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IMPROVING QUALITY OF CARE IN NURSING HOMES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

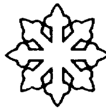
OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

WYOMING, MI
AUGUST 28, 1990



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IMPROVING QUALITY OF CARE IN NURSING HOMES

TUESDAY, AUGUST 28, 1990

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Wyoming, MI.

The hearing was convened, pursuant to notice, at 9:30 a.m., in Pinery Park Senior Center, Hon. Donald W. Riegle, Jr. (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[Press Release No. H-49, Aug. 17, 1990]

SUBCOMMITTEE TO HOLD HEARING IN MICHIGAN ON NURSING HOME QUALITY OF CARE; FIELD HEARING TO FOCUS ON IMPROVING CARE IN NURSING HOMES

WASHINGTON, DC—Senator Donald W. Riegle, Jr., (D., Michigan), Chairman of the Senate Finance Subcommittee on Health for Families and the Uninsured, announced Friday that the Subcommittee will hold a field hearing in Michigan on improving the quality of care in nursing homes.

The hearing will be *Tuesday, August 28, 1990 at 9:30 a.m.* at the Pinery Park Senior Center, 2380 Dehoop, S.W., Wyoming, Michigan.

"This hearing will focus on issues relating to quality of care and on specific recommendations to improve the care in nursing homes. With over 50,000 Michigan citizens in nursing homes, it's important to ensure high quality care," Riegle said.

"Significant Federal resources, primarily through Medicaid, are devoted to nursing home services. Close to half of all nursing home services are funded through the Medicaid program. We need to work toward a sound and efficient system to provide quality nursing home services," Riegle said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. The subcommittee will come to order. Let me welcome all in attendance this morning. I appreciate very much the effort made by our witnesses, a distinguished panel that have come from various locations around the State. We have other individuals here that I know also have very strong feelings about this subject and I want to invite, in the course of the day's activities anyone who has a statement that they want to make to submit them to us. I have staff here with me and I want to make sure that we have received your statements. We will take them down if you prefer or you can submit a written statement. In addition to the witnesses that will actually speak, we very much encourage and want your information as a part of this hearing record.

This hearing record will be not only transcribed in its entirety but it will be presented by me to the Secretary of Health and

Human Services, Dr. Sullivan, in an effort to bring to a conclusion the setting of some very important national regulations and guidelines in the area of quality of care in nursing homes. I will get into that in just a minute here.

But I want you to understand that important purpose of today's hearing and I want whatever information or insight anyone here is able to provide to us.

Let me say that we have two sign language interpreters who are helping us here today, Darlene Gould and Michelle McCoy, and I want to thank them for their efforts in that regard.

I also want to start by thanking the Pinery Park Senior Center for allowing us to meet here and conduct these meetings. As I have said, we have witnesses who have come from around the State to provide various perspectives in this hearing today, but we appreciate the hospitality and the graciousness of the senior center here for making everyone feel so welcome.

This is an official hearing of the Senate Finance Subcommittee on Health for Families and the Uninsured. We are the Subcommittee in the Senate that has the responsibility for overseeing Medicaid payments to cover the costs of persons in nursing homes.

I am the chairman of that subcommittee and am very interested in making sure that we move aggressively in this particular area where problems exist, in Michigan and across the country. We have been planning this particular hearing since May of this year.

Our principle focus today will be to examine the quality of care in nursing homes and ways to ensure high quality care for our elderly and frail Americans. With over 50,000 Michigan citizens in nursing homes—in 450 nursing homes across the State—we have an obligation to see that they are getting the best care possible.

Clearly there is a human decency requirement in making that statement, but also it is recognition of the fact that the majority of persons in our nursing homes are supported in part by public financing and particularly through Federal public financing and so we have an obligation to see that that money is well spent and is achieving a high level of quality care.

Of our witnesses today who will be testifying, we have families and guardians of nursing home residents. We have State Government officials, advocates in this area and as well as nursing home providers. And all testimony, as I say, will be a part of the official transcript in the hearing.

Now I have some charts here that I want to quickly illustrate the dimensions of this issue so that everyone starts at the same level of information. Currently, in our country we are spending just over $43 billion a year on nursing home care. In Michigan alone, we are spending about $148 million in this area. Close to one-half of the cost of nursing home care is financed through the Medicaid program.

You will see here in this chart, which we have labeled "Nursing Home Costs, Large Government Role," you will see that of the total about 44.5 percent of the total cost of nursing home expense is paid for by Medicaid. In the Medicaid program, in order to qualify for assistance, persons must have exhausted their resources resulting in a low income level.

The green part on the lower half indicates the amount of nursing home costs that is paid through direct payments by individuals who are in nursing homes and not paid for by the Government. These would be people, for the most part, drawing down their personal assets or family assets to pay for the costs of nursing home care. And nursing home care, if you are paying for it out of your own pocket, varies, but tends to run, about $2,000 or $2,500 a month. It is a very expensive proposition for anybody to be in a nursing home for any appreciable length of time.

Even someone with an accumulation of private assets tends to draw those down quite rapidly if all the costs of nursing home care is paid out of one's own pocket.

You will notice in the green area we have shown—if you can see it in the legend over on the left—are the private payment schemes and private health insurance payments. The size of the two small shaded areas show that there is very little private insurance available in its contributions to nursing homes. This shows us that there is a deficiency in our system in that area for which we need to develop additional means of providing for the cost of this service when it is needed. This is especially important as our population grows older.

Any one of us can find in the course of our lifetime the requirement for this personally or for members of our family.

But with such a huge investment of our Federal Government, this Subcommittee, which has jurisdiction over Medicaid, is holding this hearing to get directly to the issue which is the level of quality of care that people are getting. I think you know from some stories that have run in Michigan—and I want to particularly take account of one series of stories that have been done by a reporter who is here today—Sheila Gruber, who is here for the Detroit News. Ms. Gruber has zeroed in on some of the problems that can be found if one examines some of the nursing homes that are not doing a sufficient job.

It is very important, today, that we make sure that we do not allow broad generalizations to be made where nursing homes with poor standards and poor performance ruin the reputations of high quality nursing homes, which are the overwhelming majority.

So, in identifying problems we want to at the same time make sure that it is understood and stressed that there are many nursing homes in the State that are doing an exceptionally good job.

Now let me move to the next chart which relates to Michigan. In our Michigan experience, we looked at nursing home residents by the source of the payment that covers their stay in a nursing home. Remember, there are about 50,000 nursing home residents in our State. Please notice the red portion, which is the Medicaid portion is the largest share. Almost two-thirds of our total nursing home population in the State are people whose costs are being picked up by Government.

The Federal Government is paying a little over half while the State Government is paying a little less than half. It is about a 54/46 percent split on the source of the Government money, between the Federal Government and the State Government. But as you can see, as I have said before, roughly two-thirds of the persons in

nursing homes in Michigan are people who are there by virtue of public expenditures picking up the cost of that service.

You will see, by the same token, down in the shaded green area that private insurance constitutes about 30 percent of the payments to cover residents in the State of Michigan. And then that little shaded area, that is sort of the candy-striped area over there, represents Medicare payments which are about just 5 percent of the total. Medicare, as I am sure many of you would know, does not provide much in the way of assistance with respect to nursing home care.

Let us now move on to the final chart. It is important to understand these basic statistics against the backdrop of national demographic changes. We have a number of seniors here in the room today and all of us are moving in that direction, God willing, that gives us long life.

But if you take a look at the projections of our total population, todays actual figures and the next centurys, the green line at the top shows the number of people age sixty-five and over. And down at the bottom you can see this chart starts back almost a century ago in 1900, then comes up to 1930, 1960, 1990 and so forth. But you can see the rapid growth of people who comprise the part of our society in the sixty-five and over age group.

The line below that, the red line, takes an even older group. These are people in our society who are over the age of 85. And you can see that from the beginning of the century to the present, that people are living longer and longer lives. The number of people in our society who are projected to be in the 85 or above age group is a rising figure. And, of course, the longer we live, the more things can take place, whether it is Alzheimer's or some other disabling situation that can require the level of care that we normally associate with long term care.

So we can see in that profile the fact that this is not a small problem or a problem that is diminishing. This is a problem that is built right into the demographic quality structure of our society. It is built into our health care technology that helps people have longer lives over time. This situation has to be dealt with properly because more and more people are facing this situation.

Now this year marks the third year since Congress passed the Nursing Home Reform Act of the Omnibus Budget Reconciliation Act of 1987. It goes by a code name of OBRA '87. This year is the deadline for its implementation. That landmark legislation passed 3 years ago was enacted to assure high quality care in nursing homes under Medicare and Medicaid. And I, and several others, were co-sponsors of that legislation.

There were four important parts of that reform. This really goes right to the heart of our hearing today. These are Federal requirements:

One was the additional requirements that nursing homes must meet in order to participate in the Medicaid and Medicare programs: such as increased nurse staffing levels and training, and improved residents' rights, and a thorough assessment of each resident's needs.

The second major area was improvements in what is called the survey and certification process for determining whether individual nursing homes comply with quality of care standards.

The third area was an expansion of the range of sanctions or penalties that HCFA—which is the Federal agency involved—and the individual states could impose against nursing homes that did not measure up to the proper quality standards in patient care.

And finally, there is also a requirement for an appropriate placement of persons with mental health problems. Because you can have a range of situations, we must make sure that people who have that particular situation receive the care they need.

However, since the enactment of those nursing home provisions there have been numerous issues raised about the Health Care Financing Administration's implementation of the law. Concerns about the content of recent regulations and the timeliness of promulgating guidelines for certain provisions by the specific deadlines continue to be raised.

With major sections of the Nursing Home Reform provisions becoming effective on October 1 of this year—so it is right around the corner—there is an urgent need to address these issues as quickly as possible. Just this month, I have sent a letter to Secretary Sullivan and other key members of this Committee and the Aging Committee, because I wanted the ranking Republicans and Democrats to be together on these two letters. I asked the Secretary to develop a plan for how the Department will fully implement this important legislation, including an assessment of needed administrative as well as legislative modifications.

Some things can be done within the scope of existing law and if other changes of law are needed DHHS can ask for those and we will take those up on an expedited basis.

Now I think it is fair to say, at this late date, it is obvious that many of the deadlines that are required under this law will not be met as things now stand. I think instead of just letting those deadlines pass we need to use both the information from this hearing and the information requested from the Department of Health and Human Services in Washington to develop a plan for full and proper implementation of nursing home reforms.

An important part of this is HCFA's timely publication of guidelines. And I think more delays just cannot be accepted. I think the weight of our testimony will provide a very powerful lever for us to force these regulations out to places where they are very badly needed.

Now I just want to make a couple of other comments and then we will go to our first witness. I want to cite again the chart that I showed last, that older Americans are a growing percentage of the population, comprising roughly 12 percent of our population this year, rising over time. And this, of course, is contributing to the number of people needing nursing home care.

I think these demographics alone have to be a force for change. The increases in the number of patients requiring these services, as well as the severity of conditions that we are experiencing, underscore the need for a sound and efficient system to provide quality nursing home services. I think as we are commemorating the 25th anniversary of the Medicare and Medicaid programs, it is time for

us to thoroughly assess how well we are doing, and where the gaps are. We must face up to the unmet needs and see that they are addressed directly. High quality nursing home care is part of that effort and it is the focus of our effort today.

I want to say one other thing. Today's focus is on quality of care. You are going to hear some distressing things and you are going to hear some positive things. Another problem, however, with respect to people who need nursing home care, are those that are not getting any care at all. While we have about 50,000 people in nursing homes today in Michigan, we probably have close to another 100,000 who need nursing home services and are not getting them. These are people who cannot get nursing home services because there are not enough spaces out there, nor is there currently the money to pay for those people. That is a serious structural problem.

Those people who need nursing home care or other forms of long term care and are not receiving it, is another important problem that we must take up; and I will address this in due course. That is not our principle focus today, but it is important to lay out the facts. In order to properly respond to the population of people who need services the cooperation of both the Federal Government (which pays a little more than half of the cost of persons who qualify for public assistance) and the State (paying for somewhat less than half) is needed. Also more money will have to be found to respond to the unmet needs of persons, now not in nursing homes but who need that kind of care.

So, at another time, we will gather for a very specific focus in that area as well as the general problem of people who need long term care services.

Now I want to go at this time to our witnesses. I want to introduce our first panel who consist of individuals who have a loved one or a friend in a nursing home. They are going to talk about the first-hand experiences that they have had, and they will discuss the quality of care that they have found in some of Michigan's nursing homes.

They have with them some family members that are seated in the first row and I want to welcome the family members that are present as well.

The first witness that we will hear from is Fay Jones. Fay is from Novi and has a mother, Elsie Wickstrom, in a nursing home. Her aunt, Esther Taurin, was also a resident in a nursing home and recently passed away. This story has been, in part, related in at least one newspaper story and it is a very compelling story that needs to be more widely known.

Fay will testify about both experiences and discuss differences in the care received in facilities with which she is familiar. She has some family members with her. She is accompanied by Janet Pitcher, who is the daughter of Esther Taurin; and by Mary Penzien, her sister.

Next we will hear then from Van Stanchik, who is from the Traverse City area, is a Probate Court appointed volunteer guardian for an elderly woman in a nursing home. She is also the Vice President of the Citizens for Better Care, State Board of Directors. Van will share her experiences as a volunteer and guardian.

And then finally, in this first panel, we will hear from Joan Walker who is from Bangor. Her eighty-seven year old mother, Esther, is resident of a nursing home. She will testify on her continuing efforts to improve the quality of care in her mother's nursing facility and the problems that she has faced. Joan is accompanied by her daughter, Emily.

These are not always easy subjects to talk about. I am very appreciative of the fact that you have been willing to come forward today publicly and give us the important value of what you, yourselves, have seen individually.

So, Fay, let me invite you to go first.

[The prepared statement of Senator Riegle appears in the appendix.]

STATEMENT OF FAY JONES, NOVI MI

Ms. JONES. Good morning. I am Fay Jones and I live in Novi, Michigan. I am here today to share my experiences with you about my mother and my aunt. Senator Riegle, I have sent some documents for your review which can substantiate the claims I am making in this testimony.

My mother, Elsie Wickstrom, who is from the Upper Peninsula, was diagnosed with dementia of Alzheimer's type over 3 years ago. In February 1990 she became very confused and difficult to deal with. This took a hard toll on my father who was the primary care giver. At that time, our family concluded that we needed to do something. After reviewing all of our options, we decided to put our mother in a nursing home. We placed her in the Novi Care Center because her sister was a resident there, it was close to my home, and it was the only one with available beds and without a long waiting list.

My mother was a resident at Novi Care Center for 18 days. My family was not happy with the care she was receiving and decided to put her a number of different nursing home waiting lists. While she was considered a private pay patient, my father tried to see if she was eligible for Medicaid. Later, we found out that she was. During our search for another nursing home, we found that some will only take private pay patients. One home charges a base rate, plus individual charges for such things as "wandering, confusion, and needs assistance with activities of daily living," to name a few. For my mother's needs it could easily have cost my father $4,000 per month. Another facility we checked into, you had to prove that you could privately pay for the first 2 years and then be eligible for Medicaid.

My family was elated when a bed became available at Cypress Manor. We hoped our mother would receive much better care there and would now be close to my father.

I felt that the staff at Novi Care Center really didn't care about my mother's well being. I was always intimidated with the many phone calls that I received from them. For instance, when they were concerned with my mother's wandering, they called to tell me they were going to use physical or chemical restraints on her. At the time, I was afraid to disagree because I thought they would discharge her from their facility. I tried to explain to them that I

thought the restraints would be very traumatic and unnecessary. I thought that they should be able to protect her from going outdoors without the use of these restraints. They listened to my feelings, but I felt that I had to finally concede to the physical and chemical restraints as they were giving me no other options.

In addition, the staff seemed to discourage us from visiting her. After putting mom in a nursing home, we wanted to keep her alert as much as possible. While she was at the Novi Care center, the staff dissuaded us from taking her to one of our homes overnight, or out for an ice cream or even to church. They felt that it would take her much longer to adjust to the nursing home. I know that this is not the case because when she was at Cypress Manor we were encouraged to take her out and she seemed so much happier when we did.

I have noticed a lot of things that are different between the two nursing homes at which my mother stayed. Cypress Manor seems to give her the necessary, tender loving care that she needs. The staff assists her with bathing and dressing and presents her as a normal human being. They speak to her in a friendly way and are always asking if she had a nice walk or if she is having a good day.

Once a month they take the residents who are physically able on outings or walks. My mother has gone on these walks and like a typical patient with Alzheimer's, seems to really enjoy them. In addition, the staff administrator is looking into a tracking device that will locate their wandering residents. Since my mother wanders, this will really help. In the meantime, they discontinued the chemical restraints she was receiving at the Novi Care Center and have simply taken her shoes away to prevent her from leaving the home.

Even though things are much better at Cypress Manor everything is not perfect. For instance, several times we have asked the staff to make sure that mother take her bra off and dentures out every night before going to sleep. It appears, however, that this has not been happening. We have noticed a rash which has a foul smell, underneath and between her breasts. She also has a sore on her bottom gums under her dentures that has not healed in the past month.

Furthermore, my father recently noticed that the nursing home has been short staffed. These are problems which definitely need to be straightened out. While I realize that part of the problem is that my mother is resistant, I am working with the staff and hope to come up with some positive solutions to these problems.

I am also very concerned about the way my aunt, Esther Tauren, my mother's sister, was cared for prior to her death. My Aunt Esther was diagnosed with Alzheimer's and was a patient at the Novi Care Center for approximately four and a half years. We witnessed a number of unbelievable problems that occurred while she was a patient there.

On May 20, 1990 my husband I went to visit her. We were very disturbed when we walked into the lobby and found her with two very black eyes. We were told we would have to talk with the charge nurse if we wanted information. The charge nurse who was on duty the night of my aunt's incident informed us that he believed another patient hit Esther when Esther went into the other

patient's room. I felt skeptical about this explanation and reported it to the Chief Complaint Investigation Unit for the Michigan Department of Public Health. They notified me that the nursing home was short staffed but that my aunt had not been abused.

One week later, however, the same investigator called me to say that he met with his boss, and they decided to change the report to patient to patient abuse. He informed me that the change was because of the press coverage this incident received.

These were not isolated incidents. On June 24, 1990, late in the afternoon, my husband and I went to visit Aunt Esther. We were extremely upset to find her with her head hanging down on her chest. We tried to walk her down the A-wing but she seemed quite weak. We didn't know what was wrong with her until we looked into her mouth. There we found a mouthful of ground beef, which I assume was from her lunch. I scooped it out with my finger. While we could not physically lift her head she lifted it herself to get a drink, a clear indication of how dehydrated and desperate she was for a sip of water. When we informed the nurse, she told us that she would contact the doctor that day. We later learned the doctor didn't see her until 2 days later, at which time he sent her to Providence Hospital.

She was admitted to the hospital with many complications, including urosepsis and severe dehydration. Her sodium was elevated and her Potassium was low. She was impacted with stool and she had a staph infection in her blood. The bacteria in her bladder was the same bacteria that is found in feces. I think that she got the bladder infection from sitting in her feces, soiled clothing for long periods of time and from lack of fluids.

Esther's daughter, Janet Pitcher, who is with me here today, was very concerned about this incident and about the care her mother was receiving. She decided to have a care conference with the administrators of the Novi Care Center. She requested that her mother be given the proper amount of fluids during waking hours and that she be ambulated every 2 hours for at least ten minutes. She also discussed not using restraints on her mother, as she felt they were inhumane.

When Aunt Esther was released from Providence Hospital she was dehydrated and very full of energy. However, 4 days later, back in the nursing home, she passed away. The doctor wanted to treat this as a natural death. In spite of his account, we disagreed. We believed that poor care and neglect was the cause of her death as we had seen her so alive just days before. We also knew that two other patients had died the same day. It wasn't until we called in the Novi Police, that we an autopsy was approved. The results of the autopsy showed that she died of aspiration with food in her trachea from her throat to her lungs.

I have told you about the good care that my mother is now receiving at Cypress Manor. I have also told you about the poor and negligent care that my mother and aunt received while patients at Novi Care Center. No one should have to suffer the loss of dignity or die from poor care and neglect. My concern now is for all patients of nursing homes, whether they have families who can check on their care or the ones who have no family at all. I would like to see proper staffing in all nursing homes as well as the staff be

properly educated to care for their patients. The security systems in nursing homes need to be improved for wandering patients.

I would like to see the State of Michigan enforce the laws that govern our nursing homes that already are in existence as well as the new laws that come into effect in October 1990. I was pleased to hear that the State has halted admissions to the Novi Care Center. This is certainly a start in the right direction.

Medicaid and Medicare funds need to be reviewed. We need to find out if they are adequate to provide the services we need for our nursing home patients. We also need to find out why some nursing homes refuse to take patients who are on Medicaid.

I am grateful to God that he gave my aunt a good life prior to the onset of Alzheimer's disease. I will miss my aunt, but maybe God has allowed her death to happen at this time to make all of us aware of the problems that exist in our nursing homes.

Senator Riegle, thank you for giving me this opportunity to testify at this hearing.

[The prepared statement of Ms. Jones appears in the appendix.]

Senator RIEGLE. Well thank you very much for coming and giving us that very powerful and emotional family account. I know Janet Pitcher, who is seated behind you, I know how emotional it is for you to hear that account and to go through it again in your mind.

There are several things that I think need to be said at this point. One, is that it seems to me, you have seen two quite different situations in nursing homes. You have seen one that you have concluded was a very bad situation and it may, in fact, have led in your view to the death of someone that you know in your family. You have also been in another nursing home situation where you have seen quite a different situation and a much more positive situation. So, I think it is clear that we have both kinds. And it is important to note that.

With respect to the Novi nursing home, was it a for-profit or a non-profit operation? Do you know offhand?

Ms. JONES. I am not sure about that.

Senator RIEGLE. I want to find that out. I gather that the Cypress Manor where you now have your mother is a for-profit operation.

Ms. JONES. I believe so.

Senator RIEGLE. I want to just touch on another couple of points here. Your mother is on Medicaid. Did you find in searching for a place for her that the fact that she was on Medicaid worked against her in any way?

Ms. JONES. At the time we put her on waiting lists at several of the homes she was still private pay. But, we found that Whitehall Nursing Home in Novi would only take private pay for 2 years. You had to prove up front that you had the funds to pay for 2 years and then you could apply for Medicaid. And Peachwood in Rochester Hills would only take private pay. And as I mentioned, that would be about $4,000 a month for my mother's care or more.

Senator RIEGLE. I think it is important to say for the record, and for everyone in the room to know, that the Medicaid reimbursement rates are less than the amount that is expected for a person if they come in on a private pay basis. The Medicaid reimbursement rates run about 70 percent of what a person is charged who is

paying for that care out of their own personal budget. That, by itself, tends to create an incentive. If a nursing home has a choice between someone who can pay the higher rate out of their own pocket, versus someone else who is coming in as a Medicaid patient, with a lower payment rate, you can see why the nursing home, depending upon its philosophy and orientation, might well say, I do not want the Medicaid patient, I want the private pay patient. The thought being, I will earn this much more for providing the same level of care as I would for the Medicare patient.

I think this is another one of the structural problems that we have to think about as a society. When we think about what our taxes and our Social Security payments go for how we feel about them, the issue of where we want to put health care and nursing home care is a most important national question that we have to ask ourselves and answer. Not everyone in life is going to be fortunate enough to end up at an older age with a lot of money in the bank or a very strong financial situation, no matter how hard they work in their life time. Some of the people that I know who have worked the hardest in their life time end up with the least. So, you cannot assume that hard work is going to provide the private resources in a persons seventies or eighties or whatever age, to pay for these kinds of services.

So one of the fundamental public questions that we all have to be part of asking and answering is: How important is this? How important are our people to us? And how much do we as a society pay attention and commit ourselves to seeing that older people in our society, regardless of their economic circumstances, can have decent medical care and nursing home care when they need it.

If we are going to assume that people are disposable and can be thrown away, like you throw away a coffee cup at McDonalds, then that leads to one kind of an answer. If we are going to come out a different way as a society and say that what happens to our people, on a individual basis is very important to us, that we care about it, whether we know the person or don't know the person, then that leads to an altogether different kind of thinking and altogether different kind of national commitment.

We have not really addressed that question yet as a country. We have not addressed the issue of long-term care for people who really need it. We do it in part with respect to the Medicaid. But in order to qualify for Medicaid you have to reduce your assets to a poverty condition in order to be able to qualify. Even there, we are not able to accommodate all of the people who qualify. There are not enough nursing home slots, today, to handle the Medicaid case load that is standing at the door waiting to get in. So, we have not come up with a workable answer to that question yet as a country.

There is another issue of a national health insurance system of some kind—a public-private mixture. This could provide health insurance coverage to all the people in the country; however we have not addressed or solved that question either. We have tens of millions of people in the United States today without a penny of health insurance coverage. We have about a million right here just in the State of Michigan who don't have health insurance coverage today.

I take a moment to frame those issues because this is obviously an audience that is concerned enough about these questions to have made the effort to come and be in attendance today. We need, as a Nation, to focus on these questions and decide, what we want to try to do, together, in the best interests of our country as a whole.

This is a driving purpose of the Subcommittee, of which I am the Chairman, which is conducting this hearing today. While we are looking at the quality of care in nursing homes now, we should look at it in the context of these health care needs and determine what our basic philosophy as a Nation will be if we are going to pay attention and really address the problems facing our people.

I want to ask you, Ms. Jones, a couple of other questions. With respect to the contact that you have had with staff people in nursing homes—now you have been through quite a compelling and traumatic experience with what you have seen—is your experience that the staffing levels have been adequate? I mean in terms of what you have seen, do we look like we are seriously understaffed?

Obviously you only know the examples with which you are familiar. It seemed to me that that was part of what you were saying. Can you elaborate on that?

Ms. JONES. I know that at Novi Care Center on many occasions when I was there they would tell me somebody called in, and they were short of staff. The evening my aunt passed away they said they were short staffed. When I asked one of the nurses on the day shift, the charge nurse on the A wing, if they follow the Federal guidelines and exercise my aunt for ten minutes every two hours as the guidelines state, she informed me that they were too short staffed to walk her. So she outright admitted it. She is one of their better nurses and I appreciated her honesty. And she seemed to have more care and understanding when we had discussed problems in the past.

But there seems to be a definite short staffing problem. And I do not know if that is under the State requirements of the one to eight, one to twelve, one to fifteen ratio. With the State survey they did show that they were short staffed on their survey on different occasions.

Senator RIEGLE. Well, with respect to nursing homes that consistently show a serious pattern of deficiency, I think we ought to apply very tough penalties. I do not think they should be allowed to continue with that kind of a pattern of activity. They certainly ought not to get a penny of public money if those conditions exist and are not corrected.

That is one of the issues that is addressed in the OBRA 87 law. And that is: What kinds of sanctions are appropriate? I think they ought to be very tough sanctions. The industry itself has an obligation. Good nursing homes have to help put the heat on the bad ones. There are some that fall into that category. I do not think they ought to be in the business, quite frankly. I do not aim this at any particular nursing home without a due process way to make that kind of a final determination.

The industry itself has an obligation to help bring to light and expose the people in the business, the minority in the business, who injure the reputation of a whole industry. There is an affirma-

tive obligation there and I am not sure that it is being met either. These are questions we will continue to pursue after today.

I am told, by the way, that the Novi Center is also a for-profit operation. So, these two that you have compared side-by-side today both are for-profit companies and presumably, if properly run, ought to be able to provide a decent level of care. Certainly this is clear-cut from what you have testified to experiencing in your case at the Novi nursing home.

Well let me thank you very much. Your testimony has been very helpful to us and I appreciate it. I appreciate you coming as well and being here. I know this is not an easy thing for you to do, but I think it is, Janet, very important that you be here as well. So while you didn't testify, I think you did spiritually and I thank you for that.

[Applause.]

Senator RIEGLE. The only way we find out about these things is to have people come forward and lay it on the record. That is exactly what has to be done here so that we can view this picture clearly.

I have introduced Van Stanchick earlier. Van, we would like to hear from you now, please.

STATEMENT OF EVANGELINE J. STANCHIK, OF EMPIRE, MI

Ms. STANCHIK. Okay. I am Evangeline Stanchik from Empire, MI. I serve as a volunteer for Citizens for Better Care. I appreciate the opportunity to testify before this Committee and I tend to become rather emotional when speaking on behalf of residents in nursing homes.

I became involved in the issue of care for residents (not patients) because of a widow friend that I had known for many years. She had a stroke, leaving the right side paralyzed. She was first in a hospital, then transferred to a nursing home facility. The deplorable care she received was enough for me to start searching for an organization that I could get answers from. Finally, through Olivia P. Maynard, Director of Services to the Aging, I was referred to State Representative Thomas Mathieu. His office gave me the phone number for the Citizens for Better Care office in Traverse City. The office covers ten counties in northwestern Michigan.

CBC has a training program for advocates regarding the rights for residents and the responsibility of being an advocate. This is a volunteer program which offers weekly contact with residents in nursing homes, homes for the aged, and adult foster care homes. Should the residents have problems with their care, food, finances, or other worries, the CBC advocates work with the facility to attempt to resolve the problem. As an advocate, I report to our ombudsman, Mary Beth Osowski, who will assist the resident if they wish to file a complaint or have any other concerns about their legal rights.

I was fortunate enough to have the opportunity to visit the nursing homes in the ten counties. The visits were unannounced. We presented our identification, of course, and then proceeded basically to review the home the same way as the homes we visit regularly.

A short version of what we are looking for is: Are they skilled or intermediate facility, or a combination of both? What type of residents—old, young disabled, mentally ill? Any restriction on types of residents? Are there any special programs, such as social services, rehab, resident council? What kind of health care staff? Are they full-time, part-time? Do they have time to serve individual residents? Are the staff warm and friendly? Do they encourage you to come and visit or are they cold, quiet, and uncaring? What is the staff ratio to residents? We check summaries of deficiencies, which is a report on meeting standards for each home. Are the residents' rights posted?

Through CBC I discovered that rights to protect residents that should be a natural process given by one human being to another.

A problem I had while caring for my friend I mentioned earlier was when the call bell was rung and the light lit outside the resident's room for her to go to the bathroom, many, many times there was no response. Of course an accident occurred much to her embarrassment. I understood the longest resident had to wait was 20 minutes. Give me a break. Can you imagine when you were ill or your child was ill how long is 20 minutes to have to hold and wait for somebody to come in with a bedpan. As a friend, I would get her the bedpan.

I ask you, Don, can you peel an orange with one hand or cut a hard potato and meat with one hand, or how you can drink——

Senator RIEGLE. Why don't you just wait a minute. These things are very emotional because these are intense experiences. They are not easy to talk about. We understand and appreciate that. So just take a minute and see if you can continue. If not, we will have someone help you there.

Ms. STANCHIK. I know I can't do it.

Senator RIEGLE. You just can't do it?

I wonder, Ms. Jones, would you feel that maybe you could read what is there?

Ms. JONES. I'll start with the paragraph where she left off.

I ask you, Senator Riegle, can you peel an orange with one hand, or cut a hard potato and meat with one hand, or how can you drink a glass of milk that is filled to the brim with one hand? How a facility can let your skin break down to look like raw hamburger and, when you question it, the administrator becomes angry. Oh, how I wish I had known about CBC before all this.

Some of the facilities and medical doctors could care less about this older generation. While waiting for a guardian to be assigned to our widow friend the two other ladies that visited with her and myself went with the widow for a review of her health and care with her doctor. Do you know how he never looked at her? He never touched her during the 20 minutes we were in the room with her. When we left the room I asked him why he ignored her. His response was unbelievable. He acted like I was a child being patted on the head and did not understand.

I told him I hoped and wished that he would wind up with more wrinkles than anyone in the whole world. It is really sad that some of the doctors do not care, like they never will get old. It is not that they are any busier than the rest of us. There are plenty of doctors in this area and they get paid for their visits.

Because the first Citizens for Better Care office in Traverse City was given shared office space with the Grand Traverse County Probate Court Volunteer Program I became acquainted with Frances Rajkovich, who was the program director at that time. She asked me if I would consider being a volunteer guardian, as she had three residents that needed one. At that time I was pretty much filled with time devoted to my widow friend and others that I had been visiting. But I told her if there was one person at one of the facilities I was visiting I would take it on. It turned out that there was a resident there.

This new adventure, of course, took a little while to have her get to know me and me to know her. It took 3 months for me to find out she did not have any teeth. Staff did not know and could not get anyone to find out. I had to call her doctor, dentist and hearing aid person to check her eyes, ears and mouth. She did not have any teeth; her ears were in bad shape, but her vision was good, enough that she could pass a driving test. So we got her teeth but she did not want a hearing aid.

We figured if she could at this time just handle getting teeth for awhile we would be happy. The difference in her appearance and appetite was amazing. This was in the fall of 1987. Her personal toilet care was terrible. Nails, more times than not, dirty, as if she was a mechanic in a garage. Hair not done. Have a hospital gown on instead of the clothes she had. She would be in bed more than up.

I finally got hold of her doctor and went to his office. He set up a program for her to do some exercises, therapy. This was in February of 1989. He sent his assistant once after six weeks to check on the program that was not being implemented. Then another time when she had a cold.

This woman requires no medication but twice in error she was given medicine for another patient. These two times I know of because a nurse called and left a message on my recorder. Fortunately, it was not harmful or fatal. I knew she had been on medications other times but there was no way to prove that. Her eyes and apathy, if you have ever been a parent, told me.

You get tired of asking why care is not given. Her ears I discovered were in worse shape after 1 year according to the ear specialist. My concern was I knew a decision had to be made to move her from this facility. As a volunteer guardian I had that authority. Statistics show that when moving a resident near their birthdate that the death rate is higher. I did get someone of greater authority to visit her. Probate Court Judge John D. Foresman, and had a long discussion with the judge on my feelings about the move.

The decision was mine and she was moved. When I moved her to the new facility on a Sunday I took all her clothes to wash and press, except for what she would need until the next morning. When I arrived the following morning an aide asked me if her lower plate was in the clean clothes. I told her no. I called the other facility to see if they had misplaced it and forgot to pack it. They asked me if she had ever had a lower plate.

This is the facility where the dentist has his name on record for doing both plates, the dates, the costs, all of which I have a copy of.

This told me what I really felt all along, this woman had not been given any proper toilet care while at the previous facility.

This is a woman who towards the end of her stay at the facility I moved her from, was probably in bed 22 hours of the day. She now wheels herself in her wheelchair. She has a goal to go see her home in September, if she is up to it, she tells me. This is the difference a better home can make. Now she wants to check out carpeting and draperies cost.

She is always clean, dressed, and will tell them what she would like to wear. It took about four weeks for her to become comfortable with this facility. She is up for most of the day except for about one and a half to 2 hours when she requests a nap in the afternoon. She enjoys watching tennis on television, attends social functions and is friendly with other residents and staff. She asks a lot of questions, is curious, and even sometimes becomes angry. She has gained weight. Her skin is strong and her eyes clear. Her one ear has been cleared, but will take a little longer for the other because it had been so bad.

Problems created in some of the medical care facilities are, in my opinion, because of poor administration. The administration and top staff are paid very well and have excellent benefits. But the rest of the staff that holds the residents, cleans them, sees them every day, feeds them, are cheerful around them are paid practically nothing. Then the administration wonders why the turnover is so high.

Senator Don Riegle, are you aware that the average resident (this is their voting residents) pays a minimum of $25,000 a year for these services. Did you know that four of these residents could be sharing one bathroom? That is $100,000 a year.

It is sad and shameful that this group of people, who are the foundation of our community, our heritage, who in their lifetime if they made $1,000 to $1,500 a year and when Social Security came in are probably getting all of $200 a month. They know what it is to do without possessions. They should not have to do without the loving care that is their due.

We are fortunate that we do have advocates and organizations like Citizens for Better Care and the Grand Traverse Probate Court Volunteer Programs. We do need more people that are willing to go in and visit the residents. I can tell you, Senator Riegle, at one facility I knew when the State was coming in to review and check them out. I knew a week ahead of time. Somebody was informing them, I wonder who.

I hope whatever measures are imposed from this hearing to improve the quality of nursing care does not become bogged down in one of these statements. "I have to take 2 years to interpret this program or I have to make a study of it for another 2 years, or do you really need this financial support?" It does not matter if they are Medicaid, Medicare or private pay, every human being (resident) should be getting good, lovely, loving, healthy, touching care. Most residents are very bright. Some could probably stay in their own home with the help and services we now have to offer.

Another suggestion, or my opinion, we should work closer with the Probate Courts, especially when I have encountered individuals whose only concern is the wealth or possession of residents that

may be left to them. Should the residents have wills, I suggest that if an organization, school, or church be designated in the will as beneficiaries that they be alerted to it. Maybe knowing there is possibly financial help coming it would encourage the organization, hospital, school etc. to ask for volunteers to visit the residents and check on their care.

Why will I continue to be an advocate for nursing home residents? I looked at some words from a Maryknoll Brothers and Sisters booklet on being a missionary, and if one substitutes the word "advocate" for "missionary" it reads: "To be an advocate is to go where you are not wanted but needed, and to stay till you are wanted but not needed."

Thank you.

Senator RIEGLE. Thank you very much. That is a wonderful statement and a very important statement.

[Applause.]

Senator RIEGLE. I can appreciate, as we all can the emotion that you feel in recounting this. I appreciate the time you have taken to put that account together and to come down and present it to us today.

[The prepared statement of Ms. Stanchik appears in the appendix.]

Senator RIEGLE. I am going to, in the interest of time, move ahead to Joan Walker, and call on Joan now. Then I want to go shortly thereafter to Raj Wiener who is here with us today who is the Director of the Michigan Department of Public Health, and Mr. Tom Watkins who is the Director of the Department of Mental Health. They are very important witnesses as well.

At this point, let us, Joan Walker, hear from you now.

Ms. WALKER. Joan Walker hopes she won't start weeping too.

Senator RIEGLE. Well we are all with you. So if you weep a little bit we will weep with you.

Ms. WALKER. One other thing I would like to say is, if you have a text of what I intended to say, do not feel strange if you feel that you are in uncharted territory, because you really will be. I made some last minute changes. If I get into the same unchartered territory, it is because I will not be able to read my own hieroglyphics, and I apologize for that.

Senator RIEGLE. Well you take your time. We want to hear it and you will do just fine.

STATEMENT OF JOAN G. WALKER, BANGOR, MI

Ms. WALKER. My name is Joan Walker, obviously. I live near Bangor, Michigan, operating a small business I own. I have had a fair amount of exposure to nursing homes. And now, as guardian for my own mother, for whom I have had to seek such care in the last few months, I am glad to have the chance to speak before the committee because I believe my comments may be of assistance to you as you look at the problems of quality nursing home care.

Eleven or 12 years ago, because of media attention to nursing home problems, I too volunteered my services as a nursing home advocate until 1980, when the program at least temporarily was ended because of budget cuts that interfered with training funds.

At that time, my interest was based on a general concern for a sector of humanity needing a spokesperson. Now, in 1990, my concern about nursing homes has become personal, overwhelmingly frustrating—and I'm going to do it too—even heartbreaking, as I try to find acceptable care for my own mother, and have discovered that in spite of reforms and regulating agencies, enormous problems still exist.

My 87-year-old mother had to give up her home 2 years ago after surviving congestive heart failure. She required 24-hour supervision and personal care. But because one of my daughters was dedicated to helping Gram, and because we could afford some help and respite care, we managed until sometime in May when she experienced renal failure and went into congestive heart failure again. She was released from the hospital, perhaps too early, because of Medicare's infamous DRGs—which I hope you will look into—unable to walk or even stand up. She had a permanent catheter and needed 24-hour monitoring of her heart arrhythmias and she had a tendancy toward fluid retention.

We chose one of the two homes in a nearby town where my mother could maintain continuity by having her doctor make monthly visits and generally monitor her care. Of the two homes, I am sorry to say we chose the one with the relatively pretty face, part of a chain of for-profit homes, and a mistake we soon began to regret.

