July 8, 2020

The Honorable Gavin Newsom
Governor
State Capitol Suite 1173
Sacramento, CA 94249

Dear Governor Newsom:

We are writing to submit a report for the state's Master Plan for Aging specifically addressing the serious problems in California's nursing homes and residential care. While we endorse the Master Plan for Aging's Long Term Services and Supports Subcommittee Stakeholder Report in May, we believe that additional attention is needed to address nursing homes and residential care.

The COVID-19 crisis has had a devasting impact on nursing homes, resulting in 14,646 residents and 9,641 health care workers having COVID-19 infections, and causing 2,618 resident and 97 health care worker deaths by July 8th. Residents admitted to nursing homes make up less than 1 percent of the state's population and yet they represent 40.6 percent of the total deaths attributed to COVID-19. In addition, there have been many unreported infections and deaths in California's residential care facilities. These infections and deaths have had a disproportionately negative impact on racial and ethnic residents and workers, highlighting the disparities in the long-term care system.

It is clear that California needs to not only increase its efforts to protect the health and safety of residents and health care workers, but it also needs to plan for the future. A broad vision and agenda for reform of nursing homes and residential care facilities is of critical importance.

We are recommending specific policies that: (1) reconsider the staffing and care standards, (2) stabilize the workforce, (3) strengthen the regulatory oversight and penalties for non-compliance, (4) address the problems with for-profit chain ownership and third-party relationships, (5) establish and enforce minimum standards for ownership; (6) empower residents to enforce their own rights and seek justice for abuse and neglect, (7) stop inappropriate discharges, (8) require hospitals to assume responsibility for subacute and short-term rehabilitation services, (9) ensure an adequate supply of housing and residential care so that individuals are not forced into nursing homes unnecessarily, and (10) establish standards, plans, and financing to remodel and replace outdated nursing home and residential care facilities.

We want California to become the nation's leader in improving quality of care and eliminating disparities for residents as well as staff working in nursing homes and residential care. Thank you for your consideration.

Sincerely,

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California Master Plan on Aging – Long Term Care Facility Recommendations

1A. Increase staffing standards to protect residents from infections and other poor outcomes: Over the past 20 years, research studies have identified the minimum staffing levels needed to protect the health and safety of residents, which is 4.1 total nursing hours per resident day (hprd) including 0.75 RN hprd and 2.8 CNA hprd. Many experts and professional organizations have recommended setting these minimum staffing levels along with a requirement for 24 hour per day RN care in all nursing homes. Moreover, under federal law, nursing homes are required to have sufficient staffing to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. Necessary staffing levels are determined by resident assessments and individual plans of care, considering the number, acuity and diagnoses of the facility's resident population.

While California has adopted higher minimum standards than some states (2.4 CNA hprd and 3.5 total nursing hprd), these standards are well below levels considered to be adequate to protect the health and safety of residents. These standards are undermined where the state has issued hundreds of staffing waivers for shortage areas and patient needs. Recent research shows that 75 percent of California nursing homes did not meet the minimum of 0.75 RN hprd and 55 percent did not meet the minimum 4.1 total nursing hours per resident day. Staffing requirements for residential care facilities are not clearly established.

During the COVID-19 pandemic, California nursing homes reported more than 14,600 residents infected and 2,618 resident deaths and over 9,600 nursing home worker infections and 97 deaths by July 8, 2020. Those California nursing homes that did not meet the minimum standards recommended by experts and those that had poor quality of care were more likely to have COVID-19 resident infections.

Medicare nursing home payments are based on the amount of expected nursing hours in order to meet the care (acuity) needs of each resident. The federal current California Medicaid reimbursement methodology is a cost-based facility specific payment that takes into account each facility's actual staffing levels necessary to meet resident care needs. These payment systems allow adequate funding to implement higher minimum staffing standards. To improve the overall quality, the state needs to set higher minimum nurse staffing standards.

Recommendations:

1A i: Increase the minimum nurse staffing levels over a two-year time period to meet the minimum recommended standards of 4.1 total nursing hours per resident day including 0.75 RN and 2.8 CNA hours per resident day for nursing homes.

1A ii: Eliminate all waivers of the minimum staffing levels because they are unnecessary. The increases in wages and benefits needed to attract and retain nursing staff are covered by the current Medi-Cal nursing home reimbursement system.

1A iii: Adopt the federal regulatory language to clarify that each nursing home must have "sufficient staffing to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care, considering the number, acuity and diagnoses of the facility's resident population."

