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NURSING HOMES

Complaint Investigation Processes in Maryland

Statement of Kathryn G. Allen, Associate Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

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Nursing Homes: Complaint Investigation Processes in Maryland

Mr. Chairman and Members of the Committee:

We appreciate your invitation to discuss our recent findings on the effectiveness of federal and state nursing home complaint investigation practices, with a specific focus on our work in Maryland. The 1.6 million elderly and disabled residents living in nursing homes nationwide—including 26,000 in Maryland—are among the sickest and most vulnerable populations in the nation. They are frequently dependent on extensive assistance in basic activities of daily living like dressing, grooming, feeding, and using the bathroom, and many require skilled nursing or rehabilitative care.

The quality of care in nursing homes is a shared federal and state responsibility. The federal government, which will pay nearly $39 billion for nursing home care in 1999, has a major stake in ensuring that residents receive adequate quality of care. On the basis of federal statutory requirements, the Health Care Financing Administration (HCFA) defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs, and it contracts with states to certify that homes meet these standards through annual inspections and complaint investigations.

Complaint investigations are an integral part of the federal-state process to protect nursing home residents and to ensure that homes participating in Medicare and Medicaid comply with federal standards. Our recent work on this issue is one of several related projects on quality of care in nursing homes that we have conducted or are currently conducting at the request of the Senate Special Committee on Aging. In related efforts,[1] we have reported that

- one-fourth of the more than 17,000 nursing homes nationwide had serious deficiencies that caused actual harm to residents or placed them at risk of death or serious injury;
- 40 percent of these had repeated serious deficiencies;
- the extent of serious care problems portrayed in federal and state data is likely to be understated; and
- even when serious deficiencies are identified, federal and state enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected.

[1]California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998); and Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, Mar. 18, 1999).

Complaint investigations coupled with annual surveys, and any follow-up visits–visits targeted at problems found on recent surveys—are tools regulators use to assess the quality of care in a nursing home. Our work in Maryland focused on complaint investigations and did not evaluate either standard surveys or follow-up visits resulting from standard surveys. However, our work in other states has shown that systemic weaknesses also exist in many states' survey and enforcement practices. Even though they represent only one component of a state's nursing home oversight, complaint investigations provide a unique opportunity to visit a home as it appears to the resident on a day-to-day basis. Complaints provide important indicators of problems and are also one of the only mechanisms other than legal or police action for residents and family members to express concerns related to quality of care. In this context, I would like to focus the remainder of this statement on our findings on complaint investigations, particularly in Maryland.

In March, we reported on the effectiveness of states' complaint processes in protecting residents, based on our review of three states, including Maryland, and state auditor reviews in 11 other states.[2] We also assessed HCFA's role in establishing standards and conducting oversight of states' complaint practices and in using information about the results of complaint investigations to ensure compliance with nursing home standards.

In brief, federal and states' practices for investigating complaints about care provided in nursing homes are often not effective. Among many of the 14 states we examined, we found numerous problems, including procedures or practices that

- may limit the filing of complaints,
- understate the seriousness of complaints, and
- fail to investigate serious complaints promptly.

In Maryland, we identified many of these and other concerns regarding the responsiveness and effectiveness of complaint investigations. Compared with other states we reviewed, Maryland

- dedicated fewer resources to investigating complaints,

[2]See Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents (GAO/HEHS-99-80, Mar. 22, 1999). We examined Maryland, Michigan, and Washington as well as 11 other states reviewed by state auditors—Iowa, Kansas, Kentucky, Louisiana, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Wisconsin.

- recorded substantially fewer complaints than Michigan or Washington,
- generally classified similar complaints as needing less prompt investigation,
- did not meet the assigned time frames for investigating many complaints, and
- had a large backlog of uninvestigated cases and poor tracking of the status of investigations.