My mother needed—and still needs—not highly skilled technical care, but rather to be fed, to be kept clean and as comfortable as possible, and to have her medical problems stabilized as much as possible. And she needed and deserved to be treated, not like a demanding burden, but as the caring person she herself had been, having volunteered over 100,000 hours to Red Cross in her life time, which incidentally led to her being one of the few Americans ever to receive the Clara Barton award; and to a suburban Chicago hospital where her dedicated volunteerism continued well into her eighties.

When I tell you about the problems encountered in a nursing home, please bear in mind that I documented them with copious notes. As the problems mounted, I made requests, pleas, reasonable complaints, angry complaints, even threats. All complaints were met with denial, many with hostility, hostility that increased with each episode, until I am sure my mother became the object of management's hostile stubbornness as well.

When mother first entered the home, she was given a bed with a defective side rail that dropped with even the slightest finger pressure. She kept falling out of bed, sustaining severe bruises and even knocking out a tooth, and she didn't have many to spare. At first, they tried to convince me that she was climbing out of bed, which was an impossibility. Finally, when a nurse and I together determined that the side rail was faulty, we requested immediate repair or replacement.

I was assured in a telephone conversation with the assistant to the Director that the bed had been replaced. I left town on family business, assured that all was well until 3 days later when I returned. I was informed that she had again fallen out of bed. I gasped. I asked how that could happen if the rail, or the bed had

been replaced, and was told there was nothing wrong with the bed. They never, either in conversation or nurses notes, ever admitted that the bed had needed repair or replacement.

But finally, after I was reduced to making threats, magically the bed rail was repaired or replaced, never to be seen again.

Mealtime for the residents who required the most care. That was another nightmare. Because the home always operated shorthanded, and boy is that something that I observed daily, staff would begin moving those who needed to be fed to their small dining room up to 2 hours before the meals. There they would sit, laying their heads on the table, staring at each other for hours. These are people who are not capable of real socialization. While the staff moved those able to fend for themselves (and who thus could complain) as it was explained to me, to their dining room and then proceeded to serve them their food. Then, after that, they would return to the small dining room to serve and feed the noneaters, sometimes as few as 2 aides for 30 residents. More often, with 4 aides to feed the 30, although the State authorities had been told by the home management that they had a full complement of six to nine staff to feed. This was about a month previously, when a complaint had been filed by someone else.

Ultimately, after having lukewarm, stale food poked at them, the residents would be moved, some to their rooms and others merely towards their rooms to a hall where they would remain tied in, slouching in their wheelchairs, often in pain, pleading to be put to bed. Meanwhile, half of the staff ate and the other half having eaten started putting the more lucid and mobile residents to bed. Again, because they could vocalize their complaints.

I highlight the situation because sitting in a wheelchair for four to 5 hours is not only uncomfortable for anyone, but it certainly is physically detrimental for a woman of her 87 years who suffers from spinal arthritis, is susceptible to bed sores and retention of fluids collecting in the lower extremities. Neglect like this was not occasional and isolated, but part of a disturbing pattern that I witnessed after spending significant time daily at the nursing home.

Because of the poor situation at mealtime and my increasing mistrust of the home, my daughter and I tried to make sure that either she or I would be present most evenings to feed mother and help get her ready for bed. I cannot say how clean the other residents were kept, but I know my mother was never given perineal care that even approximated acceptable practices. When she had the catheter and bag, I never once witnessed them attending to even an examination of the catheter, let alone the cleaning of the external area with anything but a damp washcloth—no soap, no Betadyne, no lotion, no friction reducing powder, not even a towel drying of the area.

Later I was told that they removed the catheter, but the nurses notes reflect that it was found in the bed and they simply decided not to replace it. By this time, mother had developed a serious bladder infection that continued to give her the feeling of urgency. When she called for help to go to the bathroom, nursing staff continued to assume and say, "Oh, she always says that because of the catheter." When she finally could hold it no longer, they assumed

and said, "Oh, she's incontinent." The lack of perineal cleanliness after the so-called incontinence continued also.

When I complained because of the lack of any nursing care and any assistance with toileting they put mother on what they said was bladder-retraining. That program was largely ignored, however, becoming nothing more than a chart on the door, occasionally filled in at the end of a shift as though they had observed the routine toileting it called for. Sometimes it wasn't filled in at all.

They continued to say she was incontinent, without any evidence, whatsoever, that would show assessment based on data collection, charting or even haphazard observation to determine any pattern of incontinence. Meanwhile, the bladder infection and the feeling of urgency only increased.

Infection control at the home was not truly evident either. For example, there appeared to be no policy regarding handwashing between patients. Mother's catheter bag sometimes leaked all over the carpeting in the hallways, wet soil ignored even after I pointed it out. Once when she flooded the bathroom floor on the way to the toilet the overworked and underpaid, and probably undertrained attendant, wiped the urine with a dry mop and put the mop back in the closet without even rinsing it out.

There are several things which I would like to simply touch upon as they were again part of a pattern of neglect in the nursing home. Neglect, which in my opinion, constitutes abuse when it goes on day after day. Unnecessary restraints were used on mother and on others in her wheelchair, and in bed until I complained. They also put her on a chemical restraint, for "sleeping," which I stopped. She was to be repositioned frequently because of a developing bed sore and because of her arthritic condition. However, this was rarely done. Though my mother cannot communicate pain and discomfort as she used to, her pain and discomfort were real. It was the same pain and discomfort I saw on the faces of many residents who had no one to speak for them.

Little attention was paid to mother's fluid retention. Her legs would swell monstrously. But it was my daughter, or I, or a few kind aides who would elevate them in or out of bed. It was never a part of a care plan.

Restorative nursing techniques were not even properly assessed, let alone used. Out of ten keys on her assessment scale, only one was marked and it was not correct. It said she could operate a wheelchair, which she could not. Little, if any, actual attention was paid to other range of movement, alignment and positioning in bed to improve her condition or at least to try to keep her from deteriorating. Although very minor by comparison her finger nails were never cleaned or cut. Her hands were never washed when I was there after toileting, or before or after meals.

But the straw that broke the back of the so-called care was the improper assessment of her respiratory problems. It took a week of requests on my part, written and spoken, to get the nursing staff to pay attention to her distressed breathing. Finally, I demanded that if they would not call the doctor I would. Not until then did they put her on oxygen and increase her diuretic. But it was too late. The next day she ended up back in the hospital—cyanotic and desperately sick. In addition to the respiratory and renal failures, a

bladder infection, bed sores, skin rashes and infections, she had pneumonia and she also had a staph infection.

She remained in the hospital for more than three weeks. In the 39 days that mother resided in that home, she had lost 25 to 27 pounds and had gone downhill to a painful frailty. She now weighs 83 pounds.

Still the nursing home management continued its hostile defensive attitude, saying that because my mother was a private pay patient I expected special treatment and that the only problem was that I just could not be pleased. In fact, after mother was admitted to the hospital, the home, adding insult to injury, told me that it was my opportunity to seek a different facility for my mother. As Edna St. Vincent Millet said, "Not that this blow be dealt to me, but by thick hands and clumsily."

We did find another home, and though she has not been there very long, I do want to note the contrasts. On the surface at least, we have found the home to be cleaner and better staffed. It is a church run facility. The initial interviews were more thorough and professional. The assessment the staff gave my mother seemed more accurate and to the point. I believe that they made a greater effort to know mother before she entered the home and began receiving care.

Thus far I have approached the staff in the same manner as I did in the beginning at the first home. But the staff is more open to my impressions and some suggestions relating to mother's care. Although she has only been there two weeks, we have been able to work together to resolve any concerns that I may have. I have not been confronted with hostility, or stubbornness, and they have not denied the validity of my concerns.

My experience has taught me, however, the importance of visiting frequently on a varying pattern in order to stay finely in tune with mother's physical condition and the care she is given.

As for Brand X, I have taken the first steps in filing a formal complaint against the former home as I feel strongly that it is my responsibility to do so. I also intend to note the results of the investigation and to try to determine what follow-up there is so it won't simply be filed under forget.

This experience, Senator, has so changed my life that I can understand why every hour and 21 minutes an American senior citizen commits suicide. Where are those golden years?

Senator RIEGLE. I think that is probably as powerful and as clear a statement as I think I have ever heard anybody give. I thank you for taking the time to do it.

I think we ought to give Joan a round of applause, too.

[Applause.]

Senator RIEGLE. Not only for the time she has taken to prepare that account and share it with us, but also the kind of daughter she is and the kind of person that she is. I can see that your mother's 100,000 hours of volunteer work for the Red Cross was not lost on you in terms of your attitudes and your values. We appreciate the fact that your daughter, Emily, is here today.

[The prepared statement of Ms. Walker appears in the appendix.]

Senator RIEGLE. I want to move on to our next witnesses. But before doing so I just want to say we could have hundreds and hun-

dreds of people here today from across the State giving accounts such as you have just heard. These are particularly articulate witnesses who have very compelling stories to tell. But what they are saying, I think, constitutes a pattern that exists in many, many cases.

We have also heard the contrast, the difference between poor care and good care. We know that there are both kinds out there, and of course we do not want the good slandered by the bad, but we do not want the bad to get away with what they are doing because there are some that are good. Figuring out how we crack down in the most severe way in situations that are really inhuman and indecent is something for which we must find a better answer. Part of it is getting these national regulations finally in place 3 years after the law was passed. Also, other means of enforcement have to be taken up.

I also think that groups are going to have to get into this business. We need more people—it may well be churches, it may well be social organizations—or others who have a sense of human values who will see this large emerging unmet need and will take steps to provide, establish facilities. We must see to it that care is available in sufficient amounts and in sufficient type in order to start to meet these needs.

I will have more to say about that later. But I know Mr. Watkins has a pressing time problem.

I want to also insert into the record a letter we received from Mrs. Richard DeVos, who has also been active in this area with respect to nursing home activities for family members and others and who has written us a very useful letter. I want to make that letter a part of the record. I do not know if she is here in attendance at the moment. We appreciate that letter and all others that we will receive.

Senator RIEGLE. Let me just say in moving ahead, first to Ms. Wiener who is the Director of the Michigan Department of Public Health—I know Mr. Watkins apparently has a pressing time problem—and so if we may I am going to go right to Mr. Watkins and I appreciate your being here and what you will have to say to us. Let us here from you now.

STATEMENT OF THOMAS D. WATKINS, JR., DIRECTOR, MICHIGAN DEPARTMENT OF MENTAL HEALTH, LANSING, MI

Mr. WATKINS. Thank you, Senator. I appreciate your modifying the schedule. I do have another hearing to be in on the other side of the State. I am Tom Watkins, the Director of the Michigan Department of Mental Health and I appreciate being able to make a few comments regarding the quality of care in nursing homes, particularly as it affects persons who are mentally ill and persons who are developmentally disabled.

The Department of Mental Health has been addressing the quality of care in nursing homes for many years and the passage of the OBRA legislation in 1987 certainly has significantly increased our involvement. In 1977 the Department developed and funded projects at seven community mental health boards to provide mental health services in nursing homes. The Department contin-

ued to expand and support these programs even through the recession and severe fiscal crises of the early 1980s in our State. These nursing home consultation programs were given additional support in 1978 by the Michigan Legislature's passage of the nursing home reform provisions in the new Public Health Code.

Among other things, this law requires each nursing home to have an agreement with a local community mental health board to provide assistance and training to facilities in providing for the mental health needs of the residents in those homes. It also prohibits a nursing home from admitting any person with a mental illness or mental retardation for whom the facility is unable to provide active treatment for the person's mental illness or mental retardation.

We have also funded a number of aging specialist programs in community mental boards across the State. Given this history the Michigan Department of Mental Health supports the underlying principles of OBRA, particularly those which are intended to assure that persons with mental illness or developmental disabilities receive appropriate care and services.

While the concerns I will address may sound bureaucratic, particularly Juxtaposed to some of the testimony that we have just heard from parents and advocates, unfortunately there are problems in the statute and the implementation of this law which have prevented residents of nursing homes from fully realizing, and the State from fully implementing, the promises of this legislation.

First, unreasonable time frames and lack of final rules for implementation are major problems. Implementation of preadmission screening programs in an environment where hospitals, DRGs—Mrs. Walker touched upon that a moment ago—can limit adequate hospital discharge planning is a challenge, to say the least. Lack of professionals and adequate training of professionals make compliance with the law difficult. We have no problem with Congress setting sites high for high quality care. However, we need your help, Senator, in setting and assuring reasonable time frames in the implementation of this law, having HCFA—the Health Care Financing Administration—set rules that we are to follow and not continually change them; and certainly we can always use more Federal dollars to carry out these mandates.

As my colleague, Raj Wiener, from the Michigan Department of Public Health will discuss the manner in which the Health Care Financing Administration has failed to implement the provisions of OBRA has created confusion and uncertainty throughout the private and public sectors of the nursing home industry.

For example, as both the State Mental Health Authority—services for people with mental illness—and the Mental Retardation Authority, the Department of Mental Health has been intensely involved in the efforts to implement the mental health preadmission screening annual resident review process.

At this point in time the preadmission screening process has been in place for over 20 months and the deadline for the completion of the initial annual resident reviews, April 1, 1990, has come and gone. Yet, HCFA has failed in spite of two admonishments by you and other members of Congress to issue final criteria and rules for the preadmission screening and annual resident review process.

All that the States receive are periodic and confusing, contradictory "guidance" from HCFA. We constantly have to revise our system and procedures to meet each changing "guidance" from HCFA. We also are expected to enforce compliance by the nursing home industry, even though we are unable to provide it with a consistent, stable set of requirements. This is patently unfair.

We never know when HCFA will change the rules and stick the States with the fiscal consequences. We often times feel we are playing a fiscal shell game with HCFA, with the State—no, more importantly, the people. The people that are in these nursing homes are the ultimate losers.

Because the law mandates that the States must implement requirements even if the Federal Government does not issue final regulations in a timely manner we are faced with a specter of major disallowance in Federal financial participation, even if we do not implement HCFA requirements as they deem appropriate.

For example, one of the initial HCFA guidelines indicates that only persons with severe mental illness need to be screened. Most States, including Michigan, relied upon that direction. Within just 4 months HCFA changed its guidance to include all mental illnesses. At this point it appears that the State of Michigan could be subject to disallowance if these persons were not screened as HCFA now deems appropriate.

Another example is a mandate that the initial resident review process be completed by April 1, 1990 without Federal guidance and guidelines. These and many other obstacles have prevented Michigan and many other States from implementing this legislation in a timely and appropriate manner as we would have liked.

However, regardless of our good faith efforts Michigan and other States will be penalized financially for not implementing a law which was imposed on the States by the Federal Government, for which the Federal Government is unable to assist us in implementing. If HCFA rule writers were half as diligent as its auditors we would not be here discussing these problems today.

Senator RIEGLE. Maybe we ought to make the auditors the rule writers. Maybe that is the answer in this case.

Mr. WATKINS. It certainly could help. It could not hinder.

The potential loss of Federal dollars will mean much less services and less State money available to other persons that are vulnerable in our State as well. It seems that the Federal Government is more interested in placing the States in a Catch-22 than high quality care for persons in nursing homes.

In addition, the loss of Federal financial participation we face because of a problem with implementation, OBRA has also placed an additional financial burden on the States. In Michigan, in the human service area, we are dealing with overwhelming and competing demands for scarce resources. We have endeavored to balance these demands the best we can. As you know, Governor Blanchard has committed a tremendous amount of resources to human services. The Department of Mental Health Budget since 1983 is up over $600 million. With enactment of a law, such as OBRA, through well-intentioned imposes additional burdens on the State at the expense of other vulnerable populations.

Effectively, the Federal Government determines Michigan's human service priorities and then sends us the bill. It can be argued, of course, that this is the price the State pays for joint Federal/State participation in the Medicaid program. OBRA, however, goes beyond joint participation and imposes on the States service requirements for which only the States must pay.

For example, the OBRA legislation allows a person who has been inappropriately placed and requires active treatment to remain in the nursing home if he or she had resided in a nursing home for more than 30 months. If the person chooses to remain, the State must provide for active treatment without Federal financial participation in the cost of such services.

Already, HCFA auditors in Michigan have suggested that certain services being provided by nursing homes to persons who are developmentally disabled are active treatment services and therefore will be disallowed for Federal reimbursement. At the risk of sounding paranoid—which may be an occupational hazard from my particular position—it seems that HCFA is more interested in shifting costs to the State than in providing quality care to people who are in nursing homes.

I do not believe that it was Congress's intent in passing nursing home reform to try to shift the cost to the States to help solve the Federal deficit problems. In making these comments I would be remiss if I did not suggest some ways in which you could provide remedy to the existing situation.

First, consideration should be given to the good faith efforts that the States have made to comply with OBRA legislative requirements. HCFA should not be permitted to take disallowance, to take money away from States, for failure for implementing the law until reasonable time is allowed and until they have set final guidelines. We need to know what the target is.

This is consistent with recommendations from such organizations as the National Governor's Association, the National Association of State Mental Health Program Directors and the National Alliance for the Mentally Ill, that Congress add language prohibiting Health and Human Services and HCFA from imposing sanctions for noncompliance prior to the publication of final rules and preadmission screening and annual resident review appropriateness criteria.

Senator, we are more than willing to shoot at a moving target. But what HCFA has done is make the target invisible. Take your best shot, but if you miss there are big fiscal penalties for States to pay. Second, there is a movement on the part of various organizations to have Congress pass a number of technical amendments to OBRA. These concerns were not addressed last year and, unfortunately, it resulted in further confusion in the implementation.

One amendment of particular concern to my Department, the Department of Mental Health, is that States be permitted to amend their alternative disposition plans. As you know, each State was required to submit an alternative disposition plan to HCFA for the alternative placement for persons inappropriately placed in nursing homes.

Michigan has been granted an extension to October 1, 1994. This effort will require us to quadruple our community residential development efforts, the development of residential groups homes,

semi-independent living situations; and will cost the State approximately four times the amount, at a current cost for each individual, because we will be serving more individuals in a more expensive setting.

While we have committed ourselves to that effort, and we are going to diligently move in that direction, lack of financial resources from the Federal Government and other resources may delay implementation. Additional time makes this project more realistic.

Senator, as you know, Michigan is a national leader in developing high quality community-based services for people with mental illness and people with a developmental disability. More time for Michigan is not a delay tactic, I can assure you, but a more realistic one.

We have over the last few years, placed over 300 people in residential homes throughout the State and we are going to continue moving in that direction.

Lastly, if the legislative intent to prevent in appropriate admissions to nursing home facilities is driven out of concern for people (and not a solely cost-saving measure), the Federal Government should provide incentives to States like Michigan, which have a desire and a strong history of providing community-based alternatives. Additionally, more flexible Federal support is needed in order to provide mental health and mental retardation services to people, regardless of where they live.

Perhaps we need a Federal Headlee amendment to prevent the Federal Government from setting State priorities and then sending us the bill.

We, in Michigan, support quality care of all vulnerable citizens. We support the intent of OBRA. We want fair, consistent rules to follow, reasonable time frames for implementation and we want our Federal tax dollars to follow the Federal mandates.

You know, as we listen here today it reminds me that we are talking about serving people—people who are handicapped, but people first, not patients, not statistics, not case studies, but your family members and mine, our friends and relatives. And we have to keep that foremost in our minds as we implement this very important legislation to provide high quality care to people in nursing homes, people that are mentally ill and people that are developmentally disabled.

I want to thank you for the opportunity—first of all for having this hearing and giving me an opportunity to make these comments.

Senator RIEGLE. Very good. Thank you for an excellent presentation.

[Applause.]

Senator RIEGLE. You have made some important suggestions and they are ones that we will follow through on in the Finance Committee. I think all in attendance can see the importance of field hearings of this kind. The only way that you get down to the root of what the problems are, is to have this kind of a setting in which expert testimony can be taken and put together like fitting the pieces of a puzzle together. That will become even more obvious as we go through the rest of our witnesses today.

I very strongly agree with your point that it is wrong for the Federal Government to mandate things and not pay for them. That is part of the legacy of the 1980s and while it is very complicated, the economic strategy was designed to take a lot of the Federal money and send it off in other directions. This pushed a lot of problems down to the State and local units of government to solve these problems.

In most instances, it is very difficult to come up with the money at the State and local level. You see it in education, you see it in health care services. Revenue sharing has been discontinued and also a lot of other things.

This is a subject for a whole other debate; where did the money go? I mean the money that has been taken away from certain things and the mandates sent along—for instance, we have had a huge military build up over that period of time that should be the subject of discussion.

I appreciate the quality of your presentation and your leadership. I know you must go because you have to travel some distance. So let me thank you and excuse you at this time.

Mr. WATKINS. Thank you, Senator.

[The prepared statement of Mr. Watkins appears in the appendix.]

Senator RIEGLE. Let me say now in introducing Raj Wiener that I very much appreciate the strong leadership that you are giving as the Director of the Michigan Department of Public Health. I know you are here today representing the State Government and representing the Governor who I have spoken to about these issues. I know he feels very strongly about them, as do I. We have talked about how to get these Federal guidelines out of the bureaucracy so that we are in a stronger position to get this job done, the way it ought to be done. I appreciate the difficulties that the State faces in that situation and that is precisely why we want this hearing record, so that we can use it to compel actions that are overdue and have not yet taken place within the Department of Health and Human Services at the Federal level.

So with that we would be pleased to hear your testimony at this time.

STATEMENT OF RAJ M. WIENER, DIRECTOR, MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Ms. WIENER. Thank you, Mr. Chairman. I want to thank you for holding these hearings. There are many very troubling issues in the nursing home industry that we have to grapple with and I agree with you, we have to discuss them in these forums to get to the heart of the matter and make the changes that we need.

As you mentioned already there are 50,000 people in Michigan's nursing homes. In this State we spend in excess of $1 million a day to purchase adequate, decent nursing care for our residents.

Today I am going to focus my remarks on the areas that are of serious to us and I believe also to the rest of the country. First, the abuse and neglect continues despite our very best efforts over the years to strictly enforce standards for nursing home care and to improve the training and alert care that our nurse's aides get to

understand what proper care is, to identify abuse and to report abuse.

I am glad that you pointed out that there are many good homes in this State, Senator. But we have a serious problem with homes that continually stay at the margin. They slip, we go after them, they manage to revive themselves. They continue to stay licensed; they continue to stay in business; and they continue to offer substandard care.

In the area of abuse and neglect our own reports at this date indicate that we have seen a doubling of the reports of incidents of abuse and neglect since 1985. We have gone from about 400 cases a year to around 800 cases a year.

In 1986 the State of Michigan embarked on a plan to do something about these chronically bad homes. We had a Nursing Home Action Team that geared up and started doing many things that we thought focused in on these bad homes. And then in 1987 Congress passed the OBRA legislation and the regulators in this State and the advocates in this State rejoiced because we saw some very powerful tools, along with the promise of dollars, Federal dollars, for their support coming down the pike.

We spent a great deal of our energies over the next few years doing what was necessary to get geared up for the implementation of OBRA. As you know, 33 months later HCFA has failed to promulgate the rules and standards that we need to have. And with the reports of the increasing incidents that we were seeing I made a decision last month that we had to move forward as a State.

I want to tell you about some of the reorganizations we have put into place. We reorganized our Bureau of Health Facilities to better respond to the allegations of poor treatment and abuse. We established an Office of Nursing Home Compliance to coordinate all licensure and application activities. Because we believe this will improve our efficiency as well send a strong message to homes that such abuses will not be tolerated.

We have announced that we will be adding additional staff to the program that regulates nursing home care and to coordinate our complaint investigations investigating abuse and neglect allegations. I should tell you that no matter how many staff we add to our investigative teams we cannot post somebody at every bed and at every home. And the State is only in a home for periods of time, windows when we observe what is going on in a home, but it will require the diligence of families and communities to make sure that around-the-clock care is also good.

Also we are calling for further statutory changes to revise the current penalties and procedures that will allow us to deliver a faster response to nursing home violations. One example of the statutory changes we are requesting is that we be allowed to enforce in abuse cases the laws under the Adult Foster Care law which allows us to go after a home for patient-to-patient abuse. Up until now, under the Public Health Code we only looked at abuse where a nursing home was responsible or an employee of the nursing home was responsible. But it is clear from witnesses we have heard today that patient-to-patient abuse occurs, stranger-to-patient abuse and even sometimes family-to-patient abuse occurs.

We ought to be able to treat all of that. We are also looking for statutory changes that allow us to hold homes responsible when these things happen. The law currently allows that if a nursing home itself reports a case of abuse to us then we do not hold the home responsible. The idea is to encourage them not to hide abuse and make sure that it is reported. But I think we have reached a time now when we have to hold homes responsible as well.

The other legislative change we are seeking is automatic bans on admissions. That is something which is also in the Federal OBRA statute and we hope when those rules get written they will be similar to the ones we are writing here in Michigan. We do not want to go through a contested case hearing, a legal process, every time we have to take any kind of action on a home, including mandatory monitors and temporary managers. These requirements are all parallel to what Congress had intended in the Federal law.

Additionally, we have asked the Attorney General to dedicate two additional full-time attorneys to the nursing home enforcement cases and the State Health Department will provide the funding for these activities. And we have also directed the Department hearings unit to hire an additional hearings officer to expedite all the future nursing home enforcement cases that we expect we will see.

In addition, I want you to know, Senator, that this office will have my personal attention until we are sure that all cases of substandard care in Michigan nursing homes are routinely handled in an efficient and humane manner. We have been working very closely with Citizens for Better Care and other advocate groups to develop and strengthen the polices, the guidelines, that we will be putting into place.

As you already mentioned we have a greatly increasing aging population. We have reduced length of stays in hospitals. We have shortages of health care professionals. We have growing health care costs and all of these add to the complexity of the problems in health care. The needs of the nursing home population keep changing. And so I think we will need to constantly revise nursing home regulatory programs at both the State and the Federal level.

And if this example of taking 33 months to come up with Federal regulations is an example it does not hold well for the future, because we have to be able to respond much faster than we have responded up until now.

I would like to point out a few of the specific problems that we are having with the OBRA implementation in the hope that you, and this Committee, Mr. Chairman, will be able to influence the writing of these regulations at HCFA.

At the very starting point in the planning for appropriate care you have to have an adequate assessment of the needs of each nursing home resident. And to assure that all residents can be assessed HCFA issued a $1.5 million contract that produced an excellent and workable instrument. Unfortunately, all those nursing home residents who need action now have to wait because HCFA says they cannot implement this Nationwide until the formal ruling process takes place. And that is expected to take a whole other year.

So many States, including Michigan, have voluntarily requested that nursing homes use this draft resident assessment form. We are hoping that this will bridge the failure of the Federal Government to proceed in a timely and efficient manner. We like this new assessment tool because it allows us to observe what is going on in a nursing home, not just by going in and out on one day, but by observing over a period of time. How are they feeding, the residents? How are they dealing with the patient care?

And it also allows us greater flexibility. Somebody said earlier people knew when the surveyors were coming to the home. Before OBRA we had a window of time within which we had to do our surveys and every nursing home knew when that window of time was and they only had to be prepared during that time. Now it has been expanded to a 9-month period. That is part one of the new change we want formalized.

Another area is to provide an acceptable range of penalties or remedies when homes are out of compliance. The OBRA legislation clearly sets forth expectations that States will have a wide range of penalties, including severe civil fines, putting a ban of admitting new patients to the facility, putting in temporary managers, terminating the facility's ability to take care of Medicare and Medicaid patients, and otherwise giving those specific instructions of correcting deficiencies.

It was envisioned that this range of remedies could be used to tailor the remedy to appropriately match the observed deficiency and to stimulate facility compliance and correction. For two years, however, HCFA has been struggling with various provider groups, other interested parties, to develop a frame work for enforcement regulation, that would contain these concepts. And unfortunately there has not even been the publication of even the proposed regulations at this time.

Now here in Michigan we will go ahead with our own rules effective October 1. And so I suspect that when HCFA does come up with theirs there will be a time of confusion. We hope that the rules will be similar, but we feel the need to more forward.

I would like to explain why. Under the present system when we have found substandard homes we have tried to remove the license of that home. That is a very difficult thing to do because you have to follow due process. And we have not been successful. And during that course of time a home keeps on operating.

If we can use these intermediate sanctions, there are things that will force the home to correct the problems, even while the standard license is still in place and which will also put pressure on that operator to either correct or move in a temporary manager or bring in a monitor to take over the home.

Senator RIEGLE. Let me just stop you here and say that my inclination and intention at the moment is to seek this year a legislative mandate in some form. If the regulations are not ready to go on October 1—and it is very doubtful that they will be—we may have to craft a way to empower the States to move forward with their own regulations. Also that the States need to be held harmless to the extent that HCFA later comes along and says you did not do it right.

After this length of time, if a State is making a good faith effort to get these reforms in place they should be free to do so. I have talked with members of the Finance Committee about that and I am building some support. I am going to undertake to get that done so that you will have the kind of legal authority behind you to act without having to look over your shoulder and feel that you are going to be tripped up later in the game.

Just so that point is clear, and I want that clear for the public record.

Ms. WIENER. Thank you, Mr. Chairman. That legislation would be a great help to the State of Michigan and I know that we would also support you wholeheartedly in that effort.

Up until now HCFA's main effort has been simply to decertify homes when they are found to be substandard. What that means is they pull out all the Federal dollars. They leave the entire financial obligation—obviously, the moral, ethical obligation as well—on the State. And in order to draw in the Federal monies we have found ourself in a position where we have had to move patients out of the decertified Federal home into a certified home to capture those dollars. It is a very traumatic experience for families and for patients to be moved. It would be much better if we would oust the management of the home and could start fresh.

Senator RIEGLE. But do you have that power? Can you oust the management of the home?

Ms. WIENER. We are focusing the new State legislation that we are asking for on the ability to do that. Currently we can put in receivers, and it is a drastic step. We have used it only once in this State. We are looking for more intermediate steps, like temporary managers.

Senator RIEGLE. What other kinds of penalties are available in addition to removing somebody and replacing them with somebody else? Can you fine them? Can you seek a——

Ms. WIENER. We issue civil fines. We issue corrective actions. We issue bans on admissions. We now——

Senator RIEGLE. No, I mean to the people who are in charge. I am talking about the people that run an operation like that and who are profiting from it, and who consistently overrun the regulations. Are there criminal penalties in the law?

Ms. WIENER. There are criminal penalties if there is either Medicaid fraud involved or for patient abuse, assault.

Senator RIEGLE. But regarding chronic underperformance; If somebody skillfully does that purposefully they can get the extra money and at some point just walk away?

Ms. WIENER. That is correct.

Senator RIEGLE. I think we have to find a way to—we have to. I do not know what it is myself as I sit here. There needs to be another mechanism developed that provides a very powerful sanction to an individual who would be so inclined, so that they would pay a huge penalty. I am not quite sure how it ought to be defined, but somebody needs to go to work on that because it sounds to me that there is a gap in the law that ought to be filled.

Ms. WIENER. You are absolutely right, Mr. Chairman, it is a gap in the law; and we would support any efforts to deal with that as well.

In addition, you heard about the Medicaid—not the spend down—but requiring patients to come in as private pay for a period of time before they are Medicaid eligible. We have requested legislation to change that so we can stop that from happening. It has been pending for several years in our legislature and it could be, perhaps, stronger if the Federal Government looked at that issue as well.

There is one positive note I want to make about OBRA and that is that in this cycle additional Federal dollars were made available to the State of Michigan to help us with hiring the increased staff. We are very grateful for that. We do not know if we will have it in future cycles. We hear about Gramm-Rudman cuts. But in this cycle money has been made available to us.

In concluding, Mr. Chairman, I want to state that whether or not the Federal Government promulgates its rules, long after today we at the Michigan Department of Public Health will continue to be aggressive managers and to use our staff resources as effectively, as efficiently as we can. It is clear that public needs and expectations are changing and the need for Federal/State cooperation has never been greater. I hope today is a start in making that cooperation grow between the Executive Branches.

We intend to make our resources available in every way possible to assure that patients in our nursing homes are afforded not only protection from adversity but receive the services and care that will allow them to receive their maximum potential and to live in an atmosphere of dignity.

Thank you, Mr. Chairman.

Senator RIEGLE. Thank you very much. I think that is a very good presentation.

[Applause.]

Senator RIEGLE. I appreciate the constructive suggestions you have made. We will work with you to follow up on some of the specifics—some I mentioned and others I did not mention as you went along. I appreciate your personal leadership. I appreciate the Governor's leadership and commitment in this area. I think it is very important to continue to raise the standards and to stop the instances of abuse. I will develop some suggestions on my own.

I want to talk to some of the industry people who are here too, and get their ideas how to crack down on those providers, the ones that injure the reputation of the whole industry. I will want to hear their ideas.

Let me now move to our next witness, Hollis Turnham, who is also a very important witness for us today, because she is Michigan States long-term care Ombudsman for Citizens for Better Care. She is going to discuss also some of the recently enacted care reforms and the need for timely implementation.

Hollis, let me say I appreciate your leadership. You really are very important to a lot of people. We are running late today so I am going to have you summarize as best you can because I want to get through all our witnesses in the time we have. But let's hear from you now.

STATEMENT OF HOLLIS TURNHAM, MICHIGAN'S STATE LONG TERM CARE OMBUDSMAN FOR CITIZENS FOR BETTER CARE, LANSING, MI

Ms. TURNHAM. Certainly, Senator. I appreciate this. I must say that it was with great joy that I received a phone call from your staff saying that you wanted to use your position to look at these issues. It reminds me of the other wonderful phone call I got from legislative staff some 6 years ago when a State legislative staffer called me up and said that Grand Rapids own Tom Mathieu wanted to help the ombudsman program. And it is with that help, and his leadership here, that our program is able to help as many residents as possible.

I would also like to begin very briefly by talking about what I think is one of the most invigorating and worthful, and absolutely wonderful processes that is sweeping the nursing homes of this State. That is, a remedy to many of the issues you heard the family members talk about. That is that many of the homes in this State are going restraint free.

Last April over 200 nursing home administrators and owners came to Lansing to learn how to go through that process. A week from Thursday over 50 nursing home employees are going to extend their work day and spend their evening learning how to go about that process in Traverse City. And we expect and hope that other homes will move to that.

But getting more to the heart of what we need to talk about, and that is HCFA's failure to, as my momma would say, to get religion. HCFA does not understand at its base core the responsibility that the government needs to take on in terms of nursing homes that are deficient. It is their responsibility to evacuate the owners, not to evacuate the residents.

HCFA in some direct one-on-one discussions that we have had with the Regional Office simply does not understand and accept the principles that Congress and the Institute of Medicine saw. The resolution of this problem, is intermediate sanctions. Their attitude is, either the home meets the standards or you shut it down. While the surveyors that I have talked to and the people within HCFA that I have dealt with are dedicated to the principles of quality care, they really have not gotten religion that intermediate sanctions will work and that they are a viable solution and the needed solution for homes that do not meet compliance.

The principles of Citizens for Better Care and the Ombudsman Program is that unless the building is not capable of operating as a nursing home sufficiently to meet our standards, you do not shut it down. You come in with civil fines. You come in with bans on admissions. You come in with receivers and monitors to bring the facility back to standards. You then make a secondary determination as to whether or not those owners are capable of keeping it at that level. And if they are not, you get rid of them. You sell the facility to someone who is capable of running it in a manner that we expect.

Senator RIEGLE. Now is the law in place today to accomplish that on an expeditious basis?

Ms. TURNHAM. No, sir; it is not. In fact, it is 1 piece that Congress left out of OBRA in setting up what it terms temporary managers it only left two options for the temporary manager. Either get it back into shape and turn it back to the prior owner or close it. We think that Congress can take a look at, saying very specifically, that the States need to also consider the option of selling that resource, keeping that resource in the community and allowing it to continue to function.

Senator RIEGLE. I want to weigh how best to solve that, because that is a complex issue. It obviously is a gap in our law. Could we have a situation where the State as a part of the licensing requirement could compel a nursing home to agree to——

Ms. TURNHAM. Yes, sir.

Senator RIEGLE.—certain conditions that are enforceable, so that if nursing home veers way off course, that in effect they would have signed ahead of time an authority to allow the State to intervene. That is not a very attractive remedy particularly from the point of view of the bad operators in the nursing home business, but it seems to me—and I have to take a look at that in terms of where State law begins and ends and where Federal law begins and ends—the question is. What is the State's authority to go in there, and as you say take, and remove the management and in some fashion accomplish a turnover in manager.

Ms. TURNHAM. Right.

Senator RIEGLE. It may be that there is a way to build that in on the licensing side. That keeps certain people out of the business in the first place, and maybe those are the ones you want to keep out. I am not sure. But I just raise the question because I want to come back and examine that later.

Ms. TURNHAM. The idea of the possible solution that you had, Senator, is something that the State of Michigan has used in certain instances. But, it is not in terms of the law that allows them to do that. They have been quite creative recently in terms of some settlement agreements that they have used and implemented with homes that said, here are some triggers and you have agreed. You have agreed that you have been bad in the past. You have agreed that you are not going to be bad in the future. You have agreed that if you do be bad in the future this is what is going to happen to you.

I do not know that you could be, frankly, that creative in statute. However, I would say also that some States—Massachusetts, the District of Columbia—do have in-State law, specific clear power for the State Departments of Public Health upon determination and upon the approval of the court, the presiding Judge who is monitoring the receiver to sell the facility. And Massachusetts has used that.

Senator RIEGLE. Just in terms of the logic of the situation, if you take the Michigan experience, the fact is that Medicaid is paying essentially two-thirds of the cost and if you add on Medicare, the government finances 70 percent of the cost for people now in nursing homes in Michigan. In effect these are private operations, but one could argue a different kind of logic that they sort of belong to the public because we are paying 70 percent of the bill.

Ms. TURNHAM. Exactly.

Senator RIEGLE. So that the public accountability should be the driving force and it should be the foundation of the policy. I do not say that to be punitive. I want people to come in and provide good nursing home services. You have to structure it in such a way that it does not become too difficult for people to come and provide good quality service.

The fact of the matter is that if the public is in effect is paying two-thirds of the bill, then we have a right to expect certain standards of performance. If people are not going to meet those standards of performance then they ought to be out of the business. It is just that simple.

Ms. TURNHAM. Right. I think there are other principles that we have used in other areas in terms of government regulations—of insurance companies and other things—in terms of the public good outlaying private ownership. That does not mean that private ownership will be uncompensated. If the sale of that facility results in a profit after all of the bills have been paid for, the owners are duly entitled to that. If it does not result in a profit, then they, like any other business that sells at a loss, are stuck with that.

The philosophy that we hope is engendered in the enforcement system is that nursing homes be seen as the resource that they are to the community. And again, unless the building is not capable of providing quality care, that you find the owners that are capable of running that situation and you do it in a thoughtful process of first determining, are the current owners capable of learning how to do that. If they are not you get rid of them and you find somebody who is.

HCFA is light years from understanding that principle. They do not even understand the basic principle of doing anything other than taking away the Federal money. They have refused three direct, specific requests by us to implement the intermediate sanction of bans on payments for new admission. They admit that they have that power. They admit they need new regulations but they refuse to do it.

Senator RIEGLE. Now let me stop you there for a minute too. I am conscious of the time because we really must move along. I gather that your strong feeling about keeping the facility, assuming it is a decent facility, going with new management, new ownership, whatever, the fact is that we are so short of spaces now that if you were to take and yank the people out of nursing homes that are deficient, you really do not necessarily have another place to take them. Is that not also the case?

Ms. TURNHAM. That is part of it. But I think what more we are factoring in, Senator, as Van talked about, is the trauma of move.

Senator RIEGLE. Yes. No, no. I understand. I know there is that factor.

Ms. TURNHAM. There is a planned thoughtful move.

Senator RIEGLE. Right.

Ms. TURNHAM. And just as you said, that building, those employees, the system that they have developed, the support that it gives to the communities, the families, that needs to be preserved as much as possible.

Senator RIEGLE. Most of the people are going to come from that sort of immediate geographic area anyway.

Ms. TURNHAM. Right.

Senator RIEGLE. There is that factor as well.

Ms. TURNHAM. And why should we build a brand new building if we have a building that can function here but simply a management that cannot make it operate.