1A iv: Require all nursing homes to provide RN staffing on a 24-hour day basis, seven days a week without waivers.

1A v: Remove the current reimbursement rate ceiling on direct labor costs (set at the 95th percentile of direct labor costs by peer group) to ensure that the Medi-Cal reimbursement rate for direct resident care labor costs is sufficient to cover actual facility costs.

1A vi: Incentivize facilities to employ clinical nurse specialists, nurse practitioners, physicians, social workers and other professional to improve the leadership, management, clinical policies and practices, and resident outcomes.

1A vii: Encourage facilities to support nursing leadership, management training, and enhanced educational and training requirements for all staff regarding the care of older adults and those with chronic illnesses and disabilities.

1A viii: Establish clear standards for staffing levels for residential care facilities to ensure the health and safety of residents that take into account resident care needs.

1B. Stabilize the nursing home workforce including nursing staff, ancillary, and support staff: The California nursing home workforce has been unstable for many years primarily because wages and benefits for nursing employees are much lower than those for hospital employees and workloads are heavy. For example, the average California RN wages per hour in nursing homes are only 76 percent of RN hourly hospital wages. The large majority of direct resident care is provided by CNAs who make minimum wages. Only 39 percent of nursing home net revenues were spent on nursing and routine services, 12 percent on ancillary services, and 17 percent on support services according to 2018 California cost reports. Remaining revenue expenditures were 9 percent for property and other costs, with the remaining 23 percent spent on administration and profits.

The average California nursing home had over 53 percent nursing staff turnover and over 50 percent turnover for all employees according the 2018 nursing home cost reports. Nursing assistants were paid on average $15.63 per hour in 2018 and many workers did not have health insurance or paid sick leave. Other workers in housekeeping, food services, and laundry had even lower wages than nursing assistants according to cost reports. Wages generally do not reflect compensation for greater work experience and expertise. Workers in residential care facilities often have even lower wages and benefits. This results in many workers living under federal poverty levels, being eligible for food stamps, and being forced to work more than one

job, often in more than one facility to provide for their families. According to PHI, 86 percent of California nursing home nursing assistants are from racial and ethnic minority groups so that the low pay and benefits result in racial and ethnic disparities and income inequities. These workforce problems result in shortages of staff, lack of continuity of care, and poor-quality services.

Recommendations:

1B i: Using funds from Medicare, Medi-Cal, and private insurers, mandate that nursing homes pay workers for health insurance and sick leave. This will help stabilize the workforce, prevent workers from coming to work sick, reduce the need for workers to work multiple jobs, and address racial/ethnic disparities and income inequities.

1B ii: Establish a strong Medi-Cal payment incentive system to encourage facilities to increase wages and benefits for licensed and unlicensed nurses to be more comparable to the wages and benefits paid by hospitals in each geographic region. This will reduce shortages of staff, reduce turnover, and ensure high quality competent employees.

1B iii: Require facilities to provide worker pay differentials based on work experience and length of employment with annual wage increases in order to attract and retain experienced and skilled workers, stabilize the workforce, and reduce turnover.

1B iv: Establish a strong Medi-Cal payment incentive to encourage facilities to employ and consult with physicians, nurse practitioners, physician assistants, clinical nurse specialists, and nurses with expertise in geriatrics, chronic care management, dementia, mental health, and disability management.

1B v: Address the problems of low wages and benefits for residential care workers to stabilize the work force and improve the quality of care.

1C. Strengthen the regulatory oversight of nursing homes and residential care facilities, including the investigation of complaints and the enforcement of state and federal nursing home regulations:

California has had a long history of weak regulatory oversight. According to the California State Auditor, the state had a backlog of about 10,000 nursing home complaint investigations and incidents to investigate in 2014 which is still on-going. In 2018 and 2020, the California State Auditor found that the state was still unable to complete its required inspections and is not providing effective state oversight of nursing homes. This results in substandard quality of care in some facilities. The state's management system appears inadequate and unable to quickly complete complaint investigations, annual surveys and relicensing inspections.

Low state surveyor wages and high workloads may contribute to high state surveyor turnover rates and vacancies. Some state surveyors may use their state positions as stepping stones to

higher paying positions in the nursing home industry, encouraging surveyor turnover and the potential for conflicts of interest.

In California and other states, the General Accountability Office has found that inspectors often underrate the scope and severity of violations and penalties are often not imposed or are too low. The failure to identify and institute penalties commensurate with the seriousness of the violations has resulted in a widespread lack of compliance with regulations on staffing, infection control, and emergency preparedness. The most effective penalty of placing a hold on admissions is rarely used.

