NURSING HOMES IN KENTUCKY

RESEARCH REPORT NO. 146

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NURSING HOMES IN KENTUCKY

REPORT OF THE SUBCOMMITTEE ON LONG TERM CARE OF THE INTERIM JOINT COMMITTEE ON HEALTH AND WELFARE

Representative Gerta Bendl
Chairperson

Representative Albert Sidney Adams

Representative J. R. Gray

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Representative Bob Jones

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Research Report No. 146

Legislative Research Commission
Frankfort, Kentucky
December, 1977

This Report has been prepared by the Legislative Research Commission and paid for from state funds.

FOREWORD

The Legislative Research Commission, on May 4, 1977, approved a request by Representative Gerta Bendl that the working mandate of the subcommittee which she chaired, the Subcommittee on Long Term Care of the Interim Joint Committee on Health and Welfare, be incorporated into a formal Legislative Research Commission study. The mandate to the Subcommittee from the Chairman of the Interim Joint Committee on Health and Welfare, Representative Jerry Kleier, was to review the quality of care provided to patients by long term care facilities in the Commonwealth; the use of public monies to support patients residing in such facilities; and the reasonableness and necessity of federal and state statutes and regulations relating to the health and safety licensing for the purpose of making any needed recommendations for legislative and administrative action.

The Subcommittee held eight public meetings where testimony pertaining to nursing homes and other long term care services was obtained from health care professionals, state officials, nursing home operators, and interested citizens. In addition, the Subcommittee made unannounced tours of twenty-two nursing homes across the Commonwealth.

There were a number of factors which helped to provide the impetus for nursing homes to become a study of the Interim Subcommittee on Long Term Care. Among the most prominent of these were: the uncertainty about the quality of care being provided by nursing homes; the concern about the amounts of public monies being spent on long term care facilities; constituent complaints (including consumers, nursing home operators, and interested citizens); the concern about the most appropriate health care alternatives that should be implemented to meet the demands of an aging society; and finally, the interest created by various media reports on nursing homes.

The report was prepared by Bruce Simpson and the Subcommittee on Long Term Care with assistance from Dianna McClure and William Wharton. The manuscript was typed by Brenda Stivers and Nancy Taylor.

VIC HELLARD, JR.
Director

The Capitol
Frankfort, Kentucky
December 1977

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SUMMARY

Long term care refers to one or more services provided on a sustained basis to individuals whose mental or physical capacities are chronically impaired. Long term care services vary and can best be viewed along a continuum of care. These services range from a home delivered meals-on-wheels program to a skilled nursing facility providing 24 hour a day nursing services. There are intermediate care facilities which provide nursing services to those persons who need nursing care, but not to the level which is given by skilled nursing facilities. Finally, there are residential facilities such as family and personal care homes which generally provide custodial services, or not much more than room and board. For the purposes of this report, the long term care facilities studied are limited to skilled nursing facilities, intermediate care facilities, and personal care homes. Home health agencies are an important part of the long term care continuum in that they provide skilled nursing services to people in their own homes and thereby help prevent unnecessary institutionalization. Caretaker and homemaker services can similarly be utilized to provide assistance to a person in his or her own home and also help to keep the individual out of an institutional facility.

Most health professionals in the long term care field agree that keeping people in their own homes should be the long term care service priority. Unfortunately, there are many individuals who are placed into long term care facilities, commonly referred to as nursing homes, simply because there are not sufficient and appropriate in-home services available or they have nowhere else to go.

The Commonwealth disbursed $70 million in payments to personal care homes, intermediate care facilities, and skilled nursing facilities in 1976 for residents who were recipients of Medicaid, Medicare, State Supplementation, and Supplemental Security Income programs. However, the Commonwealth paid out only $7 million for caretaker and home health services to persons who needed long term care services and were eligible for these same government programs.

During the 1976-77 Interim, the Subcommittee on Long Term Care of the Interim Joint Committee on Health and Welfare held eight open meetings where testimony pertaining to nursing homes was obtained from various health care professionals, state officials, nursing home operators, and interested citizens. Four of these meetings were conducted in Lexington, Louisville, Owensboro, and Covington where the Subcommittee made unannounced tours of 22 nursing homes at the personal, intermediate, and skilled care levels.

The Subcommittee spent approximately one hour visiting each facility. Upon arrival at the different nursing homes, members of the Subcommittee and the Legislative Research Commission staff separated and individually talked with patients, nurses, nurses aides, and administrators. These discussions and observations were particularly helpful in gaining insight into the perspectives of those who are a part of a nursing home's day-to-day operation.

The individual Subcommittee members also spoke privately with many people who had concerns about nursing homes but who were either unable or not willing to testify before the full Subcommittee. These contributions were especially helpful in informing the Subcommittee about related areas meriting future review.

Additional Subcommittee research efforts included an extensive review of the literature published on long term care and personal interviews with many state and federal government officials who work in the nursing home field. Most of the literature which was reviewed came from such sources as the United States Department of Health, Education and Welfare; United States General Accounting Office; United States Congress; Kentucky Department for Human Resources; and the many professional health and aging publications. Similarly, the Subcommittee and its staff had many separate interviews with representatives from these different groups.

Since this was the first concentrated effort by the General Assembly to examine nursing homes, it was decided that the study would have to encompass enough of an overview to provide the Commonwealth's citizens with an initial basic orientation about Kentucky's nursing homes, but not so general as to negate any meaningful analyses or recommendations. The Subcommittee decided that its findings would include the following topics: definitions and characteristics of nursing homes and their client populations; state and federal expenditures for nursing home care; descriptions of the regulatory responsibilities for the quality of life in nursing homes shared by governmental and non-governmental agencies or entities; an examination of the rights of nursing home residents as specified by state and federal regulations; and a personal perspective on what the members of the Subcommittee saw and experienced during their tours of nursing homes.

The Subcommittee made three legislative recommendations and ten recommendations requiring administrative action. In addition, the Subcommittee recommended that the Subcommittee on Long Term Care be reestablished following the 1978 Regular Session of the General Assembly for the purpose of following up its research efforts conducted during the 1976-77 interim.

The three recommendations for legislative action included the enactment of a comprehensive bill of rights, the establishment of a system for rating the quality of care given by all long term care facilities, and the requirement that the Department for Human Resources annually perform at least one unannounced inspection of all long term care facilities.

Seven of the ten recommendations for administrative action were directed toward the Department for Human Resources. Two other recommendations were directed toward the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board. The tenth recommendation was jointly directed to the Kentucky Board of Licensure for Nursing Home Administrators, Kentucky Association of Health Care Facilities, and the Department for Human Resources.

It was recommended that the Department for Human Resources take the following seven administrative actions:

1. Ascertain the health care status of residents in specified long term care facilities;

2. Undertake a study to determine the role, responsibilities and adequate caseload size for departmental guardianship officers and limit the number of wards for which each guardianship officer should be responsible;

3. Examine its present policies and procedures for placement in long term care facilities of mentally ill and mentally retarded persons discharged from state psychiatric and mental retardation facilities;

4. Study the feasibility of creating an office of Long Term Care and an attached Citizen's Advisory Council;

5. Develop and implement a long term care data collection system;

6. Examine the feasibility of expanding its financial commitment to in-home services; and

7. Annually perform on-site financial audits of long term care facilities receiving Medicaid reimbursement or State Supplementation funds.

It was recommended that the Kentucky Certificate of Need and Licensure Board take the following two administrative actions:

1. Revoke those certificates of need granted for the construction, expansion, or modification of personal care homes, intermediate care and skilled nursing facilities that are more than 18 months outstanding; and

2. Promulgate regulations requiring personal care home administrators to have qualifications equal to that of the administrators of intermediate care and skilled nursing facilities.

The final administrative recommendation was directed toward the Department for Human Resources, Kentucky Board of Licensure for Nursing Home Administrators and the Kentucky Association of Health Care Facilities. It was recommended that these bodies should jointly develop and implement a training program for specified nursing home personnel.

CHAPTER I

INTRODUCTION

Definition of Nursing Home

In this study the term nursing home is used to describe those health care facilities in Kentucky which are classified as personal, intermediate, and skilled care facilities. These levels of long term care facilities provide services to chronically ill (mentally and physically) persons over an extended period of time. They are defined below in order of the least intensive level of care to the highest.

1. Personal care homes are establishments with permanent facilities that include resident beds and health related services to provide continuous general supervision and residential care. Residents in a personal care home are able to manage the normal activities of daily living except that they have physical or mental disabilities or in the opinion of a licensed physician are in need of residential care. (902 KAR 20:030)

2. Intermediate care facilities are permanent facilities that include inpatient beds and health related services for the purpose of providing intermittent nursing services on a 24 hour basis for individuals who do not require the degree of care and treatment which a skilled nursing home facility is designed to provide but who, because of their mental or physical conditions, require services and care which are available only on an inpatient basis and through an institutional facility. (902 KAR 20:050)

3. Skilled nursing facilities are permanent establishments with medical staffs, inpatient beds, medical services, including physician services, for the purpose of providing continuous nursing for individuals who are not in an acute phase of illness but who have a variety of medical conditions which require inpatient care of a convalescent or restorative nature. (902 KAR 20:025)

While the focus of this study is on nursing homes as defined above, this report covers in a limited manner other long term care facilities and services relating to nursing homes. These include intermediate care facilities solely for the mentally retarded and developmentally disabled, family care homes, home health agencies, caretaker services and nursing homes as described in 902 KAR 20:047. These facilities and services are described in Kentucky Administrative Regulations as follows:

1. "Nursing homes" are establishments with permanent facilities that include inpatient beds, and with medical services, to provide treatment for patients who require inpatient care, but do not currently require continuous hospital services and who have a variety of medical conditions. (902 KAR 20:047)

This term is a confusing one in light of the names for the other levels of care. "Nursing homes" are facilities which provide much the same service as skilled nursing facilities but are not certified to receive Medicare and Medicaid reimbursement. "Nursing homes" were grandfathered into the Commonwealth's nursing home system when the Kentucky Certificate of Need, Licensure, and Regulation Act of 1972 was signed into law. Since that time, no permission has been granted for new "nursing home" beds to be built. Ultimately, this level of care will be phased out.

2. Intermediate care facilities for the mentally retarded and developmentally disabled are establishments which provide on a regular basis health related care and services to individuals who, because of their mental or physical condition require care and services above the level of room and board which can be made available to them only through institutional facilities at the level of intermediate care.

   Intermediate care of the mentally retarded and developmentally disabled is defined as a distinct category of care which is provided by mental retardation specialists and other health professionals in the treatment of the mentally retarded and developmentally disabled of all ages whose needs for emotional, physical, educational, and habilitative services are below the skilled nursing level of care. (902 KAR 20:085)

3. Family care homes or mini homes are homes operated and maintained to provide 24 hour protective and personal care services in residential accomodations for two or three individuals who are not related within the third degree of consanguinity to the licensee and who because of impaired capacity for self care elect or require a protective environment but who do not have an illness, injury, or disability for which constant medical care and skilled nursing services are required. (902 KAR 20:040)

4. Home health agencies are state licensed organizations designed to provide intermittent medical services in the residence, including nursing services and other professional and technical services, required by the treatment, in accordance with the plan of treatment prescribed by a licensed physician to patients who have a variety of medical conditions. (902 KAR 20:080)

Caretaker services are not addressed by any Kentucky Administrative Regulation. The Department for Human Resources, Bureau for Social Insurance defines this service as follows:

> Caretaker services cover a broad range of personal care and chore services necessary to enable an ill or infirmed individual to remain safely and decently in his own home or other family setting, thus preventing institutionalization.
>
> The services may be provided by a live-in attendent or by one or more persons hired to come into the home at regular intervals and may include such personal services as assistance in

dressing, bathing, feeding, or performance of essential household tasks.

The service may be provided for an individual living on room and board in a family setting, not subject to licensure requirements, if care needs exceed room and board. If the individual is living in the home with a responsible relative (parent of minor child or adult), the service is provided only if it is necessary to hire someone to come into the home to provide care. (Bureau for Social Insurance, Service Manual, 1977)

This report primarily discusses three segments of a long term care continuum. (See Figure 1.) Since the study mandate directed that this Subcommittee examine nursing homes, it was decided after a review of the different levels of care in Kentucky, that this term would most appropriately apply to personal, intermediate, and skilled nursing facilities. This decision was based on the fact that, with few differences, almost all of the nationwide and individual state studies on this subject generally define nursing homes as coinciding with these three levels of care. Also, recommendations received by the Subcommittee from professionals in the field led it to limit the scope of this project to the same three types of facilities.

This, of course, does not diminish the importance of the other long term care service components but rather it is to focus on those areas in the long term care continuum which have demanded the most immediate attention.

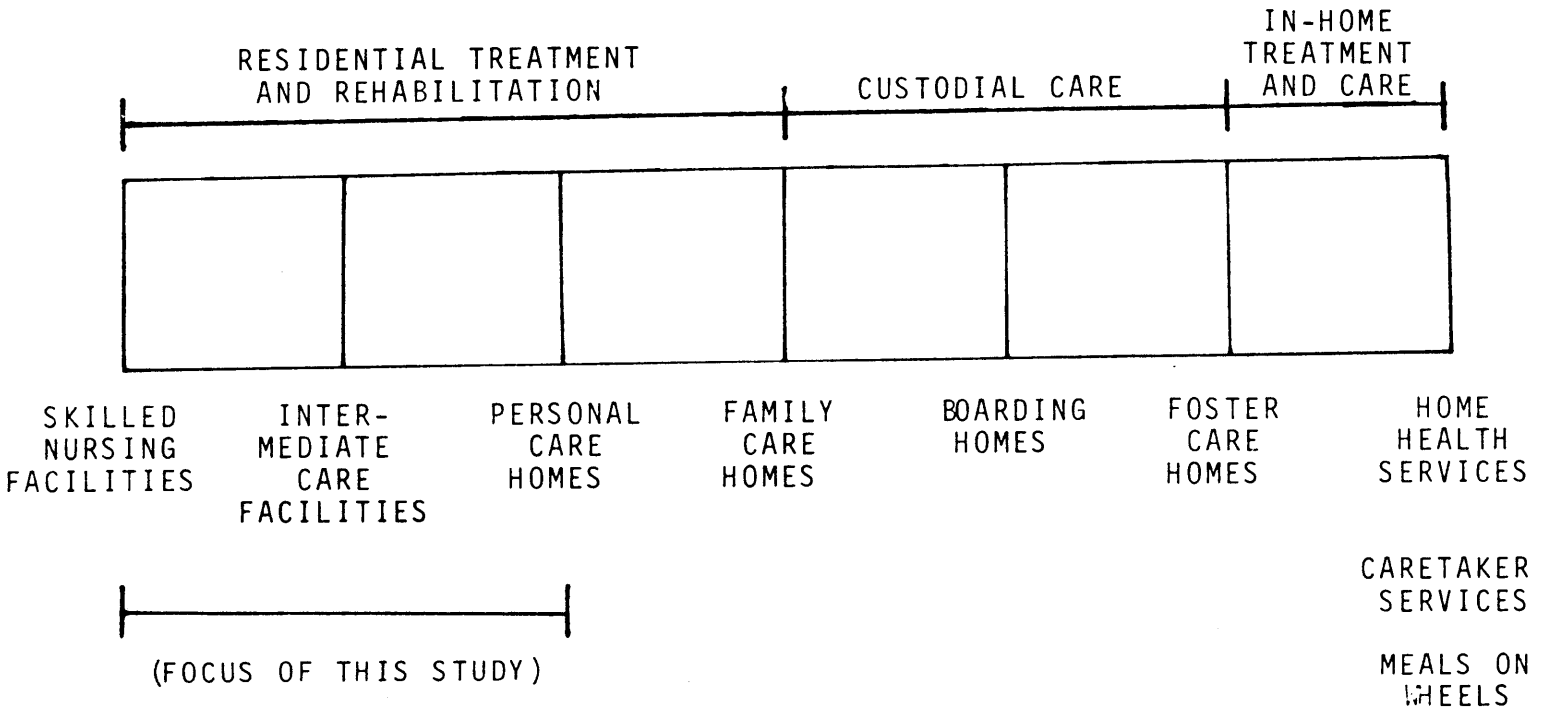
Need for a Nursing Home

Similar to the diversity which exists in regard to the definition of a nursing home, is the uncertainty about which target groups of people in our society actually need the services of a nursing home. Some of this irresolution centers on whether or not the mentally retarded and developmentally disabled person should be cared for in a nursing home. Traditionally, these facilities have been intended for use by the elderly. Most studies indicate that today the person over 65 years of age comprises between 78% and 90% of the nursing home population in the United States. (HEW, Characteristics and Social Contacts, 1977, p. 5) However, this still leaves a sizeable number of persons under 65 years of age being cared for in a nursing home.

Most of the under age 65 residents in nursing homes are mentally impaired persons. (HEW, Long Term Care Intro Report, 1975, p. 29) Also, many nursing home residents were previously treated in mental institutions. (U.S. Senate, Long Term Care Report No. 7, 1976, pp. 706-774) The Subcommittee has discovered that between 1975-77, 811 persons from Kentucky's state supported psychiatric hospitals were placed into personal, intermediate, and skilled nursing facilities. (DHR, unpublished data, 1977) Moreover, these are only the known placements from state psychiatric hospitals made by the placement agency, the Bureau for Social Services. Since the Bureau generally places only those persons who have no one else to assist them, there is likely to be a substantial number of former mental hospital patients who are placed in nursing homes by their family or friends. The hospital has no way of knowing

FIGURE I

LONG TERM CARE CONTINUUM



SOURCE: LRC STAFF COMPILATION, 1977

how many former patients eventually are placed in nursing homes. A more detailed discussion on the mentally impaired nursing home resident is included in Chapter IV.

The Elderly in Nursing Homes

Since the elderly have the highest incidence of chronic illness, disability, and functional impairment, they are the age group most in need of long term care. (Congressional Budget Office, 1977, p. 3) Due to the age distribution of the population in the United States and Kentucky, it appears that nursing homes will be a continuing health care resource for the elderly and others. Between 1900 and 1975 the percentage of the U.S. population aged 65 and over more than doubled (4.1% in 1900 and 10.5% in 1975), while the total number of aged people increased from 3 million to 22 million. (HEW, Facts About Older Americans, 1977) This trend toward an older society is expected to even further increase. It is projected that by the year 2000, in only 23 years, the population over 65 years of age will increase another 40% to approximately 31 million people in the United States. (HEW, "FACTS," 1977)

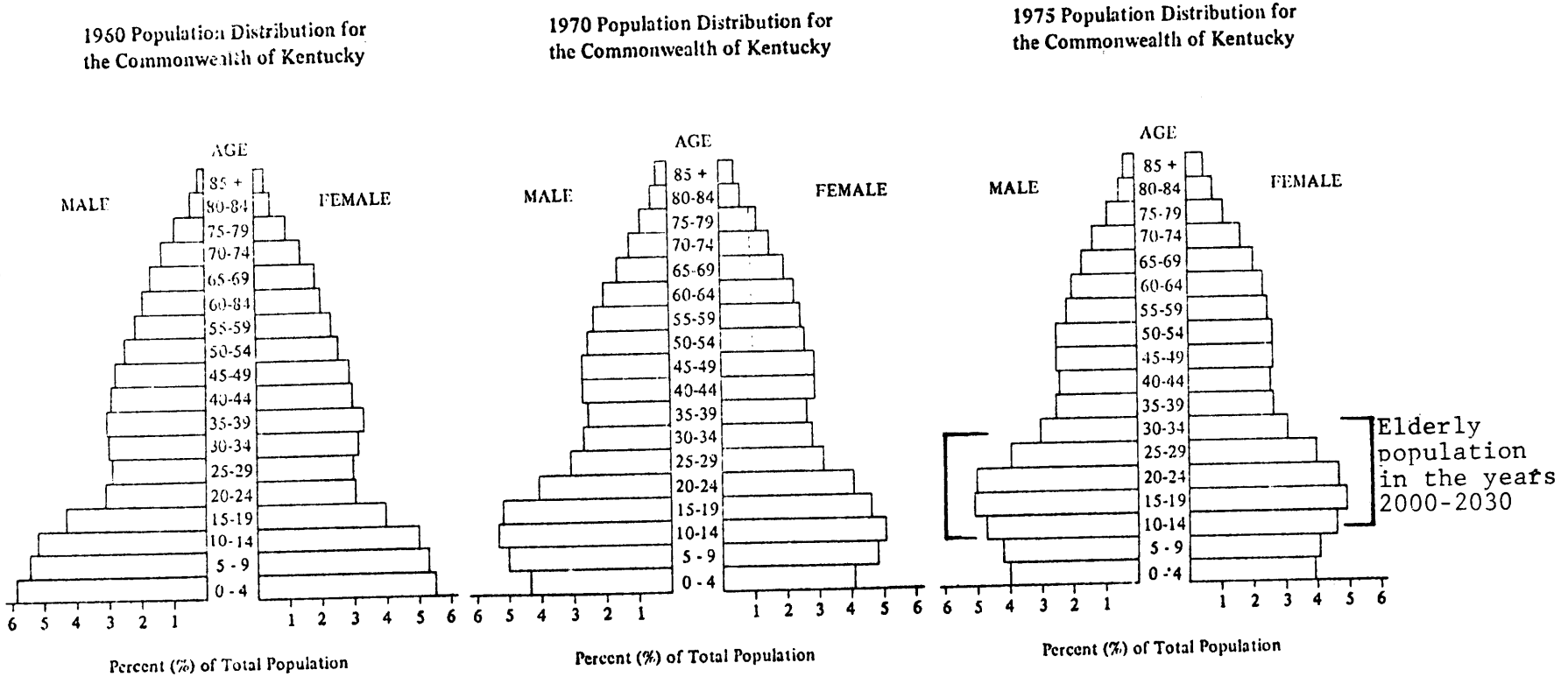
In Kentucky aged persons constituted 10.9% of the total population, or about 372,000 people, in 1975. (University of Louisville Urban Studies Center, unpublished data, 1977) This figure represents a 10% increase in Kentucky's total elderly population from 1970. The Commonwealth presently ranks 20th among the other states in population aged 65 and over.

Figure 2 details what the future age groupings will be in Kentucky. It is evident from observing Figure 2 that those persons who were between ages 10 and 34 in 1975 will make Kentucky a much older society between the years 2006 - 2030.

Today, approximately 5% of the elderly are in nursing homes in the United States. (U.S. Senate, Long Term Care Intro Report, 1974, p. 15) However, this number may be somewhat misleading. Research has indicated that while 1 in 20 aged persons is in a nursing home on any given day, 1 out of 5 elderly persons will probably spend some part of their lives in a nursing home. (Kastenbaum, 1973, p. 50)

FIGURE 2

Composition of the population of the Commonwealth of Kentucky, by age and sex, 1960-1970-1975



(Source: University of Louisville Urban Studies Center, 1977)

CHAPTER II

PUBLIC MONIES SPENT FOR NURSING HOMES

Among the greatest concerns to many citizens interested in long term care facilities is the use of public funds to support nursing homes and other long term care services. Concern has been expressed about the amounts of money which have been spent as well as the types and quality of the services which have been purchased. The Medicaid program is often the funding source which is in the middle of this controversy.

Medicaid

The Medicaid program is the main source of governmental funding for nursing homes in the United States. (Congressional Budget Office, 1977, p. 7) Established in 1965 by an amendment (Title XIX) to the Social Security Act, this federal-state government matching program was designed to provide medical services to the poor. There has been an increase in national expenditures for Medicaid programs from $1.5 billion in 1966 to $15 billion in 1976. As Figure 3 indicates, the largest percentage (33.4%) of the 1976 Federal Medicaid Funds went to nursing homes.

The Medicaid program provides money to Kentucky for three different levels of nursing home care and one long term care related service. These are composed of skilled nursing facilities, intermediate care facilities, intermediate care facilities for the mentally retarded and developmentally disabled, and home health service agencies. Each was described in Chapter I.

Table 1 shows a more specific ranking of United States expenditures by the type of service which was offered under Medicaid during fiscal year 1975-76. It is clear from these figures that the Medicaid money disbursed for long term care services is primarily allotted to nursing homes. Although expenditures for home health services nearly doubled from the previous fiscal year, the money spent on this service in 1975 was the same proportion (less than one percent) of the total Medicaid disbursements as the previous year.

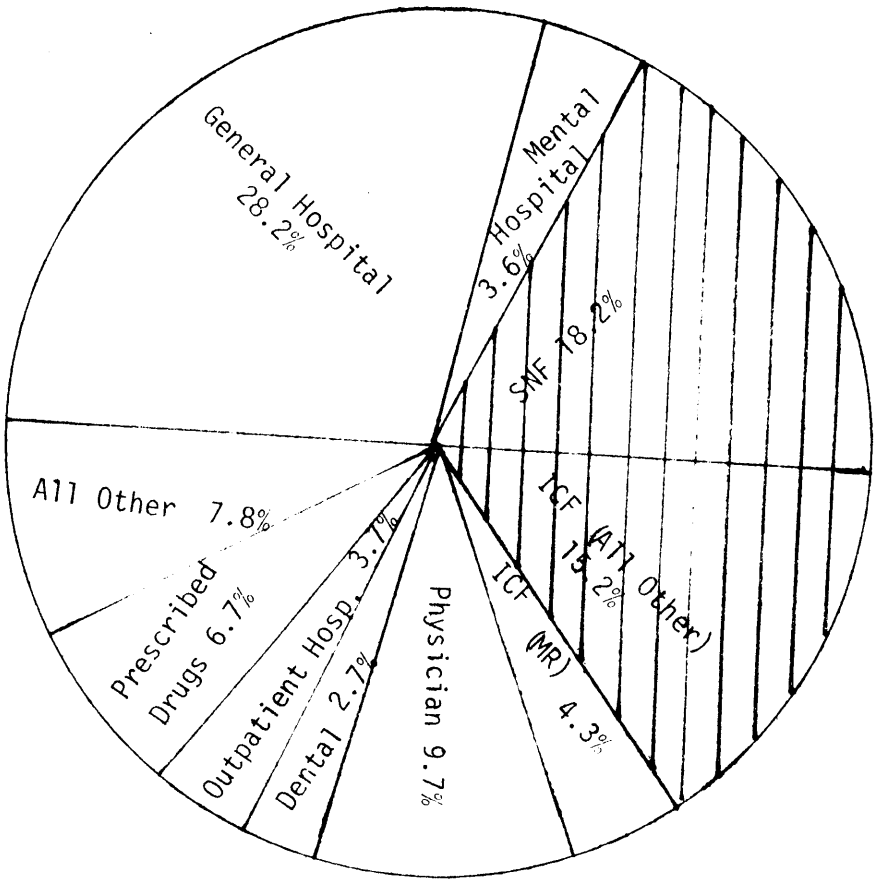
Kentucky paid $51.6 million during calendar year 1976 for Medicaid recipients in intermediate and skilled nursing facilities. (DHR, Public Assistance Form 264, 1976) This figure represents 30% of the state's entire Medicaid expenditure for this period. However, since the Commonwealth's matching share in the Medicaid program was approximately 27.5% of this $51.6 million, state funds accounted for $14.2 million of the total Medicaid dollars that went to nursing homes. Not included in this calculation is the $12.8 million in federal/state Medicaid payments which were paid to intermediate care facilities for the mentally retarded and developmentally disabled.

The Commonwealth also spent $1.5 million, or .8%, of its total $175 million Medicaid expenditure on home health services in 1976. (DHR, Public Assistance Form 264, 1976) This distribution of Medicaid disbursements in

Figure 3

DISTRIBUTION OF MEDICAL ASSISTANCE
PAYMENTS BY TYPE OF SERVICE

Fiscal Year 1976
United States



Source: Department of Health, Education and Welfare

TABLE 1

CHANGES IN UNITED STATES MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE
FISCAL YEAR 1975-1976
(Dollars in Thousands)

Type of Service	Payments Fiscal Year 1976	Pct. Change from FY 1975	Percent Distribution	Chng. in Pct. Dist from FY 1975
Total Payments	$13,977,348	15.6	100	
Inpatient hospital	4,433,615	15.4	31.7	-0.1
SNF	2,549,468	5.1	18.2	-1.9
ICF	2,728,378	27.6	19.5	1.8
Physician	1,359,996	12.2	9.7	-0.3
Dental	380,184	13.4	2.7	-0.1
Other practitioner	138,376	17.0	1.0	0
Outpatient hospital	512,969	50.3	3.7	0.9
Clinic	339,650	-11.4	2.4	-0.8
Lab. and X-ray	127,194	24.4	0.9	0.1
Home Health	129,989	92.9	0.9	0.3
Prescribed drugs	942,073	17.6	6.7	0.1
Family Planning	86,660	21.0	0.6	0
Other care	248,797	-0.4	1.8	-0.3

SOURCE: U.S. Department of Health, Education and Welfare, 1977

Kentucky, by the kind of service offered, is similar to the distribution in the United States.

If long term care services reimbursed under Medicaid are defined as skilled nursing and intermediate care facilities, and home health care, there are some interesting trends in Kentucky which emerge between the calendar years 1972 through 1976. As Table 2 and Figure 4 point out, there has been a significant and constant increase in the proportion of recipients receiving long term care services at the intermediate care facility level of care under Medicaid, while there has been a corresponding relative decrease in the number of recipients receiving services at the skilled nursing level. The average monthly number of recipients in intermediate care facilities increased 476% between 1972 and 1976.

There appear to be several possible reasons for this movement of Medicaid patients from skilled nursing facilities to intermediate care facilities. These are:

1. Many patients who received or who are receiving skilled nursing treatment may actually not need the services at this higher level of care. Presently, Kentucky has an average of 450 Medicaid patients a month who are residing in skilled nursing facilities who have been determined by a Medical Review Team from the Department for Human Resources to only need treatment in intermediate care facilities. (DHR, unpublished data, 1977)

2. With the unification of federal Medicaid and Medicare standards in 1972, a more restrictive set of eligibility criteria for persons to receive service in a skilled nursing facility was established. Thus, there were a number of Medicaid patients in skilled nursing facilities who could no longer meet this more restrictive Medicare definition for eligibility in a skilled nursing facility and were forced to be moved to an intermediate care facility.

3. The Medicaid reimbursement formula for intermediate care facilities possibly provides more profit for nursing home operators than does the skilled nursing reimbursement formula. Consequently, many operators have sought to convert their personal and skilled care beds into intermediate care.

4. There is a substantial difference in cost savings to the federal and state governments between paying for an intermediate care facility as opposed to a skilled nursing facility. Currently, a month's stay at a skilled nursing facility in Kentucky costs $827.86, while at an intermediate care facility the amount is $466.93. Thus, there is a potential incentive for government to push for treatment in an intermediate care facility when residential or institutional care is deemed necessary.

