this program is $12 million. In some areas, coordination exists between the two programs.

Recommendation 2-D: *The Governor and the Legislature should encourage counties, through funding and other incentives, to form Public Authorities to improve delivery of services under the In-Home Supportive Services program.*

Efforts to date: Implemented

- AB 1682 (chaptered in1999)

  Required each county to act as an "employer of record" for in-home supportive service personnel for purposes of collective bargaining. The Public Authority model was one option for meeting the "employer of record" requirement. 56 of the 58 counties have established Public Authorities for the administration of IHSS.

Recommendation 2-E: *The Governor and the Legislature should require counties to provide multiple modes of services so In-Home Supportive Services recipients who do not want to act as employers have options, including care through agencies, that will meet their needs.*

Efforts to date: Not implemented

- 2006 IHSS program administration

  Background: Current statue authorizes a county to deliver IHSS services using one or more of three modes of service delivery:

  1. Individual Provider (IP) Mode. The person providing the service is an independent contractor or provider who is hired directly by the consumer. The individual provider reports hours worked to the employer of record (usually a Public Authority) and is paid by a warrant issued by the state.
  2. Contract Mode. The care provider is an employee of a private or public entity that provides care services for the county under a contract for services. Examples of this mode are usually home health agencies. The county pays the agency, which in turn pays, trains, and directs their home care employees.
  3. Homemaker Mode. The care provider is an actual employee of the county and is subject to the same civil service benefits, protections, and liabilities that apply to other county workers.

  Some counties offer two or more service delivery modes and these counties are said to offer "mixed mode" services. The Homemaker mode is the least common mode of service delivery with less than 1 percent of IHSS services delivered in this manner statewide. Approximately 7,000 IHSS workers deliver services in the Contract mode, making it the second most common method of service delivery. By far the most common service delivery mode is the Individual Provider, with over 364,000 workers delivering IHSS services in the state.

  Only six counties continue to deliver services through the contract mode (Calaveras, Riverside, San Francisco, San Joaquin, San Mateo, and Santa Barbara). Alpine and Tuolumne Counties deliver services through the Homemaker (county employed civil service) Mode.

Recommendation 2-F: *The Governor and the Legislature should increase funding and expand the state role in standardizing adult protective services throughout the state.*

Efforts to date: Implemented

• SB 2199 (chaptered in 1998)	Enacted enhanced Adult Protective Services in each county, requiring: (1) a continually operational hotline; (2) timely response to all reports of elder abuse; (3) victims of elder or dependent adult abuse to be provided with case management services, including investigation, assessment and a service plan; (4) the coordination of community resources to provide victims with comprehensive treatment; and (5) emergency services such as shelter, food and aid. Budget language included a $20 million General Fund increase and an additional $25.3 million augmentation was provided in the 1999 Budget Act.

Recommendation 2-G: *The Governor and the Legislature should clarify mandated reporting laws to turn them into a more effective tool for protecting vulnerable citizens*

Efforts to date: Implemented

• AB 255 (chaptered in 2002)	Allowed the APS program to share information with county District Attorneys' offices and added a number of mandated reporters of elder abuse, including animal control officers, environmental and health code enforcement workers, firefighters, and clergy members.
• SB 1018 (chaptered in 2005)	Established the Elder Financial Abuse Reporting Act of 2005 which added officers and employees of financial institutions including banks as mandated reporters.

Skilled Nursing Care

Finding 3: Federal mandates for skilled nursing facilities have brought an improved process to monitoring quality of care -- but many previously identified issues remain unresolved and others are developing as the role of these institutions shifts to a higher level of care.

Recommendation 3-A: *The Governor and the Legislature should take steps to move medical care in long-term care settings from the costly reactive model to the more economical, preventive model, including encouraging the use of allied health professionals when appropriate.*

Efforts to date: Some progress

• Federal guidelines for Feeding Assistants (2003)	CMS published a final rule that allowed the use of paid feeding assistants in nursing facilities to supplement the services of certified nursing assistants. The intent is to provide more residents with help in eating and drinking and reduce the incidence of unplanned weight loss and dehydration. Regulations to implement the federal guidelines have not been promulgated in California.
• AB 2626 (chaptered in 2004)	Authorized physician's assistants in all settings, including skilled nursing facilities, to write and sign drug orders, including orders for controlled substances, when authorized to do so by a supervising physician.