Senator RIEGLE. Okay. Please continue.

Ms. TURNHAM. Finally, on the enforcement issue I would like to bring to attention as Director Wiener was correct, we have not seen proposed formal regulations. But everybody who spends much time in this can get a copy of the leaked regulations. Those leaked regulations have two components that we are very concerned about. One is the scope and severity scale that we are concerned will result in there will never be a citation. The other is this concept of conflict resolution.

Yesterday's mail brought to me a letter from our national association, NCCNHR (the National Citizens Coalition for Nursing Home Reform) who have just gotten a special grant from the Institute of Dispute Resolution to do a real study of this conflict resolution. I look forward to participating in that and sharing that with you and your staff.

I would quickly just make two other major points. In terms of the Medicaid discrimination that goes on in this State, Minnesota and Ohio solved those problems. They wrote a State law that said you cannot discriminate. You have to have one waiting list and you cannot pick and chose among the wealthy and the healthy, which is what goes on now. That despite the fact that Congress did put a lot of protections in OBRA that we are very thankful for around Medicaid discrimination, that Congress in 1987 did not feel comfortable enough in mandating one waiting list.

One final point that I would like to make about the mental health provisions. Again, a proposal, a technical amendment, that we have seen frankly floated by everybody but us. And that is, that Congress amend OBRA to make the mental health preadmission screening process only applicable to Medicaid recipients. To say that rich people do not have to go through that screening process will geometrically increase the Medicaid discrimination problems that we have.

If Congress believes that the protections of that preadmission screening process are good public policy then rich people ought to have the benefit of that policy. We would encourage you to oppose that technical amendment.

Thank you.

[The prepared statement of Mr. Turnham appears in the appendix.]

Senator RIEGLE. Thank you. Those are excellent suggestions.

[Applause.]

Senator RIEGLE. I appreciate having them and appreciate your leadership. I must say that having this Subcommittee Chairmanship, in effect, come to Michigan, is a great advantage. Using the Subcommittee, as a base, we are developing a National health insurance approach that we are going to be bringing forward here shortly. But also, we can make sure, using our experience here at home that what is attempted at the Federal level is really fitting

together with what actually takes place at the local level and within the separate States.

That is why putting this mosaic together is so important. If you do not have all the pieces together it is very easy for there to be misunderstandings, gaps, or slip-ups. I appreciate that testimony very much.

Let me now move to our final panel. Our final panel consists of nursing home providers. They are going to share their experiences in administering nursing homes or working in a home. As I have said repeatedly today, the majority of homes in Michigan are good solid places in which people can get good, high quality care. They are not all that way, but most are.

Our three persons that we will be hearing from today are first, Gerry Baker, who is President of the Beecher Manor Nursing Home. He has been in the nursing home community for over 15 years and will share with us the challenges he faces in providing high quality care in Clio, Michigan.

Next, we will hear from Roger Myers who is the Administrator of the Michigan Masonic Homes in Alma, a not-for-profit organization. He is also Chairman of the Michigan Non-Profit Homes. With his years of experience, Roger will discuss the day-to-day issues relating to quality of care nursing homes and ways to improve care.

Finally, Irene Podein is the Executive Board Member of the Service Employees International Union, Local 79; and is now a Dietary Aide at the Shorehaven Nursing Home in Grandhaven. Having worked in nursing homes for 20 years, Irene will provide testimony on issues related to staffing shortages, training and wages.

We thank all of you for being here. This is also a very important part of this whole story that we need to have. Mr. Baker, thank you for coming over from Clio. We would like to start with you.

STATEMENT OF GERRY BAKER, PRESIDENT OF BEECHER MANOR, INC., BOARD OF DIRECTORS OF HEALTH CARE ASSOCIATION OF MICHIGAN, CLIO, MI

Mr. BAKER. Thank you. My name Gerry Baker and I appreciate the opportunity to testify this morning. I operate four skilled nursing facilities, and consult on several others, that are comprised of 463 beds and employ over 400 nursing facility employees.

I serve on the Board of Directors for the Health Care Associate of Michigan which represents 270 nursing homes in Michigan and on the Board of Directors of the American Health Care Association which represents 10,000 nursing homes throughout the Nation.

I am pleased for the opportunity to testify today on today's nursing homes on improving quality of care. I have been in the nursing home community for over 15 years and I am increasingly concerned about the challenges facing our facility as we strive to maintain, let alone improve, the quality of care for our patients.

Although still in its infancy this industry has come a very long way since the mid-1960s in terms of our professionalism and the quality of care we provide our patients. At the same time, the complexity of our task is increasing and the expectations placed upon

us by our patients, their families, the consumer advocates, legislators, and administrative agencies are accelerating even faster.

I would like to share with the Subcommittee this morning three areas of major concern as the 1990s unfold. One of those areas is new Federal requirements. The second area is scare nursing resources. And the third area is inadequate Medicaid reimbursement.

New Federal certification requirements. In December of 1987 Congress enacted the Omnibus Budget Reconciliation Act, better known as OBRA. And in it it contains several significant nursing home reforms for facilities participating in both Medicaid and Medicare. In Michigan we are already meeting many of the new requirements. We have registered director of nurses and licensed nurses around the clock. We have extensive patient right protections in place. But the scope of the new requirements is far reaching and all facilities are undertaking significant changes.

Some of the new requirements will be relatively simple to implement, like adjusting visitor policies, et cetera. Others are simple enough to understand, but very cumbersome to implement, like providing interest on patient trust funds at a $50 balance instead of the current $200 balance.

But then there are other requirements that are going to be extremely difficult to meet, like completing a comprehensive assessment within 4 days of a patient's admission on controlling physician about prescribing antipsychotic and so-called unnecessary drugs. Of grave concern are those requirements which appear to raise care standards by quantum leaps without clear guidance from the Health Care Finance Administration or the State enforcement agency as to what will be expected.

As we have heard in previous testimony, Michigan is going to begin implementing in October and I am not sure the funds that were intended by this Federal law will be accompanying that at that point in time.

For an example, the law reads that we will be required to provide to each resident the necessary care and services to attain or maintain the highest practicable physical, mental and social well being. What exactly does that mean? In fact, what I am afraid it is going to mean is that the surveyor's judgments, expectations and desires will be pitted against the professional judgment of my staff.

What extraordinary efforts will be expected within our limited resources?

Senator RIEGLE. Gerry, let me interrupt for a minute. I have to step out of the room just for a couple of minutes. I want you to continue with your testimony. I am going to ask Debbie Chang to sit in for me and chair here just momentarily. If you will excuse me I will be right back, but I must attend to one thing. But I would like you to continue.

Mr. BAKER. Let me go back to the question I just asked. What extraordinary efforts will be expected within our limited resources? We do not know. To compound the problem we will be held to new statutory requirements where in many cases there are no rules. HCFA has failed time and time again to provide and to propose the promulgated rules on a timely basis. At this point we expect to see final rules in September, with literally days before they go into effect October 1.

It is patently unfair to hold nursing homes responsible for meeting requirements that they have not had sufficient time to incorporate and without the opportunity to study new interpretive guidelines.

The next problem—scarce nursing resources. There has been much discussion nationally, and in Michigan for sure, of the nursing shortage. There is certainly a shortage in the communities that I serve. I am currently trying to hire ten nurses and have been running ads in six papers for the last 12 months to try to recruit nurses. And in most nursing homes that is an ongoing process. It is not a matter of figuring out how many months have you been looking for nurses.

The supply of nurses is very limited and there is no quick and easy solution. Nursing homes have been on the bottom of the rung of this ladder for many, many years in terms of offering competitive wages. We keep improving but wages in other health care categories are improving at the same time and the competition is very fierce.

In my own facilities, I am only able to pay a licensed practical nurse $12 an hour compared to the local hospital rate of $13, plus shift differentials, weekend differentials, full hospitalization paid. I can pay a registered nurse $13 an hour while hospitals in my area offer $16 plus shift differentials, weekend differentials, et cetera. In one of my facilities I start my nurses aides at $4.75 an hour, while the local hospital which does not hire very many aides, but does hire some nurse aids, starts at $7.50.

We can talk all we want about how money isn't everything, and that there are other benefits and intrinsic values that can be offered, but wages are a high priority to the person who is not making enough money right now.

In the past decade the ability to recruit and retain nursing staff has been further undermined by temporary personnel agencies—nursing pools. Because we have to meet rigid staff-to-patient ratios at all times, we are often forced to call upon nursing pools to provide fill-in staff. We need the pools. But once in the facility, their utilization seems to grow and grow. Other staff of ours become attracted to pool employment which permits them to pick and choose hours, pick and choose shifts, pick and choose the days that they want to work, while providing higher wages than what we can pay.

In two of my facilities I have had to use pool staff at the rate of $137,000 per year or $5.75 per patient day cost at that facility. And in another facility at the rate of $106,000 per year, and these figures are down from a year ago.

Inadequate Medicaid Reimbursement. The Medicaid program mandates that the reasonable costs of an efficiently, economically operated facility will be paid. In Michigan, however, payments have failed to keep pace with costs. I am serving an increasingly frail patient load with increasingly complex status and increasingly high care needs. The Medicaid payments have not keep pace with my costs for providing this care.

As a last resort a year ago, the Health Care Association of Michigan was joined by the Michigan Non-Profit Homes Association and we initiated a law suit in the Federal court to protest the State's low Medicaid rates. The Federal judge has issued a summary judg-

ment indicating that the State has not made a proper analysis of the true costs of providing care in the State of Michigan. We are hopeful that adequate payments will result from this court suit in the long term.

In my nursing homes which serve an elderly clientele, my Medicaid rates range from $54 to $59 per day. A patient with a hip fracture which comes to my facility from a hospital 1 day where the daily rate is $410 per day, is now receiving care at my facility at $56 a day. I do not suggest that we should be paid that higher rate; but I do contend that the rates are drastically out of balance.

With new requirements coming on line in October that we are not sure are going to be covered with payment, we have already had to gear up with preadmission screening of all patient-applicants to determine if they are mentally ill or mental retarded. We have expanded nurse aid training and testing. And this in itself is in jeopardy at this point in time. Dozens of things will require additional time and expenditures.

I do not want to have to paint a picture of a bleak future for nursing homes. What I would like to be able to do is to paint a bright future for my patients. We will continue to do the very best that we can to provide quality care for those that are entrusted to our care, but the challenges are very great. We ask for reasonable expectation and your support in meeting those expectations. And we offer whatever help we can give in making sure that the elderly in the State of Michigan receive the care that they deserve.

Thank you very much.

[The prepared statement of Mr. Baker appears in the appendix.]

Senator RIEGLE. Thank you, Mr. Baker.

[Applause.]

Senator RIEGLE. I appreciate the points you have made. I think the issue of the underpayment for Medicaid patients is a valid and important comment. It is part of the way the Government, all levels combined, try to get by with wanting a lot in the way of service and yet wanting to pay not very much for it. There is a point, where that just does not work.

Let me ask you, when you say that in the State of Michigan that about 270 nursing homes would belong to the State association. Did I hear that right?

Mr. BAKER. Yes.

Senator RIEGLE. Who does not belong? What kind of power, if any, do you have as a group to provide sanctions or standards that would, as an industry, cover those, for one reason or another, that do not belong to your Association?

Mr. BAKER. Any nursing home in the State of Michigan potentially could belong to our Association. It is a voluntary Association that a nursing home chooses to join. So with that in mind we do not have any power, nor am I sure we should have any power to sanction a nursing home with regard to their care. We certainly do have the right to have someone either as a member of our organization or not have a nursing home as a member of our organization.

Senator RIEGLE. Has this been discussed—I am not just aiming this at your industry, I mean this is a broader question. Peer review is becoming more and more of a fact in a lot of areas. We

rely on self-regulatory organizations in a lot of places, maybe more than we should. You see it in the stock market and a lot of other places. I wonder since good nursing homes are getting a bad rap from bad nursing homes, isn't in the interest of good nursing homes to find a way to differentiate who they are and who the other people are and get that message out.

Isn't that in your long-term business interest? Assuming, as I believe to be the case, you are in the good nursing home category.

Mr. BAKER. I certainly feel that we are.

Senator RIEGLE. Yes.

Mr. BAKER. I think in the long run it might very well serve our interest to do some more internal monitoring of ourselves as nursing home providers. I sometimes thing it becomes very difficult to begin to throw stones and to——

Senator RIEGLE. Let me make a suggestion to you. This is off the top of my head and there may be reasons why, upon reflection it would not be such a great idea. But off the top of my head it seems like a pretty good idea.

I would think that if you have nursing homes in the State that are showing a chronic pattern of sanctions and are continually running up with a very high number of violations and it happens time and time again, I think it ought to be publicized. The State has an obligation to do so. Also, I think you folks would have a good moral and business purpose in saying, that outfit over there is giving everybody a bad name. You should go on record as saying so as an Association, because of certain standards of conduct and whether they belong to your organization. We do not want to have the environment poisoned by a handful of operators that are really outside the accepted norms.

Especially with these new mandates coming down, the pressures that you are feeling are real. I am very sympathetic to the points that you raise in that area. I think it is all the more important that your good reputation be protected, maintained and enhanced. Part of the way that is done may be for the Association to be willing to speak out in a more forceful way about the people in the business who give the whole business a bad name.

Mr. BAKER. There has been that discussion in our Board meetings and in our meetings at the Association. We have not, at least at this point in time, taken a definitive stand that we want to come out against particular nursing homes that may or may not be having substantiated problems with their operation.

We certainly have come out publicly and will continue to do so that we do not support, nor will we ever support, abuse and neglect or anything like that in nursing homes. It may very well serve us and it is something that the Board is grappling with and will continue to grapple with, as to whether or not that would become part of our policy at the Michigan Health Care Association.

Senator RIEGLE. I would ask you to take that message back. I think the good reputation needs to be maintained and protected. The people that do not deserve to be in the business need to be isolated. There could be objective criteria, for example if a given place is cited over a 2-year period with three violations of a certain sort, I think there are limits that you would not tolerate in your own place. At some point there ought to be an objective standard.

I would like the public to be forewarned. People should not have to find out while a nursing home might have, as someone said, a pretty face, there ends up being an outrageous case of misconduct that somebody could have been forewarned about. If there are people out there who chronically have these problems and they are not a matter of public attention they probably ought to be. They probably ought to be.

Mr. BAKER. I agree.

Senator RIEGLE. I think it is in your interest as an operator to do that. You should not have to take the slander, the general slander, off those extreme examples.

Mr. BAKER. I agree.

Senator RIEGLE. In any event take that view back if you would for me.

Mr. BAKER. And if I could, you know, I think that just one point I would like to make with regard to looking at a nursing home and thinking about a nursing home, I think that anybody who is considering placing one of their patients or loved ones in a nursing home needs to make sure that they have gone to that nursing home, not just on one occasion, but on more than one occasion and to determine first-hand whether or not they can feel comfortable in that nursing home.

Certainly we have supported that as well as the advocate groups with regard to sending out information on what to look at in a nursing home.

Senator RIEGLE. Let me ask you one other question and then I want to move to Mr. Myers. Is our shortage of trained personnel, nursing personnel and other personnel, severe enough that we should undertake to actually implement a training program of some sort—Federal, State, whatever—to begin to get more people drawn into these professions and trained to do this work?

We have lots of chronically underemployed and unemployed people. We have, it appears to me, a real need and a shortage of trained personnel in this area. Isn't it in our interest as a citizenry to comment—I mean any of us could end up in a nursing home someday. A lot of the people in this room are going to end up in a nursing home someday and I may be one and you may be one and so forth. We want good care for ourselves, our loved ones or anybody for that matter, whether we know them or are connected to them or not.

Isn't it in our interest as a society, if we have a chronic shortage, to say, let's help get well-motivated, good hearted people who can attain these skills, get this training and come into this field so that we have enough people. Why should we not have enough people. That fact seems to me to be something we should not accept.

Mr. BAKER. I think there are several reasons why we have a shortage. But I could not agree with you more that yes, Michigan especially, needs to have a very active program with regard to recruiting people to go into the nursing field. We need to make sure they are paid a fair wage. We need to make sure that they can get their education in various types of schools. And we need to make sure that we are not excluding one type of nursing.

It seems to have been the trend in the last few years that unless they are R.N.s and even beyond that, unless they are degreed R.N.s

that we really cannot use them in the health care field. That certainly is not true in the nursing home industry. We have a tremendous need, especially as hospitals have gone to primary care, we have a tremendous need for licensed practical nurses, as well as R.N.s.

Senator RIEGLE. Yes, I would think so. I hear stories about people being tied in their wheelchairs restrained and they cannot get attention for just the normal activities such as being kept clean, fed properly, moved around and gotten up, so forth, these are skills that do not necessarily require a person who is a registered nurse.

There is a different level of care and training. It sounds as if we need thousands and thousands of people trained to do that other level of activity.

Mr. BAKER. I think one of the high points of OBRA as far as I am concerned as a nursing home provider, is the nurse aide training aspect of it. I think it is something that has been needed. It is something that we are going to certainly have additional costs as we try to get into it, and that has to be looked at. But I think it is an area that has been needed for years.

The nurses aides that we have taken through the training program and are now certified in Michigan, at least in my facilities, are very, very excited about that training. They are happy with what they are doing and happy to have gotten that training. I think that is one of the very good parts of OBRA.

Senator RIEGLE. Just thinking about what we can do within the confines of our own individual State, we may need to have a program for 3 years where we set higher goals to attract a number of young people or whatever age people around the State that are willing to come in and get a particular kind of training.

We could have some training centers established through our junior college system, community college system or whatever. A goal could be to find and train 5,000 additional people in this area in the next 3 years, period, even if we have to provide the tuition or if we provide the tuition and there is a 50 percent pay back over the next 5 years.

There are a number of disconnects that are occurring in this system. We all get elderly if God favors us with a long life. As a modern society have to face the concept that you can get to an advanced age and really you are in the situation where you are sort of warehoused—I mean in the worst case, and it may be that nobody cares about you or provides care for you or attention.

We have to commit ourselves to a different level of humanity, one to the other, in our system. We can afford to do it. It is not as if we cannot afford to do it. I think there is a moral reason for doing it. I also think you can probably make the case that it is good economics, all things considered. I mean it is decent. In the end, it is probably sound for the economic system that we care for one another are decent to one another, and we help people have good lives for as long as any of us draw a breath.

We have gotten off track. In the same way we take polystyrene cups and we throw them away after we use them once or twice, there is too much of that type of thinking that is creeping into our view toward people. This is starting to apply to people we do not know, whether it is older people, people who have special problems

or people who are different than us or somehow, somebody that we ignore or don't want to care about. We have to change those attitudes and that is an important part of this debate as well.

That is just a personal thought on my part. I don't ask you necessarily to respond to that.

Mr. BAKER. Just one other point, if I could. Really, two points. One being that many nursing homes in the State of Michigan already have a scholarship type—I certainly do in mine and I know many of my colleagues do too—have a scholarship type fund within the facility where we will at least partially fund the education of nurse aides or LPNs that want to become R.N.s or aides that want to become LPNs and so on, to try to perpetuate the idea that we need those people in our facilities working and certainly could build a coalition in Michigan that would be helpful to it.

The last point on nurse aide training, I think—and I need to talk with Debbie from your staff at a later time—is that the nurse aide training that Michigan and all of us have put in place, and we have worked hard—I think a coalition has developed and we have worked hard to try to put together a good nurse aide training program in Michigan—is in real jeopardy of being taken away from the nursing home setting where we need to be able to train our aides and get them certified.

That if, in fact, a facility is deficient on one requirement——now most of us know that there are several hundred requirements that a nursing home has to abide by—if you are deficient by one requirement for 2 years running—I am not necessarily talking about a serious requirement, and if it is a serious one then maybe the facility ought not be able to do some things——but if it is any requirement that you are deficient for 2 years running, you will not be allowed to train your aides at your facility. They have to be trained somewhere else.

If that were the case and that becomes law, only about 2.4 percent of the nursing homes in all of the United States will be able to train their own aides. And at a cost—We will never be able to cover that one. And the nurse aide training will go down the tubes as far as I am concerned. That is a high point in OBRA. We have to resolve that one.

Senator RIEGLE. Well I am glad to have you flag that. Let's take a look at it and see what we can do.

Mr. BAKER. Thank you.

Senator RIEGLE. I appreciate your testimony.

Mr. Myers?

STATEMENT OF ROGER L. MYERS, ADMINISTRATOR, MICHIGAN MASONIC HOMES, PRESIDENT OF MICHIGAN NON-PROFIT HOMES, ALMA, MI

Mr. MYERS. Thank you, Senator Riegle, for providing this opportunity to speak briefly on the vital issue of quality nursing home care.

I serve as the Administrator of the Michigan Masonic Home located in Alma, a position that I have held for the past 6 years. The Masonic Home is a large non-profit continuing care retirement community that provides comprehensive care services and accom-

modations to over 400 residents. As you know, this year we are proudly celebrating our 100th anniversary.

Our Home is sponsored as a major charitable activity of the State's Masonic fraternity. Since 1891 the Masonic Home's mission has been to provide its residents with the highest possible quality of life.

For the past 2 years I have also served as the Chairman of the Michigan Non-Profit Homes Association. This Association is composed of over 150 facilities and agencies that provide housing, care and services to the aging. In addition to its legislative, regulatory and other membership activities, MNPHA is a strong advocate for individuals who reside in long-term care facilities.

OBRA '87, which you have heard a lot about this morning. I respectfully urge you to seriously review the evolution of this piece of public policy. From its last minute insertion in the Bill through the drafting of regulations, with numerous clarifications of legislative intent, with several interpretations and reinterpretations, the filing of legal actions, a constant pattern of delay, delay, delay (at least 13 of the 16 regulatory deadlines have been missed) and now today, with October 1 (OBRA Day) just over a month away.

The process has been seriously flawed and it is doubtful that the results will produce whatever was fully envisioned at the beginning. It should be pointed out that even at this late date much uncertainly still surrounds several key provisions of OBRA. This uncertainty is not just felt by nursing homes, but it also exists with the State survey agencies and HCFA itself. Nevertheless, we are committed to complying with the new requirements to the very best of our ability. Hopefully very valuable lessons can be learned for the future by studying the history of OBRA and monitoring the impact of its implementation.

The HCFA nursing home data report. Something must be done to either dramatically improve the accuracy, validity and usefulness of this report or to discontinue its issuance. For 2 years now at significant taxpayer expense HCFA has produced this report that has received widespread criticism for being misleading and accurate, untimely, and generally of limited value to the public.

It should be pointed out that a far more valuable, complete, timely and accessible source of facility and survey compliance information already exists, at least in Michigan. All licensed nursing homes are required to post and make available for public inspection copies of the facility's statement of deficiencies and plans of corrections, along with any formal complaints that have been filed.

Copies of this information can also be reviewed and secured through various advocacy groups, such as Citizens for Better Care, the State's Long-Term Care Ombudsman's Office, and directly through the Michigan Department of Public Health.

Staffing crisis. Nursing homes have increasingly found themselves struggling to maintain adequate staffing levels. Most seriously has been the continuing shortage of nurses, although many homes are now experiencing difficulties in recruiting and retaining employees in other classifications.

Another striking example of this crisis is the shrinking percentage of physicians who are willing to provide care in a nursing home setting. It must be realized and fully appreciated that work

in a nursing home is hard, demanding work. The challenges are not just physical, but also psychological and emotional. Employees serve in a high stress environment and are constantly giving of themselves.

But in spite of this difficult setting I am proud to say that nursing home staff members around the country continue to serve residents with unparalleled commitment, compassion, and love.

Before the existing staffing crisis worsens decisive action must be taken. Part of this action will be the responsibility of the individual nursing home to improve the overall quality of the work environment and enhance job satisfaction.

However, four significant issues require broader public attention. You have touched on one a few minutes earlier. (1) Increased training and education in the fields of nursing and allied health; (2) increased governmental reimbursement that is specifically tied to or passed through for wage and benefit improvements; (3) increased recognition for the impacts of additional paperwork regulations and the unfair choice staff face between documentation at the nursing station and delivering care to the resident; and (4) vastly improved public attitudes, respect and appreciate for those individuals who pursue careers in the long-term care field.

I fear that unless these items can be positively addressed soon, then fewer and fewer people will choose to work in our facilities. These trends are already occurring and they must be reversed.

Charity and reimbursement. Non-profit nursing homes have a historic commitment to providing charitable care. Care that is rendered without regard to the resident's ability to pay. Although our homes embrace this noble mission, as the annual operating deficits have become greater and greater, economic realities must begin to be recognized.

In the case of the Masonic Home, our operating losses each year are in the range of $2 million dollars. Fortunately, these deficits are offset through personal contributions and other designated sources of fraternal charity. Over 50 percent of our residents receive support through either the Medicaid or the Supplemental Security Income Program. The levels of support provided under these programs is well short of the actual cost of care, services and accommodations furnished to our residents.

The shortfall between our cost per resident day and the Medicaid reimbursement rate is about $30 per day. The size of this gap is attributable to several factors, including the home's high programming and staffing levels; the home's decision to provide fair and competitive compensation and benefit programs to its staff; the home's unwillingness to engage in cost shifting to increase the rates charged to privately paying residents to make up a portion of the deficit; increasing regulatory requirements, many of which have little direct bearing on resident care; and finally, an organizational culture that is focused entirely on meeting the highest of resident expectations with limited regard for the financial bottom line.

We find the budgetary policies and practices of the State of Michigan pertaining to the Medicaid program to be most disturbing. There has already been reference made to the litigation that both Associations have been involved with for the past year.

On a national basis there is tremendous inequality in the Medicaid reimbursement rates paid by the respective States under their Federally-approved plans. Wide disparities exist with some rates well in excess of $100 per day and others less than $50 per day. Even after accounting for regional and cost of living factors, there is still a huge difference in funding provided, although the regulatory requirements are the same.

Assuring quality. How to measure and assure the quality of nursing home care is a critical question that is driving much of today's public policy activity. Arriving at an acceptable standard that defines quality is not a simple task. "Quality" is often determined by individual judgments, subjective feelings, personal backgrounds, as well as a person's values, opinions, desires, expectations, experiences and observations. Obviously, "quality" is evaluated somewhat differently by each individual.

Laws, regulations, inspections, advocacy organizations, associations, reports and reimbursement rates will not individually or collectively assure or improve the quality of nursing home care. They are——

Senator RIEGLE. Let me just stop you for a minute, Mr. Myers. We have to yield the room to the Center here in about 12 or 13 minutes, under an agreement that we had with them before and we have obviously been running a little long today because we have covered a lot of ground. What I am going to ask you to do, if you can, because I want to leave time for Ms. Podein as well, is if you can finish in about three or four minutes. I am going to make your full statement a part of the record, but I want to make sure that you hit the points that you really want to make in that period of time and then we will have time for our last witness. So if you would please continue.

Mr. MYERS. Thank you.

I was saying that they are important components of a much larger picture, a picture that is often overlooked. That picture is of the resident living in their home, the nursing home, and the overall quality of life that they have.

What is really needed is a new sense of partnership and collaboration between all the parties concerned with quality long-term care. Unfortunately, what presently exists could be characterized as an adversarial environment with a serious lack of understanding and cooperation. Without everyone working together for a common goal in the context of a shared strategy, we will continue to miss the only real opportunity to make a significant change.

Although quality care can and should be continually improved it must be stressed that the overall quality of care that is being provided in our nation's nursing homes is generally quite good. Unfortunately, it seems as though the public often has a negative perception of nursing homes. This can be partially attributed to a regrettable reporting bias on the part of the media where front page nursing home stories that typically are covered feature an isolated situation.

Of course, even a single significant problem or failure of a home to deliver quality care requires decisive corrective action to be taken. However, it must be realized that the vast majority of nursing homes provide good care. To some the story may not be sensa-

tional or newsworthy, but it is a real life story of unusual human commitment and compassion in a world that is sadly lacking in both.

Nursing homes have done a poor job of communicating their missions and share in the responsibility for the poor public impressions that exist. This will be changing as nursing homes become more active, open, vocal and participate in discussions designed to promote better and more accurate public understanding of what resident life is like in a nursing home.

In closing, again, thank you, Senator, for your invitation to be here this morning. As you consider scheduling other hearings around the State I respectfully suggest that it would be appropriate and valuable to actually hold such hearings in nursing homes. As previously stated, to better understand and appreciate the quality of nursing home care there is no better way than to visit them and to interact with the residents who live there.

Please accept my continued best wishes as you work positively to address this significant national concern.

Senator RIEGLE. Thank you very much. That is a very good statement.

[Applause.]

Senator RIEGLE. We will make the full statement a part of the record and I will give serious thought to conducting a hearing maybe right in a nursing home so that we have to think about where we are and the circumstances.

[The prepared statement of Mr. Myers appears in the appendix.]

Senator RIEGLE. Ms. Podein, you have been very patient and we appreciate it. You have been in this field yourself for many years. You have worked in a nursing home. So we would like to get your perspective now.

STATEMENT OF IRENE PODEIN, DIETARY AIDE, SHOREHAVEN NURSING HOME, EXECUTIVE BOARD MEMBER OF LOCAL 79, SERVICE EMPLOYEES INTERNATIONAL UNION, GRAND HAVEN, MI

Ms. PODEIN. Thank you, Mr. Chairman. On behalf of Service Employees International Union, Local 79, I thank you for the opportunity to testify on this issue of improving quality of care in the nursing home.

I am Irene Podein. I am an Executive Board member of SEIU, Local 79; and a dietary aide at Shorehaven Living Center in Grand Haven, MI. I worked in nursing homes for 20 years, and the last 15 at Shorehaven. 2 years ago I decided that after spending 18 years as a direct patient care nurse's aide I decided to move into the kitchen. I made that choice out of necessity for the concern of my own health and safety at the age of 56. I did not want to risk a back injury.

High staff turnover, inadequately trained staff, residents with a higher "acuity level", combined with the high incidence of workplace injuries to nursing home workers forced me to consider changing jobs. I was not quite sure how many more residents I would be able to care for without suffering an injury.

My decision to change jobs was caused by the increased demands being put on direct patient care personnel. And by that I mean the nurse's aides who are working on the floor doing the direct patient care for the residents. Short staffing is the most chronic problem we face. Recently in my nursing home a resident restrained in a geriatric chair disappeared and was later found a mile away at 8:00 a.m. in the middle of a busy street by the police and returned to the nursing home. Another patient who had had a hip replacement surgery was on a no-weight bearing status. A new employee came in to care for that patient, stood her up, which results in a trip to the hospital. Thank God there was nothing seriously wrong and no damage was done. But there was a great risk involved.

When a resident is not bathed in a timely fashion, when food is served cold, when bathroom trips do not come on time, and when male residents do not get shaved for two or 3 days, when residents are not turned on a timely basis, daily care not done until 2:00 p.m. in the afternoon, bed sores result. A shortage of staff is at the root of each of these problems. The residents all suffer indignities and a lack of self-respect in addition to the poor patient care. We sympathize with each of these residents. They deserve better.

We, as workers, suffer too. We know these residents deserve to be treated better, but with inadequate staff we are continuing making value decisions about who should get attention first. In recent years the level of acuity of our residents has increased considerably. A smaller number of residents take a greater amount of our time each day. This leaves less time for other residents. This is an extremely frustrating and stressful position to be put in day after day.

The frustration and stress build contribute to the high staff turnover. High staff turnover has real consequences when trying to provide adequate care and none of them are good. Sufficient staffing means simply having enough people to provide the basic kinds of care essential to residents' health and well being, such as feeding toileting and bathing, as well as the tender loving care needed for their emotional health.

I and my union do not feel that sufficient staffing is being provided now. We did a survey in 1987 and short-staffing is found to be the rule and not the exception. Seventy-seven percent of the respondents reported that short-staffing is a chronic problem.

This is in contrast with the official reporting of staffing levels to the MI Department of Public Health by the nursing home industry. If you simply accept the reporting of those State standards then you will not perceive a problem. When legislation in the MI House of Representatives was introduced to change the "staffing ratio" levels to include more nurse aides the nursing home industry opposed any changes, saying that not only were no more nurse aides needed, but "staffing ratios" should be eliminated altogether.

Higher turnover reduces staff morale, prevents the development of close, caring relationships, and decreases the continuity of resident care. Most observers, including the National Commission on Nursing, agree that inadequate pay and benefits are the primary obstacles to staff retention. Nursing homes, unless they are able to compete in the broader health care market, will continue to lose their experienced staff. We see the vast majority of aides, dietary

and housekeeping workers leave their jobs in nursing homes to take other unskilled jobs in the service sector, may for pay increases as small as 15-25 cents per hour.

MI's wage levels for nursing home workers is lower than the national average. And with the majority of funding for nursing homes coming from the Medicaid program, the State and Federal Governments are largely responsible for paying nursing home workers what amounts to poverty level wages. As a matter of fact, it is below the national poverty level, approximately $4,000 per year below the national level.

Our International President, John Sweeney, said 3 years ago—and it is still true today—". . . all attempts to provide high quality nursing care are, in part, doomed until we address the issue of fair wages. The issues of wages and quality patient care are tied together in the health care industry. And the constant changes of staff with little experience in nursing homes, means little 'continuity of care' for elderly residents. This is the key ingredient in providing quality care for the elderly."

This is why we recently testified in favor of H.R. 1649, to establish minimum wage and benefit rates for nursing personnel in nursing homes and why we lobbied for what is called the "wage pass-through" here in the MI Legislature. We now know that that has been revoked, but we would still like to see some strengthening of the OBRA law.

Number one, clarify that enhanced Federal Medicaid matching funds until October 1, 1991 for State expenditures with respect to nurse aide training and competency evaluation programs. MI recently discontinued funding nurse aide programs as a consequence of the industry's "Boren" lawsuit and Federal Judge Robert Bell's order. Ban charging nurse aides for registration fees by the State. MI does not presently charge but the current policy is left open as to whether fees will be charged in the future. Require that States provide current nurse aides with training materials, including manuals and practice examinations for certification tests. MI's current policy is ". . . any training or competency evaluation program that does not impose any charges to the nurse aide student cannot be considered an approved training program by the Department."

Senator RIEGLE. Ms. Podein, let me just say that if you could finish in another minute or so that would be helpful. Because I do not want to have us trespass on the organization here that needs the room. I do want to have your full statement in the record. So maybe I can ask you to make a couple of closing comments.

Ms. PODEIN. Okay.

Senator RIEGLE. I know it is hard to do that. I have had to do it myself and I know it is not easy.

Ms. PODEIN. In concluding, Senator Riegle, I want to say that increased enforcement, improved training, better access to care and less discrimination based on source of payment, protection of resident's rights and other measures, are all policies that myself and my union support.

While I have been working in a nursing home for 20 years, most of my rewards have come in knowing that I am helping another human being maintain a sense of dignity and self worth that they might not have otherwise had. In order to really improve the care

in our nation's nursing homes our government and society must recognize the dignity and self-worth of nursing home workers too.

Again, thank you for the opportunity to address your Committee.

Senator RIEGLE. Thank you very much.

[Applause.]

[The prepared statement of Ms. Podein appears in the appendix.]

Senator RIEGLE. Thank you for your professional commitment over those 20 years. I know you have given a lot of good care to people and that is appreciated.

Let me just conclude with a couple of remarks. We have had here today nearly 400 people in attendance earlier in the morning at the high point of our attendance. I think it is a tremendous showing of interest and concern about these problems.

These are problems that touch all of our lives, in many cases directly and certainly indirectly. It is something that we all have to be involved in. I think we have had excellent testimony from our witnesses today and I think we have had the chance to hear from across the range of the experience.

Some important steps need to be taken. We need to get these Federal guidelines handed down specifically and we need them now. I am going to continue to press in every way I can to get that done. Until that is done, the State of MI has to move ahead and I will do everything I can to empower the State to be able to do so, without fear that what they do in good faith will come back and be used against them later.

I think we have to find a way to crack down on the nursing home abuse that takes place in some of the nursing homes that are not doing a proper job. It is important that the good nursing homes not be slandered by the activities of the ones that are not as good. There are steps that need to be taken that are important, including even within the industry and within the Federal and State law.

I want to say as well, that we have got to have an obligation as a society to each other to face up to these issues. These issues are here. They are going on every single day. They need our attention as a society, as a whole. Not just a seniors group or family members of seniors who have this problem, but this is a problem that belongs to America, and it belongs to MI and it belongs to all of us.

We have heard today a number of constructive suggestions. I think we need to pursue those. As Chairman of this Subcommittee I intend to pursue them. I want to continue to work with everyone who has come today. Anyone who has statements that they want to give us for the record I will make them part of the record.

We are going to forward this record to Secretary Sullivan and ask him to examine this record and to see if we cannot get these regulations that have been referred to many times this morning, finished properly, and put into place so that we can have the positive effect of those reforms in the law.

With that, I want to again thank the Center for sharing their facility with us.

The Committee stands in recess so that the room can be reconfigured for the next activity today. Thank you all for coming. The Committee stands in recess.

[Applause.]

[Whereupon, the hearing recessed at 12:35 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF GERRY BAKER

I am Gerry Baker. I operate four skilled nursing facilities that are comprised of 463 beds. I employ over 400 nursing facility personnel. I also serve on the Board of Directors of the Health Care Association of Michigan, representing some 240 nursing facilities in Michigan and on the Board of Directors of the American Health Care Association, representing 10,000 facilities nationwide.

I am pleased for the opportunity to testify today on "Today's Nursing Homes: Improving Quality of Care." I have been in the nursing home community for over fifteen (15) years and I am increasingly concerned about the challenges facing our facilities as we strive to maintain—let alone improve—the quality of care for our patients.

Although still in its infancy, this industry has come a very long way since the mid-1960's in terms of our professionalism and the quality of care we provide our patients. At the same time, the complexity of our task is increasing and the expectations placed upon us by our patients, their families, the consumer advocates, legislators, and administrative agencies are accelerating even faster.

I would like to share with the Subcommittee three areas of major concern as the 1990's unfold: New Federal Requirements, Scarce Nursing Resources, and Inadequate Medicaid Reimbursement.

New Federal Certification Requirements—In December 1987, Congress enacted the Omnibus Budget Reconciliation Act (OBRA), containing significant nursing home reforms for facilities participating in Medicaid or Medicare. In Michigan we were already meeting many of the new requirements. We have Registered Nurse Directors of Nursing and licensed nurses around the clock. We have extensive patient rights protections in place. But the scope of the new requirements is far-reaching and we are all undertaking significant changes.

Some of the new requirements will be relatively simple to implement, like adjusting visitor policies. Others are simple enough to understand but cumbersome to implement, like providing interest on patient trust funds at a $50 balance instead of the current $200 balance. Many will be extremely difficult to meet, like completing a comprehensive assessment within four (4) days of a patient's admission and controlling physician practices for prescribing antipsychotic drugs and so called "unnecessary" drugs.

Of grave concern are those requirements which appear to raise care standards by a quantum leap without clear guidance from the Health Care Financing Administration or the state enforcement agency as to what will be expected. For example the law reads that we will be required to provide to each resident "the necessary care and services to attain or maintain the *highest practicable* physical, mental and psychosocial wellbeing." What exactly does that mean? In fact, it will mean surveyors judgements, expectations and desires will be pitted against the professional judgments of my staff. What extraordinary efforts will be expected within our limited resources? We don't know.

To compound the problem, we will be held to new statutory - requirements where in many cases there are no rule. HCFA has failed - time and again to propose and promulgate rules on a timely basis. At this point, we expect to see final rules in September, with literally days before they go into effect. It is patently unfair to hold nursing homes responsible for meeting requirements they have not had sufficient time to incorporate and without the opportunity to study new interpretive guidelines.

Scarce Nursing Resources—There has been much discussion nationally and in Michigan of the "Nursing Shortage." There is certainly a shortage in the communities I serve. I am currently trying to hire ten nurses and have been running ads in six papers for the past twelve months to try to recruit nurses. The supply of nurses is limited and there is no quick or easy solution.

Nursing homes have long been on the bottom rung of the ladder in terms of offering competitive wages. We keep improving, but wages in other health care categories are improving at the same time and the competition is fierce.

