A Performance Audit of
Long-Term Care Facility Oversight

Chapter I
Introduction

Utah's long-term care system is undergoing changes that may boost the quality of life experienced by elderly residents. This report focuses on the state's role in improving the quality of care received by residents in two types of long-term care (LTC) facilities: nursing homes and residential care facilities.

The state has two independent mechanisms to protect LTC residents: a regulatory system and an advocacy system. While additional changes are needed, we feel both systems are improving.

The regulatory system, including the bureaus of Facility Review and Health Facilities Licensure in the Health Department, aims to guarantee that all facilities meet minimum quality standards. Regulators are slowly implementing fundamental reforms designed to focus their attention more directly on the quality of care received by LTC residents. We feel regulators should strive to make their monitoring visits to facilities as unpredictable as possible and to structure enforcement actions so that they deter future violations.

The advocacy system of the LTC ombudsman program in the Human Services Department protects the interests of LTC residents and helps them receive the best care possible. We believe the ombudsman program can become more effective by avoiding a regulatory orientation and adopting an aggressive philosophy of advocacy, including assuming more of a watchdog role over regulators.

Besides the government-run regulatory and advocacy systems, the market system driven by consumer decisions, may also help improve quality of care if consumer information can be improved.

LTC Facilities Provide Valuable Services

Utah's long-term care industry provides important services in a difficult environment. LTC facilities include both nursing homes and residential care facilities. Both types of facilities provide assisted living settings for elderly residents, but only nursing homes provide

nursing care. As of July 1992, Utah had 54 residential care facilities containing 1,128 beds and 92 nursing homes containing 7,049 beds. These numbers exclude intermediate care facilities for the mentally retarded (ICF-MRs), which are not discussed in this report.

Utah's residential care facilities (RCFs) range from private homes converted to three-bed facilities to large buildings constructed to provide a 100-bed capacity. RCFs provide room and board as well as some assistance with the activities of daily living. However, residents of RCFs must be able to respond to emergencies such as evacuating the building during a fire alarm and must also administer their own medications.

Residents in Utah's nursing homes often require a much greater degree of assistance than RCF residents. According to the Institute of Medicine, "Many are incontinent, mentally impaired, or so seriously disabled that they require extensive and continuous care. However, others are simply very old and very frail but are mentally competent and alert and require only moderate assistance." Nursing homes may provide special diets, administer medication, and provide other assistance for each resident as directed by a physician's plan of care.

Quality of Care Is a Major Concern

Although LTC facilities provide valuable services, many elderly people are frightened to enter one. Often the elderly are saddened at the prospect of leaving their former home and losing some of the freedom and independence they have known. The move to a facility may be emotionally upsetting to the entire family; feelings of guilt, anger, frustration and despair can be painful for all involved. The emotional situation is especially difficult because of persistent reports about poor quality care in nursing homes. In some instances, families may endure great hardships to care for their elderly at home as long as possible. Currently, less than five percent of Utahns over 60 reside in LTC facilities.

Fears about the quality of nursing home care are well founded. Over the years, investigations have revealed appalling conditions in some nursing homes; many authors have described the condition of nursing homes as a national scandal. In 1984, a federal court ruled that the federal government had failed in its duty to assure that "nursing facilities receiving federal Medicaid funds are actually providing high quality medical care," and ordered the government to revise its quality assurance program. Following the court ruling, the federal Health Care Financing Agency contracted with the Institute of Medicine to study the effectiveness of nursing home regulation. The 1986 report concluded that although many nursing homes deliver excellent care,

> *in many other government certified nursing homes, individuals who are admitted receive very inadequate--sometimes shockingly deficient--care that is likely to hasten the deterioration of their physical, mental, and emotional health.*

The Institute of Medicine study criticized the government regulatory program for allowing too many marginal or substandard nursing homes to continue in operation. In fact, the study

concluded that "the poor quality homes outnumber the very good homes." Spurred by the Institute of Medicine's report, Congress included nursing home reform legislation in the Omnibus Budget Reconciliation Act of 1987. The provisions of this major reform effort are commonly referred to as "OBRA '87."

Because the goals of OBRA '87 have yet to be realized, the quality of care in nursing homes continue to be a concern. According to a Congressional Committee, the central purpose of OBRA '87 is

to improve the quality of care for Medicaid-eligible nursing home residents, and either to bring substandard facilities into compliance with Medicaid quality of care requirements or to exclude them from the program.

To accomplish these ends, Congress changed the regulatory requirements for nursing homes as well as the regulatory procedures for monitoring and enforcing the requirements. Unfortunately, progress in implementing OBRA '87 has been slow; federal and state regulators have not met the timetable established by Congress. One reason for the delays is that the OBRA '87 reforms required sweeping changes in philosophy and approach. In fact, even advocates of the changes recognize they cannot be implemented overnight. According to the National Citizens' Coalition for Nursing Home Reform, "OBRA's standard of care will take a long time to achieve and the next several years will be a time of transition as advocates, providers and regulators seek to define, understand and achieve the intent of the new law."

The Utah Legislature has also been concerned with the quality of care in nursing homes. During the 1991 interim a committee studied quality-of-care issues. One product of the committee's efforts was passage of House Bill 401 during the 1992 general session. The bill, co-sponsored by over two-thirds of the House membership, declared that there is an important state purpose to improving the quality of care in nursing facilities. Since nurse aides provide most of the direct care received by nursing home residents, the legislature sought to increase the training, motivation and stability of the nurse aide work force by establishing a mechanism to increase their wages. Nurse aide salaries are expected to increase by about 20 percent.

Government or Market Mechanisms May Help Improve Quality of Care

A variety of factors influence the quality of care in LTC facilities. Government involvement in quality-of-care issues results from the failure of market forces to protect societal interests. Some reasons why market forces may not adequately ensure LTC facility quality are the diminished decision-making capability of many LTC residents, the absence of family involvement for some LTC residents, the lack of reliable information about LTC facility performance, and the fact that government bears the bulk of long-term care costs through the Medicaid program.

Because of the failure of market forces, and given that the often frail health of LTC residents makes them very vulnerable, the government has established two independent systems to protect them. The regulatory system is designed to guarantee minimal acceptable quality levels in LTC facilities. The advocacy system is designed to act on behalf of LTC residents to improve and supplement regulatory efforts.

Regulatory System Includes Federal and State Programs

The regulatory efforts discussed in this report include the activities of two bureaus in the Department of Health to ensure that LTC facilities provide a minimum quality of service to their residents. The Bureau of Facility Review (BFR) certifies facilities to participate in the Medicaid or Medicare programs based on their compliance with federal standards. The Bureau of Health Facility Licensure (BHFL) licenses facilities to provide LTC services based on their compliance with state standards.

While the terminology and authority for the programs are different, the regulatory activities of BHFL and BFR are similar. Both bureaus monitor and enforce compliance with minimum standards. In fact the overlapping responsibilities of the bureaus can be confusing. The state licensure rules enforced by BHFL are intended to promote quality health care through non-duplicative review of facilities. Therefore, BHFL relies on the federal program administered through BFR to regulate most nursing homes.

Federal Regulatory Program. The federal program is national in scope; its provisions are established by Congress and the federal Health Care Financing Administration (HCFA). A major purpose of the federal LTC regulatory effort is ensure minimum facility quality. In each state, a designated agency implements the federal program under the direction and review of HCFA. In Utah, BFR certifies which LTC facilities are eligible to receive reimbursement for Medicaid and Medicare clients. Although BFR is a state agency, it is largely funded by HCFA and is responsive to its oversight. As is discussed in Chapter II, the federal regulatory program underwent a major overhaul due to OBRA '87. However, many provisions of OBRA '87 aimed at improving quality of care have yet to be fully implemented.

Because it administers the federal regulatory program, BFR has authority only over certified facilities. However, since virtually all nursing homes in Utah are certified, BFR is responsible for assuring the adequacy of care received by most of the institutionalized elderly in Utah. No RCFs in Utah are certified because by federal policy they are not eligible to receive reimbursement for services to Medicare or Medicaid clients. Nonetheless, as shown in Figure I, even including RCFs, 85 percent of the LTC beds in Utah are in certified facilities and thus within the regulatory jurisdiction of BFR.

State Regulatory Program. The state regulatory program parallels the federal program. While certification is required by federal law for facilities to participate in the Medicare or Medicaid programs, licensure is required by state law for facilities to offer long-term care services. Just like the federal program, state regulators monitor facilities and enforce compliance with minimum standards. The requirements of the state licensure program have been established by the Utah Legislature and the statutorily created Health Facilities Committee.

As the state licensing agency, BHFL is responsible for all LTC facilities. However, since program requirements are very similar, BHFL avoids duplicating BFR's program by concentrating most of its efforts on non-certified facilities. Relying on BFR's work not only lessens the regulatory burden on the LTC industry, but it saves the state money since BFR is largely funded by HCFA. While BHFL conducts regular inspections at non-certified facilities, it rarely inspects certified facilities. Of course, BHFL is responsible for all licensure actions whether facilities are certified or not. Chapter III discusses BHFL's regulatory program.

LTC Ombudsman Program Has Advocacy Responsibility

In addition to the regulatory programs discussed above, the government sponsors an advocacy program to help protect LTC residents. Unlike the regulatory programs which impartially assess facilities' performance, the advocacy program acts solely on behalf of residents. However, while regulatory programs have legal enforcement authority, the advocacy program does not. The state LTC ombudsman program is federally mandated by the Older Americans Act and is housed in the Department of Human Services' Division of

Aging and Adult Services. The state ombudsman has designated "sub-state" ombudsmen in Utah's twelve Area Agencies on Aging (AAAs). The local AAAs in Utah provide a variety of services to elderly residents in their communities.

The advocacy responsibility of the ombudsman program is very different from the regulatory responsibilities of other state agencies. In one sense the ombudsman program is more limited than the regulatory programs because it lacks any enforcement authority. However, by its ability to involve citizens and cultivate political support, the ombudsman program can be a powerful force to enhance the quality of life of LTC residents. If properly implemented, the program may bridge the gap between governmental regulatory efforts and grass roots citizen efforts.

To advocate effectively, the ombudsman program should operate independently from regulatory programs. For this reason, the Older Americans Act requires that the ombudsman program be organizationally separated from the regulatory agencies. In effect, the ombudsman program supplements the regulatory system with a "second line of defense" to provide an even greater degree of protection for vulnerable LTC residents. In some instances, we feel the ombudsman program has been too close to the regulatory programs. Chapter IV discusses the changes we think are needed in Utah's ombudsman program to better focus on its advocacy role.

Market System Has Not Been Effective

The regulatory and advocacy systems described above were created because consumers have not been able to control quality through the market system. In an efficient free market setting, the public influences the cost and quality of products through their purchasing decisions. If consumers had reliable information about known problems at specific facilities, perhaps they could bring pressure on facilities to improve quality. Chapter V reviews the efforts underway to make existing regulatory findings more accessible to consumers.

