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In the Matter of a Proposed Rule
Governing the Relocation of Residents from
Nursing Homes and Certified Boarding Care Homes

STATEMENT OF NEED AND REASONABLENESS

April 15, 1985

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STATE OF MINNESOTA
COUNTY OF HENNEPIN

BEFORE THE MINNESOTA
COMMISSIONER OF HEALTH

In the Matter of a Proposed
Rule Governing the Relocation
of Residents from Nursing
Homes and Certified
Boarding Care Homes

STATEMENT OF NEED
AND REASONABLENESS

The Minnesota Commissioner of Health (hereinafter "Commissioner"), pursuant to Minnesota Statutes Chapter 14, the Rule Review Procedures of the Attorney General, (Minnesota Rules Chapter 2000), and the requirements of the rules of the Office of Administrative Hearings, (Minnesota Rules Chapter 1400), hereby affirmatively presents facts establishing the need for and reasonableness of the above-captioned rule.

I. Introduction

In Order for the proposed rule to become effective the Commissioner must demonstrate that she has complied with all the procedural and substantive requirements of rulemaking. These requirements are: (1) that there is statutory authority for the rule; (2) that all necessary procedural requirements have been complied with; (3) that the rule is needed; (4) that the rule is reasonable, and (5) that any additional requirements imposed by law have been satisfied. This Statement demonstrates that the Commissioner has fulfilled these requirements.

II. Statutory Authority

The Minnesota Legislature, in 1983, created an Interagency Board for Quality Assurance. This law requires that the Interagency Board for Quality Assurance establish "effective methods of enforcing quality of care standards." Minnesota Statutes §144A.31, Subd. 4.

The Interagency Board for Quality Assurance consists of representatives from the Department of Health and the Department of Human Services (Public Welfare) and a representative from the Department of Public Safety. As such, the Interagency Board serves in an advisory capacity to the Commissioners of these departments and does not have the authority to adopt rules in its name.

The Commissioner of Health is responsible for considering and, if found appropriate, implementing the recommendations of the Interagency Board for Quality Assurance with respect to enforcing quality of care standards.

As regards operation of boarding care homes the Commissioner of Health is empowered to adopt and enforce rules which set minimum standards for, inter alia, "operation of institutions . . . as they relate to...the health, treatment, comfort, safety, and well-being of persons accommodated for care." See Minn. Stat. §144.56.

Regarding nursing homes, the Commissioner of Health is required, to the extent possible, to establish standards for the operation of nursing homes which will "assure the health, treatment, comfort, safety, and well-being of nursing home residents". See Minn. Stat. §144A.08.

III. Compliance with Procedural Rulemaking Requirements

Minnesota Statutes Chapter 14, the rules of the Office of Administrative Hearings, and the rules of the Attorney General specify certain procedures which must be followed when an agency adopts a rule. The Commissioner has complied with all prehearing requirements of law and rule for the period preceeding publication in the State Register of the rule and the notice of intent to adopt a rule. The most significant of these requirements are addressed below.

A. Procedural Rulemaking Requirements of the Administrative Procedures Act

1. Solicitation of Outside Information

Minnesota Statutes §14.10 requires agencies which, in preparing for adoption of a rule, seek information or opinion for sources outside the agency, to publish a notice of such action in the State Register. The agency must announce that all interested persons have an oportunity to submit data or views on the subject. In the State Register issue dated Monday, February 25, 1985, the Department of Health published a notice soliciting outside opinion: "Outside Opinion Sought Regarding Rules Governing the Relocation of Nursing Home Residents". 9 S.R. 1984. See Appendix A. No comments were received in response to that publication.

2. Approval of Form of Rule

This proposed rule has been approved as to its form by the Revisor of Statutes in accordance with the requirements of Minnesota Statutes §14.07, Subd. 2. See Appendix B.

3. Incorporation by Reference

This rule contains no incorporation by reference of any Minnesota Statutes, Minnesota Rules, United States Code provisions, Laws of Minnesota, Code of Federal Regulations provisions, the Federal Reporter, or any other document or source of information. See Minnesota Statutes §14.07, Subd. 4, and Appendix B.

4. Duplication of Statutory Language

This rule contains no duplication of statutory language. See Minnesota Statutes §14.07, Subd. 5, and Appendix B.

B. Adoption of a Temporary Rule

On July 13, 1984 the Commissioner signed an order adopting 7 MCAR §1.801 [Temporary], governing the relocation of residents from Nursing Homes and Certified Boarding Care Homes. That rule was approved by the Attorney General on August 23, 1984 and filed with the Secretary of State on August 27, 1984. See Appendix C.

The language of this proposed rule contains no substantial change from that of the adopted temporary rule.

IV. Statement of Need

The statute charging the Interagency Board for Quality Assurance with the task of recommending implementation of effective methods of enforcing quality of care standards requires the Commissioner of Human Services to implement a resident relocation plan which will direct the county welfare agency in means of meeting the needs of residents during relocation. The rule which this document supports, being promulgated by the Department of Health, sets out the requirements and procedures to be followed by a nursing home or certified boarding care home should the relocation of residents be necessary. This rule parallels the requirements in the Human Services rule.

The Commissioner of Health is responsible for considering and, if found appropriate, implementing the recommendations of the Interagency Board for Quality Assurance with respect to effective methods of enforcing quality of care standards. See Minn. Stat. §144A.31, Subd. 4.

The Interagency Board for Quality Assurance recommended adoption of this rule when proposed under the temporary rulemaking authority provided in the original legislative enactment: Laws 1983, Chapter 199. The Commissioner concurred with that recommendation and initiated the rule promulgation process. The temporary rule was adopted on July 13, 1984. There are no substantial changes in the rule as now proposed.

The provisions of this rule are designed to ensure that proper and sufficient notice is given to residents and other affected or involved parties. The provisions also require that assistance is provided to residents to properly prepare for the relocation. Sufficient and proper preparation and planning are aids in minimization of "transfer trauma", a term applied to the physical and psychological effects noted in health care facility residents when they have been relocated from one facility to another, or into or out of facilities. A Report, "Task Force on Relocation Report - Department of Public Welfare", dated October 1981, goes into detail on the issue of transfer trauma and the need for specific relocation procedures. A copy of that Report is attached as Addendum 1.

V. Statement of Reasonableness

To satisfy statutory requirements, an administrative agency must demonstrate that the rule proposed for adoption is reasonable. To demonstrate that a rule is reasonable does not necessarily mean that it must be shown to be "right". Rulemaking is a quasi-legislative process which primarily involves policy decisions. Thus there is no approach which is inherently right or one which is inherently wrong. In addition,

the rule does not have to be the best possible rule. Because policy decisions are involved, determining what is best would be practically impossible. What one person or group considers essential as an administrative or procedural requirement in a rule governing relocation of nursing home or boarding care home residents, may seem frivolous to another person or group because of differing policy perspectives and biases. Thus, in examining a rule, the standard is not whether the rule is right or best, but only whether it is reasonable, and in most cases there are many reasonable ways to address a subject covered by a rule. The rule governing the relocation of residents is no exception to this. As long as the approach taken by the agency falls within the wide range of reasonableness, the agency is acting within its power when it adopts that rule.

What is the measure of reasonableness? A rule is reasonable if there is a rational basis for it. Or, to express this in the negative, a rule is reasonable so long as it is not arbitrary or capricious. The Office of Administrative Hearings has provided a detailed explanation of the standard or reasonableness and the basis for it in the Report of the Hearing Examiner in the proceeding: "In the Matter of the Proposed Adoption of Rules Governing the Identification, Labeling, Classification, Storage, Collection, Transportation and Disposition of Hazardous Wastes and Amendments to Minnesota Regulation SW 1, 2, 3, 4, 5, 6, and 7, No. PCA-78-003-SW," at pp. 6-11. A copy of those pages is attached as Appendix D.

It is the Commissioner's contention that this proposed rule is reasonable.

This rule will impose only a few new requirements on facilities. A noted below, this rule in part draws together existing requirements of Minnesota Statutes and Minnesota Rules in a format which can be readily followed in the event relocation of residents is necessary. A number of existing licensure rules address a facility's responsibility in the discharge and transfer process and since these responsibilities

are already in place, the Department does not believe that any new responsibility is imposed on the facility.

For example: Minn. Rules 4655.1400 E already requires the development of resident transfer procedures; Minn. Rule 4655.3500, Subp. 4 requires that pertinent information relative to the care of a resident accompany that resident on discharge or transfer; Minn. Rules 4655.4700, Subpart 1 requires that a resident's medical record contain information on the condition of the resident at the time of discharge or transfer; Minn. Rules 4655.5800, Subp. 2.M., requires that the Director of Nursing Service paticipate in discharge and transfer planning for residents; and Minnesota Statutes 144A.16 requires nursing homes to provide 90 days notice to the Commissioner of any plans to cease or curtail operations to the extent that relocation of residents is necessary.

In addition, several provisions of Minn. Stat. §144.651, "Patients and Residents of Health Care Facilities; Bill of Rights" address responsibilities of the facility which this rule also addresses. These provisions are noted in the Specific Comments which follow.

The Commissioner's assertion that the rule is reasonable does not mean that she will not take into consideration further suggestions or comments which might be received following publication of this rule. The rulemaking process provides an ongoing opportunity for comment by groups which will be affected by the rule and affords the Commissioner an opportunity to modify the rule in response to any such comments. As it stands, however, the rule is reasonable and meets every procedural and substantive requirement for adoption.

VI. Specific Comments

Part 4655.6810 Definitions

This subpart simply sets out definitions for terms used in this rule. The definitions are consistent with the usage of the terms both in Minnesota Statutes and the rule being promulgated by the Commissioner of Human Services.

Part 4655.6820 Notice to the Department of Health

This part requires that the licensee of a facility notify the Department of Health, in writing, at least 90 days prior to an event which would necessitate relocation of residents. This provision is needed and reasonable in order to ensure that the relocation process is appropriately planned and to provide the Department with sufficient notice to monitor the implementation of the plan by the facility. A similar notice provision, for nursing homes, is contained in Minn. Stat. §144A.16. The specific elements of the written notice contained in this portion of the rule are needed to assure that the necessary information is provided to the Department. This information is readily available to the licensee of the facility.

Part 4655.6830 Facility Responsibilities

This rule specifically establishes the responsibilities of the facility in the event a relocation of residents is necessary. A major benefit of this rule is that specific procedures will now be adopted to govern the relocation process. Prior to this time the Department has only provided recommendations to a facility required to relocate residents. While those recommendations were based on the provisions of the licensure rules and statutes, and the Residents Bill of Rights, (Minn. Stat. §144.651), the establishment of this rule will now provide a concise and readily identifiable set of standards to be followed by the facility. It is the Department's position that this rule will help to assure that the necessary steps are taken to safeguard the health, safety, and well-being of residents during the relocation process.