In light of the increased utilization of intermediate care facilities, it is not surprising that they have consistently received a greater share of the total Medicaid long term care payments between 1972

Table 2

NUMBER OF PERSONS IN KENTUCKY WHO RECEIVED LONG TERM CARE SERVICES THROUGH MEDICAID, CALENDAR YEAR 1972-1976: BY TYPE AND COST OF SERVICE

YEAR	TYPE OF SERVICE	AVERAGE MONTHLY NUMBER OF LONG TERM CARE RECIPIENTS	PERCENT OF MEDICAID LONG TERM CARE RECIPIENTS	TOTAL PAYMENTS	PERCENT OF MEDICAID PAYMENTS FOR LONG TERM CARE SERVICES	AVERAGE MONTHLY PAYMENT PER RECIPIENT
1972	Skilled Nursing	2,402	66%	$17,249,664	88%	553.45
	Intermediate Care	764*	21%	1,849,458	9%	237.45
	Home Health	475	13%	560,536	3%	98.34
TOTAL:	----------	3,641	100%	19,659,658	100%	------
1973	Skilled Nursing	2,269	59%	16,775,957	81%	575.37
	Intermediate Care	1,083	28%	3,331,710	16%	256.74
	Home Health	516	13%	614,219	3%	99.57
TOTAL:	----------	3,868	100%	20,721,886	100%	------
1974	Skilled Nursing	1,968	47%	18,591,358	69%	696.97
	Intermediate Care	1,599	38%	7,576,311	28%	393.30
	Home Health	616	15%	772,759	3%	104.80
TOTAL:	----------	4,183	100%	26,940,428	100%	------
1975	Skilled Nursing	2,204	37%	21,240,983	55%	765.66
	Intermediate Care	2,944	50%	16,356,752	42%	459.68
	Home Health	776	13%	1,085,025	3%	116.22
TOTAL:	----------	5,294	100%	38,682,760	100%	------
1976	Skilled Nursing	2,277	29%	23,893,674	45%	827.86
	Intermediate Care	4,397	56%	27,784,484	52%	466.93
	Home Health	1,123	15%	1,553,673	3%	115.21
TOTAL:	----------	7,797	100%	53,231,831	100%	------

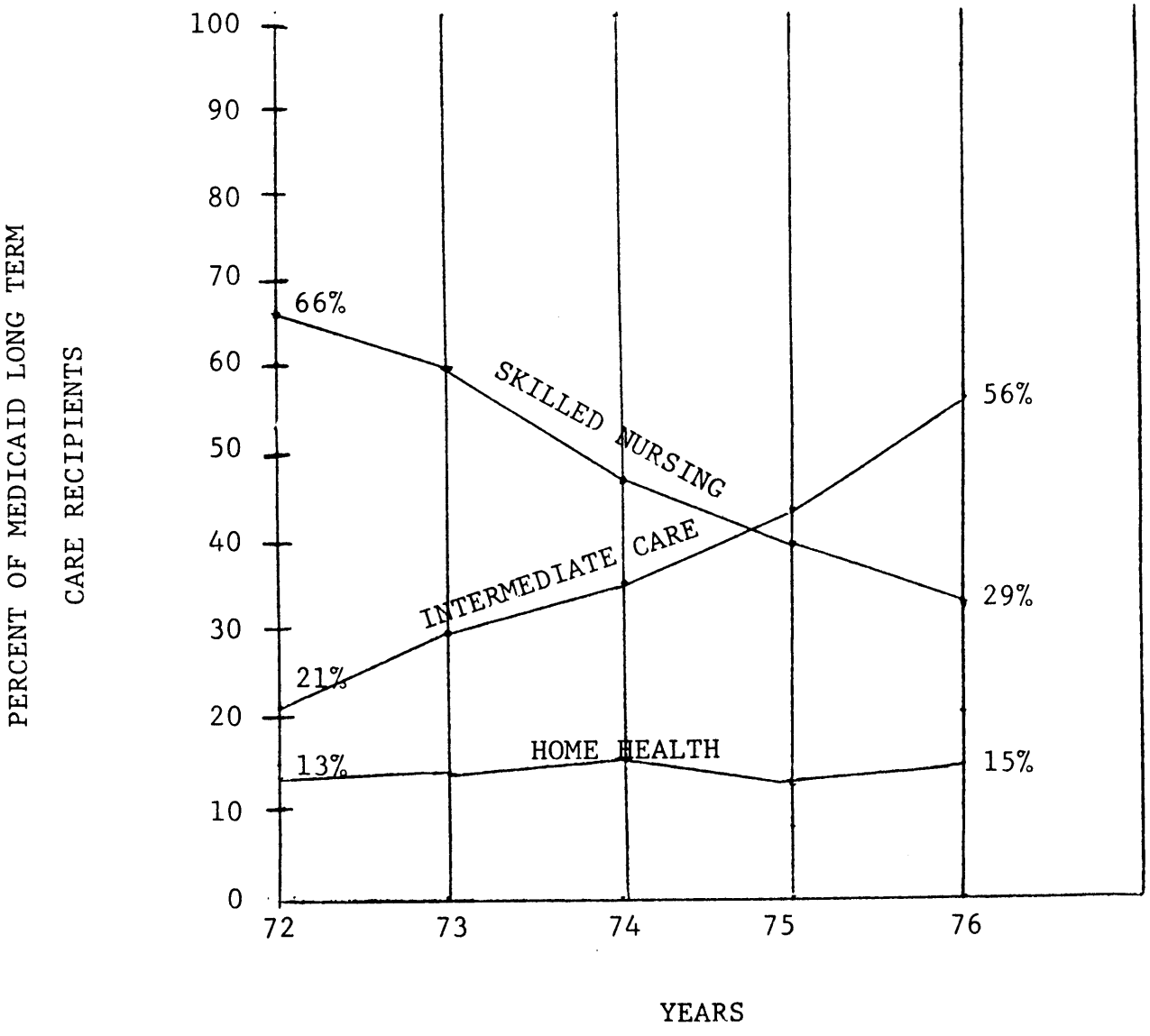
*Estimate

(SOURCE: Department for Human Resources, Bureau for Social Insurance, 1977)

FIGURE 4

DISTRIBUTION OF MEDICAID LONG TERM CARE RECIPIENTS

BY LEVEL OF CARE, 1972-76



Source: Department for Human Resources, Bureau for Social Insurance, 1976

and 1976, while skilled nursing facilities have continued to receive proportionately less and home health agencies about the same. In 1972, when Medicaid reimbursement for intermediate care facilities was first implemented, intermediate care facilities received 9% of the total Medicaid long term care disbursements. In 1976, however, intermediate care facilities received 52% of these payments. On the other hand, expenditures for skilled nursing facilities absorbed 88% of the total Medicaid long term expenses in 1972, but only 45% in 1976. (See Figure 5.) Payments for home health agencies under Medicaid, although annually increasing in total dollars spent, have consistently made up only 3% of the total amount of the Kentucky Medicaid long term care monies disbursed between 1972 and 1976.

Medicare

Medicare, also created as an amendment (Title XVIII) to the Social Security Act in 1965, is a federal government health insurance program designed to provide physicians' services and services of other suppliers of medical services to persons who meet the following eligibility criteria:

1. Persons aged 65 or over and receiving or entitled to receive Social Security or railroad retirement benefits either as an insured worker or eligible survivor of an insured worker;

2. Persons who are not yet 65 years old but who have been entitled to Social Security or railroad disability benefits for at least 24 consecutive months; or

3. Persons under age 65 who are suffering from permanent kidney failure.

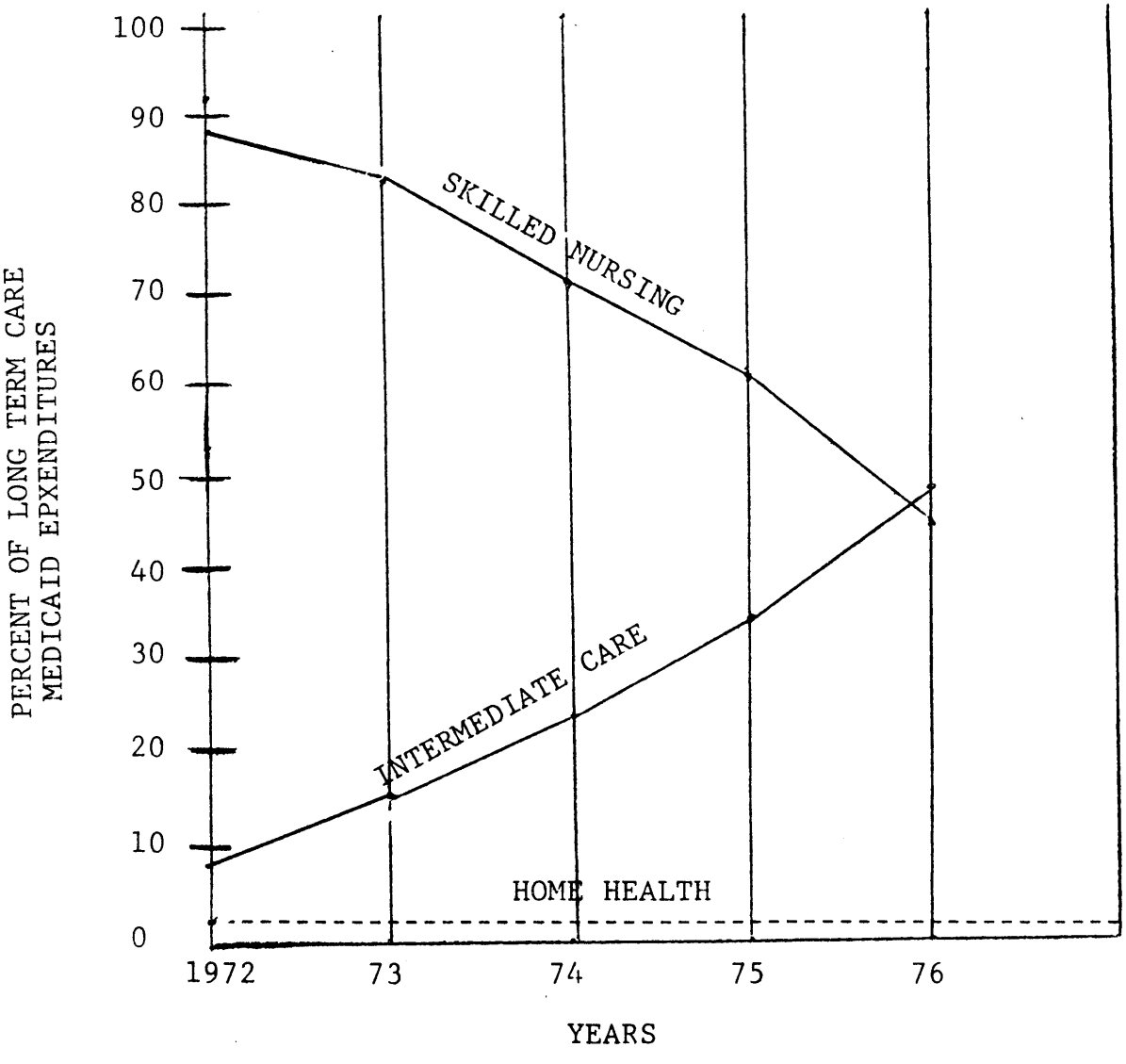
Medicare benefits are considered adjuncts to the acute care hospital system and are not designed for long term chronic care. (Congressional Budget Office, 1977, p. 9) Medicare provides up to 100 days of inpatient care in a skilled nursing facility during a benefit period. The first 20 days in a skilled nursing facility are reimbursed in full. The patient is responsible for coinsurance payments for the remaining 80 days. Services in a skilled nursing facility are not covered by Medicare unless they are preceded by the recipient being hospitalized three or more days. Also, the skilled nursing facility admission must occur within 14 days of the hospital discharge.

Home health services are also covered under Medicare, but like skilled nursing services, are designed to be an acute rather than a chronic care benefit. Up to 100 home health visits per benefit period are reimbursable under Medicare.

Due to the time constraints placed on services paid for under Medicare, this program is not a major source of financing for nursing homes or other long term care services. In fact, the $255 million Medicare expenditure for nursing homes in fiscal year 1975 represents only 5% of the federal government's nursing home payments and just 2% of the total Medicare disbursements. (Congressional Budget Office, 1977, p. 9)

FIGURE 5

DISTRIBUTION OF MEDICAID LONG TERM CARE EXPENDITURES BY LEVEL OF CARE, 1972-76



Source: Department for Human Resources, Bureau for Social Insurance, 1977

There has been a trend in Kentucky since 1971 toward more recipient utilization of home health agency services reimbursed under Medicare than there has been for use of skilled nursing facilities. (HEW Regional Medicare Office, unpublished data, 1977) In 1971 skilled nursing facilities took 78% ($2.5 million) of the Medicare long term care dollar spent in Kentucky. But four years later in 1975, the Medicare reimbursement to skilled nursing facilities had decreased to 59% ($3.8 million). The proportionate share of the Medicare long term monies spent during this same period for home health services was 22% ($700,000) in 1971 and 41% ($2.6 million) in 1975. Table 3 further details Medicare's long term care payments in Kentucky for calendar years 1971-1975. In 1975 Medicare paid $6.4 million for both skilled nursing and home health agency services.

Supplemental Security Income and State Supplementation

The Supplemental Security Income (SSI) program implemented in 1974 is a federally supported cash grant program that provides financial assistance to needy aged, blind, and disabled persons. Many of these people use their SSI incomes to obtain nursing home care and other long term care services. (DHR, Public Assistance Form 264, 1976) Generally, those SSI recipients who spend their allotments for long term care services utilize family care homes, personal care homes, nursing homes as defined by 902 KAR 20:047, and caretaker services.

Amendments to the Social Security Act (Title XVI) created SSI to provide a guaranteed annual income for those persons who attain the age of 65 or are blind or totally disabled. Previously, these persons had been provided income maintenance assistance by the federal/state financed, Aid to Aged, Blind, and Disabled program. Under SSI, states were required to use their own funds to pay any difference between an SSI payment and the payment for persons who were receiving Aid to Aged, Blind and Disabled benefits before the implementation of SSI. This funding is made by the Mandatory State Supplementation program. Kentucky elected to provide this same type of payment through the Optional State Supplementation program to those persons who became eligible for SSI benefits after SSI went into effect. Table 4 breaks down the number of SSI and State Supplementation recipients who were using their grants for long term care services in personal and family care homes or were receiving caretaker services during 1976.

State Supplementation and SSI payments totaling over $15 million went to persons who used these monies for residential services in personal or family care homes during the calendar year 1976. (DHR, Public Assistance Form 264, 1976) Approximately $5.7 million from other sources such as Railroad Retirement funds, pensions, Title II of the Social Security Act dollars, and private sources bring the total to nearly $21 million which was spent through the SSI and State Supplementation program for residential long term care services in Kentucky.

TABLE 3

MEDICARE PAYMENTS TO HOME HEALTH AGENCIES

AND SKILLED NURSING FACILITIES 1971-75: KENTUCKY

HOME HEALTH AGENCIES				SKILLED NURSING FACILITIES			
YEAR	NUMBER OF VISITS	PAYMENTS	PERCENT INCREASE IN DOLLARS OVER PREVIOUS YEAR	NUMBER OF ADMISSIONS	PAYMENTS	PERCENT INCREASE IN DOLLARS OVER PREVIOUS YEAR	TOTAL PAYMENTS FOR LONG TERM CARE SERVICES
1971	57,571	$ 685,000	----------	8,230	$ 2,492,000	----------	$ 3,177,000
1972	61,946	$ 861,000	26%	8,074	$ 2,140,000	-16%	$ 3,001,000
1973	86,046	$1,355,000	57%	8,669	$ 3,484,000	63%	$ 4,839,000
1974	91,722	$1,782,000	32%	8,416	$ 3,867,000	11%	$ 5,649,000
1975	121,486	$2,624,000	47%	8,041	$ 3,832,000	-1%	$ 6,456,000

NOTE: 1971 Medicare Long Term Care Expenditures for Home Health: $ 685,000 or 22% of Total
1971 Medicare Long Term Care Expenditures for Skilled Nursing Home: $2,492,000 or 78% of Total

1975 Medicare Long Term Care Expenditures for Home Health: $2,624,000 or 41% of Total
1975 Medicare Long Term Care Expenditures for Skilled Nursing Home: $3,832,000 or 59% of Total

SOURCE: U.S. Department of Health, Education and Welfare Atlanta Regional Office, 1977.

TABLE 4

STATE SUPPLEMENTATION AND SSI PAYMENTS

FOR LONG TERM CARE SERVICES, CALENDAR YEAR, 1976: KENTUCKY

Type of Care	State Supplementation Payments			SSI & Other Payments		TOTALS
	Mandatory	Optional	Total	*SSI	**Other	
Personal Care	$3,981,533	$4,048,647	$8,030,180	$5,386,755	$4,742,988	18,159,923
Family Care	341,379	298,899	640,278	1,051,636	905,148	2,597,062
Caretaker	364,946	652,162	1,017,108	2,457,457	2,115,114	5,589,679
TOTALS	4,687,858	4,999,708	9,687,566	8,895,848	7,763,250	26,346,664

*Estimate (Data is not kept in this form)
**Other Sources of Income Include Title II of Social Security Act - Railroad Retirement, Pensions, and Private Sources

SOURCE: Department for Human Resources, Bureau for Social Insurance, 1977

Veterans' Programs

The federal government also pays for long term care to veterans in nursing homes. The Veterans' Administration contracts for community nursing home care and contributes to the cost of caring for veterans in state institutions. (Congressional Budget Office, 1977, p. 9) It also gives cash allowances to disabled pensioners who need aid and attendance at home, although it is not known whether these supplementary payments are in fact used to purchase such assistance. Nationwide, the Veterans' Administration in 1975 spent $240 million for institutional care, $234 million in cash payments to veterans needing aid and attendance, and $5 million for health care in the home. (Congressional Budget Office, 1977, p. 9)

Private Sources

Although both federal and state governments allocate a substantial amount of their monies for nursing home services, over half of all long term care costs are paid for privately. (Congressional Budget Office, 1977, p. 11) Nationwide, private expenditures for nursing homes totaled $5.9 billion to $7.7 billion in 1976. Approximately 85% of this amount was paid for out of pocket rather than by insurance or through philanthropy. According to an analysis by the United States Congressional Budget Office on the incidence and cost of catostrophic illness, nursing home care is the principal cause of catostrophic expenses among the aged. (Congressional Budget Office, 1977, p. 23)

Summary of Government Expenditures for Nursing Homes in Kentucky

During the calendar year 1976, approximately $70 million was disbursed in payments in Kentucky by the federal and state governments to recipients in personal care homes and intermediate care and skilled nursing facilities. State funds alone were approximately $23 million of this amount. These monies encompass only the payments that were made to the facilities or the persons in them. The money that was spent for administering these and other interrelated programs is not included in this compilation. Salaries and other administrative costs would substantially inflate this total for both the state and federal governments.

An additional $6.8 million in federal and state monies was expended in payments during 1976 for in-home services, caretaker and home health. This represents 8.7% of the total $79 million in payments that were made for long term care services in Kentucky. Not included in the budget analysis for long term expenditures in Kentucky are funds from Title XX of the Social Security Act, the Older Americans Act, Medicaid monies for recipients in mental retardation centers and psychiatric hospitals, and local dollars at the county government level.

Table 5 details more fully the 1976 state and federal government expenditures for long term care service alternatives, in-home services versus residential services. Residential or institutional services, that is family care homes, personal care homes, intermediate care facilities, and skilled nursing facilities, received 91.3% of the long term care dollars disbursed in payments under the Medicaid, Medicare, SSI, and State Supplementation programs, and

TABLE 5

PUBLIC MONEY PAYMENTS FOR LONG TERM CARE SERVICES,

BY TYPE OF SERVICE (IN-HOME SERVICE VS. RESIDENTIAL SERVICE),

AND SOURCE OF FUNDS: KENTUCKY, 1976

	Medicaid		TOTAL	Medicare	SSI	State Supplement	TOTAL	Percent of Payments
	Federal	State						
*Payments for Facilities (In Dollars)	$37,500,000	$14,200,000	$51,700,000	$4,400,000	$6,400,000	$8,700,000	$71,200,000	91.2%
**Payments for In-Home Service (In Dollars)	$1,100,000	$400,000	$1,500,000	$3,200,000	$1,000,000	$1,000,000	$6,700,000	8.8%

*Payments for Facilities include family care homes, personal care homes, intermediate care facilities, and skilled nursing facilities. Does not include payments for state mental retardation facilities of state psychiatric hospitals.

**Payments for In-Home Services include home health and caretaker services. Does not include Title XX of the Social Security Act funds or monies from the Older Americans Act.

NOTE: An estimate for 1976 Medicare Payments is based on previous years' payments in this program.

TOTAL STATE SHARE: $23 million
TOTAL FEDERAL SHARE: $55 million

SOURCE: Department for Human Resources, Bureau for Social Insurance and U.S. Department of Health, Education and Welfare, Regional Offices for Medicare and SSI, 1977.

clearly have been the long term care service priority of state and federal government.

CHAPTER III

PROFILE OF NURSING HOMES IN KENTUCKY

Number of Homes and Beds

As of July, 1977, there were 424 licensed nursing homes in Kentucky, at the personal, intermediate, and skilled nursing levels of care. (DHR, unpublished data, 1977) Together, these facilities had a total of 22,112 nursing home beds. This represents a 24% increase in the total number of beds since 1972. The majority of the increase can be attributed to the influx of intermediate care beds. Therefore, it is useful to examine the five year growth trend for each level of care. This information is provided in Table 6.

The data supplied by Table 6 indicates that the preponderance of the increase in both the number of facilities and number of beds added since 1972 comes from intermediate care facilities. During this period, the number of intermediate care facilities increased by 208%, skilled nursing facilities increased by only 17%, and the number of personal care homes decreased by 6% Similarly, total beds increased by 263% for intermediate care facilities, 27% for skilled nursing facilities and decreased by 17% for personal care homes. (See Table 6.) In summary, the number of intermediate care facilities and intermediate care facility beds has more than doubled in the last five years.

Most of the same reasons can be given for the increase in the number of intermediate care beds as were given for the consistent increase in Medicaid expenditures for intermediate care facilities. Those explanations, which were discussed in Chapter II, are: (1) some persons in skilled nursing facilities may have only needed treatment in intermediate care facilities; (2) the merging of the Medicare and Medicaid regulations for skilled nursing facilities in 1972 made it more difficult for a person to qualify for skilled nursing facility care; (3) intermediate care facilities have possibly become more profitable for nursing home operators than the other levels of care; and (4) due to the cost savings to the federal and state governments, there has been a potential incentive to push for treatment in intermediate care facilities rather than skilled nursing facilities when residential or institutional services are deemed necessary. The intermediate care facility level of nursing home care has only been operative since 1972.

Certificate of Need

An overview of the certificate of need process is important in understanding how nursing homes come into existence and where they locate.

Before building or significantly altering a nursing home in Kentucky, one must first obtain a certificate of need from the state's Certificate of Need and Licensure Board. (KRS 216.405-216.485) A certificate of need is an authorization by the Board to an applicant to construct, expand, or modify a health facility or to initiate, expand or modify a health service. Upon such authorization, the Board in essence declares a proposed facility appropriate for its location and its services. The decision is to be based upon the

TABLE 6

INCREASE IN NURSING HOME BEDS (PERSONAL, INTERMEDIATE, AND SKILLED) - KENTUCKY, 1972 and 1977

	1972		1977			
Level of Care	Number of Facilities	Number of Beds	Number of Facilities	Percentage Increase	Number of Beds	Percentage Increase
Personal	220	10,333	206	6%	8,544	-17%
Intermediate	39	1,944	120	+208%	7,047	+263%
Skilled	84	5,079	98	+ 17%	6,521	+ 28%
TOTALS	343	17,356	424	---	22,112	---

SOURCE: Department for Human Resources, Office of Administrative Services, 1977

health care needs and demands of the region and the considered opinion of the respective local health care planners, providers, and consumers. A major purpose of the Certificate of Need and Licensure Board is to act as a controlling mechanism over the number, type, quality, and location of nursing homes in the Commonwealth.

The Certificate of Need and Licensure Board was established in 1972 pursuant to passage of the Certificate of Need and Licensure Act. The intent of this law was to provide for the orderly development of all health facilities and health services in accordance with the needs of the various regions in Kentucky through a certificate of need program. (KRS 216.415) Further, it was the intention of this statute to coordinate the licensure and regulation of health facilities and health services in order to insure the availability and delivery of quality health care to the citizens of the Commonwealth.

The specific functions of the Certificate of Need and Licensure Board are described in KRS 216.415(4) through (11).

(4) The board shall have three (3) separate and distinct functions:

  (a) To issue certificates of need in accordance with the provisions of KRS 216.584.
  (b) To issue licenses, regulate, and inspect health facilities and health services.
  (c) To enforce, through legal actions on its own motion, the provisions of such certificates, licenses, and regulations.

(5) The board shall develop, establish, enforce, and may repeal standards, rules, and regulations for care, health, safety, welfare, and comfort of patients in health facilities and health services covered by KRS 216.405 to 216.485 and for the maintenance and operation of health facilities and health services which shall be designed to insure that the quality of care offered by the facility or service is satisfactory and that the facility or service receives a license appropriate to its function. This shall include but not be limited to the classification and categorization of health facilities and health services according to character, size, range of services provided, type and level of care required. Further, the board shall develop and enforce standards relative to each classification or category of health facilities and health services which must be met in order to receive a license to operate and maintain health facilities and health services.

(6) The board shall adopt, establish, and enforce criteria and procedures as developed by the state health planning council for determining the need for construction, expansion or implementation of health facilities and services.

(7) Members of the board, or its representatives, are hereby authorized to enter upon the premises of any health facility or health service as covered by KRS 216.405 to 216.485, for the purpose of inspection, at any reasonable time.

(8) The composition of the board and the rules and regulations thereof shall conform to any federal law or regulations pertaining to the licensing of health facilities.

(9) The board may appoint such technical advisory committees as are deemed necessary to administer the provisions of KRS 216.405 to 216.485.

(10) The board may, by regulation, prescribe and collect reasonable fees and charges for processing applications for certificate of need and licensure. All fees and charges collected under the provisions of KRS 216.405 to 216.485 shall be paid to the state treasurer and credited to a trust agency account to be used in the administration of KRS 216.405 to 216.485.

(11) The board shall coordinate the requirements of all other state agencies which may have regulatory power over health facilities and health services covered by KRS 216.405 to 216.485 in such manner that the applicant is assured of having met the requirements of the other agencies when issued a license by this board.

Obviously, this law gives the Certificate of Need and Licensure Board much power in determining the type, size, location, and quality of the nursing homes in the Commonwealth.

The membership of the Board is composed of 16 representatives of the following groups of health care providers and consumers:

1. Two members from the Kentucky Hospital Association;

2. Two members from the Kentucky Medical Association;

3. Two members from the Kentucky Nursing Home Association;

4. One member from the Kentucky Nurses Association;

5. One member from the Kentucky Dental Association;

6. One member from the Kentucky Pharmaceutical Association;

7. Four members who are consumers with an interest in education, rehabilitation, mental health, home care program, or ambulatory care services; and

8. Three members who are consumers not associated with any health facility or delivery of health services.

Complementing the Certificate of Need and Licensure Act is Public Law 93-641, (The National Health Planning and Resource Development Act). This law, passed by the United States Congress in 1974, was designed to

> facilitate the development of recommendations for a national health planning policy, to augment areawide and state planning services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy.

Public Law 93-641 divides the country into health service areas. Health service areas are designated on the basis of geographic factors, population, and the availability of health resources. Health service areas are required to meet the following criteria.

1. The area shall be a geographic region appropriate for effective planning and development of health services, determined on the basis of factors including population and availability of resources;

2. The population must be between 500,000 and 3 million;

3. Each area must contain all health resources including, if practical, one center providing highly specialized health services;

4. The boundaries of the area shall be appropriately coordinated, to the extent practicable, with the boundaries of Peer Standard Review Organizations, existing regional planning areas, and State planning and administrative areas. Standard Metropolitan Statistical Areas are not to be split, unless governors agree in cases in which these cross state lines. Guidelines for Area designation suggested that generally area development districts, the 15 governmental regions in Kentucky, should not be divided.

The health service areas are respectively served by health systems agencies. In terms of nursing home responsibilities, the health systems agencies are primarily involved in bed planning for each level of care and in reviewing and monitoring the Certificate of Need program. The overall purposes of health systems agencies as defined by Public Law 93-641 are:

1. To improve the health of residents;

2. To increase accessibility, continuity, and quality of the health services;

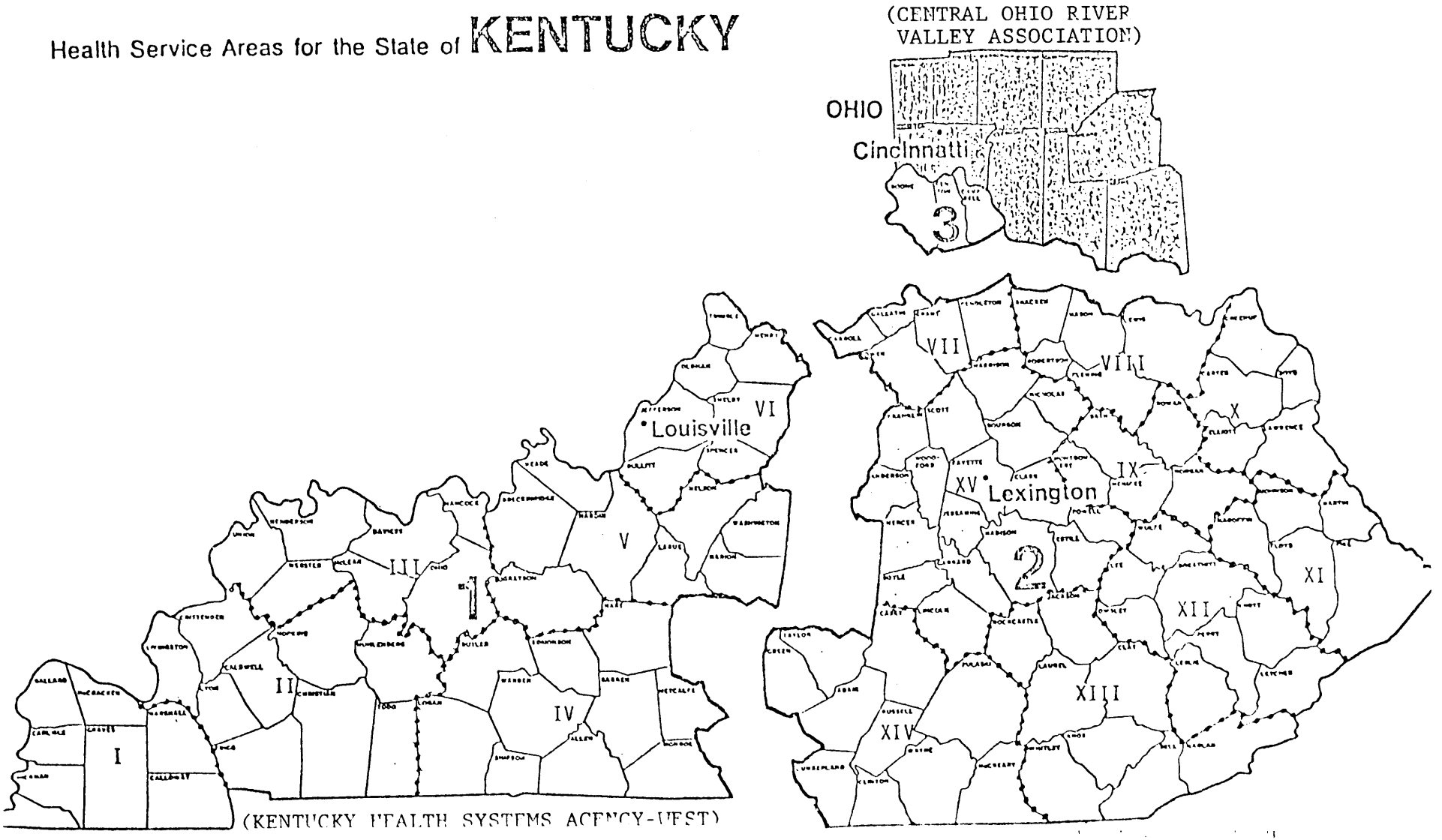
3. To restrain increases in the cost of health services; and

4. To prevent unnecessary duplication of health resources.

In Kentucky, there are three health systems agencies: East Kentucky Health Systems Agency, which is responsible for the health planning needs of 68 eastern Kentucky counties; Kentucky Health Systems Agency West, which has similar responsibilities for 49 counties in western Kentucky; and the Central Ohio River Valley Association, which conducts health planning for the three northern Kentucky counties of Kenton, Campbell, and Boone. The map in Figure 6 shows the respective boundaries of the health sytems agencies in Kentucky.

Additionally, Kentucky's three health systems agencies have formed subarea advisory councils which correspond to the boundaries of the area development districts. (See Figure 6) East Kentucky Health Systems Agency has nine subarea councils (ADD Nos. VII - XV), Kentucky Health Systems Agency West has six (ADD Nos. I - VI), and the Central Ohio River Valley Association

FIGURE 6


Health Service Areas for the State of KENTUCKY
(CENTRAL OHIO RIVER VALLEY ASSOCIATION)
OHIO
Cincinnati
3
Louisville
Lexington
I
II
III
IV
V
VI
VII
VIII
IX
X
XI
XII
XIII
XIV
XV
1
2
(KENTUCKY HEALTH SYSTEMS AGENCY-WEST)

has incorporated the three counties in the Northern Kentucky Area Development District (District VII) into a subarea council which is located in Ohio. The remainder of the counties in ADD VII form a subarea council within East Kentucky Health Systems Agency. Part of the job responsibilities of these subarea councils is to do nursing home bed planning and initial certificate of need review.

As a result of Public Law 93-641, the previous nursing home bed planning mechanism was replaced. The regional health planning councils were replaced by the subarea councils. By the end of 1977 the State Comprehensive Health Planning Council will be replaced by the State Health Coordinating Council. Serving as staff to the State Health Coordinating Council will be the State Health Planning and Development Agency (presently called the Center for Comprehensive Health Systems Development in the Bureau for Health Services which has been serving as staff to the State Comprehensive Health Planning Council). The functions of these two new organizational units in the health planning system are described below.

The functions of the State Health Coordinating Council are:

1. Review annually and coordinate the health systems plan and annual implementation plan of each health systems agency;

2. Prepare, review, and revise the state health plan (made from plans of each health systems agency);

3. Review annually the budget of each health systems agency;

4. Review applications for grants submitted by each health systems agency;

5. Advise the State Health Planning and Development Agency on its function; and

6. Review annually and approve or disapprove of any state plan and application for receipt of federal funds under specific acts.

The functions of the State Health Planning and Development Agency are:

1. Conduct health planning activities of the state and implement those parts of the state and health systems agencies' plans which relate to state government.

2. Prepare, review, and revise the state health plan which is made up of the health systems agencies. This shall be approved or disapproved by the State Health Coordinating Council.

3. Prepare a State Medical Facilities Plan and assist the State Health Coordinating Council in reviewing this plan.

4. Serve as the planning agency of the state for Section 1122 of the Social Security Act.

5. Administer the state certificate of need program. The state must consider the recommendations of the health systems agencies. (Eastern Kentucky Health Systems Agency, Instructional Material, 1977)

The steps required to obtain a certificate of need in Kentucky are outlined in detail in Appendix II, the review process generally takes four months to complete before a certificate of need is granted. Many banks will not make loans to prospective nursing home operators until the operator receives his certificate of need.