Even with better consumer information, it is questionable whether market forces can bring major quality-of-care improvements. Some regulators and industry officials feel that the public is not competent to interpret regulatory findings. In addition, factors such as facility location may be more important than regulatory findings to consumers when choosing a facility. Finally, the extent of consumer interest is sometimes questioned because the bulk of long-term care costs are paid by the Medicare and Medicaid programs rather than by consumers directly.

Audit Scope and Objectives

This audit was requested by Representative Donald LeBaron. During the 1991 interim, Representative LeBaron chaired a subcommittee of the Health and Environment Interim

Committee which studied the LTC system. He requested that we investigate a variety of issues dealing with the state's role in improving the quality of care provided in LTC facilities and the quality of life experienced by LTC facility residents.

Assessing the impact of recent legislative changes, such as those resulting from House Bill 401, is beyond the scope of this audit. Similarly, the impact of planned federal changes, such as may result from the recent reauthorization of the Older Americans Act, cannot be evaluated. Even the full impact of the 1987 revisions of the federal regulatory system cannot be known now because its provisions continue to be implemented. However, we considered ongoing changes when needed to address our audit objectives.

The specific audit objectives addressed in this report are:

1. Evaluate the effectiveness of the federal LTC facility regulatory program of the Bureau of Facility Review in the Department of Health.
2. Evaluate the effectiveness of the state LTC facility regulatory program of the Bureau of Health Facility Licensure in the Department of Health.
3. Evaluate the effectiveness of the state Long-term Care Ombudsman program in the Department of Human Services.
4. Evaluate the accessibility of consumer information to help choose an LTC facility.

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Chapter II
BFR Should Move Aggressively To Implement Nursing Home Reforms

Reforms to improve quality of care in nursing homes are slowly being implemented in Utah. As mentioned in Chapter I, Congress made sweeping changes to the federal regulatory system in its 1987 nursing home reform legislation known as OBRA '87. The nursing home reforms of OBRA '87 provide a comprehensive system to ensure quality of care and protection of resident rights in nursing homes. While some opposition to OBRA '87 has come from states and the nursing home industry, advocates for nursing home residents have embraced the reforms. Although BFR could act more aggressively to implement some reforms, many delays in realizing the goals of OBRA '87 stem from federal delays. As allowed by federal regulators, BFR should deter violations through its enforcement actions, achieve greater unpredictability with its facility monitoring visits, and make the state's nurse aide registry more comprehensive.

Federal delays in implementing OBRA '87, while frustrating, have not been unexpected. In fact, the act includes language directing states to proceed with certain provisions even if federal guidelines for doing so have not been established. Nonetheless, three years after OBRA '87 was passed, Congress felt it needed to respond to confusion caused by HCFA's failure to publish required regulations. Minor amendments to OBRA '87 prohibited federal officials from taking compliance action against states which failed to meet deadlines for nursing home reforms despite good faith efforts to do so. Although Congress clarified that states should proceed with certain nursing home reforms even without federal regulatory guidance, BFR staff report that in some instances they continue to await federal action. Unless there is strong political support for more aggressive action, OBRA '87 reforms will probably continue to be slowly implemented in Utah.

BFR is the state agency which monitors and enforces compliance with the federal regulatory system as amended by OBRA '87. The federal regulatory system is designed to guarantee that LTC facilities provide at least a minimum level of quality. In order for facilities to participate in the Medicare and Medicaid programs, they must be in substantial compliance with minimum requirements. BFR inspects facilities to certify that they provide the required quality level. Facilities failing to meet minimum standards are required to take corrective actions to maintain their certification. Non-certified nursing homes and residential care facilities are not subject to the federal regulatory system.

OBRA '87 Reforms Should Improve Quality of Care If Its Provisions Are Implemented

The purpose of the OBRA '87 reforms was to improve the quality of care provided in nursing homes by changing the regulatory philosophy. Prior to the 1987 reforms, many shortcomings in nursing home quality were felt to result from a regulatory system that has directed its attention to the wrong indicators of the quality of institutional life. Therefore, Congress acted to change the regulatory emphasis from evaluating whether facilities had the capacity to provide quality care to directly evaluating patient care and outcomes. In addition, Congress sought to focus limited regulatory resources on problem facilities by changing how facilities were monitored and how regulations were enforced.

Facility Requirements Emphasize Resident Outcomes. The 1987 revisions of certification standards added or emphasized patient outcome requirements in the areas of resident assessment, quality of care, resident rights and quality of life. Certified nursing facilities are now required to conduct a comprehensive assessment of each resident to use as the basis for a formal plan of care in order to "attain and maintain the highest practicable physical, mental and psychosocial well-being of each resident." The quality-of-care requirements are based on the assumption that a resident's abilities and condition should not diminish unless unavoidable circumstances occur. The resident rights and quality of life requirements recognize that facilities are peoples' homes where residents have a right to a dignified existence, protected against being taken advantage of and able to make choices about their daily activities and living situation. The idea behind these outcome requirements was to emphasize the factors that had the greatest impact on the daily lives of nursing home residents.

Other nursing home requirements of OBRA '87 are more process that outcome oriented. They define a minimal level of services which certified nursing homes must provide, such as medical, dietary, pharmacy, and nursing services. These rules establish minimum requirements for all certified nursing homes in the nation. If they are enforced, the outcome and process requirements for certified nursing homes should adequately protect facility residents.

OBRA '87 Addresses a Breadth of Issues. The provisions of OBRA '87 are too numerous to be fully discussed here. However, in addition to the facility require- ments discussed above, another major concern was that the annual surveys which monitored facilities' compliance with regulations were ineffective because their timing was too predictable. Nonetheless, since even predictable surveys often discovered many violations, perhaps the greatest weakness in the regulatory system was that enforcement actions taken against violators had little deterrent effect.

Since the federal program is national in scope, the state must comply with its national requirements. Indeed, BFR staff report that most of their work is performed pursuant to federal mandates. Nonetheless, OBRA '87 identified a number of state responsibilities for improving quality of care. For example, while the facility requirements themselves are

established solely at the federal level, the state has some flexibility to improve facility monitoring and enforcement systems on its own. In fact, in some instances Congress required that states act even if HCFA failed to develop implementing regulations. Still, confusion caused by the slow pace of HCFA to provide guidance to states has led BFR to be cautious when implementing reforms. In some instances, BFR appears reluctant to act without a regulatory directive to do so. However, the state's assistant Attorney General assigned to BFR told us the state may take any action it deems appropriate unless the action is prohibited by federal regulation.

Three important areas where we feel the state can act to improve quality of care are discussed in the remainder of this chapter. Perhaps the greatest opportunity for improving quality is to structure enforcement actions against poor facilities which will deter future violations. The second area, whose importance would increase with stronger enforcement actions, is to bring greater unpredictability to the monitoring of substandard nursing homes. A third important area involves making the state's nurse aide registry more comprehensive so that it better monitors the completion of required training and tracks known abusers of LTC residents.

BFR Enforcement Actions Should Emphasize Deterrence

BFR is taking reasonable steps to encourage facilities to stay in compliance with minimum quality standards by establishing consequences for violations. These steps include an incentive program to reward facilities with the fewest number of violations, and a sanction program to punish facilities with the most severe violations. While it is too early to judge the effectiveness of recent changes, BFR's actions are promising because they introduce greater incentives to deter violations. Previously, the enforcement philosophy had been to consult with violators in order to help bring them into compliance.

OBRA '87 required regulators to take more aggressive action against facilities that provided poor care. According to a congressional committee:

> *States are expected to eliminate substandard providers from the program and to deter repeat violation, not to allow substandard providers to remain in the program through a policy or practice of consultation.*

In order to deter violations, states were required to establish procedures for sanctioning facilities which provided poor care. For example, Congress felt that "civil monetary penalties are an essential enforcement tool, because they can be applied to less serious violations early and often, thereby deterring more serious violations."

Lack of Compliance Has Long Been a Concern

The inability of enforcement actions to prevent frequent violations of minimum quality standards has been a concern throughout the nation. For example, a 1987 study by the General Accounting Office found that "the ability to avoid penalty even for serious or repeated noncompliance gives nursing homes little incentive to maintain compliance with federal requirements." Also, the 1986 Institute of Medicine study found that because there was not a credible threat of sanctions, many marginal or poor-performing facilities never improved.

Officials in Utah also report that some facilities react too much to regulatory findings rather than their own proactive programs to prevent rule violations. For example, when problems with the Eva Dawn nursing facility were being reviewed, one BHFL surveyor wrote,

> *My personal experience is that for at least the past ten years unsophisticated and marginally competent management of nursing care facilities have relied upon periodic surveys by either the Medicaid certification authority, or the licensure authority, to point out gross violations of the rules and demand attention to problems that should have been, and were, obvious to the true professional nursing home operator.*

Enforcement Philosophy Has Been Too Lenient. BFR staff explain that the federal enforcement philosophy has been one of rehabilitation; the program was designed to identify and correct problems. Therefore, the model has been that regulators identify deficiencies and facilities correct them. While the rehabilitation philosophy is probably the most effective in the short run, it may allow a few providers to take advantage of the system. Throughout the nation concerns have been raised that some facilities chronically violate standards, only coming into compliance once a year when forced to by the annual survey process. According to the Institute of Medicine study, regulators estimate that 10 to 15 percent of nursing homes are "in-and-out," "yo-yo" or "borderline" facilities. Another study in Texas criticized regulators for allowing facilities to play what it called the "compliance game."

In Utah, similar concerns exist that a few facilities only come into compliance when forced to by the survey process. BFR initiatives to address such concerns employ the "carrot-and-the-stick" philosophy. The quality of care incentive program rewards facilities with few deficiencies and the alternative sanctions program punishes facilities with serious deficiencies. Because these programs are new, we cannot assess their impact. However, in the future BFR should evaluate the effectiveness of these programs.

Quality of Care Incentive May Reward Facilities for Avoiding Citations

BFR has redesigned its quality of care incentive plan to reward those facilities with the fewest rule violations. Previously, the incentive program had focused on nursing homes' expenditures rather than their quality. Payments were provided to facilities that spent the most on nursing care provided they complied with four specific conditions of participation. BFR staff felt the program needed to be revised because it did not recognize quality very well. Staff analysis determined that many facilities with an above average number of deficiencies received quality of care incentive payments.

Under the revised program, facilities performing well according to BFR's annual survey findings can receive a significant financial reward. Facilities that rank in the top 30 percent in the fewest number of deficiency citations may receive supplemental payments of $1.51 per Medicaid patient day. BFR staff estimate that an eligible nursing home with 100 beds would receive about $30,000 extra this year as a reward for performing well on its annual survey.

While its effectiveness cannot be evaluated yet, we feel BFR's revised quality of care incentive program is a good strategy to deter violations of minimum quality standards. BFR hopes facilities will make a greater effort to remain in compliance so they can compete for the additional payments. Basing a significant financial reward on survey findings will also make such findings more important. Facilities may contest BFR findings more frequently, potentially making the survey process more difficult and politicized. However, even if facilities take more frequent exception to BFR findings, these exceptions may reflect the success of the program in increasing facilities' efforts to avoid citations.