Subpart 1 of this part requires that the facility staff cooperate with the representative of the Department of Health and the county social agency. This rule is needed and reasonable to assure appropriate cooperation between the facility and the agencies assigned to assist and monitor the relocation process.

Subpart 2 requires the establishment of an interdisciplinary team which shall be responsible for coordinating and planning the relocation. This rule is needed to assure that the appropriate members of the facility staff are involved in the relocation process and to assure that a coordinated relocation plan is developed. A well organized and coordinated relocation program will protect the well-being of the residents in the facility. This requirement is reasonable in that the interdisciplinary team needn't include anyone other than persons already on the facility staff.

Subpart 3 requires that written notices be provided to the resident, to the individual responsible for the resident's care, to the commissioner of human services, to the county social service agency, and to the resident's physician. The rule details the specific contents of these written notices. The rule is needed to assure that all affected parties are informed of the need for the relocation and to provide these parties an opportunity to participate in the relocation decision or to investigate other alternatives. The information required to be provided is information which is readily available to the facility.

Subpart 4 requires that the facility prepare a listing of available beds to which a resident can be located. This list must be made available to the resident, the individual responsible for the resident's care, to the long-term care ombudsman, and to the county social service agency. This rule is needed and reasonable to provide a resident with sufficient information to appropriately participate in the relocation planning. The list can be developed by contacting facilities within the area in which the nursing home is located. Assistance in the preparation of this list could also be obtained from the county social service agency.

Subparts 5 to 8 establish the procedures to be followed prior to the actual relocation. The rules require the holding of small group meetings to assure that residents are kept advised of the process; require the completion of an inventory of possessions and an accounting of personal funds; require, unless medically inadvisable, assistance in conducting site visits at the facility to which the resident may be moved; require the preparation of the necessary information concerning the resident's care; and require a 14 day notice prior to the actual relocation unless the resident agrees to a shorter notice period. Each of these requirements is designed to assure a smooth transition to a new health care facility. The rule is needed to minimize the problems associated with the move, especially transfer trauma, and is reasonable since many of the procedures specified reflect existing licensure requirements and all the procedures specified can be handled by the facility staff. The "Task Force on Relocation Report" recommended implementation of these types of procedures as means of minimizing transfer trauma. See Addendum 1.

Subparts 10 and 11 require assistance in making transportation arrangements and require that no disruption in the provision of meals, medication, or treatment occurs as a result of the relocation. Again, these provisions are needed and reasonable to provide for a smooth transition and to assure that the health, safety, and well-being of residents is protected during this process. Requiring that such assistance be rendered by the facility is no more than a reflection of the facilities responsibilities under the Patient and Resident Bill of Rights.

Subpart 12 requires that the resident's physician be notified of the new location of the resident within 24 hours after the move if the physician has not been previously notified. This rule is needed and reasonable to assure that there is no disruption in the medical services provided to the resident. While notice to the physician is already required under Subpart 3, this provision is included to assure that the physician is informed of the actual relocation when it occurs.

Subpart 13, requires that the facility provide the Department with weekly written status reports on the progress of the relocation. A final report is also required, once the relocation process is completed. This rule is needed to assure that the Department is fully advised as to the progress being made and the steps being taken by the facility in preparation for the relocation. As the licensing authority for these facilities, the Department is responsible for monitoring the care and services being provided to the residents. These reports will provide current information for Department review. The rule will not impose an unreasonable burden on the facility. The information requested to be provided will be readily available to the facility.

Several provisions of the "Patients and Residents of Health Care Facilities; Bill of Rights" Minn. Stat. §144.651, may be cited as indices of the reasonableness of the provisions of this rule. Conducting small group meetings is an activity which is a reasonable part of patient participation in planning treatment, Subd. 10. Assurance of continuity of care, Subd. 11, may be cited as justification for many of the requirements including everything from the notice to the physician, to the arrangement of transportation. Subd. 29, on transfers and discharges, is especially applicable. The required measures help assure that there will be no arbitrary transfers or dischages from the nursing home or boarding care home. Subd. 29 also provides a statutory requirement that the patient be given the area nursing home ombudsman's address and telephone number. This requirement is found in the proposed rule at 4655.6830, Subp. 3, A.

VII. Conclusion

While this rule is being promulgated to implement the recommendation made to the Department by the Interagency Board, it should also be noted that the Department has the authority to develop rules to protect the health, safety, treatment, comfort, and well-being of residents. This rule represents an effort by the Department to minimize the adverse effects which relocation has on residents.

Those adverse effects, known as transfer trauma, most certainly impact upon the areas of resident care which the Department of Health is charged with protecting.

Under the mandate of Minn. Stat. §144A.31, Subd. 4, the Commissioner of Human Services is proposing a relocation rule. Efforts have been made to make the provisions of each Department's relocation rule compatible. It is the position of this Department that both rules are needed and reasonable, and that the rules can be simultaneously administered effectively. The differences in the rules are based on the Department's jurisdictions. As an extension of the licensure authority, this Department's rule addresses the facility's responsibilities; while the Department of Human Services' rule relates to the authority of the county social services agencies.

APPENDIX A

Notice Soliciting Outside Opinion

Department of Health

Outside Opinion Sought Regarding Proposed Rules Governing the Relocation of Nursing Home Residents

Notice is hereby given that the Minnesota Department of Health is considering adoption of 7 MCAR § 1.801 [Temporary] as a permanent rule. This rule was published February 6, 1984 at 8 S.R. 1809.

This rule is authorized by Laws of Minnesota 1983, Chapter 199. The rule establishes the procedures to be followed by a nursing home or certified boarding care home in the event relocation of some or all of its residents becomes necessary. There are no changes anticipated in the rule at this time.

All interested or affected persons or groups shall have 30 days from the date of publication of this Notice to submit written

statements of information and comments to: Robert Eelkema, Minnesota Department of Health, Health Resources Division, P.O. Box 9441, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440.

Any material received will become part of the rulemaking record.

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APPENDIX B

Revisor's Certificate

OFFICE OF THE REVISOR OF STATUTES

Proposed Rule

RD748

Agency: Department of Health

Division:

Agency Contact: Bob Eelkema

Minnesota Rules: Parts 4655.6810 to 4655.6830

Title: Proposed Rules Relating to Relocation of Residents from Nursing Homes and Certified Boarding Care Homes

Type of Rules: Permanent

Incorporations by Reference: None

Steven C. Cross
Revisor of Statutes

Susan M. Lentsch
Assistant Revisor
Phone: 296-0956

Date: March 22, 1985

APPENDIX C

Order Adopting Temporary Rules
Temporary Rules With Attorney General Secretary of State Stamps

STATE OF MINNESOTA

DEPARTMENT OF HEALTH

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Adoption of a Temporary Rule Governing the Relocation of Residents from Nursing Homes and Certified Boarding Care Homes 7 MCAR §1.801

ORDER ADOPTING TEMPORARY RULES

The above-entitled matter was published in the State Register on February 6, 1984 as a proposed temporary rule pursuant to Minnesota Statutes sections 14.29 to 14.36. After affording interested and affected persons an opportunity to submit written data and views within 20 days of the publication date, reviewing and considering the data and views, and determining that the above-captioned rules are needed and reasonable;

NOW, THEREFORE, IT IS ORDERED:

that these rules identified as 7 Minnesota Code of Agency Regulations §1.801 et. seq. [Temporary] are adopted this 13 day of July, 1984, pursuant to the authority vested in me in Minn. Stat. §144A.31, subd. 4.

STATE OF MINNESOTA

Sr Mary Madonna Richter

COMMISSIONER OF HEALTH

SF-00006-02

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO : SISTER MARY MADONNA ASHTON
Commissioner of Health

DATE: AUGUST 23, 1984

ATTN: JOHN A BREVIU
Special Assistant
Attorney General

FROM : LARRY D STARNS
Special Assistant
Attorney General

PHONE: 296-3493

SUBJECT: In the Matter of the Adoption of a Temporary Rule Governing the Relocation of Residents from Nursing Homes and Certified Boarding Care Homes 7 MCAR §1.801

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Please note that they have not been filed with the State Register. This must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of stamps of the Attorney General and Secretary of State;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages to the rules in the approved set.

If you have any questions in this regard, please contact me.

Encs.

cc: Ms. Kathy Burek
Mr. Duane Harves

LDS:cb

Department of Health
Health Systems Division

Adopted Temporary Rule Governing the Relocation of Residents from Nursing Homes and Certified Boarding Care Homes

Temporary Rule as Adopted

7 MCAR S 1.801 [Temporary] Procedures governing relocation of residents from nursing homes and certified boarding care homes.

A. Definitions.

1. Relocation. The term "relocation" means a situation when residents are to be discharged from a nursing home or certified boarding care home as the result of the closing of the facility or the curtailment, reduction, or change of operations or services offered there.

2. Nursing home. A "nursing home" is a facility licensed pursuant to Minnesota Statutes, section 144A.01, subdivision 5.

3. Certified boarding care home. A "certified boarding care home" is a facility licensed pursuant to Minnesota Statutes, sections 144.50 to 144.56 and certified as an intermediate care facility as defined in United States Code, title 42, section 1396d, as amended through December 31, 1982.

4. Facility. For the purposes of 7 MCAR S 1.801 [Temporary], "facility" refers to a nursing home or certified boarding care home.

5. Service offered in the facility. "Service offered in the facility" includes participation in the medicare and/or medicaid programs pursuant to United States Code, title 42, sections 1395 et seq., and 1396 et seq., as amended through December 31, 1982.

B. Notice to the Department of Health.

1. The licensee of the facility shall notify the Department of Health, in writing, at least 90 days prior to the cessation or the curtailment, reduction, or change of operations or services which would result in the relocation of residents.

2. The written notice shall include the information in

a.-c.:

a. the date of the closing, curtailment, reduction, or change of operations or services;

b. the number of residents to be relocated; and

c. the names and telephone numbers of the persons in the nursing home responsible for coordinating the relocation of residents.

C. Facility responsibilities.

1. The licensee of the facility and facility staff shall cooperate with representatives from the department of health and from the social service agency for the county in which the facility is located in planning for the relocation of residents.

2. The administrator of a facility shall establish an interdisciplinary team which shall be responsible for coordinating and planning the steps necessary to relocate the residents. The interdisciplinary team shall consist of members involved in providing direct care services to residents.