Recommendation 3-B: *The Governor and the Legislature should strengthen the opportunities, incentives and requirements for high quality performance by skilled nursing facility staff.*

✓ Eliminate the doubling of hours for licensed nursing professionals, explore moving to a system that requires adequate staff for proper care rather than a certain number of hours, and/or set higher standards for staffing. The Older Women's League has recommended one caregiver for each eight residents at a minimum.

Efforts to date: Implemented

• AB 1107 (chaptered in 1999)	Provided for a 5 percent wage pass-through to nursing home staff and for an enhanced staffing ratio (from 2.9 to 3.2) effective January 1, 2000. The previous ratio calculated the hours per patient day by doubling the hours that licensed staff worked. The new 3.2 ratio eliminated this doubling.
• AB 1629	Provided for the imposition of a quality assurance fee on skilled

(chaptered in 2004)	nursing facilities, and provided that the funds assessed be made available to draw down a federal match in the Medi-Cal program to provide additional reimbursement to, and support facility quality improvement efforts in, SNFs.

✓ Add more gerontology and human relations issues to the certified nurse assistant (CNA) training curriculum and provide more effective oversight to ensure that training is of high quality and actually occurs.

Efforts to date: Implemented

• AB 1731 (chaptered in 2000)	1. Added ten hours of classroom training as part of the precertification training program required by facilities. 2. Added resident abuse prevention, recognition and reporting requirements to the training requirements. 3. Required as part of the 100 hours of supervised on the job clinical training, at least four hours of supervised training to address the special needs of persons with developmental and mental disorders. 4. Included six hours of instruction on preventing, recognizing, and reporting resident abuse and four hours of instruction on preventing, recognizing and reporting instances of resident abuse as part of certified nurse assistant (CNA) continuing education requirement.
• AB 1347 (chaptered in 2001)	Required: 1. CNAs employed by a SNF or ICF to complete at least two hours of dementia-specific training as part of the facility's orientation program; 2. SNF and ICF facilities to develop a dementia-specific training component within the existing orientation program, to be implemented no later than July 1, 2002; and 3. CNAs employed by a SNF or ICF to complete five hours of dementia-specific in-service training per year, as part of the facility's in-service training requirements.

✓ Create a career ladder for CNAs by establishing progressive educational standards and work experience that would lead to licensed nursing status.

Efforts to date: Not implemented

• AB 1731 (chaptered in 2000)	Required DHS, in consultation with other appropriate organizations to review the CNA examination and develop a plan that encourages career ladder opportunities for CNAs by January 1, 2004.
• AB 704	Proposed the creation of a new level of health care worker, the

(failed passage in 2006) Geriatric Health Care Assistants between licensed staff and CNAs.

Recommendation 3-C: *The Governor and the Legislature should enhance the State's enforcement capability by eliminating counterproductive provisions in the citation and fine system, directing more frequent use of alternative tools and creating a more effective civil liability remedy.*

Efforts to date: Implemented

- ✓ Eliminating the waiver of fines for B citations and the halving of fines for payment prior to appeal. The Department of Health Services told the Commission it supports both of these reforms.

- AB 1133 (chaptered in 1998) — Eliminated the waiver of civil penalties for first time facility violations and authorized citation appeal for such violations through binding arbitration; eliminated a facilities' ability to pay a lesser penalty after the citation has been sustained following an appeal.

- ✓ Encouraging the Department of Health Services to use more frequently facility decertification, delicensing and frozen admissions, as well as creating a fee system that assesses a facility at a higher rate when frequent violations require more frequent inspections.

- AB 1731 (chaptered in 2000) — It was widely agreed that in order to take necessary action to protect patients, the use of temporary managers was a preferable alternative to delicensing and decertifying a facility. This bill defined the circumstances under which DHS may appoint a temporary manager.

- ✓ Fines, set in the mid-1980s, should be increased. In addition, consumers should be empowered to sue for civil remedies with the potential for large enough financial damages to act as a deterrent for poor quality care.

- AB 1731 (chaptered in 2000) — Established an increase in fine levels for facilities as follows:

	Previous levels	New level
Class AA citation	$5,000 – 25,000	$25,000 - 100,000
Class A citation	$1,000 – 10,000	$2,000 – 20,000
Willful material falsification or omission	$0 – 10,000	$2,000 – 20,000

Recommendation 3-D: *The Governor and the Legislature should create a more responsive complaint investigation and resolution process that is separate from the licensing and technical advice function.*

Efforts to date: Not implemented

• AB 526 (failed passage in 2005)	Would have repealed the existing requirement that DHS establish a centralized consumer response unit within Licensing and Certification to respond to consumer inquiries and complaints and instead, required that DHS establish and operate a dedicated complaint response unit in each district office to respond to consumer inquiries and complaints.

