A REPORT
TO THE
ARIZONA
LEGISLATURE

COMPREHENSIVE LONG TERM CARE IN ARIZONA

EXECUTIVE SUMMARY AND RECOMMENDATIONS

ARIZONA DEPARTMENT OF HEALTH SERVICES

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A B O U T T H I S S U M M A R Y . . .

House Bill 2081 was enacted by the 35th Arizona Legislature as a blueprint for an improved system of long-term care.

The desired system calls for one level of nursing home care within which each client or patient would receive nursing and other needed services appropriate to the acuity of his or her condition or health needs. In addition, House Bill 2081 formalizes the long-standing principle that people have a right and should be assisted to reside in the least restrictive environment.

As a part of the implementation strategy written into the legislation, the Arizona Department of Health Services is required to prepare a comprehensive report for the president of the Senate, the speaker of the House of Representatives, and the Governor. A preliminary report was submitted on December 1, 1981.

This present document summarizes the Department's final report, and includes the recommendations in that report.

In at least one respect, the Department's proposals go somewhat beyond the precise mandates in House Bill 2081. While the bill focuses primarily on the medically indigent, the proposed strategies would serve all in need of long-term care. The aging and the aged would make up the majority of those served by the desired system; however, these proposals would accommodate long-term care clients and patients of all ages.

SPECIFIC LEGISLATIVE CONCERNS

House Bill 2081 assigns to the Department a number of tasks designed to promote implementation of the desired system. These areas of exploration are set down verbatim as they appear in the legislation:

1. The voluntary certification of specialty services offered by a nursing care institution including acute care designation.

2. The establishment of levels of required nursing hours, based on patient acuity, at levels equivalent to the nursing hours that patients with similar acuity levels would receive within the current three-level system.

3. A means by which the director, if a showing that an insufficient number of nursing care institution beds were available to serve patients of a certain acuity level, could designate for certain limited geographic areas, a number of vacant beds, if any, in nursing care institutions in the geographic area for the care of those patients needing beds at the designated acuity levels.

4. Case management systems to be used by each nursing care institution evaluating and reporting patient acuity levels.

The legislation also assigns to the Department the development of proposed regulations that would be used to implement the conclusions of the report. These have been developed and are included in the Appendix of the final full report.

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1. Voluntary Certification of Specialty Services

As mentioned above, the Department has established proposed standards for specialty certification for the areas of rehabilitation and behavioral care. These are included in Appendix B of the full report.

It should be understood that facilities now can and could continue to provide specialty services without formal certification. For example, facilities certified to accept Medicare patients are already required to be staffed and equipped to provide post-hospital rehabilitation; and some facilities have established specialty programs to meet special needs. Examples of these programs are the sub-acute program established to meet the needs of those who require more intensive nursing care than is available in most nursing homes. Another example is the young adult program more precisely tailored for the disabled young.

A major advantage of certification, nonetheless, is that there would be assurance that the facilities so certified meet acceptable program standards. This assurance, which is not currently available, would greatly aid the client or his family or other concerned party in choosing a facility appropriate to meet the client's needs.

It should be noted that despite the above descriptions of the way things are, the experience in Arizona and elsewhere is limited where specialty care is concerned, and this is a relatively untested area in long-term care.

The reasons for the relative lack of specialty activity are many and varied. The restrictions and disincentives imposed by Title XIX regulations are only one such factor.

Before specialty certification programs are implemented there are potential problems and issues which need to be resolved; namely,

- What is the distinction between the services provided in a special hospital as compared to specialty services provided in a certified nursing care institution? Are these programs compatible or duplicative?
- Is there more of a market for specialization in nursing homes than there appears to be for special hospital licensure?

- Should facilities which chose to provide specialized services be required to obtain a certificate of need in order to control over-specialization and increased costs?

- Will third-party payors including counties or private pay patients be willing and able to pay for the increased costs associated with specialization?

RECOMMENDATION 1

SPECIALTY CERTIFICATION

THE DEPARTMENT OF HEALTH SERVICES CONTINUE TO EXPLORE WHETHER IT WOULD BE FEASIBLE, PRACTICAL, AND COST EFFECTIVE TO CERTIFY SPECIALTY SERVICES WITHIN NURSING CARE INSTITUTIONS.

2. Nursing Care Based on Patient Acuity

The University of Arizona conducted extensive studies of patient acuity systems in other states. The report of findings of this research is included in the full report. Based on these explorations, the University recommended, and the Advisory Committee endorsed, the Ohio Revised System deemed capable of providing the most complete and reliable information for determining nurse staffing needs based on a patient's acuity. However, the system would require extensive developmental work. The advisory committee strongly recommended delaying the implementation of a patient acuity system until a system relevant to Arizona's experience could be developed. Introducing a complex system could have a significant impact on a facility's operation and cost, thereby offsetting any potential cost benefit which might be gained under an acuity based system.