In my own facilities, I am only able to pay a licensed practical nurse $12.00 an hour compared to the local hospital rate of $13.00 plus shift and weekend differentials. I can pay a starting registered nurse $13.00 an hour, while hospitals in my area average $16.00 plus shift and weekend differentials. In one of my facilities, I start my nurse aides at $4.75 per hour while the local hospital pays their nurses aides $7.50 per hour.

We can talk all we want about how "Money isn't everything—that there are other benefits and intrinsic values to be offered." But wages *are* a high priority to the person who is not making enough money.

In the past decade, the ability to recruit and retain nursing staff has been further undermined by temporary personnel agencies nursing pools. Because we have to meet rigid staff-to-patient ratios at all times, we are often forced to call upon the nursing pools to provide fill-in staff. We need the pools. But once in the facility, their utilization grows. Other staff become attracted to pool employment which permits them to pick and choose hours, shifts and days to work, while providing higher wages. In my own facilities, I have had to use pool staff at the rate of $137,000.00 per year or $5.75 per patient day costs at one facility and in another facility at the rate of $106,000.00 per year costs. And these figures are down from a year ago.

Inadequate Medicaid Reimbursement—The Medicaid program mandates that the reasonable costs of an efficiently, economically operated facility will be paid. In Michigan, however, payments have failed to keep pace with costs. I am serving increasingly frail patients, with increasingly complex status, with increasing care needs. The Medicaid payments have not kept pace with my costs for providing care.

As a last resort a year ago, the Health Care Association of Michigan joined and the Michigan Non Profit Homes Association in initiating a lawsuit in Federal court to protest the State's Medicaid rates.

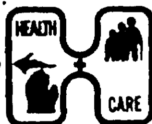
The Federal judge has issued a summary judgement, indicating the State *has not* made a proper analysis of the true costs of providing care. We are hopeful that adequate payments will result for the long term.

In my nursing homes which serve an elderly clientele, my Medicaid rates range from $54.00 to $59.00 per day. A patient with a hip fracture who comes to my facility from a hospital where the daily rate is about $410.00 per day, is now receiving care in my facility for $56.00. I don't suggest that I should be paid the higher rate; I do contend that the rates are drastically out of balance.

With new requirements coming on line in October, we have already had to gear up with preadmission screening of all patient-applicants to determine if they are mentally ill or retarded. We have expanded nurse aide training and testing. Dozens of things will require additional time and expenditures.

I do not want to paint a picture of a bleak future for nursing homes. I want a bright future for my patients. We will continue to do the very best we can to provide quality care for those entrusted to our care. But the challenges will be great. And we ask for reasonable expectations and your support in meeting those expectations.

Thank you.



Health Care Association of Michigan

Michigan Nursing Home Issues
REIMBURSEMENT - PAYING FOR QUALITY CARE

The Medicaid program currently does not pay its share of the costs to provide quality care in nursing homes. Only 30% of the homes are even paid their costs. Medicaid should pay for the quality residents deserve.

Background

Two of every three nursing home patients in Michigan rely upon Medicaid to fund most of their care. The 1990 average daily Medicaid rate is $55.00. This includes room and board, meals, 24 hour licensed nursing care, supervision and all other routine services.

The average daily Medicaid payment comes from three sources: $13.00 contribution from the resident (usually from Social Security and pension payment), $23.00 from the federal government and $19.00 from the state of Michigan.

Over 70% of the expenses involved with operating a nursing home are for staff wages and benefits. In order to operate these facilities so efficiently, nursing homes must rely upon the working poor and secondary wage earners. A significant number of employees of Michigan nursing homes are welfare recipients themselves. As a direct result of inadequate Medicaid rates the employees cannot be paid wages high enough to allow them to leave the welfare rolls.

Since 1980 the growth in the nursing home Medicaid appropriation has been slower than the Consumer Prices Index (see chart). This cost conscious approach to scarce health care resources keeps nursing home care the lowest cost option available for Michigan's elderly who need 24 hour nursing care for a chronic medical condition.

Status

Only 30% of nursing homes in Michigan receive a Medicaid rate that pays for their allowable costs. The other 70% must rely upon a high private pay rate, in part, to subsidize the Medicaid patient expenses. The average private pay rate is $75.00 per day.

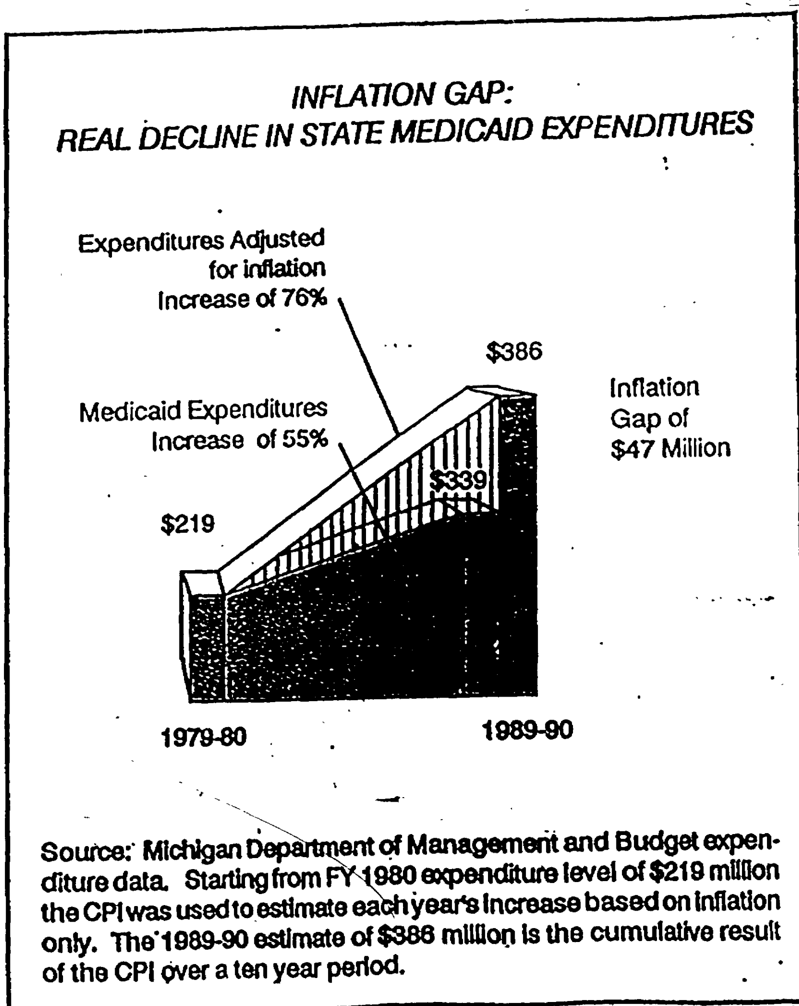
Even with the high private pay rate facilities incur a loss of over $9 million per year by participating in the Medicaid program.

The cost to care for nursing home patients continues to escalate as more patients are being released to facilities from hospitals with more acute medical conditions according to a research study reported in the January issue of the New England Journal of Medicine. In addition, new federal legislation is requiring additional staff and procedures to insure even higher quality of care.

HCAM's Position

HCAM believes the best assurance for continued quality care is the assurance that Medicaid rates pay for the legitimate expenditures to care for Michigan residents. Higher private pay rates cannot and should not be used to subsidize Medicaid underpayment.

Medicaid rates should be sufficient to provide an adequate wage to our employees and to provide to our patients the dignified care they deserve.



Source: Michigan Department of Management and Budget expenditure data. Starting from FY 1980 expenditure level of $219 million the CPI was used to estimate each year's increase based on inflation only. The 1989-90 estimate of $386 million is the cumulative result of the CPI over a ten year period.

PREPARED STATEMENT OF FAY JONES

Good Morning. I am Fay Jones and I live in Novi, Michigan. I am here today to share my experiences with you about my mother and my aunt.

My mother, Elsie Wickstrom, who is from the Upper Peninsula, was diagnosed with dementia of the Alzheimer type over 3 years ago. In February 1990, she became very confused and difficult to deal with. This took a hard toll on my father, who was the primary care giver. At that time, our family concluded that we needed to do something. After reviewing all of our options, we decided to put our mother in a nursing home. We placed her in the Novi Care Center because her sister was a resident there, it was close to my home, and it was the only one with available beds and without a long waiting list.

My mother was a resident at the Novi Care Center for 18 days. My family was not happy with the care she was receiving and decided to put her on a number of different nursing home waiting lists. While she was considered a private pay patient my father tried to see if she was eligible for Medicaid. Later, we found out that she was. During our search for another nursing home, we found that some will only take private pay patients. One home charges a base rate plus individual charges for such things as "wandering, confusion, and needs assistance with activities of daily living (ADL)," to name a few. For my mother's needs it could easily have cost my father $4000 per month. Another facility we checked into, you had to prove that you could privately pay for the first two years, and then be eligible for Medicaid.

My family was elated when a bed became available at Cypress Manor. We hoped our mother would receive much better care there and would now be close to my father.

I felt that the staff at the Novi Care Center really didn't care about my mother's well being. I was always intimidated with the many phone calls that I received from them. For instance, when they were concerned with my mother's wandering they called to tell me they were going to use physical or chemical restraints on her. At the time, I was afraid to disagree because I thought they would discharge her from their facility. I tried to explain to them that I thought the restraints would be very traumatic and unnecessary. I thought that they should be able to protect her from going outdoors without the use of these restraints. They listened to my feelings but I felt that I had to finally concede to physical and chemical restraints as they were giving me no other options.

In addition, the staff seemed to discourage us from visiting her. After putting mom in a nursing home, we wanted to keep her alert as much as possible. While she was at the Novi Care Center, the staff dissuaded us from taking her to one of our homes overnight, or out for an ice cream or even to church. They felt that it would take her much longer to adjust to the nursing home. I know this is not the case because when she was at Cypress Manor, we were encouraged to take her out and she seemed so much happier when we did.

I have noticed a lot of things that are different between the two nursing homes at which my mother stayed. Cypress Manor seems to give her the necessary, tender loving care that she needs. The staff assists her with bathing and dressing and presents her as a normal human being. They speak to her in a friendly way and are always asking if she had a nice walk or if she is having a good day. Once a month, they take the residents who are physically able on outings or walks. My mother has gone on these walks and like a typical patient with Alzheimer, seems to really enjoy them. In addition, the staff administrator is looking into a tracking device that will locate their wandering residents. Since my mother wanders, this will really help. In the meantime, they discontinued the chemical restraints she was receiving at the Novi Care Center and have simply taken her shoes away to prevent her from leaving the home.

Even though things are much better at Cypress Manor, everything is not perfect. For instance, several times we have asked the staff to make sure that mother take her bra and dentures out every night before going to sleep. It appears, however, that this has not been happening. We have noticed a rash which has a foul smell, underneath and between her breasts. She also has a sore on her bottom gums under her dentures that has not healed in the past month. Furthermore, my father recently noticed that the nursing home has been short staffed. These are problems which definitely need to be straightened out. While I realize that part of the problem is that my mother is resistant, I am working with the staff and hope to come up with some positive solutions to these problems.

I am also very concerned about the way my aunt, Esther Tauren, my mother's sister, was cared for prior to her death. My Aunt Esther was diagnosed with Alzheimer and was a patient at the Novi Care Center for approximately 4½ years. We

witnessed a number of unbelievable problems that occurred while she was a patient there.

On May 20, 1990, my husband and I went to visit her. We were very disturbed when we walked into her room and found her with two very black eyes. We were told we would have to talk with the charge nurse, if we wanted information. The charge nurse, who was on duty the night of my aunt's incident, informed us that she believed another patient hit Esther when Esther went into the other patient's room. I felt skeptical about this explanation and reported it to the State investigator from the Michigan Department of Public Health. They notified me that the nursing home was short staffed but that my aunt had not been abused. One week later, however, the same investigator called me to say that he met with his boss and they decided to change the report to patient to patient abuse. He informed me that the change was a direct result of the press coverage this incident received.

These were not isolated incidents. On June 24, 1990, late in the afternoon, my husband and I went to visit Aunt Esther. We were extremely upset to find her with her head hanging down on her chest. We tried to walk her down the A-wing but she seemed quite weak. We didn't know what was wrong with her until we looked into her mouth. There we found a mouthful of ground beef, which I assume was from her lunch. I scooped it out with my finger. While we could not physically lift her head to get her to drink, she lifted it herself—a clear indication of how dehydrated and desperate she was for a sip of water. When we informed the nurse, she told us that she would contact the doctor that day. We later learned the doctor didn't see her until two days later, at which time he sent her to Providence Hospital.

She was admitted to the hospital with many complications, including urosepsis and severe dehydration. Her sodium was elevated and her Potassium was low. She was impacted with stool and she had a staph infection in her blood. The bacteria in her bladder was the same bacteria that is found in feces. I think that she got the bladder infection from sitting in her feces, soiled clothing for long periods of time and from lack of fluids. Esther's daughter, Janet Pitcher, was very concerned about this incident and about the care her mother was receiving. She decided to have a care conference with the administrators of the Novi Care Center. She requested that her mother be given the proper amount of fluids during waking hours and that she be ambulated every two hours for at least ten minutes. She also discussed not using restraints on her mother, as she felt they were inhumane.

When Aunt Esther was released from Providence Hospital she was rehydrated and very full of energy. However, four days later, back in the nursing home, she passed away. The doctor wanted to treat this as a natural death. In spite of his account, we disagreed. We believed that poor care and neglect was the cause of her death as we had seen her so alive just days before. We also knew that two other patients had died the same day. It wasn't until we called in the Novi Police, that we received the results of the autopsy and discovered that she died of aspiration with food in her trachea from her throat to her lungs.

I have told you about the good care that my mother is now receiving at Cypress Manor. I have also told you about the poor and negligent care that my mother and aunt received while patients at Novi Care Center. No one should have to suffer the loss of dignity or die from poor care and neglect. My concern now is for all patients of nursing homes, whether they have families who can check on their care, or for the ones who have no family at all. I would like to see proper staffing in all nursing homes as well as the staff being properly educated to care for their patients. The security systems in nursing homes need to be improved for wandering patients.

I would like to see the State of Michigan enforce the laws that govern our nursing homes that already are in existence as well as the new laws that come into effect in October 1990. I was pleased to hear that the State has halted admissions to the Novi Center. This is certainly a start in the right direction. Medicaid and Medicare funds need to be reviewed. We need to find out if they are adequate to provide the services we need for our nursing home patients. We also need to find out why some nursing homes refuse to take patients who are on Medicaid.

I am grateful to God that He gave my aunt a good life prior to the onset of Alzheimer disease's. I will miss my aunt, but maybe God has allowed her death to happen at this time to make all of us aware of the problems that exist in our nursing homes.

Thank you for giving me this opportunity to testify at this hearing.

Attachments.

4323 PARK RIDGE RD.,
Novi, Michigan 48375, June 25, 1990.

Dear Mr. Buchanan: Please consider this a formal request to investigate a situation that I feel warrants your department's attention. This situation involves my aunt, Esther Tauren, and the Novi Care Center, located at 24500 Meadowbrook Rd., Novi, Michigan 48375. She has lived at the Novi Care Center nursing home for 4 to 5 years. She has Alzheimers disease and no longer communicates. She is in room A-1.

On May 20, 1990, my husband, Ron and I went to visit my aunt Esther Tauren at Novi Care Center. We found her sitting in her wheelchair in the lobby with 2 black eyes. When I would touch her hands or my husband would put his hand on her shoulder, she would jerk back as if she were afraid of something. Enclosed is a picture taken of her 3 days later. I spoke with one of the male aides who said no one was on the wing at the time of the incident and I would have to talk with the nurse, Joe, who was the nurse in charge of that wing that evening. Joe told me that another patient named [deleted] hit Esther when Esther went into [deleted] room. ([deleted] full name is [deleted] and she is in room [deleted]. I have been told by one of the nursing staff that [deleted] has mental retardation and schizophrenia, and that she has hit other people before.)

Also on June 15, 1990, I noticed 2 small bruises on Esther's chin just below her lower lip. When I asked the nurse on duty what happened, she could not find a report of any injury.

When I visit my aunt, she is usually restrained in a wheelchair and is almost always wet and soiled from being incontinent. When I take her for a walk, several of the staff have told me that they didn't know that she could walk. When I question if they exercise her for 10 minutes every 2 hours as is required by the Federal guidelines, they inform me that they are too short staffed and don't have time to walk her.

I appreciate your attention on these matters. I also believe the home does not have enough help to do the work to protect and care for the patients. Please check into this and get back to me within 30 days. I have also notified the local Citizens for Better Care office and I ask that copy of the complaint investigation report be sent them, to the attention of Ms. Karen M. Williams.

Sincerely,

FAY N. JONES, *Niece of Esther Tauren.*

CITIZENS FOR BETTER CARE,
Detroit, MI, July 19, 1990.

JAMES BUCHANAN, *Chief,*
Complaint Investigation Unit,
Division of Licensing and Certification,
Bureau of Health Care Facilities,
Michigan Department of Public Health,
P.O. Box 30195,
Lansing, MI 48909

Dear Mr. Buchanan: Please consider this letter as a formal request for MDPH to investigate the death of Esther Tauren on July 9, 1990 at Novi Care Center. Ms. Tauren's family is concerned that her death may have been caused by negligence of staff at the facility. I have enclosed copies of newspaper accounts describing the concerns of family members.

On June 25, 1990, Faye Jones, Ms. Tauren's niece, filed a complaint (copy enclosed) with your office regarding other concerns about care at Novi Care Center. Ms. Jones has asked that you add these new concerns to her earlier complaint and respond to her and us on the results of your investigation. Ms. Jones can be reached at (313) 322-7499 (work) or (313) 349-5795 (home) for additional information.

We look forward to receiving a copy of your investigative report as soon as possible.

Sincerely,

KAREN WILLIAMS, *Project Coordinator.*

Enclosures.

4323 Park Ridge Rd.,
Novi, MI, July 26, 1990.

James Buchanan, *Chief,*
Complaint Investigation Unit,
Division of Licensing and Certification,
Bureau of Health Care Facilities,
Michigan Department of Public Health,
P.O. Box 30195,
Lansing, MI 48909

Dear Mr. Buchanan: On June 25, 1990, I wrote to you to request an investigation regarding the care that my aunt, Esther Tauren, was receiving at the Novi Care Center, 24500 Meadowbrook Rd., Novi, MI 48375. I received a letter from you dated July 9, 1990 with the assigned Complaint No. 90-0641. I also spoke with you on the phone on either July 12 or 13, 1990 to update you on my aunt. I informed you that my aunt passed away on July 9, 1990 from asphyxiation, with food in her trachea from her throat to her lungs, and she was also dehydrated. I also informed you at that time that the Novi Police were doing an investigation into her death.

Prior to her death, she was a patient at Providence Hospital in Southfield, MI, from June 26 to July 5, 1990, with a diagnosis of urosepsis. She was severely dehydrated and also impacted with stool. Her Sodium was elevated and her Potassium was low. Her EKG and chest x-ray were normal. After she was rehydrated, she seemed so full energy, trying to swing her legs out of bed. Her eyes seemed so alert as she watched almost every move that I made. When I made kissing sounds with my lips, she took my hand and started kissing it.

While my aunt was in the hospital, her daughter, Lorna, put Esther on the waiting list at Cypress Manor Nursing home in Hancock, Michigan. On June 28, 1990, Esther's daughter, Janet Pitcher, visited Oak Hill Nursing Home in Farmington, MI. The admission's director there suggested that Janet discuss the problems of her mother's care with the staff at Novi Care Center and would not commit to whether a bed was available at Oak Hill Nursing Home. Janet also contacted Whitehall Convalescent Home on 10 Mile Rd, Novi, MI and was told that they only take private pay patients who can pay for 2 years.

On June 29, 1990, Janet Pitcher had a care conference at Novi Care Center with Jim Tiffen, Administrator, and Sally, Director of Nurses, regarding Esther Tauren. Janet had also spoken with Kim at Citizen's for Better Care regarding Esther's care planning, prior to the meeting at Novi Care Center. Janet requested that a bladder and bowel training program be tried and also that she be changed promptly when she was wet with urine or soiled with stool. She requested that Esther be given an 8-oz glass of water every 2 hours while awake and be ambulated every 2 hours for 10 minutes. She discussed not using restraints on her mother and they said that she would have to sign a release so they would not be liable for any injuries and that Janet would be responsible for the injuries. Janet said that she would have to get back to them regarding the issue of restraints. When Janet discussed the problem of her mother's dehydration, Jim Tiffen and Sally said that at least 70% of the patients who are admitted to the hospital are admitted to the hospital with a diagnosis of dehydration because the hospital can get more money from the insurance and can keep the patients for 7 days. Jim Tiffen and Sally said they would continue to provide the finest of care for Esther after her release from the hospital. The above information may be confirmed by contacting Janet Pitcher, daughter of Esther Tauren. at (313) 344-9638.

On July 9, 1990, Janet called me to say that her mother died. I was the first to arrive at Novi Care Cent as I lived the closest. I asked Joe, the nurse on the A-wing what happened and did he check Esther's mouth for food. He said her color was gone and he checked for breathing. He also said that 2 other patients had died that same day. From my understanding, no attempts were made to clear the airway and the physician pronounced my aunt dead over the telephone. Joe said that someone from the funeral home was on their way to pick up her body. Because of the previous problems with the care that my aunt had received at Novi Care Center and having just been released from the hospital 4 days prior to this, rehydrated and with a normal EKG and a normal chest x-ray. we had difficulty accepting this as a natural death. We called in the Novi Police and on July 11 1990 the Oakland County Medical Examiner did an autopsy. Esther's brain was sent to Duke University for Alzheimer's research.

I feel that I need to express some of my feelings about the care that nursing home patients receive and especially those patients who are totally dependent for their

care from the staff. I have to question if 70% of the patients admitted to the hospital from the nursing home are dehydrated, what does that say for the care that the patients are receiving. Are they not receiving the proper nutrition and fluid intake? Sitting in clothing that is wet and soiled with urine and stool, certainly could contribute to bladder and vaginal infections. Stool impactions can be caused by lack of adequate fluids and proper nutrition and lack of exercise. As this relates to my aunt Esther. she was a good eater and she enjoyed walking.

Finally I would like to let you know how much I miss my aunt Esther. I know she is at peace with her Heavenly Father as she knew Him as her Personal Savior. I will miss our walks around the nursing home and being able to exchange some friendly words with the other patients. I will miss her kisses and smiles. I will miss the look she would give me when she would babble a few words. Did she know what she was she trying to say? How did she know how to unclasp my bracelet and then try to clasp it back together on my visit to her on May 20, 1990? Will we ever understand Alzheimers?

Mr. Buchanan. I know I have to look ahead. My mother, Elsie Wickstrom, who is Esther's sister, also has Alzheimers and was a patient at Novi Care Center from March 12-30, 1990. She is now a patient at Cypress Manor in Hancock, MI, and is receiving very good care. She is a wanderer as Esther was in her earlier stage of Alzheimers. That in itself is a big problem. At this time, I am asking you to investigate if we have adequate staffing who are properly trained in our nursing homes. How is the security system in our nursing homes, especially for our wandering patients? The Preamble to the PATIENT/RESIDENT BILL OF RIGHTS states that every nursing home patient and home for the aged resident shall be entitled to humane care and treatment and to consideration consistent with recognition of his human dignity. Are our nursing homes providing this?

I appreciate your attention to this letter.

Sincerely,

FAY JONES, *Niece of Esther Tauren.*

37-792 - 91 - 3

PROGRESS NOTES

Last Name	First Name	Attending Physician	Room No.	Hosp. No.
Wickstrom	Elsie	Dr. A. Slaim	A15A	0024

Date | Notes Should Be Signed by Physician

THIS IS TO CERTIFY THAT THIS PATIENT/RESIDENT HAS BEEN INFORMED OF HIS/HER MEDICAL CONDITION EXCEPT AS NOTED:

☑ UNABLE TO COMPREHEND.

☐ DETRIMENTAL TO PATIENT WELFARE.

☐ RESPONSIBLE PARTY NOTIFIED

COMMENT: ....

3/14/90 — DATE

[signature] — PHYSICIAN SIGNATURE

3/14/90 Admit 74 y/o w/f see H&P; orders.
Anticipated length of stay indeterminate.
Discharge potential inappropriate.
[signature]

UTILIZATION REVIEW
[signature] 3/20/90

3/20 Pt is confused & disoriented. She is frequently walking out of the facility onto the main roads. The family has been informed many times that this is obviously dangerous to Mrs Wickstrom. They were reluctant to allow us to restrain her or to medicate her to modify her behavior. But as it is not possible to lock all the doors or have an aide watch her for 24 hrs the options were ~~[illegible]~~ to transfer Mrs W to another facility or to medicate her to prevent a possible injury (i.e. - Being struck by a car). The family therefore has agreed to [illegible] placing her on medication. Haldol [illegible] mg BID was started. The dosage may be changed depending on the results.

WHEN YOU REACH THIS POINT, TURN THE SHEET OVER TO USE OTHER SIDE

Dr. [signature] Signature

Form 65 Briggs/Will Ross, Inc., Des Moines, Iowa 50306 — PROGRESS NOTES

PREPARED STATEMENT OF ROGER L. MYERS

Thank you Senator Riegle for providing this opportunity to speak briefly on the vital issue of Quality Nursing Home Care.

PERSONAL BACKGROUND

My name is Roger Myers and I presently serve as the Administrator of the Michigan Masonic Home located in Alma, Michigan, a position that I have held for the past six years. Prior to my employment with the Masonic Home I held various other administrative positions in the health care field, including experience in both acute and long term care facilities. The Masonic Home is a large, non-profit, continuing care retirement community (also referred to as a CCRC) that provides comprehensive care, services and accommodations to over 400 elderly residents. As you know, this year we are proudly celebrating our 100th anniversary. Our Home is sponsored as a major charitable activity of the State's Masonic Fraternity. Since 1891 the Masonic Home's mission has been to provide its residents with the highest possible quality of life. The expectations of our Board members and of our fraternal constituency of 85,000 members would settle for nothing less. More importantly, our residents deserve and are entitled to the best that we can provide. For the past two years I have also served as the Chairman of the Michigan Non Profit Homes Association (MNPHA). This Association is composed of over 150 facilities and agencies that provide housing, care and services to the aging. I am proud to say that a review of our membership roster will show that nearly all of the State's non profit nursing homes are active members of MNPHA. In addition to its legislative, regulatory and other membership activities, MNPHA is a strong advocate for individuals who reside in long term care facilities.

OBRA 1987

I respectfully urge you to seriously review the legislative and regulatory evolution of this piece of public policy. From its last minute insertion in the Bill late in 1987, through the drafting and issuance of regulations, with numerous clarifications of legislative intent, with several interpretations and reinterpretations, the filing of legal actions, missed implementation schedules, a constant pattern of delay, delay, delay (at least 13 of 16 regulatory deadlines have been missed by HCFA) and now today with October 1st (OBRA DAY) just over a month away. The process has been seriously flawed and it is doubtful that the results will produce whatever was envisioned at the beginning. It should be pointed out that even at this late date much uncertainty still surrounds several key provisions of OBRA. This uncertainty is not just felt by nursing homes, but it also exists within State Survey Agencies and the Health Care Finance Administration itself. Nevertheless, we are committed to complying with the new requirements to the very best of our ability. Hopefully, valuable lessons can be learned for the future by studying the history of OBRA and monitoring the impact of its implementation.

HCFA NURSING HOME DATA REPORT

Something must be done to either dramatically improve the accuracy, validity and usefulness of this report or to discontinue its issuance. For two years now, at significant tax payer expense, the Health Care Finance Administration has produced this report that has received wide spread criticism for being misleading, inaccurate, untimely and generally of limited value to the public.

Unfortunately, the Masonic Home fell victim to a significant error in the Report that was released in late May of this year. The report, that was released nationally with great fanfare, incorrectly stated that we had failed to meet a selected performance indicator of ensuring procedures regarding residents rights/responsibilities. We immediately contacted the Michigan Department of Public Health and the Regional Office of the Health Care Finance Administration to address our concern. They quickly acknowledged the error and assisted us in communicating this fact to the media. I have attached three communications pertaining to this episode and draw your attention to the last sentence in HCFA's letter that states "we regret any inconvenience this may have caused." I am sure that you are aware of the countless other examples of mistakes from around the country. You can be assured that these mistakes were much more than mere inconveniences for those homes affected by them.

It should also be pointed out that a far more valuable, complete, timely and accessible source of facility survey and compliance information already exists (at least in Michigan). All licensed nursing homes are required to post and make available for

public inspection copies of the facility's Statement of Deficiency and Plan of Correction along with any formal complaints that have been filed with the Michigan Department of Public Health. Copies of this information can also be reviewed and secured through various advocacy groups (such as Citizens for Better Care), the State's Long Term Care Ombudsman's Office and directly through the Department of Public Health.

STAFFING CRISIS

Nursing Homes have increasingly found themselves struggling to maintain adequate staffing levels. Most seriously, has been the continuing shortage of nurses, although many homes are now experiencing difficulties in recruiting and retaining employees in other classifications. Another striking example of this crisis is the shrinking percentage of physicians who are willing to provide care in a nursing home.

It must be realized and fully appreciated that work in a nursing home is hard, demanding work. The challenges are not just physical, but also psychological and emotional. Employees often serve in a high stress environment, where they are constantly giving of themselves. As you might expect, burn out frequently occurs. But, in spite of this difficult setting, I am proud to say that nursing home staff members around the country continue to serve residents with unparalleled commitment, compassion and love.

Before the existing staffing crisis worsens, decisive action must be taken. Part of this action will be the responsibility of the individual nursing home to improve the overall quality of the work environment and enhance job satisfaction. However, four significant issues require broader public action: (i) increased training/education in the fields of nursing and allied health, (ii) increased governmental reimbursement (Medicaid/Medicare) that is specifically tied to or passed through for wage and benefit improvements, (iii) increased recognition for the impacts of additional "paper work" regulations/requirements and the unfair choice staff face between documentation at the nursing station and delivering care to the resident and (iv) vastly improve public attitudes, respect and appreciation for those individuals who pursue careers in the long term care field.

I fear that unless these items can each be positively addressed soon, then fewer and fewer people will chose to work in our facilities. These trends are already occurring and they must be reversed.

CHARITY AND REIMBURSEMENT

Non profit nursing homes have a historic commitment to providing charitable care. Care that is rendered without regard to the resident's ability to pay or other sources of potential payment. Although our homes embrace this noble mission, as the annual operating deficits become greater and greater, economic realities must begin to be recognized.

In the case of the Masonic Home, our operating losses each year are in the range of two million dollars. Fortunately, these deficits are offset through personal contributions and other designated sources of fraternal charity. Over fifty percent (50%) of our residents receive support through either the Medicaid or the Supplemental Security Income (SSI) Program. The levels of support provided under these programs is well short of the actual cost of care, services and accommodations furnished to the resident. The shortfall between our cost per resident day and the Medicaid reimbursement rate is about thirty dollars ($30.00) per day. The size of this gap is attributable to several factors, including: (i) the home's high programming and staffing levels, (ii) the home's decision to provide fair and competitive compensation and benefit programs to its staff, (iii) the home's unwillingness to engage in "cost shifting" to increase the rates charged to privately paying residents to make up a portion of the deficit, (iv) increasing regulatory requirements, many of which have little direct bearing on resident care and (v) an organizational culture that has focused entirely on meeting the highest of resident expectations with limited regard for the financial bottom line.

We find the budgetary policies and practices of the State of Michigan pertaining to the Medicaid Program to be most disturbing. After attempting, without success, for years to reach a compromise with the State that would provide for a more reasonable Medicaid rate setting methodology that recognizes the real costs involved in providing nursing home care, within the past year the State's two nursing home associations filed a joint law suit seeking judicial relief. Earlier this Summer Federal District Judge Bell issued a summary judgment in favor of our position and ordered the State to develop a new methodology for his review within 180 days. This legal

action has already cost the State's nursing homes close to one million dollars. Nevertheless, we believe that the issues in this matter are of great principle and relate direct to our ability to provide quality resident care.

On a national basis there is tremendous inequality in the Medicaid reimbursement rates paid by the respective State's under their federally approved plans. Wide disparities exist with some rates well in excess of $100 per day and other less than $50 per day. Even after accounting for regional and cost of living factors, there still is a huge difference in funding provided, although the regulatory requirements are the same.

ASSURING QUALITY

How to measure and assure the quality of nursing home care is a critical question that is driving much of today's public policy activity. Arriving at an acceptable standard that defines quality is not a simple task. "Quality" is often determined by individual judgments, subjective feelings, personal backgrounds, as well as a person's values, opinions, desires, expectations, experiences and observations. obviously, "Quality" is evaluated somewhat differently by each individual.

Laws, regulations, inspections, advocacy organizations, associations, reports and reimbursement rates will not individually or collectively assure or improve the quality of nursing home care. They are important components of a much larger picture . . . a picture that is often overlooked. That picture is of the resident living in *their HOME*, the nursing home, and the overall quality of life that they have. Many other factors impact on this larger picture. For example, (i) the closeness of friends/family members, frequency of visits and quality of these relationships, (ii) the resident's physical health status, (iii) emotional, psychological, social and spiritual issues, (iv) societal expectations, images and self fulling views about life in a nursing home and (v) potential losses of independence and diminished privacy by living in a congregate setting. Nursing homes have a strong responsibility and a moral obligation to actively promote quality care, services and accommodations for each resident.

What is really needed is a new sense of partnership and collaboration between all the parties concerned with quality long term care. Unfortunately, what presently exists could be characterized as an adversarial environment with a serious lack of understanding and cooperation. Without everyone working together toward a common goal in the context of a shared strategy, we will continue to miss the only real opportunity to make a significant change.

Although quality care can be and should be continually improved, it must be stressed that the overall quality of care that is being provided in our Nation's nursing homes is generally quite good. Unfortunately, it seems as though the public often has a negative perception of nursing homes. This can be partially attributed to a regrettable reporting bias on the part of the media where the front page nursing home stories that typically are covered feature a isolated situation. Of course, even a single significant problem or failure of a home to deliver quality care requires decisive corrective action to be taken. However, is must be realized that the vast majority of nursing homes provide good care. To some this story may not be sensational or newsworthy, but it is a real life story of unusual human commitment and compassion in a world that is sadly lacking in both. Nursing homes have done a poor job of communicating their missions and shares in the responsibility for the poor public impressions that exist. This will be changing, as nursing homes become more active, open, vocal and participate in discussions designed to promote a better and more accurate public understanding of what resident life is like in a nursing home.

I urge the public to always remember that the very best way to evaluate the quality of a nursing home is to make unannounced visits often and at different times; visit several homes to have a better basis for making comparisons; talk with the residents who live there, ask questions and listen; talk with staff members from different departments, ask questions and listen, and; use all of your senses to make a qualitative assessment. Certainly, you can review inspection reports and speak with outside agencies, however, there is no substitute for personal contacts.

CLOSING

Again, thank you Senator for your invitation to be here this morning. We greatly appreciate your personal interest in these vitally important matters. As you consider scheduling other hearings around the State, I respectfully suggest that it would be appropriate and valuable to actually hold such hearings in nursing homes. As previously stated, to better understand and appreciate quality nursing home care there is no better way than to visit them and to interact with the residents who live

there. Senator, you have previously been invited by MNPHA staff to drop in, unannounced, at any area member nursing home. We hope you will be able to accept that invitation. It will enthrall the residents and staff of that home, and enhance their esteem. It will also signal your personal interest in obtaining firsthand experiences with quality long term care, which is the hallmark of the non-profit sector. Please accept my continued best wishes as you work to positively address this significant national concern.

Attachments.

MICHIGAN MASONIC HOME,
Alma, MI, May 24, 1990.

MARK DYKSTRA, *Program Representative,*
Survey and Certification operations Branch,
Division of Health Standards and Quality,
Health Care Finance Administration,
Department of Health and Human Services,
Regional office,
105 West Adams Street, 15th Floor,
Chicago, Illinois 60603-6201

Re: HCFA Survey Report Nursing Home Profile, MICHIGAN MASONIC HOME, Alma, Michigan, Survey Date, 2/10/89

Dear Mr. Dykstra: The Michigan Masonic Home wishes to formally advise you of significant factual errors that exist in the above cited report. This notification is also to confirm conversations that you had yesterday with representatives of the Michigan Department of Public Health concerning these unfortunate mistakes.

As you know, four of the F numbers listed on the fourth page of our report (page 40 in the specific volume) were incorrectly—listed. These F numbers are F051, F055, F240 and F260. Of greatest concern are F numbers F051 and F055. These mistakenly reported deficiencies caused one of the Selected Performance Indicators to be inaccurately classified as "Not Met." This Performance Indicator was the first one listed and concerned the facility's performance of ensuring procedures regarding resident rights/responsibilities. Furthermore, since the report indicated that there was only one facility in Michigan that did not meet this requirement, namely the Michigan Masonic Home, it reflects an undeserved poor image of our facility to the public.

My point in writing this letter is not to address blame for the error (although the cause should be identified so as to avoid recurrence), rather the Michigan Masonic Home requests an official statement from your office pertaining to the error that has been made. Many hours were spent yesterday in conversations with the public, the media and our fraternal constituency in response to this regrettable incident. Once we have had the time to more fully assess the consequences of this error, further correspondence may be forthcoming. In the meanwhile, we would appreciate your immediate attention to this matter.

Sincerely,

ROGER L. MYERS, *Administrator.*

STATE OF MICHIGAN, DEPARTMENT OF PUBLIC HEALTH,
Lansing, MI, May 30, 1990.

ROGER L. MYERS, *Administrator.*
Michigan Masonic Home,
1200 Wright Avenue,
Alma, MI 48801

Dear Mr. Myers: Your concern with the Medicare/Medicaid Nursing Home Information 1988-1989 document produced by the U.S. Department of Health and Human Services, Health Care Financing Administration has been referred to my attention.

The Division of Licensing and Certification of the Michigan Department of Public Health conducted the annual survey of the Michigan Masonic Home February 7-10, 1989. Items F051, F055, F240 and F260 do not appear in the Statement of Deficiencies generated as a result of that survey.

We have already clarified this matter with members of the news media and will continue to do so.

I hope that this letter will be helpful in setting the record straight.

Sincerely,

WALTER S. WHEELER III, *Chief, Bureau of Health Facilities.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Chicago, IL, June 25, 1990.

ROGER L. MYERS, *Administrator,*
Michigan Masonic Home,
1200 Wright Avenue,
Alma, Michigan 48801

Dear Mr. Myers: This in response to your letter of May 24, 1990 regarding deficiencies cited for the survey performed at your facility on February 10, 1989. You indicated that data tags F051, F055, F240, and F260 were incorrectly identified as deficiencies in our computer records.

You are correct in stating that these data tags should not appear as deficiencies for the survey performed in 1989. Their presence in our records is due to a computer input error.

Since the 1990 survey has already been entered, we are unable to modify the 1989 data that has previously been entered into the system. Therefore, you may cite this letter as evidence that the deficiencies were not present during the 1989 survey.

We regret any inconvenience this may have caused.

Sincerely,

MARK DYKSTRA, *Program Representative, Survey & Certification Operations Branch Division of Health Standards & Quality.*

PREPARED STATEMENT OF IRENE PODEIN

I am Irene Podein, Executive Board member of SEIU Local 79, and a Dietary Aide at Shorehaven Nursing Home in Grand Haven, MI. SEIU Local 79 is Michigan's largest health care workers union, representing employees in more than 200 nursing homes, hospitals and Red Cross centers, both in the private and public sector. On behalf of local 79's 17,000 Michigan members, I thank you Mr. Chairman, for the opportunity to testify today on the issue of improving the quality of care in nursing homes.