During emergency situations where staffing is very low and the health and safety of residents is jeopardized, the state has the authority to assume the temporary management of facilities, increase staffing and pay, and take other steps to improve quality. This authority is rarely used by the state. In the situation of widespread COVID-19 infections and deaths, several California nursing homes had been evacuated rather than having the state use its authority to take over those facilities. Increased penalties and enforcement actions are needed to bring facilities into compliance and force non-complying nursing home owners and managers out of business.

Recommendations:

1C i: Streamline the state survey work activities, eliminating bureaucratic hurdles, restructuring the field offices and management, and increasing the budget as necessary to ensure that the surveys and complaint investigations can be completed in a timely fashion.

1C ii: Conduct wage and benefit comparability assessments for state surveyors, especially RN surveyors, and increase wages and benefits as necessary to attract and retain a high-quality surveyor and professional workforce.

1C iii: Ensure that state surveyors and managers have no conflicts of interest and are not allowed to work in the nursing home industry for at least two years after leaving state service.

1C iv: Prohibit state surveyors from conducting consultation and training activities for the nursing home industry to streamline work activities and reduce conflicts of interest. This is a redundant activity because consultants are readily available from the federal Quality Improvement Organization and private consultants.

1C v: Ensure that surveys meet federal requirements for using interdisciplinary teams of professionals including registered nurses, but also including but not limited to, physicians, nurse practitioners, clinical nurse specialists, therapists, registered professional nurses, dieticians, sanitarians, engineers, and social workers. Include individuals with law enforcement backgrounds, infection control experts, and others with the expertise needed to evaluate regulatory compliance.

1C vi: Hire managers and consultants who are physicians, nurse practitioners, physician assistants, and nurses with expertise in geriatrics, chronic care management, dementia, mental

health, and disability management to enhance the state oversight of nursing homes and residential care.
1C vii: Increase the enforcement of regulatory violations by issuing higher penalties and placing holds on resident admissions to enforce immediate compliance with regulations.

1C viii: Develop specific criteria for the use of temporary management and use this option more frequently to ensure the health and safety of residents, prevent injuries, deaths, and unnecessary resident transfers and relocations.

1C ix: Encourage greater coordination and cooperation with state attorneys general, district attorneys, county health departments, ombudsman, consumer advocacy groups, and others.

1D. Strengthen the penalties for failure to comply with life safety, emergency preparedness, and infection control:
While CMS has established life safety, emergency preparedness, and infection control regulations, many California facilities have failed to comply with these regulations. Few California nursing home operators have prepared to keep residents safe during power shutoffs, fires, earthquakes, floods, and other emergencies. The federal HHS Office of the Inspector General (2019) found that some California facilities failed to comply with life safety requirements related to building exits, smoke barriers, and smoke partitions; fire detection and suppression systems; hazardous storage areas; smoking policies and fire drills; and electrical equipment testing and maintenance. They also found noncompliance with emergency preparedness requirements related to written emergency plans; emergency power; plans for evacuation, sheltering in place, and tracking residents and staff during and after an emergency; emergency communications plans; and emergency plan training and testing. These identified deficiencies reportedly occurred because facilities lacked adequate management oversight and had high staff turnover. State surveyors did not adequately follow up on deficiencies previously cited and failed to consistently enforce CMS requirements.

During the COVID-19 pandemic, most facilities did not have adequate supplies of personal protective equipment (PPE) including: N95 masks, gowns, gloves, and other PPE. Staff were not adequately trained in the proper use of PPE. In the year prior to the pandemic, over 60 percent of California nursing homes were found to have inadequate infection control plans and inadequate implementation of basic procedures such as handwashing and isolation techniques. This contributed to the rapid spread in COVID-19 throughout many California facilities.

Recommendations:
1D i: Require facilities to have a backup power supply to protect resident health and safety and maintain safe temperatures for at least 96 hours during any type of power outage, in accordance with federal standards (in contrast to California's 6-hour requirement on backup power).

1D ii: Establish that non-compliance with life safety, emergency preparedness, and infection control requirements are automatically assumed to cause harm and jeopardy to residents. Commensurate penalties should be automatically issued at a level sufficient to achieve compliance (such as from $10,000 to 100,000 for violations) and include using the state's authority to place holds on resident admissions until compliance is obtained.

1D iii: Give the highest priority to the investigation and follow-up of violations of life safety, emergency preparedness, and infection control as well as complaints especially by ombudsmen.