3. The facility shall send written notices in a.-c. at least 60 days in advance of the date by which the relocation of residents is to be completed.

a. Notice shall be sent to the resident who will be relocated and to the individual responsible for the resident's care. This notice must include the name, address, and telephone number of the individual in the facility to be contacted for assistance and further information; the social service agency for the county in which the facility is located; and the area long-term care ombudsman, provided under section 307(a)(12) of the Older Americans Act, United States Code, title 42, section 3027, as amended through December 31, 1982.

b. Notice shall be sent to the social service agency for the county in which the facility is located. This notice must include the name of each resident to be relocated, the name, address, and telephone number of the individual responsible for the resident's care, and the name and telephone number of the individual in the facility to be contacted for further information.

c. Notice shall be sent to the attending physician of the resident to be relocated. The resident's attending physician shall be requested to furnish any medical information needed to update the resident's medical records and to prepare transfer forms and discharge summaries. This written notice must include the name and telephone number of the individual in the facility to be contacted for further information.

4. A list of available beds to which the resident can be relocated must be prepared. This list must contain the name, address, and telephone number of the facility, the certification level of the available beds, the type of services available, and the number of beds that are available. This list must be made available to the resident, the individual responsible for the resident's care, the area long-term care ombudsman, and the county social service agency.

5. The facility shall conduct small group meetings for the residents and the individuals responsible for the care of the residents to notify them of the steps being taken in arranging for the transfer. Individual residents shall be assisted as necessary.

6. The inventory of the resident's personal possessions must be updated and a copy of the final inventory provided to the resident, the individual responsible for the resident's care, or both. A final accounting of personal funds held in the facility must be completed in accordance with the provisions of 7 MCAR S 1.048 A.8.d. Arrangements must be made for the transfer of the resident's possessions and personal funds.

7. Unless it is medically inadvisable, as documented by the attending physician in the resident's care record, the resident shall be assisted in making site visits to facilities to which they may be transferred.

8. All administrative duties must be completed prior to the actual relocation of the resident. Personnel in the facility to which the resident will be moved shall be provided with the information necessary to provide care and services to the resident, in accordance with 7 MCAR S 1.048 A.3. (MHD

48(a)(3)).

9. Unless otherwise agreed to by the resident or the individual responsible for the resident's care, at least a 14-day notice shall be provided to a resident prior to the actual relocation.

10. The resident shall be assisted in making arrangements for transportation to the new facility.

11. There must not be a disruption in the provision of meals, medications, or treatments of the resident during the relocation process.

12. If not previously notified, the resident's attending physician shall be informed of the new location of the resident within 24 hours after the actual relocation.

13. Commencing the week following the relocation notice to the Department of Health, the facility shall provide weekly written status reports to the Department of Health as to the progress being made in arranging for the relocation. The initial status report must include the relocation plan developed by the facility, the identity of the interdisciplinary team members, and a schedule for the completion of the various elements of the plan. Subsequent status reports must note the progress being made, any modifications to the relocation plan, any change of interdisciplinary team members, and must include the names of residents who have been relocated during the time period covered by the report. Once relocation has been completed, a listing of the residents who have been relocated and the identity of the facilities or other locations to which the residents were moved must be provided to the Department of Health.

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
AUG 27 1984
Joan Anderson Growe
Secretary of State
10:07 AM

APPROVED AS TO LEGALITY
August 23, 1984
BY
SPECIAL ASSISTANT ATTORNEY GENERAL

APPENDIX D

Office Of Administrative Hearings
Reasonableness Standard

APPENDIX D

"In the Matter of the Proposed Adoption of Rules Governing the Identification, Labeling, Classification, Storage, Collection, Transportation and disposition of Hazardous Wastes and Amendments to Minnesota Regulations SW 1, 2, 3, 4, 5, 6 and 7, No. PCA-78-003-SW."

8. Having determined that there is a need for rules to regulate hazardous waste, this Report will address the issue of whether the proposed rules are reasonable.

9. In determining the reasonableness of the within considered hazardous waste rules, the Examiner applied the following meaning to the word "reasonableness": "Reasonableness" is the opposite of arbitrariness and caprice. An arbitrary and capri

cious standard can be defined as follows:

> That standard [arbitrary and capricious] is a narrow one, to be applied only where administrative action "is not supportable on any rational basis" or where it is "willfull and unreasoning action, without consideration and in disregard of the facts or circumstances of the case."

Greenhill v. Bailey, 519 F.2d 5, 10 (8th Cir. 1975). Reasonableness, then, means to have a rational basis for the action.

In setting forth the findings that establish the rational basis for adoption of these hazardous waste rules, the Agency is not limited to only those facts that are supported by substantial evidence in the record. Rulemaking is a legislative function; it is not an adjudicatory function like a contested case is. There is a difference between the kind of facts relied on in a rulemaking hearing and the kind of facts relied on in an adjudication. Professor Kenneth Culp Davis identifies this difference:

> Two main elements in rulemaking are (1) facts, and (2) ideas about policies. The two are generally interwoven in such a degree that in some parts of the whole problem of what to do, they are inseparable. Even so, a main element in rulemaking is necessarily the policy choice that the administrator must make. Adoption of a rule may require some understanding of facts, but it always requires legislating. Courts must leave administrators free to legislate, within the limits of rationality. And legislating inevitably involves the addition of something to the facts in the rulemaking record.

K. Davis, Administrative Law of the Seventies, (Cumulative Supp. 1977) (emphasis in original).

The Minnesota Supreme Court has recognized the difference between legislative facts and adjudicatory facts and has identified the support needed to uphold the two kinds of facts. In St. Paul Area Chamber of Commerce v. Minnesota Public Service Comm'n., 251 N.W.2d 350 (Minn. 1977), the Court said:

> [T]he substantial evidence test of § 15.0425 [is] applicable to commission decisions only when it is acting in a quasi-judicial manner, in a role similar to that of a trial judge sitting without a jury. In cases where the commission acts primarily in a judicial capacity, that is, hearing the views of opposing sides presented in the form of written and oral testimony, examining the record, and making findings of fact, the administrative process is best served by allowing the district court to apply the substantial evidence standard on review. . . .

> . . .[H]owever, rate allocation is not a judicial or quasi-judicial function. Once revenue requirements have been determined it remains to decide how, and from whom, the additional revenue is to be obtained. It is at this point that many countervailing considerations come into play. The commission may then balance factors such as cost of service, ability to pay, tax consequences, and ability to pass on increases in order to achieve a fair and reasonable allocation of the increase among consumer classes. . . .It is clear that when the commission acts in this area it is operating in a legislative capacity, as the above cases have stated. The careful balancing of public policies and private needs is not a matter for the courts, unless statutory authority has been exceeded or discretion abused. . . .In ascertaining whether or not the statute has been contravened, the district court must give wide latitude to the commission in allowing it to consider many factors which might not ordinarily be considered by a court, as we have explained above. This is so because, while the court is qualified to review agency findings when an agency acts in a quasi-judicial manner in factual matters, it is not so qualified to review legislative judgments when social policies must be weighed in the balance.

Id. at 356-357.

In the within considered rulemaking proceeding, many of the facts are legislative facts —policy decisions and judgments. A dermal toxicity value that distinguishes a hazardous waste from a nonhazardous waste is a legislative fact. There is no one right answer—there are only reasonable answers.

In another Public Service Commission ratemaking case, Northwestern Bell Telephone Co. v. State, 253 N.W.2d 815 (Minn. 1977), the Minnesota Supreme Court distinguished the two kinds of facts involved in exercising a legislative function. There the Court said:

> In determining the extent of the allowable adjustment, it appears that the PSC was acting in both a judicial and a legislative capacity. In finding as a fact the amount of the 1974 impact of the contract, the PSC's decision was amply supported by the evidence. In deciding to limit the adjustment to a one-year period, the PSC determined as a matter of public policy that changes occurring more than one year beyond the test year would best be considered in proceedings taking into account all of the facts necessary to accurately set Bell's rates. This determination cannot be said to be arbitrary or unjust. . . .

Id. at 822. See also, Northwestern Bell Telephone Co. v. State, 299 Minn. 1, 216 N.W.2d 841 (1974) and Reserve Mining Co. v. Herbst, 256 N.W.2d 808 (Minn. 1977).

Although the federal rulemaking process differs from that of Minnesota, it would be helpful to examine the federal system.

An example of a federal agency acting on legislative facts is Mourning v. Family Publications Service, Inc., 411 U.S. 356 (1973), where the U.S. Supreme Court upheld regulations of the Federal Reserve Board governing credit transactions of more than four installments. Professor Davis' discussion of the Mourning case is helpful:

> [T]he Supreme Court had no power to change "four" to three or five, because Congress had delegated that power to the Board and the Board had made its determination. On the question of what the number should be, the Court could do no more than determine whether "four" was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

K. Davis, Administrative Law of the Seventies, 206 (Cumulative Supp. 1977).

Dry Color Manufacturers' Ass'n v. Department of Labor, 486 F.2d 98 (3rd Cir. 1973), involved temporary emergency standards of the Department of Labor intended to prevent exposure to 14 chemicals found to be carcinogens. In striking down the regulations, the Court essentially said the Department did not have sufficient reasons for the regulations. Davis, however, is critical of the Court's decision:

> If carcinogenicity of the chemicals in humans can be neither proved nor disproved by scientific evidence, the problem for rulemakers is not one of fact; it is one of making a legislative choice of policy in light of the absence of evidence. When an agency is assigned the task of making rules that are in the public interest, it seldom can prove with evidence what is in the public interest; it has to use its policy preferences when proof is lacking.

K. Davis, Administrative Law of the Seventies, 674 (1976).

Some of the recent cases involving rulemaking by federal agencies in the environmental and health areas indicate the kind of latitude agencies have in making these legislative policy decisions. A leading example is Ethyl Corp. v. EPA, 541 F.2d 1, 8 E.R.C. 1785 (D.C. Cir. 1976), where the Court upheld regulations of the EPA requiring a reduction of lead in gasoline.