I have worked in nursing homes in Michigan for 20 years. The last 15 years at my present place of employment, Shorehaven Nursing Home. Just 2 years ago, in 1988, I decided, after spending 18 years providing direct patient care as a nurse aide, to move into the kitchen. I made this choice out of necessity and out of concern for my own health and safety. High staff turnover, inadequately trained staff, residents with a higher "acuity level," or sicker residents, combined with the inordinately high incidence of workplace injuries to nursing home workers forced me to reconsider my options at 56 years of age.[1] Quite frankly, I wasn't sure how many more residents I would be able to lift by myself before my back gave out

My decision to change jobs was caused by the increased demands being put on direct patient care personnel. Shortstaffing is the most chronic problem we face. Recently, in my nursing home, a resident disappeared and was later found 1 mile away in the middle of a street. Without adequate staff, this resident got lost in the shuffle. When a resident is not bathed in a timely fashion, when food is served cold, when bathroom trips don't come on time, when a resident doesn't get shaved for 2-3 days, when residents are not turned in their beds often enough so that bed sores result, a shortage of staff is at the root of each of these problems. The residents all

[1] According to the Bureau of Labor Statistics, there are 14.8 injuries per year for every 100 full-time nursing home workers. The national average is 8.3 injuries per 100 full-time workers. This is a higher incidence rate than coal miners, factory workers and construction workers.

suffer indignities and a lack of self respect in addition to the poor patient care. We sympathize with each of these residents. They deserve better.

We as workers suffer, too. We know these residents deserve to be treated better. But with inadequate staff we are continually making value decisions about who should get attention first. In recent years, the level of acuity of our residents has increased considerably. A smaller number of residents take a greater amount of our time each day. This leaves less time for other residents. This is an extremely frustrating and stressful situation to be put in day after day.

The frustration and stress build and contribute to the high staff turnover. High staff turnover has real consequences when trying to provide adequate care, and none of them are good. Recently, one of our more frail residents had been designated as "no-weight bearing," meaning they cannot stand on their own. Not knowing this, a new employee stood the patient out of bed, resulting in that resident having to be transported to the hospital for treatment.

Sufficient staffing means simply having enough people to provide the basic kinds of care essential to residents' health and well-being, such as feeding, toileting, and bathing, as well as the tender loving care needed for their emotional health. I and my union do not feel that sufficient staffing is being provided now. Local 79 surveyed our members in 1987 and found short-staffing to be the rule, not the exception. Fully 77% of the respondents reported that short-staffing is "often" a problem at their facility, and 21% more responded that it is "sometimes" a problem.

This is in contrast with the "official" reporting of staffing levels to the Michigan Department of Public Health by the nursing home industry. If you simply accept the reporting of State standards, then you will not perceive a problem. When legislation in the Michigan House of Representatives was introduced to change the "staffing ratio" levels to include more nurse aides the nursing home industry opposed any changes, saying that not only were no more nurse aides needed but "staffing ratios" should be eliminated altogether.

Reduced turnover rates are generally associated with improved care for nursing home residents. High turnover reduces staff morale, prevents the development of close, caring relationships, and decreases the continuity of resident care. Most observers, including the National Commission on Nursing, agree that inadequate pay and benefits are the primary obstacles to staff retention. Nursing homes, unless they are able to compete in the broader health care market, will continue to lose their experienced staff. We see the vast majority of aides, dietary, and housekeeping workers leave their jobs in nursing homes to take other unskilled jobs in the service sector, many for pay increases as small as 15-25 cents per hour.

Michigan's wage levels for nursing home workers is lower than the national average. And with the majority of funding for nursing homes coming from the Medicaid program, the State and Federal governments are largely responsible for paying nursing home workers what amounts to poverty level wages.[2]

Our International President, John Sweeney, said it best 3 years ago in testimony before the House of Representatives, and it is still true today, ". . . all attempts to provide high quality nursing care are, in part, doomed until we address the issue of fair wages. The issues of wages and quality patient care are inextricably tied together in the health care industry. Low wages and inadequate benefits are a recipe for high turnover. And the constant changes of staff with little experience in nursing homes, mean little "continuity of care" for elderly patients. This is the key ingredient in providing quality care for the elderly."

This is why we recently testified in favor of H.R. 1649, to establish minimum wage and benefits rates for nursing personnel in nursing homes and why we lobbied for what is called the "wage pass-through" here in the Michigan legislature.

Our union worked hard, in conjunction with many other organizations, for the OBRA 1987 amendments and subsequent fine tunings in 1989. The legislation's efforts to provide assessments of all residents, to strengthen inspections of the industry, to protect residents' rights and to provide more equal access and equal services to the poor and to provide a base level of training to nurse aides, a nursing homes primary caregiver, will go a long way to upgrading the standards of care given our Nation's elderly in nursing homes.

We would still like to see some strengthening of the OBRA law. Specifically:

1. Clarity that enhanced Federal Medicaid matching funds will be available until October 1, 1991 for State expenditures with respect to nurse aide training and competency evaluation programs. Michigan recently discontinued funding nurse aide

[2] "Why Ending the Wage Pass-Through is Unfair to Michigan Nursing Home Workers," SEIU Michigan Council 35, August 1990.

training, as a consequence of the industries "Boren" lawsuit and Federal Judge, Robert Bell's, order. The State Medicaid agency assures us that funding will be available, once again, at the start of next years State fiscal budget.

2. Ban charging nurse aides for registration fees by the State. Michigan presently does not charge a registration fee and for that they should be commended. But in the Departments (MDPH) current policy it is left open as to whether fees will be charged in the future. Charging fees to workers whose average wage is below the poverty level is not fair in our estimation.

3. Require that States provide current nurse aides with training materials, including manuals and practice examinations, free of charge, for certification tests. Michigan's current policy is ". . . any training or competency evaluation program that does impose any charges to the nurse aide students cannot be considered an approved training program by this Department." We are in agreement with MDPH's policy.

4. Prohibit the use of nurse aides from a temporary agency, nursing pool or other outside personnel agency unless that aide has successfully completed the same competency evaluation or the same training and competency evaluation as permanent nurse aides must complete. The temporary aides must also be on the State nurse aide registry. Michigan is in the forefront of this policy nationally. Michigan DPH is to be commended and we would hope that the Senate and Congress would embrace this important policy for the rest of the country.

5. Specify that 75% of the nurse aides employed by a facility must have passed the competency evaluation and be listed on the State registry.

6. Add due process provisions to the abuse and neglect registry to protect individual due process rights including the right: to notice of action; to fair investigation and hearing; to representation; to copies of the record; to call and examine witnesses; to present evidence; to submit written statement; to challenge and appeal the decision; and to receive a written decision.

7. Require 6 hours of paid continuing in-service training and education for nurse aides per three months.

8. Clarify that States are free to grandmother nurse aides under guidelines of OBRA 1989 without triggering any additional training requirements.

9. Clarify that deemed and waived aides are to be listed on the State registry. This is where we have a serious disagreement with the MDPS. The department waives the testing requirement for employees with at least 24 months of job experience, as the Federal law allows, but then takes away the benefit of that job longevity by refusing to place these "grandmothered" employees on the registry. By doing so they limit an employees job mobility and deny the experience that the Federal law recognized. While the department is on the forefront with some other OBRA-inspired policies, they are the only State we are aware of that punishes long-time employees by refusing then access to the nurse aide registry because they meet the Federal "grandparenting" statute provision.

In concluding, Senator Riegle, I want to say that increased enforcement, improved training, better access to care and less discrimination based on source of payment, protection of resident's rights and other measures, are all policies that myself and my union support

While I've been working in nursing homes for 20 years, most of my rewards have come in knowing that I'm helping another human being maintain a sense of dignity and self worth that they might not have otherwise had. In order to really improve the care in our Nation's nursing homes our government and society must recognize the dignity and self worth of nursing home workers, too. Again, thank you for the opportunity to address your committee.

Prepared Statement of Senator Donald W. Riegle, Jr.

Good Morning. This is an official hearing of the Senate Finance Subcommittee on Health for Families and the Uninsured that we have been planning since May this year. Today, we will be examining quality of care in nursing homes and ways to ensure high quality care for our elderly and frail Americans. With over 50,000 Michigan citizens in nursing homes, and over 450 homes, we have an obligation to see that they get the best possible care.

We have some important witnesses that will testify, including families and guardians of nursing home residents, State government officials, advocates, and nursing home providers. I welcome others to submit their testimony in writing or orally to my staff. All testimony will be included in the official transcript of the hearing.

In this country, we spend over $43 billion on nursing home care. In Michigan alone, we spend $148 million. Close to one-half of the cost of nursing home care is paid by the Federal government, primarily through the Medicaid program. With such a huge investment of our Federal government, this Subcommittee is holding this oversight hearing to be sure that our citizens are getting the care they need and deserve.

In Michigan, the Medicaid program finances the care for about two-thirds of all our nursing home residents. In fact, less than one-third of nursing home care is paid for with private payments or insurance.

This fall marks the third year since Congress passed the Nursing Home Reform Act of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) and the deadline for its full implementation. This landmark legislation was enacted to ensure high quality care in nursing homes under Medicare and Medicaid. I was an original co-sponsor of this legislation.

Since the enactment of OBRA 87's nursing home provisions, however, numerous issues have been raised about the Health Care Financing Administration's (HCFA) implementation of the law, including concerns about the content of recent regulations and the timeliness of promulgating guidelines for certain provisions by the specific deadlines. With major sections of the nursing home reform provisions becoming effective on October 1, 1990, there is an urgent need to address these issues as expeditiously as possible. On August 20, 1990, I sent a letter to Secretary Sullivan with other key members of this Committee and the Aging Committee asking him to develop a plan for how the Department will fully implement this important legislation, including an assessment of needed administrative as well as legislative modifications. I plan to send the entire transcript of this hearing to Secretary Sullivan for his review. We must see that these major reforms are implemented properly. This will involve a cooperative effort between Congress, States, advocates, and providers.

Older Americans are a growing percentage of the population, with 12% this year and rising. Together with this is a growth in the number of people needing nursing home care. These demographics should be a force for change. Future increases in the number of patients requiring these services as well as the severity of conditions, underscore the need for a sound and efficient system to provide quality nursing home services.

As we commemorate the 25th Anniversary of the Medicare and Medicaid programs, it is a good time to reflect and renew this country's commitment to our senior citizens and disabled individuals needing quality nursing home care. The availability of high quality nursing home care is a key part of our continuing efforts to address this country's long-term health care needs. Placing a loved one in a nursing home is perhaps one of the most difficult decisions a person has to face. No one wants to go into a nursing home. But when a home is appropriate, high quality care is essential. I will continue to work in Congress to ensure high quality nursing home care for all Americans.

Attachments.

RIEGLE EXAMINES QUALITY OF CARE IN MICHIGAN NURSING HOMES

WYOMING, MICHIGAN—U.S. Senator Donald Riegle today heard testimony from individual family members and guardians of nursing home residents as well as State government officials, advocates and nursing home care providers at a field hearing just outside Grand Rapids.

"The availability of high quality nursing home care is a key part of our continuing efforts to address this country's long-term health care needs. Placing a loved one in a nursing home is perhaps one of the most difficult decisions a person has to face. No one wants to go into a nursing home, but when a home is appropriate, high quality care is essential," said Senator Riegle.

Over 50,000 Michigan citizens reside in nursing homes. In Michigan, the Medicaid program finances the care for about two-thirds of all nursing home residents. Senator Riegle is Chairman of the Finance Subcommittee on Health Care for Families and the Uninsured which has jurisdiction over Medicaid.

Three years ago, Congress passed the Nursing Home Reform Act (OBRA'87) and this fall marks the deadline for its full implementation. The legislation was enacted to improve the quality of care in nursing homes under Medicaid and Medicare. Administrative hurdles have delayed many much-needed changes.

Recently Senator Riegle, joined by Senators Chafee, Heinz and Pryor asked Secretary of Health and Human Services, Louis Sullivan to develop a plan for the full implementation of this important legislation. A transcript of today's Michigan hearing will be forwarded to Secretary Sullivan.

UNITED STATES SENATE, COMMITTEE ON FINANCE,
Washington, DC, August 20, 1990.

Hon. LOUIS W. SULLIVAN, M.D., *Secretary,*
Department of Health and Human Services,
200 Independence Avenue, S.W.,
Washington, DC.

Dear Mr. Secretary: We are writing to you about an issue of major importance to us and our Nation's elderly and disabled—ensuring the full and timely implementation of the Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87). These provisions were a landmark step towards assuring quality services for Medicare and Medicaid beneficiaries residing in nursing homes.

Since the enactment of OBRA 87's nursing home provisions, however, numerous issues have been raised about the Health Care Financing Administration's (HCFA) implementation of the law, including concerns about the content of recent regulations and the timeliness of promulgating guidelines for certain provisions by the specific deadlines. With major sections of the nursing home reform provisions becoming effective on October 1, 1990, there is an urgent need to address these issues as expeditiously as possible. We urge you to respond to this letter with a plan for how the Department will fully implement this important legislation, including your assessment of needed administrative as well as legislative modifications.

With the exception of the February 2, 1989 Final Rule, there are no regulations in place for OBRA 87, and very few have been released in draft form, making it very difficult for States and nursing homes to comply. States are expected to be in compliance as of October 1, 1990, and the lack of reasonable and timely guidance from the HCFA have made this virtually impossible. It is imperative that the HCFA get all remaining regulations underway as soon as possible, working closely with the States. At the same time, the HCFA should be prepared for how to deal fairly with the difficult issues resulting from the late release of these various regulations.

As you know, nearly one-half of the cost of nursing home care is paid by the Federal government, primarily through the Medicaid program. Future increases in the number of patients requiring these services as well as the severity of conditions, underscore the need for a sound and efficient system to provide quality nursing home services.

Thank you for allowing us to share our thoughts with you on this very important issue. We look forward to working with you to achieve the nursing home reform objectives of OBRA 87.

Sincerely,

DONALD W. RIEGLE, JR., *Chairman, Subcommittee on Health for Families and the Uninsured.*
JOHN H. CHAFEE, *Ranking Minority Member, Subcommittee on Health for Families and the Uninsured.*
DAVID PRYOR, *Chairman, Aging Committee*
JOHN HEINZ, *Ranking Minority Member, Aging Committee.*

NURSING HOME QUALITY OF CARE REFORMS PROVISIONS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA 87)

HISTORY

- In 1982, the Health Care Financing Administration (HCFA) published controversial regulations that eased the regulatory requirements nursing homes had to meet in order to participate in Medicare and Medicaid.
- In response to patient care concerns, the HCFA commissioned the Institute of Medicine (IOM) to study Federal nursing home regulations, and recommend changes to assure quality of nursing home care.
- The IOM completed its report in 1986. The IOM found the quality of care provided in many nursing homes to be unsatisfactory and argued that a strong Federal role is essential to improve the quality of care in nursing homes.
- The IOM's recommendations served as the basis for the provisions of OBRA 87. Those provisions are divided into four major parts:

(1) requirements nursing homes must meet in order to participate in the Medicaid and Medicare programs, such as increased nurse staffing levels and training, improved resident's rights, and a comprehensive needs assessment of each resident;
(2) revision of survey and certification process for determining whether nursing homes comply with requirements;
(3) expansion of the range of sanctions and penalties that the HCFA and the States may impose against noncompliant nursing homes;
(4) pre-admission screening and annual resident review mechanisms for determining appropriate placement of mentally ill or retarded individuals.

- The provisions are scheduled for phase in from 1988 to 1991. Major sections of OBRA 87 become effective on October 1, 1990.

WHERE WE ARE NOW

- Nursing home associations, advocate groups for residents of nursing homes and States have expressed concern with HCFA's failure to meet deadlines for providing guidance on certain provisions that became effective in 1988 and 1989.
- The recently enacted Omnibus Budget Reconciliation Act of 1989 requires the HCFA to publish regulations by specified dates and to delay certain effective dates in order to assure full and proper implementation.

PERSPECTIVES

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) has not met OBRA 87 deadlines for providing guidance on certain provisions that have become effective in 1988 and 1989, making it difficult for States and providers to comply with the new law.

STATES are awaiting the HCFA's guidance on certain provisions including regulations on the range of sanctions and penalties for noncompliant nursing homes among others.

PROVIDERS AND ADVOCATES are concerned that they have not been afforded an opportunity to comment on the HCFA regulations prior to implementation. They are also concerned with the HCFA's failure to meet deadlines for publishing regulations for certain other provisions. Providers are also concerned that while it is unlikely that final regulations on several key OBRA 87 provisions will be ready by October, facilities will none the less be surveyed for compliance.

NURSING HOME BACKGROUND INFORMATION

NUMBER OF PEOPLE IN NURSING HOMES IN U.S.

- 1.4 million senior citizens persons are residents of nursing homes in the U.S.; an estimated 2 million will be residents by the year 2000.
- Seniors are 12% of the total U.S. population (31.1 million in 1989).

MICHIGAN NURSING HOMES

- 52,040 seniors are residents of nursing homes. By the year 2000, an estimated 65,350 seniors will be in nursing home.
- Almost 10 percent of Michigan's total population are seniors (1.1 million in 1989). 4.7% of Michigan seniors are in nursing homes.
- In Michigan, there are 454 facilities. An average facility has 113 beds and an occupancy level is 94 percent.
- The average resident is an 84 year old female. 60% of nursing home residents suffer from Alzheimer's disease or dementia.
- Average length of stay is over one year with one-third discharged within 1 month, two-thirds discharged within 6 months and the balance staying longer than 6 months.

AVAILABILITY OF NURSING HOMES

- For every senior in a nursing home, there are two in the community requiring care from an institution.
- From 1976 to 1986, the number of beds per senior citizen decreased by 4% while the same population increased by 27 percent.
- A limiting factor is a State's control of the number of homes by using construction limits and screening mechanisms.

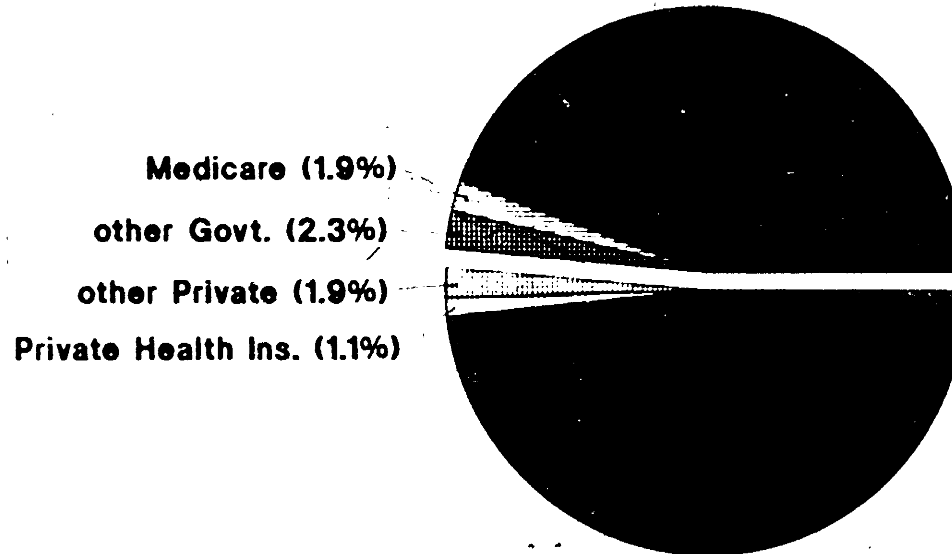
FINANCING OF NURSING HOMES

- In 1988, total expenditures for nursing homes was $43.1 billion, 9% of total personal health care costs.
- There is a large government role in financing nursing home costs. Close to one-half of all nursing home costs are paid for by Medicaid and less than 2% is paid for by Medicare.
- Direct patient payments account for 48% of all nursing home costs.
- Public financing of nursing home care decreased from 56% to 47% from 1979 to 1985.
- Lower income elderly who are ineligible for Medicaid while living in community become eligible for care once they deplete resources.
- A provision retained from the Catastrophic Coverage Act, however, allows the spouse of a person entering a home to retain some income and assets worth up to $60,000.

MICHIGAN

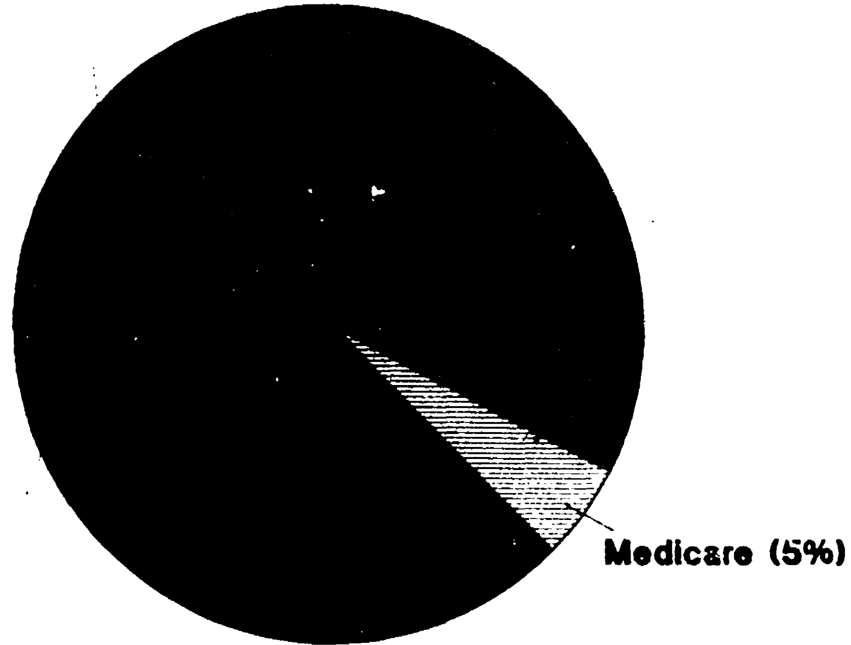
- 1988 expenditures for nursing home care were $148 million; 8.7% of total State health care costs.
- For close to two-thirds of all residents, Medicaid was the source of payment.
- The Medicaid payment rate was $47 a day to provide care for each patient last year, less than what was received in 40 other States and the District of Columbia. The national average was $66 per day.

Nursing Home Cost
Large Government Role

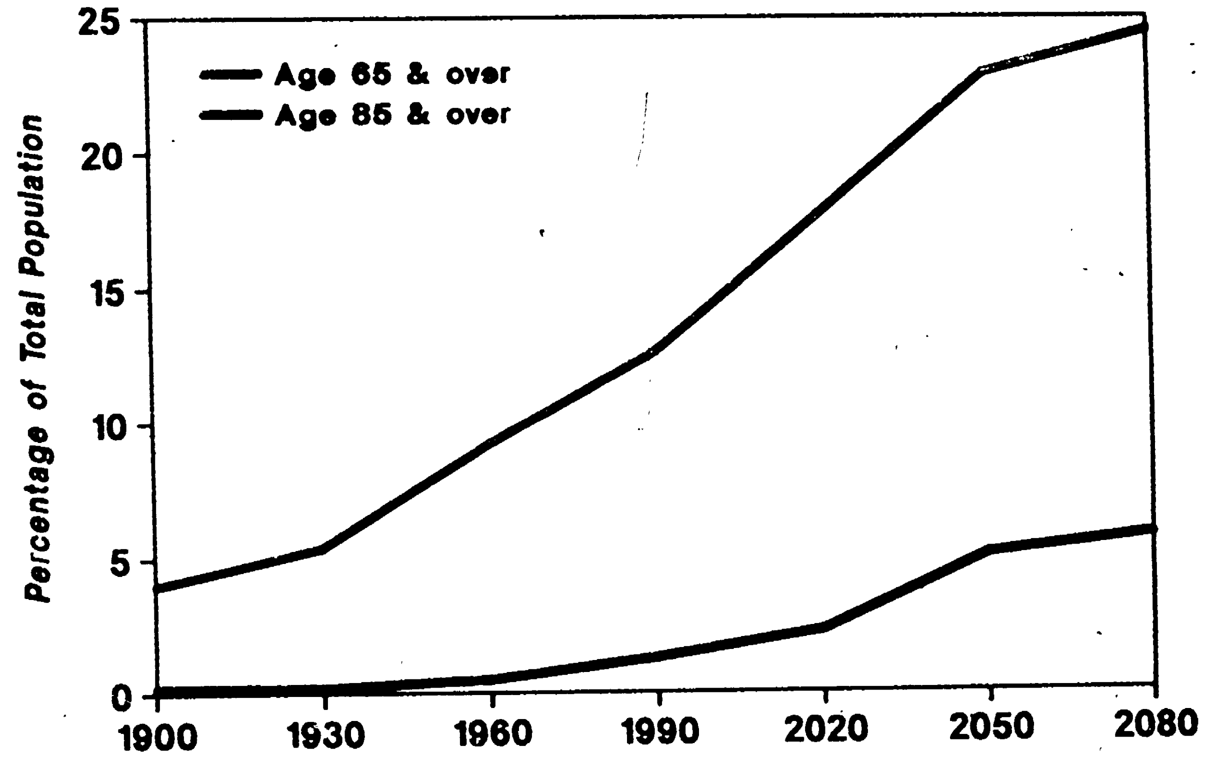


1988 Total U.S. expenditures for nursing homes: $43.1 billion
1988 Michigan expenditures for nursing homes: $148.0 million

Michigan Nursing Home Residents by Source of Payment



Older Americans in the Total Population Actual and Projected, 1900–2080



August 24, 1990

Senator Don Riegle
Western District Office
Suite 720 Federal Building
110 Michigan Avenue, N.W.
Grand Rapids, Michigan 49503

Dear Senator Riegle,

In regard to your upcoming hearings concerning the quality of care in Michigan nursing homes, I am writing to provide your committee with information concerning my own positive experience with the not-for-profit Holland Home organization. I feel very fortunate to have received excellent long-term care for my parents at their Raybrook Manor supportive care facility in Grand Rapids.

Initially, my parents chose to join a for-profit retirement community that did not provide supportive care for its residents. When my mother fell and broke her hip, her therapy required the use of a walker; unhappily, the facility had a policy prohibiting walkers in public areas, including the dining room. It finally became evident that, as my father began to also require nursing home care, we needed to find a more suitable residence for both my parents.

A concerned friend recommended Raybrook Manor, which had supportive care and four vacant rooms! After a thorough interview, including a complete review of their medical needs, my parents were accepted into the Holland Home community. They continued to live there happily, receiving excellent medical and custodial care for many years. Their apartment had two large rooms and was roomy enough for them to feel "at home."

Finally, my mother passed away after a brief illness; my father then moved into a single room. Having developed problems with incontinency, he was finally moved to Nursing, where he was always treated with the utmost care and sensitivity. As he grew older (he lived to be 95), my father's legs became weaker and he fell frequently. I was always contacted after one of these episodes; communication between the staff and myself was consistently excellent. Throughout my parents' years at Raybrook Manor, I was always at peace knowing they were in capable, caring hands.

I realize that not everyone has been as fortunate as I, and that nursing home "horror stories" abound. But my own personal experience with Holland Home proves that it is not possible to generalize about this very important industry and the human needs it serves.

Sincerely,

Mrs. Richard M. DeVos

PREPARED STATEMENT OF EVANGELINE J. STANCHIK

My name is Evangeline J. Stanchik. I serve as a volunteer for Citizens for Better Care (CBC), and was elected to the CBC State Board of Directors. I appreciate the opportunity to testify before this committee. I am not an orator and I tend to become rather emotional when I speak on behalf of residents in nursing homes.

I became involved in the issue of care for residents (not patients) because of a widow friend that I has known for many years. She had a stroke, leaving the right side of her body paralyzed. She was first in a hospital, then transferred to a nursing home facility. The deplorable care she received was enough for me to start searching for an organization that I could get answers from. Finally, through Olivia P. Maynard, Director of Services to the Aging, I was referred to State Representative Thomas Mathieu. His office gave me the phone number for the Citizens for Better Care office in Traverse City. The office covers ten counties in northwestern Michigan.

CBC has a training program for advocates regarding the rights for residents and the responsibility of being an advocate. This is a volunteer program which offers weekly contact with residents in nursing homes, homes for the aged, and adult foster care homes. Should the residents have problems with their care, food, finances, or other worries, the CBC advocates work with the facility to attempt to resolve the problem. As an advocate, I report to our ombudsman, Mary Beth Osowski, who will assist the resident if they wish to file a complaint or have any other concerns about their legal rights.

I was fortunate enough to have the opportunity to visit the nursing homes in the ten counties. The visits were unannounced. We presented our identification of course, and then proceeded basically to review the home the same way as the homes we visit regularly. A short version of what we are looking for is:

1. Are they a skilled or intermediate facility, or combination of both? What type of residents, old, young, disabled, mentally ill?
2. Any restriction on types of residents?
3. Are there any special programs such as: social services, rehabilitation programs, resident council?
4. What kind of health care staff. Are they full time, part time, do they have time to serve individual residents? Are the staff warm and friendly, do they encourage you to come and visit and help, or are they cold, quiet, and uncaring?
5. What is the staff ratio to residents? We check summaries of deficiencies, which is a report on meeting standards for each home. Are the residents' rights posted?

Through CBC I discovered that rights to protect residents should be a natural process given by one human being to another.

I'd like to take this time to cite some of the problems encountered in caring for a widowed friend of mine. To indicate when she had to go to the bathroom, she would ring a bell and a light would go on outside her room. Many, many, times there would be no response. Of course, upon occasion an accident occurred much to her embarrassment. I understood that the longest a resident was to have to wait was twenty minutes. Give me a break, twenty minutes is a long-time for anyone who is ill to hold and wait for a bedpan? As her friend, I would get her the bedpan.

I ask you Senator Riegle, can you peel an orange with one hand, or cut a hard potato and meat with one hand, or how you can drink a glass of milk that is filled to the brim with one hand? How can a facility let a residents' skin break down to the point that it looks like raw hamburger? Then, when questioned, the administration becomes angry. Oh, how I wish I had known about CBC before all this.

Some of the facilities and medical·doctors could care less about this older generation. I and two other ladies were able to sit in on a health and care review of my widow friend that was conducted by her doctor. He never looked at her, he never touched her during the entire twenty minute review. When we left the room, I asked the doctor why he ignored her. His response was unbelievable. He acted like I was a child being patted on the head and did not understand. I told him I hoped and wished that he would wind up with more wrinkles than anyone in the whole world. It is really sad that some of the doctors do not care and act like they never will get old. It is not that they are any busier than the rest of us. There are plenty of doctors in this area and they get paid for their visits.

Through my work with CBC I became acquainted with Frances Rajkovich, who was the program director of the Grand Traverse County Probate Court Volunteer Program at that time. She asked me if I would consider being a volunteer guardian. Though much of my time was committed to my widow friend, in the early fall of 1987 I agreed to take on the guardianship of another women.

It took some time, of course, for us to get to know each other. After three months I discovered that she did not have any teeth. Not only did I call a dentist, but also doctors to check her eyes and ears. We found her hearing to be very poor, though her vision was so good she could have passed a driving test. We ended up getting her fitted for dentures, but she did not want a hearing aid. We figured if she could just handle getting teeth, then for a while we would be happy. The difference that resulted in her appearance and appetite was amazing.

The personal toilet care administered to her by the home was terrible. Her nails more times than not were very dirty (as if she was a mechanic in a garage), and her hair was not done. Rather than being dressed in her own clothes, she would be in a hospital gown. She would be in bed more than up. In February of 1989, as a result of my concern, her doctor prescribed for her a program exercises. After six weeks he sent his assistant to check on the program and found that it was not being implemented.

There was another time when she had a cold. This woman requires no medication, but twice in error she was given meds intended for another patient. I know of these instances because the nurse called me and left a message. Fortunately the mix-up in medication was not harmful or fatal. I believe she had been on medication other times but there is no way to prove it, though I could sense it in her eyes.

You get tired of asking why care is not being given. After one year her health and hearing had deteriorated. I was concerned because I knew a decision had to be made to move her to another facility. Statistics show the death rate is higher among seniors if a move is made near a birthday. I had a long discussion with a judge and about my feelings to move her. As a volunteer guardian I had the authority to make that choice. At the appropriate time I made that decision and she was moved.

When I moved her to the new facility, I took all her clothes to wash and press except for what she would need till the next morning. When I arrived the following morning an aide asked me if her lower plate was in the clean clothes. I told her no. I called the other facility to see if they had misplaced it or forgot to pack it. They asked me if she ever had any lower plate. This is the facility where the dentist has his name on record for doing both plates, the dates, the costs, all of which I have a copy of. This told me what I really felt all along, this woman had not been given any proper toilet care while at the previous facility.

This was a woman who towards the end of her stay at the facility I moved her from was in bed probably 22 hours of the day. She now wheels her wheelchair, has a goal to go see her home in September, if she is up to it. This is the difference a better home can make. Now she wants me to check out carpeting and drapes cost. She is always clean, dressed, and will tell them what she would like to wear. It took about four weeks for her to become comfortable with this facility. She is up for most of the day except for about one and half to two hours when she requests a nap in the afternoon. She enjoys watching tennis on television, attends social functions, and is friendly with other residents and staff. She asks lots of questions, is curious, and even sometimes becomes angry. She has gained weight, her skin is strong and her eyes clear. Her one ear has been cleared, but will take a little longer for the other because it was so bad.

Problems created in some of the medical care facilities are, in my opinion, because of poor administration. The administration and top staff are paid well and have excellent benefits. But the rest of the staff that hold the residents, clean them, see them ever day, feed them, are cheerful around them, are paid practically nothing. Then the administration wonders why the turnover is so high.

Senator Riegle, are you aware the average resident (this is their voting resident) pays a minimum of 25,000 dollars a year for these services. Did you know that four of these residents could be sharing one bathroom? That is a hundred thousand dollars a year.

It is sad and shameful that this group of people who are the foundation of our community, our heritage, who in their lifetime if they made $1,000 to $1,500 a year, and when Social Security came in are probably getting all of $200 a month. They know what it is to do without possessions. They should not have to do without the loving care that is their due.

We are fortunate that we do have advocates and organizations like CBC and the Grand Traverse Probate Court Volunteer Programs. We do need more people that are willing to go in and visit the residents. I can tell you Senator Riegle at one facility I knew when the State was coming in to review and check them out. I knew a week ahead of time. Somebody was informing them, I wonder who?

I hope what ever measures are proposed from this hearing to improve the quality of nursing home care, do not become bogged down in one of these, "I have to take two years to interpret this program, or I have to make a study of it for another two

years, or do you really need this financial support?" It does not matter if they are receiving Medicaid, Medicare, or private pay. Every human being (resident) should be getting good, lovely, loving, healthy, touching care. Most residents are very bright. Some could probably stay in their own home with the help and services we now have to offer.

Another suggestion, or my opinion, is that we should work closer with the Probate Courts. This is especially true when I have encountered individuals whose only concern is the wealth or possessions of residents that may be left to them. Should the residents have wills, I suggest that an organization, school, or church be designated in the will as beneficiaries. Maybe with knowing there is possibly financial help coming it would encourage some more volunteers to come see residents and their care.

Why will I continue to be an advocate for nursing home residents? I looked at some words from a Maryknoll Brothers and Sisters booklet on being a missionary, and if one substitutes the word advocate for missionary it reads: "To be an advocate is to go where you are not wanted but needed, and to stay till you are wanted but not needed."

Thank you.

Prepared Statement of Hollis Turnham

INTRODUCTION

My name is Hollis Turnham and I serve as Michigan's State Long Term Care Ombudsman for Citizens for Better Care. As you know, CBC is a 21 year old non-profit membership organization dedicated to maintaining and improving the quality of life and care for the 95,000 residents of Michigan's nursing homes, hospital long term care units, homes for the aged and adult foster care homes. Michigan's Long Term Care Ombudsman Program is one of the nation's oldest, as one of the original demonstration States funded in 1972 by the Nixon Administration.

On behalf of CBC and Michigan's Ombudsman program, we thank you, Senator Riegle, for your unsolicited leadership in examining the implementation of the Nursing Home Reform Act amendments to Medicare and Medicaid as part of the Omnibus Budget Reconciliation Act of 1987.

There is much for Congress to look at in evaluating the fulfillment of the dreams and visions of better nursing home care from OBRA '87. We hope this testimony and our continued work with you and your staff will insure that those dreams and visions become reality.

BACKGROUND FOR OBRA '87

The Congressional reforms mandated in OBRA '87 did not spring from thin air but are grounded in years of history and struggle about the regulation of nursing homes. Those reforms were seeded in attempts in the earliest years of the Reagan Administration to "deregulate" nursing homes.

The proposal to deregulate nursing homes was rejected by Congress with a mandated study by the Institute of Medicine of the National Academy of Sciences on whether and how the Federal Government ought to be involved in the regulation of the country's nursing homes.

The IOM concluded that

> *More effective government regulation can substantially improve quality in nursing homes. A stronger Federal role is essential.* Regulation of nursing homes both by State and Federal governments is necessary to assure safety and acceptable quality of care for nursing home residents because of the vulnerability of the residents and the lack of institutional choices available to them. The committee is convinced that more effective government regulation can achieve substantial improvement in quality of care in many nursing homes in all States. A stronger Federal leadership role is essential for improving nursing home regulation because not all State governments have been willing to regulate nursing homes adequately unless required to do so by the Federal Government.

With that charge and the active participation of consumer advocates and the nursing home industry through the Campaign for Quality, many of the IOM's recommendations became law in OBRA '87.

And, then, quite frankly, there was great joy in our community. Finally, many of the concepts which we believe are cornerstones of quality nursing home care are in OBRA '87.

- Intermediate sanctions rather than no enforcement or too heavy handed enforcement.
- Resident control and self-determination.
- Comprehensive resident assessment at admission and periodically.
- Extended, measurable nurse aide training and competency testing.
- Mandates to meet the mental health needs of residents, in the nursing home.

All that and more was seen by Congress as necessary and appropriate to improve the quality of nursing home care.

IMPLEMENTATION OF OBRA '87

There has been progress in implementing OBRA '87. Thousands of nurse aides across Michigan have received the 75 hours of training and have passed the competency test. The resident assessment tool is looked upon by many as a great instrument for beginning thoughtful, meaningful care planning. Many nursing homes have taken the concepts of OBRA as affirmation of their good practices and built in new practices and programs which nurture the dreams and visions of quality nursing home care. For example, the use of physical and chemical restraints have been dramatically decreased just since January, 1990, in a number of homes.

But the dreams and visions of quality nursing home care have not materialized *because* of the leadership of the Health Care Financing Administration of the Department of Health and Human Services. Again and again on critical issues and timeframes, HCFA has failed to take up the challenge of improving the quality of nursing home care. Instead, the leadership of some State officials and individual nursing home trade associations, owners and employees has been largely responsible for the improvements in the quality of nursing home care envisioned and mandated by Congress.

The major elements of HCFA's failings is its lack of production of regulations mandated by Congress and its all too apparent non-acceptance of several basic tenets of OBRA '87. As the attached listing from *Long Term Care Management's* July 19th edition prepared by the American Health Care Association Illustrates, the Federal agency has missed by years, not months, the promulgation of final regulations to implement OBRA '87.

The failure of HCFA to meet its responsibilities has significant ramifications. Some States are using the Federal government's failure to promulgate regulations as an excuse not to implement the law. Undoubtedly, some homes, in proper and improper circumstances, will use the Federal government's failure as one more legal defense against enforcement actions taken by State and/or Federal officials.

Senator, we urge you continue to communicate directly with HFCA Administrator Gail Wilensky about these delays. We believe that HCFA's time would be much better spent in producing regulations than in producing the highly inaccurate *Medicare/Medicaid Nursing Home Information.*

SPECIFIC OBRA ISSUES WHICH NEED ATTENTION

We would also use this opportunity to bring to your attention a number of specific issues which need Congressional attention.

Intermediate Sanctions

As illustrated with Federal enforcement actions implemented or threatened at three Michigan nursing homes, the Chicago Regional Office of the HCFA does not and will not use intermediate sanctions against nursing homes and hospital long term care units which do not meet Federal minimum standards. Using its own failure to promulgate regulations, HCFA refuses to use the OBRA '87 mandated sanctions of temporary management (receivership), civil fines, and monitors. While the regional office admits to having the power to ban payments for new Medicare and Medicaid admissions, it has refused to do so in at least two cases where we believed and recommended that it would be an appropriate intermediate sanction.