1D iv: Require facilities to obtain and maintain a full complement of PPEs for staff and residents to ensure adequate infection control for at least one month in the event of an infection outbreak.

1D v: Establish a mechanism for facilities to declare an emergency, such as when a shortage of staff, testing, equipment, and supplies occurs, with a mechanism for counties or the state to provide emergency assistance and resources as needed.

1E. Address the problems associated with for-profit chain ownership and third-party relationships:

In California, 89 percent of nursing homes are for-profit and 75 percent of nursing homes are a part of a nursing home chain. As the California State Auditor reported in 2018, nursing home owners, as well as related-party businesses that they or an immediate family member owns or controls, can legally receive income from their nursing facilities. By contracting with related-party individuals and organizations for services that include management services, nursing and therapy services, lease agreements and loans, facilities are able to siphon money out of the facilities as expenses and hide the profits through these third-party contractors.

California nursing homes are required to disclose to CDPH the ownership of individuals or corporations with 5 percent or greater ownership and the name of the licensee. California has not been enforcing the requirement to fully report the names of all the parent companies of the licensee and their related owners and corporations. This allows each facility to largely hide its chain ownership arrangements by individual owners or groups of owners as well as by parent companies. Some nursing homes have as many as eight or ten layers of parent companies and dozens of related companies.

California nursing homes are required to report any payments to third-party or related-party organizations on their cost reports to the Office of Statewide Health Planning and Development (OSHPD). The California State Auditor's 2018 report found that financial auditing and oversight needs to be better coordinated between OSHPD and DHCS.

A 2018 California legislative change requires nursing home licensees to disclose all services provided to the nursing home, the number of individuals who provide that service, and any other information requested. If goods, fees, and services collectively worth $10,000 or more

per year are to be delivered to the nursing home, the related party's profit and loss statement and the Payroll-Based Journal public use data of the previous quarter for the skilled nursing facility's direct caregivers must be provided.

A more comprehensive approach is to require a consolidated cost report for the owner/operator of the chain and/or parent company with all its nursing homes and related party companies and individuals that includes profits and losses. The nursing homes can be required to submit consolidated and certified audited annual financial reports.
California nursing homes have high administrative costs and profits. The California 2018 cost reports showed a total of 23 percent of net nursing home revenues were spent on administration and profits, not counting the hidden profits from third party contracts.

A medical loss ratio (the proportion of revenues spent on clinical services versus administration), similar to that imposed at the federal level for private health insurance companies by the Affordable Care Act, could be imposed on California nursing homes. Since the vast majority of nursing home revenues in California are from Medicare and Medicaid, the total amount of administration and profits could be limited to 15 percent of net income annually. Nursing homes in California reported 23 percent ($2,622 million) for administration and profits in 2018. A medical loss ratio of 15 percent would have saved the state $914 million dollars in 2018 (not counting profit-taking on related-party costs). Research has shown the for-profit nursing homes and for-profit chains often have lower nurse staffing levels and more deficiencies than non-profit or government nursing homes and non-chains. By limited administrative costs and profit taking, nursing homes can reallocate its revenues to nursing, ancillary, and support services.

Recommendations:
1E i: Enforce the requirement that all nursing homes owned or operated by individuals or corporations need to fully report all their parent companies and all related party companies along with an organizational chart for the complete chain to the CDPH and the OSHPD. Any changes in the nursing home owners, related parties, and parent companies must be reported within 60 days to CDPH and OSHPD or be subject to a daily penalty until the information is provided.

1E ii: Require the Cal Health CDPH website to present information on deficiencies and complaints as well as staffing for each individual facility as well as for the chain organization and to prepare an annual report on the quality of care for all facilities within each chain.

1E iii: Require OSHPD to provide public access through its website to its long-term facility cost and utilization data not only for individual facilities but for all facilities owned and/or operated by each chain and to prepare an annual report on the cost and utilization data for each nursing home within each chain.

1E iv: Require each nursing home to provide a consolidated and certified audited annual financial cost report for all related party companies, including management companies, along

with a report of the parent chain's individual or corporate owners and operators through state legislation.

1E v: Place a ceiling on the combined administrative costs and profits of each nursing home and its related parties, and parent companies of 15 percent of net revenues per year through legislation. This combined maximum would be on all net revenues regardless of source including Medi-Cal. Expenditures over the ceiling would be forfeited to the state's general fund each year.

1E vi: Establish a combined the financial auditing and oversight unit of DHCS and OSHPD to conduct Medi-Cal and cost report audits including home office and related party payer audits, and to administer the medical loss ratio ceiling for administrative costs and profits.