Alternative Sanctions Rule May Punish Facilities With Serious Citations

An alternative deterrent strategy to rewarding facilities for avoiding citations is to punish facilities for incurring them. OBRA '87 required states to establish sanctioning procedures by October 1, 1989. Although BFR enacted an emergency rule to meet the OBRA '87 deadline, its provisions were not implemented based on advice from federal officials that the state could wait for forthcoming federal guidelines. Even though federal regulations have still not been issued, a new state rule, effective April 15, 1992, allows BFR to impose sanctions on Medicaid facilities based on the severity and scope of the deficiencies found on annual surveys. The rule is intended to provide a range of sanctions so the penalty is commensurate with the seriousness of the violation. The rule fills a void in the ability of BFR to impose reasonable consequences on facilities that violate minimum quality standards.

The lack of available sanctions has long been recognized as a key weakness in the federal regulatory system. Perhaps because of its rehabilitation philosophy, the principal sanction for failure to comply with minimum quality standards has been to decertify a facility. However,

decertification is such a severe penalty that it is rarely used. As early as 1981, an American Bar Association study concluded that intermediate sanctions were needed to help prevent deficiencies. Subsequent studies by the Institute of Medicine and General Accounting Office reached similar conclusions. Therefore, OBRA '87 required the establishment of procedures providing a range of sanctions.

The delay in implementing the alternative sanction procedures of OBRA '87 raises a concern about the willingness of regulatory authorities to use such remedies. Although OBRA '87 required HCFA to provide guidance through regulations by October 1988, it still has not done so. Further, OBRA '87 required states to act by October 1989 even if HCFA failed to provide guidance, but many, including Utah, did not based on HCFA's advice that implementation could wait. Nevertheless, if it is used, the new state rule provides BFR an effective tool to encourage compliance with federal rules.

The new rule requires that BFR impose sanctions on a facility based on the severity and scope of its rule violations found on annual surveys. BFR must evaluate the severity of deficiencies by whether they have or are likely to harm facility residents, and the scope of deficiencies by how isolated or widespread they are in the facility. Both the severity and scope scales include four levels. Based on the severity and scope levels, BFR may impose sanctions including:

- a plan of correction
- denial of payment for new admissions
- department monitoring
- civil fines
- termination of certification for Medicaid program

The initial sanction imposed under provisions of the rule includes a $2,800 fine against a nursing home for an incident which resulted in a resident's leg being amputated. The sanction was imposed on August 31, 1992 and is now under appeal.

The effectiveness of the alternative sanctions rule to deter violations of quality standards will depend on how it is used. While the new rule provides the opportunity for BFR to influence facilities' compliance, it must be properly implemented. While minor and unintentional violations should not be punished, serious violations must be punished harshly enough that the sanction is not considered a "cost of doing business." We think the alternative sanctions rule can help increase facilities' compliance with minimum quality standards if BFR applies the rule aggressively but fairly.

Publicizing Monitoring Results May Encourage Better Compliance with Standards

Another method of improving facilities' compliance may be to publicize violations. A greater public awareness about BFR's findings may provide a greater incentive for facilities to stay in compliance with standards. Consumers remain largely unaware of the tremendous

amount of data BFR gathers about nursing home quality. However, BFR plans to provide better public information about its facility monitoring findings. BFR's plan to provide more accessible public information is discussed in Chapter V.

BFR Should Strive To Make Monitoring Program Less Predictable

If BFR takes enforcement actions which deter violations, its facility monitoring program may also be affected because as the consequences for violations increase so too may facilities' efforts to conceal problems. In the past, BFR's program has been able to identify frequent violations of minimum quality standards and it has received good ratings on recent federal evaluations. However, BFR has made little progress on a key goal of OBRA '87 to make facility monitoring visits less predictable. Although BFR has moved to target more of its efforts on problem facilities by improving its complaint investigations, standard surveys continued to be scheduled very predictably. BFR staff report that federal regulations prevent them from reducing the predictability of their surveys. Even so, OBRA '87 appears to allow the aggressive use of an investigation team to visit any facility whenever the state has any concern about its performance.

BFR devotes a considerable portion of its staff time to monitoring the performance of LTC facilities. Teams of professionals, both nurses and facility experts, visit facilities on routine annual surveys and complaint investigations. Both surveys and complaint investigations may result in citations for more serious "Level A" deficiencies or less serious "Level B" deficiencies. BFR's monitoring program is similar to programs in other states; federally specified procedures must be followed. The program is based on federal requirements, mostly paid for by federal financing, and subject to federal monitoring.

OBRA '87 addressed a number of concerns with how regulators monitored facilities, including predictability and an emphasis on paper compliance. According to a congressional committee report:

> *The purpose of the unannounced "annual" standard survey is not to determine whether every nursing facility is in compliance with every requirement of participation. Instead, its purpose is to detect facilities where residents are not receiving quality care. This will allow limited survey and enforcement resources to be targeted on substandard quality facilities.*

Despite the concerns raised about facility monitoring, it should be recognized that regulators have always been able to identify many violations of standards.

Despite OBRA '87 Intent BFR Routine Surveys Remain Predictable

BFR staff report that their surveys remain predictable because HCFA has failed to provide the implementing regulations. Indeed, many aspects of OBRA '87 have been delayed due to delays by HCFA. Furthermore, rather than criticizing how BFR schedules surveys, federal reviews of BFR's survey process show that it meets requirements.

A key goal of OBRA '87 reforms was to make surveys less predictable. The Institute of Medicine criticized the federal monitoring program because facilities could easily predict when surveyors would arrive and thus were able to prepare for them. According to a congressional committee:

> *The standard survey, while "annual," would not have to be conducted every 12 months in every facility. Indeed, such a rigid schedule would conflict with the requirement that the survey be conducted without any prior notice to the facility....The Committee would expect survey cycles to vary so that facilities would not able to predict the arrival of a survey team.*

BFR staff told us that each survey is scheduled within a 1-month window, 90 to 120 days before a facility's certification expiration date. The framers of OBRA '87 envisioned a 6-month window when facilities might be subject to their annual survey. However, BFR staff told us that if facility operators can count to 12 they know when the survey team will arrive.

Despite its predictability, federal reviewers of BFR's survey program indicate the program operates effectively. Although federal reviewers found that BFR did not fully explain and properly document all deficiencies, BFR has taken appropriate steps to improve its performance in this area. Another concern raised by the federal review is that state and federal surveyors sometimes reached different conclusions about facilities' compliance with critically important standards. The different results indicate that facilities' performance may change rapidly.

Eva Dawn Case Shows How Rapidly Conditions Can Change. In order to evaluate BFR, federal staff visit some facilities soon after BFR has conducted a survey. In their 1992 review of BFR's performance, federal surveyors arrived at different conclusions about the existence of critical Level A deficiencies at three of the five nursing homes they visited. Level A requirements are considered so important that they are referred to as "conditions of participation." BFR deter- mined that Murray Care Center failed four conditions of participation and that Hillside Villa failed three. However, federal reviewers subsequently concluded that both nursing facility met all conditions of participation.

In contrast, at the Eva Dawn nursing facility, federal reviewers found violations of conditions of participation not discovered by BFR. Although BFR cited Eva Dawn for a number of Level B deficiencies, it found no Level A deficiencies. A month later, federal reviewers found that Eva Dawn failed to meet minimum standards in four Level A

requirements: Quality of Life, Quality of Care, Nursing Services, and Administration. The deficiencies discovered by federal review resulted in the closing of Eva Dawn due to its failure to meet the minimum quality standards.

Because federal reviews were not concurrent with but occurred after BFR surveys, there are two reasons why results may be different. First, different survey teams may make different subjective judgements about complex issues such as the adequacy of care and quality of life of nursing home residents. Second, conditions in nursing homes may change rapidly. If both state and federal surveys are accurate, then the improvement in conditions at Murray Care Center and Hillside Villa may be due to the effectiveness of the state program in improving facilities. In contrast, the Eva Dawn results may show how quickly facility performance can deteriorate.

The prospect of rapid deterioration in facility performance following annual surveys indicates a need for unpredictable visits to facilities. Unfortunately, BFR staff report that the federal monitoring program which they must follow to receive federal funding does not provide for random surveys. However, OBRA '87 does provide for on-site monitoring of facilities on a as needed basis.

BFR Complaint Team Could Regularly Monitor Substandard Facilities

In addition to regular surveys, OBRA '87 provides for additional monitoring of substandard facilities. According to OBRA '87, states shall maintain procedures and adequate staff to (A) investigate complaints, and (B) "monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements." Even if a facility has corrected its deficiencies and achieved compliance, the state may periodically visit the facility if it feels "verification of continued compliance is indicated" or "has reason to question the compliance of the facility with such requirements." OBRA '87 further emphasizes the goal of an aggressive monitoring and enforcement program by stating:

> *A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.*

BFR has recently improved it monitoring program by forming a specialized complaint investigation team of health care professionals. However, BFR's monitoring and enforcement philosophy still appears to be far more modest than that envisioned by OBRA '87. It focuses on doing surveys and responding to complaints rather than seeking out poor quality care.

BFR Complaint System Has Improved. Recent changes by BFR have strengthened its complaint processing system. While BFR formerly relied on the ombudsman program to do complaint intake, it now uses its own staff. BFR hopes to further strengthen the intake process

through the development of standard questions to ask complainants. In addition, BFR has formed a three-person team which investigates complaints. Formerly, a complaint investigation was conducted by those staff which had been assigned to a facility's annual survey.

Findings of the federal reviewers verify that BFR's complaint processing system has improved in the past few years. In 1988 the regional office recommended that BFR become more involved in investigating complaints rather than relying on the ombudsman program. The federal reviewers found the ombudsman complaint reports to be unclear and incomplete. Then in 1990, federal reviewers faulted BFR's handling of complaints after finding 13 instances where complaints were not fully investigated. While BFR did not agree with some of the federal reviewers' findings, it did strengthen its complaint system, making the changes noted above. In 1991 federal reviewers found all complaints reviewed were investigated properly.

Our review supports federal evaluations that BFR is properly investigating complaints. We reviewed 88 complaints against 10 facilities. In general, we found all complaints were properly investigated. Nonetheless, we feel BFR should reconsider two of its complaint handling procedures.

One concern we have is that BFR staff have recently begun to sometimes substantiate a complaint against a facility without citing any rule violation. Since regulatory staff have no authority outside of rule enforcement, the purpose and meaning of substantiating a complaint against a facility that has violated no rules is unclear. However, BFR staff explain the federal system allows them to do this and that they do not want to cite facilities for rule violations if no corrective action is needed. For example, one recent investigation found that a facility had reacted properly to a minor power outage: "the facility took reasonable steps to minimize resident impact and remedy the situation. In addition, the situation posed little danger to residents and their care." Even though no citation was warranted, BFR substantiated the complaint against the facility apparently on the basis that the facts reported by the complainant were correct. While a substantiated complaint implies that a facility is at fault, the failure to cite a rule violation indicates that the facility is not at fault. Especially since BFR plans to provide greater public information about its findings, we do not feel it is fair to facilities to substantiate complaints against them if they have not violated any rules.