In both written and oral communications with officials in the Chicago office, it has become clear to CBC that these Federal officials DO NOT BELIEVE in the wisdom of using intermediate sanctions. In their world, there are only two options . . . resident evacuation of a substandard facility or simply continuing to live in it. Both the IOM report and the clear language of OBRA '87 envision a very different approach to substandard facilities.

By failing to promulgate regulations on intermediate sanctions, HCFA may succeed in turning the dreams and visions of OBRA '87 into a nightmare. While the new requirements for empowering residents, more carefully assessment, and close evaluation of functional losses are implemented in the new survey process, the enforcement tools to deal with deficiencies are not be in place. We are very concerned that the past enforcement patterns will continue, either nothing will happen or the residents will be evacuated through decertification.

HCFA must implement and use intermediate sanctions and States can and should follow that lead. Most problems can be corrected while residents continue to live in a carefully monitored facility. If current owners cannot correct the problems, those owners should be evacuated not the residents.

Also, Senator, we are very concerned about the continued interest which HCFA displays in a concept called "dispute resolution." Leaked proposed Federal enforcement regulation describe the process as an "informal" process which will allegedly run parallel to the "formal" citation and enforcement process.

At the same time, the leaked regulations explain a tortuous process for surveyor decision-making on when to issue a citation for a problem or "finding." The two-tiered, eight point scale is extremely difficult to grasp conceptually. We firmly believe that this process, if implemented, will result in administrative hearings which last years, not months or days as surveyor's attempt to explain why this finding was a 3 not a 4 on the scope scale and a 2 not a 1 on the severity scale.

We strongly believe that both these proposals ("dispute resolution" and the "scope and severity scale") are conscious attacks on the survey process with the desired outcome of insuring that no facility is ever cited for any deficiency. if no deficiencies are ever cited, there will never be any need to ban admissions, impose fines, or appoint a receiver.

Nurse Aide Training

Despite the problems in implementation, nurse aide training and competency testing is happening in Michigan. Preliminary anedocatal information validates our hopes for these new Federal requirements. Aides are learning needed information. Passing a test and receiving a certification card bearing the seal of the State of Michigan adds a measure of self-esteem and accomplishment for the most important people in care delivery. Congress has had a positive impact on the quality of nursing home care.

However, OBRA '87 must be amended to clearly provide that temporary direct care staff from pool agencies must have had their 75 hours training and certification prior to being assigned to any nursing home.

Also, Federal requirements must specify 6 hours per quarter of in-service training for direct care staff. This requirement which appeared for months in HCFA draft guidelines must reappear in Federal regulations.

Costs Charged to Resident Funds

For over a decade, Congress has mandated that HCFA protect residents from the few unscrupulous nursing home operators who financially exploit Medicaid residents. Since 1977, Federal law has mandated that HCFA specifically outline charges which cannot be extracted from resident's funds. With OBRA, Congress piggybacked an additional requirement mandating a listing of what will be included in the State's Medicaid rate and what, therefore, cannot be charged to residents.

Proposed regulations issued in March, 1990, once again blatantly ignored Congressional mandates. Some HCFA officials, off the record, claim that the Boren Amendment and the Eleventh Amendment of the U. S. Constitution prohibit the Federal agency from specifying to the States what must be included in the State's Medicaid rate. Meanwhile, the Federal agency hides behind the duplicitously alternating arguments of that "covered items are obvious" and "it is too difficult to draft an all-inclusive listing of covered items."

Senator, we urge you to seek a direct answer to this issue from Administrator Wilensky.

Minimum Data Set

Congress mandated a process for effective assessment of resident strengths and weakness, the necessary first step for effective, rational care planning. Through contract with Triangle Research Institute in North Carolina, a set of tools have been created which pilot testing homes give great reviews. Once mastery of the tools is obtained, homes and nurses report great improvement in care planning and therefore improved quality.

However, HCFA has massively delayed the effective use of these tools. First, since February, HFCA has been promising that every certified nursing home in the coun-

try would receive copies of the documents. The homes are still "waiting for Godot." Second, HCFA has ruled that the assessment tool must go through the rulemaking process. If past rulemaking practices hold, the tool will not be finalized for two years.

Assessment and care planning is a dynamic and changing science and art form. It cannot survive intact for improving the quality of care in nursing homes the hegemony of rulemaklng. The process for implementing the minimum data set must be changed.

Mental health provisions

With the sweeping requirement that homes "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident," CBC believes that the first step has been taken to meet the mental health needs of nursing home residents. For far too long, those needs have been neglected by government programs.

We encourage you, Senator Riegle, to monitor HCFA and all State agencies including the Michigan Department of Mental Health and Social Services to assure that nursing homes are made a part of the mental health continuum of services as envisioned by this and other provisions of OBRA '87. The mental health needs of nursing home residents must now become a part of the established mental health service delivery system.

Also, we are very disappointed that most national associations of State officials and the nursing home industry are pressuring Congress to amend OBRA '87 to restrict the applicability of the mental health pre-admission screening requirements to Medicaid eligible applicants. Their motivations have been clearly stated. Nursing homes do not want obstacles placed in the way of the admissions of highly sought private pay residents. National associations of State officials are only motivated by money. The pre-admission screening requirements are very costly to implement.

While our community did not propose these pre-admission provisions of OBRA '87, Congress thought they were important to include. We can discern no reason why rich people should be denied the benefits Congress saw in these provisions. If the mental health pre-admission screening provisions only apply to Medicaid recipients, the serious problems these people face in getting admitted to a nursing home will be exacerbated.

If the mental health pre-admission screening provisions are quality nursing home care for Medicaid recipients, they are quality care for rich people. Senator Riegle, we ask you to forcefully oppose all attempts to limit any portion of OBRA '87 to any particular economic class of residents in certified homes.

Financing OBRA '87

Quality nursing home care is not a free lunch. Government, as the major payor of nursing home and hospital long term care, has the major responsibility to assure that money goes to care.

The cost centers to fully implement the dreams and visions of OBRA '87 are in two places . . . the homes and government agencies. The homes must be appropriately and rationally funded to do the new things which OBRA '87 requires them to do. For example, additional costs for more licensed nurse coverage, nurse aide training, and more time spent in assessment. Government must be appropriately and rationally funded to develop the new policies, hire more surveyors for the longer survey, and implement intermediate sanctions.

Generally, we believe that State officials have taken a reasonable approach to funding increased costs to nursing homes, notwithstanding the injection of Federal District Court Judge Bell's May 18th ruling which has *lowered* Medicaid rates for most homes. HCFA's expected approval of Michigan's State Medicaid Plan amendments looks as if the Federal Government will hold to its part of the bargain for homes.

As for HCFA's funding of State regulatory functions, we were recently very pleased to hear that HCFA has encouraged States to hire additional inspectors and that Federal matching funds are available.

However, we would encourage you and your staff to closely monitor how HCFA reimburses the State for enforcement actions. We have heard disturbing reports that the Federal Government does not want to fund intermediate sanctions, ascribing those functions as " State licensing actions" and not "Federal certification functions." Once again, HCFA hides behind its own failure to issue enforcement regulations and that therefore intermediate sanctions are not a Federal certification function. Such reports add to our fears described above that Federal officials do not believe in the philosophy of measured enforcement.

CONCLUSIONS ON OBRA '87

Congress did the right thing in passing the Nursing Home Reforms of OBRA '87. The quality of nursing home care and life has improved as a result. That improvement will continue and grow significantly if HCFA does its job in a vaguely timely fashion.

We urge you to take a leadership role in assuring that HCFA does its job in improving the quality of nursing home care.

SPOUSAL IMPOVERISHMENT

In your announcement of this hearing, you mentioned the important provisions contained in the Medicare Catastrophic Coverage Act protecting the financial health of a married couple when one needs nursing home care. Although the implementation of those provisions likely could not have been more chaotic, the law is largely working to protect community spouses.

In the course of our advocacy, we have learned of two thorny problems which we believe need Congressional attention. As you know, one of the basic premises of the spousal impoverishment provisions was to assure the community spouse a basic income. This income is to be assured by allowing the community spouse to retain part of the nursing home resident's monthly income.

When the resident's income is Social Security, VA, or railroad retirement, one of the easiest way to accomplish that income retention is to make the community spouse the "representative payee" for the government check. However, Federal regulations specify that a "representative payee" can only use the funds for the benefit of the resident. One Social Security office has already threatened one community spouse if she uses the residents funds for her benefit. This local Social Security office refuses to recognize that Congress meant for the community spouse to use the resident's funds.

We have enlisted the support of the National Senior Citizens Law Center to amend the Social Security Act to provide that in these very limited circumstances a representative payee may use funds to her/his own benefit. We enlist your support in this endeavor.

The second issue of Medicaid eligibility in which Congressional support is needed involves the indexing provisions found in the program. As you know, Congress wanted spousal impoverishment to reflect the economic changes due to inflation. As a result, critical numbers in the program (the income and resource allowances) are indexed to inflation and poverty income levels. Congress wanted those numbers to change January 1st of each year.

Unfortunately, the Federal office of Management and Budget controls the release of the poverty income figures. Regularly, OMB does not get around to releasing the poverty income numbers until months after January 1st. This practice reeks havoc on the eligibility process. The computers at the Michigan Department of Social Services have to be changed twice. Thousands of income and asset calculations have to be done twice.

Senator, we urge you to convince OMB to issue these indexed numbers in a timely fashion so that MDSS can do their job and that residents and families are afforded the protections and rights Congress intended.

LONG TERM CARE OMBUDSMAN PROGRAM

As Treasurer of the National Association of State Long Term Care Ombudsman Programs, I must also take the liberty of addressing the programmatic needs of the "residents advocates." Copies of the National Association positions papers on issues we hope that Congress will deal with in the reauthorization of the Older Americans Act are attached. We need clarification of our obligations to report abuse and neglect and the confidentiality and control Congress vested with residents in using Ombudsman services. Before, the Ombudsman program is mandated to serve as advocates for older persons receiving long term care services outside a licensed health facility, Congress must grapple with a number of issues including conflicts of interest and funding.

CONCLUSION

Again, Senator Riegle, thank you for including quality nursing home care in the Subcommittees agenda. We appreciate your willingness to work on insuring that Congress's dreams and visions for quality nursing home care become a reality.

The work is not easy. But it can and will be accomplished with the help of your leadership on behalf of the State's 50,000 nursing home residents.

REGULATORY ACTIVITY

HCFA Struggles To Implement OBRA

Beginning Oct. 1, 1990, nursing homes have to implement a comprehensive series of nursing home reforms (OBRA '87).

The bulk of the law was initially effective Aug. 1, 1989. Under pressure from consumers, providers, and states, who complained about HCFA's failure to issue implementing rules, Congress delayed the law until Oct. 1 (*LTCM* 11/30/89). Even with the delay HCFA has only issued proposed rules governing preadmission screening, costs charged to patients' funds, and nurse aide training. What follows is a chart summarizing the statutory deadlines for rules as compared to the actual or in some cases anticipated date of publication.

OBRA '87 Regulatory Calendar
Statutory Deadlines and Actual/Estimated Publication Dates

Subject	Statutory Deadline	Actual/Est.* Publication
Nurse Aide Training/Competency Evaluation, Nurse Aide Registry	September 1988	March 23, 1990 (P)
Final Rule on Nurse Aide Training	September 1988	October 1990* (F)
Preadmission Screening and Annual Resident Review (PASARR)	October 1988	March 23, 1990 (P)
Final Rule on PASARR	October 1988	October 1990* (F)
Costs Charged to Patients' Funds	July 1988	March 20, 1990 (P)
Costs Charges to Patients' Funds	July 1988	July 1991* (F)
Restraints	No deadline in statute	September 1990* (P)
Psychopharmacological Drugs	No deadline in statute	September 1990* (P)
Nurse Staffing Waivers	October 1988	September 1990* (P)
Administrator Standards	March 1988	September 1990* (P)
Swing Beds	No deadline in statute	September 1990* (P)
Statement of Medicaid Rights	No deadline in statute	September 1990* (P)
Final-Final on Requirements	No deadline in statute	September 1990* (F)
Survey and Certification	January 1990	September 1990* (P)
Enforcement	October 1988	September 1990* (P)
Specify Minimum Data Set	January 1989	September 1990* (P)
Designate Assessment Instrument	April 1990	September 1990* (P)

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National Association of State Long-Term Care Ombudsman Programs

Position Paper
Adopted April 30, 1990

<u>1990 Older Americans' Act Reauthorization: Confidentiality Issues</u>

1. Access to Residents Records

<u>Current OAA language</u>: 307(a)(12)(J)
The State will...ensure that representatives of the Office shall have..with the permission of a resident or resident's legal guardian have access to review the resident's medical and social records or, if a resident is unable to consent to such review and has no legal guardian, appropriate access to the resident' medical and social record.

The current language does not prohibit states from granting Ombudsmen access to residents record.

It is the position of NASLTCOP that this issue should be resolved at the state level.

No change in the law is requested.

2. Release of Client Information

<u>Current OAA language:</u> 307(a)(12)(D)
The state agency will establish procedures to assure that any files maintained by the Ombudsman program shall be disclosed only at the discretion of The Ombudsman having authority over the disposition of such files, except that the identity of any complainant or resident of a long term care facility shall not be disclosed by such Ombudsman unless "(I) such complainant or resident, or the individual's legal representative, consents in writing to such disclosure; or (II) such disclosure is required by court order (emphasis added).

A. Written vs. Oral Consent
Many Ombudsmen are concerned that the requirement to obtain <u>written</u> consent is unnecessarily burdensome and impractical at times. Although Ombudsmen agree that consent is essential before information is released, and that consent must be documented, it is the position of NASLTCOP that documented oral consent is sufficient for the protection of clients.

Suggested language: 307(a)(12)(D)...the identity shall not be disclosed...unless "(I) such complainant or resident, or the individual's legal representative, **consents to such disclosure in writing or orally. Such oral consent must be documented**." (emphasis added)

B. Life-threatening Situations
After passage of the 1987 Reauthorization of the Older Americans Act, State Ombudsmen received clear guidance from Congressional authors that the O.A.A.'s prohibition against release of client information applied to referrals to Adult Protective Services programs or law enforcement agencies in

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abuse/neglect situations. Many LTC Ombudsman programs had made such referral part of their practice/policy in response to mandatory abuse reporting laws. Variety continues to exist among states' practices related to abuse investigation/referral.

These Adult Protective Services laws generally require Social Workers, health care professionals, human services employees and others to report suspected abuse, neglect, endangerment or financial exploitation of an adult, particularly older or disabled adults, to a state agency. State agencies are then required to determine if the adult is making informed choices and/or needs "protective services". Some state laws specifically require the Ombudsman to report.

Federal OAA provisions and some state ombudsmen enabling legislation prohibit the release of residents' identity without "written consent". These laws represent conflicting values. Adult Protective Services seeks to prevent and treat abuse, neglect, endangerment, and financial exploitation. OAA seeks to prevent reprisals for filing complaints and to empower residents to control their lives.

These legislatively stated goals and values must be clarified for effective operation of the Ombudsman programs.

It is NASLTCOP's position that clarification in the Act and/or the regulations is necessary to address the Ombudsman concerns which lead to these inconsistencies.

National Association of State Long-Term Care Ombudsman Programs

Position Paper
Adopted April 30, 1990

1990 Older Americans' Act Reauthorization: Conflict of Interest Issues

Conflict of Interest

Current OAA language: 307(a)(12)(A)
"The State agency will establish and operate, either directly or by contract or other arrangement with any public agency or other appropriate private nonprofit organization, other than an agency or organization which is responsible for licensing or certifying long-term care services in the State, or which is an association **(or an affiliate of such an association)** of long-term care facilities (including any other residential facility for older individuals), an Office of the State Long-Term Care Ombudsman ..." (emphasis added)

and, 307(a)(12)(F)
"The State agency will... (i) ensure that no individual involved in the designation of the long-term care ombudsman (whether by appointment or otherwise) or the designation of the head of any subdivision of the Office is subject to a conflict of interest;"

NASLTCOP is aware of at least one state agency which directly operates the State Long-Term Care Ombudsman Program, which also operates long-term care facilities. (It should be noted that a long-term care facility can operate without affiliation to any trade or other association.) This situation creates a clear conflict of interest.

It is the position of NASLTCOP that action must be taken to correct and prevent this type of conflict. Clarification may be required in the Older Americans Act that **the Long-Term Care Ombudsman Program may not be operated by or contracted to an entity which operates any long-term care facility**.

Also, it is the position of NASLTCOP that **enforcement** of this and other provisions of the Older Americans Act by the Administration on Aging is vital for the protection of clients of State long-term care ombudsman programs. To this end, NASLTCOP recommends that specific sanctions related to the operation of the Long-Term Care Ombudsman program be added to the Act, for enforcement by AoA. These sanctions must extend to include removal of the Long-Term Care Ombudsman program from the purview of a State Agency on Aging when that Agency also operate a long-term care facility which houses clients served by the Long-Term Care Ombudsman Program, or substantially violates the Act's other requirements

In addition, when the State Ombudsman Program is housed in a State Agency which is responsible for licensing or certifying long-term care facilities, that the State Plan must provide specific protections to assure the independence and integrity of the Office of the SLTCO. The State Plan must also describe a specific mechanism to identify andresolve disputes or conflicts of interest between the host agency and the Office of the State Long-Term Care Ombudsman.

National Association of State Long-Term Care Ombudsman Programs

Position Paper

Adopted April 30, 1990

1990 Older Americans' Act Reauthorization: Adequate Legal Counsel for Ombudsman Programs

Adequate Legal Counsel for Ombudsman Programs

Since 1987, the Older Americans Act has contained provisions related to the provision of legal counsel for the Office of the Long-Term Care Ombudsman by the State Unit on Aging. Those provisions require the State Unit to minimally assure three things:

1. That adequate legal counsel is available to the Office for advice and consultation.

2. That legal representation is available to defend or bring lawsuits for the "performance of official duties."

3. That the Office has the ability to pursue administrative, legal, and other appropriate remedies on behalf of residents.

As of this date, most state Ombudsman programs do NOT have legal counsel for one or more of the three areas. In order to assure the provision of the first two items (advice and representation), the National Association of State Long-Term Care Ombudsman Programs proposes that the regulations of the Administration on Aging be amended to provide:

A. That the provision of adequate legal counsel for the Office is NOT met by having an attorney as State or Local Ombudsman or by assigning these duties to the Legal Services Developer. The duties of State or Local Ombudsmen and Legal Services Developers are too complex and broad to simultaneously require the same person to be his/her own lawyer, or to directly represent the Ombudsman Program.

B. That provision of legal counsel for advice and consultation must include the dedicated time of at least one attorney, fully licensed in the state, to be directly available to the State Ombudsman as needed. The attorney must demonstrate skills, experience, or interest in the objectives of the Ombudsman program.

C. That provision of "legal representation" means that at least one attorney, fully licensed in the state, is always available to defend the Ombudsman against litigation filed or threatened against any designee of the Office in connection with performance of official duties.

D. That provision of "legal representation" also means that at least one attorney, fully licensed in the state, is always available to initiate litigation against any individual, corporation, agency, governmental entity, or partnership which substantially interferes with a designee of the Office in connection with performance of official duties.

E. That when the Ombudsman Program is represented by an attorney, or a division of the Attorney General which also represents a state agency which licenses or certifies the State Plan, that Plan must provide specific protections to assure no conflict of interest for the attorney providing legal counsel to the Ombudsman Program.

Ideally, the third legal provision regarding remedies for residents would be implemented by granting the Office the same legal standing to sue as any resident and funding a sizable number of attorneys to act directly as counsel for residents, individually and collectively. NASLTCOP does not believe that this ideal can or will be implemented now, in most states.

Alternatively, we propose that AoA direct the state units to assure that:

A. Title IIIB legal services providers exist in sufficient numbers to serve all long-term care residents;

B. Title IIIB legal services providers clearly give priority to long-term care residents and their legal representatives request for services;

C. Title IIIB legal services providers are adequately trained and supervised to provide quality legal representation to long-term care residents.

Also, we request that AoA focus its work plan on assuring:

A. That the rights and remedies guaranteed to nursing home residents in the Nursing Home Reform Act of the Omnibus Budget Reconciliation Act of 1987 are properly implemented by the Health Care Financing Administration and individual states to assure the availability of adequate legal remedies.

B. State units on aging understand how to legislatively achieve the Congressional statement that ombudsmen will "have the ability to pursue administrative, legal, and other appropriate remedies on behalf of residents of long term care facilities," within their respective states.

National Association of State Long-Term Care Ombudsman Programs

Position Paper
Adopted April 30, 1990

1990 Older Americans' Act Reauthorization: The Role of the Long-Term Care Ombudsman Program in the Resolution of Home Care Complaints

The National Association of State Long-Term Care Ombudsman Programs recognizes the great need which community-based elders have for advocacy to ensure quality in-home services. Homebound elders are often isolated and extremely dependent upon home care services for safety, assistance and sustenance. We believe that as states expand their role in community-based long-term care, they must do so with particular attention to the need for consumers of these services to have an effective advocate.

The Long-Term Care Ombudsman Programs have struggled for years to meet the mandates of the Older Americans Act to advocate for positive changes to the long-term care system and provide residents of facilities with an avenue to have complaints addressed. Many of the state programs today, after fifteen years, have not fulfilled these mandates. This failure is due principally to the lack of funding and the lack of state legislation to ensure access to facilities.

Therefore, the Association **recommends that Congress direct the establishment of an expert panel to review the options to provide complaint resolution and advocacy for home care recipients.**

The Association does not support the inclusion of the receipt and resolution of home care complaints in the 1991 reauthorization of the Older Americans Act as it pertains to the Long-Term Care Ombudsman Program.

We believe that a thorough review and program evaluation be conducted of all the present models for resolution of home care complaints, including those demonstration projects funded by the Administration on Aging.

Further we recommend that a representative of the National Association of State Long-Term Care Ombudsman Programs be included in the review process.

The issues which we specifically recommend be considered by the panel of experts are as follows:

I. The Home Care Program is not regulated.

The federal government and most states do not register, regulate, or license home care services or providers. The lack of regulations or other specific, objective criteria such as standards of care, will make any determination of a failure to deliver proper home care services problematic, at best.

Points to Consider:

1. *Access* - How will Congress or state legislatures which do not regulate home care services ensure access to the elders' homes? The 1978 Amendments to the Older Americans Act required that states "establish procedures for appropriate access by the Ombudsman to Long Term Care Facilities and patient records ..." (307(a)(12)(B)). Today, there are still states that have failed to enact legislation that guarantees the Ombudsman's access to all long-term care facilities.

2. *Jurisdiction* - What will be the relationship between Home Care Advocacy and Adult Protective Services Programs in each state? Adult Protective Services has jurisdiction in cases of abuse, mistreatment and neglect o. elders and, in some states, the self neglect by elders who, may be refusing home care services

II. Expanding the current Long-Term Care Ombudsman programs' mandates requires extensive program changes.

1. *Conflicts of Interest* - If home care advocacy is included in the 1991 reauthorization, how will the issues of conflict of interest, independence and program integrity be addressed? Congress has specifically prohibited the placement of long-term care ombudsman programs in an agency which may be "an agency or organization which is responsible for licensing or certifying long-term care facilities ..." 307(A)(12)(A). Ombudsman Programs are operated directly or by contract with the State Units on Aging and Area Agencies on Aging which fund and/or operate Home Care Programs.

2. *Capacity* - While there are states that have strong Long-Term Care Ombudsman Programs which provide regular visits and problem resolution to all the facility-based residents in the state, the majority of the states have Long-Term Care Ombudsman Programs that despite major efforts, have not reached this goal. Congress intends a stronger role for the Long-Term Care Ombudsman Program in the area of Board and Care Facilities and enforcing the provisions of the 1987 OBRA - Nursing Home Reforms. Further expansion of the mandate will result in diminished services for the institutionalized elderly.

3. *Funding* - What additional types and amounts of funding will be appropriated for programs for the resolution of home care complaints which do not reduce resources from current facility-based resident focused services? The Long-Term Care Ombudsman Program is underfunded and in some states, is unable to meet current obligations and mandates.

4. *Liability Issues* - What type of liability issues will be addressed, both for client and Ombudsman safety?

5. *Staffing* - What type of staff will be utilized to conduct investigations? Will Congress require programs to utilize volunteers?

6. *Training and Support* - What type of training and other support or guidance will be made available through the Administration on Aging or other sources for the development of home care advocacy programs? The Long-Term Care Ombudsman Programs have only recently began to receive on-going technical assistance, despite the model projects being established in 1972-73

Advocacy for the residents of long-term care facilities is our primary focus and it is under this aegis that we urge caution. The National Association of State Long-Term Care Ombudsman Programs must advocate to protect residents' access to our services which will be diminished if expansion to other areas takes place without adequate funding and proper authority. Our first commitment must be to the residents. However, we recognize that we have developed considerable expertise over the years which will benefit home care recipients. We further recognize that in a few states, the Long-Term Care Ombudsman Program is already responsible for advocating on behalf of recipients of community based long-term care services. We are enthusiastic about working with Congress and others to share our expertise in a manner that will provide the most effective services for community and facility-based, vulnerable elders.

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PREPARED STATEMENT OF JOAN WALKER

My name is Joan Walker. I live in Bangor, MI, where I am a small business owner and someone who has had great exposure to nursing homes, both as a volunteer and now as the guardian for my own mother who has had to seek such care in the last two years. I am pleased to have the opportunity to testify before this Committee, and I hope my comments will be of assistance to you as you look at the ever-persistent problems of quality nursing home care.

Eleven or twelve years ago, because of media attention to nursing home problems, I volunteered my services as a nursing home advocate until the program I was with ended in 1980 due to budget cuts. At that time, my interest was based on a general concern for a sector of humanity needing a spokesperson. Now, in 1990, my concern about nursing homes is personal, overwhelmingly frustrating, even heartbreaking, as I try to find acceptable care for my own mother and discover that in spite of reforms and regulating agencies enormous problems still exist.

My 87-year-old mother had to give up her home two years ago after surviving congestive heart failure. She required 24-hour supervision and personal care, but because one of my daughters was dedicated to helping "Gram" and because I could afford some help and respite relief, we managed until sometime in May when she experienced renal failure and went into congestive heart failure again. She was released from the hospital, perhaps too early, but nonetheless, unable to walk or even stand-up. She had a permanent catheter and needed 24 hour monitoring of her heart arrhythmias and fluid retention.

We chose one of the two homes available to us. It was in a nearby town where my mother could maintain her same doctor and he could make monthly visits and monitor her care. Of the two homes, I am sorry to say, we chose the one with the relatively "pretty face," a mistake we soon began to regret.

My mother needed—and still needs—not highly skilled technical care, but rather she needs to be fed, to be kept clean and as comfortable as possible. And she needs and deserves to be treated not like a demanding burden, but as the caring person she herself has been, having volunteered over 100,000 hours to Red Cross which led to her being one of the few to ever receive the Clara Barton award.

I'll make as brief a recitation of the problems encountered as possible. Please bear in mind that I documented these problems, and as they mounted, I made requests, pleas, quite reasonable complaints, angry complaints, even threats. All were met with denial and hostility—hostility that increased with each episode until I am sure my mother became the object of the hostile stubbornness as well.

When Mother first entered the home she was given a bed with a defective bedrail that dropped with even the slightest finger pressure. She kept falling out of bed, sustaining severe bruises and even knocking out a tooth. At first they tried to convince me that she was climbing out of bed (an impossibility). Finally, when a nurse and I determined together that the siderail was faulty we requested repair. At a later date the home called to inform me that Mother had again fallen out of bed. I asked if the rail had been repaired; they said it wasn't broke. They finally admitted that the bed needed repair and repaired it but it is sad that it had to come to the point of extreme emotions, even threats and injury to my mother before the home made the repairs.

Mealtime for the residents who required the most care was another nightmare. Because they always operated short-handed, staff would begin moving those who needed to be fed to their dining room up to two hours before the meal. There they would sit laying their heads on the table and staring at each other for hours while the staff moved those able to fend for themselves (and thus complain) to their dining room and feed them. Then, they would feed the non-eaters, sometimes as few as two aides for 30 residents, more often with four aides to feed the thirty. Ultimately, after having lukewarm, stale food poked at them, the residents would be moved. Staff would move some to their rooms and others to a hall close to their rooms where they would remain sitting in their wheelchairs. Meanwhile half of the staff ate and the other half, having eaten, started putting the more lucid and mobile residents to bed.

I highlight this situation because sitting in a wheelchair for five hours is not only uncomfortable, but also detrimental for a woman of 87 years, who suffers from spinal arthritis and is susceptible to bed sores and distressed breathing. Events and circumstances of neglect like this that I have mentioned, and other examples that I will cite later in my testimony, were not isolated events. Rather they were a part of a disturbing trend that I witnessed after spending significant time daily at the nursing home. Because of the poor situation at mealtime and my increasing mistrust of

the home, my daughter and I would make sure that either she or I would be present every evening to feed Mother and help get ready for bed.

I can't say how clean the other residents were, but I know my Mother was not given perineal care that even approximated acceptable practices. When she had the catheter and bag, I never witnessed them attending to even an examination of the catheter. As a result they told me that they had removed the catheter, however, the nurses notes reflect that it was found in the bed and they decided not to continue using it. By this time, she had developed a serious bladder infection that continued to give her the feeling of urgency, but when she called for help to go to the bathroom, nursing staff continued to assume (and say) "Oh, she always says that because of the catheter." When she finally could hold back no longer, they assumed (and said) "Oh, she's incontinent."

When I complained because of the lack of any nursing care to the catheter to the toileting, they put her on a bladder-retraining program. That program was largely ignored, becoming nothing more than a chart on the door occasionally filled in at the end of a shift as though they had observed the routine toileting for which it called. Sometimes it wasn't filled in at all.

They continued to say she was incontinent, without any evidence whatsoever that would show assessment by data collection to determine any pattern of incontinence. Meanwhile the bladder infection and the feeling of urgency only increased.

Infection control at the home was not evident in any way either. For example, staff rarely washed their hands before handling my mother or other patients. Her catheter bag sometimes leaked all over the carpeting in the hallways, a condition ignored even after I pointed it out. Once when she flooded the bathroom floor on the way to the toilet, the attendant wiped up the urine with a dry mop and replaced the mop back in the closet without even rinsing it out.

There are several things which I would like simply to touch upon as they were again part of a trend of apparent neglect at the nursing home. Unnecessary restraints were used on Mother in her wheelchair and in bed. She was to be repositioned frequently because of a bedsore and due her arthritic conditions, however, this was very rarely done. Though my mother cannot communicate pain and discomfort as she used to, this does not suggest that she not longer feels pain or discomfort. To cleanse the bedsores they used a wet wash cloth. The did not use pariwash or cleanser to clean them and they didn't towel dry the area or apply ointment or powder to prevent friction and promote healing. Little attention was paid to her fluid retention. Her legs would swell monstrously, but it was I or a few kind aides that would elevate them.

Restorative nursing techniques were not even properly assessed let alone used. Out of ten keys on her assessment scale, only one was marked and it was improperly assessed. She had little, if any actual attention paid to range of movement, alignment and positioning to improve her condition, or at least try to keep her from deteriorating. Her finger nails were never cleaned or cut, nor her hair. But those things cannot even compare with improper assessment of her respiratory problems.

It took a week of requests, some written, to get the nursing staffs to pay attention to her distressed breathing. Finally I demanded that if they wouldn't call the doctor I would call him myself. Not until then did they put her on oxygen and increase her diuretic. By then it was too late. The next day, she ended up back in the hospital—cyanotic and desperately sick. She had in addition to the respiratory and renal failures, contracted pneumonia. She remained in the hospital for more than three weeks.

In the 39 days that Mother resided in that particular home she had lost 27 pounds and had gone downhill to a painful frailty. Still the nursing home management continued their hostile, defensive attitude, attempting to say that because my mother paid privately we expected special treatment and that I just couldn't be pleased!

Upon Mother being admitted to the hospital the home told me that the opportunity would be a good one for me to seek an alternative facility for my mother. We did find another home and though she has not been there very long I do want to note the contrasts.

On the surface, we have found the home to be cleaner. The initial interviews we held were professional. The assessment the staff gave my mother seemed thorough and more accurate. I believe that they made a greater effort to know Mother before she entered the home and began receiving care. Thus far, I have approached the staff in the same manner as that which I did in the beginning at the former home. The staff is open to my impressions and suggestions related to Mother's care. Already we have been able to work together to find resolutions to my concerns that may even be carried over for the benefit of other residents as well. I have not been met with hostility or stubbornness and as yet they have not denied the validity of

my concerns. Past experience has taught me the importance of visiting frequently so as to stay finely in tune with Mother's physical condition and the care which she is given. I will continue to work and hope that Mother will receive the care and attention she needs in the new home we have chosen. I have taken the first steps in filing a formal complaint against the former home as I feel strongly that it my responsibility to do so. I will proceed in the process as soon as Mother is settled in her new environment.

Thank you for allowing me to share my story with you, Senator. I hope it will be helpful to you and the Committee.

PREPARED STATEMENT OF THOMAS D. WATKINS, JR.

Good morning: I am Tom Watkins, Director of the Michigan Department of Mental Health. I appreciate being able to make a few comments regarding the quality of care in nursing homes. The Department of Mental Health has been addressing quality of care in nursing homes for many years and the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1987 has significantly increased our involvement.

In 1977, the Department developed and funded projects at seven community mental health boards to provide mental health services to persons in nursing homes. The Department continued to expand and support those programs even through the recession and severe fiscal crises of the early 1980's. These nursing home consultation programs were given additional support in 1978 by the Michigan Legislature's passage of nursing home reform provisions in the new Public Health Code. Among other things, this law requires each nursing home to have an agreement with the local community mental health board to provide assistance and training to the facility in providing for the mental health needs of the facility's residents. It also prohibits a nursing home from admitting any person with mental illness or mental retardation for whom the facility is unable to provide active treatment for the person's mental illness or mental retardation. Given this history, the Michigan Department of Mental Health supports the underlying principles of the Omnibus Budget Reconciliation Act (OBRA) of 1987, particularly those which are intended to ensure that persons with mental illness or developmental disabilities receive appropriate care and services. Unfortunately, there are problems in the statute and in the implementation of this law which have prevented residents of nursing homes from fully realizing, and the States from fully implementing, the promises of this legislation.

Unreasonable time frames and lack of final rules for implementation are major problems. Implementing pre-admission screening programs in an environment where hospital DRG's can limit adequate hospital discharge planning is a challenge, to say the least. Lack of professionals and adequate training of professionals make compliance with the law difficult.

As my colleague from the Department of Public Health will discuss, the manner in which the Health Care Financing Administration (HCFA) has failed to implement the provisions of OBRA has created confusion and uncertainty throughout the private and public sectors of the nursing home industry. For example, as both the "STATE MENTAL HEALTH AUTHORITY" and the "STATE MENTAL RETARDATION AUTHORITY," this Department has been intensely involved in efforts to implement the mental health preadmission screening/annual resident review process. At this point in time, the preadmission screening process has been in place for over twenty months and the deadline for completion of the initial annual resident reviews, April 1, 1990, has come and gone. Yet, HCFA has failed in spite of two admonishments by Congress, to issue final criteria and rules for the preadmission screening and annual resident review process.

All that the States have received are periodic confusing and contradictory "guidance" from HCFA. We constantly have to revise our system and procedures to meet each changing "guidance" from HCFA. We are also expected to enforce compliance by the nursing home industry even though we are unable to provide it with a consistent, stable set of requirements. This is patently unfair. We never know when HCFA will change the rules and stick the States with the fiscal consequences.

Because the law mandates that States must implement requirements even if the Federal Government does not issue final regulations in a timely manner, we are faced with the specter of major disallowances in Federal financial participation if we have not implemented in what HCFA deems the appropriate manner. For example, one of the initial HCFA guidelines indicated that only persons with severe mental illness needed to be screened. Most States, including Michigan, relied upon

that direction. Within just four months, HCFA changed its guidance to include all mental illnesses. At this point, it appears that the State of Michigan could be subject to disallowances if those persons were not screened as HCFA now deems appropriate. Another example is the mandate that the initial resident review process be completed by April 1, 1990 without final Federal guidance. These and many other obstacles have prevented Michigan and other States from implementing this legislation in as timely and appropriate a manner as we would have liked. However, regardless of our good faith efforts, Michigan and other States will be penalized financially for not implementing a law which was imposed on the States by the Federal Government, but which the Federal government has been unable to assist us in implementing. *If HCFA's rule writers were half as diligent as its auditors, we would not be discussing these problems today.* The potential loss of these Federal dollars will mean much less State money available for services to persons in nursing homes, as well to the many other citizens whose needs the State must address. *It seems the Federal Government is more interested in placing the States in a catch-22 than high quality care for persons in nursing homes!*

In addition to the loss of Federal financial participation which we may face because of problems in implementation, OBRA has also placed an additional financial burden on the States. In Michigan in the human service area, we are dealing with overwhelming and competing demands for scarce resources. We have endeavored to balance these demands as best we can. Enactment of a law such as OBRA, though well-intentioned, imposes an additional burden on the State at the expense of some other population or some other service. Effectively, the Federal government determines Michigan's human service priorities and sends us the bill.

It can be argued, of course, that this is the price the State pays for joint Federal/State participation in the Medicaid program. OBRA, however, goes beyond joint participation and imposes on the States service requirements for which only the States must pay. For example, the OBRA legislation allows a person who has been inappropriately placed and requires active treatment to remain in the nursing home if he or she has resided in a nursing home for more than 30 months. If the person chooses to remain, the State must provide for active treatment without Federal financial participation in the cost of such services. Already, HCFA auditors in Michigan have suggested that certain services being provided by nursing homes to persons who are developmentally disabled are active treatment services and therefore, should be disallowed for Federal reimbursement. At the risk of sounding paranoid, it seems that HCFA is more interested in shifting costs to the State than in providing quality care.

In making these comments, I would be remiss if I did not suggest some ways that Congress could remedy the existing situation. *First,* consideration should be given to the good faith efforts States have made to comply with OBRA legislative requirements. The Federal Government should not be permitted to take disallowances against the State for failures in implementation until a reasonable time following the issuance of final rules or criteria. This is consistent with recommendations of organizations such as the National Governor's Association, the National Association of State Mental Health Program Directors, and the National Alliance for the Mentally Ill that Congress add language prohibiting HHS/HCFA from imposing sanctions for non-compliance prior to the publication of final rules and preadmission screening and annual resident review appropriateness criteria.

We are more than willing to try to shoot at a moving target—but what HCFA has done is to make the target invisible. Take your best shot—but if you miss, there are *big* penalties to pay.

Second, there is movement on the part of various organizations to have Congress pass a number of technical amendments to OBRA. Congress did not address these concerns last year and that unfortunately has resulted in further confusion in implementation. One amendment of particular concern is that States be permitted to amend our Alternative Disposition Plans. As you know, each State was required to submit an alternative disposition plan to HCFA for the alternative placement of persons inappropriately placed in nursing homes.

Michigan has been granted an extension to October 1, 1994. This effort will require us to quadruple our community residential development efforts and will cost the State approximately four times the amount of the current cost for each individual, because we will be serving more individuals in more expensive settings. While we have committed ourselves to that effort, lack of financial and other resources may delay implementation. Additional time makes this project much more realistic.

Lastly, if the legislative intent to prevent inappropriate admissions to nursing facilities is driven out of concern for clients (and not as a cost-saving measure), the Federal government should provide incentives to States like Michigan, which have a

desire and strong history of providing community-based alternatives. Additional, more flexible Federal support is needed in order to provide mental health and mental retardation services to people, regardless of where they live.

Perhaps we need a Federal Headlee amendment to prevent the Federal Government from setting State priorities and then sending us the bill.

We in Michigan, support quality care to all vulnerable citizens. We support the intent of OBRA. We want fair, consistent rules to follow and we want our Federal tax dollars to follow the Federal mandates.

Thank you for the opportunity to make these remarks. I would be pleased to answer any questions you may have now or to provide you with further information at a later date.