Location of Present Beds

While nursing homes are scattered throughout the Commonwealth, there are some counties which do not have certain levels of nursing home care. (See Appendices V, VI, VII for maps depicting these shortages.) As of September, 1976, there were 24 counties without personal care homes, 57 counties with no intermediate care facilities, 65 counties which had no skilled nursing facilities, and five counties that had none of these levels of nursing home care. (DHR, unpublished data, 1976) Those counties which lacked a particular level of care are noted in Table 7. Also, most of the counties which do have nursing homes actually maintain multiple levels of care located in the same facility. That is, one nursing home may be permitted to have personal, intermediate, and skilled care bed units all housed in the same building.

The fact that not all counties have every level of nursing home care means that those persons who are in need of a level of care which is absent must then go to another county which has the available and appropriate level of care. Moreover, an adjacent county may not have an available bed in the particular level of care which is required and the person needing this service may have to travel even further. This forced movement is likely to exacerbate the frustration and difficulties that both the patient and his family are likely to already be experiencing as a result of having to utilize a nursing home as a long term care alternative.

Certificates of Need Outstanding, or "Paper Beds"

Although there is considerable review and scrutiny which takes place throughout the certificate of need process, some serious problems have emerged since the Certificate of Need and Licensure Act was passed, in regard to certificates of need which are outstanding. These are sometimes referred to as "paper beds," or nursing home beds which have been granted a certificate of need to be built, but are not yet operating. There are certificates of need which were granted in 1973 for 805 nursing home beds in personal care homes and intermediate care and skilled nursing facilities which are still not operating and serving patients.

A certificate of need, when issued, is valid for six months. At the end of this time the holder must submit a progress report to the Certificate of Need and Licensure Board pertaining to the completion of his project. This report passes through the same levels of review as does the certificate of need application, with the Certificate of Need and Licensure Board making the

TABLE 7
COUNTIES IN KENTUCKY WHICH LACK NURSING HOMES,
BY LEVEL OF CARE: 1976

COUNTIES	NO FAMILY CARE HOMES	NO PERSONAL CARE HOMES	NO INTER-MEDIATE CARE FACILITIES	NO SKILLED NURSING FACILITIES
Allen	x		x	x
Anderson	x			x
Ballard			x	x
Bath				x
Bell			x	
Boone	x	x		
Bourbon			x	
Boyd			x	
Bracken			x	x
Breathitt	x			
Breckinridge				x
Bullitt			x	x
Campbell	x			
Carlisle		x	x	x
Carroll			x	x
Carter		x	x	x
Casey			x	x
Clay	x	x		x
Clinton			x	x
Crittendon				x
Cumberland		x	x	x
Edmondson	x		x	x
Elliott		x	x	x
Estill				x
Fleming		x	x	
Floyd			x	
Franklin				x
Fulton		x	x	
Gallatin		x	x	x
Garrard	x		x	
Grant	x		x	x
Graves			x	x
Grayson	x			x
Green				x
Greenup				x
Hancock	x		x	x
Harlan	x			
Harrison			x	
Hart			x	x
Henderson	x			
Hickman	x			x
Hopkins	x			
Jackson	x	x	x	x
Jessamine				x
Johnson	x		x	x
Knott	x	x	x	x

Continued

COUNTIES	NO FAMILY CARE HOMES	NO PERSONAL CARE HOMES	NO INTER-MEDIATE CARE FACILITIES	NO SKILLED NURSING FACILITIES
Lee				x
Leslie	x	x	x	x
Letcher		x	x	x
Lewis		x	x	x
Livingston	x		x	
Lyon			x	x
Magoffin			x	x
Marion				x
Martin	x	x	x	x
Marshall	x			
Mason		x		
Meade				x
Menifee			x	x
Mercer				x
Metcalfe			x	x
McClean	x			x
McCreary	x		x	x
Monroe	x			
Montgomery			x	
Nelson	x		x	x
Ohio	x			x
Oldham				x
Owen		x	x	x
Owsley	x	x		x
Pendleton			x	x
Perry	x			
Pike		x	x	
Powell	x			x
Robertson		x	x	x
Rockcastle		x		x
Rowan	x		x	
Russell		x	x	x
Scott			x	
Shelby	x		x	x
Simpson				x
Spencer	x	x	x	x
Todd			x	x
Trigg	x		x	
Trimble	x		x	x
Union	x			
Washington				x
Wayne			x	x
Webster	x			x
Whitley		x		
Wolfe	x		x	x
Woodford			x	x

SOURCE: Department for Human Resources, Bureau for Administration and Operations, 1976

final decision as to whether the holder should be granted a six month extension. Such a report is required every six months until the project is completed. Most nursing home facilities should be operating within 12 to 18 months after obtaining a certificate of need. (Interviews with Health Care Planners, 1977) However, as Table 8 illustrates, there are many beds which have taken much longer to become operable.

As of May, 1977, there were 1,837 beds at the personal, intermediate, and skilled care levels which had been holding a certificate of need between 18 and 42 months. This represents 31 % of the 4,017 certificates of need which are presently outstanding. Also, these figures do not include those "paper beds" which exist in the Jefferson subarea. The "paper beds" located in the remaining 14 subareas, and which are between 18-42 months outstanding are broken down as follows: personal care, 438 beds; intermediate care, 1,249 beds; and skilled nursing, 150 beds. These are beds which, in the opinion of many health planners who spoke with the Subcommittee, should be providing services to patients.

What makes "paper beds" a problem is that each subarea through its own bed planning formula (based on a percentage of people over age 65) establishes a limited number of beds that can be operating at any one time in each level of nursing home care. This is done to insure that there will not be surplus of nursing home beds in operation. However, once a certificate of need is granted for beds in a particular level of care, these beds can no longer be made available to other potential nursing home operators. They can be made available only if a certificate of need is returned by the bearer or revoked by the Certificate of Need and Licensure Board. Thus, depending on the number and types of beds allocated and certificates of need granted, "paper beds" can be more of a problem in some subareas of the state than in others. A holder of a two-year-old certificate of need for 100 intermediate care facility beds in a subarea that has a limit of 600 intermediate care facility beds available would not create the problems for prospective operators and patients that a similar certificate of need bearer would produce in a subarea where only 30 such beds were available for a certificate of need.

Table 9 and Table 10 include information on the number of "paper beds" in each subarea and subareas experiencing significant problems due to paper beds, respectively.

Number of Homes Accepting Medicaid Patients

Most of the intermediate care and skilled nursing facilities will accept persons whose care is paid for by the Medicaid program. Ninety-eight percent of the intermediate care facilities and 89% of the skilled nursing facilities in Kentucky are certified by the Department for Human Resources to be reimbursed for Medicaid patients. (DHR, unpublished data, 1977) Moreover, Medicaid recipients occupied 68% of all available intermediate care beds that existed as of March, 1977. Thirty-five percent of all skilled nursing beds were being used by Medicaid clients at this same time. (See Table 11.)

TABLE 8

CERTIFICATES OF NEED OUTSTANDING ("PAPER BEDS")

BY LEVEL OF CARE AND LENGTH OF TIME OUTSTANDING, MAY 1977

	Length of Time Outstanding Since May, 1977							
Level of care	42 months	36 months	30 months	24 months	18 months	12 months	6 months	less than 6 months
Personal Care	140	131	41	62	64	-80	-227	209
Intermediate Care Facility	188	224	33	481	323	750	963	1,052
Skilled Nursing Facility	92	30	68	-40	0	150	51	2

NOTE: (1) Net Certificates of Need Outstanding is used because some certificates of need were issued to take away as well as to add them. Thus, the numbers in the different cells indicate what the net total of certificates of need outstanding were for that particular level of care at that point in time. Therefore, a minus (-) sign means that the net effect for that time period was to take away beds.

(2) These totals do not include the Jefferson County Area Development District since their data was not available.

1. Total number of certificates issued for PC beds between 18-42 months outstanding were: 438
2. Total number of certificates issued for ICF beds between 18-42 months outstanding were: 1249
3. Total number of certificates issued for SNF beds between 18-42 months outstanding were: 150

TOTAL: 1837

Source: Department for Human Resources, Bureau for Health Services, 1977

TABLE 9

*Number of Certificates of Need Outstanding (Paper Beds) Between 18 and 42 months: By Area Development District and Level of Nursing Home Care, May 1977

ADD DISTRICTS	PCH and ICF Beds Available for a C of N	Certificate of Need Outstanding Between 18-42 months		Total PCH and ICF's Outstanding 18-42 months	SNF Beds Available for a C of N	SNF Certificates of Need Outstanding Between 18-42 months
		ICF	PCH			
1	0	188	50	238	None: 12 over limit	-1
2	10	278	-32	246	3	50
3	51	43	69	112	30	38
4	63	93	65	158	38	0
5	82	44	26	70	None: 9 over limit	30
6	362	?	?	?	None: 136 over limit	?
7	151	27	0	27	64	0
8	175	0	0	0	7	0
9	73	0	50	50	None: 10 over limit	0
10	17	0	0	0	None: 24 over limit	0
11	495	105	0	105	None: 12 over limit	0
12	112	57	0	57	None: 83 over limit	50
13	503	90	97	187	None: 87 over limit	-37
14	156	148	77	225	None: 44 over limit	20
15	185	176	36	212	18	0
TOTALS	2,435	1,249	438	1,687	245 over limit	150

*Note: A minus (-) sign indicates that a certificate of need was issued to take away beds.

SOURCE: Department for Human Resources, Bureau for Health Services, 1977

TABLE 10

SUBAREAS EXPERIENCING SIGNIFICANT PROBLEMS DUE TO "PAPER BEDS"

Data as of May, 1977

1. Purchase - There were no personal care/intermediate care facility beds available for new construction in this 8-county area, yet there were 188 intermediate care facility beds that had held a certificate of need between 18 and 42 months.

2. Pennyrile - There were only 10 personal care/intermediate care facility beds available for new construction in this 9-county area, but there were 278 intermediate care facility beds which had held a certificate of need between 18 and 42 months. Also, 3 skilled nursing facility beds were available while 50 beds had held a certificate of need between 18 and 42 months without being constructed.

3. Barren River - There were 63 personal care/intermediate care facility beds available for new construction in this 10-county area while there were 93 intermedicate care facility beds that had held a certificate of need between 18 and 42 months. There were 65 personal care beds which had held certificates of need between 18 and 42 months.

4. Lake Cumberland - There were 156 personal care/intermediate care facility beds available in this 10-county area, but there were 148 intermediate care facility beds and 77 personal care beds which had held certificates of need between 18 and 42 months. Also, this subarea was 44 over its limit for skilled nursing facility beds and had certificates of need for 20 more of these beds which were outstanding between 18 and 42 months.

5. Green River - There were 51 personal care/intermediate care facility beds available for new construction in this 7-county area. However, there were 43 intermediate care facility beds and 69 personal care beds which had held certificates of need between 18 and 42 months. Additionally, there were 30 skilled nursing facility beds available, but there were 38 certificates of need outstanding for 18 to 42 months.

6. Lincoln Trail - There were 82 personal care/intermediate care facility beds available for new construction in this 8-county area, but there were 44 intermediate care facility beds and 26 personal care beds which had held certificates of need outstanding between 18 and 42 months.

Table 10 (contd.)

7. Kentucky River - There were 112 personal care/interemediate care facility beds available for new construction in this 8-county subarea. However, there were 57 intermediate care facility beds that had held a certificate of need between 18 and 42 months. Also, this subarea was 83 over its skilled nursing facility bed limit and had an additional 50 beds which had held certificates of need between 18 and 42 months.

8. Bluegrass - There were 185 personal care/intermediate care facility beds available for new construction in this 17-county subarea. But, there were 176 intermediate care facility beds and 36 personal care beds which had held certificates of need between 18 and 42 months.

*Nine of the 15 subareas presently have more skilled nursing beds than their bed formulas permit, and the remaining 6 subareas are fast approaching their allotted number of skilled beds.

SOURCE: Department for Human Resources, Bureau for Health Services, 1977.

Obviously, intermediate care facilities in Kentucky acquire much of their revenue from the Medicaid patient. Skilled nursing facilities also depend upon Medicaid reimbursement, but not as greatly as do intermediate care facilities.

There are also many family and personal care homes which accept people whose care is paid for through the Supplemental Security Income (SSI) and the State Supplementation programs. However, the total number of family and personal care homes that will accept these recipients is unknown.

Lack of Appropriate Beds for Medicaid Patients is Costing State Money

Even though 98 % of all intermediate care facilities have been certified to accept Medicaid patients by the Department for Human Resources, there is still a substantial number of Medicaid recipients who need intermediate care facility beds which are locally unavailable. Some of these patients are presently receiving services at a higher level of care than they need. This, of course, is an expensive burden to both the state and federal governments, since they must reimburse the facilities for the level of care which is provided and not the level of care which is needed.

As of August, 1977, there were 425 Medicaid patients receiving services at skilled nursing facilities who actually needed the services of an intermediate care facility. (DHR, unpublished data, 1977) This number has been estimated to range between 400-500 per month over the past two years. In 1976 the average monthly Medicaid reimbursement for a skilled nursing facility was $828, while the similar rate for intermediate care facilities was $467. (DHR, Public Assistance Form 264, 1976) Thus, based on the current number of Medicaid recipients in skilled nursing facilities who need intermediate care, the state is spending approximately $153,000 per month in Medicaid monies it would not have to spend if these intermediate care facility beds were available.

Additionally, there were 213 Medicaid recipients residing in intermediate care facilities for the mentally retarded and developmentally disabled who were also determined by a DHR medical review team to need less intensive levels of care. These are broken down in Table 12.

From Table 12, it can be seen that the Commonwealth is spending approximately $273,000 per month that it could be saving if the present alternate levels of nursing home care were available to those qualified Medicaid recipients who are presently residing in intermediate care facilities for the mentally retarded and developmentally disabled. This amount is based upon the 1976 average monthly difference between the cost for the level of inappropriate care which is provided and the cost of the level of care which is needed but not available. Also, this cost projection utilizes only personal care homes as the non-Title XIX (Medicaid) supported level of care when cost differences are analyzed. The average monthly payment to personal care homes during 1976 was $310. Kentucky could reduce its Medicaid Program expenditures by a total of approximately $426,000 per month if the appropriate levels of nursing home care were available.

TABLE 11

UTILIZATION OF
INTERMEDIATE CARE FACILITIES & SKILLED NURSING FACILITIES BY
MEDICAID RECIPIENTS, KENTUCKY: 1977

Level of Care	Number of Facilities	Number of Facilities Accepting Medicaid Recipients	Percent Accepting Medicaid	Total number of beds available	Total number of beds used by Medicaid Recipients	Percent of all beds used by Medicaid Recipients
ICF	120	118	98%	7,407	5,058	68%
SNF	98	87	89%	6,521	2,264	35%

SOURCE: Department for Human Resources,
Office of Administrative Services, 1977.

TABLE 12

INAPPROPRIATELY PLACED MEDICAID RECIPIENTS IN LONG TERM CARE FACILITIES, BY LEVEL OF CARE AND MONTHLY ADDED COSTS TO STATE, 1977

LEVEL OF CARE INAPPROPRIATELY PLACED	LEVEL OF CARE NEEDED, BUT NOT AVAILABLE			**ESTIMATED MONTHLY MEDICAID COSTS TO STATE DUE TO UNAVAILABLE BEDS
	ICF	NON-TITLE XIX*	SNF	
SNF	425	-----	------	$ 153,000
ICF/MR OUTWOOD	7	21	3	28,400
ICF/MR OAKWOOD	12	76	7	155,000
ICF/MR HAZELWOOD	34	10	22	83,600
ICF/MR EXCEPTICON LEXINGTON	3	15	3	5,000
TOTALS	481	122	35	$ 426,000

*Includes Family Care Homes, Personal Care Homes, Foster Homes and Group Homes. (If placed, most of these people will be relocated in family and personal care homes.)

**This estimated added monthly Medicaid cost to the state is based upon the 1976 average monthly difference between the cost for the level of inappropriate care which is provided and the cost of the level of care which is needed but not available. Also, this cost projection utilizes only personal care homes as the non-title XIX (Medicaid) supported level of care when cost differences are analyzed.

SOURCE: Department for Human Resources, Bureau for Social Insurance, 1977)

Why Appropriate Levels of Care Are Not Available

There are several reasons why appropriate levels of care are not available to all qualified Medicaid recipients in skilled nursing and intermediate care facilities for the mentally retarded and developmentally disabled. First, for the recipients in skilled nursing facilities who need the intermediate care facility level of care, there may be no beds available in their particular locale. Policies issued by the Department for Human Resources' Bureau for Social Insurance state that an extension of Medicaid payments to skilled nursing facilities for persons who have been determined to need the intermediate care facility level of care can be made if all the following criteria are met.

1. There are no intermediate care facility beds available in participating facilities within the normal placement area. The normal placement area is defined as

   a. the client's home county,

   b. any county adjoining the home county, or

   c. any other nearby county if the ICF is within 50 miles of the client's home address; and

2. The client refuses to move to an intermediate care facility outside the normal placement area. (DHR, Bureau for Social Insurance, Service Manual, 1977)

Additional placement problems for Medicaid recipients who need lower levels of care occur when a facility certified to participate as a Medicaid vendor refuses to accept a recipient. These facilities are not required to accept every Medicaid recipient who needs their services. Those Medicaid recipients who require more nursing services than normal or exhibit abnormal behavior, risk the chance of being refused admittance.

Finding available and appropriate intermediate care facility and skilled nursing facility beds for Medicaid recipients is also made more difficult when "private pay" individuals utilize needed beds even though these beds may be in a higher level of care than they need. Persons who pay for their own care in an intermediate care facility or skilled nursing facility can reside in whichever level of care they desire.

It would appear, however, that if the 1,249 intermediate care facility beds in the 14 subareas across the state and an unknown number of "paper beds" in the Jefferson Subarea which have held certificates of need between 18 and 42 months were made available to nursing home operators who would make these beds become operative, then some of this costly expense for providing inappropriate care to 425 Medicaid recipients in skilled nursing facilities might be eliminated.

The placement of the 213 qualified Medicaid recipients from intermediate care facilities for the mentally retarded and developmentally disabled into appropriate levels of care poses different types of difficulties. There is the argument supported by some professionals in the field of mental retardation that nursing homes are not appropriate for providing care to mentally

retarded persons at all. This position is discussed in more detail in Chapter IV. Aside from the issue of whether nursing homes are appropriate or not for the treatment of the mentally retarded, many of the extensions which have been granted for Medicaid recipients in intermediate care facilities for the mentally retarded and developmentally disabled to stay in a higher level of care than they need are due to nursing homes not wanting these particular individuals in their facilities. (Interviews with DHR placement workers, 1977) Some owners feel that these mentally retarded persons exhibit such abnormal behavior that they are unsuitable for nursing home facilities.

Proprietary and Non-Profit Nursing Homes

Like the other nursing homes in the United States, almost 80% of Kentucky's nursing homes are proprietary, that is, a home which is operated under a private commercial ownership. (DHR, unpublished data, 1977) A non-profit home, on the other hand, is one which is operated under voluntary or non-profit auspices, including churches, as well as local, state, and federal governments. Kentucky does not have a federal or state government operated nursing home. There are a few local government supported facilities.

Proprietary facilities were recently criticized by a nationwide AFL-CIO study on nursing homes. This report, issued in February, 1977, concluded that:

> Most of the problems in nursing homes can be traced to the profit motive, which is incompatible with social programs. Ultimately, in order to correct the problems of nursing homes, profit must be eliminated from the nursing home industry.
>
> This is not to state that there have not been some problems uncovered in non-profit homes; the most frequent being pressure on relatives to make donations. But the facts are that non-profit nursing homes spend more on patient care and more on staffing than profit making institutions, and the results are evidenced in better care for nursing home residents. (AFL-CIO, 1977, p. 18)

There are other studies which have also found non-profit nursing homes to provide a better quality of care. A study done by N. N. Anderson in 1969 found that more physician hours per patient were provided in the non-profit than in the proprietary facilities they surveyed. (Anderson, 1969, pp. 519-524) Five years prior to this research effort, Beattie and Bullock rated the social milieu, staff attitudes, and other features of 80 nursing homes in St. Louis which differed by level of care offered. (Beattie and Bullock, 1964, p. 251) They reported that non-profit homes rated higher in these different areas than did proprietary facilities.

However, similar research efforts into this field have established no significant difference in the quality of care given when a comparison is made between profit and non-profit nursing home care. A study of 129 Massachusetts nursing facilities by Levey concluded that there was no significant relationship between quality of care and facility ownership. (Levey, 1973, pp. 222-229) Compounding this problem in documenting which type of ownership is better for the patient is the difficulty which health care professionals have experienced over the years in measuring quality of care. Thus, the Subcommit-

tee understands that while the weight of the available evidence suggests that nonprofit making nursing homes may deliver a better quality of care to the patient, more substantial information is needed before a conclusion can be drawn as to the preferred type of ownership.

Reimbursement Policies

Since state and federal government monies account for such a substantial proportion of the revenue obtained by both proprietary and non-profit nursing homes, reimbursement policies which implement these public funded programs are of great concern to providers, government officials, and the taxpayers. As has already been mentioned, the Medicaid program provides funding for intermediate care and skilled nursing facilities. Medicare also supports a limited number of days in a skilled nursing facility. The State Supplementation and the Supplemental Security Income programs indirectly fund family and personal care homes.

Unfortunately, the Subcommittee was not able to devote the time needed to fully explore the adequacy or viability of the various government reimbursement mechanisms. As a result, the Subcommittee could not reach a conclusion as to whether or not nursing homes are making reasonable or unreasonable profits from tax dollars.

Chapter Summary

The number of nursing homes and nursing home beds has increased markedly during the past five years. However, most of this increase can be attributed to the intermediate care facility level of care which was implemented in 1972. The number of intermediate care facility homes and beds have increased by 208% and 263%, respectively, between 1972 and 1977. The other levels of care have not even approached this growth rate. In fact, there has been an actual decline in both number of homes and beds at the personal care level.

Geographically, nursing homes are disbursed throughout the state; but there are some counties which lack particular levels of care. Skilled nursing facilities, for instance, are absent in more than one-half of Kentucky's counties, while there are no intermediate care facilities in 57 counties. This condition is likely to produce added hardships on families and patients who live in these areas, since the forced movement of a loved one to a distant county is likely to increase the frustration which already exists.

Although there are many levels of review which take place before a nursing home can serve patients, there have been some problems in forcing certificate of need bearers to get their projects completed in a reasonable amount of time. In order to obtain a certificate of need to build or add beds to an existing facility, an applicant must have the proposal reviewed on nine different occasions within a four month period. Only after a certificate of need is granted can actual construction take place. The problem has been that a number of applicants have been holding their certificates of need for an unreasonable amount of time. As a result, this may be unnecessarily costing the taxpayers money.

Even though the great majority of the intermediate care facilities in Kentucky accept Medicaid patients, there is a significant monthly number (400-500) of Medicaid recipients in skilled nursing facilities who need intermediate care facility beds that are not available. The Commonwealth must still pay for the much more costly skilled nursing facility care until an appropriate placement can be made. There are also over 200 Medicaid recipients in intermediate care facilities for the mentally retarded and developmentally disabled who need an alternate level of care which is not available. Each month these inappropriately placed recipients remain in their present levels of treatment, the Commonwealth is spending approximately $426,000 per month in its Medicaid program which could be saved if appropriate beds were available.

CHAPTER IV

PROFILE OF THE NURSING HOME PATIENT

Introduction

Due to the lack of a comprehensive data collection system for nursing homes or long term care services in Kentucky, adequate information regarding the characteristics of nursing home patients in the Commonwealth is not available. There is no designated agency in Kentucky state government that is mandated the task of collecting, analyzing, monitoring, and disseminating all relevant information which pertains to nursing homes, their patients, or other long term care services. Therefore, most of the data which is discussed in this chapter on characteristics of patients in nursing homes must come from national sources.

The problem in using national data and attempting to apply it to Kentucky is that most national studies on nursing homes group all levels of care together when research is performed. There are exceptions, of course. Skilled nursing facilities seem to be singled out more for individual study than either personal care homes or intermediate care facilities. Additionally, all states do not adopt the same eligibility criteria for patients placed in the different levels of care, nor do all states adopt precisely the same labels for these levels. While it is true that there are specific federal requirements for the intermediate care and skilled nursing facility levels, there is some flexibility for the states to use their own discretion in establishing patient eligibility criteria. The result of this lack of nationwide uniformity in nursing home levels of care is a lot of confusion for the interested citizen, legislator, or researcher.

Age of Nursing Home Residents

Most nationwide surveys of patients in nursing homes estimate their average age to be 79 years. (HEW, Characteristics, 1977, p. 3) Nearly 83% of the patients are over age 75, indicating for the most part a very old population. (HEW, Characteristics, 1977, p. 6) However, these age distributions may vary depending upon the level of care which is examined. A 1975 study by HEW of 6,591 skilled nursing facilities across the country reports that 22% the patients in this level of nursing home care were under 65 years of age. (HEW, Intro Report, 1975, p. 18) Finally, no matter what the age, the average length of stay will probably be 2.6 years (HEW, Characteristics, 1977, p. 4), and approximately 50% of all nursing home patients are likely to die in these facilities. (U.S. Senate, Special Committee on Aging, Intro Report, 1974, p. 17)

Sex of Nursing Home Residents

Women outnumber men in nursing homes almost three to one. (HEW, Characteristics, 1977, p. 2) Men comprise approximately 30% of nursing home patients. Much of this difference can be accounted for by the fact that there are more women in the general population age 65 and over. Females have an eight year longer life expectancy than do males in the United States. (U.S.

FIGURE 7

81 years old

Female

White

Widowed

Less Than High School Education

Annual Family Income of Less Than $3000

3.4 Separate Chronic Conditions

Average Length of Stay in Nursing Home is 2.6 years

Half are likely to die in the facility

NATIONAL CHARACTERISTICS OF AN AVERAGE NURSING HOME RESIDENT

Census, Statistical Abstract, 1976, p. 59) A 1974 report by the U. S. Public Health Service found that a woman over age 65 has a much greater chance of being placed in a nursing home than does a man of similar age. Their data reveal that while there were 75 men per 100 women aged 65 and over in the general population, there were only 40 men per 100 women aged 65 and over in the nursing home population. (HEW, Measures of Chronic Illness, 1974, p. 6)

Race of Nursing Home Residents

Most studies indicate that almost 94% of nursing home patients are white, 5% are black, and the remaining 1% are composed of such groups as Mexican-Americans, Asian-Americans, and Indians. Although there have not been many research efforts into the reasons for the lower utilization of nursing homes by minorities, it has been postulated by some that generally, non-whites have a greater inability to pay for costly long term care when compared with whites. (HEW, Measures of Chronic Illness, 1974, p. 6)

Marital and Other Relationships of Nursing Home Residents

Slightly more than 60% of nursing home residents are widowed. (HEW, Characteristics, 1977, p. 4) Approximately one out of every eight residents in nursing homes is married. Nineteen percent of all the nursing home patients have never married and most persons in this group are composed of individuals under age 65.

Data regarding nursing home patients' relationships with persons outside the nursing home has been conflicting. The U. S. Senate Special Committee on Aging reports that a 1972 New Hampshire study discovered that 58% of the nursing home patients in their sample had no weekly visitors. (U.S. Senate, Special Committee on Aging, Intro Report, 1974, p. 18) By contrast, a report by the National Center for Health Statistics states that about 61% of the nursing home residents receive visitors at least once per week. (HEW, Characteristics, 1977, p. 11) However, both of these studies agree that more than 66% of the nursing home residents never leave the facility for overnight visits with family or friends. Also, only 25% of the nursing home residents who were former patients of mental hospitals receive weekly visitors. (HEW, Characteristics, 1977, p. 12)

Education, Occupation, and Family Income

Information obtained from a 1975 nationwide HEW study on skilled nursing homes reveals that 63% of these patients had less than a high school education, 78% had held jobs in skilled, semiskilled or unskilled work, and 69% had family incomes of less than $3,000 per year. (HEW, Intro. Report, 1975, p. 20) A Congressional Budget Office report on long term care concluded that:

> Many families not on welfare and therefore ineligible for Medicaid deplete their resources in providing or purchasing long-term care for their elderly relatives. Only by 'spending down' to income levels that make them eligible for Medicaid payments do they in effect get government assistance for long-term care. This impoverishment of the disabled is suggested by the fact that 69

percent of nursing home residents have incomes under $3,000 and that over 47 percent of nursing home patients whose costs are paid by Medicaid were not initially poor by state definitions but depleted their resources and became qualified as 'medically needy.' (U.S. Congressional Budget Office, 1977, p. xi)

Health Care Status

Most studies on nursing home patients have found that on the average, each resident has 3.4 separate chronic conditions. (HEW, Measures of Chronic Illness, 1974, p. 8) Chronic conditions are those which are listed below:

1. Senility
2. Mental illness
3. Mental retardation
4. Arthritis or rheumatism
5. Paralysis or palsy due to stroke
6. Paralysis or palsy not related to stroke, arthritis, or rheumatism
7. Glaucoma or cataracts
8. Diabetes
9. Any chronic trouble with back or spine
10. Amputation of extremities
11. Heart trouble

The U. S. Public Health Service reports that senility, mental illness, heart trouble, and arthritis or rheumatism are the most common chronic conditions. (Kovar, 1977, p. 19) However, the types of chronic conditions appear to be different for those under age 65 as opposed to those who are over this age. Available data on patients under 65 years of age in skilled nursing facilities indicates that two out of three patients have chronic conditions relating to pathology of the nervous system, such as neurological disease, mental retardation, neuroses and psychoses, stroke, and chronic brain disease. (HEW, Intro. Report, 1975, p. 29)

On the other hand, this same data shows that those skilled nursing facilities patients age 65 and older suffer most commonly from chronic conditions relating to heart disease, stroke, fractures, and generalized arteriosclerosis. Thus, most nursing home patients under age 65 are more likely to be suffering from pathology of the nervous system while those patients over 65 years of age are more likely to have a diagnosis pertaining to cardiovascular or cerebrovascular disease. This later diagnostic grouping is more often associated with the normal characteristics of aging.

The U. S. Public Health Service further notes that the most significant implication of the conditions noted above are the effects that they have on the activities of daily living such as bathing, dressing, eating, toileting, and walking. (HEW, Intro. Report, 1975, p. 22) In Kentucky, the number of chronic conditions and their resulting implications should increase in severity as one compares the respective differences that exist between personal, intermediate, and skilled care facilities.

National data on the health care status of nursing home patients which has been correlated to conform as much as possible with the three levels of

TABLE 13

HEALTH CARE STATUS OF PATIENTS IN
SKILLED NURSING FACILITIES, INTERMEDIATE CARE FACILTIIES
AND PERSONAL CARE HOMES: UNITED STATES

Health Care Status of Skilled Nursing Patients

1. Number of chronic conditions per patient:	3.6
2. Bathing:	Sixty percent of all skilled nursing patients require partial assistance with their baths, while 34% of them require complete assistance.
3. Dressing:	Approximately 72% of the patients require the services of another individual in putting on or taking off all items of clothing which are worn daily.
4. Eating	Patients are almost evenly divided between those who require assistance of some kind to eat (50%) and those who were able to eat unaided (48%). Two percent are required to be fed parentally.
5. Toileting:	Toileting is the act of getting to and from the toilet room for bowel and bladder functions, transferring on and off the toilet, cleansing self after elimination, and arranging clothes. Sixty-eight percent of these patients need assistance of some kind in their toileting.
6. Mobility:	Approximately 86% of the skilled nursing facility patients are non-ambulatory or require some assistance in walking, moving their wheel chairs, standing, climbing, or functional ability to move about. Fifty-seven percent are totally bedfast. However, two separate studies reveal that between 14% and 38% of the skilled nursing facility patients are fully ambulatory and able to walk outdoors at will.
7. Bladder and Bowel Functions:	Fifty-five percent of these patients are incontinent of urine at least occasionally. Likewise, 50% are incontinent of feces.
8. Condition of the Skin:	Slightly more than 9% of the patients have decubitis ulcers, bed sores.

9. Sensory Perception (Sight, Hearing and Speech): The majority of these skilled nursing facility patients, 70%, have sight impairments. Of this 70%, 3% are legally blind, 51% wear glasses, and 16% are not users of glasses at all.

Sixty-seven percent of the residents have no hearing impairments, while 31% have at least one impairment in one or both ears. Less than 2% are deaf.

Sixty-eight percent have no speech impairments, while there are 32% who have at least one speech defect.

Health Care Status of Intermediate Care Patients

1. Number of chronic conditions: 2.9

2. Mobility: Sixty-three percent of these residents were found to be ambulatory, while 14% were bedfast.

Health Care Status of Personal Care Patients

1. Number of chronic conditions: 1.9

2. Mobility: None of these residents were found to be bedfast, and 80% are ambulatory.

SOURCE: HEW, Intro Report, 1975, pp. 23-29; HEW, Measures of Chronic Illness, 1974, pp 18, 40-41.

nursing home care that exist in the Commonwealth are noted in the profiles described in Table 13. Unfortunately, almost all of this information is restricted to skilled nursing facilities as little data is available on intermediate or personal care homes or their patients.

It is not too difficult to determine from the national patient profile in Table 13 what some of the health care needs might be for persons in skilled nursing facilities. However, the intermediate care facility and personal care home patient profiles are grossly inadequate and do not give enough information about the types of problems and needs of these individuals.