As a consequence, serious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months in Maryland. Such delays can prolong situations in which residents may be subject to abuse or neglect resulting in serious care problems like malnutrition and dehydration, preventable accidents, and medication errors.

Despite problems such as those in Maryland, HCFA has minimal standards and has exercised limited oversight related to states' complaint practices. To address these issues, we recommended that HCFA strengthen its standards for and oversight of states' complaint practices as well as its management information systems to more completely include complaint investigation results. In response to our March report, both HCFA and the state of Maryland have initiated several important improvements intended to increase the responsiveness and effectiveness of complaint investigations. For example, HCFA has instructed states to investigate any complaint alleging actual harm to a resident within 10 workdays. In Maryland, the recent budget approved by the General Assembly includes funding for a significant increase in the number of nursing home surveyors.

Complaint Practices Provide Limited Protection to Residents

Although investigations of complaints filed against nursing homes can provide a valuable opportunity for determining whether the health and safety of residents are threatened, complaint investigation practices do not consistently achieve this goal in many of the states we reviewed. In Maryland, several factors hindered the effectiveness of complaint investigations: limited resources, policies or practices that limited the filing of complaints and understated their severity, slow response times, and poor tracking of complaints. Consequently, we found substantiated complaints in which residents had been in harmful situations for extended periods, numerous complaints alleging serious care problems that remained uninvestigated, and other cases in which the state was unable to

determine whether the allegations were true, partly because so much time had elapsed since the complaint was received.

Maryland Dedicated Fewer Resources to Complaint Investigations Than Other States

While we did not assess the resource requirements for an effective state complaint process, our work indicates that Washington, which commits more resources to its complaint process than Maryland or Michigan, has a more responsive complaint system. Compared with the other two states we reviewed, Washington received a much higher volume of complaints, conducted more complaint investigations per home, prioritized most complaints within its two highest categories, and was more timely in conducting investigations. But to do this, Washington spent nearly 2 times the national average on complaint investigations per certified home in fiscal year 1998. In contrast, Maryland spent about one-fourth the national average and Michigan spent about 80 percent of the national average in fiscal year 1998. (See table 1.) In commenting on our report, Maryland and Michigan officials highlighted resource constraints as contributing to their problems with complaint investigations.

Table 1: Complaint Investigation Expenditures, FY 1998

	Maryland	Michigan	Washington	U.S. total
Percentage of total survey and certification expenditures	8	16	30	20
Average expenditures per home	$885	$2,694	$7,592	$3,397

Some Practices May Limit the Filing of Complaints or Quick Responses to Complaints

Some states have practices that may limit the number of complaints that are filed and investigated. For example, Maryland's policy is to accept and act on a complaint submitted by telephone even though callers are encouraged to submit a written complaint. However, state officials gave us conflicting information as to whether calls would be consistently documented and investigated when callers agreed to submit a written complaint but did not do so. Over 70 percent of Maryland's publicly reported complaints that the state investigated were identified as written complaints between July 1997 and June 1998.[3] In contrast, Washington readily accepted and acted on telephone complaints without encouraging a written follow-up, and nearly all its complaints were received by telephone. This practice appears to contribute to the much higher volume of complaints in Washington compared with Maryland. (See table 2.)

[3]The percentage is based on the total number of complaints in which information was available about whether the complaint was in writing or by telephone.

Table 2: Complaints Received, July 1997-June 1998

	Maryland	Michigan	Washington
No. of complaints	642	2,243	8,748
No. of complaints per 1,000 nursing home beds	21	45	336

Maryland, Michigan, and Washington each have a toll-free "800" telephone number that they make available for residents and families, the concerned public, and nursing homes to report complaints. For example, nursing homes in Maryland display a sign with the 800 number. However, our calls to 800 numbers indicated that some states are less consumer-friendly than others. As recently as June 11, 1999, the message on the Maryland 800 number indicated that it is for complaints regarding home health, with no mention of nursing homes. Also, Maryland's 800 number is not accessible by out-of-state family or friends who may have concerns about a resident's care. In addition, the direct (non-800) telephone number that Maryland publicizes rang unanswered and did not provide a message when we called it during nonbusiness hours. In contrast, Washington's 800 number is accessible both in and out of state, clearly states that it is for complaints regarding nursing homes and other settings, provides clear automated menu options allowing consumers to record their initial complaints, and promises to call the complainant back during business hours to confirm receipt of the complaint. The differences in the ease for consumers to file complaints among the states we examined may contribute to the large differences in the volume of complaints received.