COMMUNICATIONS

RESPONSES TO A REQUEST FOR COMMENTS BY SENATOR RIEGLE

United States Senate

WASHINGTON, DC 20510

TODAY'S NURSING HOMES: IMPROVING QUALITY OF CARE

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: Mrs Josephine (Carl) Dartscht

Address: 2270 Timberlane Dr
N. Muskegon Mi 49445

not **Representing:** but I am a delegate to MEA-R & Asst State ~~Director~~ AARP

****

I have also been on State Legislative Board AARP

I invite you to attach a prepared statement or to submit your written testimony: I wish to state - Michigan State does not pay enough to nursing Homes for Medicaid patients so they can obtain better help.

I also feel that some people are being imposed upon as they are requested to pay (Medicare patients) which is against the law according to "Citizens for better care" The clothes are not taken care of properly - again because of the poor help & I would like to tell you my experience in trying to help a retired teacher this past 8 months - I have been in Many Nursing homes +

find the same problem in "most" — Nursing home in Hart Mich is an excellent home as to what we have seen in a small town

I listen to all these things to do to the Nursing Homes — Why don't they try to pay the Nursing homes (what other states do) for Medicaid patients so the nursing homes can hire more efficient help? see if that would not eliminate a lot of the [illegible] You know AARP is working very hard to find out what the people want in long term or National help care

It won't help to train people if you cannot pay them enough to continue in that job — & if Medicaid does not pay enough the Nursing homes cannot pay the salary either —

August 18, 1990

Marian Vanden Berg
1318 Adams S. E., Grand Rapids, Michigan 49506

Dear Senator Riegle,

I'm grateful for your interest in improving the quality of care in nursing homes; - some give excellent care and some give very poor care.

My husband and I are co-conservators for a 97 year old friend who lives in the

Michigan Christian Home
1845 Boston S.E.
Grand Rapids, Mi 49506

where we visit frequently.

The quality of care at Michigan Christian Home is excellent in every respect.

The poor homes must be upgraded and the excellent homes should be celebrated. We recommend Michigan Christian Home for celebration.

Sincerely yours,
Mrs. Marian Vanden Berg

WILLIAM O. BIANCONI
7760 BLUEBIRD DRIVE
JENISON, MICHIGAN 49428

Aug 14-1990

To: The Honorable Donald W. Riegle, Jr.
Chairman, Finance Subcommittee on Health for Families and the Uninsured

Dear Senator:

Thank you for your letter of July 19, 1990 and the concern you expressed on improving the quality of care in Nursing homes. This is a noble and humane effort.

However, I feel that there are a growing number of people like myself that are much more concerned with the Right to DIE with Dignity. I do not want to be helplessly strapped in a bed and force fed! For my-self I would prefer voluntary Euthanasia, before I become too disabled.

I would appreciate making this point to your Subcommittee when you may have the appropriate opportunity.

Respectfully yours,

William O. Bianconi

1410 BLUEBERRY LN.
FLINT. MI. 48507
AUGUST

SENATOR REIGLE.

I WAS TOLD THAT YOU WERE HAVING A MEETING IN GRAND RAPIDS ON AUGUST 28TH ON NURSING HOMES.

I WOULD LIKE TO COME - AS MY PARENTS HAVE BEEN IN A NURSING HOME FOR TWO AND HALF YEARS AND I FEEL I COULD TELL YOU - WITH AUTHORITY - QUITE ALOT ABOUT NURSING HOMES. UNFORTUNATELY I DON'T THINK THAT I CAN BE THERE.

SO, I AM GOING TO ATTEMPT TO WRITE YOU OF A FEW OF THE MAJOR PROBLEMS THAT I'VE FOUND & HAVE TO DEAL WITH - BUT WHAT MY PARENTS HAVE TO LIVE WITH & ENDURE!

THE REGULATION OR LAW CONCERN-ING THE RATIO OF AIDES OR NURSES TO PATIENTS IS ABSURD - ON 1ST SHIFT 1 AIDE OR NURSE TO 8 PATIENTS / 2ND SHIFT 1 AIDE OR NURSE TO 12 PATIENTS / 3RD SHIFT 1 AIDE OR NURSE TO 16 PATIENTS. THE ABSURD PART IS COUNTING NURSES IN THIS RATIO. I HAVE NEVER SEEN NURSES DOING AIDES WORK. THEY HAVE ENOUGH WORK OF THEIR OWN TO DO!

IF YOU HAVE FIVE NURSES THE LAW ALLOWS THE "HOME" TO ASSIGN FORTY PATIENTS TO THEM. SINCE THE NURSES CAN'T TAKE CARE OF THESE PATIENTS —

THE PATIENTS ARE REASSIGNED TO THE AIDES. "UPING" THEIR PATIENT WORK "LOAD" TO MORE THAN EIGHT.

SO OUR MOMS + DADS - THE PATIENTS - ARE LUCKY TO GET EVEN BASIC CARE - LET ALONE ANY LUXURIES - AS A HUG OR A KISS.

BUT - THAT ISN'T ALL - WHAT HAPPENS WHEN ONE OR TWO AIDES CALL IN SICK? THE "HOME" CALLS THE AIDES WHO ARE NOT SCHEDULED TO COME IN - IF THEY CAN'T - THE HOME IS SUPPOSE TO CALL AN EMPLOYMENT AGENCY TO GET AN AIDE. IF THE AGENCY CAN'T SEND ANYONE, THE HOME "GOES WITH" WHAT AIDES THEY HAVE. PATIENTS ARE RE-ASSIGNED TO THE REMAINING AIDES - GIVING THE AIDES EVEN MORE PATIENTS THAN THE EIGHT THE REGULATION "CALLS FOR."

THIS HAPPENS ALMOST ON AN EVERY DAY BASIS - WHICH MAKES THE PATIENTS' FAMILIES WONDER IF THEY REALLY DO CALL THE AGENCIES. THIS WOULD BE AN EXCELLENT WAY TO CUT EXPENSES - WOULDN'T IT?

WE DO SEE A FEW AGENCY AIDES - ONCE IN AWHILE - BUT SO VERY FEW - WHILE WE SEE THE AIDES WITH TOO MANY PATIENTS SO MUCH OF THE TIME.

WE'VE SEEN ONE AIDE WITH FIFTEEN PATIENTS. HOW CAN ONE AIDE CARE FOR FIFTEEN PATIENTS? WHAT KIND OF CARE

DO YOU THINK OUR PATIENTS ARE GETTING?

WHAT THE ANSWER IS - WHEN THEY CAN'T GET "HELP" TO COME IN - I DON'T KNOW! I CARE MORE THAT MY PARENTS AREN'T BEING CARED FOR.

THE LAST PROBLEM IS - WHY SHOULD THE AIDES COME IN TO WORK ON THEIR "OFF" DAYS WHEN THE "HOME" OVERLOADS THEM WITH PATIENTS AND THEIR STARTING WAGE IS ONLY BETWEEN FOUR + FIVE DOLLARS AN HOUR AND NO MATTER HOW LONG THEY WORK THEY DON'T USUALLY DON'T GET MUCH OVER SIX DOLLARS.

MEDICAID SHOULD PAY MORE PER DAY PER PATIENT - SO THE AIDES COULD BE PAID HIGHER WAGES.

HOW DO YOU THINK THESE AIDES FEEL WHEN THEY'RE ASSIGNED MORE PATIENTS THAN THEY'RE, BY LAW, SUPPOSE TO HAVE AND THEN THEY DISCIPLED BECAUSE THEY DON'T + CAN'T GIVE THE PATIENTS PROPER CARE? DO YOU THINK THAT THEY MIGHT GET "UP TIGHT" OR SHORT TEMPERED?! GUESS WHO GETS THE BLUNT OF THESE FEELINGS - OUR ELDERLY PATIENTS!

MORE IS PAID PER DAY - PER PERSON TO PROVIDE CARE FOR ROBBERS, MURDERERS + RAPISTS! WHILE OUR SENIOR CITIZENS WHO WITH THEIR HARDWORK, INTEGRITY + HONESTY BUILD OUR STATE + NATION!

IS THIS THEIR REWARD?

THIS LETTER IS PROBABLY TOO LONG BUT THESE ARE ONLY THE MAJOR PROBLEMS - THE MINOR PROBLEMS ARE EVEN MORE NUMEROUS. ISN'T THAT APALLING!

HOW WOULD YOU LIKE TO LIVE LONG ENOUGH TO HAVE TO LIVE IN ONE OF THESE HOMES?

MY HUSBAND & I VISIT MY PARENTS DAILY - SO WE ARE VERY CLOSE TO THE PROBLEMS AND WE HAVE NIGHTMARES OF THIS IS WHERE WE WILL BE FORCED TO TO SPEND OUR "GOLDEN YEARS" IN A NURSING HOME.

THANK YOU FOR HAVING THIS MEETING IN GRAND RAPIDS. AT LEAST YOU CARE ENOUGH TO DO THIS - NOW IF YOU CAN ONLY DO SOMETHING WITH WHAT YOU LEARN AT THE MEETING. WE ARE COUNTING ON YOU!

I HOPE YOU KNOW HOW MUCH WE APPRECIATE WHAT YOU ARE DOING. THERE ARE ALOT OF FAMILIES WITH PARENTS IN NURSING HOMES & THE ONES I HAVE TOLD OF WHAT YOU ARE DOING ARE VERY PLEASED - WHAT IS MORE PRECIOUS THAN YOUR PARENTS! I FEEL THIS IS GAINING YOU ALOT OF POPULARITY AND PROBABLY ALOT OF VOTES!

THANK YOU!

SINCERELY

Betty Dell

P.S. IS THERE ANY CHANCE OF HAVING ANY OF THESE MEETINGS IN THE FLINT AREA?

STATEMENT OF THE DETROIT AREA AGENCY ON AGING

The establishment of the Medicaid and Medicare program created a significant demand for nursing home services. This altered configuration changed the nursing home system from one run largely by religious organizations, philanthropic institutions and non-profit organization into a boom industry. It is indeed unfortunate that the enactment of Federal and State nursing home regulations has lagged far behind this growth and was greatly effected by industry pressure and conflicts of interest. It appears that regulations currently are far from adequate in addressing the problems in the system; and, as the older population continues to rapidly expand, it is imperative that problems be recognized and addressed immediately.

To this end, we submit the following recommendations (it should be noted these items are adapted material developed by the National Citizens Coalition for Nursing Home Reform. This organization is pre-eminent among nursing home advocacy groups and federal policy-makers would to well to acknowledge and study these suggestions):

** Prohibit discriminatory practices against Medicaid beneficiaries.

** Increase coordination between state survey agencies and the long term care ombudsman program.

** Improve residents' access to the Long Term Care Ombudsman Program and others, and protect residents from improper transfer from the home.

** Improve nursing care in nursing homes by upgrading staffing requirements and developing staffing ratios and case-mix reimbursement based on assessments of residents' needs.

** Improving coordination between federal and state government agencies with quality assurance responsibilities.

** Mandating development of a range of state enforcement mechanisms.

** Strengthening federal and state enforcement capabilities and authorities.

** More incorporation of social services and mental health into assessments of residents' needs and care planning and delivery activities.

In addition to these fundamental needs of long standing, these are other issues of more recent vintage that may neccessitate action.

A major reason for inadequate nursing home care in a lack of qualified staff. In a December, 1988 report, the Secretary's Commission on Nursing made the following recommendations to address this situation. We feel that they bear serious consideration:

** States should assess their Medicaid programs on an ongoing basis to ensure that their payment levels allow nursing homes, hospitals and home health agencies to offer compensation adequate to recruit and retain nurses. In addition, Medicaid levels should be updated in a timely manner to reflect increases in nurses' salaries.

** Congress should direct the creation of specific payment methodologies to assure equity between hospital nursing salaries and salaries for nurses working in nursing homes and home health agencies.

** The federal government should reassess its cost cap reimbursement levels to home health care agencies to ensure adequate compensation for recruiting and retaining nurses in home care.

** Private payers should monitor their payment levels for health care provided by hospitals, nursing homes and home health care agencies to ensure that their payment levels permit these organizations to recruit and retain nurses.

We would also add that it appears that the quality of nursing home care would be increased significantly if nurses' aide received adequate compensation. Persons who are entering the field of gerontology are interested in such work if the pay were better. Federal intervention in this regard appears to be necessary.

A November, 1989, symposium on restraint-free care in nursing homes (sponsored by the Senate Special Committee on Aging and the Kendal corporation) indicated that instead of modifying nursing home patients to the environment through the use of restraints, more efforts need to be made to modify the environment to fit the needs of patients. It was also suggested by Gregory Paulson, president of the American Geriatrics Society, that "we need a major national campaign to decrease the use of restraints and develop alternatives."

Finally, in May 1990, the NCCNHR suggested changes to HCFA's Nurse Aid Training Proposal. These suggestions appeared to be both relevant and practical:

Among its suggestions, NCCNHR said HCFA should: make nurse aide training a Level A requirement, as recommended by the Institute of Medicine; require aides in training to wear a badge identifying them as such; require volunteer nurse aides to be qualified and listed on the state registry; and require an additional 24 hours a year of in-service education, including special training for persons working with cognitively impaired residents.

NCCNHR also recommend that HCFA: make each state develop a "train-the-trainer" program; prohibit CPR training from being counted toward the minimum 75 hours of training; require that temporary private duty nurses (sitters) be trained, evaluated and listed on the nursing registry before being allowed to provide such services; and allow licensed practical nurses to conduct or supervise nurse aide training under the supervision of a registered nurse, meeting certain strict conditions.

In February, 1989, the California Law Center on Long Term Care released a study on nursing home residents and waives for facility liability. The study covered five states, but we suspect the information is applicable to many others. The authors indicated that, in fact, their findings reflect what may be a nationwide pattern of violations.

** Lack of Essential Information: Information on patients' civil rights is sometimes not included in the agreement. Instead residents are lead to believe their only rights are those listed in the contract. admissions agreements often do not tell the admittee what services are covered by the daily fee.

** Vague Documentation: The large number of distinct documents given to the admittee make it difficult to define what is part of the formal contract. Generally all such documents should be considered part of the contract. However, the importance of, for example, a patient's rights is clouded when it is dispensed as merely one of a large number of additional hand-outs.

In addition, the survey's authors found many of the papers were difficult to read because of unclear reproduction, obscure legal terminology and the use of non-contrasting paper and ink.

** Waivers of Facility Liability: It is particularly common for facilities to attempt to get the admittee to sign a waiver for personal injury, medical and personal property damage. These waivers are often accompanied by requests for a blanket consent for medical treatment. The authors emphasized that a blanket consent secured upon admission makes a mockery of promises often made to a patient or their family about informed consent.

Other problems listed in the study include: added charges for items or services covered by Medicaid; restrictions on choice of physician or pharmacy; and requiring "responsible parties" to co-sign admissions contracts.

I hope these suggestions prove to be helpful. If you have any questions regarding these comments, please feel free to contact our office.

Paul Bridgewater, Executive Director
Detroit Area Agency on Aging
August 21, 1990

Material for this testimony drawn from the following:

1) Older Americans Report, December 16, 1988; February 10, 1989; December 8, 1989; May 25, 1990.

2) Legislative Reform for Quality Care in Nursing Homes - National Coalition for Nursing Home Reform, Spring, 1987.

3) Program Development Handbook for State and AAA's on Nursing Home Ombudsman Services fot the Elderly, USDHHS, AoA.

August 20, 1990

Mary Lou Dwan
2504 Charlevoix Ave.
Petoskey, Mich. 49770

Senator Don Riegle
110 Michigan Ave.
Room 720
Grand Rapids, Mich. 49503

Dear Senator Riegle:

My mother, Eva L. Moore, has lived at the Michigan Christian Nursing Home on Boston Ave. in Grand Rapids for approximately 3 years. When she originally moved there, she was in the independent side where she had a room of her own with her own furniture, etc. Both my mother, and our entire family, were very happy with the quality of services that she received there.

On 8/17/89, Eva fell and broke both hips and both arms. Since she was 84 years old at the time, the prognosis for her recovery was not very optimistic. Nevertheless, with the marvelous care that she has received there, she has progressed to the point where she can take a few steps on her walker. She spends most of her day in her wheelchair, but she has come from being entirely dependent on others for feeding, dressing, and going to the bathroom to the point that she can now do all these things for herself.

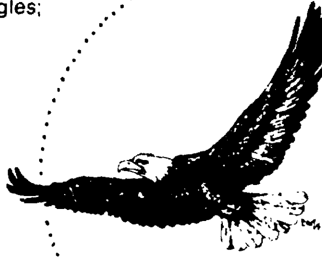
Not only are the personnel at the home very caring, but the other residents are willing to help one another who have needs that they can perform. For instance, when my mother was completely incapacitated, many residents contributed their time in whatever ways they were able. One resident read to her almost daily, another fed her, and many were just there with encouragement.

I would highly recommend this home to anyone who has this type of need. I'm sure my mother would agree with these comments.

Sincerely,

Mary Lou Dwan

But they that wait upon the Lord shall renew their strength;
they shall mount up with wings as eagles;
they shall run, and not be weary;
and they shall walk,
and not faint.
Isaiah 40:31



August 22, 1990

Dear Senator Riegle,

I am writing this letter to let you know about the Michigan Christian Home.

My mother, Marie Blain, has been down in the Health Care Center since Feb. 1990.

She has received excellent care from all of the nurses. They treat each patient with lots of love and extra special care.
The patient is kept clean, dressed everyday, good meals, clean room, and what ever it takes to make the patient comfortable and happy
The home never has a bad odor like many of the nursing home.
My mother and all of the others like it there
It's a home away from home.
I'm so thankful that we do have places like the Michigan Christian Home for our loved ones
When I'm old I hope I'll be cared for like my mother is at the M.C.H.

There is no comparison to the other nursing homes she has been in.
The care and nursing staff is excellent.
My sister and three brothers also confirm this.

Yours truly,
Mrs. Leona Hage
Mrs Vivian Robbins
Mr Clifford Blain
" Harry Blain
" Ray Blain

376 Wildwood Dr.
Holland, 49423
August 13, 1990

Donald W. Riegle, Jr.
Chairman, Finance Subcommittee on
Health for Families and the Uninsured
Suite 716 Federal Bldg.
110 Michigan Ave, N.W.
Grand Rapids, Mi. 49503

Dear Sir:

I wish to thank you for this opportunity to submit written testimony regarding nursing homes in this area of Michigan.

For the past fifteen years my work has taken me into the nursing homes of Holland and Zeeland. Like many other individuals I have witnessed incidents which heighten the inequalities laid on the residents in nursing homes - men and women who, as soon as they enter the doors of such an establishment, often lose their identity as one with a given name, but become a number in a bed, down one corridor. I have seen a resident swirling her false teeth in her cup of coffee in order to clean them; a resident unable to take her glass of water from the stand--she was blind but no-one had come to check on her. I have seen the use of physical restraints and residents sagging with exhaustion; the use of chemical restraints and patients lying in a stupor. I have seen bad food. To be honest, though, I have also witnessed cases where residents have received skilled, loving care. However, a litany of abuses is common. My contention had been that when the small personally managed nursing home was 'taken over' by the large 'for profit' companies, then the quality of care diminished rapidly.

One of the sad realities is that government inspection of nursing homes became less feared during the past decade, when Federal funding was cut, inspections were less frequent; nursing home administrators were aware when the inspectors would arrive at their facility and scramble to 'tidy up'. How one longed an inspector could arrive, unannounced!

During the past 18 months there has been a change taking place amongst the nursing homes in this area. One facility was taken over by a small not-for-profit organization. The facility is in need of renovation, but the the morale of the staff rose. Wages were increased; more aides were hired; training of both aides and nurses became the norm. The personhood of the resident was stressed. Offering the staff a decent wage and good working conditions soon became an issue with the other nursing home facilities--to compete and hold their staff they too had to offer a better wage. Life within the walls of the nursing home in this area is not perfect, but I would stress that morale of both resident and staff has improved and recognizing the worth of nurses, aides, and administrative staff by giving them a better salary and training, can lift the quality of care offered to the resident.

Federal budget cuts threatens the quality of care in nursing homes when much-needed changes cannot be implemented; and Medicare and Medicaid reimbursement should be greater. Since hospitals have had to comply with DRGs and the patient has been discharged from the hospital after a short stay, the role of the nursing home has altered. Many of their residents are sent to them from the hospitals for skilled nursing care, then basic care. Many of these residents walk out of the nursing home facility and return to their homes - the legend that you enter the nursing home to die is not true. The nursing home can, and does, offer long-term rehabilitative care, but there is no reimbursement for such services in the present Medicare and Medicaid rates. If you are a 'private pay' patient regular rehabilitative services can be given--but once the money runs out, or you become a Medicaid patient--what then?

If the Federal government truly wishes to offer good quality care to the elderly and those other men and women who must seek help from nursing home facilities, then a key to improving the quality of care in nursing homes is to increase Medicare and Medicaid reimbursements.

The financial costs of care in nursing homes are staggering. For many, nursing home care is unattainable - under present conditions, the nursing home operator insists some residents must be 'private pay' if the facility is to remain open. The present health care system discriminates against those men and women on low income. Their voices must be heard.

Attached is a letter written by one who has been an administrator of a nursing home. She gave me permission to submit it as testimony.

Sincerely,

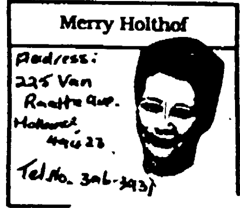
Marjorie Hoeksema

Marj. Hoeksema

Encl. 1.

Opinion

Per diem for long-term care patients must be raised



My Side

I have heard on the news and read in the "Sentinel" with great interest the articles and items relating to long-term health care in rural areas in the state of Michigan.

Although many of the points stated are well-intentioned and important, there are significant items that are being overlooked. As a recent director of nursing in a long-term care facility, there are several points that are not being considered in the greater scheme of long-term care.

First, it is important that legislators and the public revise their opinions on long-term care in general. Nursing homes are no longer places where elderly people are "dumped" or "left to die." I am not denying that this is true in some cases, but the focus of long-term care has changed within the past few years.

I am not denying that residents die in nursing homes, but it must be pointed out that the focus in nursing homes and long-term care is toward self-independence and rehabilitation. Many residents who come into long-term care facilities are now walking out with either canes, walkers, or entirely on their own. This is a great tribute to all personnel employed in long-term care facilities.

Second, these legislators are entirely accurate when they state that the Medicaid and Medicare per diem rate must be changed. It is impossible to provide quality patient care, as well as rehabilitative care, on the daily rate that government agencies provide.

State and federal regulations indicate that long-term care facilities must provide special services, but do not reimburse for these services. Elderly people who have less rehabilitation potential than others suffer. This is not fair. A resident with less potential will indeed profit from extensive rehabilitative care, but they are denied this care by the very legislators who are "advocates" of geriatric nursing.

Third, nursing homes are rated upon the type of nursing care provided. Yet, the state legislators do not seem fit to award a decent Medicaid and Medicare per diem rate to offer competitive wages for licensed nurses. I am sick and tired of hearing that licensed nurses who work in long-term facilities are "inferior" nurses.

These nurses must be experts in assessment skills. Nurses that work in hospitals have physicians on call or in the hospital who can respond to emergencies. Licensed nurses in long-term care facilites are "on their own."

These nurses work from a broad set of "standing orders" that provide for nursing judgment. If the judgment is wrong, the resident may die. This, fortunately, does not happen. Why? Because licensed nurses in long-term care facilities are unique and special. They are willing to take the risk for lower pay and autonomy because they truly care about the needs of the elderly.

I have frequently heard geriatric nurses express, "The government doesn't care, so I must." This truly indicates a "superior" nurse. In order to keep and recruit superior nurses in long-term care, wages and benefits must be competitive with acute (hospital) care nurses.

Family members should appreciate the care these nurses attempt to provide under extremely adverse conditions, rather than to condemn the nurses. What are these adverse conditions? Namely, nursing home owners and administrators who do not care about the residents, whose main concern is the "bottom dollar." If the Medicaid and Medicare reimbursement rate was adequate, this attitude might disappear.

Fourth, the caring and dedication of the hard-working nursing assistants is too underrated. As of Oct. 1, 1990, nursing assistants in long-term care facilities must be certified. This is not true of nursing assistants who work in hospitals. What kind of double standard is this? Yet, nursing assistants in hospitals earn more money and benefits. This, again, should speak of the dedication and caring these nursing assistants give.

They could be working in a hospital or a factory and gaining more salary and benefits than they ever hope to receive in a long-term care facility. Yet, they stay! Congratulations to them all.

Fifth, the state surveyors themselves are a problem. These are the people who are supposed to insure that nursing care is adequate in long-term care facilities. These surveyors are more interested in paper work and documentation than in actual nursing care. Licensed nurses are currently spending at least one-half of their working shift documenting, rather than supervising nursing care given by the nursing assistants.

I am not saying that documentation is not important, but physical care should be more significant. However, this is not the criteria that state surveyors use when evaluating nursing homes. A "happy medium" must be reached between the two for long-term care to be truly effective and meaningful.

Those of you who may be reading this letter should contact their state legislator and demand reforms and a per diem rate that will allow administrators to "open the purse-strings" so that decent care is not the "Impossible Dream" but a reality.

We must realize that the way Americans treat the elderly is abominable, that we do not appreciate the resources the elderly have, and what they can teach us. Citizens of the United States (and Michigan) must begin to realize that the elderly are very precious, and that we will all be elderly some day.

Holland resident Merry Holthof is a registered nurse.

115

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August 28, 1990

Sen. Donald Riegle, Jr.
700 Washington Sq. Bldg
Lansing, Michigan

Dear Sen. Riegle,

Unfortunately, I was unable to attend the meeting this morning. I lead a Senior Citizen group and am certainly interested in the topic of "improving nursing home care", however.

Will you please send me any information or types of action that have come out of this meeting? We all appreciate your interest in this matter.

Sincerely,

(Mrs. Duane) Virginia Huntoon
2831 Kibby Road
Jackson, Michigan
49203

1845 Boston S.E.
Grand Rapids, Mi. 49506
8-13-90

Honorable Senator Don Riegle,
Chairman, Senate Finance Subcommittee
on Health for Families

I am thankful for your concern in holding a "Hearing" on Today's Nursing Homes.

We entered Michigan Christian Home in 1957, where we get excellent quality care.

In February, I received notice that he could no longer remain in my care. I have Multiple Sclerosis, and was losing too much weight. He was so helpless and kept me awake nights.

After the doctor examined him and he was diagnosed as having Dementia, he would have to be placed in a nursing center.

There are 70 rooms here for people who can care for themselves, and a 30 bed wing for those who need 24 hr. nursing care.

There was no empty bed there, so I had to place him at a distant nursing home, until there would be an empty bed here. He was there three months, until it became available here. He has been here since June 6, and gets such wonderful, loving care. He is always kept neat and clean, and smiling, when I go down stairs to see him.

The Administration are planning to build a wing for 20 beds, for those who need some assistance from nurses, but not a great deal. If you can suggest any way to speed this on the way, it would be appreciated, we really need it.

Sincerely,

Virginia + Edward Knapp.

John Kuiper.
2000-32nd St. S.E.
Grand Rapids, MI
49508

Luther Village.

Dear Mr. Riegle.

I am Living in a retirement Home
my wife and I moved in here
4 years ago in June. my wife
passed away, may 18-1990 she
was moved to Brookcrest nursing
Home in Grandville in march 21.
now I live alone in 1 room
in Luthervillage. I have Pagets
decease and have prostate cancer
am 90 years old in Oct 28-1990
live of Social security and
S.S.I. supplement $215 S.S.I. and
$560 social security. Have $500.00
in savings account 120 Dollars
in cheking account. and have to
Pay part of the Funeral expense of
my wife. not enough to pay my
rent here, Can I get some help
somewhere?

Sincerely John Kuiper.

STATE OF MICHIGAN

JAMES J BLANCHARD, Governor

DEPARTMENT OF PUBLIC HEALTH

3500 N LOGAN
P O BOX 30035, LANSING MICHIGAN 48909
GLORIA R SMITH PhD MPH, FAAN, Director

September 8, 1986

Ms. Opal Meekhof
207 Pickett, S.W.
Wyoming, MI 49508

Complaint #86-0662
Cascade Care Center

Dear Ms. Meekhof:

Your recent communication alleging possible violations of laws, rules, and regulations by a health care facility has been received by the Department. The allegations have been reviewed and assigned to one of our investigators, who will be visiting the facility without advance notice. Upon completion of the investigation, we will notify you in writing of our findings.

Thank you for bringing this matter to our attention.

Sincerely,

James L. Buchanan, Chief
Patient Rights Investigation & Monitoring Section
Division of Licensing and Certification
(517) 335-8511

JLB:ce

STATE OF MICHIGAN

JAMES J BLANCHARD Governor

DEPARTMENT OF PUBLIC HEALTH

3500 N LOGAN
P O BOX 30035 LANSING MICHIGAN 48909
GLORIA R SMITH PhD MPH FAAN Director

November 5, 1986

Opal Meekhof
207 Pickett, S.W.
Wyoming, Michigan 49508

Complaint # A86-0662
Cascade Care Center

Dear Ms. Meekhof:

This letter is the Department's report to you regarding our completed investigation of your complaint against Cascade Care Center on September 8, 1986. The [redacted] Paulann Andrews, R.N., Health Facilities Representative of this Division in conjunction with Dodie Denman, Business Manager; Rhonda Bishop, R.N., Director of Nursing and Mary Santorelli, R.N., Nursing Coordinator.

In regard to the allegations, our findings and conclusions please see the enclosed complaint investigation report.

> The facility must respond to the cited violation(s) with a plan of correction. If this plan is not submitted or is inadequate may result in Department actions against the facility as provided for in the Public Health Code or, [redacted].

You have a right to request a hearing if you are dissatisfied with our investigation or determination. However, prior to the hearing an Informal Conference will be scheduled, if you desire, with representatives of the facility and the Department which may resolve

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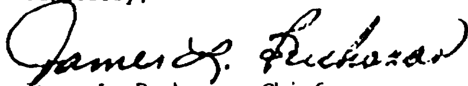
November 5, 1986
Page 2

the matter prior to a formal hearing. If the matter is not resolved at the Informal Conference, a hearing will be scheduled within 30 days after receipt of your written request for a hearing which should be submitted to:

Gloria R. Smith, Ph.D., M.P.H., F.A.A.N.
Director
Michigan Department of Public Health
3500 N. Logan Street
P. O. Box 30035
Lansing, Michigan 48909

Thank you for bringing this matter to our attention.

Sincerely,



James L. Buchanan, Chief
Patient Rights Investigation and Monitoring Section
Division of Licensing and Certification
(517) 335-851[illegible]

JLB:ce

[illegible]-332
[illegible]hority: P.A. 368 of 1978

Michigan Department of Public Health
Statement of Deficiencies and Plan of Correction

Facility Name: Cascade Care Center | Report Source: Abuse Report A86-0662 | Facility No. 41-4330
Type of Cert: SNF

Cited for #	STATEMENT OF DEFICIENCIES	FACILITY PLAN OF CORRECTION and PLANNED COMPLETION DATE
/86	20201(2)(e) The facility did not provide adequate care to protect the patient from injury. There is documentation in both the patient record and the Accident/Incident Report that the patient "slid out of the hoyer net" resulting in a basilar skull fracture. The Accident/Incident Report further cites as measures to be taken to prevent a recurrence of the Incident, "Be more careful of how hoyer net is placed." Staff who were involved in the transfer corroborated the report stating that the net "slipped from under" the patient. "There were only two of us and we just couldn't hold (him/her)."	

I hereby certify that I have evaluated this facility for compliance with the applicable licensure and/or certification requirements. The deficiencies listed constitute those requirements found to be not in compliance, and that the deficiency statements accurately describe conditions on the indicated citation date.

Paulann Andrews, R.N. 123 #173

Date

5/84

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STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL

STANLEY D. STEINBORN
Chief Assistant Attorney General

FRANK J. KELLEY
ATTORNEY GENERAL

LANSING
48913

April 13, 1987

Mr. William J. Garlington
Attorney at Law
2640 Dehoop Avenue, S.W.
Wyoming, MI 49509

Dear Mr. Garlington:

RE: DONALD MEEKHOF

I represent the Michigan Department of Public Health (Department) in an administrative proceeding concerning care rendered by Cascade Care Center to Donald Meekhof, deceased. The Department determined that the facility failed to render adequate and appropriate care to Mr. Meekhof and issued a Civil Penalty Order against the facility pursuant to the Public Health Code. (A copy of the Civil Penalty Order is attached.) The facility appealed and an administrative hearing before an independent hearing officer is scheduled for [illegible] 1987.
there are 206 pages of testimony on file in the proceedings [illegible]
I contacted your client, Opal Meekhof, to obtain an authorization to divulge the contents of medical records in connection with these proceedings. She asked me if I would send the authorization to you for your review before she signed it. It is necessary that the contents of these records be divulged in order for the Department to prove that the care rendered to the patient was deficient. I will also be required, prior to the hearing, to provide to the facility's attorney (Andrew Rothman) copies of records which I intend to use since Mr. Rothman has filed a written request for these under the Administrative Procedures Act.

I have attached an authorization for Ms. Meekhof to sign. If this meets your approval, please have her sign the authorization and return it to me as soon as possible. A self-addressed, stamped envelope has been enclosed for her convenience.

Administrative Law Judge Joyce Hensley
[illegible] Depart Public Health from 10:21 [illegible] 4:35PM
3500 N. Logan
Lansing, MI

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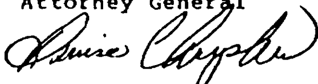
Mr. William Garlington
April 13, 1987
Page 2

Additionally, I would like to discuss with you the possibility of Ms. Meekhof testifying at the hearings specifically about her observations of the staff's prior misuse of the hoyer lift. Please contact me at (517) 373-3488 so that we may discuss this. Please note, the Department intends to proceed with the matter whether or not Ms. Meekhof testifies.

Thank you for your assistance.

Very truly yours,

FRANK J. KELLEY
Attorney General



Denise Chrysler
Assistant Attorney General
401 S. Washington Square
Plaza One Building, Suite 2
Lansing, MI 48913
Telephone: (517) 373-3488

DC/dg
Enclosures

In the Matter of:

Cascade Care Center
1095 Medical Park Drive, S.E.
Grand Rapids, Michigan 49506

CIVIL PENALTY ORDER

Based on a report of Paulann Andrews, R.N. dated October 30, 1986, I find that the facility made one (1) violation of Section 20201(2)(e) of 1978 PA 368 as amended, being MCLA 333.20201(2)(e), MSA 14.15(20201(2)(e). This violation is more fully described in Attachment A which is adopted and incorporated herein by reference. Further, I find that this violation is to one patient, Mr. Donald Meekhoff.

Now, therefore, it is ordered that:

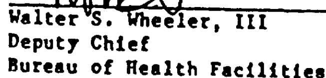
1. The facility is assessed $100.00 to be paid Mr. Donald Meekhoff. Evidence shall be presented to the Department within 30 days after the date of this order confirming payment Mr. Donald Meekhoff.

2. A civil penalty of $500.00 is assessed and to be paid to the Department within 30 days after the date of this Order in accordance with Departmental Published Guidelines effective February 2, 1982.

Under the provisions of the Administrative Procedures Act of 1969, 1969 PA 306, Section 71 et seq, MSA 24.271 et seq, MSA 3.560(171) et seq, you have a right to an administrative hearing before the above penalties assessed in this matter are required to be paid. If you choose to be heard in this matter, you must demand a hearing from the Michigan Department of Public Health in writing within 20 days after the date of this order. A request for a hearing will stay the 30-day payment provisions of paragraphs 1 and 2 of this order until further order of this department.

This order is issued in accordance with the provisions of the Public Health Code, 1978 PA 368, as amended, being Sections 21799c(3) and 21799d of MCLA 333.21799c(3) and 333.21799d; MSA 14.15(21799c)(3) and 14.15(21799d).

This order is made and dated on this 30th day of January, 1987, in Lansing, Michigan.



Walter S. Wheeler, III
Deputy Chief
Bureau of Health Facilities

LC-150a
2-14-84

MICHIGAN DEPARTMENT OF PUBLIC HEALTH
Bureau of Health Facilities

SUBJECT: Complaint Investigation
Facility No: 41-4330
Facility Name: Cascade Care Center
Address: 1095 Medical Park Dr., S.E.
City: Grand Rapids, MI 49506
County: Kent
Date: 10/20/86
Announced ___ Unannounced XXX

Complaint #86-0662
Investigated by: Paulann Andrews, R.N.
Nurse Consultant
Investigator

PARTICIPANTS

Dodie Denman, Business Manager
Rhonda Bishop, R.N., Director of Nursing
Mary Santorelli, R.N., Nursing Coordinator

NATURE OF COMPLAINT

Inadequate care due to poorly trained aides. The patient fell from Hoyer lift.

Staffing shortages.

REPORT

Pursuant to Act 368, Public Acts of 1978, as amended, an unannounced visit was made to the Cascade Care Center to investigate this complaint.

INVESTIGATION:

The investigator interviewed the Business Manager, Director of Nursing, Nursing Coordinator and several staff. The facility was toured. Staff was observed giving morning care and transferring with a Hoyer lift. Personnel files were reviewed. The Nurse Aide Competency form and lesson plan for Assistance with Movement were reviewed. Accident/Incident Reports for 1986 to date were reviewed. The patient's facility and hospital records were reviewed. Staffing reports, submitted by the Nursing Coordinator, were reviewed.

COMPLAINT #1:

The facility is short of staff.

FINDINGS #1:

Staffing reports for the period of August 10 through August 30, 1986, submitted by the Nursing Coordinator, were reviewed.

COMPLAINT INVESTIGATION REPORT
Cascade Care Center - 86-0662
Page 2

The facility met the mandated staff for the period reviewed. The facility provided the required 2.25 hours of care per patient per day as required.

CONCLUSION #1:

The complaint is not substantiated.

COMPLAINT #2:

Aides are not properly trained in the use of the Hoyer lift.

FINDINGS #2:

Transferring a patient using the Hoyer lift is listed as a part of the over-all competency record for nurse aides. The personnel files of the two aides involved with the transfer of the patient in question indicated that both had received training in this procedure.

Two other aides, one an experienced female aide and the other a relatively inexperienced male aide, using the Director of Nursing as the patient, demonstrated the transfer technique properly. The more experienced of the aides "coached" her partner throughout the procedure. The equipment was in good working order for this demonstration.

Both staff members indicated that they had been taught this method of transfer during orientation. The Business Manager and Nursing Coordinator were present for the demonstration.

CONCLUSION #2:

At the time of the investigation, the complaint could not be substantiated.

COMPLAINT #3:

The patient fell from a Hoyer lift, resulting in serious injury.

FINDINGS #3:

The patient was first admitted to the facility on 2/14/83 with a diagnosis of multiple sclerosis. The admission notes indicate that the patient was dependent on staff for all activities of daily living. While on a regular diet, the patient had to be fed. Transfers at that time were to be done with two staff assisting and a Hoyer lift was to be used.

There is evidence throughout the record of the patient's slow, gradually weakening condition. There is documentation of continued use of the Hoyer lift throughout the Patient Care Notes.

On 9/4/86, there is an entry in the Patient Care Notes, stating, in part, "1:50 p.m. was being transferred per hoyer from chair to bed (with) assist of two (nurse aides) - when hoyer was in (up) position, (patient) slid out of hoyer net and to floor hitting back of head. (large) amount bright red blood spurting from (right) ear. back of head felt mushy - blood present on nurse's hand - BP (Blood Pressure) 80 and palapable. P (Pulse) - 80."

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COMPLAINT INVESTIGATION REPORT
Cascade Care Center - 86-0662
Page 3

One of the aides involved in the transfer at the time of the incident described the techniques used to transfer the patient. The description was clear and accurate. The aide described the incident as happening when the net "slipped from under" the patient. "There were only 2 of us and we just couldn't hold him/her."

Ambulance staff were in the facility at the time of the incident. The physician was called at 2 p.m. and orders were received to send the patient to the hospital. Efforts to reach the family at that time were unsuccessful. The patient's spouse was reached at 2:30 p.m. and informed that the patient had been sent to the hospital.

The patient was received in the hospital Emergency Room at 2:35 p.m. The admitting and discharge diagnosis was Basilar Skull Fracture.

