CANHR *Long Term Care Justice and Advocacy*
CALIFORNIA ADVOCATES FOR NURSING HOME REFORM

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Heidi Steinecker, Deputy Director
Center for Health Care Quality
California Department of Public Health
MS 0512, P.O. Box 997377
Sacramento, CA 95899-7377
By email to: Heidi.Steinecker@cdph.ca.gov

Re: Quality and Safety State SNF Survey Model

Dear Ms. Steinecker:

We are writing to urge the Department to withdraw the Quality and Safety State SNF Survey Model plan due to serious concerns about its development, purpose, viability, effectiveness and timing. The plan you sent to us on September 29, 2020 will divert a large part of the surveyor workforce from urgent legislatively mandated duties, including investigation of the enormous backlog of complaints on nursing home abuse and neglect. It was developed and finalized without any meaningful legislative oversight and no opportunity whatsoever for the public to review and shape it.

The undated executive summary you sent us on September 29 is the fourth in a series of ill-advised plans to remodel the survey system that we have urged you to withdraw since you announced the Adopt-a-SNF plan to the Legislature during hearings on June 9 and 10.

The original Adopt-a-SNF executive summary (undated) stated that its purpose was to provide "collaboration, education, and technical assistance to SNF providers" through "daily check-ins, frequent trainings and weekly visits" by assigned surveyors. You testified that the Adopt-a-SNF plan would completely change and reform how nursing home oversight is conducted throughout California and then the nation.

Once we became aware of the Department's highly misguided plan to turn hundreds of CDPH surveyors into consultants to nursing home operators, we immediately urged you to withdraw the Adopt-a-SNF plan due to grave concerns about conflicts of interest that would compromise the Department's ability to enforce federal and state nursing home standards.

On July 14, you sent us a revised executive summary with a new name, Quality and Safety State SNF Survey Model. The undated plan stated that monthly visits from assigned surveyors would replace yearly state licensing surveys and provide more technical assistance to SNF providers. We responded in writing on July 16, urging you to withdraw the plan for a multitude of reasons: the plan was not legal, practical or properly designed; it threatened the integrity of the survey process; the middle of the pandemic is not the time to remodel state licensing surveys; and the plan is not what is needed now to improve resident safety.

On July 31, the Department sent us a revised executive summary that had a date of 7/23/20 in the document title (State SNF Quality & Safety Executive Summary 072320). The plan would assign surveyors to make monthly visits to engage in cooperative efforts with the steering committees of SNF QAPI (Quality Assurance Performance Improvement) teams. CANHR wrote you on August 3 urging withdrawal of the plan, while raising objections that it had a false premise, was driven by providers, threatened the integrity of the survey process, was extraordinarily divisive and would institutionalize the Department's transformation of surveyors into guidance counselors to nursing home operators. We strongly objected to the highly inappropriate directive that surveyors engage with SNF operators on QAPI planning.

Notwithstanding our repeated requests to withdraw the plan and our serious objections to both the plan and the process used to establish it, the Department moved forward and produced the latest version, which you advised us is now final. CANHR has numerous concerns about the final plan and the process for developing it, including, but not limited to, the following:

The plan will divert the surveyor workforce from investigating complaints and other urgent priorities.

Making visits every four to six weeks to California's more than 1200 skilled nursing facilities will require more than 10,000 additional visits annually from a surveyor workforce that has never come close to carrying out the Department's existing mandates to oversee nursing homes. The plan provides no new positions or resources, making it inevitable that it will divert surveyors from recertification surveys, complaint investigations and re-licensure surveys, the foundational elements of the oversight system.

We are particularly concerned about the impact on investigations of complaints and facility reports of abuse and neglect. The plan directly questions their value, declaring that *"Periodic surveys to conduct complaint or facility reported incident investigations are also intermittent based on triaged priority and do not appear to have any real-time greater impact on overall long sustainable improvement."* To the extent there is any truth to this statement, it is an indictment of the Department's longstanding failures to investigate complaints and facility-reported neglect and abuse cases in a timely, thorough and effective manner.

It is beyond the purpose of this letter to detail our concerns about the Department's dysfunctional complaint investigation system, but you are certainly familiar with them. Abused and neglected nursing home residents often die before the Department investigates complaints about their mistreatment. Due to the long delays and the poor quality of investigations, the Department substantiates only one in five complaints and less than one in ten facility reports of abuse and neglect. Increasingly, the Department fails to take any action even when it substantiates complaints against nursing homes. As we documented earlier this year, the Department is closing thousands of substantiated complaints against nursing homes with a history of abuse without issuing deficiencies or citations. In doing so, the Department is constantly sending the message to nursing home operators that there are no consequences for abusing and neglecting residents.