RECOMMENDATION 2

PATIENT ACUITY SYSTEM

THE DEPARTMENT OF HEALTH SERVICES DEVELOP A SYSTEM OF NURSE STAFFING BASED ON PATIENT ACUITY BY JANUARY 1, 1983. THE DESIRED SYSTEM SHOULD:

- BE COMPATIBLE WITH ANY SUBSEQUENT PROPOSAL TO INCLUDE LONG-TERM CARE IN ARIZONA'S HEALTH CARE COST CONTAINMENT SYSTEM; AND
- BE BASED ON A CONSIDERATION OF REIMBURSEMENT FACTORS; AND
- BE COST EFFECTIVE

3. Designating Nursing Care Beds in Shortage Areas

In Arizona there is a maldistribution of available nursing home beds. Among existing homes, occupancy rates are high. This is particularly true in rural areas.

On the other hand, occupancy rates in rural hospitals are often below fifty percent. It has been demonstrated in several other states that the so-called "swing bed" concept could help meet the need for long-term care beds while increasing the use of hospital beds in rural areas.

Under the swing bed concept, vacant beds in hospitals which provide acute care are simply used for patients who need long-term care. Unfortunately, at present federal reimbursement regulations present a major roadblock to the use of acute care beds for long-term care. Although the 1980 Amendments to the Social Security Act do allow reimbursement for the swing bed program, the Department of Health and Human Services has up to now delayed issuing the required implementing regulations.

RECOMMENDATION 3

DESIGNATING NURSING HOME BEDS IN SHORTAGE AREAS

THE DEPARTMENT OF HEALTH SERVICES REQUEST A WAIVER FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO FACILITATE IMPLEMENTATION OF THE SWING BED CONCEPT IN HELPING MEET THE NEED FOR LONG-TERM CARE BEDS; AND

THE IMPLEMENTATION OF SWING BEDS IN RURAL HOSPITALS BE PROMOTED BY A CONSORTIUM WHICH WOULD INCLUDE THE DEPARTMENT OF HEALTH SERVICES, THE ARIZONA NURSING HOME ASSOCIATION, THE ARIZONA ASSOCIATION OF HOMES FOR THE AGED, THE ARIZONA HOSPITAL ASSOCIATION, THE HEALTH SYSTEMS AGENCIES AND OTHER CONCERNED GROUPS.

4. Case Management in Nursing Care Institutions

Traditionally, case management has usually meant the management of community-based services, or combinations of services, as needed by the client. Through this concept of case management, the client or patient is assured of continuity of care and other needed community support.

The case management mandated in House Bill 2081 refers to the evaluation of the acuity level of each patient within a nursing care institution in order to determine the numbers and types of nursing staff needed to serve adequately the total population within that institution.

As can be seen, a major yardstick of this kind of case management is the patient acuity system. Thus the development of the patient acuity system called for in House Bill 2081 must precede the fashioning of the case management system. Ideally, the two mandates should be developed as dovetailing parts of a more comprehensive strategy for improving long-term care.

RECOMMENDATION 4

CASE MANAGEMENT SYSTEMS

THE DEPARTMENT OF HEALTH SERVICES DEVELOP A CASE MANAGEMENT SYSTEM COMPATIBLE WITH THE PATIENT ACUITY SYSTEM BY JANUARY 1, 1983; AND

THE DEPARTMENT OF HEALTH SERVICES IN COOPERATION WITH THE DEPARTMENT OF ECONOMIC SECURITY WORK WITH OTHER CONCERNED GROUPS TO FACILITATE THE DEVELOPMENT OF A CASE MANAGEMENT SYSTEM DESIGNED TO MANAGE COMMUNITY-BASED SERVICES IN BEHALF OF THE AGED AND AGING AND OTHERS BESET WITH DISABLING CONDITIONS; AND

THE ASSESSMENT AND CASE MANAGEMENT SYSTEM BE PROVIDED ON A COUNTY-WIDE OR AREA-WIDE BASIS WITH THE FOLLOWING SERVICES AVAILABLE ON REQUEST:

... AN ASSESSMENT OF THE CLIENT'S PHYSICAL, MENTAL AND SOCIAL FUNCTION

... AN EVALUATION OF THE CLIENT'S NEEDS FOR SERVICE

... DEVELOPMENT OF AN ORGANIZED PLAN TO MEET THE CLIENT'S NEEDS

... ASSISTANCE IN OBTAINING NEEDED SERVICES

... EVALUATION FOLLOW UP OR CONTINUING CASE MANAGEMENT, WHEN APPROPRIATE

... COUNSELING SERVICES FOR FAMILIES

... AVAILABILITY OF CASE MANAGEMENT IN EACH COUNTY TO ALL AGED AND OTHER POPULATIONS ON A FEE FOR SERVICE OR SLIDING SCALE BASIS.