There is an Accident/Incident Report documenting the above incident and stating, in part, "was being transferred per hoyer from chair to bed. Hoyer was in (up) position when (patient) slid out of Hoyer net to floor hitting back of head."

Under <u>Preventive Measures</u> there is the statement: **"ALWAYS double check hoyer net for proper placement - use caution."**

In reviewing the facility's Accident/Incident Reports for 1986, an Incident, dated [illegible], involving another patient, was found. The description of this [illegible] read as follows: "(two) aides were attempting to weigh (patient) per hoyer - and (patient) slipped out of end of hoyer net slipping to floor in semi-sitting position." The Preventive Measures listed were "Be more careful of [illegible] is placed."

<u>CONCLUSION #3</u>:

In both incidents with the Hoyer lift, the patient was documented to have [illegible] net. The Preventive Measures in both instances were the need to check the placement of the net. Clearly, this was not done.

The complaint is substantiated. See LC-160.

<u>RECOMMENDATIONS</u>:

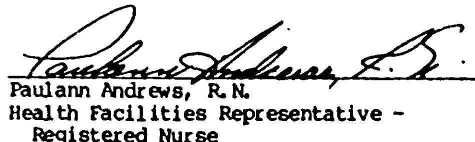
Since the facility has had two incidents of patients falling by "slipping out of Hoyer net", and in each case, two aides were moving the patient, it is suggested that:

1. The actual movement of the patient from one site to another be reviewed with consideration being given to placement of the chair/bed to which the patient is being transferred;

2. Consideration be given to having a third person assist with the transfer of totally dependent patients.

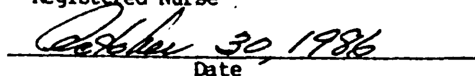
<u>FOLLOW-UP</u>:

The findings were discussed with the complainant. Further follow-up will be directed by the Licensing Officer.



Paulann Andrews, R.N.
Health Facilities Representative -
Registered Nurse

cc:



Date

(517) 335-8511

DAVID LEBENBOM, P. C.
ATTORNEY AT LAW
3000 TOWN CENTER
SUITE 2000
SOUTHFIELD, MICHIGAN 48075
313 355-9010

DAVID LEBENBOM
OF COUNSEL
ANDREW R. ROTHMAN
HOWARD ALAN KATZ
BARBARA KLARMAN
S. LAWRENCE STEIN
MYLES B. HOFFERT
ROBERT L. LITT
HARVEY L. SOLWAY
MICHAEL Z. DAITCH
IRVING TUKEL

July 17, 1987

JUL 21 1987
Public Health Division
RECEIVED

Raj Wiener, Chief
Bureau of Health Facilities
Michigan Dept. of Public Health
3500 N. Logan
P.O. Box 30035
Lansing, MI 48909

Re: Cascade Care Center, civil penalty appeal

Dear Ms. Wiener:

Please be advised that my client, Cascade Care Center, has decided to pay the penalty amount imposed, rather than continue its appeal, which would be unduly lengthy and expensive.

In agreeing to pay the penalty amount, Cascade Care Center is in no way waiving any ~~of the arguments it has raised~~ in opposition to the Department's findings in this matter, nor is it waiving ~~the arguments previously raised in opposition to the penalty.~~ To the contrary, it has been and remains my client's position that it is in no way liable to the Department or the patient for any penalty amount whatsoever. Further, we are still of the opinion that the Department's findings and imposition of the penalty are contrary to the law and facts and unsupported by evidence.

However, my client has decided that in spite ~~of the above arguments~~, a continuation of this appeal would be prohibitively expensive and time consuming, ~~when weighed against the amount of the penalty.~~

Please advise me as to the amount of each check, to whom it should be made out, and the name and address of each person or entity to whom it should be forwarded.

Sincerely,

DAVID LEBENBOM, P.C.

Andrew R. Rothman
of Counsel

cc: Mike Jalacki
Pat Stollicker
Denise Chrysler, Esq.

BEST AVAILABLE COPY

STATE OF MICHIGAN

JAMES J BLANCHARD, Governor

DEPARTMENT OF PUBLIC HEALTH

3500 N LOGAN
P O BOX 30035, LANSING, MICHIGAN 48909
GLORIA R SMITH, PhD, MPH, FAAN, Director

July 21, 1987

JUL 22 1987
blic Health Divisi
RECEIVED

Mr. Andrew R. Rothman
Attorney at Law
3000 Town Center
Suite 2990
Southfield, Michigan 48075

Re: Cascade Care Center
Civil Penalty Order dated
January 30, 1987

Dear Mr. Rothman:

Your letter to Raj Wiener, Chief, Bureau of Health Facilities dated July 17, 1987 relative to Cascade Care Center has been referred to me for reply.

The Department requests $500.00 be paid by check to "The State of Michigan", and mailed to the Michigan Department of Public Health at the above address. You can have your client forward to my office and we will handle processing.

In addition, a $100.00 penalty assessment has been issued and should be paid to the estate of Donald Meekhoff or his representative. The facility should have a record of his/her address. Upon receipt of the cancelled check, a copy should be forwarded to the Department and, at that time, we will acknowledge this matter complied with.

Should you have any additional questions, please feel free to contact me.

Sincerely,

Paul D. Phelps, Jr., Chief
Office of Compliance and Regulation
Bureau of Health Facilities
(517) 335-8636

cc: ✓Ms. Denise Chrysler

STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL

STANLEY D. STEINBORN
Chief Assistant Attorney General

FRANK J. KELLEY
ATTORNEY GENERAL

LANSING
48913

July 24, 1987

Ms. Opal Meekhof
207 Pickett, S.W.
Wyoming, MI 49508

Dear Ms. Meekhof:

RE: CASCADE CARE CENTER
(Civil Penalty Order)

This is to advise you that Cascade Care Center has [illegible] Order issued by the Department of Public Health. (See attached letters.) The facility will be paying the fine, and I will be closing my file on this matter.

Thank you again for your assistance.

Very truly yours,

FRANK J. KELLEY
Attorney General

Denise Chrysler
Assistant Attorney General
401 S. Washington Square
Plaza One Building, Suite 2
Lansing, MI 48913
Telephone: (517) 373-3488

DC/dg
Enclosures
cc: Paulann Andrews, R.N.

BEST AVAILABLE COPY

STATEMENT OF THE MERCY SERVICES FOR AGING

Introduction

I am Ray Rabidoux, Vice President, Eastern Region, of Mercy Services for Aging. Senator Riegle on behalf of Mercy Health Services, let me thank you and your Subcommittee on Health for Families and the Uninsured of the Senate Finance Committee for bringing your committee to the Grand Rapids area today. The State's 450 nursing homes and 50,000 residents in these homes welcome the opportunity to bring our perspective to the public policy debate on care provided in these facilities.

Our Philosophy in Providing a Continuum of Care

Mercy Health Services has been involved in providing acute care hospital services in Michigan and Iowa since the end of the last century. In addition, we have long provided subacute care in some of our hospital facilities and through our home health agencies.

Mercy Services for Aging, a not-for-profit corporation which is a subsidiary of Mercy Health Services, was incorporated on October 9, 1984 to promote services for elderly persons and their families. In examining patient needs and changes in the practice of medicine, Mercy Health Services has come to recognize the need for a community health care system in each of the geographic areas in which we have provided acute care hospital services.

Inherent in this community health care system is a continuum of care of services from the acute hospital to the final recuperative and/or maintenance phase of care. At one time the hospital was in essence the total health care system for the community and the full range of services was integrated under its roof. While the under-one-roof concept is no longer practical, it is up to us as health care providers to assure

that the continuum of care is at least available within the community in which the individual needing services resides.

To this end, Mercy Services for Aging at the inception of this calendar year, made an acquisition of twelve Michigan nursing homes. These homes have a complement of almost 2,000 beds, or about 4 percent of the State's total.

These homes are in the geographic areas served by our hospitals and include Alexander, 92 beds (Royal Oak); Hillcrest, 79 beds (Detroit); St. Joseph's Living Center, 170 beds (Hamtramck); Abbey, 201 beds (Warren); Fraser Villa, 279 beds (Fraser); Orchard Hills, 360 beds (Pontiac); Faith Haven, 108 beds (Jackson), Evergreen Manor, 117 beds (Springfield); Shore Haven, 126 beds (Grand Haven); Sherman Oaks, 98 beds (Muskegon); University Park, 99 beds (Muskegon); and Saint Mary's Living Center, 207 beds (Walker). We also manage a 264 bed nursing home for another Mercy division.

With the purchase by Mercy Services for Aging of most of these homes from Tendercare, their previous owner, they have become organized under the nonprofit rather than the business corporation act. It is our intention that the change in ownership will not be just a paper transaction and a change in the sign on the front door, but the chance to assure that care provided in these facilities comports with our mission and values.

The Challenge of Providing Compassionate Care

While we believe that the hospitals owned and operated by Mercy Health Services have the strong support of the communities in which we operate, we are not so sure that this same high regard is accorded to our -- or any other -- nursing homes. This lukewarm community support exists despite the fact that the vast majority of the residents in our newly-acquired nursing

homes previously resided within a radius of ten or fewer miles from the facility; this percent varies from a low of 76 at Provincial House Battle Creek to a high of 96 at Hillcrest Convalescent Center.

Medicaid reimbursement. To achieve our mission, we must to the extent possible involve families and loved ones in the care provided to our patients. While we have a deep and abiding commitment to serving the poor, we cannot achieve our mission unless we are successful in controlling our maximum percent of Medicaid recipients on an overall corporate basis.

Certain advocacy groups, believing that they are acting on behalf of potential Medicaid residents, have pushed for enactment of state legislation to require one, and only one, waiting list for each nursing home and to further require that admissions be on a first-come first-serve basis (House Bill 4440 sponsored by Representative Perry Bullard [D-Ann Arbor]). We believe that enactment of this legislation would result in the deterioration of the quality of care provided to all of our nursing home residents.

Across the state our nursing homes receive an average of $55 per day from Medicaid, while a private patient typically pays from $75 to $90 per day for care at our, and most other, nursing homes. Our dependency on Medicaid varies from 84 percent at Pontiac Nursing Center, a 360-bed facility, to 24 percent at Fraser Villa in Fraser, a 279-bed facility.

Not only is the annual income from a private patient higher than that from a Medicaid patient, it is far more reliable. The abruptness and vagaries of State executive, legislative, and judicial branch actions combined serve to limit access to care of the Medicaid nursing home patient. As you well know both nursing home associations and their members are engaged in

litigation against the State to attempt to restore adequate reimbursement for the care of nursing home patients. While the plaintiff nursing homes have, to date, prevailed on a summary judgment motion, the State has chosen to make a harsh, arbitrary, and unwarranted interpretation of the Judge's summary judgment order. Specifically, the State has decided to rescind both the 50 cents per hour pass through for employees who render direct patient care and the 60 cents per day pass through to implement the OBRA-1987 requirements. This decision has resulted in a loss of $75,000 per month to Mercy Services for Aging, and is likely to start affecting the quality and consistency of patient care in our and other nursing home facilities.

Senator Riegle, we urge that your Subcommittee on Health for Families and the Uninsured enact measures to require states to continually maintain adherence to its state plan and that state plans at a minimum incorporate reasonable and predictable payment systems, an especially essential feature for nursing homes, most of which operate on a very narrow margin. As you know the State must have its Medicaid plan approved by the Health Care Financing Administration (HCFA), although this exercise has proven to be perfunctory at best since there are no monetary penalties to be imposed on the states for deviation from the plan. The Boren lawsuit, as you know, has its genesis in State payment policies which ignore the requirements for the Title XIX State Medicaid plan.

OBRA 1987 Requirements. Mercy Services for Aging supports the move towards outcome-oriented assessments of patients and commends Congress for urging HCFA to move its enforcement and incentives in this direction. The October 1, 1990 deadline for implementing these mandates is fast approaching and the Health Care Financing Administration (HCFA) simply is not ready to

carry out the directives of Congress. We have no final regulations. We have no knowledge about the protocols that will be utilized for enforcement purposes.

Not knowing the specific requirements to which we will be held and which will be measured in the survey process makes us uneasy and imposes uncertainties upon our residents should we be sanctioned on the basis of requirements for which we had no prior knowledge or information. For example we are required to provide care to residents which will enable them to meet the highest practicable physical, mental and psychological well being. Without defined norms expressed as specific activities which the resident should be able to accomplish, we can only roll the dice and guess how a surveyor will measure and interpret the phrase "highest practicable...".

While a member of our board of trustees is a participant on a national advisory committee which is crafting the resident assessment document, HCFA has asserted that it must publish the elements to be measured prior to use by nursing facilities of the resident assessment document. Many of us have worked diligently to understand and to actually practice the use of the measurement scheme with our staff and residents. We strongly urge that Congress direct, with personal penalties to be imposed on the individuals in HCFA who are being dilatory, an explicit deadline and effective date for the use of the resident assessment tool. Congress also needs to provide an enumeration of the items to be assessed since HCFA has been unable to come to closure on this matter. In short, the threat of the imposition of monetary sanctions in the absence of defined federal regulations puts nursing homes in an untenable situation, especially when we, like most other nursing care facilities in the state, operate on next-to-nil margins in providing care to our residents.

Conclusion

Thank you again for this opportunity to provide testimony. We strongly urge that Congress explicitly hold harmless the states in which the new requirements are implemented in good faith. Monetary penalties on the nursing facilities, which have no relation to any reasonable outcome-oriented protocols, should not be the repercussion from Congress's highly desirable legislation designed to improve care provided in our nursing facilities.

TESTIMONY: QUALITY OF CARE

August 28, 1990

Quality care is our priority and mission. It is being provided to patients with ever-changing needs. Acuity and complexity of patient needs are influenced by changing reimbursement systems and policies. As an example, Medicare DRGs have caused earlier hospital discharges and transfer of higher acuity patients to long-term care facilities.

Staff ratios must accommodate changing patient health care needs. Quality care and service have new demands. Higher Medicare/Medicaid reimbursement is necessary to provide higher levels of skilled care. Facilities are unable to pay a competitive wage. Staff retention, particularly among professionals, is difficult. Continuity of care is difficult to maintain.

Regulations are sometimes inappropriate to actual patient and facility need. Economic inefficiencies create higher quality of care through related use of resources of time, employee management, and governmental survey. Dollars must be allocated to provide direct quality patient care.

Government, health care providers, and the public must work together to establish economically feasible, efficient standards of care that address changing health care needs with quality.

MIKO Care, Inc. manages six skilled nursing facilities in West Michigan.

Senator Don Riegle Aug 21, 1990
Suite 720 Federal Bld
110 Mich. Ave N.W.
Grand Rapids, Mich 49503

Dear Senator;

I am writing to you in regards to quality care in nursing homes.

I am a trustee of the Michigan Christian Home and can verify that this home gives top quality care to its health care patients.

Many of our patients live for a decade due to the tender loving care they receive. The staff and administrator apply Bible truths (methods and attitudes) in caring for our patients. these are the highest standards that can be applied to human relationships.

Sincerely,

Paul L. Metzger

MR & MRS PAUL METZGER
2104 CRANBROOK DR NE
GRAND RAPIDS, MI 49505

August 24, 1990

The Honorable Donald Riegle, Jr.
U.S. Senator
716 Gerald R. Ford Federal Bldg
110 Michigan NW
Grand Rapids MI 49503

Dear Senator Riegle:

I understand you are holding a hearing on long-term health care needs this month, and I want to describe to you a program to meet the oral health needs of institutionalized patients.

The Nursing Home Dental Program is a community-based program which has been developed in the Grand Rapids area over the last several years. Service delivery is in its third full year. It is designed to reach those patients in nursing homes and similar facilities whose dental care is often "forgotten" in the face of multiple other health and personal care needs. The program uses a hygienist/coordinator to identify the unmet oral health needs of patients, refer them to cooperating dentists for treatment, and help train nursing home staffs in techniques of continuing oral hygiene for patients who often present challenges to their care personnel.

This is a program of the West Michigan Dental Foundation, which receives funding from the United Way and other donors to support it. The West Michigan Dental Society names an Advisory Board, which I chair, to establish policy for the program. It is administered on contract by the Michigan Academy of Dentistry for the Handicapped. The Advisory Board includes dentists, and representatives of the Area Agency on Aging, the nursing home industry, dental hygienists, physicians, and the Community Health Center. The Alliance for Health was active during the organizational phase, until this year.

The State of Michigan has provided funding for the program for fiscal years 1990 and 1991, in recognition of its value as a pilot program for meeting this health care need which has been too often neglected in the past. When people enter nursing homes, their former dentists are often not informed of where they are, staffs are untrained in oral hygiene techniques, and care is often limited to emergency situations. In addition to putting a hygienist in the

2929 PLYMOUTH ROAD ■ SUITE 212 ■ ANN ARBOR, MI 48105 ■ (313) 761-5655

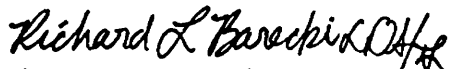
Riegle, Aug. 24, 1990, page 2

facilities, our program has purchased mobile equipment which allows dentists to work in the nursing facility--even at bedside if necessary--and has identified a cadre of dentists who are willing to serve this population even at extremely inadequate Medicaid reimbursement rates.

The program model we are developing has the potential to be used in many other communities around the nation. This kind of program needs to be community-based, with strong support from the local dental profession. Our Advisory Board is committed to preparing descriptions and manuals which can be used by others to start similar efforts. We would support actions by the Congress which would highlight the need for adequate oral health care in institutions as well as for homebound patients, and would assist those communities willing to organize programs similar to ours.

If you would like further information on this program, please feel free to contact me or our consultant, Thomas H. Logan of Logan Street Associates, 446 Logan Street SE, Grand Rapids MI 49503-5310, (616) 454-7649.

Sincerely yours,



Richard L. Barecki, DDS
Chairman, Advisory Board
Nursing Home Dental Program

RECEIVED AUG 1 3 1990

MERCY·MEMORIAL
Medical Center Inc.

August 09, 1990

TO WHOM IT MAY CONCERN:

The following difficulties have resulted from the decertification of a nursing home in our area:

1. Placement of patients at facilities further from their homes. This makes family visitation more difficult, particularly for elderly spouses and working children. At times, this also means that a patient's family physician cannot continue to follow them at the new facility.

2. Placement of dialysis patients is extremely difficult and requires longer hospital stays. The facility that was decertified was closest to the outpatient dialysis unit. Since public transportation is extremely limited in this area, other facilites will not take dialysis patients.

3. Waiting lists at area facilites are longer due to fewer skilled beds.

4. Patients coming to the hospital from the decertified facility had to be uprooted and sent to another facility when their care became skilled. Some residents had lived at the decertified facility for many years, and considered this "home". Often times they only needed skilled care for a short time but it was necessary to uproot them and many patients grieved for the loss of what they considered their home.

Sincerely,

Raelene Stickney, Director
Medical Social Work Department

RJ/jk

Mercy•Memorial Medical Center Inc. • 1234 Napier Ave. • St. Joseph, MI 49085 • 616-983-8300

Michigan Christian Home

BYRON G. WILD
Administrator

August 14, 1990

Honorable Senator Donald Riegle
716 Federal Building, Suite 716
110 Michigan, N. W.
Grand Rapids, MI 49503

Dear Senator Riegle:

The nursing home industry across America has been providing care primarily to senior citizens in numerous kinds of settings with accommodations for both the poor and the wealthy. These homes are licensed by state agencies and certified to provide private pay care, medicaid, medicare or any combinations of these.

During the period since 1966 until the present, the industry has encountered many changes for conditions of participation in both the Medicaid and Medicare programs as well as state licensure regulations.

The nursing home providers are at the mercy of the regulators and therefore several issues must be addressed by those who control how the industry is to perform.

1. The free enterprise system must not be replaced by governmental intervention. The American way is to encourage competition and the right of choice. In other words, let me run my own business. If people like it they will purchase my services; if they don't, they will go elsewhere. If the market is there, someone will always be ready to provide the service. Basic rules for operation are, of course, of necessity but certainly not an environment of almost total control.

2. When regulations are mandated then obviously the cost must be assessed and reimbursement programs such as Medicare and Medicaid must include fair and equitable facility reimbursement. What our government and many special interest groups want, is first class care at a budget style payment system. I've always been told: "If you want quality, then you must be willing to pay for quality."

"Cast me not off in the time of old age; forsake me not when my strength faileth" - PSALMS 71:9

1845 Boston S.E. Grand Rapids, Michigan 49506 (616) 245 9179

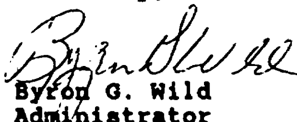
Honorable Senator Donald Riegle
Page 2
August 16, 1990

3. Some form of regulations will always be necessary and, in fact, good enforcement of these regulations are likewise expected from those who are licensed care providers. More regulations do not make any situation better. Enforcement is what is necessary. Let's not keep facilities licensed who do not measure up to the regulations. If a facility is not willing to make corrections or adjustments regarding the rules to which they agree to abide by, let's begin closure and de-certification immediately.

Due to the fact that elderly is a rapidly growing age market for services, and because most family members do not want or even care to provide care in their own homes for these elderly people, including their own relatives, let's not put the nursing home industry down. Actually, many children feel guilty because they do not desire to care for their own aged loved ones. Far too little is said about all the good nursing homes provide and far too much is publicized about the few poor and unacceptable care providers. Let's close down the poor providers and rid them of every opportunity to continue to provide services.

Across America there are thousands of homes just like the Michigan Christian Home who are concerned with quality care and service to the elderly. Enclosed is a brochure supporting our commitment to meeting the housing and health care needs of our residents.

Sincerely,



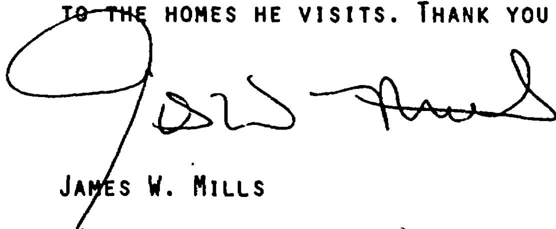
Byron G. Wild
Administrator

BGW/md

SENATOR DON RIEGLE
SUITE 720 FEDERAL BUILDING
110 MICHIGAN AVE. NW
GRAND RAPIDS, MI 49503

DEAR SENATOR RIEGLE;

THIS NOTE IS TO INFORM YOU OF THE CARE MY MOTHER IS RECEIVING AT THE MICHIGAN CHRISTAIN HOME. THE FACILITIES THERE ARE IN MY OPINION EXCEPTIONAL. MY MOTHER HAS JUST HAD TO MOVE FROM THE RESIDENT AREA OF THE HOME TO THE HEALTH CARE UNIT AND SHE HAS BEEN TREATED VERY WELL AND WITH THE GREATEST DIGNITY. SHE IS ENCOURAGED TO BE AS INDEPENDENT AS POSSIBLE YET IS PROVIDED THE CARE NECESSARY. THIS FACT IS SUPPORTED BY MY FATHER-IN-LAW, WHO IS A PASTOR IN LANSING, MICHIGAN AND AS A MINISTRY VISITS MANY OF THE PEOPLE IN NURSING HOMES IN THAT AREA. HE HAS REPEATED MANY TIMES THAT THE FACILITIES AND CARE PROVIDED AT MICHIGAN CHRISTAIN HOME ARE SUPERIOR TO THE HOMES HE VISITS. THANK YOU FOR YOUR CONCERNS.



JAMES W. MILLS

COUNTY BOARD
Robert Anderson
Thomas Cooper
Peter Smalligan

STATE OF MICHIGAN

NEWAYGO COUNTY
DEPARTMENT OF SOCIAL SERVICES
1025 James Street
White Cloud, Michigan 49349

JAMES J. BLANCHARD, Governor

DEPARTMENT OF SOCIAL SERVICES

C. PATRICK BABCOCK, Director

August 23, 1990

The Honorable Donald Riegle
The State Senate
Western Regional Office
Suite 720, Federal Building
110 Michigan Avenue, N.W.
Grand Rapids, Michigan 49503

Re: Nursing Homes

Dear Senator Riegle:

As the Director of the Newaygo County Department of Social Services, I have been appointed the Interim Administrator of the Newaygo Medical Care Facility. Our former Administrator resigned due to financial problems at the Facility.

Several issues directly related to quality of care have surfaced in my short tenure. Unequivocally, quality of care is directly related to finance, especially in publicly-owned facilities. Our goal, which I believe we meet quite well, is to provide the highest standard of care possible. Our one and only barrier to this goal is having the financial ability to meet regulatory rules and staff costs.

At the heart of this matter is cost-based reimbursement, from both Medicaid and Medicare. Both are government funded health insurance programs and both determine inclusive rates for our Facility, meaning that we may not bill for special services for residents funded by either program. Medicaid has determined our cost based rate to be $63.44 per patient day. Medicare has determined our cost based rate to be $82.50 per day. This thirty (30) percent difference, calculated by two different units of the same government, defies logic and hurts our Facility badly. Since Medicaid recipients account for eighty (80) percent of our residents, and we had over 32,000 Medicaid days last year, the effects on quality of care are enormous. An additional $610,000 would be available to us were both rates at Medicare's level.

To compound the problem, we must bill Medicare and receive their written determination prior to billing any other funding source. Even if the remittance advice will simply say "benefits exhausted", which we can predict in advance, we must wait. Medicare is our <u>slowest</u> payer. They claim a sixty-day cycle once a claim is received and this sixty days is often exceeded. Medicaid, by the way, pays in less than three weeks.

Both Medicaid and Medicare use cost reports from 13 to 25 months old to determine rates. Both are currently looking at 1989 data to determine 1991 rates. While an inflation factor is applied, it never equals our true inflationary costs. Contrary to their stated policy, cost-based reimbursements do not contain health care costs, they only contain health care reimbursement.

An associated problem is regulation. The OBRA 1987 Federal nursing home reform requirements, which we strongly support, hurt us tremendously. More and more professional staff time must be spent on documenting the care provided rather than providing that care. The cost of OBRA in 1990 will not affect our rates until 1992. While an up front pass through has been talked about by Medicaid, the announced rate is seriously deficient.

If the government is truly interested in quality of care, it must be willing to fund that quality. I would strongly urge the following:

1) Force Medicare, Medicaid, and private insurers to coordinate benefits amongst themselves thereby eliminating lengthy waits for Medicare remittance advices. I would propose this be done through the State's Medicaid systems as they are more efficient.

2) Force States' to use Medicare's cost-based rates. The quality of care of our residents cannot be dependent on States' financial condition.

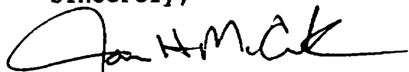
3) Require rate pass throughs in both Medicaid and Medicare for any increased regulation. Base these pass throughs on actual time studies in actual long term care institutions involved as pilot projects.

4) Require all insurers, whether private or public, to pay interest on any valid claim amount not remitted within thirty days. You should know that Medicare charges interest on any claims adjustment not paid within ten days!

5) Establish a "super skilled" rate to be paid on acute care patients. People are discharged from acute care hospitals far quicker than ever before. We simply cannot care for them for what we are paid.

Thank you for the chance to comment.

Sincerely,



James H. McCormick
Director
Newaygo County
Department of Social Services

JHM/cmp

8/20/90

Dear Mr Don Riegle

You are having a meeting Tues Aug. 28 in regards to Nursing Home Care. Im sorry I can not attend but would like to express my opinion about the care my sister Sadie Bengort receives at the Michigan Christian Home Sadie has been in the Care Unit for 19 months now and I think she is getting excellent care. I have been in a couple of nursing homes in the last several years as a visitor and M.C.H. is much better in giving care to its people than those I visited. No smells people look really cared for and Im glad my sister is at M.C.H.

Sincerely
Peter J Palma
928 Andover Ct SE.
Kentwood Mi 49508

Aug. 30, 1990

RECEIVED SE[illegible] 1990

Dear Senator Riegle:

I'm sorry this did not reach you by 8/28 but my mother is in the hospital & all our time has been spent there.

I wanted to tell you that she has been in the Michigan Christian Home Health Care Facility (1845 Boston, G.R.) for several years now and has received the very best care, they not only meet the patients physical needs but also endeavor to meet their spiritual & emotional needs. The care she has received could not have been better.

Sincerely,

Mrs. Charles Peterson
10570 Hemlock Rd
Howard City, MI 49329

Re: Lydia Fessenden
MCH

Testimony

Board of Trustees
Pilgrim Manor
2000 Leonard, NE
Grand Rapids, Michigan
Sandra L. Davis, President

Public Hearing-Quality of Care in Nursing Homes

Pinery Park Senior Center
Wyoming, Michigan
8/28/90

The Pilgrim Manor Board commends Senator Riegle for his attention to the issue of quality care in Michigan nursing homes. This attention appears especially important considering the dearth of Presidential leadership to implement major social policy concerning health care.

Pilgrim Manor is the residence of 167 older Michiganians. A continuing care community affiliated with the United Church of Christ, it makes available independent, assisted, supportive and nursing care residency. Slightly over one-third of its residents receive nursing care.

Recent community studies show that longevity of residents at Pilgrim Manor is one of the highest in the Grand Rapids area. It also has enjoyed one of the lowest turnover rates of service staff. Both result from attention to providing residents with quality care.

In pursuit of continuing quality care, we urge increasing the amount of federal Medicaid coverage available to qualifying older adults. Currently, nursing care residents qualifying for Medicaid are abused by a process that agrees to their Governor's vetoing Michigan's Medicaid responsibility as a method of budget balancing. A higher federal floor is required to prevent this travesty.

The Manor must fill a gap of approximately $25.00 a day to meet the expense of quality care for each Medicaid reimbursed resident. Payments to fill this gap have come from charitable donations. However, this gap has enlarged dramatically in the last few years. Increasingly, individuals', families' and communities' resources are sacrificed as they provide the bulk of health care for older adults. When they finally need to reach to the payer of last resort, Medicaid, its purse is nearly empty.

For similar reasons, we urge that eligibility for home and community based care be expanded and the level of protected assets for nursing home residents be raised.

The Pilgrim Manor Board will continually strive to provide quality nursing home living. Will Senator Riegle also work toward shoring up the Medicaid floor under those lives?

August 25, 1990

Honorable Donald W. Riegle, Jr.
United States Senator
716 Federal Building
110 Michigan N. W.
Grand Rapids, MI 49503

Dear Senator Riegle:

I am writing to express my concerns for the quality of care for persons confined to nursing homes. I am aware of the hearing being held on August 28, 1990 at Pinery Park Senior Citizens Center in Wyoming, regarding this topic and I hope that some answers are found to this very difficult problem.

I am a registered nurse in the state of Michigan and the daughter of a disabled Veteran who was a patient in a Veterans Administration approved, and financially supported, nursing home from February, 1983 until September 4, 1986.

As a nurse and a human, I feel that each person has the right to be treated with respect and dignity, and persons in my professional care have the right to expect their physical, emotional, social, and spiritual needs to be considered and met, as much as possible, in the course of their care.

My father was afflicted with Multiple Sclerosis from his early twenties until the time of his death--September 17, 1986. Because the early symptoms of his disease appeared while he was serving his country in the Army during the Korean Conflict, he received a service connected disability and was granted Veterans Benefits. My mother, sister, and I cared for him at home until, after both children married and moved away from home, my mother was no longer able physically or emotionally to care for him around the clock.

In 1983 the Veterans Administration approved payment for him to be transferred from home to a local nursing home, so he could maintain contact with his family. During his three and a half years at this facility there were several times I felt the quality of care was less than desirable, but dad preferred to accept them and was sure they would get better.

Within the first year of his stay, he was dropped on the floor while being transferred with a Hoyer lift--a hydraulic lift used to transfer heavy patients. The reason given for the incident was faulty equipment. There were also several times, during his last year there, I found him in bed and his call button (a flat disk that layed near his head and was activated by rolling his head to the side-he couldn't use his hands) was on the bedside stand. The nurses complained that he kept bumping it and turning it on accidentally, so they took it away, because, they didn't like having to answer "false alarms"--his room was one room from the nurses' station. This left him unable to have any means of calling for assistance and took away what little bit of independence he had.

He complained many times about his medications being late or the medication nurse giving him "a bad time" about needing his medication at certain times, and it wasn't convenient. He basically was a "happy-go-lucky" person but could be very demanding at times, so this may have been his being demanding. I do know there were times when his medication was as much as one and a half hours overdue. When I searched for a nurse at these times, I was told she was "at break".

All the above, while frustrating, demeaning, and potentially dangerous, were not the incident that really has me concerned for others in similar positions. The last day my father was at this facility he had his trust and right to dignity totally violated. On September 4, 1986, while being transferred from a chair back to bed, it was reported to me he "slid out of the sling of the Hoyer lift and slid to the floor". When I saw him at the hospital that day, he had blood oozing from his ear and the CAT scan showed a basilar skull fracture and some brain trauma. Thirteen days later my father died. The nursing home did finally admit liability for his injury but denied he died as a result of the head injury. While my mother did file a wrongful death suit in civil court; the case was settled out of court in the spring of 1990, leaving that question still unanswered in the legal system and in my mind.

The grief and anger associated with my father's death was really heightened when we received a phone call, the night before his funeral, from one of the nurses that worked at the facility. While what she reported is hearsay; I think it is pertinent here. We were told that my father had been injured two times more in the last week he was at the home, in addition to the injury that required hospitalization. A week before the last injury, the lift he was in malfunctioned, and on September 2(two days earlier than the September 4 date) he had somehow been tipped over in the lift and hit his head on the floor. There was no visible injury, except that he was dazed for a few minutes. No report was ever filed on this and my father (for whatever reason) didn't report it.

She also stated that two of the nurse aides and one of the charge nurses were "excessively rough and nasty" with my father. It was also reported that on the Labor Day weekend there was one licensed nurse in the facility--the same nurse-- for the entire three days. This person slept and ate at the facility, would do treatments and pass medications, etc. , and go back to sleep. While this is not against any regulations that I know of, it is generally not good nursing practice and I question the alertness and accuracy of someone who is woke up in the night to pass medication or do treatments.

After my father's injury and before his death, the state licensing agency was contacted and they did investigate the nursing home. Their nurse consultant went to the facility, reviewed records, and talked to and observed staff working with patients and equipment. She reported that the direct care givers(nurse aides) who were working with the lift that day, had only been working for the facility a short time-less than one month. One had assisted a more experienced person in transferring a patient one time before, and the other had never performed this task other than in training classes before the day my father was injured. The attorney general's office determined that the facility was indeed guilty of providing inadequate

and inappropriate care, and they were fined by the state. The nursing home legal counsel, in their reply to the determination and fine, stated they were not appealing not as an admission of liability or guilt, but because the time and expense involved in the appeal process outweighed the fine and consequences of the determination. (I have enclosed copies of the states determination and the facility's response for your information.) The consequences were merely a slap on the wrist, and did not concern them. They could still continue to exist and 'care' for patients as though nothing happened.

The reason I have gone into detail with the specifics of this incident, is that, though state regulated and licensed, this facility was; and to the best of my knowledge, still is; receiving reimbursement from Medicare insurance and is still on the Veterans Administration's list of approved facilities for VA reimbursement - both are federal monies going to this facility. Through my professsional contacts with nurses who have worked at this facility in the last six months or less, I have been told the same types of incidents are still occurring. When this kind of care is given, it literally means, patients are at the mercy of the caregivers, not the caregivers are providing a service to those they care for and are accountable to them.

I do, however, have empathy with the professionals who staff long term care facilities. I have worked as a registered nurse for 14 years. Most of my experience has been in acute care, but in 1980 I worked in a nursing home for 6-8 weeks. While there, I was very frustrated with what I saw.

On the evening shift, the staffing was four or five nurse aides and myself to meet the physical, emotional, social, and spiritual needs of 60 patients--2/3's of which were considered total care. This meant they had to be assisted to eat or be fed, washed up by staff, assisted with elimination, and assisted in and out of bed. My first responsibility, as the only licensed staff, was to dispense medications, do treatments the nurse aides were not authorized to do, and do the documentation. This took up all the shift, usually. This also meant there were usually 4 people to do the feeding, changing, bathing, and getting into bed at night--for 60 people; or 1 person for 15 patients, and the frustrating thing was this was within the state staffing guidelines. TRY IT, SOMETIME!!! The obvious physical needs get met, but the other needs are far from even considered, most of the time. The most frustrating thing was, because the facility was a 'for-profit' organization, the staff and patients were not as important to the administrative bodies as the stockholders. Due to my frustration and my concern for my legal liability; I finally resigned and went back to acute care.

Also most recently, 1988 to 1990, I worked in a county-owned long term care facility, here in Kent County. While staffing numbers have improved from those days in 1980, the 'acuteness' of the patients have increased due to DRG's and hospitals discharging sicker patients sooner, and the needs of these patients are more. The staff I worked with I consider excellent, but many of the frustrations are still the same-- too many people needing more care than the available numbers can physically provide. When this happens, even the best natured, kindest people get short-tempered or preoccupied and patients do not get the respect and dignity they are entitled to expect from their caregivers.

I don't know what the answers are. I don't even know if I have a good grasp of what the problems and questions are. I do know that I have concerns for the future for my child and myself. Someday, I will - God willing - be elderly and may, sooner or later, need to be cared for by others. I only hope and pray, if and when that day comes, some of the answers have been found and I can receive the same loving care, respect, and dignity I try to give to others now.

Thank you for your time and I hope that through the questioning, some answers come.

Sincerely yours,

Bernice Rosenberger
2603 Charlesgate, S.W.
Wyoming, MI 49509

August 23, 1990

Dear Senator Riegle

I regret that I will be unable to attend the U.S. Senate Finance Sub Committee Hearing on August 28 at Rivery Park Senior Center Wyoming.

I am in agreement that all seniors residing in Nursing Homes in Michigan deserve quality care and would recommend that when it is observed that such is not being received that the Nursing Home be placed on probation + if a pattern is established of providing less than quality service that the license for such homes be revoked. I am associated (Board Member) with the Michigan Christian Home located @ 1455 Boston S.E. Grand Rapids and our residents receive highest quality care. We are a Non-Profit association care facility and we must depend on Charitable Contribution in that the Medicaid reimbursement from

the State of Michigan is not adequate to cover our costs. This is a major problem. The State prescribes rules yet will not provide adequate funding for the facility to meet the costs associated with the rules.

I commend you for your interest in our senior citizens. Would recommend that rather than impose additional requirements as a result of new legislation we should focus renewed efforts on policing the quality of care under current legislative requirements.

I know you would receive a warm welcome should you have time to visit our facility.

Thank You
Roy A Sturgeon

R. A. Sturgeon
3431 Hidden Hills Ave. SE
Grand Rapids, MI 49546

Aug 18, 1990

Dear Senator Riegle,

I understand you will have a hearing on nursing Homes. I Cannot attend but want you to know my Mother has been in the Michigan Christian Home in Grand Rapids for 5 years and has had excellant care, the staff is out standing and the building always clean and pleasant.

Thanks for Caring about our Senior citizens.

Sincerely,
Mrs Earl Thompson

8/18/90

My dear Senator Riegle:

My 94 year old mother has received excellent care at Michigan Christian Home on Boston S.E. here in Grand Rapids. First she had a one room apartment then had to be placed in Health Care Center about seven years ago.

They are caring people there and do their very best to help all the seniors there.

Thank you for caring for our elderly, too.

Russell and Gladys Thrall

United States Senate

WASHINGTON, DC 20510

TODAY'S NURSING HOMES: IMPROVING QUALITY OF CARE

Senate Finance Subcommittee on Health for Families and the Uninsured

Chairman Donald W. Riegle, Jr.

Sign In Name: Mary Winckel

Address: 3123 Mc Dermott St
Muskegon, Mi. 49444

Representing: no organization - active in MEA-R
MARSP - AARP

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I invite you to attach a prepared statement or to submit your written testimony: My niece was in a nursing home and her husband gave her as much care, as the personel of the home. One very old lady in the same room, when her food was brought to her, it was left, not being in her reach. My nephew helped her get her meal down because there was no one, who worked there, that would help her.

Nursing homes are not given enough money, to hire competent, caring help, for medicaid patients.