Low Priority Levels Often Assigned to Serious Complaints

We found that some states classify few complaints at high-priority levels that would require an immediate or prompt investigation. In the 1-year period from July 1997 through June 1998, Maryland did not classify any complaints as having the potential to immediately jeopardize residents and thereby, according to federal policy, require a visit by an investigator within 2 workdays. In contrast, Michigan categorized about 2 percent and Washington about 8 percent of investigated complaints as requiring an investigation within 2 workdays. (See table 3.)

Table 3: State-Investigated Complaints Considered Potential Immediate Jeopardy, July 1997-June 1998

	Maryland	Michigan	Washington
No. of complaints classified as immediate jeopardy	0	24	223
No. of immediate jeopardy complaints per 1,000 nursing home beds	0	0.5	8.6
Immediate jeopardy complaints as a percentage of total complaints investigated	0	2	8

Some states also categorized relatively few complaints in other high-priority categories, such as those to be investigated within 10 days. For example, Maryland most frequently placed complaints in its lowest-priority category–to be investigated at the next on-site survey. This contrasts with Washington, which categorized nearly 90 percent of its complaints to be investigated within 10 workdays. Table 4 compares the three states' relative prioritization of complaints.

Table 4: Percentage of State-Investigated Complaints by Priority Category, July 1997-June 1998

Priority time frame	Maryland	Michigan[a]	Washington
Within 2 workdays	0	2	8
Within 10 workdays	22	N/A	81
Within 45 workdays	34	92	9
At next survey[b]	44	N/A	3
Other	N/A	5	N/A

Notes: Percentages may not add to 100 because of rounding.

N/A = not available.

[a]Michigan defines its priority time frames in terms of calendar days rather than workdays.

[b]Maryland defines this category as "the next on-site survey," whereas Washington defines it as being within 90 days or at the next on-site survey, whichever is sooner.

Several states have explicit procedures or operating practices that do not place serious complaints in high-priority categories for investigation. A Maryland official, for example, acknowledged reducing the priority of some complaints because the agency recognized that it could not meet shorter time frames because of insufficient staff. Both Maryland and Michigan gave some complaints low priority if the resident was no longer at the nursing home when the complaint was received—even if the resident had died or been transferred to a hospital or another nursing home as a result of care problems. For example, in testimony before the

Senate Special Committee on Aging, one complainant indicated that she was told that her complaint regarding the care her mother received in a Maryland nursing home was given low priority because her mother had died.

In reviewing complaints from Maryland, we identified several that raised questions about why they were not considered as involving potential immediate jeopardy, thereby requiring a visit within 2 workdays. Examples of these allegations include the following:

- An alert resident who was placed in a nursing home for a 20-day rehabilitation stay to recover from hip surgery was transferred in less than 3 weeks to a hospital because of an "unprecedented rapid decline [in his condition]." A member of the ambulance crew transporting the resident to the hospital reported that the resident "had dried . . . blood in his fingernails and on his hands . . . sores all over his body . . . smelled like feces . . . and [was] unable to walk or take care of himself . . .. I personally feel he was not being properly cared for." The Maryland state agency eventually determined that the nursing home had harmed the resident, but only after categorizing this complaint as not needing an investigation until the next on-site inspection, which was more than 4 months after receipt of the complaint.
- In another instance, the police reported suspected abuse and neglect to the state survey agency after a resident was brought twice to the hospital emergency room because of falls. The resident's first hospitalization identified a broken elbow, and the second found a contusion on the resident's cheek. The police did not believe the nursing home staff's account of how the resident had sustained these injuries. This complaint, filed 13 workdays before our visit, was being held by the Maryland state agency until the next on-site investigation.