Obtaining a comprehensive profile on the problems and needs of nursing home residents would seem to be mandatory before the state can do any meaningful long term care planning or appropriate resource allocation to this group of Kentucky's citizens. During 1976 the Commonwealth made $70 million in payments for its citizens to receive care in nursing homes. Yet, it is not known how many of these people could have remained in their own homes if appropriate "in-home" services were available. It seems illogical for federal and state governments to continue to promulgate administrative regulations that require nursing homes to offer certain services to their residents when the collective needs of these individuals at the various levels of care are not known.

Mentally Retarded, Developmentally Disabled, and Mentally Ill Nursing Home Residents in Kentucky

While the exact number of mentally retarded, developmentally disabled, or mentally ill persons who currently reside in Kentucky's nursing homes is not known, there is evidence which indicates that a significant number of these people are being placed in nursing homes each year. A recent U. S. General Accounting Office report on this subject stated, "it appears that more mentally ill persons reside in nursing homes than in public mental health hospitals." (U.S. General Accounting Office, Returning the Mentally Disabled, 1977, p. 10)

Table 14 contains data supplied by the Department for Human Resources indicating the number of mentally retarded and developmentally disabled persons living in family care homes, personal care homes, intermediate care facilities and skilled nursing facilities as of 1974.

TABLE 14

Number of Mentally Retarded and Developmentally Disabled Nursing Home Residents, Kentucky, 1974

Family Care Homes	350
Personal Care Homes	500
Intermediate Care Facilities	100
Skilled Nursing Facilities	120

Total number of known mentally retarded and developmentally disabled persons in the above noted facilities in Kentucky as of 1974	1,070

Source: Department for Human Resources, Office of Administrative Services, 1977

Between January, 1975 and June, 1977, 998 patients from state psychiatric hospitals were placed in family care homes, personal care homes, and intermediate care and skilled nursing facilities. (DHR, unpublished data, 1977) (See Table I5) This figure does not include the 1975 River Region Hospital data, nor does it include those patients from state psychiatric hospitals who were not directly placed into nursing homes upon their discharge, but eventually were placed in one. Finally, in addition to the 998 patients from state psychiatric hospitals who have been placed in nursing homes, there have been another 80 persons during the same time period who have been placed in nursing homes from state mental retardation facilities. (DHR, unpublished data, 1977)

The Bureau for Social Services in the Department for Human Resources has the responsibility for locating a placement for those patients discharged from psychiatric hospitals and mental retardation facilities who have no family or friends to assist them in finding an appropriate place to live. Consequently, data on the number of placements in nursing home facilities made from psychiatric hospitals and mental retardation facilities is only kept for those persons who are placed by the Bureau for Social Services. There is no information available on the number of patients discharged from psychiatric hospitals or mental retardation facilities who are placed in a nursing home by a family member or friend. However, estimates from those directly involved in the placement of these mentally retarded, developmentally disabled, and mentally ill patients suggest that the number who are eventually placed in nursing homes from psychiatric hospitals or mental retardation facilities may double the number which the Bureau for Social Services places each year.

Most of those placed in nursing homes from psychiatric hospitals and mental retardation facilities are put in personal care homes. Table I5 notes that almost 62% of all placements from state psychiatric hospitals made by the Bureau for Social Services were to personal care homes. Family care homes were the second most frequently used alternative, having nearly 20% of these placements.

Appropriateness of Nursing Home Placements for the Mentally Retarded, Developmentally Disabled, and Mentally Ill

The placement of mentally retarded, developmentally disabled, and mentally ill persons into nursing homes has been a continuing source of debate about whether or not this is appropriate. In 1972 the Kentucky Governor's Advisory Council on Mental Retardation, after a study on personal care homes in the Commonwealth, recommended that

TABLE 15

NUMBER OF FORMER PATIENTS FROM KENTUCKY STATE PSYCHIATRIC HOSPITALS PLACED IN ALTERNATE LONG TERM CARE FACILITIES, BY THE BUREAU FOR SOCIAL SERVICES: BY LEVEL OF CARE, JANUARY, 1975 - JUNE, 1977

Level of Care	June 1977	1976	1975*	TOTAL	Percent of Total Placement
Family Care Homes	25	104	70	199	19.5%
Personal Care Homes	145	245	240	630	61.6%
Intermediate Care Facility	56	65	27	148	14.5%
Skilled Nursing Facility	16	14	3	33	3.2%
Boarding Home	4	5	3	12	1.2%
TOTAL	246	433	343	1,022	100.0%

*Does not include placements made from Central State/River Region during 1975.

SOURCE: Department for Human Resources, Bureau for Social Services, 1977

> personal care facilities should be used only as interim resources for placement of the mentally retarded until such adequate facilities become available and in the future used only in selected cases when aging is the primary diagnosis. (Governor's Advisory Council, 1972, p. 24)

Similarly, a 1973 report by the Health and Social Service Facilities Review Commission of the Legislative Research Commission recommended that "until the placement of the mentally retarded into personal care homes, nursing homes, and other inappropriate private facilities becomes appropriate, any future placements should be prohibited." (Health and Social Services, 1973, p. 42)

Another study published by the Legislative Research Commission in 1974, entitled Society's Stepchildren: The Mentally Retarded, concluded that

> the placement of the mentally retarded in personal care homes is inappropriate.... Placement of the mentally retarded in personal care homes should cease until such time that personal care homes become appropriate for the mentally retarded. (Society's Stepchildren, 1974, pp. 27-32)

The findings of the Health and Social Services Facilities Review Commission and this later study did not state how personal care homes could ever become appropriate.

The Subcommittee on Long Term Care of the Special Committee on Aging in the U.S. Senate recently reported its findings on the role of nursing homes in caring for discharged mental patients. This report stated:

> There is a distinct lack of programs to help nursing homes care for discharged mental patients;
>
> Nationwide, thousands of former patients have been 'returned to the community' and then shuttled back again to state hospitals;
>
> The end result is that the states play musical chairs with the frail and impaired elderly, moving them away from home, away from town, from mental hospital to nursing home, from nursing home to mental hospital to boarding homes, from floor to floor, and from room to room in whatever direction will save the most money. (U.S. Senate Special Committee on Aging, Report No. 7, 1976, p. 771)

The U. S. General Accounting Office reported in 1977 that many of the nursing homes which kept patients who have been discharged from mental hospitals and institutions for the retarded are not staffed or prepared to handle the developmental or psychiatric needs of the mentally disabled. (U.S. General Accounting Office, Returning the Mentally Disabled, p. 10) This report also pointed out that nursing homes are frequently the only alternative to continued inpatient or residential care in a public institution, rather than the most appropriate setting.

Kentucky statutes and administrative regulations do not require personal and family care homes to provide psychiatric services, habilitation plans, or that other restorative treatment regimen be instituted for the residents. Nor do these same statutes and regulations allow for these respective facilities

to be reimbursed by state or federal dollars should they choose to provide such services to indigent residents. Thus, the end result for the poor and mentally retarded, developmentally disabled, or mentally ill residents in a personal or family care home is little more than a custodial arrangement.

Those who would argue against providing these rehabilitative measures state that if these services were required without the necessary reimbursement, it would create an unbearable expense to the owners of these facilities. The Subcommittee received testimony from various providers and health care professionals who stated that the current reimbursement rates for personal and family care homes are so inadequate that these facilities have much difficulty in even providing for the daily nourishment of their patients. Reimbursement rates to personal care homes for SSI and State Supplementation recipients who are residents of these facilities is presently $320 per month or slightly over $10 per day. Family care homes receive $258 per month, or $8.60 per day for the same type of residents.

As was stated previously, due to time constraints, the Subcommittee was unable to ascertain the degree to which operators of nursing homes made or lost money at any particular level of care. However, the Subcommittee strongly believes that given the types of individuals who are currently being placed into personal and family care homes, there must be much more done by these homes to provide appropriate services to their residents.

Guardianship of the Mentally Incompetent Nursing Home Patient

Many of the mentally retarded, developmentally disabled, and mentally ill nursing home patients have court appointed committees or guardians who are empowered to make necessary legal decisions and other transactions in their behalf. The Commonwealth, through the Department for Human Resources, presently has guardianship responsibilities for 2,810 persons. These people are primarily residing in state psychiatric facilities, mental retardation centers, and nursing homes. The exact number of persons residing in nursing homes who have court appointed guardians is not known, but it is estimated to be substantial.

The roles and responsibilities of these guardians or committees, however, have not been specifically defined by statute; and this may result in some problems for both the guardian and his ward. KRS 387.230(1) provides:

> The power and duty of the committee of a person of unsound mind shall, in all respects, be the same as those of the guardian of a minor, except as to education.

Accordingly, the powers and duties of a guardian for a minor or ward are set forth by KRS 387.060(1) below:

> A guardian shall have custody of his ward, and the possession, care and management of the ward's property, real and personal. He shall provide for the necessary and proper maintenance and education of the ward out of the estate.

It is difficult to ascertain from these statutes what specific responsibilities are entailed in guardianship. It is not clearly stated whether or

not guardianship is solely a fiduciary role or if it also encompasses broader responsibilities for the ward's wellbeing.

Nor have precedent court decisions helped to clarify the responsibilities of guardians. In Baker vs. Thomas, 272 Ky. 605, 114 S.W.2d 1113, (1938) the court ruled that "the committee has no power other than to have possession, care and management of the estate of the person of unsound mind. However, in Makemson vs. Commonwealth, 292 Ky. 634, 167 S.W.2d 313, (1942) the court decided that the committee has charge of the incompetent person or will or his estate. In Williams vs. First National Bank and Trust Co., 328 S.W.2d 152, (1959) the court ruled that, "A court appointed committee for an incompetent has the duty of caring for the incompetent person and the property of the incompetent person."

This guardianship dilemma was emphasized in 1975 by the Special Committee on Mental Health Facilities of the Interim Joint Committee on Health and Welfare. This committee reported that:

> The role of the court appointed committees acting in guardianship roles needs to be specified. Traditionally, these committees have concerned themselves primarily with fiduciary matters, but how far does and should their role extend toward overseeing the on-going welfare of their charges. (Special Committee on Mental Health, 1975, p. 12)

The potential difficulties that this lack of clarity in guardianship and committee roles may cause would seem to be exacerbated when a guardian or committee is placed in charge of several hundred people. The current average monthly caseload of the four guardianship officers in the Department for Human Resources is approximately 700 persons. Broken down by individual guardianship officers who have offices located at the three state psychiatric hospitals and in Frankfort, the monthly caseloads are detailed in Table 16.

TABLE 16

DHR GUARDIANSHIP CASELOAD

1.	Eastern State Hospital	1,200
2.	Western State Hospital	660
3.	Central State Hospital	350
4.	Office of Administrative Services (all mentally retarded clients)	600
	Total Number of Incompetent Persons who Have Guardianship Officers from the Department for Human Resources	2,810

Source: Department for Human Resources, Office of Administrative Services, 1977

The Kentucky State Hospital closed in the spring of 1977 and approximately 400 of its clients were assigned to the guardianship officer at Eastern State Hospital. This accounts for the significant difference in caseload size for the Eastern State Hospital guardianship officer.

During calendar year 1976, slightly over $7 million was disbursed by the four guardianship officers on behalf of their clients. This figure includes data for Kentucky State Hospital, which was operating during 1976, but does not include the monies that were disbursed by the guardianship officer at Central State Hospital. Additionally, another $359,000 was kept in a savings account during 1976 for the then 2,400 clients. Again, this does not include Central State Hospital data. The average amount of money which has been placed in savings for each of these clients is $147. Finally, the four guardianship officers during this period had a total average monthly cash balance of $913,000, which represents the total average monthly amount of uninvested money that was left over after the bills were paid for all of the clients each month. Thus, each client had an average of $374 placed in what could be termed a "checking account" that was managed by the guardianship officer.

With so many clients assigned to each guardianship officer, it is not surprising that most of the guardianship officer's time must be consumed in trying to manage financial affairs. However, if one of their charges, who may live 125 miles away, requires emergency surgery in the middle of the night, the guardianship officer is the one who is called by the attending physician in order to obtain permission to perform the operation. Similarly, when a nursing home operator wants to relocate a guardianship officer's client because of the "trouble" that particular patient is causing, the guardianship officer is the one from whom action is demanded. Other examples can be cited where the broad implications of the guardianship statutes sometimes place these designated officers in the position of being a parent to their wards.

This problem was alluded to by the 1975 Special Committee on Mental Health Facilities, which examined the guardianship program for the mentally retarded. It stated in its report that:

> It seems inappropriate for one person carrying a caseload of 500 mentally retarded individuals to make decisions which may greatly affect the future of such persons, even when the guardianship officer is extremely competent. Many decisions in this area are extremely complex and to require one person to bear such a grave and awesome responsibility for so many individuals is unfair...This caseload seems unwieldy and the committee questions the extent of interest and guardianship which can actually be provided under these circumstances. (Special Committee on Mental Health, 1975, p. 12)

The Interim Subcommittee on Long Term Care strongly endorses these conclusions.

Chapter Summary

The most substantial barrier in trying to obtain an adequate profile on the personal characteristics of individuals who reside in Kentucky's nursing homes is the lack of a data collection mechanism designed to gather such

information. There is no comprehensive up-to-date information available on the age, sex, race, education, income or marital status of patients who reside in the Commonwealth's nursing home. Even more important, there is no data available on the health care status and physical and mental needs of the residents in the different facilities. It is not known, for example, how many or what type of chronic conditions exist for patients in the different levels of care. Nor is it known how many and to what degree these patients require dental, eye care, podiatric, physical therapy, or mental health services. Finally, it is not known how many present residents in nursing homes could remain in their own homes if appropriate in-home services such as home health, caretaker, or homemaker, were available. This lack of information would appear to severely hinder any long term care planning or resource allocation done on behalf of Kentucky's nursing home population. The Subcommittee does not see how the Commonwealth can continue to make $70 million or more a year in payments for nursing home services when the health care status or the long term care needs of the citizens who use these facilities is not known.

Many studies of nursing home patients have been primarily concerned with the characteristics of residents at the skilled nursing level and have generally neglected the intermediate and personal care homes. Still other research efforts have grouped all levels of care together in developing their patient profiles. Some of the general findings of these studies reveal the portrait of the personal care home, intermediate care, and skilled nursing facility patient as is described below:

1. The average age of nursing home residents is 79 years. Over 80% of the nursing home population is over age 75. However, between 12% and 22% of the residents are under age 65.

2. The average length of stay in a nursing home is approximately 2.6 years.

3. About 50% of all nursing home patients eventually die in these facilities.

4. Women outnumber men in nursing homes almost three to one.

5. Ninety-four percent of the nursing home patients are white.

6. Approximately 60% of the residents are widowed.

7. Most nursing home residents rarely leave the facility for an overnight visit with family or friends.

8. Most residents have less than a high school education and an annual income of less than $3,000.

9. Almost 50% of those patients whose costs are now paid by Medicaid were not initially poor by state definition. Thus, these people had to deplete their resources in order to become eligible.

10. Approximately two-thirds of the residents in Kentucky's intermediate care facilities are on Medicaid. Similarly, almost one-third of the skilled nursing facility patient care is being paid for by this program.

11. Most residents under 65 years of age have a primary diagnosis relating to mental disorders, while those over age 65 are affected by such physical ailments as heart disease, fractures, and arteriosclerosis.

This profile is the result of all nursing home levels being grouped together. If data were available on patients for each level of care in Kentucky, several different types of patient profiles should emerge.

Since it is apparent that nursing homes in Kentucky and the rest of the country are being increasingly utilized to place large numbers of former patients of psychiatric hospitals and mental retardation centers, it is important that information be obtained on the needs and health care status of this group. Presently, this data is not available on an estimated 1,100 to 2,200 persons who have been moved from Kentucky's psychiatric and mental retardation institutions into nursing homes and other long term care facilities during the past two and one-half years.

Eighty-two percent of the placements made from psychiatric hospitals and mental retardation facilities are to personal and family care homes. These homes are not equipped to provide necessary rehabilitative or restorative treatment programs to this group of Kentucky's citizens. Neither are they required or paid to provide these services or programs for indigent residents. Yet, they are continuing to be repositories for a significant number of persons who usually have no other place to live.

An additional problem for some of the mentally retarded, developmentally disabled, and mentally ill nursing home residents is that some of them have had guardians appointed to represent their interests who have extremely large guardianship caseloads. There would appear to be much difficulty in giving appropriate individual attention when each guardianship officer in Kentucky averages approximately 700 clients. For example, guardianship officers do not have time to visit with their wards for a first hand observation of their well-being. Also, reimbursement requirements for those nursing home residents whose care is paid for by SSI or Medicaid mandate that a certain portion of money (between $19 and $25) be set aside each month for each resident's personal use. The guardianship officer mails to the nursing home operator a check for each ward's care each month. Included in this check is an amount that is to be used by the ward for his or her personal use. Due to the size of their caseload, guardianship officers are not able to check to see if each ward is receiving his personal fund money or how it is being used. Finally, the Kentucky Revised Statutes pertaining to the responsibilities of guardians are so imprecise and incomplete that the result is a client or ward may have varying degrees of supervision or none at all.

Certainly, there needs to be much more work done by the Commonwealth in more comprehensively assessing and meeting the real needs of its citizens who are in need of long term care services.

CHAPTER V

KENTUCKY STATE GOVERNMENT'S NURSING HOME RESPONSIBILITIES

The organizational response of state and federal government to long term care has traditionally been very fragmented. The Department for Human Resources is Kentucky's largest administrative agency and the state agency most involved in long term care. Within the Department for Human Resources, three of the four existing bureaus and one former bureau (now attached to the Office of the Secretary) have substantive responsibilities in the nursing home area. Also, within these 4 bureaus are 11 divisions and a number of branches within the divisions which have 1 or more functions devoted to nursing homes or their patients. As Figure 8 reveals, there is not one centralized state governmental unit that has been mandated the assignment for coordinating, implementing, and monitoring all of the Commonwealth's programs that pertain to nursing homes, nursing home patients, and long term care in general.

Likewise, at the federal government level, the principal cabinet level department which has nursing home responsibilities, the U. S. Department of Health, Education and Welfare, has 9 separate agencies and 21 individual offices that have some responsibility for nursing homes or their patients.

The fragmentation phenomenon at the federal agency level was noted by a 1977 Congressional Budget Office report. This study, entitled Long Term Care for the Elderly and the Disabled concluded that:

> In general, the elderly face a bewildering array of fragmented long-term care services and financing arrangements. In few communities is there a centralized, unified, coordination, referral, and placement agency. This should not be surprising in view of the (many) agencies at the federal level that all run programs that could fall under the heading of long term care. (U.S. Congressional Budget Office, 1977, p. 32)

The U. S. Congress has established eight subcommittees which address various elements of the nation's nursing home and long term care service delivery system. They are:

1. Senate Select Committee on Aging, Subcommittee on Long Term Care, which has jurisdiction over long term care and health services for the elderly;

2. House Select Committee on Aging, Subcommittee on Long Term Care and Health Services, jurisdiction over long term care and health services for the elderly;

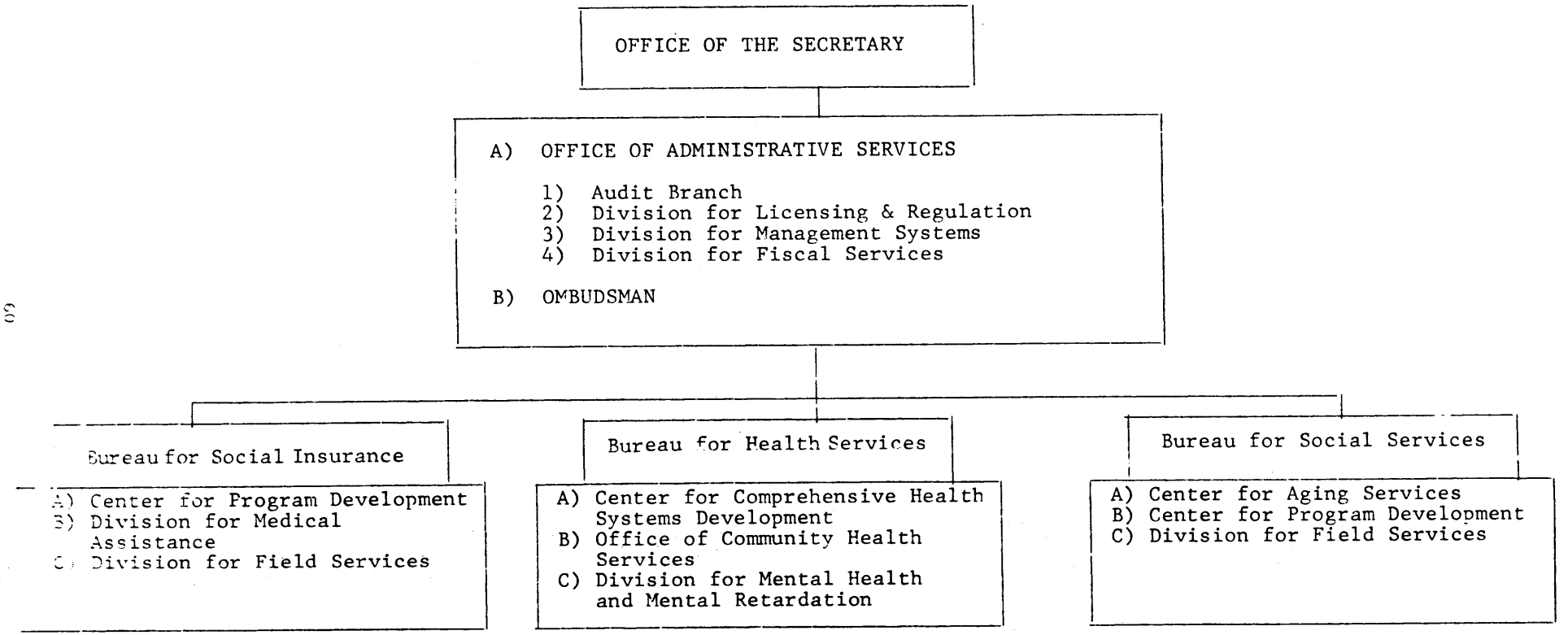
3. House Ways and Means Committee, Subcommittee on Public Assistance and Unemployment Compensation, which has jurisdiction over income maintenance appropriations for residents in nursing homes;

4. House Interstate and Foreign Commerce Committee, Subcommittee on Health and the Environment, which has jurisdiction over legislation affecting the mentally retarded, developmentally disabled, and men-

FIGURE 8

LONG TERM CARE RESPONSIBILITIES OF

THE DEPARTMENT FOR HUMAN RESOURCES



SOURCE: LRC STAFF COMPILATION, 1977

tally ill in nursing homes, and also Medicaid payments to nursing homes;

5. Senate Human Resources Committee, Subcommittee on the Handicapped, which has jurisdiction over legislation affecting the mentally retarded, developmentally disabled in nursing homes;

6. House Ways and Means Committee, Subcommittee on Health, which has jurisdiction over Medicare payments to nursing homes and home health agencies;

7. Senate Finance Committee, Subcommittee on Health, which has jurisdiction over Medicare and Medicaid Payments to nursing homes and home health agencies; and

8. Senate Human Resources Committee, Subcommittee on Health and Scientific Research, which has jurisdiction over the mentally ill in nursing homes.

The scope of this chapter is limited to an examination of responsibilities that Kentucky's administrative agencies have in regard to nursing homes and their residents.

Functions of the Department for Human Resources

The Department for Human Resources (DHR) is by state statute the state government agency most involved with the nursing homes and long term care. Under the provisions of KRS 194.010, DHR is charged with being

> the primary state agency responsible for the development and operation of human services, health, income supplement, manpower training, employment and unemployment programs, facilities, and other related services, including all such federal programs in which the state elects to participate. The department shall promote, supervise, and regulate local, public, and private programs, services, and facilities, which protect, develop, and maintain the health, welfare, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth.

The Department for Human Resources is presently composed of four bureaus: Bureau for Social Services, Bureau for Social Insurance, Bureau for Health Services, and the Bureau for Manpower Services. The first three bureaus have substantive job responsibilities which pertain to the nursing home area. The Office of Administrative Services, formerly a bureau, but now assigned to the Department's Office of the Secretary, has important nursing home responsibilities. The nursing home related functions of each organizational unit are explained in this chapter. Figure 8 is an organizational chart of DHR showing the Department's nursing home responsibilities.

DHR Office of Administrative Services

Created under Executive Order 77-270 in April, 1977, the Office of Administrative Services was dissolved as a bureau and its functions were subse-

quently attached to the Office of the Secretary in the Department for Human Resources. The Office of Administrative Services is divided into four divisions and one support branch which is assigned to the director's office. (See Figure 9.)

The general responsibilities of the Office of Administrative Services are (1) fiscal management activities, including accounting and payroll; (2) providing management support to the four program bureaus; (3) licensing and regulating health care facilities and services in the Commonwealth; and (4) coordinating the Department's purchasing and space planning of facilities.

As Figure 9 indicates, the Division for Licensing and Regulation, Division for Management Systems and the Division for Fiscal Services are involved with some aspect of nursing homes or nursing home patients.

Division for Licensing and Regulation

The Division for Licensing and Regulation is the primary organizational unit in state government responsible for monitoring the quality of care that is delivered by nursing homes to the citizens of the Commonwealth. Its responsibilities include (1) serving as staff to the Certificate of Need and Licensure Board; (2) certifying nursing homes for Medicaid and Medicare reimbursement; (3) investigating complaints made against nursing homes; (4) providing consulting services to nursing home operators; and (5) implementing and enforcing state and federal regulations which relate to the health and safety licensing of such facilities.

Field staff from the Division for Licensing and Regulation conduct inspections or surveys of nursing homes at all levels of care. The type of survey may vary according to the level of care. All nursing homes are surveyed at least annually for the purpose of renewing their license to operate. As was noted in Chapter III, licensure is based upon nursing homes fulfilling the requirements of state administrative regulations, which are promulgated by the Certificate of Need and Licensure Board.

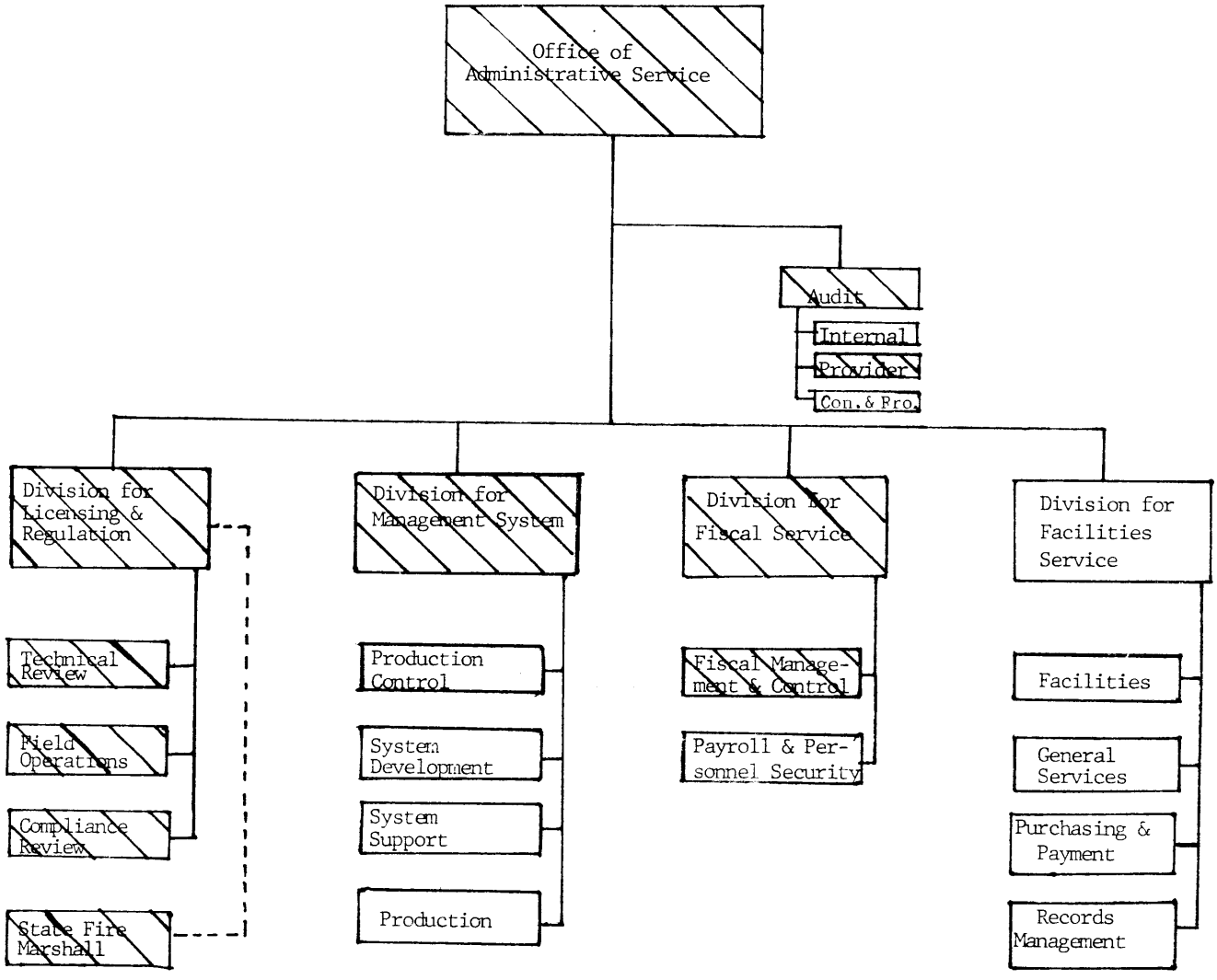
Surveys are also performed annually on those intermediate and skilled nursing facilities participating in the Medicaid or Medicare program for the purpose of recertifying their eligibility. It is the usual practice for this division to make its annual Medicaid or Medicare eligibility determination at the same time the annual licensure inspections are conducted. Nursing home operators usually have prior knowledge as to when these inspections will occur, since they are conducted when a nursing home's license is about to expire or when eligibility for participation in the Medicaid or Medicare program needs to be renewed.

Follow-up inspections are made of intermediate care and skilled nursing facilities if deficiencies are found to exist in the annual licensure or recertification survey. If deficiencies are found to exist, the facility must submit a plan for correcting these deficiencies. Visits are then made by the Division to see if the nursing home is in compliance.

FIGURE 9

LONG TERM CARE RESPONSIBILITIES OF

THE OFFICE OF ADMINISTRATIVE SERVICES



Indicates Long Term Care Responsibilities

SOURCE: LRC STAFF COMPILATION, 1977

The Division contracts out to the State Fire Marshal's Office similar inspection functions in regard to surveying facilities for their compliance with the Life Safety Code. These are regulations pertaining to fire safety to which all licensed nursing homes must adhere. The Fire Marshal's Office conducts annual inspections and reports its findings to the Division for Licensing and Regulation.

Surveys of nursing homes also occur when a complaint is received about individual facilities. These inspections are unannounced. In addition, the Division has been conducting unannounced surveys on a 10 % random sample of the intermediate care and skilled nursing facilities as part of a nationwide study to determine if there are differences between the results of announced and unannounced inspections. These unannounced surveys are in lieu of the annual surveys conducted for licensure and Medicaid or Medicare recertification.

The Division for Licensing and Regulation also has the responsibility for conducting quarterly surveys of family and personal care homes. These are unannounced inspections in which the surveyors assess the conditions in the homes as well as assess the appropriateness of placement for those persons residing in the family and personal care homes. Staff from the Bureau for Social Services are also required to visit family and personal care homes every three months.

As of August, 1977, this Division employed a total of 86 people statewide as surveyors, or inspectors, of home health agencies, primary care centers, intermediate care facilities for the mentally retarded and developmentally disabled, skilled nursing facilities, intermediate care facilities, personal care homes, and family care homes. It is the responsibility of the 86 surveyors to monitor the quality of care that is given by these health care providers.

The number and type of surveyors who are employed by the Division for Licensing and Regulation are included in Table 17.

TABLE 17

Division for Licensing and Regulation
Statewide Nursing Home Survey Personnel

Staff	Number	
1. Registered Nurses	10)	[personal care home,
2. Public Health Representatives	14)	intermediate care facility
3. Dieticians	6)	and
4. Social Workers	9)	
5. Medical Records Librarians	4)	skilled nursing facility surveyors]
6. Family Care Home Inspectors	43	(family care home surveyors only)
STATEWIDE TOTAL	86	

Source: Department for Human Resources
Office of Administrative Services, 1977

Forty-three of the 86 surveyors are responsible for monitoring 22,1[illegible] respective beds in personal care homes and intermediate care and skilled nursing facilities. The remaining 43 surveyors are responsible for monitoring family care homes. Again, these responsibilities are in addition to those they have for monitoring the quality of care given by home health agencies, primary care centers, and intermediate care facilities for the mentally retarded.

Skilled nursing and intermediate care facilities are generally inspected by a four to five person survey team which includes a public health representative, social worker, medical records librarian, dietician, and a registered nurse. The public health representative is the coordinator of the survey team.

Personal care homes are surveyed by a three or four person team comprised of similar personnel. Thus, based on a statewide average of four persons per survey team, each team is responsible for monitoring approximately 2,010 nursing home beds. This ratio, of course, is subject to variation depending on the number of facilities located in a particular area in Kentucky and the number of survey personnel assigned to monitor that area.