> Man's ability to alter his environment has developed far more rapidly than his ability to foresee with certainty the effects of his alterations. It is only recently that we have begun to appreciate the danger posed by unregulated modification of the world around us, and have created watchdog agencies whose task it is to warn us, and protect

> us, when technological "advances" present dangers unappreciated—or unrevealed—by their supporters. Such agencies, unequipped with crystal balls and unable to read the future, are nonetheless charged with evaluating the effects of unprecedented environmental modifications, often made on a massive scale. Necessarily, they must deal with predictions and uncertainty, with developing evidence, with conflicting evidence, and, sometimes, with little or no evidence at all. Today we address the scope of the power delegated one such watchdog, the Environmental Protection Agency (EPA). We must determine the certainty required by the Clean Air Act before EPA may act to protect the health of our populace from the lead particulate emissions of automobiles.
>
> • • •
>
> . . .We find that deletion of the findings requirement for action under Section 211(c)(1)(a) [of the Clean Air Act] was a recognition by Congress that a determination of endangerment to public health is necessarily a question of policy that is to be based on an assessment of risks and that should not be bound by either the procedural or the substantive rigor proper for questions of fact.
>
> • • •
>
> . . .The Administrator may apply his expertise to draw conclusions from suspected, but not completely substantiated, relationships between facts, from trends among facts, from theoretical projections from imperfect data, from probative preliminary data not yet certifiable as "fact", and the like. We believe that a conclusion so drawn—a risk assessment—may, if rational, form the basis for health-related regulations. . . .
>
> All of this is not to say that Congress left the Administrator free to set policy on his own terms. To the contrary, the policy guidelines are largely set, both in the statutory term "will endanger" and in the relationship of that term to other sections of the Clean Air Act. These prescriptions direct the Administrator's actions. Operating within the prescribed guidelines, he must consider all the information available to him. Some of the information will be factual, but much of it will be more speculative—scientific estimates and "guesstimates" of probable harm, hypotheses based on still-developing data, etc. Ultimately he must act, in part on "factual issues", but largely "on choices of policy, on an assessment of risks, [and] on predictions dealing with matters on the frontiers of scientific knowledge . . . ." Amoco Oil Co. v. EPA, supra 163 U.S. App. D. C. at 181, 501 F.2d at 741. A standard of danger—fear of uncertain or unknown harm—contemplates no more.

Id. at 6, 24, and 28, 8 E.R.C. at 1786, 1801, and 1804-1805. The Amococase cited in Ethyl was another case by D. C. Circuit in which the court upheld for the most part regulations of EPA prohibiting use of leaded gasoline in automobiles fitted with

catalytic converters. Amoco Oil Co. v. EPA, 501 F.2d 722, 6 E.R.C. 1481 (D.C. Cir. 1974).

Another leading case in this area, and one relied on by the Ethyl court, is Industrial Union Department, AFL-CIO v. Hodgson, 499 F.2d 467 (D.C. Cir. 1974), involving a review of asbestos regulations promulgated by the Secretary of Labor. There the court said:

> From extensive and often conflicting evidence, the Secretary in this case made numerous factual determinations. With respect to some of those questions, the evidence was such that the task consisted primarily of evaluating the data and drawing conclusions from it. The court can review that data in the record and determine whether it reflects substantial support for the Secretary's findings. But some of the questions involved in the promulgation of these standards are on the frontiers of scientific knowledge, and consequently as to them insufficient data is presently available to make a fully informed factual determination. Decision making must in that circumstance depend to a greater extent upon policy judgments and less upon purely factual analysis.

Id. at 474 (footnote omitted).

10. Note must be taken that during the hearing process and before the close of the record, the Pollution Control Agency made various amendments to the proposed rules as originally published for hearing.

One of the principal benefits of a public hearing process is that it gives the administrator the benefit of criticisms and suggestions from representatives of the industries that will be regulated. It was just such a give-and-take process that prompted the Pollution Control Agency to amend the rules as finally proposed for adoption.

Because of such amendments, it will be necessary during certain portions of this Report, to specify whether an examination of the "reasonableness" of the proposed rules is being examined in light of the original proposal or the rules as finally proposed for adoption.

11. In determining the issue of "reasonableness", this Report will first examine the reasonableness of the wastes regulated by reason of being designated as "hazardous" pursuant to the proposed rules.

ADDENDUM 1

Relocation Task Force Report

ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT Minnesota Board on Aging

Office Memorandum

TO : DPW Relocation Task Force Members

DATE: October 9, 1981

FROM : Karin Sandstrom, Chairperson
Pamela Parker, Staff

PHONE:

SUBJECT: Task Force on Relocation Report

Enclosed is the final Relocation Task Force Report and memo to Commissioner Noot. Thank you for your helpful comments on the draft report many of them have been incorporated into the final report. We did not recopy all of the attachments sent in the early draft as there were no changes in that section of the report.

Once again we wish to thank you for your valuable contribution to this effort. This is a complex and difficult issue and we feel these recommendations represent a practical and effective approach to the problem.

We hope you will continue your efforts to support adoption and implementation of a State Relocation Plan as one element of a comprehensive approach to Adult Protection in this state.

lc

Enc.

ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT Minnesota Board on Aging

Office Memorandum

TO : Arthur Noot
Commissioner of Public Welfare

DATE: October 9, 1981

FROM : Karin Sandstrom, Chairperson
DPW Relocation Task Force

PHONE: 296-2062

SUBJECT: Task Force on Relocation Report

RECEIVED
OCT 20 1981
DIVISION OF
HEALTH SYSTEMS

Enclosed is the final report and recommendations of the Department of Public Welfare Relocation Task Force. The report reflects the consensus of a variety of qualified individuals representing many human service sectors on how to deal practically with a difficult and complex problem. We are very pleased with the task force efforts and hope our recommendations will be adopted as a mechanism to reduce the trauma that institutionalized persons experience in instances of facility closure, certification loss or provider agreement termination.

We believe that the existance of a State Relocation Plan is a necessary element in a comprehensive approach to adult protection in this state.

We would like to meet with you at your earliest convenience to discuss methods of implementing these recommendations. We will be contacting you shortly to arrange an appropriate time and date.

lc

Enc.

FINAL

TASK FORCE

ON

RELOCATION

REPORT

DEPARTMENT OF PUBLIC WELFARE - STATE OF MINNESOTA

October 1981

Report Prepared for
the Commissioner of
Public Welfare by

Long Term Care Ombudsman Program
Minnesota Board on Aging
Minnesota Department of Public Welfare
204 Metro Square
St. Paul, Minnesota
612/296-7465

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Introduction

Purpose

This report summarizes the deliberations of the Relocation Task Force and presents the members' recommendations to the Commissioner of Public Welfare.

The impetus for appointing the task force arose primarily out of concerns raised by advocates, county case workers, medical personnel and families of nursing home residents upon termination of facility certification or licensure. These concerns were expressed to the Minnesota Board on Aging Long Term Care Ombudsman Program, located in the Aging Division of the Department of Public Welfare. Earlier, a Technical Assistance Memorandum from the Administration on Aging to the Minnesota Board on Aging encouraged state agency on aging involvement in the development of relocation procedures which would protect residents of nursing homes from unnecessary trauma and disruption during mass transfer to another institution. The Minnesota Board on Aging had worked closely with the Medical Assistance Division in development of an informational bulletin addressing this issue. However, new concerns arose out of implementation of the 1976 law equalizing private and medicaid rates. Final implementation of the law had been held up by pending litigation brought by provider groups. There was potential that some facilities would choose to withdraw from the Medicaid program should their lawsuits be unsuccessful. Informal meetings between consumer groups, Legal Aid and Department of Public Welfare officials led to a recommendation that a transfer policy be developed for the state to augment existing procedures in hope of providing clear direction for procedures to protect residents health and safety should such a situation arise.

A nineteen member task force representing diverse provider, consumer, and county and health professional expertise was appointed by Commissioner Arthur Noot on July 15, 1981.

Dr. Norman Bourestom, who has done extensive research on relocation trauma, was hired as a consultant for the task force through Title IVA funds provided to St. Cloud State University by the Minnesota Board on Aging. Mr. Bourestom and Aging Advocacy staff are available to assist in training and orientation of county personnel. The task force was given the following charge, duties and goals.

CHARGE: To develop and coordinate an orderly program for relocation of residents of long term care facilities which is consistent with established Department of Public Welfare policy regarding the transfer of Medical Assistance residents. (Policy Bulletin #79-77, Guidelines for Relocation of MA Residents in Long Term Care Facilities).

The relocation program must anticipate any future situations in whicn residents of long term care facilities may face transfer to other facilities due to emergencies such as facility closure, loss of certification, and termination of receivership.*

*Please note that state and federal regulations already require nursing homes to have a disaster evacuation plan in case of flood, fire, tornado, etc.

Relocation Task Force, continued:

DUTIES:

To review, revise and develop a statewide Relocation Plan and Implementation strategy.

To identify appropriate personnel to serve as a Relocation Committee in target counties.

To develop and sponsor training regarding relocation procedures for Relocation Committees.

GOALS:

To preserve the lives of residents being relocated.

To minimize trauma and discomfort of residents relocated from facilities.

To avoid hazards and suffering which may result from repeated moves by assisting in appropriate placement at the time of the first move.

Clarification of Objectives

The charge was discussed and clarified by the task force as follows:

- Relocation should only take place after all other avenues have been exhausted. Attempts should be made to prevent relocation except as a last resourt when the health and safety of residents is jeopardized.
- The plan should clearly cover state hospitals
- Such a plan should cover private pay patients as well as Medicaid patients. (However county and DPW statutory authorities to require the application of the plan to private pay residents is not clear.)
- Amendments to the Minnesota Department of Health licensing rules would be needed to require facility compliance with a plan.
- The plan should attempt to address individual as well as group relocation.
- The plan should augment and coordinate earlier guidelines developed by the Minnesota Department of Health and Department of Public Welfare but should be more specific about procedures taking place at the county level.

Work Process

Twelve meetings were held from July 23, 1980 to November 19, 1980. The task force work progressed as follows:

1. Review of the charge to the task force and clarification of the objectives.

Work Process, continued:

2. Presentation by Dr. Norman Bourestom. General orientation of the task force to the issue of transfer trauma and related problems arising out of the forced relocation of frail and vulnerable adults. Review of plans and approaches utilized in other states.
3. Identification of principles and components which should be included in a State Relocation Plan.
4. Development and refinement of a Draft Relocation Plan.
5. Discussion and design of implementation strategies.
6. Discussion and design of a training package for implementation of the plan.
7. Final recommendations.

RELOCATION ISSUES: OVERVIEW

Statement of the Problem: Transfer Trauma

A growing body of research (over 200 studies since 1945) suggests that involuntary relocation of elderly or frail persons, particularly from one institution to another, entails considerable risk. In many cases, disruption of social relations, decline in morale, disorientation and increase in mortality and morbidity rates have occurred after involuntary relocation. This phenomena has been termed "transfer trauma". However, it has been shown that transfer trauma can be substantially reduced by providing adequate advance notice of the move coupled with a program of counseling, visitation to the new home and coordination of the transfer process.

Instances of relocation of large groups of residents have been numerous in other states leading to frequent litigation and varying outcomes. In general the courts have recognized "transfer trauma" as a legitimate problem and in many cases have required states to develop measures to alleviate the potential harmful effect of facility closure decertification on residents.

As a result, a number of states have state law, regulation or policies outlining procedures for relocation of institutionalized residents when a facility is closed, decertified or voluntarily withdraws from the Medicaid program or when large groups of residents are reclassified from one level of care to another. These states include Connecticut, Florida, Illinois, Iowa, Michigan, New York, Oklahoma, Rhode Island, Texas, and Wisconsin. In addition, Pennsylvania has developed an elaborate relocation plan by departmental directive.