Recommendation 3-E: *The Governor and the Legislature should eliminate duplicate regulations and streamline the oversight process while ensuring that no deterioration in the quality of care occurs.*

Efforts to date: Not implemented

No legislation introduced to implement this legislation

Residential Care

Finding 4: Regulatory changes have not kept pace with the changing role of residential care facilities.

Recommendation 4-A: *The Governor and the Legislature should restructure state policies regarding RCFE rates.*

- Eliminate the ceiling on the rates RCFEs may charge SSI/SSP recipients.
- Petition the federal government to increase SSI.
- Increase the state-funded SSP portion of the monthly benefit.
- Craft a Medi-Cal benefit using the personal care waiver that will allow RCFEs to collect money for services beyond food and shelter that help keep residents out of skilled nursing facilities where the Medi-Cal bill would be much higher.

Efforts to date: Some progress

• SSI/SSP recommendations	None of the first three recommendations have been addressed.
• AB 499 (chaptered in 2000)	Required DHS to develop a Medi-Cal assisted living benefit federal waiver program to test the provision of assisted living services as an alternative to receiving services in a facility. Serves 500 to 1,000 people in residential care facilities or publicly funded housing.

Recommendation 4-B: *The Governor and the Legislature should revamp the regulatory structure for RCFEs.*

Efforts to date: Substantial Progress

• 2004 – Regulatory elimination of Facility Waivers for specified conditions	Community Care Licensing eliminated the requirement for an RCFE obtain prior approval to provide routine care for certain health related conditions and procedures such as the administration of oxygen; catheter care; colostomy or ileostomy care; contractures; diabetes, enemas and suppositories; incontinence of bowel and/or bladder; certain injections; IPPB machines; and stage 1 and 2 pressure ulcers.
• SB 1248 (chaptered in 1999)	Eliminated the requirement that a RCFE resident must have resided in the facility for at least six months prior to obtaining hospice services.
• SB 1896 (chaptered in 2000)	Required DSS and the State Fire Marshal to promulgate regulations for RCFEs to clarify requirements for facilities serving six or fewer persons, at least one of whom is bedridden.

Recommendation 4-C: *The Governor and the Legislature should encourage more clarity and consistency in enforcement efforts by dedicating more resources to staff training and enhanced technical support services.*

Efforts to date: Not implemented

• Governor's 2000 budget proposal	Eliminated the Technical Support Program for RCFEs. This program was supported by provider fees and was widely believed to have been effective in promoting compliance before problems developed.

Recommendation 4-D: *The Governor and the Legislature should revise restrictions on RCFE medication practices while at the same time safeguarding consumer protections.*

Efforts to date: Not implemented

• AB 1964 (failed passage in 2006)	Would have allowed unlicensed direct care staff trained to assist a licensed health care professional to administer blood glucose testing and emergency glucagon injections for severe diabetic hypoglycemia to an adult who has developmental or physical disabilities, and diabetes in RCFEs.
• AB 2609 (currently under consideration in 2006)	Increases training for staff at RCFEs who assist residents with self-administration of medication. The bill increases hours of training required for employees in RCFEs who assist residents with self-administration of medication from two hours to: 1. Sixteen hours, consisting of eight classroom and eight hands-on shadowing hours for facilities licensed to provide care for 16 or more persons; and 2. Six hours of training, including four hours of classroom instruction and two hours of hands-on shadowing training, for facilities licensed to provide care for 15 or fewer persons.

Recommendation 4-E: *The Governor and the Legislature should couple a strengthened process for protecting residents from unwarranted evictions with the creation of a limited probation period when a resident can be asked to move without cause.*

Efforts to date: Some progress

While neither of the following bills specifically addresses evictions, they do address resident's rights, which if ignored, could lead to inappropriate admissions.

• SB 211 (chaptered in 2002)	• Specified requirements for admission agreements for RCFEs and requires a facility to conspicuously post a copy of its agreement within the facility. The admission agreement is required to include a comprehensive fee schedule, an explanation of third-party services, information relating to residents' rights, and information relating to billing and payment, terms of contract, refunds, and termination of the agreement.
• AB 1898 (chaptered in 2002)	• Limited application fees and regulated rate increases charged by residential care facilities for the elderly.

Recommendation 4-F: *The Governor and the Legislature should request that the federal government restructure its health information collection process to include specific data on residential care facility residents.*

• 2006	No legislative or regulatory efforts have been undertaken to date to implement this regulation.