1F. Establish minimum criteria for the purchase or management of any nursing home or residential care facility in California, require applications for prior approval of all ownership and management changes to be made within 90 days of when a change is requested, and prohibit changes without prior approval by the state:

The California is responsible for approving any changes in facility ownership or management. Yet California has not established criteria for making decisions about changes in ownership or management, and has primarily allowed any changes without review and approval. Nursing homes with the worst quality of care are more frequently bought and sold than high quality nursing homes. Proposed new owners may have histories of providing poor quality of care in their facilities within the state or in other states. California has no specific quality and financial standards such as: meeting minimum staffing standards in all facilities; meeting the quality, life safety, emergency and infection control regulations in all facilities; preventing abuse and neglect of any residents; complying with all financial and ownership reporting requirements; having liability and other insurance coverage; and having adequate financial reserves for six months of operation or other requirements.

In some cases, California state has not made any decision about changes in nursing home ownership and management for years and has de facto allowed ownership and management changes that do not meet a reasonable standard to ensure resident safety and quality of care. A 2020 complaint alleges that the state has knowingly allowed a defunct licensee to operate nursing homes that had been previously rejected for California licensure. Moreover, the state has not imposed a fine on the licensee for illegally operating facilities that were not approved by the state. California is not enforcing its current licensure screening requirements and is allowing unsuitable and unscrupulous persons or companies to acquire and operate facilities in the state.

Recommendations:

1F i: Establish in regulations the minimum criteria for the purchase or management of any nursing home (change of ownership) (CHOW) to receive prior approval from the state. The criteria should prevent individual or corporate owners from the purchase, operation or

management of another facility if they have a history of owning or operating facilities with low staffing, poor quality care, such as having A or AA citations, immediate jeopardy citations, and/or deficiencies that include violations of infection control, abuse and neglect, and substandard care in California or other states.

1F ii: Establish an effective prior approval process and strong qualification criteria to ensure: 1) that applicants are suitable, 2) there is a comprehensive system to review ownership and management changes at every level of corporate ownership, and 3) that there are meaningful opportunities for the public to have a voice in CHOW and licensure decisions. No person or entity should be allowed to operate or manage a long-term health care facility unless and until the state reviews and approves their CHOW or management company.

1F iii: Establish minimum financial standards for the purchase or management of any nursing home. This should include 12 months of reserve funding and requirements for appropriate insurance. Licenses should be denied to owners with previous financial problems in California or other states.

1F iv: Require the state's centralized application unit for ownership and management review: 1) to collect and analyze financial and quality data on licensee applicants (both within the state and in other states as necessary), 2) to complete a comprehensive analysis of the suitability of the ownership and management changes with a 7-year look-back period based on the state's criteria, and 3) provide meaningful opportunities for the public to have a voice in the change or ownership and licensure decisions. The reviews should apply to all persons and entities that have a five percent or greater ownership interest including, but not limited to, management companies, subsidiaries, related parties and parent companies.

1F v: Prohibit the current practice of allowing interim management agreements to take over control of facilities while change of ownership applications are pending and give the state the authority to ban admissions at any facility that is operated or managed by an entity that is not licensed.

1F vi: Enforce a requirement that any request for a new licensee or change of ownership must be made at least 90 days in advance of the proposed date of change and establish minimum per day penalties for any owner or operator that has not received prior approval for a licensee or a change of ownership. Require the new change of ownership applicant to give notice to the public and employees 90 days in advance of a proposed change.

1G. Empower residents to enforce their own rights and seek justice for harmful abuse or neglect.

State laws and regulations set forth critical standards of care and specify important personal rights for residents of long term care facilities. Unfortunately, they are almost entirely reliant on state agencies to enforce these standards and rights and the state agencies do a poor job of

guaranteeing compliance. Violations of care standards and residents' rights are all-too common.

Residents of RCFEs have no private right of action. Nursing home residents do have a private right of action (Health and Safety Code Section 1430(b)) but an appellate court decision (Nevarrez) eviscerated its impact by limiting victims' recovery to a maximum of $500.

Victims of elder abuse or neglect face significant barriers to justice, from the high burden of proof required in civil elder abuse cases to the lack of a meaningful private right of action. Attorneys can sometimes secure injunctive relief orders, which compel care providers to comply with the law, but they are stayed for years when defendants file frivolous appeals.

A robust resident-driven enforcement system empowers residents and their families - those with the most at stake regarding the quality of care - to ensure compliance with our care standards and obtain appropriate remedies for violations.