According to the Department's most recent performance metrics data, the average age of open nursing home complaints statewide is 636 days. In Los Angeles County, the average age of open

cases is an astonishing 1,121 days. The backlog of nursing home complaints and facility reported cases of neglect and abuse was 13,504 cases.

In 2015, the Legislature established timelines for completing nursing home complaints through SB 75 and funded hundreds of new positions requested by the Department to meet these mandates. The Department's 2015-16 Budget Change Proposal on this matter (4265-018-BCP-DP-2015-GB) provides this statement on "Outcomes and Accountability."

"The CHCQ estimates that with the 237 positions requested in this Budget Change Proposal, program staff could complete the current pending investigation workload in approximately four years, while also addressing new workload and avoiding any new cases from aging. After the existing aging complaint and entity-reported incidents investigations have been completed, staff will focus on reducing the average time needed to complete investigations and on increasing the frequency of periodic surveys."

Five years later, the Department is not complying with the complaint investigation timeliness standards set in SB 75 (codified at Health and Safety Code §1420) and it still has a scandalously large complaint backlog.

Immediately prior to the pandemic, we urged you to address the failures of the complaint system and to engage consumers and the public in transforming the Department's troubling "Debt Free 2021 Campaign" into a campaign to make nursing homes "Neglect and Abuse Free." The urgent need to do so has only grown since the outset of the pandemic, with the public desperate for meaningful and timely interventions to the dangerous conditions in nursing homes that have killed and harmed so many residents.

It is beyond our understanding how the Department can redirect its resources to a new oversight system without having fixed its failing complaint investigation system as the Legislature directed. California nursing home residents will not be safe from neglect and abuse until the Department establishes a system that investigates complaints and facility reported cases of neglect and abuse in a timely, thorough and effective manner. We strongly oppose diverting resources from that mission.

The plan's monitoring visits are described as supplemental to state re-licensing surveys, although legislatively mandated re-licensure surveys are not being conducted.

According to the plan, *"Routine Quality and Safety Oversight periodic inspections are not intended to replace CMS recertification surveys, other CMS directed investigations or State re-licensing surveys."*

Yet, the Department is conducting only a small fraction of the re-licensure surveys at long-term health facilities mandated by California Health & Safety Code §1422. Through the third quarter of FY 2019-20, the Department's performance data reports it conducted only 18 percent of the mandated re-licensure surveys. During the same period in Los Angeles County, **zero percent** of long-term health facilities received legislatively mandated re-licensure inspections.

In FY 2018-19, prior to the pandemic, the Department reports conducting re-licensure surveys at only 35 percent of the long-term health facilities that were required to receive them.

The plan is predicated on false assumptions.

The lessons the Department reports it has learned from the pandemic are highly questionable, including the following justification presented in the plan.

The Mitigation Surveys served as the pilot for the Q&S Survey Model to increase the frequency of CDPH's presence in SNFs. One of the lessons learned in this pandemic is regardless of where the SNF is located, the size of the SNF, the compliance history of the SNF, or the actions taken by CDPH at the SNF, the most critical difference is frequency in which CDPH surveyors and HAI are onsite. Even though California case rates continued to soar upward in summer, and the numbers of hospitalizations surged in late summer, the SNF case rate remained stable, and SNF resident death rates decreased since the beginning of the pandemic and have since stabilized. Taking this model and applying it to broader compliance monitoring will result in long-term better outcomes for SNF residents.

CANHR does not question the value of surveyor presence in skilled nursing facilities. However, we strongly dispute the Department's narrative that its initiatives spared California nursing home residents from death and harm during the pandemic.

No amount of whitewashing can disguise the fact that over 4,500 California residents and over 150 health care workers at skilled nursing facilities died from Covid-19. Many more residents have died from poor care and extreme isolation. Nearly 50,000 residents and staff members have been infected. All involved and their families have suffered immensely. CANHR has been flooded with calls from people who are enduring heartbreaking tragedies in nursing homes that have failed to keep residents safe. The Department's indifference to their suffering is appalling.

As a public health agency, one would hope that the Department would know better than to characterize the horrific death toll as a success story.

The self-serving nature of the Department's conclusions only raise doubts about their legitimacy.

The Department's revised duty statement presents an unreconcilable conflict of interest for surveyors.

You advised us that the revised duty statement is final notwithstanding SEIU Local 1000's Unfair Practice Charge and that the duty statement does not change the role of HFEN surveyors despite the fact that it requires them to spend thirty percent of their time advising and assisting operators on regulatory matters.