Complaint Investigations Often Not Conducted in Timely Manner

Furthermore, we found that states often did not conduct investigations within the set time frames for the categories to which they assigned complaints, even though some states frequently placed complaints in priority categories that would increase the time available to investigate them. Some of these complaints, despite alleging serious risk to resident health and safety, remained uninvestigated for several months after the deadline for investigation. As shown in table 5, Maryland met its time frames for only 21 percent of complaints assigned to the 10-workday category and for 69 percent of complaints assigned to the 45-workday category.

Table 5: Percentage of State-Investigated Complaints Meeting Time Frame for Investigation, by Priority Category, July 1997-June 1998

	Maryland[a]	Michigan	Washington
Within 2 workdays	N/A	42[b]	78
Within 10 workdays	21	N/A	47
Within 45 workdays	69	26[c]	89
Within 90 workdays	N/A	N/A	100

Note: N/A = not applicable.

[a]Maryland's data provide information on the last date of the investigation, but not when the investigation was initiated. On the basis of our review of complaints received in early 1998, only 1 of 18 complaints was initiated within the assigned time frame of 10 workdays, and only 4 of 11 complaints were initiated within the assigned time frame of 45 workdays.

[b]When using the state requirement of 24 hours to investigate immediate jeopardy complaints, Michigan investigated 21 percent of these complaints on time.

[c]Michigan defines this as 45 calendar days rather than workdays.

Overall, Michigan met its time frames in about one-fourth of cases. Washington, which assigned most complaints to the category requiring a visit within 10 workdays, met its time frames for more than half (55 percent) of all complaints.

Failure by states to investigate complaints promptly can delay the identification of serious problems in nursing homes and postpone needed corrective actions. For nearly three-fourths of investigated complaints in 1998, the Maryland state agency was unable to make a determination as to whether or not the complaint was valid. The state agency's poor timeliness record in investigating complaints may in part contribute to the difficulty in establishing the validity of the allegations. These delayed investigations can prolong, for extended periods, situations in which residents are harmed. We reviewed all available complaints received in Maryland during the first 2 months of 1998 and found that in the following four cases, the state agency substantiated that residents had been harmed by poor care after an extended delay in investigating the complaint:

- A nurse charted that the resident's intravenous fluid was flowing well; however, the fluid was going under the resident's skin and not into a vein. The resident had to be hospitalized. The state investigated this complaint 139 days after receipt and confirmed that the home had harmed the resident.
- In the example cited earlier in which an ambulance crew member reported the resident smelled like feces and had dried blood under his nails and

pressure sores, the state substantiated harm to the resident 130 days after receiving the complaint.

- The state found that one home's inadequate supervision led to resident falls, including a resident who suffered a dislocated jaw and could not chew, which required a feeding tube, and who later developed pneumonia and was placed on life support in the hospital. The state cited the home with a deficiency for harming the resident after investigating 59 days after receiving the complaint.
- Three residents were hospitalized with several pressure sores. One resident had a sore that was exposed to the bone. Another resident had four sores; a third resident had three sores. The state, investigating 39 days after the complaint, noted only that the home did not ensure proper nutrition for one of these residents to prevent the development of the sores.

Since our report was issued, the state agency informed us it has conducted 170 complaint investigations to address pending complaints that exceeded the assigned time frame for investigating them. The state reported that about 20 percent of these investigations resulted in finding deficiencies that the home caused serious harm to residents.