A second concern we have is the referral of complaints alleging federal rule violations to the ombudsman program by BFR. Although BFR used to refer most complaints to the ombudsman program, it now does so only rarely. By making such referrals, the complaint is transferred from an agency with enforcement authority to one without enforcement authority. BFR explains that it only refers less critical "resident rights" complaints to the ombudsman program, providing it the opportunity to resolve the issue. BFR hopes the ombudsman can resolve the issue without further regulatory involvement; if not, the ombudsman can refer the complaint back to BFR. While this process works well for BFR, because resident rights are protected by federal rules, BFR does have a regulatory responsibility to investigate alleged

violations. Moreover, as discussed in Chapter IV, because the ombudsman devotes so much effort to investigating complaints, it does not have the resources to complete many important

tasks. In Chapter IV, we recommend that the ombudsman program focus its efforts less on investigating complaints and more on making sure regulatory agencies fulfill their responsibilities.

Nurse Aide Registry Should Be More Comprehensive

Although it is a big step forward, the state's registry of nurse aides contains a loophole because it does not include non-certified nurse aides. The registry's purpose is to promote the quality of care in nursing homes by requiring nurse aides to complete a training and competency program, and by recording verified incidents of abuse, neglect or theft by nurse aides. While the registry generally accomplishes its goals, LTC residents would be better protected if aides were placed on the registry when hired, rather than when they complete a training program.

OBRA '87 requires that each state establish and maintain a registry of certified nurse aides. To become certified, an aide must successfully complete a training and competency evaluation program. Aides who do not become certified within four months of being hired may not continue to serve as a nurse aide, although they could fill another position at the facility. In addition, the state must include confirmed incidents of abuse, neglect or misappropriation of residents' property by an aide. Since facilities must consult the registry when hiring new aides, it should prevent aides who have been fired from a facility for abusing residents from being rehired at another facility. However, since non-certified aides are not tracked by the state's registry, those aides who do not take the required training or who abuse residents at one facility could be unknowingly hired by a different facility.

Some confusion exists about the ability of the state to add names to the registry before they have completed a training program. BFR staff have felt they could not register non-certified aides because federal regulations do not direct them to do so. However, the assistant Attorney General assigned to BFR told us that because federal regulations do not specifically prohibit registering non-certified aides, BFR may do so. If BFR can make the registry more comprehensive, LTC residents would be better protected against both incompetent and abusive nurse aides.

Aides Could Avoid the Training Program. Some concern exists that nurse aides may avoid completing the required training program by "facility hopping." We did not attempt to determine if aides in Utah really do avoid training by changing facilities every four months. However, in 1990, a congressional committee expressed concern that the OBRA '87 intent of providing a grace period to become certified was instead being used by some aides as a loophole to avoid the training program. Furthermore, some nursing home administrators told us they believe some aides do change facilities to avoid the certification requirements. While

we doubt that facility hopping is a common occurrence, the problem could be eliminated by adding aide names to the registry when they are hired, rather than when they complete training.

Abuse By Non-Certified Aides Should Be on Registry. Because the potential consequences of an aide abusing an LTC resident are so great, the failure to include known instances of abuse by non-certified aides on the state's registry is a serious concern. Both nursing home administrators and BFR staff feel the failure to record confirmed abuse by non-certified aides is a weakness of the registry. Nursing home administrators are concerned that they could unknowingly hire aides who had been fired from other facilities for abusing residents. BFR staff report that when resident abuse by non-certified aides is found, they notify the appropriate agency because the information cannot be recorded on the registry. Adding aide names to the registry when they are hired, rather than when they complete training, would enable all known abuse to be included on the registry. Alternatively, the state could establish a separate list including the names of only those few aides who have abused residents.

Recommendations:

1. We recommend that BFR strive to achieve better quality care through a full range of actions which deter violations.
2. We recommend that BFR continue its efforts to strengthen its enforcement actions by:
    a. Implementing the planned changes to its quality of care incentive program,
    b. Applying provisions of its alternative sanctions rule whenever warranted, and
    c. Publicizing the results of its facility monitoring program.
3. We recommend that BFR strive to achieve less predictability in its facility monitoring methods.
4. We recommend that BFR review its complaint handling procedures in the following areas:
    a. Substantiation of complaints against facilities without rule violations, and
    b. Referral of complaints to ombudsman program when federal rule violations are alleged.
5. We recommend that BFR add aide names to the nurse aide registry when they are hired.

Chapter III
State Regulatory System Can Improve With Better Data Management

Because the state regulatory system is similar to the federal system, the concepts discussed in Chapter II apply to it as well. For example, the licensure system can also be strengthened by achieving a deterrent effect with enforcement actions and by focusing monitoring efforts on problem facilities. However, unlike their federal counterparts, state regulators have a significant weakness in their inability to readily access facilities compliance histories. Better data management will enable BHFL to use staff more efficiently, and increase the objectivity of its enforcement program.

As the state licensing agency, BHFL has a regulatory responsibility for all LTC facilities. However, as explained in Chapter I, BHFL concentrates its efforts on those facilities not covered by the federal regulatory system. A total of 4 nursing homes and 54 residential care facilities (RCFs) have state licenses but are not federally certified. The basic activities of the state regulatory system are identical to those of the federal system. BHFL monitors facilities in order to enforce minimum quality standards.

BHFL has made a number of changes in recent years to improve its regulatory program. Although not directly affected by OBRA '87, licensure staff have implemented reforms modeled on the federal requirements. For example, survey procedures at RCFs were changed to make them focus more on resident outcomes and quality of life and less on facility paperwork. In addition, licensure standards for skilled nursing facilities are modeled on the federal standards. Some efforts have also been made to improve the enforcement process.

Besides its regulatory role, BHFL has assumed a consumer education role. BHFL staff feel that by providing information about facility quality to consumers they can contribute to increased facility performance above that required by minimum quality standards. However, BHFL staff acknowledge that data is currently not available to be accessed by consumers in a manner which makes it easily understood or useful in selecting a LTC facility. Consumer information is discussed in Chapter V.

BHFL Enforcement Mechanisms Should Focus on Deterrence

As was discussed in Chapter II, enforcement procedures are most effective when they deter violations. Obviously, standards do not protect residents if facilities do not comply with them. Thus, even the ability to discover and correct problems through a facility monitoring program

does not adequately protect residents if facilities drift back out of compliance when regulators leave. Recognizing that some facilities repeatedly violate state standards, BHFL is considering implementing a mandatory sanctioning process. We feel that BHFL's enforcement program could help deter violations of minimum quality standards through a more aggressive use of even mild sanctions and through better data management so that repeat violations or patterns of violations can be monitored.

Effective Deterrence May Require A More Aggressive Use of Sanctions

BHFL staff acknowledge that they have not acted aggressively against facilities that chronically violate licensure standards. Although licensure rules provide for sanctions, they are rarely used. Instead, when violations have been detected, BHFL has emphasized working with facilities to bring them back into compliance. As described in Chapter II, the rehabilitation philosophy, while effective in the short run, provides little incentive for facilities to remain in compliance between regulatory monitoring visits.

Range of Sanctions Are Already Available. Existing state rules provide for a range of sanctions depending on the seriousness of a violation and the facility's prior history of compliance. When BHFL staff detect a violation at licensed facilities, its seriousness is judged as:

Class I:	imminent danger to residents,
Class II:	direct or immediate relationship to health, safety or security of residents, or
Class III:	any violation not class I or class II.

Although Class III violations are not subject to sanctions, the failure to correct a Class I or Class II violation may result in:

a. license revocation,
b. prohibition of new admissions,
c. newspaper publication of rule violations,
d. placement of state monitors in a facility, and
e. assessing the cost of state monitors.

Licensure rules provide that when a facility fails to correct a Class I violation, appropriate sanctions be pursued through a formal adjudicative hearing. However, no additional guidance is provided to determine what sanction may be appropriate. For the failure to correct a Class II violation, rules direct staff to determine the appropriate sanction by considering:

a. the gravity of the violation,
b. the effort exhibited by the licensee to correct violations,

c. previous facility violations, and
d. other relevant circumstances.

Reportedly, BHFL staff are reluctant to initiate sanctions because of concern that due process requirements take too long and that the sanction may be changed upon appeal. While due process procedures, which may take months, are necessary to protect facility rights, staff are concerned that a sanction may not be imposed in time to protect residents. Staff also are concerned that upon appeal, the Health Facilities Committee or its designee may change the staff action based not on conditions that led to the original sanction but on facility improvements since that time. Sanctions cannot have a deterrent effect if there is not a credible threat that they will be used. Therefore, whether staff perceptions are correct or not, their reluctance to start the sanction process inhibits it potential effectiveness.

Mandatory Sanctioning Process May Help Keep Facilities in Compliance. In an effort to bring more structure to the enforcement process, the Health Facilities Committee established a Mandatory Sanctions Committee with membership representing the LTC industry, consumers, and regulators. The purposes of the committee are first to identify when rule violations are a serious threat to patients' health and safety, and second to provide clear guidance for appropriate sanctions of facilities with specific rule violations. The committee has started by reviewing possible sanctions for violating nursing home rules.

The Mandatory Sanctions Committee is charged with linking specific violations to specific sanctions. In the past, the lack on any specific link may have caused BHFL staff to feel their judgements would be overruled by the Health Facilities Committee. A more specific policy to guide actions will encourage staff to initiate action when justified. While additional guidance linking rule violations with sanctions should be valuable, any new policy should focus on deterring future violations. Therefore, the committee should not focus only on when mandatory revocation of a license should occur. Instead, efforts should identify intermediate sanctions that can be applied to less serious violations early and often, thereby deterring more serious violations.

The formation of the Mandatory Sanctions Committee highlights two concerns with BHFL's ability to enforce licensure rules. One concern is that staff cannot readily evaluate a facility's history of violations to identify patterns or repeat violations, nor make comparisons among facilities. Even if additional guidelines are developed, data management improvements will be needed to implement them. The second concern is that the Health Facilities Committee may not be an effective hearing body.

Better Data Management Is Needed. BHFL needs a more useful computer database. Inspection staff conduct surveys and complaint investigations and identify violations. However, staff are unable to track and compare facilities' compliance histories except by reviewing paper files. In order to determine appropriate sanctions, the bureau should be able to compare a facility's current violations with its prior violations as well as with similar facilities' violations. As is discussed in Chapter V, better data management is also important for providing consumer information about facility quality.

An improved data management capability will be an important part of implementing a more objective enforcement program. As noted above, current rules require BHFL to consider the gravity of a violation and previous facility violations to decide upon an enforcement action. However, BHFL staff recognize that they do not have a system to determine serious or repeat violations of minimum quality standards. Therefore, one task of the Mandatory Sanctions Committee is to determine what specific violations or combination of violations are serious enough to warrant an enforcement action. In order to implement any policies developed by the committee, BHFL staff will need to be able to use existing data more effectively.