Recommendations:

1G i: Establish a private right of action through legislation that includes: the ability to seek a court order to stop illegal residential care facility activities, compensation to the resident for each violation of their rights, and a "private attorney general" component allowing any member of the public to enforce standards that protect resident health or safety.

1G ii: Amend Health and Safety Code Section 1430(b) to include a meaningful statutory damages component commensurate with the seriousness of the violations to assure facilities do not violate resident rights.

1G iii: Bring parity to the Elder and Dependent Adult Civil Protection Act by making the standard of proof in physical abuse and neglect cases the same preponderance of the evidence standard as in financial abuse cases. (SB 558 Simitian, 2011).

1G iv: Make our statutory and regulatory standards the same as our judicial standards. Codify that our statutory and regulatory standards may be used in civil trials as proof of the relevant standards of care. Provide for the admissibility of state enforcement actions as evidence of breach of those standards of care.

1G v: Amend the state provider agreements to prohibit the use of pre-dispute arbitration agreements in long term care contracts.

1G vi: End the automatic stay of injunctive relief on appeal, in cases involving long term care facility resident rights.

1H. Stop the inappropriate discharges of long term care residents by nursing homes and residential care facilities:

Nursing homes routinely and openly violate the rules meant to protect residents from unsafe, unplanned, hurried discharges. The rules are barely enforced, giving operators a green light to send undesirable, poor, and disabled residents to the streets, motels, or homeless shelters. Facilities cast out residents whose care is primarily paid for my Medi-Cal, in favor of new residents with more lucrative Medicare or private pay benefits. Other residents who speak up or "act out" are dumped into hospitals and refused readmission, despite California law that requires their beds be held open for them.

A recent New York Times investigation reported resident dumping in Los Angeles where an 88-year old nursing home resident with dementia was discharged to an unregulated boarding house without his or his family's consent. He later ended up wandering the street and was placed in jail.

This problem has been exacerbated during the COVID-19 pandemic where several nursing homes across the United States have reportedly maintained an unofficial policy to clear out less-profitable residents to make room residents with COVID-19 who would generate more revenue. Over the past three months, over 6,000 nursing home residents have reportedly been deposited at homeless shelters, motels, boarding houses, or even sidewalks without consent from the resident or adequate advance notice to the resident or resident representative. Some facilities, likely concerned about the liabilities inherent in eviction, have "pressure[d] residents to leave" and misinformed them of their right to remain.

These actions clearly do not adhere to the statutory requirements that skilled nursing facilities and nursing facilities provide notice "at least 30 days before the resident is transferred or discharged" and "ensure a safe and effective transition of care." Though CMS relaxed the discharge planning requirements during the pandemic, these violations appear to put residents in immediate jeopardy. There are no strong federal or state penalties and sanctions against facilities that are inappropriately discharged.

Recommendations:

1H i: Require nursing homes to give at least a 30 day notice of discharge including those for changes in payment sources, together with a proposal for being transferred or discharged and obtain a signed receipt of written discharge notice from the resident or the resident's representative to ensure they have been fully informed and consent to the change.

1H ii: Give the highest priority to investigate violations of inappropriate discharge and issue minimum penalties to be set at $50,000 per violation.

1H iii: Impose an automatic ban on admissions for any facility that has been ordered by a state agency to readmit a resident but refuses to immediately comply.

1I. Require California hospitals to assume responsibility for providing subacute and short-term rehabilitation services to residents after discharge to in-facility care or in-home care, thus avoiding the transfer of residents to free-standing facilities which are not adequately prepared to serve post-acute care individuals:
California reports having 483 hospitals with over 86,700 beds that served with over 3.3 million discharges and over 18 million days of stay in 2018. These hospitals had over 7,000 skilled nursing beds and served 22.7 thousand residents and provided almost 2 million days of care according to OSHPD 2018 reports. Many hospitals have experience providing sub-acute (a level of care between hospital and skilled nursing care) and post-acute care services.

Because of the incentives in Medicare, health plans, and private insurers payment systems, hospitals are focused on keeping patient stays as short as possible. Hospital patients, especially those who are aged or disabled, frequently need post-acute care services. As the complexity of patient care needs have grown, so has the difficulty in developing appropriate discharge goals for post-acute and long term care (LTC), choosing the appropriate setting(s), and selecting appropriate providers. Post-acute and LTC needs may include rehabilitation, nursing care, home health, supportive services, and/or palliative care in an institutional setting or at home.