The federal requirements that a State Medicaid plan be designed so as to provide for the best interests of recipients, while not specifically requiring a state relocation plan, is frequently cited as supportive of the states authority and responsibility to implement a plan. (SSA Section 1902 (a)(19))

Statement of Problem: Transfer Trauma, continued:

While incidents of relocation of large groups of instititionalized residents in Minnesota have not been so frequent, relocations have occurred. Little documentation or information is available on these relocations, which have been related to sale of a facility, voluntary withdrawal from the Medicaid program, closure of a facility by legislative action and withdrawl of program or health standards license by a state agency. Medical professionals, consumer advocates, county caseworkers, residents or families have expressed concern about various problems experienced during the relocation including lack of notice to residents, families, and physicians, inappropriate subsequent placement, lack of coordination or supervision of the placement process, violations of patients rights to choice of vendor and lack of time to prepare for the move. Other situations have also arisen where the relocation of large groups of residents has been barely averted. These include facility bankruptcy, facility sales and lack of compliance with program standards which threatened licensure.

In addition to these instances, there remains the potential for future closure of facilities for one reason or another, decertification or voluntary withdrawal from the Medicaid program, termination of facility receivership after the period allowed by law, or changes in facility program licensure or bed certification.

It should be recognized that individual nursing home transfers are much more frequent. These are usually due to medical necessity (e.g. change in care level) though in a few cases retaliation for complaints made may be an underlying factor. Transfers within a facility (e.g. from room to room or floor to floor) are even more common and may be due to medical necessity or administrative convenience. The effects of these individual transfers on residents, particularly when there is a lack of preparation or involvment in the decision, may be equally severe; however, little research or documentation is available in this area.

Existing Policy and Practice in Minnesota

The Minnesota Residents Bill of Rights and Federal regulations for rights of patients in skilled and intermediate care facilities provide that residents must receive reasonable advance notice of transfer (for ICF patients at least 5 days) and that transfer of residents may occur only for medical reasons, his or her welfare or that of other residents or for nonpayment of care (except as prohibited by Medicare or Medicaid). The issue of what are patients rights during closure or decertification of a facility has been addressed primarily in court actions. Most recently the United States Supreme Court held that residents of nursing facility are not constitutionally entitled to a hearing prior to decertification of a facility. The court held that the residents do not have the right to continue to receive benefits in a home that is not qualified for those benefits. However the court did recognize that revocation of the homes certification and subsequent relocation of patients may be harmful to some patients. The court also found that, though the regulations protect patients by

Existing Policy and Practice in Minnesota, continued:

limiting the circumstances under which a home may transfer a Medicaid patient, they do not purport to limit the governments right to make a transfer necessary by decertifying a facility (O'Bannor v. Town Court Nursing Center.)

Both Department of Public Welfare and the Minnesota Health Department have recognized the value of outlining some procedures for the location of groups of institutionalized residents, though no specific regulations exist covering relocation in Minnesota.

In March of 1978 the Health Systems Division of Minnesota Department of Health, responsible for licensing and inspecting health care facilities, developed an outline providing guidelines for facilities to follow in the event of relocation. When the division is aware or has been notified of an impending relocation it is their practice to contact the facility to provide technical assistance. (See Exhibit 1.)

In 1977 staff of the Medical Assistance Division of the Department of Public Welfare began work on a Relocation Plan to provide a uniform and humane approach for avoiding trauma associated with relocation, and coordination for the relocation process. After extensive review and revision by numerous individuals and groups the plan was distributed as Informational Bulletin #79-77 on September 10, 1979 as a proposed guideline. While the plan clarified formal notice and hearing procedures to facilities and outlines some steps to be taken at the local (county level), the plan did not cover voluntary termination or withdrawal from the Medicaid program.

Staff was unable to document any precedent setting court cases specific to Minnesota involving involuntary transfer or relocation of residents.

Issues Identified by the Task Force

A summary of task force discussions follows:

A. Stress Factors in Relocation

The task force reviewed literature and heard a presentation by Dr. Norman Bourestom who has done extensive research on transfer trauma. Dr. Bourestom identified particular factors increasing stress and potential adverse effects of involuntary relocation. These included:

1) Forced transfer of dependent persons
2) Radical environmental changes
3) Lack of preparation
4) Frailty, age and psychological disturbances

The potential for adverse effect of a relocation increases in proportion to the degree to which these elements are present.

Relocation research has demonstrated repeatedly that multiple site visits are of a crucial importance in mitigating mortality and morbidity. Since frail elderly people require concrete and redundant cueing to assimilate imformation adequately, multiple site visits are needed so that information can be processed and adequate learning take place in order to counteract the effects of sudden uprooting from the familiar environment.

Dr. Bourestom outlined the Bourestom/Pastalan Studies done in Michigan and the studies of Dr. Martin Leiberman which provided evidence that prior site visits and advance preparation had significant positive effects on relocated residents. (See Exhibit 3).

B. Early Closure

While Minnesota Department of Health regulations require facilities to provide ninety days advance notice of final closure, nothing appears to prohibit the facility from moving patients immediately after this notification to Minnesota Department of Health. Task force participants were familiar with one recent incident in which this occurred and where residents received very little advance notice of their move. Concern was expressed that notification of residents should not be left to the facility but should be done by the county to provide uniformity. County staff are often uninformed of the moves until it is too late to intervene to provide assistance to residents on placement.

C. Termination of Medicaid Payments

Federal regulations allow for only thirty days of medical assistance payment after the facility is notified discontinuance of FFP. Even if the facility appeals the decision, medical assistance payments will not continue beyond this date. Some cases are resolved very close to the thirty day limit and FFP is then reinstated. This situation gives rise to the question of when should the relocation

process begin? It may be difficult to implement preparation procedures in these cases since final outcome is still not clear. Timing of appeals and last minute facility compliance are uncontrollable factors in the process. Court action (e.g. a temporary restraining order) may be sought by advocates in some cases to gain time to implement relocation preparation procedures.

D. Notification of Private Pay Residents

There was concern that private pay residents be notified in a manner consistent with notification of Medical Assistance residents. The question of who was responsible for this notification was discussed at length. It was the consensus of the task force that responsibility for notification and an offer of service to the private pay resident could be appropriately assigned to the county under its general adult protection activities.

E. Lack of Facility Cooperation in Relocation

The question of what can be done if the facility will not cooperate and assist in appropriate relocation activities was discussed. Medicaid regulations require the facility to demonstrate reasonable good faith efforts to provide appropriate relocation. However documentation of this is required only after the fact and may come too late to stop poor relocation methods. Therefore the involvement of persons outside the facility (e.g. county staff) was considered necessary to ensure that proper procedures are followed.

Decertified facilities may have little incentive to assist in appropriate relocation. In addition, facility staff may be leaving or be terminated making continuity in the facility relocation process impossible.

F. County Responsibilities

The question arose as to whether the counties could be required to undertake these activities upon Department of Public Welfare direction. The question of whether or not further Department of Public Welfare authority is needed was referred to the attorney general's office.

G. Plan Format

How the plan should be issued (e.g. as a rule, guidelines or instructional bulletin etc.) was a major issue for the Task Force. The Task Force felt this was up to the Commissioner-dependent upon the Attorney General's office determination regarding Department of Public Welfare authority in this area. However it was felt that in order to be effective the plan should be issued in as strong a form as possible. The following memo was sent to the Commissioner requesting clarification of Department of Public Welfare's authorities. (See Attached).

1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT Aging

Office Memorandum

TO : Arthur E. Noot
Commissioner

DATE: 11/5/80

FROM : Pamela J. Parker, Staff
DPW Relocation Task Force

PHONE: 6-7465

SUBJECT: DPW Relocation Plan

As the Relocation Task Force continues its work on development of a Relocation Plan for long term care facility residents we have identified several issues which may need clarification by your office.

1. Does DPW have sufficient authority to implement a Relocation Plan? If present authorities are not sufficient, we may need to pursue legislation to clarify.

Discussion

While some states (Wisconsin) appear to have state statutes referring to relocation plans other, (e.g., Pennsylvania) have developed plans without specific statutes. A number of transfers related court cases cite broad references in U.S. code to the state's responsibility to provide "care and services consistent with the best interests of recipients". (42 USC S1296(a)). Other directives from the office of Nursing Home Affairs (Policy circular #2, March 29, 1974) and the Administration on Aging (AoA-TA-75-1 re-issued 7/20/77) cite state responsibilities in Relocation Plan development. There is also a reference to "the state's relocation plan" in proposed SF/ICF Conditions of Participation.

Discussions with staff of the Medicaid Division in Pennsylvania indicate that legislation is being pursued to strengthen their plan which has been in effect for several years.

2. Should the Relocation Plan now being developed be promulgated as rule, or should it be issued as a DPW policy? (e.g. MA manual instructional bulletin).

3. Can Relocation situations be considered Adult Protection cases. And if so, how should our efforts be coordinated with implementation plans for Vulnerable Adults Protection Act?

We will be happy to discuss these questions further with any other appropriate staff.

PJP:db

H. Facility Relocation Plans

Department of Public Welfare and County Welfare Departments do not appear to have the authority needed to require facilities to comply with a state relocation plan. Therefore a recommendation was made to the Commissioner of the Department of Public Welfare that a memo be sent to the Commissioner of Health requesting that a relocation plan requirement be included in Minnesota Department of Health regulations currently being revised.

The following memo was subsequently sent by Commissioner Noot to the Commissioner of Health, Dr. Petterson. (Memo Attached.)

ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

10.

DEPARTMENT of Public Welfare

Office Memorandum

TO : George R. Pettersen, M.D.
Commissioner
Minnesota Department of Health

DATE: October 30, 1980

FROM : ARTHUR E. NOOT
Commissioner

PHONE: 6-2701

SUBJECT: Proposed MDH Regulations

As you know, sometime ago I appointed a Relocation Task Force to address many of the issues we have discussed previously with respect to emergency situations in nursing homes and other facilities.

Given that you are now proposing Rule-making, may I recommend that your Rule promulgation include a requirement that each facility establish and implement a "relocation plan" which incorporates at least the following elements:

a) That the facility be responsible for written notification to each affected resident, and to their representative or family member, guardian and physician of the pending relocation, reasons, and the rights of the resident, within 7 days of notice to or by MDH/DPW of withdrawal or decertification.

b) That the facility must establish a facility Relocation Team.

c) That the facility Relocation Team shall assist in identification of residents to be relocated, resident preparation, facilitating site visits if appropriate, coordination of medical records information, and transfer arrangements.

d) That the facility shall contact and cooperate with the county welfare department in their county regarding the relocation of resident.

e) That no resident may be involuntarily transferred prior to the completion of these elements and in no case sooner than 14 days from the date of notification of the resident.