Role of Health Facilities Committee Should Be Reevaluated. Concerns have been raised about the ability of the Health Facilities Committee to be an effective appeal body. Currently, the committee acts as both a legislative body which formulates policy and as a judicial body which hears appeals. Health Department officials are concerned with the dual role of the committee, in part because it is inconsistent with other department procedures. In addition, since the committee receives regular briefings from staff about problem facilities and possible sanction actions, the Attorney General's office is concerned that the objectivity of committee members could be compromised. Although an assistant Attorney General has advised BHFL staff against briefing the committee about problems which could lead to sanctions, some committee members feel that such briefings are essential to its policy role and more important than serving as an appeal body. Staff are also concerned that the committee's lack of expertise in due process requirements could cause a decision to be overturned in a subsequent court action, placing LTC facility residents at risk. Therefore, BHFL staff have proposed that an administrative law judge hear appeals instead of the committee. Such a change could streamline the process and help bring to it a deterrent emphasis.

One benefit from changing the appeal body is logistics. The Health Facilities Committee is a large group that schedules meetings quarterly. The thirteen committee members include five representatives of facilities, four representatives of health related professions, and four representatives of consumers. Such a large body is difficult to assemble when appeal hearings are needed. Furthermore, if the committee establishes adequate rules to guide the appeal officer, there should be no need for all thirteen members to consider an appeal. Since hearings may continue for days, it is awkward and expensive for the full committee to remain in attendance.

Using administrative law judges to hear appeals may also help bring more of a deterrent philosophy to the enforcement process. Perhaps because they represent different constituencies, committee members view their role as hearing officers in a variety of ways. One member's view is that the hearing process is a final step in the effort to counsel substandard facilities back into compliance. Another member's contrasting view is that the bureau should avoid leaning over backwards to keep non-compliant facilities in operation. Still another member's view is that the appeal board should offer a sympathetic hearing which is supportive rather than threatening. Since most committee members represent either health facilities or professionals, it may be difficult to place them in the position of

sanctioning their peers. However, as discussed earlier, a number of studies have concluded that the failure to use sanctions to deter violations may contribute to continuing poor quality of care.

Performance Monitoring Should Focus Efforts On Problem Facilities

A better data management system could also allow BHFL to focus its routine survey efforts onto facilities with poor compliance histories. Facilities with good compliance histories may not need the same frequency or intensity of surveys as facilities with poor compliance histories. Some improvements can also be made in BHFL's complaint handling system.

BHFL's monitoring program is modeled after the federal program, including regular annual surveys and complaint investigations as needed. Similar to BFR's program, BHFL sends teams of professionals, both nurses and facility experts, into facilities to evaluate compliance with minimum standards. However, an important difference is that the BHFL program is not constrained by the federal procedures which BFR must follow.

Routine Surveys Should Focus on Problem Facilities

BHFL should attempt to focus its facility surveys into known problem areas. Similar to BFR, BHFL now completes standard surveys at predictable intervals. However, the Institute of Medicine recommended that good facilities receive only a relatively short "standard" survey, while problem facilities receive an "extended" survey, and that the timing of surveys range from 9 to 15 months in order to maximize the element of surprise. Unlike BFR, which must comply with the federal program, BHFL is free to restructure its monitoring program. By considering facilities' compliance histories when scheduling regular monitoring visits, BHFL can direct regulatory efforts to where they are most needed.

Both regulatory and industry representatives feel BHFL monitoring efforts should be more focused. BHFL staff have discussed the possibility of conducting limited-scope reviews of facilities with a good history of compliance, and full-scope reviews at facilities with a poor history of compliance. Industry representatives also told us that a few problem facilities merit more intensive scrutiny than other facilities. We agree that it makes sense to focus monitoring efforts more on bad facilities and less on good facilities if BHFL has an objective method to differentiate among facilities.

Establishing a more focused monitoring program will require reliable data about problem areas. Currently, although BHFL staff know which facilities are better than others, they have difficulty supporting their judgements with objective data. We feel basing monitoring efforts

on subjective opinions of regulatory staff could be unfair to facilities. Although BHFL has a computerized database, it has a very limited capability for extracting and summarizing information. BHFL staff generally refer to paper files to review a facility's compliance history; however no good method exists to compare facilities. BHFL staff feel improving their computerized data management is a critical program need.

BHFL Complaint System Also Needs Some Changes

BHFL staff recognize that their complaint investigation database also needs to be improved. Staff are unable to sort computer records in ways they feel are needed. In addition, data in the computer records was occasionally incomplete and in a of couple instances incorrect. Our review of all complaints which BHFL logged in against LTC facilities from the start of 1991 until March 1992, 32 complaints in 15 months, showed that most were handled properly. However, we feel BHFL needs to track complaints that it refers to other agencies to make sure they are properly investigated, at least in life-threatening situations. In addition, we feel BHFL should reconsider its practice of substantiating complaints against facilities without citing rule violation.

Safeguards are needed to ensure that serious complaints are properly investigated, even if they are referred. When a complaint is referred to another agency, BHFL has no way of knowing whether it is investigated. As a result, we were unable to verify whether two complaints which BHFL had categorized as potentially life- threatening were investigated. Because the two complaints involved certified nursing homes, they were referred to BFR. However, we could not locate any information about these two complaints at BFR. In a similar situation, we discovered two complaints where BHFL referred an allegation to the ombudsman program. Apparently, in neither instance did the ombudsman program investigate the allegation which was referred.

The referral of complaints alleging resident rights violations from BHFL to the ombudsman program is another concern. Resident rights, such as having ones privacy respected, keeping personal possessions, and being treated with respect, are protected by licensure rules. The referral of such complaints by BHFL may indicate that resident rights are of little importance. However, the Institute of Medicine study emphasized that violating these basic rights in the resident's home can have a serious impact on his or her psycho- logical and emotional health. Even though resident rights violations may not cause an immediate threat to a resident's health, they may represent a long-term threat which should be subject to sanctions for serious and repeat violations. Furthermore, whenever a complaint alleges a rule violation, it is BHFL's responsibility to investigate it. In Chapter IV we recommend that the ombudsman program focus its efforts on making sure that regulatory agencies fulfill their responsibilities and avoid helping regulators with their workload.

Another complaint handling concern is whether regulators should substantiate complaints against facilities without citing rule violations. Similar to the practice at BFR described in Chapter II, BHFL sometimes substantiates complaints even though it does not cite any rule

violations. It is inconsistent to verify a complaint without citing a rule violation. Furthermore, the failure to cite rule violations on verified complaints prevents BHFL from tracking a facility's history of violations.

BHFL has frequently substantiated complaints without citing rule violations when the problem investigated was remedied before investigators arrived. Investigators are placed in a difficult situation when they discover that a rule violation which had existed has recently been corrected. Although investigators could cite a facility for having violated a rule, they generally have not done so if additional corrective action was not required. In our opinion, if a citation is not warranted because a facility has acted appropriately to remedy a problem, then BHFL should not publicly report that it has substantiated a complaint against the facility. In one instance BHFL, wrote a letter to a facility administrator advising him that it was substantiating a complaint even though no rules had been violated. Although the BHFL letter stated no rules had been violated, it threatened action against the facility's license. We do not think it is fair to verify complaints against facilities if they have not violated established standards. Certainly, facilities should not have their licenses threatened in the absence of rule violations.

BHFL also investigates complaints concerning providers which should be licensed, but are not. BHFL received 19 such complaints in 1991. Investigations at unlicensed facilities should focus on whether they are performing any services which require licensure. In reviewing some of these unlicensed investigation reports with BHFL staff, they observed that the investigators had occasionally gone beyond that issue, and reviewed irrelevant issues. The BHFL complaint coordinator now identifies the rule number of potential rule violations before each complaint investigation to help focus complaint investigations on the appropriate issues.

Recommendations:

1. We recommend that BHFL revise its database so that it can readily review and compare facilities compliance histories.

2. We recommend that the Health Facilities Committee attempt to bring more of a deterrent emphasis to its enforcement process by:

    a. making sure facilities cannot avoid sanctions merely by coming into compliance after rule violations are discovered,
    b. continuing its effort to bring more structure to the enforcement process through mandatory sanctions for serious violations, and
    c. identifying and using intermediate sanctions for less serious violations.

3. We recommend that BHFL base survey frequency and intensity on objective information about facilities' compliance histories, including surprise surveys of facilities with poor compliance histories.

4. We recommend that BHFL review its complaint handling procedures in the following areas:

   a. tracking referred complaints to make sure they are investigated, especially if the complaint involves a potentially life-threatening situation,
   b. substantiating complaints against facilities without rule violations, and
   c. referring complaints to ombudsman program when licensure rule violations are alleged.

Chapter IV
The Long-Term Care Ombudsman Program Should Broaden Its Advocacy Focus

The LTC ombudsman program can better fulfill its advocacy role by bringing a broader system orientation to the program. In the past, the program has focused too much of its attention on complaint investigations to the exclusion of other important responsibilities. We feel the program should focus more attention on system issues, including being a "watchdog" to make sure regulatory agencies are fulfilling their responsibilities and establishing a greater presence in facilities through regular visits. While the ombudsman program should continue reacting to problems raised by complainants, it should also strive to proactively prevent problems by adopting a broader system view.

In addition to changing its focus, the ombudsman program needs to be organized more effectively. The state ombudsman should provide better policy guidance to local ombudsmen. In the past, local ombudsmen have not been adequately trained nor received needed oversight from the state. As a result, ombudsman competence has been questioned, and adequate records have not been maintained. In the future, the state ombudsman needs to provide better policy direction and make sure local staff comply with program requirements. The Division of Aging and Adult Services recognizes that problems have existed with the ombudsman program, and is trying to make improvements. The new state ombudsman has already begun to resolve many of the concerns raised in this chapter.

The advocacy role of the ombudsman is very different from and more ambiguous than the regulatory role of BFR or BHFL. According to **Utah Code**, the ombudsman program is created for the purpose of "promoting, advocating, and ensuring the adequacy of care received, and the quality of life experienced by elderly residents of long-term care facilities." The state ombudsman program is established pursuant to the federal Older Americans Act to serve LTC residents who are 60 years of age and older. The ombudsman is to be a buffer between citizens and their government and should be activist oriented, identifying weaknesses in regulatory programs and arguing for needed changes. Unlike regulatory programs which enforce clearly defined minimum quality standards, the ombudsman program should advocate for any change which promotes better care or an improved quality of life for the LTC residents it serves.

The ombudsman program includes state and local efforts. The **Utah Code** establishes an office of the state ombudsman within the Division of Aging and Adult Services, which provides administrative support for the program. There is a single ombudsman at the state level who is to establish local ombudsman programs to help protect LTC residents. The state ombudsman's responsibility is to establish policies and procedures for the program, and to cooperate and coordinate with governmental entities and voluntary organizations in exercising its powers and responsibilities. In Utah, the ombudsman's power and authority has been delegated to representatives in each of the state's 12 Area Agencies on Aging (AAAs). Figure II shows the number of LTC facilities and beds in each local ombudsman district. While important, the local ombudsman program is a minor part of a AAA's responsibilities; each AAA receives federal and state funding to provide a variety of services (such as transportation, meals on wheels) to elderly in their local areas.

Ombudsman Program Should Focus on Advocacy And Avoid a Regulatory Orientation

The greatest improvement in the ombudsman program would come from refocusing its efforts. In the past, the ombudsman program has been too willing to assist regulators with their workload rather than insist that regulators do their jobs. As a result, complaint investigations have become the dominant focus of the program to the exclusion of other important roles. While complaint investigations are important, they must not be allowed to consume the program. In fact, other types of advocacy activities may be able to prevent problems which lead to complaints. In most cases, LTC system changes which improve care for all residents are the most valuable function the ombudsman program can perform.