The hospital discharge process is sometimes deficient in: discussing goals of care; assessing discharge needs; appropriately choosing discharge locations; and providing additional or different home services. Discharge decisions are complicated by the stressful circumstances of hospitalization (poor health, new diagnoses/prognoses, changes in function) and discharge deadlines. Research studies show inadequate discharge planning for post-acute and LTC continues to contribute to high rates of all-cause 30-day rehospitalization rates.

A 2014 Office of the Inspector General (OIG) report found that 33 percent of Medicare residents experienced adverse events or harm within 15 days of admission to a post-acute skilled nursing facility. Almost 60 percent of those residents with adverse events had substandard treatment, inadequate monitoring, or failures and delays in treatment that resulted in harm or jeopardy or hospital readmissions, and the cost of these problems was about $2.8 billion.

In 2018, California nursing homes provided 5 million days (14 percent) of Medicare short-term post-acute care and 6.6 million days (19 percent) of managed care services out of a total of 34.7 million days of care in 1100 facilities according to OSHPD financial reports. Although most California nursing homes offer post-acute and LTC services, these post-acute services provided by free-standing nursing homes are often inadequate because of low nurse staffing levels and poor quality services.

Hospitals that provide sub-acute care and skilled nursing care services often have higher professional nurse staffing levels than free-standing nursing homes and provide higher quality of care. Moreover, these hospital-based programs have access to physicians, therapists, and a wide range of clinical experts who can ensure high quality of services.

Recommendations:

1I i: Develop a plan to expand and shift short-term sub-acute and post-acute care services to California hospitals over the next three-year period and to phase out the provision of sub-acute and post-acute services in free-standing skilled nursing homes.

1I ii: Require that California hospitals assume responsibility for providing sub-acute, post-acute and short-term rehabilitation services to post-discharge residents either in post-acute units or at home.

1I iii: Establish a California accountability system for hospitals to ensure that they provide adequate post-acute care services to individuals to reduce hospital readmissions and negative patient outcomes.

1J. Ensure that all Californians needing long term services and supports have the option to receive those services at home or in the community and are never forced into nursing homes because such services are unavailable. Ensure an adequate supply of independent living units residential care/assisted living beds, with a special focus on meeting the housing needs of low-income individuals and moving nursing home residents to more home like and less restrictive settings:

California had 1,100 nursing homes with over 109,000 beds, providing 344.7 million days of care according to OSHPD financial reports in 2018. Of the total, 83 provided sub-acute care, 23 provided mental health, 9 provided developmentally disability services, 1,068 provided skilled nursing, and 5 provided intermediate care. Of the total nursing homes, 89 percent were for-profit, about 10.9 percent were non-profit, and less than one percent were government homes. In spite of the growing numbers of older people and people with disabilities in California, nursing home facilities have declined from 1,143 facilities and 112,500 beds since 2005.

Occupancy rates have declined from 88 percent in 2005 to 87 percent in 2018. Facilities have a financial incentive to keep their beds fully occupied which can interfere with residents' rights to be discharged and live in the community.

In California there has been a maldistribution of nursing home beds and facilities. Some communities, where land is limited (like San Francisco), in rural areas, and inner-city urban areas, have more limited access to nursing homes and residential care, while other communities and higher income areas appear to have an excess supply, which contributes to the inappropriate use of expensive nursing home services

Most individuals with long term disabilities prefer to live in their own homes and are opposed to living in restricted environments, such as nursing homes, with general reputations for poor quality. Many experts have argued that individuals living in nursing homes should be and are able to live in less restrictive settings such as residential care or independent living communities. However, there has been limited availability of such programs and poor access,

especially for low income individuals. Strict limits on nursing homes and bed supply could ensure that only those individuals who cannot be managed in other settings would receive these services.

Federal programs such as "Money Follows the Person" have been valuable in assisting individuals to move out of nursing homes and back to the community. California established the California Transitions Program but it has been hampered by a lack of resources. Moreover, the HCBS waiver programs, residential care waivers and other home support services have proved limited, resulting in an over reliance on nursing homes.
Future planning is needed to ensure access to adequate levels of housing, independent living, residential care, and alternatives to nursing homes at the community level.

Recommendation:
1J i: Establish a housing program that plans for and finances residential care and assisted living beds as well as independent living units in California. These provisions should focus on meeting the housing needs of low-income individuals who are aging and have disabilities, including homeless people, to avoid inappropriately nursing home use.

1J ii: Establish a renewed effort for Community Transitions to facilitate moving nursing home residents to less restrictive settings. Provide funding for these programs that is sufficient and allows for flexibility to design programs that will facilitate successful transitions.