ADDITIONAL CONCERNS AND RECOMMENDATIONS FOR IMPLEMENTING HOUSE BILL 2081

5. Nursing Home Licensure

House Bill 2081 calls for "...implementation of a system, based on one level of care..." but within which a strategy would be developed and put in place to assure that even within

the single-license structure, each patient would receive a level and amount of nursing care required and justified by the patient's condition. The Department's proposals for meeting this mandate are described in the section of this report entitled "2. Nursing Care Based on Patient Acuity".

Carrying out those proposals and recommendations would lead to a single level of nursing care licensure. At present--since 1977--nursing facilities in Arizona have been licensed for three levels of care: skilled, intermediate and personal care.

The majority of facilities are licensed as skilled nursing facilities: 86 percent of the 79 licensed facilities are licensed in whole or in part as skilled nursing facilities. Of the total licensed beds, 75 percent are licensed as skilled nursing beds; 11 percent as intermediate and 14 percent as personal care. Despite such class distinctions in licensing, there are wide variations in the types of patients in any given facility, and variations in the amount of nursing care they require. But at the same time, most facilities licensed for only one level of care presently charge the same rate to all patients regardless of the acuity of their conditions.

There are exceptions. Twelve facilities currently licensed as skilled care have established two rate structures to reflect somewhat more precisely the amount of care and nursing staff the patient requires.

In addition, in the absence of established acuity standards, 22 skilled nursing facilities in Maricopa County accept County-established differential rates for skilled and intermediate care. These, of course, are the nursing facilities with which the county contracts for the provision of nursing home services for medically indigent patients.

It is clear that single level nursing care licensure cannot be put in effect until the Patient Acuity System has been developed and implemented. This is because the total legal mandate calls also for assurances that nursing care staffing will be appropriate to true patient needs. The return to a single level licensure should be postponed until the patient acuity system and other implementing strategies are developed and in place.

RECOMMENDATION 5

NURSING CARE INSTITUTIONAL LICENSURE

THE DEPARTMENT OF HEALTH SERVICES CONTINUE TO LICENSE THREE SUBCLASSES OF NURSING CARE INSTITUTIONS IN ACCORDANCE WITH A.R.S. 36 § 405.B.

6. Developing Least Restrictive Alternatives to Institutionalization

House Bill 2081 includes a clear mandate that strategies be developed to place persons in the least restrictive health care environment possible. While the mandate applies specifically to the indigent, the movement toward deinstitutionalization is a wider one affecting all who might be spared full institutional domicile. The following discussions and recommendations would promote development of new or expanded opportunities for placement in the least restrictive alternatives.

Supervisory Care Homes

Supervisory care homes are a new class of residential care institution created through enactment of A.R.S. § 36-401 in 1977. With enactment of this legislation, personal care homes became classified as a sub-class of nursing care institutions.

The intent of this legislation was to enable boarding homes to be licensed if they had been or would provide health related services. This resulted in upgrading standards of care. Most of the supervisory care homes had provided services to the chronic mentally ill and elderly.

The legislation defined a supervisory care home as a residential care institution which provided only supervisory care services to five or more ambulatory persons unrelated to the administrator or owner of such home. Supervisory care services were defined as board and general supervision, including assistance to persons in the self-administration of prescribed medications.

Many of the persons receiving services in supervisory care homes require services above those such a facility can provide. Some of the residents are not capable of self-administration of medications, and they need help with bathing, feeding and dressing. These are the aged and those who have mental or physical impairments. Such persons are imperfectly served by present classifications of homes: they need more care than is available in a supervisory care home, but less than is available in a nursing care institution. Clearly, there is need for further refinements in present legal definitions.

RECOMMENDATION 6

SUPERVISORY CARE HOMES

THE STATUTES AND REGULATIONS GOVERNING SUPERVISORY CARE HOMES BE MODIFIED TO ALLOW PERSONAL CARE SERVICES TO BE PROVIDED BY THESE FACILITIES; AND

LICENSED NURSES AND HOME HEALTH AGENCIES BE PERMITTED TO ADMINISTER MEDICATIONS AND TREATMENTS TO RESIDENTS IN THESE FACILITIES; AND

THE PRESENT DEFINITION OF 'AMBULATORY PERSON' BE RETAINED IN THE STATUTE TO ASSURE PATIENT SAFETY; AND

PERSONS WHO MAY BE MORE MENTALLY IMPAIRED AND UNABLE TO FIND THEIR WAY TO SAFETY WITHOUT ASSISTANCE BE PLACED IN A CERTIFIED ADULT FOSTER CARE HOME WHERE THE NUMBER OF RESIDENTS IS RESTRICTED TO FOUR OR LESS.