In the four years that the Division for Licensing and Regulation has been operating, six personal care homes have closed either voluntarily or through action taken by the Certificate of Need and Licensures Board. No intermediate or skilled nursing facilities have been closed. (DHR, unpublished data, 1977) Also, during the past two and one-half years, the Division has investigated 650 complaints received against individual nursing homes. Forty-three percent of these 650 complaints were found to be valid. (DHR, unpublished data, 1977) (See Table 18.) The Division's administrative review officer is responsible for receiving complaints and insuring that these nursing home complaints are investigated in a timely manner.

Intermediate care facilities had the greatest percentage of complaints that were justified when compared with personal care homes and skilled nursing facilities. Fifty-four percent of the complaints against intermediate care facilities that were investigated were valid complaints. Skilled nursing facilities had comparatively the fewest complaints valid, with 34%, while 40% of the complaints made against personal care homes were discovered to be justified.

A closer scrutiny of the categories of complaints reported and investigated in intermediate care facilities reveals that complaints regarding the staff of intermediate care facilities were valid in 68% of the investigations. Similarly, 57% of the complaints were valid regarding the physical plant, or cleanliness of the facility, and 53% of the complaints pertaining to direct patient care were found to be justified.

In further comparing the kinds of complaints that were found to be valid among all levels of care, the Subcommittee learned that complaints relating to the staff of a nursing home were discovered to be justified more often than any other single category of complaint. Sixty percent of the complaints pertaining to the staffs of personal care homes, intermediate care and skilled nursing facilities were valid. Complaints relating to the cleanliness of the facility comprised proportionately the next highest category, with 49% of them being justified.

Table 18

Nursing Home Complaints Reported to the Division for Licensing and Regulation:

By Level of Care and Percent Justified 1975 - June, 1977

TYPE OF COMPLAINTS	Skilled Nursing Facility		Intermediate Care Facility		Personal Care Homes		TOTALS	
	Number of Complaints Reported	Percent of Reports - Justified	Number of Complaints Reported	Percent of Reports - Justified	Number of Complaints Reported	Percent of Reports - Justified	Number of Complaints Reported	Percent of Reports - Justified
Administrative	36	28%	39	51%	25	36%	100	39%
Dietary	21	33%	26	38%	25	44%	72	39%
Licensure	N/A	----	N/A	----	6	50%	6	50%
Over Population	N/A	----	N/A	----	6	17%	6	17%
Patient Care	93	30%	79	53%	76	33%	248	38%
Physical Plant	43	42%	46	57%	39	49%	128	49%
Staffing	23	48%	38	68%	29	48%	90	60%
TOTALS	216	34%	228	54%	206	40%	650	43%

SOURCE: Department For Human Resources,
Office of Administrative Services, 1977

Finally, while it is true that the majority of the complaints (57%) which the Division for Licensing and Regulation received and investigated were found not to be justified, the Subcommittee believes it is still significant that such a substantial portion (43%) were found to be valid. The fact that these complaints were made by persons (family and friends of a resident, social workers from the Bureau for Social Services, or concerned citizens) outside the Division whose job responsibility is to monitor the quality of nursing home care, raises questions about the adequacy of the Division's monitoring program. Thus, the Subcommittee is concerned that many other complaints may need to be made but are not made either because nursing home residents or their family members are hesitant to complain or because no one is interested in getting involved enough to do so.

Division for Management Systems

The Division for Management Systems within the Office of Administrative Services is the data processing and information retrieval mechanism for all of the programs in the Department for Human Resources. While the expressed mission of this Division is to process data and retrieve information about program activities within DHR, its involvement in the nursing home field has been minimal. One of the great concerns of this Subcommittee is that there needs to be much more data generated and analyzed on nursing homes and nursing home patients in order for state administrative agencies to make appropriate decisions on how the Commonwealth's resources should best be utilized.

Audit Branch

The Audit Branch is placed within the Office of Administrative Services. The Branch performs financial field audits of health care providers participating in the Medicaid program. The Audit Plan, published by this Branch in May, 1977, states that:

> Due to the limitation of the staff, this Section has heretofore been concerned only with audits of intermediate care facilities which involves auditing expenditure statements of the ICFs and determining the rates these institutions may charge for the care of Medicaid recipients. (DHR, Audit Plan, 1977, p. 10)

The Audit Plan further states that during fiscal year 1976-77 only 65% of intermediate care facilities receiving Medicaid reimbursement were audited.

Division of Fiscal Services

The supervising guardianship office for the Commonwealth is located within the Division for Fiscal Services. Many clients of these guardianship officers live in nursing homes. The supervising officer's responsibilities include supervising the work of the other guardianship officers who are located at the state psychiatric hospitals and monitoring some 600 mentally retarded persons who are assigned to the Officer as wards of the state.

DHR Bureau for Social Insurance

The Bureau for Social Insurance was established in 1973 and was statutorily charged to develop and operate all programs of the Department for Human Resources that provide income maintenance or income supplementation services and all social insurance benefit programs. [KRS 194.040(6)] The Bureau is also responsible for eligibility determination and certification functions associated with these programs. This Bureau is responsible for administering Kentucky's Medicaid and State Supplementation programs. Medicare and the Supplemental Security Income program are administered by the Social Security Administration, a federal agency.

The Bureau for Social Insurance has two divisions, and the Center for Program Development which is attached to the Commissioner's Office, that have nursing home responsibilities. In addition, there are 13 branches within these three organizational units that are also involved with nursing homes in some capacity. (See Figure 10.) Perhaps the most actively involved division with nursing homes in this Bureau is the Division for Medical Assistance.

Division for Medical Assistance

The Division for Medical Assistance has been delegated primary responsibility for the day-to-day operation of the Kentucky Medical Assistance, or Medicaid program in Kentucky. Medicaid, as was discussed in Chapter II, provides reimbursement to qualified providers who operate intermediate care or skilled nursing facilities or Home Health Agencies. Responsibilities of this Division include assessing the appropriateness of care for Medicaid recipients, performing preliminary reviews of the invoices which nursing homes participating in the Medicaid program submit for reimbursement, and consulting with providers and recipients about reimbursement and eligibility matters.

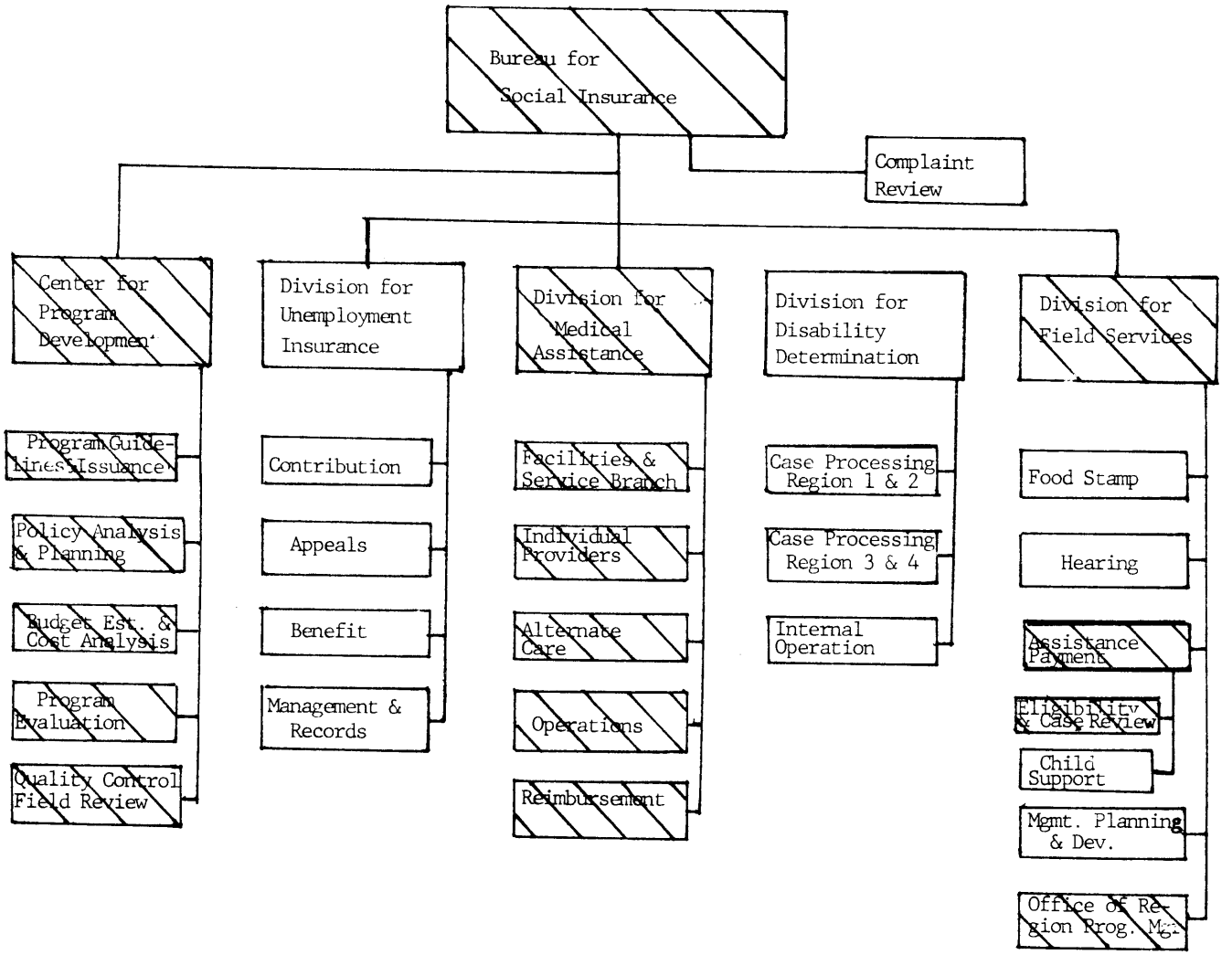
It has been shown that the availability of beds in the appropriate levels of care for the present 637 Medicaid recipients who are in a higher level of care than they need is a definite problem in Kentucky. (See Chapter IV.) Not only is it a problem for the patient who is receiving inappropriate care, but it is costing about $426,000 a month which could be saved if appropriate beds were available.

A medical review team from the Division for Medical Assistance is required to annually review the patient status of each Medicaid recipient in intermediate care facilities for the mentally retarded and developmentally disabled and intermediate care and skilled nursing facilities. (Bureau for Social Insurance, Service Manual, 1977) This medical review team is composed of nurses, social workers, allied health professionals, and a consulting physician. The purpose of this review is to determine whether or not the level of care is appropriate for the respective recipient's health care needs. Since August 1, 1977, however, skilled nursing facilities have been allowed on a trial basis to determine the appropriateness of care for the Medicaid patients who receive care in these facilities.

FIGURE 10

LONG TERM CARE RESPONSIBILITIES

OF THE BUREAU FOR SOCIAL INSURANCE



Indicates Long Term Care Responsibilities

SOURCE: LRC STAFF COMPILATION, 1977

If it is determined that a Medicaid recipient in an intermediate care facility for the mentally retarded and developmentally disabled or skilled nursing facility is receiving a higher level of care than needed, necessary steps are taken to find a more appropriate level of care. Should it be found that no beds are available in an appropriate level of care, the Division will grant an extension of payments for the recipients to remain in their current facility of residence until the bed in the appropriate level of care is located. Extension of payments are valid for a maximum of 60 days. In order for another 60-day extension to be granted, documentation must be made by the Bureau for Social Services which shows that a bed in the appropriate level of care is still not available. No extension payments are made for those recipients who have been determined to need the skilled nursing facility level of care but are currently placed in an intermediate care facility, which is a lower level of care. (Bureau for Social Insurance, Service Manual, 1977) Also, no extension of Medicaid payments is made for those present recipients who need a level of care for which Medicaid does not provide coverage, such as personal and family care homes.

The practice of not providing an extension of payments for those Medicaid clients who have been receiving treatment in intermediate care facilities but who have been judged by the medical review team to need the services of a non-Medicaid supported facility such as family care, personal care, foster care, or group home, etc. has caused placement problems in some areas of Kentucky where these alternate levels of care are not available. Interviews with persons in the Bureau for Social Services who are responsible for finding placements for these individuals report that sometimes there are simply no alternate levels of care available within the individual's community. This means that the client has to be moved to another county, across the state, or to temporarily utilize emergency shelter facilities until something more appropriate becomes available.

An area of concern regarding the medical review team which was brought to the Subcommittee's attention involves those Medicaid recipients in state psychiatric hospitals and mental retardation centers who have been determined by the medical review team to have achieved maximum benefit from the program at these institutions. Like other Medicaid recipients, persons receiving services from these facilities are at least annually reviewed for the purpose of determining their eligibility for Medicaid and for the appropriateness of care. When these particular recipients are determined by the medical review team to have obtained maximum benefits from these institutions, many of them are subsequently forced to live in family and personal care homes that are not necessarily equipped to serve them.

The staff of the Division for Medical Assistance also spends a significant amount of its time on matters pertaining to providers of nursing homes who are reimbursed by the Medicaid program. Their work in this area involves securing the appropriate Medicaid participation agreements with nursing home operators initially reviewing and processing facility payment requests and joining with appropriate persons in the Bureau to establish reimbursement policies. Thus, a substantial portion of this Division's workday is devoted to resolving questions of interpretation relating to nursing home guidelines, insuring nursing

home compliance with the terms of the participating agreement, and providing technical assistance regarding reimbursement to nursing homes by developing appropriate instructional materials and forms.

Division for Field Services

This division is the field operations unit in the Bureau for Social Insurance and includes eligibility workers, the field staff which are located in all 120 of Kentucky's counties. Their involvement with nursing homes consists primarily of determining eligibility of those citizens in the Commonwealth who are seeking State Supplementation and Medicaid benefits in order to obtain nursing home care. It was pointed out in Chapter II that $8 million in calendar year 1976 was spent in State Supplementation monies on services provided by personal care homes. Likewise, $53 million was spent in Medicaid monies for recipients in intermediate care and skilled nursing facilities.

Center for Program Development

The Center for Program Development, which is attached to the Commissioner's office, maintains responsibility for planning, developing, evaluating, budgeting and making ultimate decisions regarding policy for Bureau for Social Insurance programs.

Nursing home responsibilities within the Center for Program Development include: (1) monitoring and taking appropriate action on federal regulations that relate to Medicaid reimbursement of intermediate care and skilled nursing facilities and home health agencies; (2) developing and distributing to field staff, manual material pertaining to nursing homes and nursing home related services, such as eligibility criteria for Medicaid and State Supplementation, and a description of programs available to qualified persons; and (3) developing pertinent state administrative regulations which implement the Bureau's programs involving nursing homes or nursing home patients.

DHR Bureau for Social Services

The Bureau for Social Services is statutorily mandated to develop and operate all social service programs of the Department for Human Resources [KRS 194.030(8)]. This Bureau has three divisions and six branches within the divisions that have functional responsibilities involving nursing homes or nursing home patients. (See Figure 11.) Most of these responsibilities rest with the Division for Field Services.

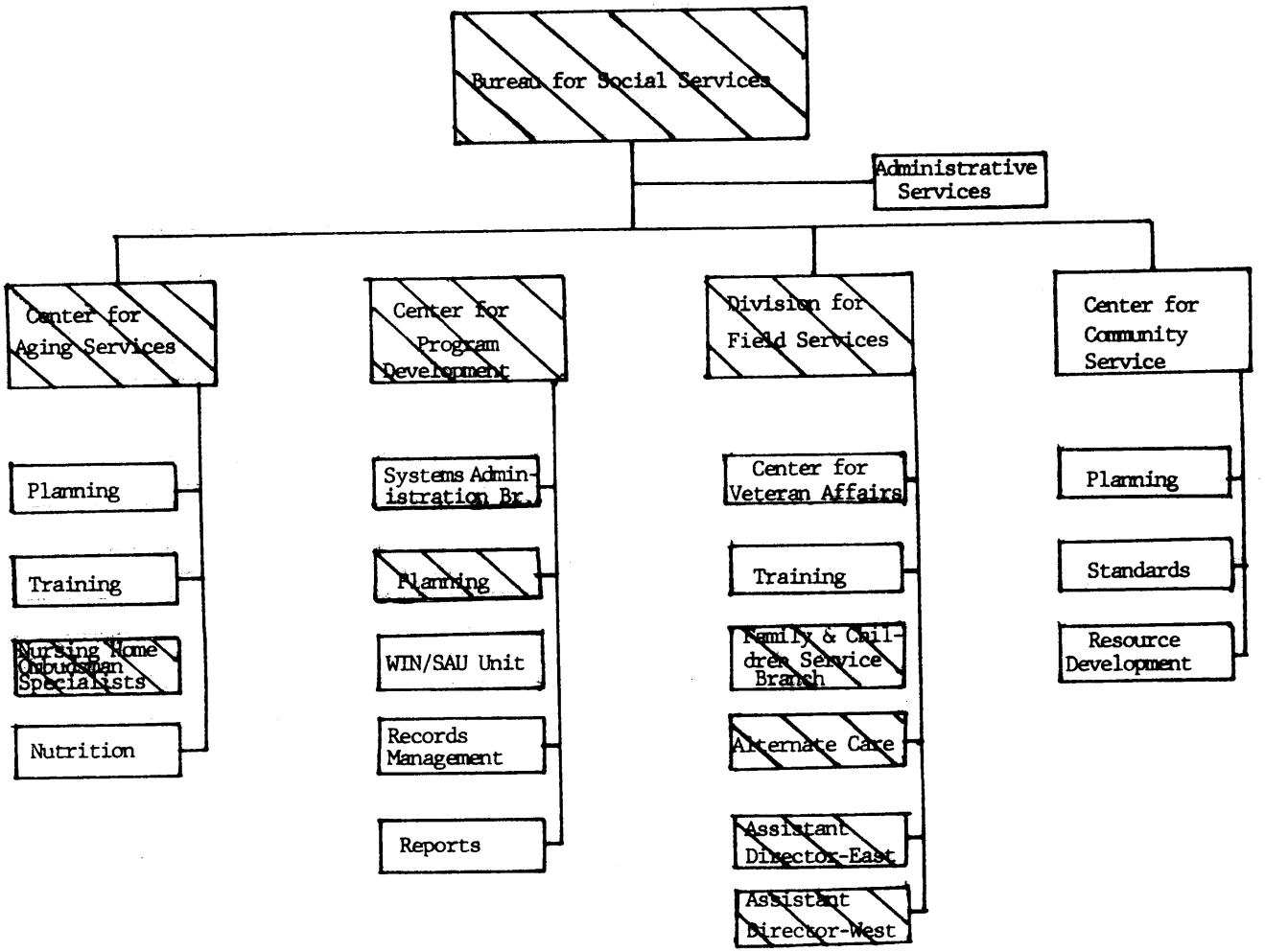
Division for Field Services

Staff from the Division for Field Services actually implement the Bureau's programs. Social workers have responsibilities which include the following:

FIGURE 11

LONG TERM CARE RESPONSIBILITIES

OF THE BUREAU FOR SOCIAL SERVICES



Indicates Long Term Care Responsibilities

SOURCE: LRC STAFF COMPILATION, 1977

1. Social workers from the Bureau for Social Services are responsible for providing services only on request, with the exception of protective services, to any client residing in an intermediate care or skilled nursing facility. Some services to nursing home residents might include: personal counseling with the client, family or guardian; assistance in strengthening the relationship between the nursing home resident and other family members; or helping to smooth the transition between the resident's former independent living status and the new experience of being dependent in an institutional setting.

2. Quarterly visits to family and personal care homes are required of the Bureau's staff, as are additional visits as necessary for the purpose of providing protective services to residents and supportive services to both residents and operators of these facilities. During these visits, social workers assess the personal, physical, and emotional condition of the client. They do not function as a licensing or regulatory agent, since this is the responsibility of the Division for Licensing and Regulation in the Office of Administrative Services. However, these social workers report to the Division for Licensing and Regulation any improprieties in care to patients.

3. Designated social workers from the Bureau for Social Services provide services to the operators of family and personal care homes. Services whicch are offered include counseling to help the operator understand the aging process; assisting the operator in securing information about proper nutrition, medical services and budgeting; and counseling to help operators alleviate conflicts between operators, clients, and clients' families. The operators of these facilities are not required to take advantage of the offered services.

4. Social workers from the Bureau for Social Services have duties involving the placement of clients into and out of family care homes, personal care homes, intermediate care facilities, intermediate care facilities for the mentally retarded/developmentally disabled, skilled nursing facilities, and psychiatric hospitals. Generally, these clients are persons who have no relative or friend to aid them in their movement into or out of these facilities. Social workers are also responsible for transferring patients from one level of nursing home care to another.

5. Bureau for Social Services social workers are responsible for documenting Medicaid extension of payment requests, when a skilled nursing or intermediate care facility for the mentally retarded and developmentally disabled patient has been determined to need a lower level of care which is not available. It is the responsibility of social workers from the Bureau to verify that every effort has been made to locate an available and appropriate bed and that none have been found to exist. This extension of payments provision applies to only Medicaid certified facilities. Documentation must be completed by the Bureau for Social Services every 60 days in order for the patient to continue receiving the extension of Medicaid payments in his present level of care.

6. The Adult Protection Act, enacted by the 1976 General Assembly, mandated to the Bureau for Social Services the responsibility for providing protective services to adults who are abused, neglected, or exploited. (KRS 209.020) In cases of abuse, neglect or exploitation, social workers have the authority to take appropriate measures to keep these acts from taking place. This may include removing an individual from a life endangering situation.

One of the effects of the Adult Protection Act is that the Bureau for Social Services has the mandate to investigate incidences of abuse, neglect, or exploitation reported to exist in nursing homes. Before the enactment of this legislation, this responsibility was, and to some extent still is, vested with the Division for Licensing and Regulation. The Division for Licensing and Regulation is responsible for monitoring the quality of care in these facilities and investigating any complaints made against them. The present policy of the Department for Human Resources is that joint investigations are to be made when possible, with the Bureau for Social Services assuming primary responsibility for the case. (Bureau for Social Services, Service Manual, 1977)

7. Social workers from the Bureau for Social Services are responsible for placing persons discharged from psychiatric hospitals and mental retardation centers into nursing homes. A social worker is located at each psychiatric hospital and mental retardation center. Eighty-two percent of these placements have been to family and personal care homes.

8. Bureau for Social Services social workers are mandated to provide follow-up social services to all persons released from psychiatric hospitals and mental retardation centers. Local social workers in the Bureau for Social Services are notified when a person is discharged from one of these institutions to a nursing home within their geographical area of responsibility.

9. Social workers from the Bureau for Social Services on occasion join with staff from the Division for Licensing and Regulation to document those instances in family and personal care homes where moving patients to higher levels of care would actually be detrimental to their health.

Cases of this nature generally arise when a resident strongly desires to remain in a family or personal care home even if he has been determined to need a higher level of care. For example, there are occasions when both husband and wife are in the same personal care home, and desire to remain together, even though one needs to be placed in an intermediate care facility. The Division and the Bureau for Social Service may determine that the party to be moved would be so upset that it would be best for him to remain where he is if he can be properly cared for by using auxilliary resources.

This procedure is known as the Bedfast Exception Policy. All such requests must be presented before the Certificate of Need and Licensure Board for its approval. If approved, social workers from the Bureau are required to visit these bedfast residents no fewer

than once every 30 days. Since 1975, 46 bedfast exceptions have been granted.

Center for Aging Services and the Nursing Home Ombudsman

The Center for Aging Services is the primary organizational unit in the Department for Human Resources which develops, monitors and evaluates programs for the elderly. A nursing home ombudsman developmental specialist is located within the Center. This position, established in February, 1977, has yet to be filled. However, a nursing home ombudsman worked out of the office of the ombudsman for DHR between January, 1976 and July, 1977. The office of the ombudsman is attached to the Department's executive office. (See Figure 8.)

There has been much confusion between the state and federal governments as to the kind of nursing home ombudsman program to be implemented. Presently, the ombudsman for DHR receives by a 24-hour toll free telephone number and the mail) complaints on individual nursing homes and forwards them to the appropriate agencies for action.

As originally proposed by the U. S. Department of Health, Education, and Welfare (HEW) in 1976, a nursing home ombudsman developmental specialist was to develop ombudsman citizen groups at the area development district level. These groups were to monitor nursing home care in their respective communities. Moreover, this HEW grant stated that the nursing home ombudsman developmental specialist was not to receive and investigate complaints. (HEW, unpublished data, Administration on Aging, Atlanta Office, 1977) The Department for Human Resources has stated that the original guidelines for this position are unclear and that little technical assistance has been provided by HEW in implementing this program. (DHR, unpublished data, 1977)

Center for Program Development

The functions and nursing home responsibilities of this administrative unit are generally analogous to those of the Center for Program Development in the Bureau for Social Insurance. Thus, their duties relative to nursing homes include developing and distributing manual material to social workers in the field regarding the Bureau's responsibilities for nursing homes and their patients; performing research; evaluating the efforts of field staff in regard to nursing home clients; and developing appropriate state administrative regulations which implement the Bureau's programs.

DHR Bureau for Health Services

The Bureau for Health Services is mandated by KRS 194.030(7) to develop and operate all programs of the Department for Human Resources that provide health and mental health services and all programs for the prevention, detection, care, and treatment of physical and mental disability, illness, and disease. The Bureau has three divisions involved in some capacity with nursing homes, Center for Comprehensive Health Systems Development, Division for Mental Health and Mental Retardation Services, and Office of Community Health Services. Within these divisions are 9 branches which have some responsibilities towards persons served by nursing homes or the facilities themselves.

The Bureau for Health Services' organizational unit with the most nursing home responsibilities is the Center for Comprehensive Health Systems Development. (See Figure 12.)

Center for Comprehensive Health Systems Development

The Center's specific nursing home related responsibilities as extrapolated from its mission statement are outlined below.

1. The Center is responsible for developing a health service needs assessment of those citizens in the Commonwealth who need nursing home care or other long term care services. Adequate information on the specific long term needs of Kentucky's citizens is not known.

2. Staff from the Center review and subsequently monitor each one of the 15 health service plans submitted by the subarea councils (area development districts). Each subarea council is responsible for developing and implementing a health service plan for its area. This includes planning for and monitoring the number and type of nursing home beds that can be constructed at any one time. The subarea councils also propose health care plans pertaining to the use of home health agencies.

3. The Center for Comprehensive Health Systems Development also provides technical assistance to a variety of groups. Nursing home operators are provided assistance when they apply for licensure. Staff from the Center regularly provide assistance to the State Comprehensive Health Planning Council (soon to be the State Health Coordinating Council) and the Certificate of Need and Licensure Board.

4. One of the Center's most important functions is to collect, maintain, and provide for the quick retrieval of accurate and timely data to support the health planning and evaluation functions of the health care delivery systems and of the Bureau for Health Services. Unfortunately, adequate data to support planning for long term care services has not been available. The primary reason for this information not being available is fact that there is no established data collection mechanism which collects and analyzes data from all the divisions and branches within the different Bureaus of DHR having responsibilities related to long term care.

Division for Mental Health and Mental Retardation

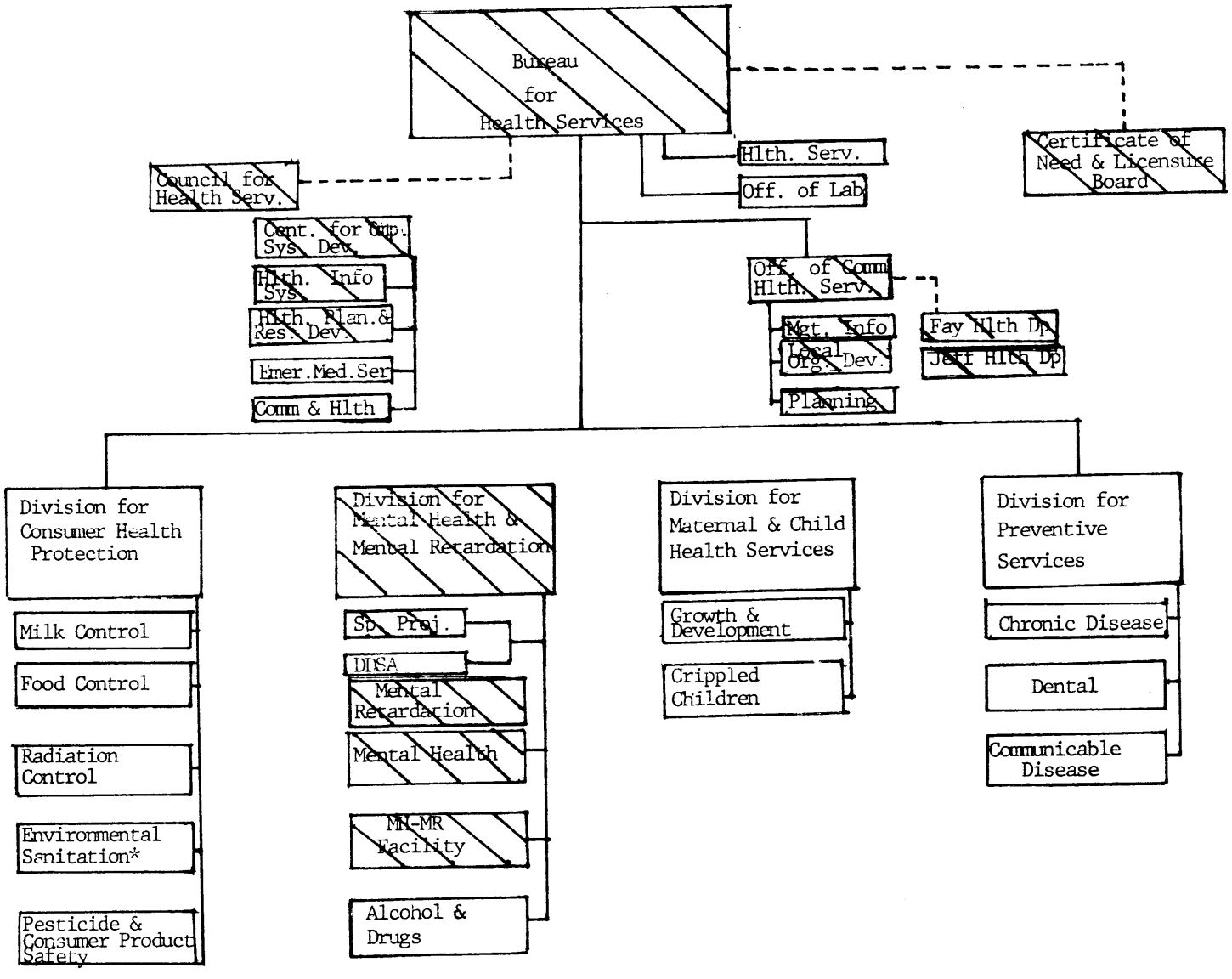
This Division and its four branches created by the Governor's Executive Order 77-370 in April, 1977, is charged with the on-going responsibility for all programs in the Department for Human Resources relating to mental health, mental retardation, and alcohol and drug abuse including the following:

Institutional care of mentally retarded and mentally ill individuals;

FIGURE 12

LONG TERM CARE RESPONSIBILITIES

OF THE BUREAU FOR HEALTH SERVICES



Indicates Long Term Care Responsibilities

SOURCE: LRC STAFF COMPILATION, 1977

The administration of all state owned hospitals and facilities for the mentally retarded and mentally ill;

Providing administrative support to Comprehensive Care Centers and the monitoring and evaluation of those programs; and

Perform all state agency functions as prescribed by P.L. 91-517 as amended by P.L.94-103 in relation to the developmentally disabled. (Executive Order 77-370)

Since many nursing home residents are placed from state psychiatric hospitals and mental retardation centers into nursing homes, this newly formed Division should be significantly involved with nursing homes. However, due to the fact that this is a new Division and a permanent director recently took office in November 1977, any specific future involvement with nursing homes and nursing home patients is still uncertain. Based upon the Division's mandate, the Subcommittee believes that it should be the Division's responsibility to determine what service alternatives should be available for the mentally retarded, developmentally disabled, and mentally ill persons who have been discharged from state psychiatric hospitals or mental retardation centers.

The Subcommittee believes that it should also be this Division's responsibility to assess the present needs of former patients at state psychiatric hospitals and mental retardation centers who have already been discharged into nursing homes. This information is not presently available.

Another organizational unit located within the Division for Mental Health and Mental Retardation Services with nursing home responsibilities is the Special Projects Office. One of the programs within this office provides for the full care and treatment of 50 retired Merchant Seamen who were former psychiatric patients of the U. S. Public Health Service Hospital in Lexington. The Department for Human Resources has contracted with the federal government to provide supervision of these men. All of these individuals are now in nursing homes located throughout Kentucky.

Office of Community Health Services

The Office of Community Health Services and its three branches were established to assist and strengthen local health units. This involves providing financial and technical resources to the 91 local health departments and the 15 regional mental health centers.

Only two local health departments in the Commonwealth, located in Lexington and Louisville, are actively involved with nursing homes. Lexington, as will be noted later, is by far the health department in the state most involved with nursing homes and other long term care services.

The 15 regional mental health centers, called comprehensive care centers, are presently providing mental health services to a portion of the residents in nursing homes. Most of their services are directed

towards clients in family and personal care homes, although they do provide services to residents in all levels of care.

Summary of Responsibilities

It has been shown that Kentucky State Government, through the Department for Human Resources, is very much involved with nursing homes and nursing home patients. Responsibilities relative to nursing homes and their patients are spread throughout three of the Department's four bureaus and one former bureau which is presently attached to the Department's executive office.