1J iii: Strengthen the states system of home and community based services to ensure access and affordability of services.

1J iv: Establish a state planning and certification unit responsible for approving any remodeling, refinancing, and replacement programs for California facilities, according to established minimum standards, with the goal of severely limiting the supply of nursing home beds and ensuring an appropriate distribution of facilities throughout rural, inner-city, and low-income areas.

1K. Establish a state Commission to direct the remodeling, refinancing, and replacement of outdated California nursing homes and residential care facilities. This would involve setting new minimum standards and establishing financial mechanisms for remodeling or replacing non-conforming nursing homes and residential care facilities within the next ten years. The primary purpose of the commission would be to protect the health and safety of residents while promoting resident quality of care and quality of life:
California facilities are subject to a variety of natural disasters including but not limited to earthquakes, fires, storms, power shortages, and floods. The vast majority of nursing home buildings are old, outdated, poorly configured, out of scale and often do not meet contemporary seismic standards. These deficiencies make it almost impossible to provide humane care services to residents. The COVID-19 pandemic has exposed serious problems with

the design, structural qualities, ownership, and operation of existing California facilities. These shortcomings facilitated the rapid and unchecked spread of the virus.

California passed Senate Bill 1953 (SB 1953) in 1994 requiring hospitals to meet basic requirements for seismic safety to protect from earthquakes. The requirements, amended over time and administered by the California Building Standards Commission and OSHPD, have been used to rebuild hospitals to meet earthquake standards but similar requirements have not been placed on facilities. The COVID-19 crisis has demonstrated the need to examine facilities throughout the state and develop a replacement/remodeling plan.

Norway, Denmark and other nations have pioneered the design and operation of small modern nursing home clusters. These have residential, home-like environments, private rooms and bathrooms, therapeutic outdoor spaces, and other environmental and safety features that ensure the protection of residents. California is fortunate in having some of the leading architectural schools and experts in designing facilities and other living environments for aged and frail populations, including those with dementia. Drawing on Californian expertise and experience of other countries, California needs to take leadership in redesigning or replacing its outmoded nursing home stock.

Since 1968, the Cal-Mortgage Loan Insurance Program has guaranteed loans to permit health care facilities to obtain lower interest rates. To be eligible for loan insurance, the borrower must be either a California, nonprofit public benefit corporation or a political subdivision and it must assure that its services are available to all persons residing in the facility's service area. Loans may be insured to finance or refinance the construction of new facilities; acquire existing buildings; expand, modernize, or renovate existing buildings; or finance fixed or movable equipment needed to operate the facility. Nursing homes, as health care facilities, are eligible for the program. This program can be expanded to provide direct loans and issue bonds to replace nursing home and residential care facilities, limited to non-profit and government facilities.

Recommendations:

1K i: Appoint a joint Governor and Legislative Commission to include leading experts in architecture, engineering, geriatric clinical care, advocates, state officials, ombudsmen, and others to plan, set new standards, and implement the redesign and replacement of existing facilities and assisted living facilities to protect the health and safety of residents and promote resident quality of care and quality of life within the next ten years. Although the Commission should consult with nursing home providers, no member of the Commission should be a nursing home or residential care owner or operator or association representative or have a financial or professional conflict of interest in the existing long term care system.

1K ii: As part of the planning process, take into account minimum standards for the protection of LTC residents during earthquakes, fires, storms, power outages, floods and other disasters.

1K iii: As part of the planning process, take into account designs that reduce the spread of infections and that enhance the quality of care including but not limited to: single rooms with private bathrooms, clusters of 8-10 single rooms, and configurations with adequate common space that appear homelike and residential. This also includes the ability to bring personal furniture and display meaningful objects. Furthermore, spaces should have adequate natural light, easily accessible outdoor spaces, pathways for walking and places for family/group events. The size of facilities should be limited to small clusters of units within a one or two-story envelope. The total number of rooms should also be limited to avoid the appearance of an institution. The locations of facilities should be accessible and well-integrated into local communities. Plans should also take into account the physical, clinical, and psychosocial needs of residents as well as the work environment for caregivers, and the social environment for family members, friends and caregivers. These up-to-date structures should capitalize on advances in information technology to aid and assist caregiving and prevent isolation for residents as well as protecting the health and safety of residents and caregivers.

1K iv: Create mechanisms for financing the development of new environments through California mortgage loan programs, direct loans, bonds, and state and federal leading programs. Limit these financial resources to locally owned and operated non-profit and government facilities.