Home Health Services

With implementation of Medicare in July, 1966, home health services were formalized and minimum standards were developed to assure adequate care for the homebound aged sick.

Despite the obvious potential of home health services for reducing the more costly inpatient care, the development of home health agencies in Arizona has lagged, particularly outside Maricopa and Pima Counties. In seven of Arizona's fourteen counties there are no home health agencies at all. In several ways, the home health agencies play a mandated role in implementing House Bill 2081. For example, the bill calls for extension of home health services to the aged and physically and mentally disabled in supervisory care homes and adult foster care homes. In addition, the bill mandates that there be preadmission and annual screening of indigent persons placed in Long-Term Care settings and that the counties certify adult foster care providers which meet sanitation, nutrition and medication administration standards. Home health agencies could perform many, if not all of these functions.

RECOMMENDATION 7

HOME HEALTH

FUNDING BE PROVIDED FOR ESTABLISHMENT OF A HOME HEALTH AGENCY IN EACH COUNTY; AND

FUNDING FOR ESTABLISHMENT OF OTHER ALTERNATIVES TO INPATIENT CARE AND REIMBURSEMENT SYSTEMS TO PAY FOR ALTERNATIVE SERVICES BE EXPLORED.

Shortages in Rural Areas

Traditionally in Arizona, the rural areas have suffered most from shortages of health manpower and services. In the rural areas in particular, every health-related resource must be fully exploited.

RECOMMENDATION 8

EXPANDED UTILIZATION OF HEALTH CARE FACILITIES

THE DEPARTMENT OF HEALTH SERVICES COLLABORATE WITH OTHER PUBLIC AND PRIVATE AGENCIES TO PROMOTE MORE APPROPRIATE AND EXPANDED UTILIZATION OF EXISTING HOSPITALS AND NURSING CARE INSTITUTIONS IN RURAL AREAS.

Need for Reliable Data

A major and significant feature of House Bill 2081 is the built-in mandate to promote and develop alternatives to total institutional care. At present there is a scarcity of reliable data concerning the costs of alternatives to institutional placement.

RECOMMENDATION 9

COST STUDY

A COST STUDY BE CONDUCTED TO DETERMINE COSTS ASSOCIATED WITH:

- ESTABLISHING A CENTRALIZED CASE MANAGEMENT SYSTEM IN EACH COUNTY OR AREA OF THE STATE.
- ESTABLISHING OTHER ALTERNATIVE PROGRAMS SUCH AS DAY CARE, RESPITE CARE, HOME HEALTH PROGRAMS BOTH INSTITUTION-BASED AND COMMUNITY-BASED.
- IMPLEMENTING SPECIALIZED CERTIFICATION PROGRAMS IN NURSING CARE INSTITUTIONS.

7. Organizational Format to Implement House Bill 2081

To fully implement House Bill 2081 will require development of both statewide and local entities with collaborative power beyond the several organizational prescriptions in this report. While such synergetic influence would properly begin at the state level, perhaps the most effective promotional effort is to be expected at the county or areawide levels of promotional activity.

RECOMMENDATION 10

INTERAGENCY COLLABORATION

THE GOVERNOR'S COUNCIL ON AGING TAKE ON A LEADERSHIP ROLE IN COORDINATING THE HEALTH, SOCIAL SERVICES AND OTHER RESOURCES NEEDED TO KEEP AS MANY AGED, PHYSICALLY AND MENTALLY IMPAIRED AND OTHER DEVELOPMENTALLY DISABLED PERSONS IN THE LEAST RESTRICTIVE ENVIRONMENT POSSIBLE; AND

ORGANIZED CONSORTIUMS BE ESTABLISHED IN EACH COUNTY OR AREA TO COORDINATE EXISTING COMMUNITY RESOURCES AND TO PROMOTE THE ESTABLISHMENT OR EXPANSION OF OTHERS. THE CONSORTIUM PARTICIPANTS SHOULD INCLUDE RESPRESENTATIVES OF AREA AGENCIES ON AGING; REPRESENTATIVES OF STATE AND COUNTY GOVERNMENTS, INCLUDING BOARDS OF SUPERVISORS AND BOARDS OF HEALTH; CONSUMER ADVOCATE GROUPS; HEALTH SYSTEMS AGENCIES AND OTHER CONCERNED ORGANIZATIONS AND INDIVIDUAL CITIZENS.