Backlogs of Uninvestigated Complaints and Inadequate Tracking System Contribute to Delayed Responses

Each of the three states we visited had a backlog of complaints to be investigated and that exceeded the designated investigation time frames. As of December 1998, 12 nursing homes in the Baltimore metropolitan area had at least three complaints that had not yet been assigned to an investigator and that exceeded the designated time frames.[4] These unassigned complaints included a nursing home with three complaints alleging neglect or abuse that had not yet been investigated and had been pending for at least 3 or 4 months. These allegations included a resident who was not fed for nearly 2 days and was hospitalized with dehydration, pressure sores, and an infection; a resident whose condition had deteriorated, who had lost 10 percent of her body weight in 2 months and suffered from poor hygiene; and a resident who, as a result of being improperly repositioned, suffered two fractured legs.

The unassigned complaints in the Baltimore area represented only a subset of the complaints that had not been investigated. We were not able to fully identify the scope of Maryland's backlog, in part because of the inadequate information available in its tracking system. The Maryland

[4]For complaints designated to be investigated during a home's next on-site survey, we included only those received 45 or more workdays before our review.

backlog listed in our March 1999 report included only unassigned complaints, whereas the largest metropolitan areas in the other two states were held to stricter criteria—all unassigned and uninvestigated complaints for homes with at least three such complaints. We did not request all 209 Baltimore-area complaints that met these criteria because of the large volume—they represented 30 percent of all complaints filed in Maryland in 1998.

Federal and state tracking systems are vital to the timely investigation of complaints. The ability to track complaint investigations is important for quality assurance as well as ensuring that complaints are conducted within appropriate time frames. The incompleteness of Maryland's tracking data indicates that Maryland's automated system cannot be effectively used as a management tool for handling complaints. At the time of our visit, two-thirds of complaints received in 1998 did not have an investigation date recorded in the tracking system. Missing investigation dates went back to complaints received in 1995.

In contrast, Washington State has developed a complaint management information system that is used both for recording when complaints are called in to the agency and for tracking purposes. In addition, Washington has developed an electronic referral system for complaints that need to be sent to other state or external agencies. Its computer system also allows central office staff, who receive complaints statewide, to fax complaints directly to the district offices responsible for investigating them. Washington's tracking system allows active management of complaints throughout the investigation process, whereas this appeared to be lacking in Maryland.

As discussed in our report, we found that inadequacies in HCFA's data system and the linkage between federal and state systems hinder HCFA's and states' ability to adequately track the status of complaint investigations and for HCFA to maintain a full nursing home compliance history. In short, one HCFA official stated that the complaint system, contained in the On-Line Survey, Certification, and Reporting System is "not used as a management tool."[5]

[5]For an assessment of the weaknesses of HCFA's management information systems and the effect those weaknesses have on HCFA's enforcement activities, see GAO/HEHS-99-46, Mar. 18, 1999.

HCFA Oversight of States' Complaint Processes Is Limited

Although states have the primary investigatory role in complaint investigations, HCFA also plays a role in both oversight of states and partnerships with states through guidance, technical assistance, and training efforts. Although federal funds finance over 70 percent of complaint investigations nationwide and 60 percent of complaint investigations in Maryland, HCFA plays a minimal role in providing states with oversight or guidance regarding these investigations.

HCFA has left it largely to the states to determine which complaints are so serious that they must be investigated within the federally mandated 2 workdays. Until March 1999, HCFA had no formal requirements for the prompt investigation of serious complaints that could harm residents but were not classified as potentially placing residents in immediate jeopardy. Moreover, HCFA's oversight of state agencies that certify federally qualified nursing homes has not focused on complaint investigations. We found the following:

- A HCFA initiative to strengthen federal requirements for complaint investigations was discontinued in 1995, and resulting guidance developed for states' optional use had not been widely adopted.
- Federal monitoring reviews of state nursing home inspections primarily focus on the annual standard survey of nursing homes, with very few conducted of complaint investigations. HCFA's Philadelphia regional office did not conduct any federal monitoring reviews of complaint investigations in Maryland in 1998.
- Since 1998, HCFA has required state agencies to develop their own performance measures and quality improvement plans for their complaint investigations, but for several states we reviewed, complaint processes were addressed superficially or not at all. Maryland's 1998 report to HCFA indicates that it had not developed a quality improvement program or baseline performance measures for nursing home complaints.[6]