It is our understanding that your Department has statutory authority to require the above. We feel that this is necessary for any successful relocation plan. Please advise if you need further information.

AEN:mmv

cc: Gary Haselhuhn
Karin Sandstrom
Barbara Stromer

I. Facility Admission Agreements

Are private pay residents required to provide notice of their move as specified in their admission agreement in situations where licensure of certification is terminating (either by state or facility initiation)? How would residents receive notice that they did not have to abide by the agreement if this is so? A legal opinion on this question sought by Minnesota Department of Health stated that any penalities under such agreements would probably be considered null and void since the circumstances may make it impossible for residents to provide notice. Legal Assistance for such residents should be sought.

J. Appeal Rights

Should facility appeal mechanisms be addressed in the Plan? It was decided that this is provided for in earlier Department of Public Welfare and Minnesota Department of Health documents so it need not be included in this Plan.

Resident appeal rights were also discussed at length. Due to the recent Supreme Court decision it was decided not to include appeal rights or hearings for residents in cases of closure or decertification; however, choice of vendor or other services provided under the plan should be appealable.

It was assumed individual residents would continue to have protection under the Bill of Rights for other types of transfer prohibited by that act.

K. Adult Protection Aspects of Relocation

Throughout the discussions, the relationship of the Relocation Plan to adult protection activities was evident. In the absence of manual material or statewide definitions of adult protective services some counties are developing their own. The Department of Public Welfare will be developing some rules in conjunction with the Vulnerable Adults Reporting Act; however, it is unclear whether relocation situations would be covered under that act. The Task Force Staff and Chairman met with Department of Public Welfare Adult Protection personnel to discuss this. The Task Force decided to recommend that all Relocation cases be considered Adult Protection situations.

L. Other Questions

The problem for transportation for site visits was raised. Would Medical Assistance be available? Could local volunteer sources be utilized?

Will other facilities cooperate in holding beds for placement to allow time for site visits and other preparation? Since beds are scarce in many areas this could be a problem; however placement should not be dependent only on the arbitrary timing of vacancies in other facilities.

M. Individual Transfers

While these were discussed at length by the Task Force and much concern was generated, it was decided that the Relocation Plan could not require the same procedure to be followed in all individual cases. Utilization review or PSRO decisions involving level of care changes are covered under other procedures and cases of medical necessity may require more immediate transfer. Other transfer situations would vary greatly with individual circumstances. However, the provisions of the plan should be utilized wherever possible for individual relocations.

RECOMMENDATIONS

1. The Task Force recommends that the attached Relocation Plan (Attachment A) be implemented through rule or Medical Assistance Manual Instructional Bulletin, and that the Commissioner seek any additional authorities necessary to implement the plan. Copies of the plan should be sent to each county welfare department, long term care facility, and state hospital.

2. The Task Force recommends that all institutional relocation situations due to closure, decertification provider withdrawal or provider agreement termination from the Medicaid program be considered adult protection cases and that provision for this be included in appropriate state plans, policies, guidelines, or regulations authorizing adult protection services.

3. The Task Force recommends that Four (4) Regional one-day training sessions be held at various locations in the state to orient appropriate county personnel to the plan, commencing in the fall of 1981. (See Training Outline Attachment C.)

Attachment A

Recommendation #1

DPW Relocation Plan

The Minnesota Relocation Plan for Long Term Care (LTC) facilities is a statewide systematic approach to the involuntary relocation of Medical Assistance residents from LTC facilities due to facility closure, loss of or changes in certification, termination of receivership, or termination of provider agreement.

The plan delineates the procedures to be utilized and responsibities shared by DPW, MDH, county welfare agencies and LTC facilities in cases of voluntary or involuntary termination of a LTC provider in order to protect the best interests of the residents of such facilities.

OBJECTIVE

The purpose of the plan is to implement uniform and consistent procedures for involuntary relocations of MA residents which ensure protection of resident rights, minimize trauma and discomfort of relocated residents, and facilitate appropriate placement of residents to new living situations. Orderly relocation of private patients is also expected in accordance with these procedures.

DEFINITIONS

Involuntary Relocation is any movement of MA residents between LTC facilities that is not initiated by the residents, families, or guardians and which is not defined under Emergency or other below.

Long Term Care Facility includes nursing and boarding care homes, SLF facilities and state hospitals.

Emergency Relocation

This plan does not cover emergency procedures for fire, flood, bomb threats, severe weather or natural disaster, utility or nuclear emergencies, strikes, etc. Guidelines for emergency procedures are available from local civil defense agencies or the Minnesota Division of Emergency Services, Room B-5 State Capitol, St. Paul, Minnesota 55025.

However, emergency procedures should, wherever time permits, attempt to follow this Relocation Plan.

OTHER RELOCATIONS

Procedures outlined in this plan should be adapted as necessary and followed in cases of involuntary relocation due to changes in financial eligibility or service needs.

STRUCTURE

Relocation Task Force

a) Develops State Relocation Plan and implementation strategy.
b) Identifies County Relocation Committees.
c) Develops and sponsors initial training for County Relocation Committees and Coordinators.

County Relocation Committee

a) Each County Board designates appropriate county staff (3 suggested) to serve as the Relocation Committee in that county.
b) The Committee is responsible for supervising the implementation of the Relocation Plan in that county.
c) The Committee is trained in the Relocation Procedure.
d) The Committee is responsible for developing a procedure for identifying alternate and/or emergency placement resources (e.g. vacancy lists, advocates, volunteers, transportation resources, etc.)
e) The Committee assigns a Relocation Coordinator to each facility in which relocation is necessary.
f) The Committee ensures that orientation and training is provided to Relocation Coordinators.

County Relocation Coordinators

a) The Relocation Coordinator is an appropirate county staff as assigned by the Relocation Committee (may be a Relocation Committee member).
b) The Relocation Coordinator is responsible for coordination and monitoring notification, preparation and follow-up of relocation for residents in assigned facilities.
c) The Relocation Coordinator works with facility staff, residents, families, MDH, other county staff or volunteers to ensure that the Relocation Plan is implemented.
d) The Relocation Coordinator monitors the relocation of private pay residents.

Facility Relocation Team

a) Each LTC facility designates appropriate personnel to assist in the Relocation process. (e.g. Administrator, Director of Nurses, Social Worker, Medical Director, etc.)
b) The Relocation Team assists the Relocation Coordinator in relocation of residents according to the Relocation Plan.
c) The Relocation Team assists in identification of residents to be relocated, families, guardians or responsible parties, volunteers and transportation resources during the Relocation process.
d) The Relocation Team assists in resident preparation, facilitating site visits, coordination of medical records information and transfer arrangements.

PLAN IMPLEMENTATION

Notification

1. MDH notifies DPW of official action requiring relocation with a copy to County Relocation Committee including date and reasons.
2. Upon receipt of MDH's notice of decertification, DPW sends the LTC facility formal notice regarding termination from MA program participation. Such notice indicates the reason for and date of termination. DPW notifies MDH and County Relocation Committee by telephone and provides them with a simultaneous copy of the facility termination notice.
3. Upon notification the County Relocation Committee identifies alternate resources and assigns a Relocation Coordinator to the facility.

Preparation

1. The Relocation Coordinator visits the facility to provide orientation to facility staff and discuss Relocation plans. The visit is done in cooperation with MDH wherever possible.
2. The Coordinator works with the designated Facility Relocation Team to assist in the relocation.
3. The Facility Team, in cooperation with the coordinator, identifies family members, guardians, physicians, etc. volunteers, transportation vehicles and other resources etc., to assist in relocation and site visits.
4. The Coordinator provides information to the Facility Relocation Team regarding alternate resources.
5. The Relocation Coordinator in cooperation with the Facility Relocation Team identifies each resident to be moved.
6. The Relocation Coordinator ensures that written notification is provided to each affected resident, and to their representative or family member, guardian and physician of the pending relocation, reasons, and the rights of the resident, within seven days of notice to or by MDH/DPW of withdrawal or decertification. (See Attachment B for Sample Letter.)
7. The Relocation Coordinator offers, provides or facilitates counseling to help each resident adapt to the situation and adapt to the situation and to minimize trauma. The Coordinator can facilitate meetings of small groups of residents and families to discuss the reasons for relocation and the planning process.
8. The Relocation Coordinator ensures that each resident is assigned to and personally contacted by an appropriate representative(s) to assist in the relocation process.
9. The representative assists in the choice of a new LTC facility or care arrangement according to the wishes of the resident, their family (or if appropriate friends, conservators or legal guardians) and physicians and according to needs and services available. Such choice is subject to the availability of beds or care arrangements at the appropriate care level.

Site Visits

1. The Coordinator ensures that each resident is provided with written information about the new facility and the opportunity to visit the new facility and meet staff and/or residents as soon as possible and preferably no later than two days prior to the final transfer.

2. Site visits should be geared to: a) presenting an overview of the physical layout; b) familiarizing the resident with the program and activities; c) familiarizing the resident with other residents and staff; and d) maximizing opportunities for choice and decisionmaking, e.g. in the choice of room and roommate.

3. Where a physician determines that site visits would jeopardize the physical health of the resident, visits to the resident by staff and/or residents of the new facility are encouraged prior to transfer wherever possible.

4. Where the Coordinator determines that site visits are not possible due to placement beyond a 50 mile radius or where staff visits are not possible, written information and/or pictures such as newsletters, policy handbooks, and brochures about the new facility are made available to the resident and individual counseling is offered prior to the move.

5. No resident is to be involuntarily transferred prior to the completion of these elements and in no case sooner than fourteen (14) days from the date of notification of the resident.

Discharge

The Relocation Coordinator monitors the transfer of each resident to ensure prior to the move that the following items are completed:

a) Notification of family member or guardian and physician of discharge, date, and location of new placement.
b) Transfer/referral form with physician's signature is obtained.
c) The new physician (if any) is notified by telephone as soon as the placement is completed.
d) Resident's care plan is updated and taken with resident to new facility
e) Resident's personal inventory list is updated - funds in resident account at facility are carefully checked. Resident has signed receipt for personal funds or belongings. Belongings are delivered to the new facility.
f) Medications belonging to the resident accompany them in accordance with physician's order.
g) The resident's representative accompanies the resident to the new facility.

Appeals

Any relocated resident shall have the right to an appeal regarding the services provided under this plan including but not limited to choice of facility.

The initial written notification of relocation provided to the resident under Preparation #6 shall contain information regarding the right to a choice of vendor, legal representative and to receive an administrative hearing within forty five days of an appeal request to the county welfare department.

Decertification or closure of a facility by Department of Public Welfare or Minnesota Department of Health shall not provide the basis for an appeal under this section.