We think the ombudsman program can improve by more clearly distinguishing its role from the regulatory role. For example, complaint investigations should focus on resolving the problem which led to the complaint. When ombudsmen become too concerned with whether a complaint is "verified," they assume a regulatory posture for which they have neither expertise nor authority. In addition to refocusing its complaint investigations, the ombudsman program should attempt to recruit more volunteers to provide resources needed to broaden its advocacy focus.

Broader Focus Can Make Ombudsman Program More Proactive

The ombudsman program should devote more of its efforts to preventing problems. While it is important to solve problems as they occur, it is even more important to prevent problems when possible. National studies have concluded that ombudsman programs most effectively promote the adequacy of care and quality of life in LTC facilities when they take a broad system view of their role. Some activities which need additional emphasis in Utah's ombudsman program include establishing a greater presence in facilities, recommending ways to improve the performance of regulatory agencies, and more aggressively publicizing the conditions and needs of LTC residents and facilities.

Regular Presence in Facilities Is Important. It is widely agreed that frequent routine visits to facilities by ombudsmen is an important way to promote quality care. A regular presence in facilities enables the ombudsman to observe conditions and communicate with facility residents and staff.

Routine visits to facilities put an ombudsman in a proactive role, avoiding problems through early intervention. Ombudsmen may be able to help establish family councils in facilities and make sure resident councils are operating effectively. Regular contact with residents can make them more aware of ombudsman services and enable them to voice concerns or complaints. Regular contact with facility staff can remind them that resident

interests are being protected and allow a discussion of how the quality of care may be improved.

Nationally, establishing a regular presence in LTC facilities is recognized as a critical part of an effective ombudsman program. A study by the federal Department of Health and Human Services' Inspector General found programs which were highly visible tended to be most effective. The Inspector General concluded that the best ombudsman programs visited facilities routinely, even if no complaints had been received. Many states have policies requiring local ombudsmen to make regular visits to each facility in their area, such as on a monthly basis.

In Utah, ombudsmen seldom visit facilities except to respond to complaints. While some ombudsmen felt they had no authority to visit facilities without a complaint, most local ombudsmen said they did not have time to make routine visits to every facility. Almost all local ombudsmen have other job responsibilities that consume most of their time. While they must respond to complaints, local ombudsmen have not been required to make other visits to facilities. A significant improvement in Utah's ombudsman program would be achieved by establishing a regular presence in facilities.

Ombudsman Program Should Monitor BFR and BHFL. According to the Older Americans Act, an ombudsman should "analyze and monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long-term care facilities and services in the state." By identifying and reporting weaknesses in LTC facility regulation, the ombudsman program can help ensure that quality care is provided and resident rights are protected. Far from being a watchdog over regulators in the past, the Utah ombudsman program has been almost a part of the regulatory system. Inasmuch as ombudsmen tell us they lack adequate time and manpower to effectively do their jobs, we feel they must avoid assuming part of the regulatory workload.

Ombudsmen in other states have been able to bring about changes in regulatory agencies by exposing problems. For example, the governor of Texas immediately acted to make improvements based on an ombudsman's report. The Texas ombudsman found that "the Texas Department of Health operates in an environment of lenient regulation and apparent disregard or ignorance of its authority and responsibility for the regulation of nursing homes in Texas." In particular, the Texas ombudsman reported that the fines for violations of minimum standards had no deterrent effect because they were so minor that facilities regarded them as a cost of doing business.

By monitoring regulatory agencies' performance, the Utah ombudsman program may be able to expose problems and bring about improvement. For example, as was done in Texas, the Utah ombudsman program may need to report on the success of BFR enforcement actions to deter violations. As described in Chapter II, recent changes at BFR enable it to reward or punish facilities based on their violations. While the success of these new tools cannot be evaluated yet, in the future the ombudsman program will be in a position to do so. Just as

regulators are responsible for monitoring facilities, the ombudsman program is responsible for monitoring the regulatory agencies.

In order to make sure regulatory agencies fulfill their responsibilities, the ombudsman program should avoid assuming a regulatory role. The ombudsman program used to investigate complaints on behalf of BFR. As recently as last year, the state ombudsman provided the complaint intake function for regulatory agencies. Centralized complaint intake by the ombudsman was designed as a convenience to the public, however it further strained the program's limited resources. BFR and BHFL now do their own complaint intake, not because the ombudsman program was no longer willing to do it for them, but because they were dissatisfied with the ombudsman's performance. However, BFR and BHFL still refer resident rights complaints to the ombudsman program for investigation even though resident rights are protected by regulatory standards. Given its limited manpower and many responsibilities, the ombudsman program should be cautious about accepting referrals for alleged violations of regulatory standards. While ombudsmen should communicate frequently with regulators and maintain a cordial relationship, they must not become co-opted. Otherwise, the ombudsman program will not be able to call attention to regulatory failings when necessary.

The organization placement of the ombudsman program is an important factor in its ability to be an effective watchdog over regulatory performance. In fact, to protect the ombudsman's independence, the Older Americans Act requires that the ombudsman program be located in a different agency than LTC regulators. Thus, the Utah ombudsman is located in the Department of Human Services and regulators are located in the Department of Health. However, some employees of each department express concern that it creates an awkward situation for one department to critique another's performance. Some states have addressed this concern by contracting for ombudsman services or placing the program in the governor's office or an independent state agency. However, most states' ombudsman programs are located in the state unit on aging.

Ombudsman Program Should Publicize LTC Issues. The Older Americans Act also directs ombudsmen to "provide information to public agencies, legislators, and others, as deemed necessary … regarding the problems and concerns, including recommendations related to such problems and concerns, of older individuals residing in long term care facilities." In addition to reporting on regulatory performance, as described above, we feel the ombudsman program could do more to bring to the forefront consumer and policy issues.

Far from being a leader in providing consumer information, the ombudsman program has avoided providing any comparative information about facility quality. However, the new Ombudsman Advisory Council, established in May 1991, has made consumer information a priority. Consumer information is discussed in Chapter V.

Ombudsman programs in other states provide regular information about LTC issues. For example, the Oklahoma ombudsman publishes an annual report publicizing facilities whose poor quality has led to regulatory sanctions and policy recommendations for legislative consideration. In other states, ombudsmen take an active role in policy development and monitoring by publishing monthly newsletters and mailing them to concerned citizens, special interest groups, legislators, and other entities that are concerned with the rights of the LTC

residents. Whether through periodic reports, regular newsletters, or press releases, we feel the Utah ombudsman program can more aggressively bring LTC issues to public awareness, thereby helping improve resident care.

Complaint Investigations Should Not Dominate Ombudsman Program Resources

The ombudsman program has not been able to complete some of the important functions discussed above because so much of its resources have been devoted to complaint investigations. We feel a close association with regulatory programs has caused the ombudsman program to take too much of a regulatory orientation in its complaint investigations. In some instances, the ombudsman program has allowed itself to be used by regulators to achieve regulatory purposes. Instead, the ombudsman program should use regulatory complaint investigation teams as a resource to achieve advocacy purposes.

Complaint Investigations Should Avoid Regulatory Focus. One reason the ombudsman program devotes so much of its efforts to complaint investigations is that it approaches them from a regulatory perspective. Local ombudsmen do not attempt simply to resolve complaints but to judge whether they have been verified. Complaint resolution requires only that the complainant's concern be satisfied. In contrast, complaint verification must be determined by comparing conditions in a facility to some standard. It is an advocacy role to help solve problems regardless of standards. It is a regulatory role to evaluate facilities against minimum standards.

The verification of complaints by ombudsmen can be confusing. Initially, we thought that a verified complaint indicated that a facility had done something wrong. However, the state ombudsman explains that verification only means that the facts stated in a complaint are accurate; it does not indicate that a facility was at fault. Given the ombudsman's definition of "verified," the program should be very cautious about sharing the results of its investigations because the public could be easily misled into thinking facility problems had been identified.

While ombudsmen must be conversant with regulatory standards, they should avoid an enforcement posture. Unlike regulatory staff, ombudsmen are not trained to judge facilities' compliance with minimum standards. Furthermore, it is not relevant for ombudsmen to classify a complaint as verified because they have no enforcement authority. Nonetheless, ombudsmen need to be familiar with regulatory standards to make appropriate complaint referrals.

Complaints Should Be Quickly Resolved or Referred. As advocates, ombudsmen should focus on getting problems corrected, not on assigning blame. Hopefully, ombudsmen can quickly resolve problems by reviewing records and making inquiries on behalf of the resident involved. If a complaint cannot be resolved, then it should be referred to the regulatory agency with authority to require action. Of course, an ombudsman is able to

follow up on any complaintreferred to regulators when notified of their conclusion. Those few types of complaints that cannot be resolved by an ombudsman, nor solved through regulatory involvement, then may be taken to the broader public arena.

By avoiding a regulatory approach to complaints, the ombudsman program will have more time for other advocacy functions. Several local ombudsmen we spoke with said they did not have time to make routine visits to facilities because complaint investigations took all their time. Yet, one local district sends two staff to investigate each complaint. With limited resources, two ombudsmen should not be needed to respond to a complaint if the objective is either to get the parties to agree to a resolution or else refer the issue to regulators.

Greater Use of Volunteers Could Provide Needed Manpower

Besides shifting resources from complaint investigations, using more volunteers could help provide manpower to broaden the focus of Utah's ombudsman program. Although **Utah Code** provides for the use of volunteers, few are used in Utah. In contrast, other states have recruited large volunteer work forces.

A greater use of volunteer ombudsmen could add needed manpower to Utah's program. Currently, some local ombudsmen are unable to dedicate very much time to ombudsman tasks because of other responsibilities. These part-time ombudsmen generally give priority to other job responsibilities except when they need to respond to a complaint. Thus, volunteers could be especially useful for conducting routine visits to facilities. However, few volunteers have been recruited for use in this capacity. Some ombudsman districts report having tried using volunteers without much success. One local ombudsman told us volunteers are not dependable or committed to the program. Nonetheless, the experience of other states shows that with adequate training and supervision, volunteers can be a significant benefit to an ombudsman program.

Other states rely heavily on volunteers to perform important tasks and free paid staff for other responsibilities. A survey was conducted by the National Association of State Units on Aging in which 44 states with ombudsman programs responded. The majority of the states agreed to the following statements: volunteers permit programs to maintain a greater presence in the facilities; volunteers bring a wider range of skills and experience to the ombudsman role; volunteers foster community interest and political support for ombudsman programs; volunteers free paid staff to devote more time to issue and policy work; volunteers allow programs to perform a wider variety of activities.

State Ombudsman Should Improve Policy Direction and Program Oversight

Besides broadening its focus to be more proactive and less regulatory in orientation, the second major need of the ombudsman program is to more effectively organize and run the program. Even well-intentioned local ombudsmen do not protect residents if they are unable or unwilling to meet program needs. The state ombudsman is moving to ensure that local ombudsmen are competent through improved training and quality assurance reviews. In order to protect residents as well as be fair to facilities, the state ombudsman must provide better policy direction and enforce program standards.