Responses by HCFA and Maryland to GAO Findings Since March 1999

In our March report, we recommended that HCFA develop additional standards for the prompt investigation of serious complaints, strengthen its oversight of state complaint investigations, and develop better management information systems to integrate the results of complaint investigations. HCFA concurred with our recommendations and immediately initiated several actions to address issues raised in our report:

[6]While not reflected as a part of HCFA's quality improvement program, the director of Maryland's survey and certification unit indicated that the unit had implemented some improvements during this time.

- HCFA instructed states to investigate complaints alleging actual harm to residents within 10 workdays. HCFA is developing additional guidance to further clarify which types of complaints meet this criterion.
- HCFA also reemphasized that states should cite federal deficiencies based on complaint investigations where appropriate, thereby reporting these deficiencies in the federal On-Line Survey, Certification, and Reporting System as well as in relevant state licensing systems. This allows HCFA and states to better capture and use the complete history of nursing homes' adherence to quality standards.
- HCFA is developing a Complaint Improvement Project that will develop additional standards and guidance for effective complaint investigations as well as establish performance measures and enhance HCFA oversight related to complaints.

As you know, the Maryland legislature has enacted and the state agency reported several important changes intended to improve the state's oversight of nursing homes in general and investigation of complaints in particular. While we have not evaluated the extent to which these have been implemented or their effectiveness, these actions appear to be important steps toward addressing the issues we raised. Maryland's recent actions include the following:

- An additional 20 long-term-care survey staff have been approved, including 10 additional staff in the current and next fiscal year. This represents a significant increase in resources from the existing 35 long-term-care survey staff.
- The state agency reported that all backlogged complaints were resolved. However, these complaints were resolved in part by temporarily suspending annual surveys. According to a state official, by integrating the surveyors responsible for conducting complaint and annual surveys and gaining additional staff resources, the state agency intends to maintain a better balance between complaint investigations and annual surveys.
- The state agency is developing a new complaint tracking database.
- After the state licensing and certification office moves to a new space in the late summer, a new telephone system will allow the long-term-care unit to have a separate 800 number. A message system is being considered but has not yet been agreed upon.
- A new Web page was put on the Internet 2 months ago, and several updates have been made since then. A system is being designed to allow complaints to be submitted via this Internet site.

In addition, as you know, this Committee established a task force to study the quality of care in Maryland nursing homes and required the Health Care Access and Cost Commission to produce a nursing home report card. Also, the General Assembly has required the Maryland Department of Health and Mental Hygiene to report by October 1 of this year on steps it has taken to improve the efficiency and effectiveness of the system to address complaints.

Conclusions

As the Congress, HCFA, and the states seek to better ensure adequate quality of care for nursing home residents, our work has demonstrated that complaint investigations need to be strengthened to provide better protections for the growing number of elderly and disabled Americans who rely on nursing homes for their care. Without such improvements, many federal and state policies and practices will continue to allow weeks or months to elapse before investigation of complaints that allege serious harm to residents. Both HCFA and Maryland have taken positive initial steps aimed at improving the responsiveness and effectiveness of complaint investigations. However, the seriousness and systemic nature of the weaknesses we identified in our review require sustained commitment and strengthened oversight to ensure that complaint investigations are used effectively to better ensure adequate care to nursing home residents.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or other members of the Committee may have.

GAO Contacts and Acknowledgment

For future contacts regarding this testimony, please call Kathryn G. Allen at (202) 512-7118 or John Dicken at (202) 512-7043. Gloria Eldridge also made key contributions to this statement.

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