Follow Up

1. The Relocation Coordinator ensures that a follow-up visit is made by appropriate county staff* to each relocated resident within 30 days of the relocation in order to:

    a) Check on the adjustment of the relocated resident. The follow-up visit includes interviewing and/or onsite observation of the resident, discussion with appropriate staff and review of pertinent medical or social records.

    b) Recommend appropriate services or methods to meet any special needs of each resident arising out of the relocation.

2. The Relocation Coordinator provides a summary report to the County Relocation Committee within 60 days of the relocation of each facility relocation process including names of residents relocated, new placement, status at follow-up and any problems encountered in the relocation process.

3. The County Relocation Committee reviews such reports, monitors the effectiveness of the plan and makes recommendations for change at the Department of Public Welfare where appropriate.

* Where the relocated resident resides in another county or state contact should be made with the receiving county to provide follow-up services.

Attachment B

SAMPLE RESIDENT NOTICE LETTER

(Decertification)

Dear _____:

This notice is to inform you that the Minnesota Department of Public Welfare Medical Assistance Program cannot pay for your care or the care of any other resident in _____ after _____. This facility will no longer be eligible to receive Medical Assistance payments after that date. This means you will probably have to seek placement in another facility.

The Department of Public Welfare will continue to pay for your care at another facility participating in the Medical Assistance Program.

The County has designated _____ as Relocation Coordinator for your facility. He/She can be reached at _____. He/She will be contacting you to offer assistance in finding appropriate placement in another eligible facility, and to help prepare you for the move.

You have the right to your choice of a new facility provided that the facility is eligible to participate in the Medicaid program and has an appropriate bed available. You may also visit the new facility to become acquainted prior to the final move if possible. You cannot be forced to move to a home you do not choose as long as you make other appropriate arrangements for your care.

You have the right to appeal decisions made about your care and treatment during the relocation process. However, the closure or decertification of your facility is not appealable.

Appeals can be made by writing or contacting the county within _____ days after _____. An administrative hearing will be held within Forty Five (45) days of the receipt of your appeal request. You have the right to legal representation at that hearing if you so desire.

If you have any questions about this matter please contact _____ at the number stated above.

Attachment C Recommendation #2

RELOCATION TRAINING OUTLINE

Purpose of Training

- To orient Adult Service Staff person from each county to the purpose and procedures outlined in the State Relocation Plan.
- To provide technical assistance information to counties on how to implement the plan.

Method

- Develop and make available a 1-2 hour video taped presentation including hand out materials for use by county adult service staff. Principal Presentors: Dr. Norman Bourestom and Aging Division Staff.
- The Minnesota Board on Aging Resident's Rights Slide Show is also available for use in conjunction with the Relocation video tape.

Content of Video Tape

1. History, Purpose, and Development of Plan
2. Sensitization to the Trauma of Relocation
3. Review of Relocation Plan Components and Discussions
4. Placement Issues and Principles.

Arrangements

Notice to counties of the availability of the Video Tape on Relocation and the Resident's Rights Slide Show and materials should be sent by the Commissioner's Office.

Each county in which a potential relocation situation is identified should immediately contact Aging program staff for assistance in obtaining the video and slide presentations and any other resources which may be available. These counties will then conduct a relocation in service for the County Relocation Committee and other appropriate staff. Long Term Care Ombudsman Program Staff may also be available for additional technical assistance to counties as needed to implement the Relocation Plan.

Attachment D

Medical Center St. Cloud MN 56301

Veterans Administration

September 16, 1981

In Reply Refer To: 656/116B

Ms. Karin Sandstrom, Chairperson
Task Force on Relocation
Minnesota Board on Aging
204 Metro Square
7th and Robert
St. Paul, MN 55101

Dear Ms. Sandstrom:

I have read the draft report prepared by the Task Force on Relocation. It appears to me to be a well-prepared report, concise, and comprehensive. I have telephoned Pamela Parker with a few comments and suggestions. On one of my suggestions, however, Pam suggested I write this letter.

This suggestion concerns the matter of site visits. Although the preparation plan is quite specific and detailed, the question of the number and nature of site visits to be made appeared to me to be rather ambiguous. Since this is one of the most important aspects of the preparation program, I would suggest it be spelled out in greater detail. The following points could be made:

1. Relocation research has demonstrated repeatedly that multiple site visits are of crucial importance in mitigating mortality and morbidity.

2. That frail elderly people require concrete and redundant cuing to assimilate information adequately.

3. To satisfy the above requirement, multiple site visits are needed so that information can be processed and adequate learning take place.

4. Site visits should be geared to: a) presenting an overview of the physical layout; b) familiarizing the resident with the program and activities; c) familiarizing the resident with other residents and staff; and d) maximizing opportunities for choice and decision-making, e.g. in the choice of room and roommate.

I hope this information can be incorporated into the plan. If you have any questions or would like to discuss the matter further, please write or call me at (612) 252-1670, Ext. 360. Thank you for the opportunity to review this important work.

Sincerely,

Norman Bourestom

NORMAN BOURESTOM, Ph.D.
Coordinator, Psychological Services, IMM Section

MINNESOTA DEPARTMENT OF HEALTH
Survey and Compliance Section
Division of Health Facilities

EXHIBIT 1.

RELOCATION PLANNING OUTLINE

March, 1978

I. Establish a facility Relocation Team - Suggested Composition: Administrator, Director of Nursing Service, Facility Social Worker, Medical Director, other Allied Health Professionals as desired.

II. Develop an Activity Chart with Time Table Plan for each activity:

III. Relocation Team Function:

A. Set up the relocation events based upon the established time tables:

1. Meet with facility nursing staff to:

a) explain reasons for potential move;
b) enlist their cooperation in planning and in allaying resident fears, etc.,
c) secure advice regarding each resident's personal habits, etc.

2. Review resident's medical records to:

a) evaluate their current physical and mental health status and potential needs,
b) establish resident characteristics,
c) initiate a transfer/referral form for each resident to be completed at time of transfer,
d) identify kinds of therapy needed for each resident,
e) update each resident's personal inventory,
f) consider any possible attending physician changes necessitated by the move.

3. Compile a list of available <u>appropriate</u> beds in area: consider services needed, sex, location to family, certification.

4. Meet with small groups of residents at a time to discuss reason for relocation and planning process. If possible give resident a facility choice in moving.

5. Meet with relatives and guardians to discuss plans for relocation and enlist their assistance.

6. Contact all attending physicians regarding relocation necessity and process.

B. Develop list of homes and scheduled dates on which individual residents will be transferred to the new facility. (Encourage family member to accompany resident on day of discharge).

C. In accordance with time table:

1. Notify each resident, his/her family, or guardian and the social worker and the attending physician of new facility location and date for his/her transfer.

2. If possible, set up a day prior to the actual move for resident and his/her family to visit new facility (no more than 4-6 residents to one facility at a time) to meet new administrator, nursing staff and some residents.

3. Develop list of vehicles to be used for actual relocation and pre-visit.

4. Assign a staff member from old facility to accompany resident(s) on visit.

5. Discuss visit with resident(s) on return to old facility.

D. Team Leader: (Administrator)

1. Provide status reports to MDH and DPW regarding progress in accordance with planned events and time table.

2. Maintain on-going check list of beds available.

3. Maintain contact with administrators of facilities designated to receive residents regarding progress.

4. Maintain current tabulation on vehicles to be used for transfer.

E. At time of discharge:

1. Complete transfer/referral form assuring physician's signature is obtained prior to move.

2. Update resident's care plan and take with resident to new facility.

3. Update resident's personal inventory list - carefully check any personal funds in resident account at facility. Have resident sign receipt for personal funds or belongings.

4. Assure medications accompany resident in accordance with physician's order.

5. Assure a staff member accompanies residents.

6. Assure physician and nursing staff complete discharge chart for closed file storage.

IV. Follow-up visit should be made by member of old staff to check on resident's adjustment to new facility.

EXHIBIT 2.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE COMMISSIONER
612/296-2701

GENERAL INFORMATION
612/296-6117

INFORMATIONAL BULLETIN #79-77 September 10, 1979

TO: Chairperson, County Board of Commissioners
Attention: Director
Nursing Home Liaison Workers

SUBJECT: Proposed Guidelines for Relocation of Medical Assistance Residents in Long Term Care Facilities.

The Minnesota Relocation Plan for Long Term Care (LTC) Facilities is a statewide systematic approach to the relocation of Medical Assistance residents from facilities terminated by the Department of Public Welfare and the Minnesota Department of Health (DPW/MDH) as eligible providers under the Minnesota Medical Assistance Program.

In the administration of the MA program, the financial resources provided to LTC facilities for MA residents places a specific responsibility on each facility and local agency for assisting these individuals should group relocation become necessary because of loss of certification. This plan is not intended to deal with the relocation of residents individually for other reasons (such as Utilization Review, emergencies).

This plan is not mandatory, but may be used as guidelines to adopt or amend as appropriate. DPW recognizes that some kinds of relocation plans are required for LTC certification and licensure. This plan delineates only the overall responsibilities shared by DPW, MDH, LTC facilities, and local welfare agencies in cases of involuntary termination. Voluntary termination plans may follow these guidelines, adapted as applicable. Emergency plans (not covered in this Relocation Plan) are available from local Civil Defense agencies or the Minnesota Division of Emergency Services, Room B5, State Capitol, St. Paul, MN 55025. These include plans for fire, flood, bomb threats, severe weather, utility emergencies, tornadoes, nuclear emergencies, et., to update or supplement existing facility plans. If time permits, some emergencies could also follow these Relocation Plans.

OBJECTIVE

The purpose of this plan is to implement uniform and consistent procedures for any involuntary relocation of MA residents in LTC facilities due to non-renewal or termination of a Provider Agreement between DPW and the LTC facility. Orderly relocation of private patients is expected also.

DEFINITIONS AND ABBREVIATIONS

Involuntary Relocation is any multiple movement of Medical Assistance residents between Long Term Care facilities that is not initiated by the residents, families, conservators, legal guardians, or medical necessity.

Long Term Care (LTC) facility is a certified participating facility in the Minnesota Medical Assistance program, Title XIX of the Social Security Act.

DPW is the Minnesota Department of Public Welfare.

MDH is the Minnesota Department of Health.

MA is Medical Assistance.

TARGET GROUPS - Individuals and Groups Involved in Relocation:

1. MA resident who must be relocated, as well as his/her family [or, if necessary and appropriate, friend(s)] and/or legal guardian or conservator.

2. Staff of the LTC facility from which the MA resident is being moved.

3. Staff of the LTC facility to which the MA resident is being moved.

4. MDH, Division of Health Facilities.

5. Local welfare agency personnel.

6. DPW, MA Division

7. Community Resources (ex., Volunteers)

PLAN IMPLEMENTATION

Target groups should cooperate with each other so that orderly, successful relocations occur, minimizing physical/emotional negative reactions. Each target group should be knowledgeable of the total relocation process as it relates to each of their responsibilities.