Effective Advocacy Requires Qualified Ombudsmen And Adequate Record Keeping

The best way to ensure the adequacy of care and promote the quality of life for LTC residents is to have qualified ombudsmen who follow important program requirements. Because of the nature of the ombudsman role, it is natural for some tension to exist between ombudsmen and some industry and regulatory officials. Nonetheless, it is a concern that many questions have been raised about the competency of the ombudsman program. Furthermore, we discovered very different and sometimes very poor records were maintained by local ombudsmen.

Questions Have Been Raised About the Competence of Some Ombudsmen. Representatives of both the LTC industry and regulatory agencies have expressed concern about competence in the ombudsman program. While at least some of the criticism appears to be justified, we were impressed with the commitment and caring which many ombudsmen bring to their job.

Criticism of ombudsmen by the LTC industry should be viewed with some skepticism. The role of an ombudsman is not to please facility operators but to protect LTC residents. However, facilities should be able to expect professionalism and fairness from the ombudsman staff. Some facility representatives told us that some ombudsmen approached their responsibilities with "a chip on their shoulder," always assuming facilities were guilty. Other facility representatives indicated that some ombudsmen made unreasonable demands which could never be satisfied. While we did not evaluate the competency of individual ombudsmen, industry representatives expressed a concern with their qualifications.

Regulatory staff also are critical of some ombudsmen. However, in light of the ombudsman's watchdog role, some disapproval of them by regulators should be expected. Some regulators told us that ombudsmen overstep their authority by trying to make regulatory judgements. Furthermore, some regulators complained that ombudsmen draw medical

conclusions that they are not qualified to make. In addition, as noted in Chapter II, federal reviewers found that ombudsman complaint reports were unclear and incomplete.

Ombudsman Record Keeping Is Not Reliable. We discovered little consistency among local ombudsmen for documenting their work. While some local ombudsmen failed to adequately maintain complaint files, others may spend time on detailed reports. Reliable records are important because they help identify common problems at facilities and protect individual residents who are the subject of a complaint.

Poor record keeping in Utah's ombudsman program may prevent the early identification of system-wide problems in LTC facilities. Federal law requires the establishment of a statewide uniform reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities. However, Utah's annual reports showing complaint statistics are unreliable. We reviewed the annual complaint reports and tried to reconcile them with the source documents, but we could not replicate the data. The main reason the state's annual report has been unreliable is that some of the districts did not keep accurate complaint logs and they had to guess when filling out their annual records. Although administrative rules require that complaints be entered onto a central complaint log and assigned a file number upon receipt, some ombudsmen fail to do so. Other districts did not even bother to send in the required annual records and the state ombudsman entered statistics for them by guessing.

Our review of individual complaint files in five local districts revealed a range of practices. Although the law requires a uniform reporting system, and rules prescribe required forms, we saw many different ways to document and report complaints. Unfortunately, there is a great deal of confusion about how files and records should be kept and what documentation is necessary. In many instances we found files failed to contain the minimum documentation required by state rules. In fact, one small district did not have any complaint files even though it had received and investigated complaints. In another larger district, we found some files with proper documentation but others where we could not determine whether the complaint was properly resolved. In conclusion, some ombudsmen have kept accurate complaint logs, complaint files, and documentation of complaint investigations, others have kept a complaint log but no records in the files, while still others have kept no records at all.

Better Training and Program Oversight Are Needed

One reason we found poor documentation is that local ombudsmen have not been properly trained nor received adequate oversight from the state ombudsman. Most of the local ombudsmen are not aware of what information needs to go in a complaint file. Furthermore, the state ombudsman has not provided on-site visits in local districts to review their compliance with program requirements. Inadequately trained ombudsmen without strong quality assurance reviews cannot be relied on to adequately protect residents and may not treat facilities fairly. Fortunately, the state ombudsman is already attempting to strengthen these controls over ombudsman competence.

Ombudsmen Need Adequate Training. Both the state and local ombudsmen agree that more and better training is needed. Although the state ombudsman told us all local ombudsmen should have received at least eight hours of introductory training, some local ombudsmen did not even receive that modest amount of training. For example, one local ombudsman said she received no initial training and another local ombudsman said the only training she got was about an hour of instruction when she picked up some materials at the state office. Others said they received only a few hours of training at the time they were appointed to the position.

Other states require ombudsmen to attend both initial and continuing training. For example, Montana requires 45 hours of training to become an ombudsman, followed by 16 hours of annual training to remain an ombudsman. Similarly, California requires ombudsmen to attend 36 hours of initial training and 12 hours of annual training. Some states also require ombudsmen to pass an examination before they assume the position. A survey of 28 states found that they provided an average of 21 hours of training to volunteers who participated in the ombudsman program.

While adequate training is essential to ensure competent ombudsman services, increasing the hours required may not be practical in some instances. As shown in Figure II, four AAA districts contain but one LTC facility. With such a small workload, it would not make sense to incur the time and travel costs associated with a greater training commitment. Some states have addressed this concern by establishing different levels of ombudsmen. For example, Oregon has "ombudsman representatives" and New Mexico has "friends of the ombudsman" who receive some training and may visit facilities to meet with residents and staff but may not conduct complaint investigations. In both states, only fully trained ombudsmen may conduct complaint investigations and review confidential information.

Local Ombudsmen Need Program Oversight. The state ombudsman should provide periodic quality assurance reviews of local ombudsman programs. Such reviews can provide technical assistance and support to help local programs protect LTC residents. Reviewing the records maintained by local ombudsmen can also bring greater professionalism and consistency to complaint processing and record keeping, so that program data is more meaningful than its has been in the past.

Most local ombudsmen would welcome additional technical assistance from the state. Several local ombudsmen said that since they became an ombudsman, they had been left on their own to figure out how to operate the program. Since all but one local ombudsmen have other job responsibilities that command most of their time, they should be expected to need state support. Furthermore, if more volunteer ombudsmen are recruited, they can be expected to require even greater support than the part-time staff. A study by the National Center for Ombudsman Resources found that supportive supervision is one of the most important factors in retaining a core of volunteer ombudsmen. The most commonly used methods of supervision among 51 state ombudsman programs were individual meetings, group meetings, telephone conferences, site visits, and activity logs or summary forms.

The state ombudsman should also visit local ombudsmen to review their records. In some cases the local ombudsmen could not remember ever having been visited at their location by the state ombudsman. None of the local ombudsmen we visited had ever had their files reviewed by the state, resulting in the record keeping problems discussed above. The only way to verify that local ombudsmen are complying with program requirements is to periodically review their files. The state ombudsman reports that she has recently conducted on-site reviews in two districts and plans to regularly visit all districts.

Ombudsman Program Policies Need To Be Developed and Followed

Important program requirements, such as how much training and program oversight local ombudsmen should receive, need to be established by policy. Much of the confusion we found about ombudsman practices could be eliminated with well-defined policies and procedures. Along with establishing program standards comes the responsibility to enforce them. The best policies are useless if they are not followed. For example, even well intentioned local staff should not be allowed to participate as state certified ombudsmen if they will not or cannot comply with program requirements.

Better Ombudsman Policies Are Needed. We found a great deal of confusion about policies within the ombudsman program. According to the state ombudsman, the only policies which exist are those in the **Utah Code** or in the State Administrative Rules. However, when visiting local ombudsmen, we found many different understandings about policies. For example, one ombudsman produced a policy manual dated 1983 of which the state ombudsman had been unaware. Another local ombudsman regarded the federal nursing home regulations as policy.

The state ombudsman recognizes that adequate policies do not exist and is acting to remedy that situation. Although the **Utah Code** and Administrative Rules provide a good foundation, additional detail is needed. We found that many other states have detailed policies and procedures regarding such things as complaint investigations and referrals, training requirements, and oversight. The state ombudsman has formed a committee which is helping to draft ombudsman program policies.

State Ombudsman Must Enforce Program Requirements. Good policies are not helpful unless they are followed. According to the **Utah Code**, the state ombudsman will establish local programs and the local ombudsmen will meet the standards developed by the division. The main tool to enforce program standards is the certification process. When the state certifies an ombudsman, that person is authorized to exercise the program's authority. Facilities must allow a certified ombudsman to conduct investigations, including access to confidential records if they obtain the resident's permission. The state should not delegate such authority to any individual who cannot or will not comply with program requirements.

In the past, the certification process has not been used to ensure the quality of program services. Even the minimal policies which did exist were often not followed because the certification process was not used to insist that they were. Required reports were not always completed, and required forms were not always used. In some cases files were not even maintained, and training was not attended. Rather than considering the qualifications and competence of local ombudsmen, the state has extended certification to whoever the local AAA designated for the position. Indeed, there is no clear certification process. We have not even been able to determine which of the local ombudsmen are certified because the state ombudsman does not maintain the necessary records.

Facilities should not need to monitor ombudsman competence. However, in one instance a volunteer ombudsman who had not attended any state training conducted a complaint investigation and requested confidential information from a facility. Although the facility appropriately denied access to the confidential information, such incidents place facilities in a difficult position and could strain relationships between facilities and ombudsmen.

In the future, the state should certify ombudsman based on their qualifications. Thus, initial certification should only be extended to individuals who are prepared for the position by completion of a basic training course. Furthermore, continuing certification (perhaps annual recertification) should only be provided to individuals who demonstrate their competence by following program requirements and attending in-service training. For example, previously certified ombudsmen who refuse to follow program policies should have their certification withdrawn. While the state must not make unreasonable demands on local ombudsmen, the failure to enforce minimal program requirements not only places vulnerable LTC residents at risk, but also puts the state in the unwise position of extending authority without demanding responsibility.

Recommendations:

1. We recommend the state ombudsman strive to make the program more proactive by:
    a. establishing a greater presence in facilities through regular visits,
    b. monitoring any concerns with the performance of regulatory agencies, including analyzing the development and implementation of laws, regulations, and policies, and
    c. publicizing important issues affecting LTC residents, including lobbying for political action.

2. We recommend the state ombudsman distinguish the program's advocacy role from other programs' regulatory roles by:
    a. focusing on the resolution of complaints without undue concern about verification of violations against facilities,

b. referring any complaint that cannot be resolved to regulatory agencies if it may involve a regulatory standards, and
c. publicizing valid issues raised by complaints which cannot be resolved by ombudsmen nor solved by regulatory agencies, and lobbying for political action.

3. We recommend the state ombudsman strive to develop a greater volunteer program to help complete ombudsman tasks, especially to help provide a greater presence in facilities and meet with resident and family councils.

4. We recommend the state ombudsman establish and communicate important program requirements by policy, including:

   a. record keeping and reporting requirements,
   b. initial and ongoing training requirements to become and remain a fully ertified ombudsman or a limited capacity ombudsman representative,
   c. responsibilities and authority of different types of ombudsmen, and
   d. scheduled record reviews and program oversight in each local district.

5. We recommend the state ombudsman use the certification process to enforce program requirements by:

   a. certifying only those individuals who have attended required initial training, and
   b. decertifying those individuals who fail to comply with program requirements or who do not attend required ongoing training.