DHR's responsibilities for nursing homes and nursing home residents within the Commonwealth are outlined in Tables 19, 20, 21, and 22.

Although the duties are many and varied, no single administrative unit within DHR bears accountability for all of the Department's responsibilities to nursing homes, nursing home patients, and long term care in general. No single established body within the Department for Human Resources is mandated to :

1. Assess the citizens' needs for nursing homes and other long term care services;

2. Collect, analyze and disseminate pertinent data on nursing homes, nursing home residents and other long term care programs;

3. Develop and implement the most appropriate long term care alternatives;

4. Coordinate and direct the state's financial commitment to nursing homes, nursing home patients and other long term care programs;

5. Initiate and monitor a long term care policy for the people of the Commonwealth.

Thus, the Subcommittee believes that without the designated leadership necessary for adequately administering the state's responsibilities for nursing homes, nursing home patients and ultimately the long term care service delivery system, the Commonwealth will not be able to respond appropriately to the long term care needs of its people. The present network of long term care responsibilities is so complex, diversified, and costly that it needs to have a purposive and planned direction.

DHR's Recognition of Fragmentation Problems

Subsequent to the creation of this Subcommittee, the Department for Human Resources provided the impetus for establishing the Long Term Care

TABLE 19

RESPONSIBILITIES OF THE OFFICE OF ADMINISTRATIVE SERVICES FOR NURSING HOMES AND THEIR RESIDENTS

Responsibilities Regarding Nursing Homes

1. Inspects and certifies all nursing homes for licensure.

2. Inspects and certifies intermediate care facilities and skilled nursing facilities for their eligibility to participate in the Medicaid and Medicare programs.

3. Provides consultive services to nursing home operators and their staffs.

4. Monitors fire marshal's inspections of nursing homes.

5. Audits financial reports of intermediate care facilities participating in the Medicaid program and contracts with a private accounting firm to provide audits of participating skilled nursing facilities.

Responsibilities Regarding Nursing Home Residents

1. Monitors the quality of care given by nursing homes to all residents.

2. Receives and investigates complaints about patient care in nursing homes.

3. Ascertains the appropriateness of care for residents in family and personal care homes.

4. Maintains guardianship responsibilities for 2,810 people (the majority of whom are in nursing homes).

SOURCE: LRC Staff Compilation, 1977.

TABLE 20

RESPONSIBILITIES OF THE BUREAU FOR SOCIAL INSURANCE
FOR NURSING HOMES AND THEIR RESIDENTS

Responsibilities Regarding Nursing Homes

1. Establishes reimbursement rates for intermediate care facilities and skilled nursing facilities participating in the Medicaid program.

2. Establishes rates for family and personal care homes for State Supplementation recipients.

3. Performs preliminary desk reviews of the financial statements of intermediate care facilities participating in the Medicaid program.

4. Provides consultive services to nursing home operators regarding reimbursement from government funded programs.

Responsibilities Regarding Nursing Home Residents

1. Determines eligibility of persons who are receiving Medicaid benefits in order to obtain intermediate care or skilled nursing facility care.

2. Determines eligibility of persons who are seeking state supplementation benefits in order to obtain care in a family care home or personal care home.

3. Determines which level of nursing home care a Medicaid recipient should be placed.

4. Consults with nursing home residents and family members of residents who have concerns regarding eligibility.

SOURCE: LRC Staff Compilation, 1977.

TABLE 21

RESPONSIBILITIES OF THE BUREAU FOR SOCIAL SERVICES
FOR NURSING HOMES AND THEIR RESIDENTS

Responsibilities Regarding Nursing Homes

1. Inspects family and personal care homes on a quarterly basis for purposes of providing supportive services to both residents and operators of these facilities.

Responsibilities Regarding Nursing Home Residents

1. Provides social services only on request to residents in intermediate care and skilled nursing facilities.

2. Makes quarterly inspections of family and personal care homes for the purpose of providing protective and support services to residents.

3. Provides assistance to those persons who require help in moving into or out of a nursing home.

4. Documents Medicaid extension of payments requests, where a skilled nursing facility or resident has been determined by the medical review team from the Bureau for Social Insurance to need a lower level of Medicaid supported care which is not available. The Bureau for Social Services must document that no appropriate Medicaid subsidized bed is available in order for payments to continue to the resident in his present level of care.

5. Provides protective services to adults who are abused, neglected, or exploited in nursing homes.

6. Provides follow-up services to persons who are placed in nursing homes from state psychiatric hospitals or mental retardation centers.

7. Along with the staff from the Division for Licensing and Regulation in the Office of Administrative Services, the Bureau documents those instances in family and personal care homes where moving residents to a higher level of care would be detrimental to their health.

SOURCE: LRC Staff Compilation, 1977

TABLE 22

RESPONSIBILITIES OF THE BUREAU FOR HEALTH SERVICES
FOR NURSING HOMES AND THEIR RESIDENTS

Responsibilities Regarding Nursing Homes

1. Monitors the certificate of need program in all 15 subarea health councils.

2. Provides consultive services to nursing home operators on licensure questions.

3. Provides technical assistance to local health departments. Two local health departments conduct inspections of nursing homes which are independent of state inspection.

Responsibilities Regarding Nursing Home Residents

1. Determines nursing home and other long term care needs for all citizens.

2. Determines the special needs of those persons who are placed into nursing homes from state psychiatric hospitals and mental retardation centers.

3. Determines what programs and services are required to most appropriately meet the long term care needs of all citizens including the mentally retarded, developmentally disabled, and mentally ill.

4. Monitors and evaluates the performance of the community mental health centers providing mental health services to residents of nursing homes.

5. Provides technical and financial assistance to local health departments. Two health departments are actively involved with nursing home residents.

6. Provides supervision for 50 retired merchant seamen in nursing homes.

SOURCE: LRC Staff Compilation, 1977

Multi-Agency Study Group. Starting in January, 1977 representatives from all of the bureaus and the three health system agencies joined together to examine their respective long term care efforts. Their expressed mission was to examine the true need for the several types of long term care facilities and services in Kentucky.

The original time frame for completing the work of the study group was six months. However, as it met and explored the magnitude of the subject, they realized the inadequacy of the original six month deadline. Therefore, it extended the completion schedule by one year to June, 1978.

In March, 1977 the Long Term Care Multi-Agency Study Group divided itself into two task forces which were to report findings to the membership of the full study group. These task forces are the Criteria for Long Term Care Placement Task Force and Determination of Need Task Force. The mission of the Criteria for Long Term Care Placement Task Force is to ascertain those factors which should be considered in placing a person in the different levels of long term care. The Determination of Need Task Force has the responsibility for determining what specific long term care needs exist in the Commonwealth.

Since their inception, the two task forces have met approximately once every four weeks, with the full study group meeting about once every six weeks. While the Subcommittee commends DHR, particularly the Center for Comprehensive Health Systems Development in the Bureau for Health Services, for initiating the action to form this group, it believes that a full time commitment needs to be made by those undertaking such a study arrangement. The Subcommittee's strong conviction is that permanent and full time staff are immediately needed to plan, coordinate, implement, and monitor all the Department's long term care efforts.

The Long Term Care Multi-Agency Study Group has itself documented the fact that priority should be given to the Department's involvement in long term care. Some of the findings are:

1. There are no standards developed by which the long term care planning process can be evaluated.

2. Data concerning long term care is inaccessible, uncoordinated, and inadequate. Thus, there is a lack of pertinent data to aid in the decision making process.

3. Data collection and analysis relative to long term care is not coordinated among the Bureau for Health Services, Bureau for Social Insurance, Bureau for Social Services and the Office for Administrative Services.

4. No mechanism exists to assure on-going inter-agency exchange of data and information.

5. A maze has been created of field manuals, regulations, and legislation pertaining to long term care and agency responsibilities.

6. No criteria has been established pertaining to the maintenance of an individual in his own home as opposed to a nursing home.

7. The true needs of the Commonwealth's citizens for long term care is not known. (DHR, Long Term Care Status Report, unpublished data, July, 1977)

The Subcommittee concludes that sufficient evidence has been found to document that the present manner in which the Department for Human Resources is organized to respond to nursing homes, nursing home patients and other dimensions of long term care in the Commonwealth is extremely fragmented, inappropriate and nonproductive.

CHAPTER VI

AUXILIARY AGENCIES AND NURSING HOMES

In addition to the involvement of the U. S. Congress; U. S. Department of Health, Education and Welfare; and the Kentucky Department for Human Resources, there are several auxiliary agencies or entities located in the Commonwealth which also have significant responsibilities pertaining to nursing homes and their patients. Some of them, the Certificate of Need and Licensure Board and the Health Systems Agencies, have already been mentioned for the significant relationship that they have with nursing homes and other long term care services. (See Chapter III.) There are others such as the Kentucky Board of Licensure for Nursing Home Administrators, Lexington-Fayette County Health Department, Louisville-Jefferson County Health Department, and the Kentucky Peer Review Organization, which also merit discussion for their involvement with nursing homes.

Kentucky Board of Licensure for Nursing Home Administrators

The Kentucky Board of Licensure for Nursing Home Administrators is, as its title suggests, responsible for the licensure of nursing home administrators. This means that persons who perform the role of a nursing home administrator in an intermediate care or skilled nursing facility must be licensed by the Board. Persons who act as administrators in personal care homes do not have to obtain a license.

The 1970 General Assembly enacted KRS 216A.070, which vests the Board of Licensure for Nursing Home Administrators with the responsibility to

> develop, improve, and enforce standards which must be met by individuals in order to receive a license as a nursing home administrator which standards shall be designed to insure that nursing home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as nursing home administrators. (KRS 216A.070)

The Board itself is composed of nine members appointed by the Governor. These members are chosen from a variety of groups such as physicians, hospital administrators, allied health professionals, nursing home administrators, and interested citizens. The Secretary of the Department for Human Resources is an ex officio member of the Board.

As a result of this 1970 law, all nursing homes at the intermediate care and skilled nursing facility levels of care must have a licensed nursing home administrator in their employment. Statutory qualifications for becoming a licensed nursing home administrator include:

1. Be at least 21 years of age;

2. Be a citizen of the United States or have declared intent to become a citizen of the United States;

3. Provide proof satisfactory to the Board that he or she is of good moral character;

4. Pass an examination administered by the Board; and

5. Meet such other requirements as may be established by the Board, provided that such requirements are uniform and are applied to all other applicants for a license. (KRS 216A.080)

More specific requirements for obtaining a license to become a nursing home administrator are set forth in the Kentucky Administrative Regulations as follows:

(1) Establish a bona fide residency or express an intent to reside in Kentucky, unless employed by a health care facility located in Kentucky.

(2) (a) Have satisfactorily completed a course of study or have been awarded a baccalaureate degree; and have six (6) months continuous management experience in a health care facility within three (3) years from the date of application. Said management experience shall include at least partial responsibility for personnel management, budget preparation, and fiscal management and public relations, or

(b) Have satisfactorily completed at least sixty-four (64) college semester hours and one (1) year of continuous management experience in a health care facility within three (3) years from the date of application. Said management experience shall include at least partial responsibility for personnel management, budget preparation, and fiscal management and public relations.

(3) Pay a license fee of $100 at the time of application, $75 of which shall be refunded in the event the applicant is not subsequently licensed. (201 KAR 6:010)

Persons who perform the functions of a nursing home administrator in a personal care home must meet the following qualifications:

(a) The administrator must have sufficient education to maintain adequate records, submit reports requested by the board and interpret any written material related to all phases of home operation and resident's care.

(b) The administrator must be over twenty-one (21) years of age and shall present a certificate that he/she is in good physical and mental health, and is free from communicable disease. The administrator should be a person of integrity and good character, and have a liking for older people.

(c) The administrator or other individuals connected in any capacity with the home shall not receive any compensation for acting as a guardian or committee for a resident of the home. (902 KAR 20:030)

Administrators of personal care homes do not have to regularly attend training courses as do administrators of family care homes. Thus, it seems inconsistent for state administrative regulations to require an administrator of a family care home (composed of no more than three residents) to attend at least one DHR sanctioned training program per year and not have the same requirement instituted for administrators of personal care homes (composed of three or more residents and sometimes including 100 or more residents).

Given the fact that there are a number of vulnerable mentally retarded, developmentally disabled, and mentally ill persons in personal care homes whose care is paid for by the state and federal governments, it would seem appropriate to also require administrators of these facilities to have demonstrated some ability to meet the needs of this resident population. The present state administrative regulations do not require that this be done.

Lexington-Fayette County Health Department

Duties and Functions

The Lexington-Fayette County Health Department is actively involved with nursing homes and nursing home patients, perhaps more so than any other local health department in the Commonwealth. Their nursing home program (Division of Long Term Care) which began in 1973 enforces local standards and regulations which pertain to family care homes, personal care homes, intermediate care facilities for the mentally retarded, skilled nursing homes, and nursing homes as defined in 902 KAR 20:047. (Committee Testimony, February, 1977)

The Lexington-Fayette County Health Department is staffed by an MSW social worker, two registered nurses, one nutritionist, a health environmentalist and a consulting physician and provides a variety of services to both nursing home patients and nursing home operators. Some of these services include (1) implementing a monitoring system of nursing homes to ensure that standards are being met regarding medical care, nutrition, and the physical environment; (2) receiving and investigating complaints; (3) assisting in the placement of individuals into nursing homes; (4) providing staff training to facility operators; and (5) providing college students with practical experiences in the field of gerontology.

The Lexington Health Department promulgates its own regulations for all the different levels of care and is the only local health department in the state to do this. Thus, nursing homes in this community must meet these local standards as well as those promulgated by the Commonwealth's Certificate of Need and Licensure Board before they will be allowed to operate.

The regulations issued by the Lexington Health Department generally coincide with the state administrative regulations pertaining to nursing homes except that they are more specific and stringent in their requirements with respect to personnel and staff, medical supervision of patients, dietary services, pharmaceutical services, and enforcement provisions.

Inspections of nursing homes by the Lexington Health Department are made on an unannounced basis. These inspections are in addition to the ones performed by the Division for Licensing and Regulation in the Department for Human Resources. The Lexington Health Department has closed five nursing

homes in the four years that its nursing home inspection program has been in operation.

The Health Department also receives and investigates complaints. During fiscal year 1975-76 it received 34 complaints against nursing homes. Ninety-five percent of them were found to be either partially or fully justified. (Committee Testimony, February, 1977) The following complaint cases exemplify the types of problems that the Lexington-Fayette County Health Department investigates:

Complaint Example 1

Type of Facility: Skilled Nursing Facility

Person Making Complaint: Social Worker

1. The patients' clothing were soiled.
2. One patient in a wheelchair observed with bottom torso exposed.
3. Urine odors present.
4. Floors and hallways were cluttered, sticky, and generally messy.
5. No activities for the patients.

Findings:

1. One wing of the facility found messy and cluttered.
2. Wheelchair patients were not exposed.
3. Several suction machine bottles and urine bags were found not emptied.
4. Patients complained of noon meal being cold.
5. Seven patients stated that little activity had been provided during the day.

Evaluation: Complaint was justified.

Action:

Director of Nursing was contacted and she stated she would correct deficiencies.

Complaint Example 2

Type of Facility: Skilled Nursing Facility

Person Making Complaint: Relative of a Patient

Nature of the Complaint:

On several occasions the relative observed the patient lying in wet linens, frequently not bathed. The food was reported being served cold. The evening meal was often weiners and grits. The nursing staff did not respond to requests for assistance.

Findings:

The complaint was consistent with others received during the same time period. Complaint could not be verified because violations take place at varying intervals.

Action:

Complainant was advised to discuss problems with the Administrator of the home.

Complaint Example 3

Type of Facility: Skilled Nursing Facility

Person Making Complaint: Relative of patient

Nature of Complaint:

One patient was observed lying in her urine for 5 1/2 hours. The patient was not cleaned up and was fed cold food hurriedly. Male patients were seen unclothed, and one patient was observed eating his own feces.

Findings:

On the day the complainant saw the referenced problems, it was found that there were two nursing aides and a nurse on duty. The Director of Nurses stated this was inadequate -- four aides and one nurse are needed. She added that they needed more staff, but couldn't find any. At the time of our visit, no patients were unclothed or soiled.

Evaluation: The complaint was justified.

Action: Continue with routine visits.

Complaint Example 4

Type of Facility: Skilled Nursing Facility

Person Making Complaint: Relative of a Patient

Nature of Complaint:

The complainant's father had been a patient in the facility, then hospitalized, and subsequently died. Checks were reportedly given to the facility and placed in the home's Trust Fund without the patient's signature. The complainant felt that this was unfair and that she had not received answers to her questions from the facility.

Findings:

The complaint was referred to the Department for Human Resources.

Complaint Example 5

Type of Facility: Skilled Nursing Facility

Person Making Complaint: Family of a Patient

Nature of the Complaint:

Patient was admitted to the home alert and responsive. The patient soon became stuporous and it was necessary to restrain her. The family discovered the patient was receiving large dosages of Dolmane and Valium. Patient was transferred to another home: physician found patient severely impacted and with lesions of lower limbs and trunk. Several discrepancies were found on the pharmacy billing from the first home.

Action:

The family notified the Food and Drug Administration of drug problems and obtained a court order to have the medical records released from the home.

The pharmacy and medical record consultants from the Division for Licensing and Regulations were notified for investigation and follow-up.

Synopsis of Problem

The Lexington-Fayette County Health Department reported that during fiscal year 1975-76 it made 279 routine inspections to 16 nursing homes at the personal, intermediate, and skilled levels of care. At the end of fiscal year 1975-76 it found that:

1. Seven of the 16 nursing homes did not consistantly meet environmental health standards.

2. Sixteen of the 16 nursing homes did not consistantly meet medical care standards.

3. Eight of the 16 nursing homes did not consistantly meet nursing care standards.

4. Five of the 16 nursing homes did not consistantly meet nutrition standards.

5. Six of the 16 nursing homes did not consistantly meet social standards. (Committee Testimony, November 1977)

The staff of the Health Department suggested several possible reasons for the deficiencies to continuously exist.

1. Nursing home staff members are poorly motivated due to low job status, low financial return, lack of supervision and training, and inadequate staffing.

2. Administrators often do not want to make changes that require financial expense.

3. Physician services are not sufficient to meet the need.

4. Patients are placed at inappropriate levels of care by relocation personnel who are unable to find suitable vacancies at the correct level of care.

5. Supervisory personnel are not always held accountable for job performance and are not well informed of regulatory requirements.

6. Nursing staff are poorly trained in supervision and gerontological nursing standards.

7. There is a rapid turnover of nursing personnel due to low job status and low financial return.

8. Minimum staffing does not allow staff time for patient socialization outside of routine care.

9. Volunteer programs are minimal and available programs do not always function during the summer months.

10. Few educational opportunities are available for operators and staff. (Committee Testimony, November, 1977)

Louisville-Jefferson County Health Department

The Louisville-Jefferson County Health Department has three full-time staff members, two sanitarians and a registered nurse, who provide regulatory supervision for all nursing home type facilities in Jefferson County. A minimum of four unannounced inspections are annually conducted at all levels of care. These nursing homes are surveyed for their compliance with the regulations promulgated by the Certificate of Need and Licensure Board.

The staff of this Health Department provide consultative services to the owners and operators of nursing homes in the area of management, hygiene, and overall patient care. They also assist families and persons needing placement to locate a facility that meets the need in terms of facility type, financial requirements, and adequacy of care.

The Louisville-Jefferson County Health Department reported that during its inspections of nursing homes the following problems were frequently found to exist.

Frequent Problems

Problems common to all facilities are:

1. There is a constant turnover in staff which results in periods of understaffing, causes errors in treatment and medication, and intensifies the need for more frequent in-service training.

2. Poorly qualified personnel work in the areas of food planning, charting and administration of care needs.

Problems in Personal Care Homes

1. Non-professionals are not adequately instructed on charting, cards, and record keeping.

2. There is a tendency to cut costs by reducing quality and quantity of food for residents. Health Department personnel constantly check for proper and adequate diet.

3. Trash and garbage are handled improperly.

Problems in Intermediate and Skilled Care Homes

1. Physician's orders and visits are not kept up to date on residents' records.

2. Non-professionals perform professional duties.

3. Persons who feed patients do not always do it properly with warm, edible food and within a reasonable time.

4. Phone-in physician's orders are not always signed in the allotted time.

5. Employee health records are not always kept current. The Health Department is not always provided a current employee list.

6. Odor is not adequately controlled. Workers are not always aware of new methods for odor control. When appropriate, the removal of carpeting must be advised. (Committee Testimony, March, 1977)

The Health Department also receives and investigates complaints against nursing homes. It reported that between January, 1976 and March 1977, 24 complaints were received. Six of these, or 25% were discovered to be valid. The Louisville-Jefferson County Health Department forwards copies of its inspection reports and complaints which it receives to the Division for Licensing and Regulation in DHR.

Kentucky Peer Review Organization

The Kentucky Peer Review Organization, established in 1976 under the authority of Public Law 92-603, will likely be intimately involved with nursing homes and nursing home patients in the near future. This organization, independent of state government, is funded and monitored by the U. S. Department of Health, Education and Welfare. It was created to assure the medical necessity, quality, and appropriate utilization of institutional health care services provided to beneficiaries of the Medicare, Medicaid, and Maternal and Child Health Program. (Public Law 92-603)

Since its inception, the Kentucky Peer Review Organization has been primarily involved in performing utilization review of health care services in acute care hospitals. However, the organization reports its efforts are likely to be expanded in May, 1978, to include the responsibility for assessing the quality and appropriateness of care to Medicaid and Medicare recipients in intermediate care and skilled nursing facilities. (Interviews with KPRO Officials, 1977) As was previously discussed, the Division for Medical Assistance in the Department for Human Resources is currently performing the utilization review for intermediate care facilities, with skilled nursing facilities recently being allowed to do their own utilization review on a trial basis. Therefore, with the implementation of the Kentucky Peer Review Organization nursing home utilization review program, the Division for Medical Assistance will only be involved in utilization review to the extent of periodically assessing the quality and adequacy of the reviews which are done by the Kentucky Peer Review Organization.

Additionally, the Kentucky Peer Review Organization will make a significant contribution to the collection of long term care data. This will be done through medical care evaluation studies. These studies are a type of retrospective medical review in which an in-depth assessment of the quality and utilization of health care services is made. Each intermediate care and skilled nursing facility will be required to complete at least one medical care evaluation study per year and will follow the guidelines that are issued by the Kentucky Peer Review Organization. The essential characteristics of medical care evaluation studies are outlined below:

(a) Focus is upon a known or suspected problem area impacting on the quality of health care.

(b) Focus is on a well defined topic and is carried out in accordance with objectives explicitly stated in, and specifically developed for, the study.

(c) Written criteria is utilized against which actual patterns of health care practice are compared.

(d) Data on a sample of patients is collected, the size and composition of which is appropriate to the study topic and objectives. The study identifies patterns of care related to the subject under study and is not generally concerned with individual patients or payment. Therefore, the sample should be drawn from all patients in the institution and not be limited to Titles V, XVIII, and XIX patients.

(e) Thorough peer analysis is made of the reasons for any discrepancies between the written criteria which reflect optimal achievable health care practices and the data collected on actual health care practices to determine whether variations are objectively justifiable or represent problems that require corrective action.

(f) Specific written recommendations are made to individuals, the governing body of the facility or committees who are responsible for assuring the quality of care in the institution, and to those who are responsible for effecting changes in health care practices, either through appropriate continuing health education activities, through changes in the organization and administration of health

care delivery, or through other means appropriate to the deficiencies identified by the study. The purpose of the recommendations is to improve the quality of care and promote more effective and efficient utilization of facilities and services.

(g) Documentation is made regarding when, where, and by whom the recommended actions were implemented.

(h) A plan for follow-up evaluation is made to determine what changes have occurred as a result of actions recommended pursuant to subparagraph (f) to correct specific deficiencies identified by the study.

(i) A follow-up evaluation when necessary, to be completed in a reasonable time, but usually no later than one year following the performance of the initial study. The follow-up evaluation is limited to relevant key indicators which will reflect the effectiveness of the actions recommended.

(j) At least periodic reporting of a summary of the quality of assurance activities is made to the governing body of the long term care facility to assist the body in meeting its public responsibility to assure the provision of quality care in its institution. If results of a study require specific action, such results of the particular study must be reported to the governing body. (Kentucky Peer Review Organization, Draft Guidelines, 1977)

Finally, since one of the expressed objectives of the Kentucky Peer Review Organization is to assure that services provided to Medicaid and Medicare patients in intermediate care and skilled nursing facilities meet professionally recognized standards of quality, there may be some overlapping of responsibility with DHR's Division for Licensing and Regulation. Presently, this Division has responsibility for monitoring the quality of care given by all nursing homes in the Commonwealth. The possibility also exists that the Kentucky Peer Review Organization will become involved in the receipt and disposition of complaints which are made against nursing homes. Again, this is another of the responsibilities of the Division for Licensing and Regulation.

Thus, although the final implementation plans are yet to be approved by HEW, it is the understanding of the Subcommittee that the Kentucky Peer Review Organization has the potential to become significantly involved with long term care in Kentucky. Further, it is the Subcommittee's hope that the Kentucky Peer Review Organization will be properly integrated with the other components of the long term care network in the Commonwealth so that a further fragmentation of effort does not take place.

Summary

This chapter has discussed those auxiliary agencies or entities which have nursing home related functions that are not directly connected to the Kentucky Department for Human Resources. These include the Kentucky Board of Licensure for Nursing Home Administrators, Lexington-Fayette County Health Department, Louisville-Jefferson County Health Department, and the Kentucky Peer Review Organization. Two other auxiliary entities, the Certificate of Need and Licensure Board and the Health Systems Agencies, have previously been mentioned for the important role they have in the delivery of long term care services within the Commonwealth.

The Board of Licensure for Nursing Home Administrators bears a great deal of responsibility for the quality of nursing home administrators in Kentucky. Unfortunately, a licensed nursing home administrator is only required for intermediate care and skilled nursing facilities. A licensed nursing home administrator is not required for the personal care home. Nor is the person who functions in the role of an administrator in a personal care home required to attend and complete successful training courses on an annual basis. This is in contrast to the administrators of the family care homes, a lower level of care, who, though not licensed, have to attend annual training programs approved by the Department for Human Resources. (902 KAR 20:040)

It is the Subcommittee's belief that the qualifications of persons who act as administrators of personal care homes need to be strengthened to insure that these individuals are capable of administering to the needs of their residents. Presently, there is no requirement that administrators or staffs of personal care homes be knowledgeable about the kinds of problems that are often associated with persons who are mentally retarded, developmentally disabled, or mentally ill. Yet, there are a number of these individuals who are already in personal care homes and an equally substantial number who will eventually be placed in one of these facilities from state psychiatric hospitals and mental retardation centers. (See Chapter IV.)

Other auxiliary entities which are involved with long term care are the local health departments in Lexington and Louisville. Lexington is probably the most active health department in long term care matters, having promulgated its own regulations regarding nursing home standards of care.

Nursing homes in Lexington must abide by at least two and possibly three regulatory standards before they are allowed to do business. They must first meet state regulations in order to obtain a license; then local regulations must be followed; and finally, Medicaid and Medicare regulations must be adhered to by those intermediate care and skilled nursing facilities participating in these programs.

Both the Lexington and the Louisville health departments perform unannounced inspections of nursing homes in addition to the surveys conducted by the Division for Licensing and Regulation in DHR. Lexington conducts at least annual unannounced inspections of all nursing homes. The Louisville-Jefferson County Health Department performs unannounced inspections of all nursing homes every four months. Each health department also receives and investigates complaints made about nursing homes. Lexington reported that during fiscal year 1975-76, 46 complaints were received and 95% of them were found to be either partially or fully justified. Louisville, on the other

hand, received and investigated 24 complaints between January, 1976 and March, 1977, and only 25% were found to be valid.

The final auxiliary entity discussed in this chapter was the Kentucky Peer Review Organization. This organization, in the near future, is likely to play an important role in long term care in Kentucky. Expected to begin its formal operations with respect to nursing homes in May, 1978, the Kentucky Peer Review Organization will be responsible for assuring the medical necessity, quality, and appropriate utilization of institutional health care services provided to beneficiaries of the Medicare, Medicaid, and Maternal and Child Health programs. This means that the Kentucky Peer Review Organization will be involved in assessing the quality and appropriateness of care to Medicaid and Medicare recipients in intermediate care and skilled nursing facilities.

Other related long term care responsibilities of the Kentucky Peer Review Organization will include the collection of pertinent data through medical care evaluation studies. These studies of patients and their utilization of nursing homes should provide useful and much needed information to those persons who participate in the Commonwealth's long term care decision making and resource allocation process.

While it is not under administrative control of state government, the Subcommittee believes that DHR and the Kentucky Peer Review Organization should establish formal linkages. The Kentucky Peer Review Organization will replace the functions now held by DHR's Division for Medical Assistance in performing the utilization review of Medicare and Medicaid recipients in intermediate care and skilled nursing facilities. Subsequent to performing a utilization review, the Kentucky Peer Review Organization will have to report to the Department its findings and recommendations on each respective Medicaid and Medicare recipient.

It also appears likely that the Kentucky Peer Review Organization will need to work closely with DHR's Division for Licensing and Regulation with respect to monitoring the quality of care and the receipt and disposition of complaints which are made against intermediate care and skilled nursing facilities.

One of the primary purposes of the Kentucky Peer Review Organization is to assure that Medicare and Medicaid recipients in intermediate care and skilled nursing facilities receive treatment which is appropriate and meets professionally recognized standards of quality. It has been noted that the Department for Human Resources has much the same mission. It would seem, then, that coordination of nursing home activities between the Kentucky Peer Review Organization and those of the Department would be essential if either is to accomplish its tasks in the best interest of the people.

Clearly, there are a number of state, federal, and private entities or agencies in the Commonwealth that have different areas of responsibilities which pertain to nursing homes and their patients. Presently, there is no established mechanism which coordinates and monitors all of them. As had been stated, the Subcommittee strongly believes that designated and accountable leadership in the long term care field in Kentucky is necessary if appropriate and professional long term care services are to be provided.

CHAPTER VII

RESIDENT RIGHTS: STATE AND FEDERAL REGULATIONS

State and federal regulations are intricately involved with nursing homes and nursing home patients. Each level of nursing home care has regulations which require the nursing home to operate by certain standards. Intermediate care and skilled nursing facilities must meet the demands of the federal regulations if they choose to participate in the Medicare or Medicaid programs. However, nursing homes at all levels of care, including personal care homes, must be in compliance with state regulations in order to be licensed and thus allowed to do business in Kentucky.

These state and federal regulations cover a broad range of requirements and vary according to the particular level of care. (There are no federal regulations for personal care homes.) Some of the regulations have already been discussed in previous chapters. The Subcommittee discovered during its study that a thorough analysis of each state and federal regulation which relates to nursing homes would not be feasible. Thus, the Subcommittee has only addressed those state and federal requirements which it feels warrants immediate attention. However, one area in the state and federal nursing home regulations which has not been discussed and which is of the utmost concern to the Subcommittee pertains to the rights of residents in nursing homes.

Residents' Rights

State and federal regulations relative to residents' rights in nursing homes have significant implications for nursing homes, nursing home residents, and the families of persons in nursing homes. Depending on the degree of comprehensiveness and clarity of the regulations, nursing homes can be more or less accountable for insuring that residents' rights are upheld.

The present state regulations regarding residents' rights differ in their coverage among the three levels of care. Table 23 compares the residents' rights which are included in the Kentucky Administrative Regulations for personal, intermediate care, and skilled nursing facilities.

As can be seen in Table 23 rights of nursing home residents are not consistently uniform in the state regulations throughout all the levels of nursing home care. Federal regulations concerning residents' rights apply to Medicaid and Medicare recipients who reside in nursing homes. Nearly 98% of the intermediate care facilities and 89% of the skilled nursing facilities in Kentucky are certified for Medicaid or Medicare reimbursement. Thus, a substantial number of these facilities must also adhere to the residents' rights which are established in the federal regulations. However, these federal regulations are not necessarily adequate for the resident or the facility.