Neither of these claims is credible, especially given the Department's failure to repudiate the plans it touted throughout the summer that surveyors would be required to provide additional collaboration, education and technical assistance to SNF providers.

We fully share the Union's and surveyors' concerns about the fundamental conflicts of interest the Department has created for surveyors and the harmful impact this conflict will have on their ability to properly enforce nursing home standards and to protect residents' rights. The revised duty statement threatens the integrity of the survey process.

Nursing home operators have many other options for obtaining advice on regulatory matters that do not involve the inherent conflicts created by the Department's duty statement and plan.

CANHR is also deeply troubled by the Department's dismissive attitude toward frontline surveyors who have raised concerns that the Department is putting the interests of nursing home operators above those of residents. We have heard from surveyors throughout California who share these concerns. It is to their credit that they are speaking out on behalf of residents whose needs and concerns appear to have been abandoned by the Department.

The Department should collaborate with residents on their safety, not appease providers.

The plan describes the monitoring visits as "a professionally cooperative approach between the facility and the surveyor," it requires surveyors to engage with leadership of the facility, and it makes the outcome of facility evaluations a measure of success of the surveys.

The plan's language reflects the Department's misguided orientation that SNF operators are their customers, and that its surveyors are expected to satisfy operators' expectations. Unscrupulous operators take advantage of this troubling dynamic, which undermines surveyors' abilities to hold facilities accountable when residents are mistreated or neglected.

In contrast, the plan is silent on engaging with residents or their representatives. Their views are not sought on the surveys or on the quality of their care. The Department should be taking its cues from residents and their representatives, not nursing home lobbyists.

The plan is not needed to expand monitoring.

The Department has existing authority to monitor nursing homes as often as it deems necessary to ensure the health and safety of residents. Indeed, CANHR has often called on the Department to monitor facilities operated by entities that the Department has determined to be unfit.

The Department failed to consult with the Legislature or the public about the plan.

It is hard to imagine a less transparent process than the one the Department used to develop this plan. Given its significance to the health and safety of nursing home residents and the dire conditions they face right now, one would think that the Department would have engaged in an open process where anyone who is interested could learn about its oversight proposal and express their views on it. That certainly has not been the case.

There has not been a single public meeting on the plan. To this day, we don't know who the Department has consulted or what views they have expressed. Any discussions the Department may have held with stakeholders have been held in silos.

Nor has there been any meaningful legislative oversight, which certainly would have been triggered had the Department been transparent about the impact of redeploying its surveyor workforce from legislatively mandated duties. It is remarkable that the Department has not developed any budget analysis of the plan or any other briefing documents that examine the plan's impact on its duties and workforce.

What has been apparent is the Department's agenda to reward nursing home lobbyists by inhibiting surveyor independence and promoting the industry's fallacious narrative about a punitive survey system. These are long sought goals of nursing home lobbyists. It is no surprise that providers characterized the Department's plan and duty statement as "Christmas in July."

The incredibly divisive plan is not what is needed now to protect resident health and safety.

It is profoundly unwise to adopt such a controversial plan in the midst of the pandemic.

With respect to nursing home oversight, what's needed now is to restore regular recertification and life safety code surveys, to give urgent attention to current and backlogged complaints and facility reported cases of abuse and neglect, and to increase monitoring of facilities and chains with poor performance histories and those facilities at the earliest signs of outbreaks.

This recommendation reflects our great concern that surveyors have performed very little assessment of individual resident quality of care and quality of life during the pandemic because the Department redirected them to very narrowly focused infection control and mitigation surveys. Refocusing inspections on resident concerns and outcomes is long overdue.

Outside of the survey process, CANHR has made numerous reform recommendations to the Department. We urge it to act on them.

Once again, we strongly urge you to withdraw the plan and the revised duty statement. Thank you for your consideration.

Sincerely,

Michael Connors
Advocate

Patricia McGinnis
Executive Director

cc: Honorable Gavin Newsom, Governor of California
Mark Ghaly, Secretary, Health and Human Services Agency
Sandra Shewry, Acting Director, California Department of Public Health
Tam Ma, Deputy Legislative Secretary, Office of Legislative Affairs
Honorable Adrin Nazarian, Chair, Assembly Aging and Long-Term Care Committee
Honorable Jim Wood, Chair, Assembly Health Committee
Honorable Richard Pan, Chair, Senate Health Committee
Senate and Assembly Budget Committees
Steven Chickering, Associate Regional Administrator, CMS