6. We recommend the legislature consider placing the ombudsman program in the governor's office rather than the Department of Human Services in order to help the ombudsman program fulfill its role of monitoring the performance of regulatory agencies in the Department of Health.

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Chapter V
Better Consumer Information May Provide Market Incentives To Improve Facility Quality

In addition to the regulatory and advocacy systems discussed in previous chapters, the market system provides a third way to affect the quality of care in LTC facilities. In an efficient free market setting, consumers influence the cost and quality of products through their purchasing decisions. However, due to the failure of the market to adequately protect LTC residents, policy makers felt that regulatory and advocacy programs were needed. Some people now feel that market forces could be more effective if consumers had access to information about facilities which already exists in government agencies. Increased public awareness about facilities' performance would empower consumers to make more informed choices and may encourage facilities to improve their quality of care.

Efforts are being made to provide better information to consumers. Regulatory agencies recognize that, although their findings are public information and should be useful to consumers, the data's format makes it too difficult for the public to access or understand. Therefore, efforts are being made to present the information in a more easily understood format. The ombudsman program should play an important role in helping distribute and interpret consumer information. In addition to providing a valuable consumer service, better public information may also serve an important regulatory purpose. Public knowledge about which facilities violate minimum quality standards may provide a powerful deterrent to future violations.

Consumers Deserve Access to Public Information

One reason to provide better public information is simply that the public has a right to know. According to Utah's Government Records Access and Management Act, it is the legislature's intent to promote the public's right of easy access to public records and to prevent abuse of confidentiality by government entities. Thus, public employees' findings about LTC facilities should be readily available to consumers unless there is a valid reason to keep information confidential. Unfortunately, consumers have not had good access to existing information. Even though much regulatory data is now classified as "public information," consumer access is limited because the information is not available in an easily

understandable format. While some regulators still question the usefulness of regulatory findings to consumers, there now seems to be a renewed interest in providing more accessible information.

Good Consumer Information Has Not Been Available

Although regulatory findings should be valuable to consumers, there appears to be little public awareness of them. BFR and BHFL surveyors visit all LTC facilities to evaluate whether they are complying with minimum quality standards. Regulators also investigate complaints about facilities. Both agencies keep records of survey findings and verified complaint findings. Yet, both agencies report that the public very seldom asks for any information about facilities' performance. In fact, according to BFR's division director, "the information generated by these inspections and investigations seem to be a largely unknown resource to most Utahns." Furthermore, consumers who do ask to review public files face a daunting task to understand them. In fact, BHFL has routinely made staff available to assist any lay person reviewing the public files. Although not required, lay persons reviewing the files have been encouraged to consult with staff since the information is so difficult to interpret.

Regulators have been reluctant to summarize survey results into a more readily usable format for consumers. Survey reports are often lengthy technical documents which are difficult for lay persons to interpret. However, regulators have been concerned that the complexity and interactions among problems found during surveys made it impossible for any summary to accurately describe the operation of a facility. In addition to being subject to misinterpretation by consumers, regulators felt that summarizing survey findings could initiate a more hostile environment between themselves and facility staff, including increased efforts by facilities to deceive regulators.

Another reason that it has been difficult to get consumer information has been the concern about confidentiality. When agencies are unsure about whether public access should be allowed, they tend to invoke confidentiality as a reason to deny making information public. For example, there is a wide disparity among the amount of information available on different agencies' complaint investigation reports. BHFL makes virtually the entire contents of their internal report available. Only the specific identifying information such as complainant and resident identities are withheld from the public. In contrast, both BFR and the ombudsman program have kept most information about complaint investigations confidential. BFR makes public only a one sentence statement, thereby denying public access to the details of the complaint investigation. The ombudsman program provides no information about individual complaints. While the state ombudsman publishes some gross statistics about the program's complaint investigations, no information about specific facilities is available.

Usefulness of More Accessible Information Remains Uncertain

Although consumers deserve access to non-confidential records, the usefulness of more information remains questionable. The additional costs to improve public access to regulatory data can only be justified if the information assists consumers or serves a regulatory purpose. Concerns have been raised about whether regulatory data provides a good basis for consumer judgements. In some instances, consumer choice is limited by facility location and bed availability. Of course, even consumers who have little choice among facilities may want reliable information about a facility. Furthermore, better public information may help improve facility quality by deterring violations of minimum standards.

Even if consumers have a choice of facilities, regulatory staff raise a number of concerns about consumers' ability to properly interpret regulatory findings. For example, consumers may not realize that findings represent conditions only at the time of the site visit and that corrective action would have been required. Besides the impact of regulatory intervention, staff point out that facility conditions are subject to rapid changes due to staff turnover and a varying patient mix. Thus, comparisons over time may not be meaningful. Furthermore, some regulators feel that consumers should not rely on a regulatory assessment of compliance with minimum standards to replace a consumer's responsibility for investigating and determining the facility best capable of providing the services they require. Finally, regulators point out that a major federal effort to provide public information about survey results was abandoned after only two years in 1990. Apparently, federal officials felt the usefulness of the information did not justify the cost of providing it.

Regardless of whether regulatory data provides an adequate basis for consumer judgements, publicizing regulatory findings could exert pressure on facilities to improve quality. Of course, since good public information about facilities compliance with minimum quality standards has not been available in the past, it is difficult to know what impact it may have. However, the prospect of consumer knowledge about rule violations may have a deterrent effect. Thus, a greater public awareness about regulatory findings may provide a greater incentive for facilities to stay in compliance with standards, thereby improving quality in the long run. Current licensure rules suggest that publicity be used to affect facilities' performance. One of the sanctions available to BHFL is public disclosure in newspapers or other media of violations of licensure rules or illegal conduct. However, BHFL staff report that this sanction has not been used.

Efforts Are Being Made To Provide More Accessible Public Information

Although the usefulness of better public access to regulatory findings remains uncertain, efforts are being made to provide more readily available information. Hopefully, government agencies can provide public information that is both understandable and meaningful. The misgivings of some regulatory staff may simply reflect a natural lack of confidence in market solutions on the part of regulators. Despite the concerns which have been voiced, both BFR and BHFL are moving to improve public access to information. The ombudsman program has also shown a new interest in providing consumer information.

BFR Is Developing a Public Information Program

In response to what it sees as an unmet need for information on the performance of nursing homes, BFR plans to summarize its findings in an annual report. The report will include the results by facility of surveys and complaint investigations for the prior year. Much of the information to be included in the report is already public, but its form makes it inaccessible. According to BFR, even other state agencies and patient advocates seem unaware of what data is available or how to review it.

Regulatory results provide an objective basis to compare facilities. While they should not be relied upon exclusively by consumers, regulatory rule violations provide a good starting point. The annual surveys of certified nursing facilities identify many rule violations at most facilities. Between July 1991 and June 1992, 86 of 88 facilities were cited for one or more violations. However, because the rules are so detailed and comprehensive, even very good nursing homes often are found to be out of compliance with some requirements. Nonetheless, comparing the survey results among facilities shows that some facilities have more numerous and more serious rule violations than others. The Appendix provides a summary prepared by BFR of their survey findings for the year ended June 30, 1992.

BHFL Intends To Improve Its Public Information

Although BHFL has not provided accessible consumer information in the past, its staff has shown a genuine interest in providing better information. In fact, BHFL views consumer information as an essential tool to improving facility quality. In addition to the bureau's regulatory role described in Chapter III, BHFL has adopted a second major role of providing consumer information. While the regulatory role addresses only minimum quality, staff feel that consumer information provides an opportunity to influence facility quality to exceed minimum requirements.

Chapter III described the importance of better data management for BHFL to fulfill its regulatory role. Likewise, an improved data management system will enable BHFL to provide a more useful consumer service. Although the bureau is a primary collector of information

relating to the quality of LTC facilities, the data is not available currently to consumers in a manner which makes it easily understood or useful in selecting a facility.

Although BHFL hopes to provide better consumer information, it is unclear what format the information may take. At one time staff developed an "annual facility profile" format based on survey and complaint investigation findings. While this profile is no longer used, the BFR consumer report described above will provide the same type of information for certified nursing homes. Certainly, BHFL should not duplicate the BFR program. Therefore, BHFL may focus its consumer information effort on non-certified facilities.

Ombudsman Program Should Be An Important Information Resource

The ombudsman program could play a vital role in improving consumer access to information about facility quality. As discussed in Chapter IV, the ombudsman's advocacy role includes both providing public information and monitoring regulatory agencies. Thus, the ombudsmen may not only help distribute and interpret summaries of regulatory findings provided by BFR and BHFL, but may also assess the adequacy of the information and recommend improvements.

In the past, the ombudsman program has provided little consumer information. Although the ombudsman program has focused on complaint investigations, it has provided no public information about individual complaints or facilities. The annual complaint activity report includes information about types of complaints statewide, but no facility-specific information. The former state ombudsman did develop a "How to Choose a Nursing Home" brochure which includes the rates charged by individual facilities as well as guidelines for selecting a facility. However, the current state ombudsman feels consumers need additional information to meet their needs. The Ombudsman Advisory Council has recommended a "consumer information service" that would show performance patterns and some sort of ratings for individual nursing home facilities.

While the ombudsman program should play an important consumer information role, it should be cautious about judging facilities. In fact, we think ombudsmen should focus their efforts on distributing regulatory findings rather than their own judgements. Certainly, any information provided by the ombudsman program should be reliable and objective. Even if record keeping is improved, as discussed in Chapter IV, we feel the ombudsman role in complaint investigations should focus on resolution rather than on assigning blame. Furthermore, since complaint verification by an ombudsman does not indicate that a facility had done anything wrong, the program should be careful not to mislead the public into believing a verified complaint does indicate a facility problem. One approach would be to limit any consumer information about complaints generated by the ombudsman program to data about complaints resolved or referred, and not include data about complaints verified unless regulatory agencies have made that judgement.

A new role of providing consumer information is now emerging for the ombudsman program. In addition to focusing on complaint investigations, public information may have been neglected in the past because nobody had determined what could be released and what is valuable information to the public. Without meaningful public information and education, consumers cannot make a valid assessment of the conditions in nursing homes, and will not be able to make an informed decision when choosing an LTC facility. While the ombudsman program may provide original information about facilities, it does not need to do so. Instead, the ombudsman program can help make sure the summary information provided by regulatory agencies meets consumer needs. Furthermore, ombudsmen should fill a vital role by helping distribute and interpret summaries of regulatory results to consumers.

Recommendations:

1. We recommend that BFR continue its efforts to provide the results of its facility monitoring efforts to the public in the most complete, accessible, and understandable format possible.
2. We recommend that BHFL provide easily accessible and understandable information about facilities' compliance with minimum quality standards without duplicating BFR information.
3. We recommend that the ombudsman program promote good consumer information by:
    a. taking an active role in distributing and interpreting public information from regulatory agencies,
    b. evaluating the adequacy of public information provided by regulatory agencies on an on-going basis and recommending improvements as needed, and
    c. making sure that any consumer information it provides is reliable and objective.

APPENDIX I

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Agency Responses

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