Personal care homes and those intermediate care and skilled nursing facilities which are not certified for Medicaid or Medicare are not covered

Table 23

RIGHTS OF NURSING HOME RESIDENTS, BY LEVEL OF CARE, AS DEFINED BY KENTUCKY ADMINISTRATIVE REGULATIONS, 1977

RIGHTS	PERSONAL CARE HOMES (902 KAR 20:030 & :035)	INTERMEDIATE CARE FACILITIES (902 KAR 20:050 & :055)	SKILLED NURSING FACILITIES (902 KAR 20:025)
1. Before admission, the resident, his family, and/or guardian is fully informed in writing of services available at the facility (including resident's rights and responsibilities).	"Upon admission the resident and a responsible member of his family or committee shall be informed in writing of the established policies of the home in regards to fees, reimbursements, visitation rights, services rendered, etc."	"Facilities are required to have available a written statement of objectives, goals and policies which shall include a statement of rights of its patients and its relationship to their surrogates." No provision for fully informing a resident, his family, and/or guardian of services available and resident's rights before admission.	"Information describing the care and services provided by the facility shall be accurate and not misleading. "No provision" for informing, in writing, residents, their families and/or guardian of services available and resident's rights before admission.
2. Resident, his family and/or guardian is fully informed prior to or at the time of admission and quarterly during his stay, of all service charges in the facility.	"Resident and a responsible member of his family must be informed at the time of admission of service charges", but not thereafter.	No provision.	"There shall be appropriate written policies and procedures relating to notification of responsible persons in the event of significant changes in patient status, patient charges, billings and the related administrative matters." No written requirement for the residents, their families, or guardians to be fully informed prior to admission and quarterly thereafter of all service charges of the facility.
3. Resident is transferred or discharged only for medical reasons or his own welfare or that of the other patients or for non-payment, except where prohibited and reasonable notice for such action is given to the resident and/or his representative.	"A persistently disturbed and unmanageable resident must be transferred to an appropriate facility within a period of time not to exceed five (5) days." No provision for giving a reasonable notice of such action to resident or his representative.	"As validated changes occur which would enable the resident to function in a less structured and restrictive environment, the facility shall offer assistance in making arrangement for patients to be transferred to facilities providing appropriate services and the less restrictive environment cannot be offered at the facility. Except in an emergency, the patient, his next of kin, the attending physician and the responsible agency, if any, are consulted in advance of the transfer, release, or discharge of any patient.	"There shall be appropriate written policies and procedures relating to notification of responsible persons in the event of significant changes in patient status, patient charges, billings, and other related administrative matters. Patients shall not be transferred or discharged without prior notification of next of kin or sponsor.

Table 23 (contd.)

RIGHTS	PERSONAL CARE (902 KAR 20:030 & :035)	INTERMEDIATE CARE FACILITIES (902 KAR 20:050 & :055)	SKILLED NURSING FACILITIES (902 KAR 20:025)
4. Written policies defining procedures for submission of complaints and recommendations to the facility administration and DHR if necessary. Such policies shall be conspicuously displayed throughout the facility.	"A written procedure shall provide for an effective means of resolving grievances of residents. This procedure will assure that grievances and complaints of residents will be conveyed within a reasonable time to a decision making level which has the authority to take corrective action."	No provision.	No provision.
5. Resident is encouraged and assisted, throughout his period of stay to exercise his rights as a resident and as a citizen.	No provision.	No provision.	No provision.
6. Resident if free from mental and physical abuse.	"No form of punishment shall be meted to any resident of a home."	No provision.	No provision.
7. Confidential treatment of residents' personal and medical records.	No provision until resident dies or is discharged.	"The facility shall develop and maintain a system of records retention and filing to insure completeness and prompt location of each patient's records. These records shall be the property of the facility and shall be held confidential."	"All information contained in the clinical records shall be treated as confidential and shall be disclosed only to authorized persons."
8. Resident is free from physical or chemical restraint except as authorized in writing by a physician for a specified period of time.	No form of restraints shall be used except under written order of the attending physician and shall be comfortable and easily removed in case of fire. No limit stated as to how long restraints may be used.	"Restraints can be used if ordered by the attending physician. In emergencies, restraints can be used temporarily, never to exceed 12 hours. Restraints refer to those devices utilized to confine a patient that has become unmanageable, thus requiring restraints as protection against self-endangering acts to other patients or staff."	No provision.

Table 23 (contd.)

RIGHTS	PERSONAL CARE (902 KAR 20:030 & :035)	INTERMEDIATE CARE FACILITIES (902 KAR 20:050 & :055)	SKILLED NURSING FACILITIES (902 KAR 20:025)
9. Resident may manage his personal financial affairs. If facility accepts this responsibility, proper accounting and monitoring is made of residents' personal funds and other possessions.	"Care shall be taken to safeguard the resident's personal belongings and clothing."	"The facility shall keep records of any personal money, regardless of source, or valuables kept by the facility for a patient. When purchases are made for a patient from personal monies, proper accounting shall be made. A written account available to patients and their families is maintained on a current basis for each patient with written receipts for all personal possessions and funds received by or deposited with the facility and for all disbursements made to or on behalf of the patients."	No provision.
10. If resident is married, privacy is assured for spouses' visits and if both are patients in the facility, they are permitted to share a room unless medically contraindicated and documented by a physician.	No provision.	No provision.	No provision.
11. Mechanism established for a resident to participate in the planning of his care while a resident of the facility.	No provision.	"The resident and his family will be included, whenever possible, in the planning and participation of activities and therapeutic recreation at the facility."	"The nursing care plan shall be a personalized daily plan for individual patients. It shall indicate what nursing care is needed, how it can best be accomplished for each patient and how the patient likes things done..."
12. Resident is not required to perform services for the facility.	No provision.	No provision.	No provision.

Table 23 (contd.)

RIGHTS	PERSONAL CARE (902 KAR 20:030 & :035)	INTERMEDIATE CARE FACILITIES (902 KAR 20:050 & :055)	SKILLED NURSING FACILITIES (902 KAR 20:025)
13. Resident is free to communicate and associate with people of his choice.	Residents shall not be denied visitation rights, the right to a degree of privacy, nor choice of spiritual affiliation.	"Visitors shall be permitted for each patient. Provision shall be made for privacy with his visitors."	"Visiting hours shall be flexible and posted to permit and encourage visiting friends and relatives."
14. Resident is free to receive his mail unopened except when medically contraindicated and documented in writing by his physician.	"A resident's correspondence shall not be opened except as authorized by the resident, his guardian, committee or family."	"Each resident shall be permitted to send and receive mail. His mail shall be delivered to him unopened unless the resident's physician has requested in writing that the mail be reviewed. His outgoing mail shall not be censored."	No provision.
15. Resident may retain use of personal clothing, unless medically contraindicated or unless it would infringe upon the rights of others.	"Residents shall be suitably dressed at all times and given assistance when needed in maintaining body hygiene and good grooming."	"Residents are encouraged to be dressed in their own clothing whenever possible (unless otherwise indicated by the physician). This should be street clothes and shoes."	No provision.
16. No responsible resident is detained against his will.	"No responsible resident is detained against his will."	"Residents shall be permitted to go outdoors and leave the premises as they wish to visit, shop, attend church, see a movie, attend a social function, or for any similar reason, unless a legitimate reason can be shown for refusing such activity."	No provision.
17. Right to choose religious affiliation.	"Residents shall not be denied the choice of spiritual affiliation in worship."	"Residents shall be assisted and/or permitted to attend religious services if he desires. Requests from a patient to be seen by a clergyman are acted upon as soon as possible."	"Residents who are able and wish to do so are assisted to attend religious services. Patients' request to see their clergyman shall be honored and space shall be provided for privacy during visits."

Table 23 (contd.)

RIGHTS	PERSONAL CARE (902 KAR 20:030 & :035)	INTERMEDIATE CARE FACILITIES (902 KAR 20:050 & :055)	SKILLED NURSING FACILITIES (902 KAR 20:025)
18. Privacy.	"Resident has a right to a degree of privacy. In multi-bed rooms, a method of assuring visual privacy for each resident shall be provided."	"A method of assuring visual privacy for each patient shall be provided in each multi-bed patient room and in tub, shower, and toilet rooms."	"Cubicle curtains or equivalent built in devices for complete privacy for each resident shall be established in multi-bed rooms."
19. Choice of physician.	"Arrangements will be made by the resident and his family or guardian or the facility for physician services for residents at the time of admission."	"The resident or guardian shall be permitted the choice of physician."	"To the extent possible, each patient or his sponsor shall designate a personal physician."
20. Listing of patient rights posted in conspicuous places throughout the facility.	No provision.	No provision.	No provision.
21. Return to legally authorized person any unused monies, personal properties, and the like from any resident in case of discharge, transfer or death.	No provision.	"The facility shall return to the patient his valuables, personal possessions, and any unused balance of monies from his account at the time of his transfer or discharge from the facility. In case of his death or for valid reasons when he is transferred or discharged, they shall be returned promptly to any legally authorized person."	No provision.

Table 23 (contd.)

RIGHTS	PERSONAL CARE (902 KAR 20:030 & :035)	INTERMEDIATE CARE FACILITIES (902 KAR 20:050 & :055)	SKILLED NURSING FACILITIES (902 KAR 20:025)
22. If resident is adjudicated incompetent in accordance with state law, then all the resident's rights also devolve to the resident's guardian or sponsor.	No provision.	No provision.	No provision.
23. At least semi-annual private meetings between licensing and regulatory surveyors and patients during inspections regarding their concerns on the quality of care given then by the facility.	No provision.	No provision.	No provision.

SOURCES: 902 KAR 20:025; 902 KAR 20:030; 902 KAR 20:035; 902 KAR 20:050; and 902 KAR 20:055, 1977

under federal regulations. State regulations pertaining to noncertified Medicaid/Medicare skilled nursing facilities are lacking concerning residents' rights. Thus, after reviewing state and federal regulations pertaining to residents' rights, it is the Subcommittee's conclusion that there should be certain rights which encompass all levels of nursing home care.

Table 23 helps to denote the rights of residents among the different levels of care that need to be further addressed by state regulations. Clearly, there are numerous instances in the present state regulations for nursing homes where there is no provision for certain residents' rights. Also, there are other state regulations currently in effect that the Subcommittee judges to be inadequate. Several of the areas pertaining to the rights of nursing home residents which need improvement are discussed below.

Examples of Rights of Residents in Nursing Homes Which Need Improvement

The Subcommittee feels that each resident, his family, and guardian should have the right to have clearly written policies established by a nursing home which will define the procedures for submission of complaints and recommendations to the facility's administration and the Department for Human Resources if necessary. Residents should also have the right to have notices of these written procedures conspicuously placed throughout the facility.

Presently, only personal care homes are required by state regulation to develop written procedures for resolving residents' complaints. However, they are not required to post these procedures in conspicuous places throughout the home. Intermediate and skilled nursing facilities are not required by state regulation to develop or implement any mechanism for resolving the complaints of residents.

The Subcommittee believes that since most residents of nursing homes are at particularly vulnerable and dependent stages in their lives, much more needs to be done to insure that the grievances of residents are properly heard and addressed. Therefore, the Subcommittee concludes that it would be in the best interest of the nursing home residents to require all nursing homes to adopt similar and effective policies for resolving the complaints by their residents. This should include conspicuously posting these procedures in the facilities. Along with this posted complaint resolution process, the residents, should be informed by conspicuously placed posters that they may contact the Department for Human Resources should they have a grievance relating to their care or the care of others in the nursing home.

The Subcommittee believes that if a resident is adjudicated incompetent in accordance with state law, then all the resident rights should also devolve to the resident's guardian or sponsor.

Presently, there is no provision in state regulations which would provide for the guardian of an incompetent nursing home resident to invoke the resident rights of his charge who is incapable of understanding his rights. The Subcommittee strongly urges that guardians be held accountable for monitoring the rights of their wards in nursing homes.

The Subcommitee feels that the resident, his guardian, and family should have the right to be informed of all service charges for which they are responsible prior to admission and quarterly during the length of a resident's stay at a nursing home.

State regulations now in effect do not require personal care homes, intermediate care, and skilled nursing facilities to quarterly inform residents, their guardians or families of all the service charges for which they are responsible during a resident's stay at the facility.

Personal care homes are required to inform residents, their families, and guardians of all service charges at the time of admission but are not required to do so on a regular basis thereafter. Skilled nursing facilities are mandated to develop appropriate written policies and procedures relating to notification of responsible persons when significant changes in patient status, patient charges, and billings occur.

No mention is made of notifying the resident, his family and guardian at the time of admission nor regularly during the resident's stay of the specific service charges which accrue. Similarly, there are no statutes or regulations which require residents, their families and guardians to be informed upon admission to an intermediate care facility or afterwards of the specific service charges that are incurred by the resident.

Since many of the residents of nursing homes are in dependent circumstances and therefore vulnerable to exploitation, the Subcommittee believes it appropriate to require all nursing homes to submit itemized bills to residents, their guardians and families on a quarterly basis. This would help to insure that the resident's money is being properly spent. For those nursing home residents whose care is paid for by the Medicaid and Medicare programs, quarterly itemized statements should be sent to the residents and their families and guardians for any service charges for which these government programs do not provide coverage. The service charges in a nursing home which are not reimbursed by Medicaid or Medicare must come from other sources and often this means the resident's or his family's personal funds.

The Subcommittee believes that residents should have the right to manage their personal financial affairs. If a nursing home accepts this responsibility, the resident should have the right to be assured that there will be proper accounting and monitoring of his personal funds and possessions.

The state regulations which pertain to nursing home residents' personal funds are set forth below.

Personal Care Homes

> Care shall be taken to safeguard the resident's personal belongings and clothing. (902 KAR 20:030 [9])

There is no regulation which specifies how this requirement is to be implemented.

Intermediate Care Facility

Administrative regulations for intermediate care facilities include a large number of requirements and safeguards not mandated for personal care homes. These regulations are:

> Care shall be taken to safeguard the resident's personal belongings and clothing. (902 KAR 20:030 [9])
>
> The facility shall keep records of any personal money, regardless of source, or valuables kept by the facility for a patient. When purchases are made for a patient from personal monies proper accounting shall be made. (902 KAR 20:050 [6])
>
> The facility shall provide and maintain an adequate system for identifying each patient's personal property and facilities for safekeeping of his valuables. A written account, available to patients and their families is maintained on a current basis for each patient with written receipts for all personal possessions and funds received by or deposited with the facility and for all disbursements made to or on behalf of the patient.
>
> The facility shall return to the patient his valuables, personal possessions and any unused balance of monies from his account at the time of his transfer or discharge from the facility. In case of death or for valid reasons when he is transferred or discharged they shall be returned promptly to any legally authorized person. (902 KAR 20:050[15])

Skilled Nursing Facility

There are no state regulations for skilled nursing facility residents' rights in the areas of personal possessions, clothing and money.

Sources of Residents' Personal Funds

The individual resident may obtain his personal funds from a variety of different sources. Medicaid residents residing in participating intermediate care and skilled nursing facilities who are also SSI recipients receive $25 per month for their personal needs, while SSI recipients in personal care homes currently receive $19.80 per month for their personal needs. This personal fund money is to be used by the resident or his legal representative as he deems necessary. Additional personal funds may come from Social Security benefits, veteran's benefits, disability compensation and contributions from relatives.

Federal Regulation Regarding Residents' Personal Funds

Federal regulations regarding nursing home residents' personal funds which are applicable to those intermediate care and skilled nursing facilities which participate in the Medicaid or Medicare program are:

Intermediate Care Facility

> (A resident) may manage his personal financial affairs and to the extent, under written authorization by the resident, the facility assists in such management that it is carried out in accordance with paragraph (A)(1)(iii) of this section. (45 CFR 249.12)
>
> A written account, available to residents and their families, is maintained on a current basis for each resident with written receipts for all personal possessions and funds received by or deposited with the facility and for all disbursements made to or on behalf of the resident. (45 CFR 249.12, (A)(1)(iii))

Skilled Nursing Facility

> (A resident) may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made in his behalf should the facility accept his written delegation of this responsibility for any period of time in conformance with state law. (20 CFR 405.112[K][6])

Problem Areas

It would not be unlikely for problems to emerge with the maintenance of a resident's personal funds by a nursing home in light of the varied state and federal regulations which have been promulgated on this subject. There is simply no uniform system that has been developed and which all nursing homes in the Commonwealth have been required to adopt regarding the maintenance of a resident's personal funds. The absence of such a system and the varied and sometimes nebulous ways in which current state and federal regulations address this issue causes the Subcommittee to question whether the personal funds of nursing home residents are being adequately safeguarded.

The United States General Accounting Office recently completed a study of how 30 nursing homes in 5 states manage residents' personal funds. They identified these major problem areas:

1. Discrepancies exist between residents' ledger balances and the bank accounts.

2. Medical supplies and services were being charged to patients' personal funds inappropriately.

3. Funds of deceased and transferred patients were being kept by the facilities.

4. Interest earned on patients' funds were being kept by the facilities.

5. There was some question as to the nursing home inspector's ability to determine whether a facility had properly implemented the policies and procedures for handling patients' funds.

6. More than 50% of the skilled nursing facilities did not provide patients with at least a quarterly accounting of their accounts as required by federal regulations. (U.S. General Accounting Office, Improvements Needed in Monitoring Patients' Funds, 1976, pp. 8-20)

This General Accounting Office report concluded:

> For the 30 institutions we visited in 5 States, we identified an average of 4 major and/or procedural deficiencies in the facilities' management of patients' unds. Because our selection of institutions for review was not based on any prior knowledge of facilities with deficiencies, we believe it is logical to conclude that the mismanagement of patients' funds in the custody of SNFs and ICFs participating in Medicaid is likely to be widespread. Further, because we found major deficiencies at all types of facilities (e.g., proprietary, private nonprofit, or public) we believe that none of the types could be considered any better or worse than any other type of facility. (U.S. General Accounting Office, Improvements Needed in Monitoring Patients' Funds, 1976, p. 14)

While the Interim Subcommittee on Long Term Care was not able to fully examine the status of residents' personal funds in Kentucky nursing homes, it does believe that the present state regulations on this issue need to be made more clear and specific so Kentucky can avoid or resolve the kinds of conditions that were found to exist in other states relative to the personal funds of their nursing home residents.

Chapter Summary

The absence of uniformity and preciseness of state regulations pertaining to the rights of residents in nursing homes serves little purpose except to create confusion among nursing home residents, their families and guardians, nursing home operators, and state inspectors of nursing homes. The Subcommittee believes that present state regulations on resident rights need to be clarified, strengthened and be made more consistent for all levels of nursing home care. Subsequently, the Subcommittee has developed a list of resident rights which it believes will be beneficial to all of those involved in Kentucky's long term care system. This list is included in Chapter IX.

Finally, it is the Subcommittee's judgment that more clearly defined and strengthened residents' rights cannot be considered as over-regulation. Rather, it is the Subcommittee's conclusion that the rights of Kentucky nursing home residents should be so well defined and meaningful that a misinterpretation of these rights is not possible. The citizens of the Commonwealth who are in nursing homes deserve nothing less.

CHAPTER VIII

A PERSONAL PERSPECTIVE

It has been the intention of the Subcommittee to collect as much hard data as possible regarding the present status of nursing homes and nursing home patients. The Subcommittee believes that it is necessary to share with the citizens of the Commonwealth a personal perspective of what it saw and experienced as a result of unannounced visits to 22 nursing homes in Kentucky. The Subcommittee recognizes that these personal views cannot necessarily be equated with cold statistics but they can be judged in the context of one human being observing the life conditions of another.

Personal Care Homes

Visits were made to personal, intermediate and skilled nursing facilities. Some facilities had multiple levels of care while others had just one. It was primarily in the homes which had only personal care beds that the Subcommittee found the most distressful situations.

With few exceptions, it was not unusual to enter a personal care home and see 20 to 30 residents silently sitting in chairs which were placed along the sides of the hallways. If they were not in the hallways, they were in day rooms sitting quietly and watching television or staring out a window. There was virtually no activity other than just sitting. There was little conversation among the residents themselves. To say the least, it was a pathetic sight.

As the Subcommittee walked down the halls, one could not help but notice the despair in these people's lives. The "future" seemed to mean little to them. It was as if they were living only by memory.

The physical surroundings within most of the personal care homes visited were drab and depressing. Most facilities were painted in shades of gray and brown. In general, there seemed to be little effort on the part of the facility to create an atmosphere of warmth and concern.

The physical maintenance of the personal care homes toured had the appearances of being recently improved but still left much to be desired. Most of the buildings which housed the personal care beds were old. Many appeared to have been converted from older homes and they generally did not present a well-cared-for appearance. Roaches were observed in the homes on several occasions. One resident commented that he had grown accustomed to the roaches which were running up and down the wall directly behind the chair in which he was sitting.

The Subcommittee discovered on one visit that a resident's bathroom had been boarded up and a dresser moved in front of it. The resident stated that rather than repair the plumbing fixtures in the bathroom, the operator had decided to prevent the bathroom from being used again.

It was particularly interesting in one personal care facility to compare the decor of the nursing home administrator's office with the rooms of the

residents. The administrator's office was blessed with plush shag carpeting, an executive desk with an accompanying chair, decorative bookshelves, attractive wall pictures, air conditioning and a stereo. However, three rooms down the hall were the residents' living quarters which had bare wooden floors, no air conditioning, bare walls and little furniture besides a bed and a night stand.

Other Levels of Nursing Home Care

Staff

In most of the nursing homes which were visited, the attitudes of the staff, particularly the aides, seemed apathetic and indifferent toward the residents, yet they had more daily contact with the residents than anyone else. Very rarely were nursing home staff observed to smile or exude any human affection. Rather, they went about their tasks stoically as if they were working on an automobile assembly line.

In too many of the nursing homes, the Subcommittee observed little respect for the residents as adults. They were often spoken to by staff in condescending tones. One particularly disturbing example of this occurred in a skilled nursing facility. Two members of the Subcommittee were observing how a complaint was investigated by a local health department. Upon arrival at the resident's room, the inspecting health officer asked the supervising nurse to turn the resident over on his stomach so that it could be seen if any decubitis ulcers (bed sores) existed as had been reported. The nurse responded gruffly, saying to the resident, "OK, Pops, let's turn over so we can see if you've got any sores on ya." The resident was found to have severe bed sores and also to have toenails that had grown to such a long length that they had become gnarled and twisted. This toenail condition was obviously causing the resident much pain as he cried out when the nurse removed his socks. Subsequently, the facility brought in a podiatrist to treat the resident's feet.

Another nursing home which had all three levels of care employed a personal care resident to operate an elevator and use the intercom system to alert the other residents when it was their turn to eat. The employed personal care resident called over the intercom: "Second floor, women walkers." Subsequently, all women on the second floor who could use walkers or canes to assist them in walking would line themselves up, in a single file, and wait by the elevator door until it opened. This process was repeated for three different floors and for "men in wheelchairs.", "men walkers.", and "women in wheelchairs." This occurred during breakfast, lunch and dinner.

Meals

The types of meals that were served residents varied from facility to facility. Some nursing homes had done a lot of work in preparing their meals. These meals were appealing and the residents appeared to enjoy them.

There were other nursing homes that had obviously spent little effort in their food preparation. The Subcommittee noticed a number of times that a plain hot dog, two slices of bread, some fruit and a cup of milk were all that was served.

Odor

Some nursing homes, as perhaps can be expected, have a particular odor which is unique to these facilities. This is especially true for intermediate care and skilled nursing facilities where some residents may be incontinent of urine and feces from time to time. However, the Subcommittee noticed in some of the intermediate care and skilled nursing facility instances where urine had been allowed to dry on the floor. When the Subcommittee members walked over these areas, their shoes would pick up some of this sticky substance.

The Subcommittee observed residents on several occasions in intermediate care and skilled nursing facilities who had their lower torsos exposed. These residents were wearing nothing more than a pajama top. It was explained by the nursing home staff in these facilities that the residents were so incontinent of urine and feces that it was not practical to fully dress them. Thus, some residents were sitting in wheelchairs in the corridors or in their rooms with the doors opened wearing no lower garments.

Mentally Retarded Residents

As has been mentioned, the Subcommittee has gathered data to show that a number of mentally retarded persons are placed in nursing homes each year and that these homes are not necessarily equipped to provide proper services. This was clearly evident in one intermediate care facility which the Subcommittee visited.

There were approximately 15-20 young, severely mentally retarded youngsters in one nursing home who were found lying closely next to one another on what resembled a wrestling mat. They were waiting to be fed. The aide who was spoon feeding these youngsters stated that they were placed on the floor to allow them more room to exercise. However, the children were placed so close together, they would have had more room to exercise in their own beds.

There were other mentally retarded residents in this facility who were hydrocephalic and totally blind. There was virtually no stimulation present and most of the residents just laid in their beds or were restrained in their chairs.

Inappropriately Placed Residents

Besides the mentally retarded who were placed in nursing homes, there were a number of other persons who seemed to be inappropriately placed for the level of care which was being provided. In one personal care home, there was a man approximately 80 years old who had only one leg. His other leg had been amputated up to his groin area. He moved around by scooting his buttocks about on the floor. It was later discovered by talking with other residents that this elderly man often had to sleep on the floor because no one would help him into his bed.

Lack of Privacy

There appeared to be little privacy for the residents in most of the nursing homes we toured. There were at least two to three residents per room and sometimes four. Doors were open to the rooms almost all of the time. There were cloth partitions in some of the homes, but generally there was little a resident could do to have some personal privacy.

Dental Care

Although there were no dentists on the Subcommittee, it was not too difficult to see that for the most part dental care had been a neglected area. Yellow and blackened teeth were not an uncommon occurrence. This problem was particularly evident at the personal care level.

Comments from the Residents

Before summarizing the experiences and perceptions on what took place during visits to the nursing homes in Kentucky, the Subcommittee believes it appropriate to note some of the comments that were made by the residents during their conversations with Subcommittee members.

The Subcommittee members had just entered one multi-level care facility and were walking down the hallway past several residents' rooms when the group heard a shout, "What the hell is this, a parade?" Needless, to say the Subcommittee members were taken aback and two members of the group stopped to talk with the elderly spokesman.

This very outspoken gentleman proceeded to inform the Subcommittee members that it could not find out what nursing home life is all about by walking up and down the hallways. He said the Subcommittee would have to spend at least a week in one in order to find out what it was really like. He then explained some of the frustrations that he and the others who lived there experienced as a result of having no money and no one to "actually give a damn whether you live or die." This gentleman's remarks are not likely to leave us for some time.

In another conversation with one elderly woman resident in an intermediate care facility, she was asked if the nursing home staff provided good care. She responded by saying, "Well, it's sort of like a game, if you're nice to them, they won't do you wrong, but you start complaining, and you're in trouble." This type of comment was echoed more than once during our visits.

Finally, there was one man in a personal care home who said he did not know who was paying for his care in the facility. This 65-year old man reported that "somebody from the welfare office got me in here since there was no place else for me to go." When asked how he liked the two roommates who were sharing the same room, he stated: "They're both crazy, they just got here a couple of weeks ago from that Western State place." Later, as our conversation was about to end, he was asked how he liked living in this facility. His response: "Well, it's better than being on the street."

A Final Note

The Subcommittee wishes to point out that those nursing homes which were visited were said by local representatives that coordinated our visits to be a cross section of the good, average, and bad nursing homes. Unfortunately, it is the personal judgment of Subcommittee members that more nursing homes are below average than are above it.

The visits which were made to 22 nursing homes were not pleasant experiences. There were occasions where it was difficult to eat or sleep after spending an entire day visiting the different facilities. Quite frankly, the meetings were not always looked forward to by the respective Subcommittee members.

Yet, the examination of nursing homes and the long term care system was long overdue. Too many vulnerable Kentuckians exist in nursing homes to be deserted now. Certainly, much more work needs to be done. It is, therefore, the earnest hope that this Subcommittee be reestablished after the 1978 Regular Session of the General Assembly for the purpose of following up on those areas in long term care which it was unable to address during this past interim. The Subcommittee sees the need and hopes that others will also.

CHAPTER IX

SUBCOMMITTEE RECOMMENDATIONS AND THEIR RATIONALE

Legislative Recommendation #1

(1) The General Assembly should enact legislation that would provide residents in all long term care facilities (family care homes, personal care homes, intermediate care facilities, skilled nursing facilities, intermediate care facilities for the mentally retarded/developmentally disabled, and nursing homes as defined by 902 KAR 20:047), with certain basic rights. These rights should include, but not be limited to, the following:

A. Before admission to a long term care facility, the resident, his family and guardian shall be fully informed in writing of all services available at the facility. The resident, his family and guardian shall also be informed in writing before admission of all residents' rights and responsibilities. Posters describing residents' rights shall also be conspicuously displayed throughout the facility.

B. The resident, his family and guardian shall be fully informed in writing prior to or at the time of admission and quarterly during his stay of all service charges for which the resident, his family and guardian is responsible for paying.

C. The resident shall be transferred or discharged only for medical reasons, or his own welfare, or that of the other residents, or for non-payment, except where prohibited by law or regulation. Reasonable notice of such action shall be given to the resident, his family, and his guardian.

D. All long term care facilities shall establish written procedures for the submission of complaints and recommendations. Such policies shall be conspicuously placed throughout the facility pending approval of their adequacy by the Department for Human Resources. The Department for Human Resources shall develop and distribute posters to all long term care facilities which clearly detail how the resident, his family, and guardian, or a visitor may make a written or oral complaint to the Department. These posters shall also be conspicuously displayed throughout each facility.

E. All residents shall be encouraged and assisted throughout their periods of stay in long term care facilities to exercise their rights as a resident and a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and to outside representatives of their choice, free from restraint, interference, coercion, discrimination or reprisal.

F. All residents shall be free from mental and physical abuse, and free from chemical and physical restraints except in emergencies and except as authorized in writing by a physician for a specified and limited period of time.

G. All residents shall have confidential treatment of their medical and personal records. Each resident, his guardian and family shall approve or refuse the release of such records to any individuals outside the facility.

H. Each resident may manage his personal financial affairs. If the facility accepts this responsibility in writing, proper accounting and monitoring shall be made of the resident's personal funds and possessions. This shall include giving quarterly itemized statements to the resident, his family and guardian for the transactions in which personal funds and possessions of the resident were received or disbursed. Each facility shall maintain a separate banking account for each resident's personal funds. The facility shall return to the resident his valuables, personal possessions, and any unused balance of monies from his account at the time of his transfer or discharge from the facility. In case of death or for valid reasons when he is transferred or discharged, the resident's valuables personal possessions and funds shall be promptly returned to the resident's family and guardian. The Department for Human Resources shall conduct an audit no fewer than every six months of the manner in which facilities are safeguarding resident's personal funds and possessions.

I. If a resident is married, privacy shall be assured for spouse's visits and if they are both residents in the facility, they may share the same room unless medically contraindicated and documented by a physician.

J. Every facility shall develop and implement a mechanism which will allow residents, their families and guardian to participate in the planning of the residents' care. Each resident shall be encouraged and provided assistance in the planning of his care.

K. Residents shall not be required to perform services for the facility that are not included for therapeutic purposes in their plan of care.

L. Residents may associate and communicate privately with persons of their choice and send and receive personal mail unopened, unless medically contraindicated (as documented by their physician in their medical records).

M. Residents may retain the use of their personal clothing, unless medically contraindicated or unless it would infringe upon the rights of others.

N. No responsible resident shall be detained against his will unless medically contraindicated by his physician and documented in his medical record. Residents shall be permitted and encouraged to go outdoors and leave the premises as they wish unless a legitimate reason can be shown and documented for refusing such activity.

O. Residents shall be permitted to participate in activities of social, religious, and community groups at their discretion unless medically contraindicated (as documented by their physician in their medical record).

P. Residents shall be assured of at least visual privacy in multi-bed rooms and in tub, shower, and toilet rooms.

Q. The resident, his family and guardian shall be permitted the choice of physician and pharmacist.

R. If the resident is adjudicated incompetent in accordance with state law, the resident's guardian or committee shall be authorized to act on the resident's behalf in order that his rights be implemented.

S. Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs.

T. Every resident, his family, and guardian shall be fully informed of his medical condition unless medically contraindicated or documented by a physician in his medical record.

U. Residents have the right to be suitably dressed at all times and given assistance when needed in maintaining body hygiene and good grooming.

V. Residents shall have access to a telephone at a convenient location within the building for making and receiving telephone calls.

W. The resident's family or guardian shall be notified immediately of any accident, sudden illness, disease, unexplained absence, or anything unusual involving the resident.

X. Residents shall have the right to have at least semi-annual private meetings with the appropriate health facility inspectors from the Department for Human Resources. Such meetings shall be held for the purpose of ascertaining the residents' concern about the quality of care which is being given to them by the facility.

Y. Each resident, his family, and guardian shall have the right to know what deficiencies have been found to exist in their respective facilities by licensing inspectors. Therefore, all long term care facilities shall conspicuously post summaries of the most recent licensure inspection as issued by the Department for Human Resources.

Z. Residents, their families, and guardian shall have the right to be assured that the Department for Human Resources will monitor and enforce each of the resident's rights in long term care facilities.

RATIONALE

Present policies governing the rights of residents in long term care facilities are scattered throughout the Kentucky Administrative Regulations. They differ in their coverage among the different levels of care. Residents in long term care facilities are in a dependent and vulnerable position due either to poor health, mental confusion, or the lack of the usual support systems such as is offered by family members or friends in their own communities. Because of this dependency and vulnerability, many residents may be unable to exercise their rights or to articulate their concerns. In view of this dependent state, greater than usual efforts must be made to guarantee certain rights to residents of long term care facilities in the Commonwealth. (See Chapter VII.)

Legislative Recommendation #2

(2) The General Assembly should enact legislation requiring the Department for Human Resources to develop and implement a system for rating the quality of care given by all long term care facilities (family care homes, personal care homes, intermediate care facilities, skilled nursing facilities, intermediate care facilities for the mentally retarded/developmentally disabled and nursing homes as defined by 902 KAR 20:047).

The Department should develop and promulgate rules and regulations establishing uniform criteria for the evaluation of long term care facilities with respect to their compliance with licensure standards as indicated by inspection results. Such criteria shall include a detailed listing of the types, and degree of severity or unacceptability or deficiencies which inspections might indicate, and shall also indicate areas of care and performance in which long term care facilities exceed required minimum standards.

Such a rating system should include four rating categories entitled from highest to lowest: "A", "B", "C", and "D." "D" rated long term care facilities should be those whose performance is sufficiently below minimum standards to require suspension, revocation, or denial of a license to operate. The rating assigned to each long term care facility on the basis of its immediate prior inspection should be required by the Department to be posted conspicuously within the long term care facility to which it applies. For purposes of review and comment, ratings assigned to facilities should be forwarded by the Department to the Subarea Health Planning Council in whose district the facility is located. A long term care facility should be able to appeal the assignment of a particular rating to the Department within 20 days after notice of its assignment.

RATIONALE

The Subcommittee believes that most individuals, their families and guardians who are seeking a long term care facility of high quality are inexperienced in knowing, what to look for when choosing a facility. Further, most citizens are unfamiliar with regulatory standards for long term care facilities and would have difficulty knowing to what degree a particular facility is providing quality care to its residents.

During the Subcommittee's visits to 22 nursing homes, it became obvious that the facilities of the same level of care differed in their quality of food, cleanliness, staff, programs, and other long term care services. Thus, the Subcommittee believes that those facilities providing higher standards of care should be differentiated. A rating system would inform potential residents, their families and guardians of the quality of care that they can expect to be given at a particular facility. (See Chapter VIII for a personal perspective of the Subcommittee's visits.)

Legislative Recommendation #3

(2) The General Assembly should enact legislation requiring the Department for Human Resources to annually perform at least one unannounced inspection of all long term care facilities (family care homes, personal care homes, intermediate care facilities, skilled nursing facilities, intermediate care facilities for the mentally retarded/developmentally disabled, and nursing homes as defined by 902 KAR 20:047). This unannounced inspection should be in addition to the annual licensure and Medicaid or Medicare survey. The purpose of these unannounced inspections would be to ascertain the degree to which facilities did or did not conform to licensure requirements.

RATIONALE

Presently, truly unannounced inspections of long term care facilities are only done on family care homes and personal care homes or when a complaint is made against a facility. The normal procedure for inspecting other long term care facilities is to conduct an annual survey at the time a facility's license or certification for Medicare or Medicaid is about to expire. Thus, these long term care facilities are generally aware of the time that the inspections will take place.

In the judgment of the Subcommittee, an unannounced survey of long term care facilities would provide the licensure surveyors with a more realistic perspective of the day-to-day operation of a long term care facility. The Subcommittee found during its unannounced visits to long term care facilities, certain deplorable conditions that surely could not have existed when some facilities were annually inspected or else they would have been forced to take corrective measures. (See Chapters V and VIII.)

THE SUBCOMMITTEE ON LONG TERM CARE RECOMMENDS THAT THE DEPARTMENT FOR HUMAN RESOURCES APPOINT APPROPRIATE AND SUFFICIENT STAFF TO CONDUCT THE FOLLOWING RESEARCH:

The Department for Human Resources is requested to report its findings concerning the first six recommendations below to the Interim Joint Committee on Health and Welfare no later than January 1, 1979.

Administrative Recommendation #1

The Department for Human Resources should ascertain the health care status of those residents presently in family care homes, personal care homes, intermediate care facilities, nursing homes as defined by 902 KAR 20:047, and skilled nursing facilities for the purpose of determining: (1) to what degree the present state administrative regulations which are promulgated for these facilities are adequate, sufficient, and appropriate to meet the needs of those individuals who reside in the facilities at each level of care; and (2) how many of the residents currently in these facilities could, if appropriate in-home services were available, remain in their own homes or the homes of relatives or friends.

RATIONALE

In Kentucky today adequate data is not available on the health care status and physical and mental needs of the residents in the different facilities. It is not known, for example, how many or what kind (type and severity) of chronic conditions exist for residents in the different levels of care. Nor is it known to what degree residents require dental, eye care, podiatric, physical therapy, or mental health services. Finally, it is not known how many residents in long term care facilities could, if appropriate in-home services were available, remain in their own homes or the homes of relatives or friends. This lack of information would appear to hinder any long term care planning or resource allocation that is performed on behalf of Kentucky's citizens. The Subcommittee does not understand how the Commonwealth can continue to disburse millions of dollars per year in payments for services in long term care facilities when the long term care needs of our citizens are not known. (See Chapters IV and V.)

Administrative Recommendation #2

The Department for Human Resources should immediately undertake a study to determine an adequate caseload for departmental guardianship officers and limit the number of wards (persons who have been declared legally incompetent) for which each guardianship officer is responsible at any one time. In addition, the Department for Human Resources should immediate review and clarify the roles and responsibilities of the departmental guardianship officers. The Department should examine the adequacy and appropriateness of the present guardianship statutes as they pertain to the reality of demands and responsibilities of the guardianship officer and make any needed recommendations to the 1978 General Assembly.

RATIONALE

The average monthly caseload of the four guardianship officers employed by the Department for Human Resources is approximately 700 persons. During calendar year 1976, slightly over $7 million was disbursed by the officers on behalf of their wards. Almost all of their wards are in long term care facilities. Although the principal duties of the guardianship officers have involved the management of their wards' financial affairs, these officers are often placed in the role of being a parent to the clients. They are frequently asked to make decisions which may greatly affect the future of their wards such as granting permission for emergency surgery, and relocating hard-to-place clients.

The Subcommittee believes that decisions pertaining to guardianship are extremely complex and to require one person to bear such a grave and awesome responsibility for so many individuals is unfair and not in the best interests of our citizens. (See Chapter IV.)

Administrative Recommendation #3

The Department for Human Resources should immediately examine its present policies and procedures for placement in long term care facilities of

; (2) collect, analyze, and dis-
homes, nursing home residents and
ities; (3) develop and implement
alternatives; (4) coordinate and
to nursing homes, nursing home
ams; and (5) initiate and monitor
of the Commonwealth.

without the designated leadership
inistration of state government's
s, nursing home patients and other
the Commonwealth will not be able
erm care needs of its people. The
nsibilities is simply too complex,
rposive and planned direction.

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e purpose of collecting, analyz-
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:are services and facilities.

ıts through which comprehensive
ıre can be obtained in the Common-
the implementation of a long term
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ıards the long term care needs of

ıld immediately examine the feasi-
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a long term care policy for the people

Thus, the Subcommittee believes that
which is necessary for the adequate adm
responsibilities regarding nursing home
long term care facilities and services,
to respond appropriately to the long t
present network of long term care respo
diversified, and costly not to have a p
(See Chapter V.)

Administrative Recommendation #5

The Department for Human Resources sl
term care data collection system for the
ing, monitoring and disseminating perti
ing home patients, and other long term

RATIONALE

Presently, no established mechanism exis
and relevant information on long term ca
wealth. The Subcommittee believes that
care data collection system is paramou
ately plan or allocate its resources tow
its people. (See Chapter V.)

Administrative Recommendation #6

The Department for Human Resources shou
bility of expanding its financial commit
caretaker, homemaker, and home health
taining its present financial commitment
long term care alternatives.

RATIONALE

Sufficient evidence has not been found
cial commitment to long term care is b
our citizens.

It is the Subcommittee's belief that
being provided the resources to remai
sible. (See Chapter II.)

Administrative Recommendation #7

The Department for Human Resources should annually perform on-site financial audits of those long term care facilities (family care homes, personal care homes, intermediate care facilities, skilled nursing facilities, and intermediate care facilities for the mentally retarded/developmentally disabled) receiving reimbursement either through the Medicaid program or from persons who receive State Supplementation funds.

RATIONALE

During Fiscal Year 1976-77, the Department for Human Resources performed on-site field audits on 65% of the intermediate care facilities which received Medicaid reimbursements. Due to lack of sufficient staff, the Department reported it was unable to audit the financial records of the remaining facilities. However, at the time of this writing, the Department for Human Resources has stated enough staff have been hired to audit all of the intermediate care facilities certified to receive Medicaid. The responsibility for auditing Medicaid certified skilled nursing facilities has been contracted to a private accounting firm.

The Department for Human Resources does not conduct an audit of the financial records of those family care and personal care homes accepting persons whose care is paid for by the State Supplementation and Supplemental Security Income programs. The Subcommittee has learned that many family and personal care homes depend on this reimbursement as a primary source of their revenue. Further, it has been argued by operators of these facilities that the present amounts of reimbursement are inadequate. An annual field audit should benefit both the facility operator and the taxpayer. Audits may reveal that current reimbursement rates are inappropriate. Similarly, the audit would assure taxpayers that state monies were being properly spent for services rendered. (See Chapter V.)

Administrative Recommendation #8

The Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board should take immediate action to revoke those certificates of need granted for the construction, expansion, or modification of personal care homes, intermediate care facilities, and skilled nursing facilities that are more than 18 months outstanding. Subsequently, the Board should redistribute those certificates of need to applicants who can clearly demonstrate plans to operationalize them within 18 months.

The Kentucky Health Services Certificate of Need and Licensure Board should also modify the present bed planning and allocation formula to include consideration of the fact that a significant portion of residents in personal, intermediate, and skilled care facilities are under age 65.

RATIONALE

As of May, 1977, there were 1,837 beds at the personal, intermediate, and skilled care levels for which certificates of need had been issued but

which had not become operational between 18 and 42 months after the certificates were initially granted. This does not include those "paper beds" in the Jefferson Subarea that were 18 months outstanding. When a subarea of the Commonwealth reaches its maximum allocation of beds no new certificates of need can be granted to the subarea.

One result of the prevalence of outstanding certificates of need or "paper beds" is the creation of lengthy waiting lists of persons seeking admission to particular levels of long term care facilities. For example, as of August, 1977, 425 Medicaid patients were receiving services in skilled nursing facilities even though they had been reclassified as needing the services of an intermediate care facility. These individuals were being maintained in the skilled nursing facilities because of the unavailability of intermediate care beds in the same facility or within a 50 mile radius of the facility.

The existence of these "paper beds" may also be costing the taxpayers some unnecessary expenditures. The state must reimburse the facility for the level of care which is provided and not the level of care which is needed. Thus, the 425 Medicaid patients in skilled nursing facility who actually need intermediate care facility beds are costing the state approximately $153,000 per month in its Medicaid funds it would not have had to spend if enough intermediate care facility beds were available.

Likewise, as of August, 1977, there were 213 Medicaid recipients in intermediate care facilities for the mentally retarded/developmentally disabled who needed alternative levels of care that were not available. The estimated monthly cost to the state in Medicaid monies for this inappropriate care is $273,000 per month.

The Subcommittee realizes that the revocation of all certificates of need which have been outstanding for 18 months or more will not completely eliminate this costly burden of providing higher levels of care to those Medicaid patients who need less intensive levels of treatment. However, some of the unnecessary waiting for beds in certain levels of care can be resolved by redistributing these "paper beds" to those operators of long term care facilities who can clearly demonstrate that they will operationalize them within 18 months.

Finally, the present bed planning and allocation formula for personal care homes, intermediate care facilities, and skilled nursing facilities should reflect the actual need for services in nursing homes. The present formula utilized for planning nursing home beds in each subarea is based only on the percentage of the population in that area over 65 years of age. National studies reveal that between 12% and 22% of nursing home residents are under age 65. If Kentucky can be reasonably compared to the United States as a whole, it would appear that those in need of nursing home care who are under age 65 are not taken into consideration when beds are planned.

In addition, the Long Term Care Multi-Agency Study Group reports that the geographic determination of need by subarea reflects political boundaries rather than areas of service need. This study group further notes that the true need for service in a nursing home is not known. (See Chapter III and V.)

Administrative Recommendation #9

The Kentucky Health Services and Health Facilities Certificate of Need and Licensure Board should promulgate regulations requiring administrators of personal care homes to have qualifications equal to those persons who are licensed to be nursing home administrators of intermediate care facilities and skilled nursing facilities.

RATIONALE

The present qualifications for administrators of personal care homes are: (1) the administrator must have sufficient education to maintain adequate records, submit reports required by the board and interpret written materials related to all phases of home operations and resident's care; and (2) the administrator must be twenty-one years of age and present a certificate that he/she is in good physical and mental health and is free from communicable disease. The administrator should be a person of integrity and good character, and have a liking for older people.

The Subcommittee believes that the present qualifications for administrators of personal care homes are not reflective of the demands which are placed on them by their residents. Given the fact that there are a number of vulnerable mentally retarded/developmentally disabled, and mentally ill persons in personal care homes, it is essential that administrators of these facilities demonstrate some ability to meet the needs of this resident population. The current requirements fail to do so. (See Chapter VI.)

Administrative Recommendation #10

The Department for Human Resources, in conjunction with the Kentucky Board of Licensure for Nursing Home Administrators and the Kentucky Association of Health Care Facilities, should fully develop and implement a training program for nursing home (family care homes, personal care homes, intermediate care facilities, skilled nursing facilities, intermediate care facilities for the mentally retarded/developmentally disabled and nursing homes as defined in 902 KAR 20.047) personnel including orderlies, aides and nurses. Each nursing home employee should be required to successfully complete an appropriate training program as a pre-condition for employment and as a condition for retaining employment.

RATIONALE

Meeting the needs of the chronically ill, handicapped and elderly in long term care settings requires specialized knowledge and expertise. Awareness of the physical processes of aging and disease along with the concommitant emotional changes is prerequisite to working effectively with nursing home residents. A training program would provide nursing home personnel with the knowledge and skills required for a particular level of care, thus improving the quality of service provided and decreasing the probabilities of inadequate care through ignorance on the part of an untrained staff.

Additionally, a training program increases the staff's level of confidence and job satisfaction thus affecting the rapid turnover of nursing home personnel. With stabilization of staff also comes a more effective continuity of care for the residents for whom a primary need is consistency.

Although training programs for personnel of nursing homes was not a specific focus of the Subcommittee's research, it was recommended to the Subcommittee on countless occasions by nursing home administrators and consumers that training programs were desperately needed for those orderlies and aides, who provide most of the direct patient care to residents.

RECOMMENDATION

The Subcommittee on Long Term Care should be reestablished following the 1978 Regular Session of the General Assembly for the purpose of following up its research efforts conducted during the 1976-77 interim.

RATIONALE

The Interim Subcommittee on Long Term Care can serve as a forum for the General Assembly's involvement in long term care. It can also serve as a public forum whereby nursing home residents, nursing home operators, health care professionals, and interested citizens would have the opportunity to address their concerns on long term care.

The Subcommittee learned through its year-long research efforts that there were numerous components involved in the long term care service delivery system. Unfortunately, due to time constraints, the Subcommittee was not able to appropriately address all of these different components. Rather, the Subcommittee focused its efforts on those aspects of long term care which demanded the most attention. Surely, much more work needs to be done by state and federal officials. Therefore, it is strongly recommended that the Subcommittee on Long Term Care be allowed to continue its research and evaluation assignment.

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APPENDICES

I. Map of Area Development Districts

II. Steps Required to Obtain a Certificate of Need in Kentucky

III. Sources of Nursing Home Reimbursement in Kentucky by Level of Care

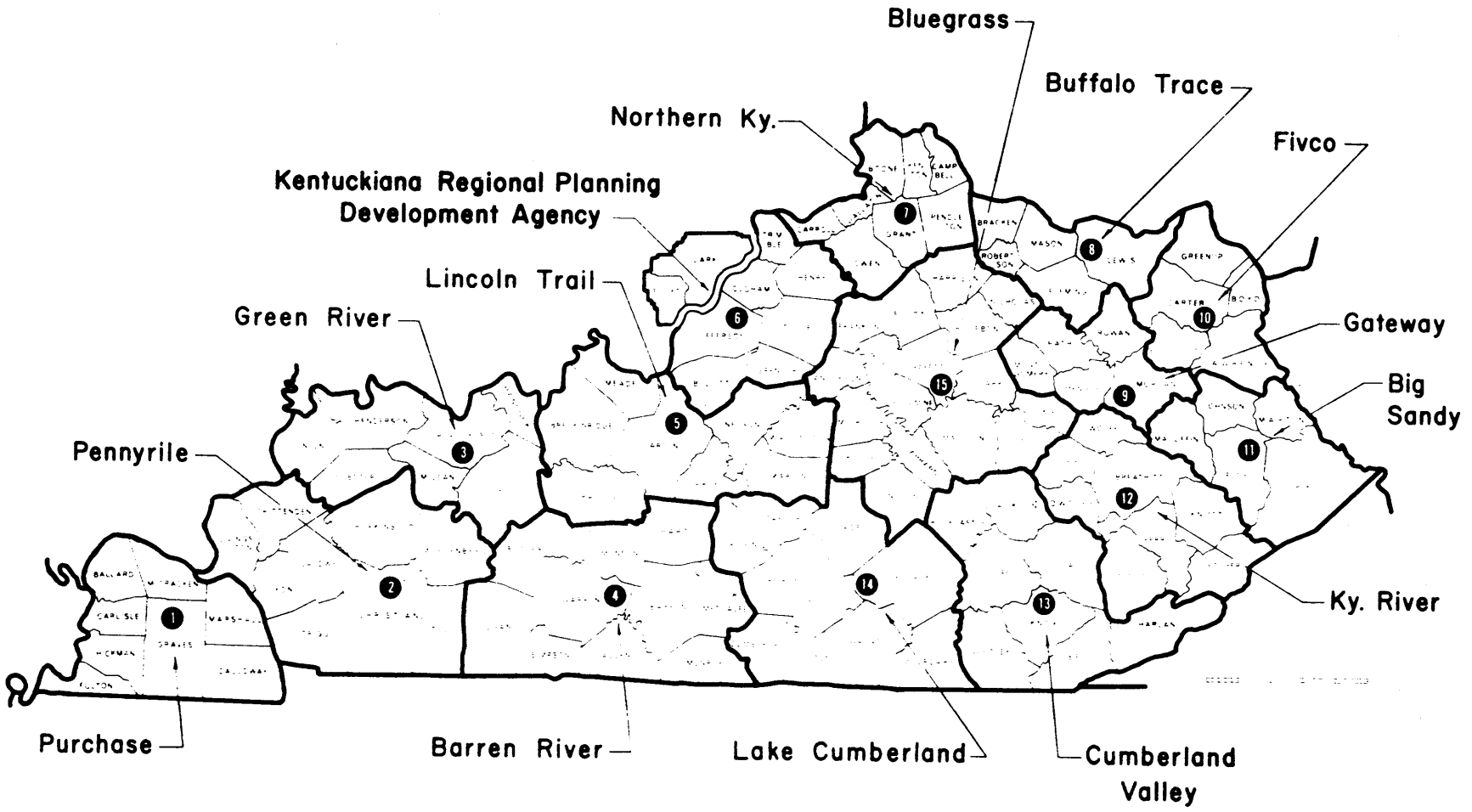
IV. Counties in Kentucky which have no Skilled Nursing Facility Beds

V. Counties in Kentucky which have no Intermediate Care Facility Beds

VI. Counties in Kentucky which have no Personal Care Beds

APPENDIX I

OFFICIAL BOUNDARIES OF THE KENTUCKY AREA DEVELOPMENT DISTRICTS



APPENDIX II

STEPS REQUIRED TO OBTAIN A CERTIFICATE OF NEED IN KENTUCKY

What happens between the applicant's initial contact with the Subarea Council of the HSA and the final decision of the Kentucky State Certificate of Need and Licensure Board?

The process of application for a Certificate of Need begins when the

Applicant	(Potential nursing home operators or other respective health care providers)

submits a letter of intent to the

HSA Staff	(This is a group of health planning professionals who, depending on which HSA they are in (EKHSA, KHSAW, CORVA), are responsible for doing health planning for a number of Kentucky counties)

which supplies an application kit to the applicant and notifies the subarea staff (health planners at the Area Development District level) which then sends the completed application to the

Subarea Council	(This group is composed of various consumers, health care providers, and interested citizens at the Area Development District level)

The Subarea staff provides assistance and advice to the Council in the formulation of the elements of the proposed project. The applicant completes the application form with the assistance of the Subarea staff and then files the form with the Subarea Council for its review. The staff sends a copy of each proposal to a Special Committee of the Subarea Council which does the initial review of the certificate of need application.

Subarea Council Project Review Committee	(This is a special committee of the Subarea Council which does the initial review of the certificates of need application.)

This committee studies the proposals in depth and makes recommendations of approval or disapproval back to the

Subarea Council

This Subarea Council completes the review process, and transmits the proposal with its recommendation to the

Health Systems Agency
(HSA) Staff

HSA staff reviews the application and summary and submits the summary to a Project Review Committee of the Health Systems Agency Board for recommendations. (The Board is made up of consumers, providers, and health care professionals on a regional level.)

HSA Project Review Committee	(Regional level citizens group of providers and consumers)

This committee reviews the proposal and submits its recommendations to the

Health Systems Agency
(HSA) Board

The HSA Board makes its final recommendations and sends the proposal to the:

State Health Planning Development Agency (SHPDA) Staff	(This is the Center for Comprehensive Health Systems Development in the Bureau for Health Services. They are made up of professional health planners which do health planning on a statewide level.)

The SHPDA staff examines the application and transmits it to the:

Health Facilities and Services Committee of the State Health Coordinating Council (SHCC)	(This is a special committee of the State Health Coordinating Council.)

This committee transmits the proposal with its recommendations to the:

State Health Coordinating Council (SHCC)	(This group is made up of health care consumers, providers, and citizens throughout the state.)

The proposal, with the SCHH's final recommendation, goes to the:

State Certificate of Need
and Licensure Board

The Board reviews the application and notifies the applicant of its actions.

The Board establishes procedures for the hearing of appeals from applicants whose applications are denied by the Board. The application will be processed through all levels as prescribed unless it is withdrawn by the applicant.

SOURCE: EAST KENTUCKY HEALTH SYSTEMS AGENCY, 1977

APPENDIX III

SOURCES OF NURSING HOMES REIMBURSEMENT IN KENTUCKY BY LEVEL OF CARE

Personal Care Homes - Establishments with permanent facilities that include resident beds and health related services to provide continuous general supervision and residential care. Residents are able to manage the normal activities of daily living except that they have physical or mental disabilities or in the opinion of a licensed physician are in need of residential care.

Source of Payment: Private; SSI; State Supplementation to SSI.

Intermediate Care Facilities - Services are provided intermittently on a 24-hour basis by establishments with permanent facilities and health-related services to patients who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental and physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities on an inpatient basis.

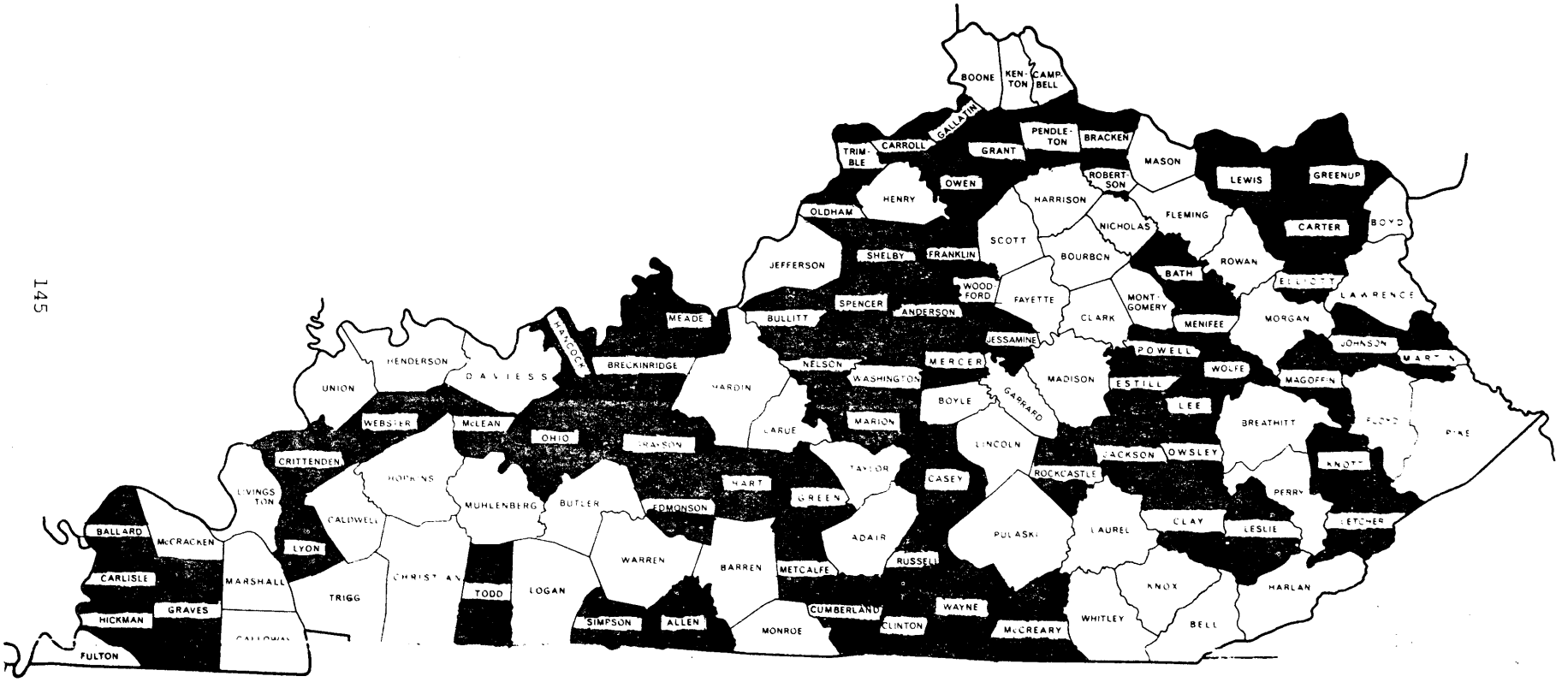
Source of Payment: Private; Medicaid.

Skilled Nursing Facilities - Provides treatment for patients who require in-patient care, but who are not in an actue phase of illness; who currently require primarily convalescent or restorative services; and who have a variety of medical conditions. These facilities have an organized medical staff or one that serves the institution through an affiliation.

Source of Payment: Private; Medicaid; Medicare.

APPENDIX IV

COUNTIES IN KENTUCKY WHICH HAVE
NO SKILLED NURSING FACILITY BEDS

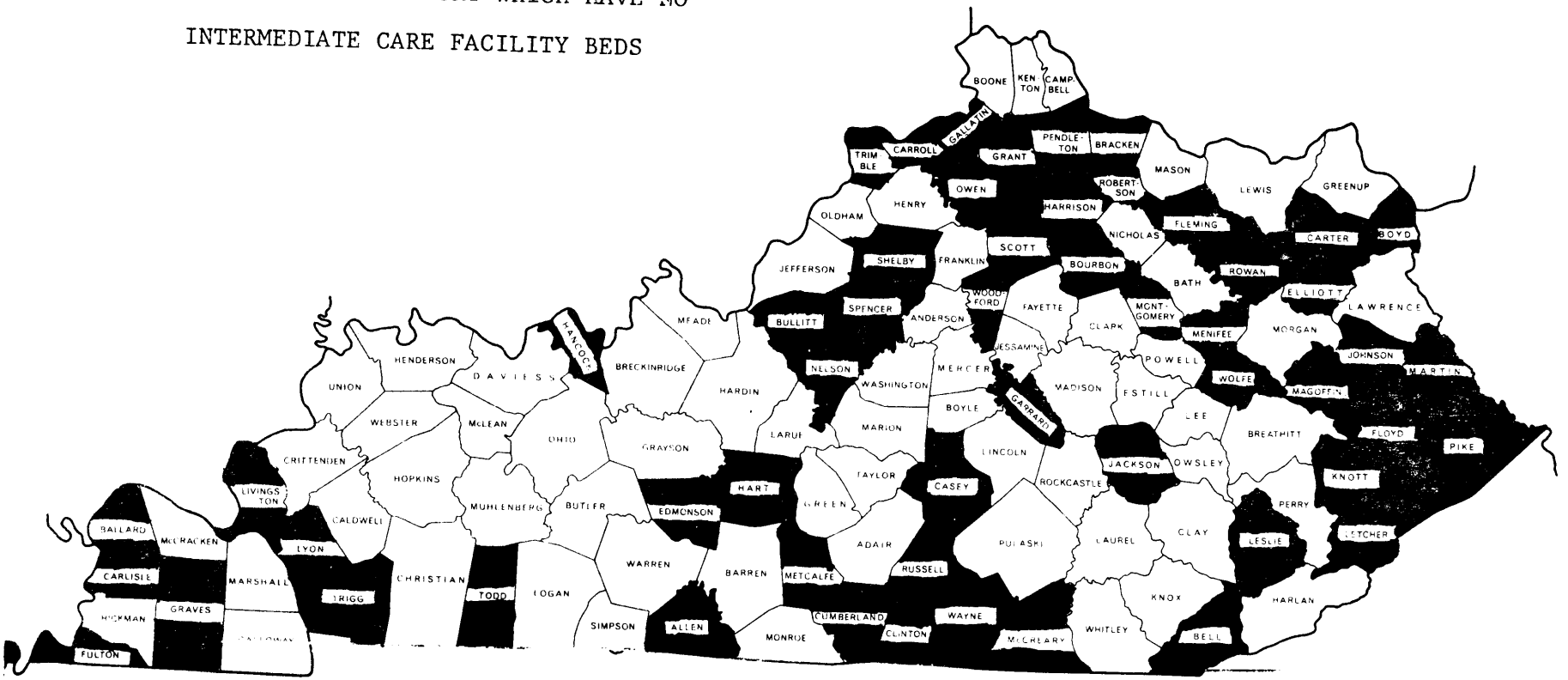


NO SKILLED CARE BEDS

SOURCE: Department for Human Resources, Bureau for Administration and Operations, September, 1976.

APPENDIX V

COUNTIES IN KENTUCKY WHICH HAVE NO INTERMEDIATE CARE FACILITY BEDS

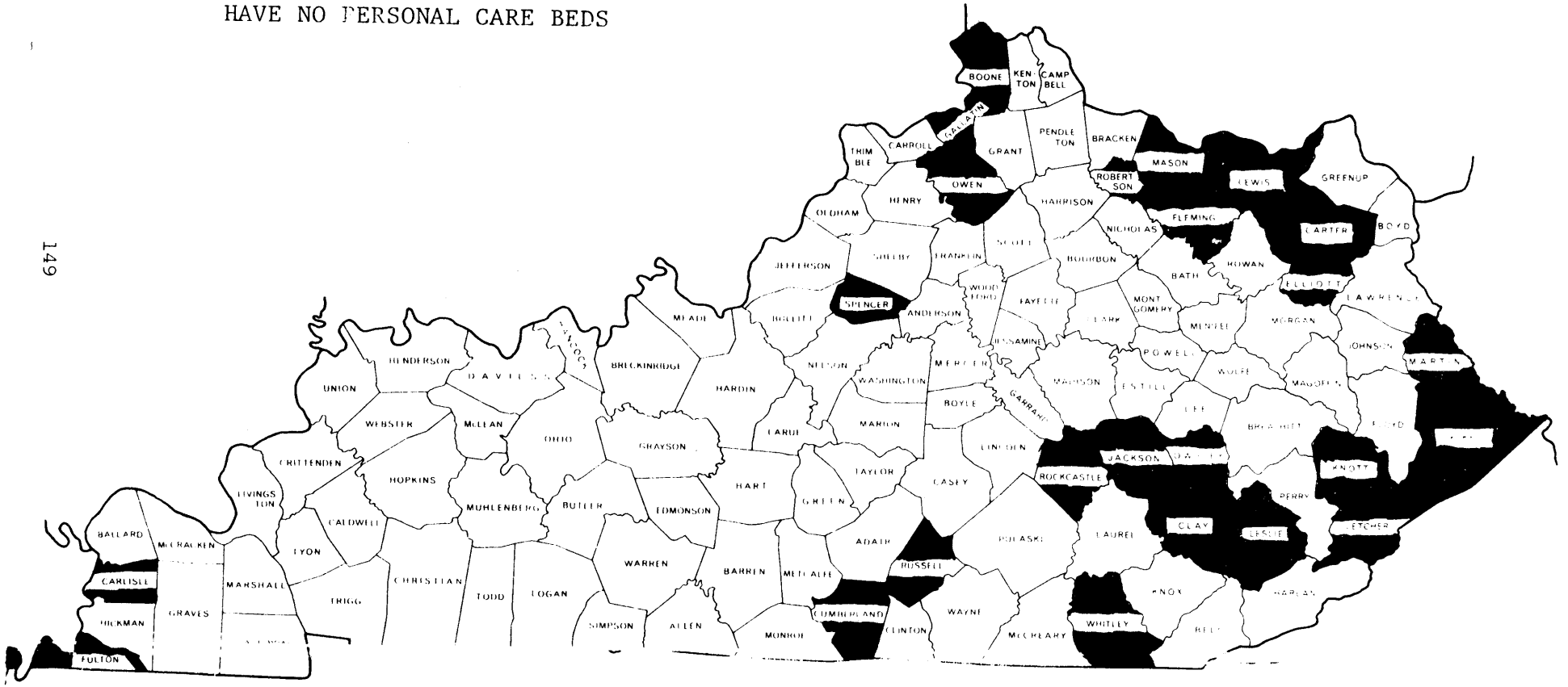


NO INTERMEDIATE CARE BEDS

SOURCE: Department for Human Resources, Bureau for Administration and Operation September, 1976.

APPENDIX VI

COUNTIES IN KENTUCKY WHICH HAVE NO PERSONAL CARE BEDS



NO PERSONAL CARE BEDS

SOURCE: Department for Human Resources, Bureau For Administration and Operation, September, 1976.