I. Preparation

A. Notification of pending termination.

1. MDH is to notify DPW in writing before the scheduled termination of certification. Such notice must specify the date of withdrawal and reasons for decertification.

2. Upon receipt of MDH's notice but at least thirty (30) days prior to the termination, DPW sends the LTC facility formal notice regarding its termination from MA program participation. Such

notice shall indicate the reason for and the date of termination. DPW notifies other offices such as MDH and the local welfare agency, with a copy of its termination notice to the LTC facility.

3. DPW also notifies the LTC facility of its right to an evidentiary hearing pursuant to Chapter 15 of the Minnesota Statutes. Facility must request (in writing) a hearing within thirty (30) days of this notification. A hearing will be provided within 120 days of termination. Federal financial participation will be continued consistent with applicable Federal regulation (42CFR Sec.441.11), as the same may be amended from time to time.

4. If the opportunity for the hearing follows denial, termination or non-renewal, DPW/MDH offers the LTC facility an "informal reconsideration: before the effective date of termination.

5. Where DPW determines that there are serious health or safety risks to residents, DPW may proceed with immediate relocation of residents provided that:

   a) DPW determines that danger to residents outweighs the possible trauma attendant upon their leaving the facility; and

   b) The provider is offered a full post-termination evidentiary hearing at a future date.

B. On notice from DPW, the LTC facility notifies the local welfare agency by identifying the MA residents to be moved.

C. Upon receipt of DPW's formal notice of termination, the LTC facility notifies each MA resident, as well as his/her family, [or, if necessary and appropriate, friend(s)] and/or his/her legal guardian. Such notice should indicate the necessity of, the reason for and the date of scheduled relocation.

D. Upon receipt of a list of MA residents to be relocated, the local welfare agency advises MA residents and/or their responsible representatives of their right to a fair hearing and of procedures for intervening in the hearing.

E. The local welfare agency, in cooperation with other appropriate individuals and/or agencies, determines current and anticipated vacancies according to levels of care in the area's LTC facilities.

F. Local welfare agency assures that a social worker or representative has been assigned to each MA resident. The social worker assists in the choice of a new LTC facility according to the wishes of the residents, their families [or, if necessary and appropriate, friend(s)] and/or their conservators or legal guardians, and according to needs and services available. Such choice is subject to the availability of beds at the appropriate level of care. The social worker should provide consultation to help the MA resident adapt to this potentially stressful situation so that trauma is minimized.

II. Facility Relocation Planning - LTC Administrator, Social Worker (and other staff as applicable) arrange for orderly transfer of MA residents.

A. Transferring facility completes transfer/referral form with physician's signature and date within five (5) days prior to move and not later than the day of the move.

B. Both the old and new LTC facilities note in each MA resident's record that the residents (or their responsible representatives) have notified the Post Office and the local Social Security District Office when appropriate, of the change in residence.

C. DPW recognizes that some facilities in Minnesota have developed their own plans as part of good management. However, specific Relocation plans for facilities are available on request from:

MDH

(Ms.) Clarice Seufert
Chief, Survey and Compliance
MN. Dept. of Health
717 S.E. Delaware
Mpls., MN 55440
(612) 296-5420

or

DPW

(Ms.) Gene L. Slocum
Nursing Home Certification Specialist
Policy and Planning Unit
Medical Assistance Division
MN. Dept. of Public Welfare
690 N. Robert - P.O. Box 43170
St. Paul, MN 55164
(612) 296-4745

III. Post Relocation

A. New LTC facility completes the Physician's Certification, Form DPW-1503, from the transfer/referral form within seventy-two (72) working hours of transfer and sends to the local welfare agency.

B. DPW, local agency, LTC facility personnel cooperate to provide a continuing program of adaptive counseling for relocated residents.

C. DPW-MA and MDH continue to develop guidelines for concerned individuals and groups that may be utilized and adapted as appropriate.

For further information, please contact:

(Ms.) Gene L. Slocum at the above address and phone number.

Sincerely,

Arthur E. Noot
Commissioner

EXHIBIT 3

RELOCATION REPORT 3

Preparation for Relocation

Institute of Gerontology
THE UNIVERSITY OF MICHIGAN • WAYNE STATE UNIVERSITY

This issue of Relocation Reports is the third in a series. The first issue provided an overview of a two-year study of the impact of involuntary relocation of groups of chronically ill institutionalized elderly. The second issue focused on some preliminary findings, especially the impact of relocation on patients' death and survival. This issue describes a program to prepare elderly patients for imminent involuntary relocation. The major result reported here is that a preparation program which includes site visits to the new facility with environmental familiarization and multiple task assignments dramatically increases the chances that the patient will survive the trauma of the move.

We have received many requests for a description of the preparation program. This is not surprising, for thousands of ill, vulnerable elderly are moved involuntarily all the time: from mental hospitals to nursing homes, from private homes to hospitals, from nursing home to nursing home. Typically these moves happen suddenly, seldom with any attempt to prepare the older person. The dramatic results of the preparation program described here suggest that older people in all these situations would benefit from similar attempts to ease their transition into a new environment.

We would like to give special thanks to the administrators and staff of the Whitmore Lake Con-

valescent Center and the Washtenaw County Medical Care Facility for their gracious cooperation and assistance. Also, special thanks to the Michigan Department of Social Services for its help and cooperation. This research is supported by grant number 1 R01 MH 20746-01 MHS, National Institute of Mental Health, Norman Bourestom, Ph.D. and Leon Pastalan, Ph.D., Principal Investigators. For copies of Relocation Reports or for further information, write to:

Relocation Project
Institute of Gerontology
543 Church Street
Ann Arbor, MI. 48104

I

In the Spring of 1971, the Washtenaw County Board of Commissioners announced a decision to close the old county home and transfer most of its population of elderly patients to the Whitmore Lake Convalescent Center, a new private facility about 15 miles away. The move was expected to cause sharp disruption in the patients' lives. They would be moving from an old building and a familiar environment to a very modern and unfamiliar milieu. The staff of the county home was to be terminated; they would not be on hand to ease the patients' adjustment at their new home. The move would also disrupt the social patterns and schedule routines which the patients had developed over the years. In short, the move would be very traumatic. At a time in their lives when familiar surroundings, routines, patterns, and faces seemed crucial for their well-being, everything was about to be changed.

About three months before the scheduled closing, a research team from the Institute of Gerontology entered into formal agreement with the county to develop and implement a pre-move preparation program. The preparation program was part of the team's two-year study of the effects

of involuntary relocation on elderly individuals.

The team hypothesized that the way patients were prepared for a move would influence their fate afterwards. There had been a few previous efforts at developing pre-move preparation programs for institutionalized elderly, but the evidence of effectiveness was sketchy. A particularly serious deficiency was the absence of any control group in previous studies. Without a control, judgments of the effectiveness of any particular preparation program were mainly guesswork.

The preparation program designed by the research team emphasized assuring the patient that the new facility would offer continuity of care and concern. To do this, the program encompassed three strategies: 1.) to reduce the anxiety of the unknown; 2.) to familiarize the patients with the new milieu; and 3.) to ease the psychological, social, and environmental transition through a network of support services. The team also decided to use the staff of both facilities and the patients' relatives to help in the program. The actual program was carried out by the medical care facility staff in consultation with the research team. The entire preparation program lasted 10 weeks. The actual relocation of the patients occurred

during the final two weeks of that period.

Early in the planning, the research team decided that the value of a pre-move preparation program for institutionalized elderly was not an issue. It was assumed that nearly any attempt to prepare patients for a move would be of some value. The more important question was which method of preparation would be most effective. For this reason, the team decided to give some preparation to every patient. There was no "control" group in the strict, experimental sense of the term. Ethical considerations also seemed to rule out an experiment which would prepare some patients for the move while giving others no preparation at all.

Therefore, the team divided the patients into two groups and offered each a different preparation program. The programs differed mainly in the exposure to task-oriented visits to the new facility before moving day. Group I visited the convalescent center a total of four times, once for a tour and three times to experience various aspects of the new facility. Group II visited only once, for a tour. In place of the other three visits, Group II participated in several sessions at the old facility which included slides and pictures of their new home. Both groups met with the new facility staff.

II

Staff Preparation

The program's first phase was a two-week period of staff preparation. Because the staff of the county home often had great influence on patients' attitudes, it was felt they could help greatly if they were familiar with the new setting. The staff preparation consisted of two parts. First, the county staff visited the convalescent center, talked with its administrator and staff, and became familiar with the new pfocedures patients would have to adjust to. Second, staff and the research team held weekly open-ended meetings where staff could discuss their problems, grievances, and concerns and ask factual questions about the new facility. These meetings were valuable in maintaining staff morale. This was particularly important since the staff was being terminated and many were looking for new jobs while the preparation for the move was underway.

Patient Preparation

The patient preparation program took place in three phases.

1. Phase I. During the middle of April, all

patients who were medically able were taken to the new convalescent center and given a tour of the facility. Patients visited in groups of five to seven and were escorted on the tour by staff members from the county home and Whitmore Lake Convalescent Center. The visit was followed immediately by a group discussion led by one county home staff member, who encouraged the patients to talk openly about the move and to ask questions. The staff person also told the patients about the rest of the preparation program and invited discussion about it. The purpose of the initial visit and discussion was to decrease the number of unknowns and to bring anxiety and fear into the open.

Most of the patients who were able to comment on the initial visit to the new facility said, in general, that it was helpful. Some complained that the tour was too short and that they didn't see much besides the lounge and the dining room. The visit did succeed in prompting many questions about the new facility.

2. Phase II. In the second phase of preparation, the patients were divided into two groups. Group I visited the new setting three more times. Group II remained at the county home and was acquainted with the convalescent center through slides and

pictures.

The two groups were of equal size and were matched as closely as possible according to sex, age, length of hospitalization, and physical condition. Each of the large groups was sub-divided into small groups of six or seven with a county home staff member as leader.

The Multi-visit program was carried out with Group I over a period of three weeks. The first visit was to acquaint the patients with the dining room at the new facility. They toured the dining room, observed the routine, and then ate lunch, sitting together in their sub-groupings. This visit was thought to be important since meal times are usually the most important events in the day-to-day lives of the institutionalized elderly and food is a subject of great interest and concern.

The second visit was to the Center's recreational and workshop areas. Patients met the area supervisor, were shown tools and other equipment, and were told about the various activities available.

The third visit was a formal attempt to acquaint the patients with the staff and patients of the new facility. Patients met the administrator and staff who would care for them. On this final visit, patients had an opportunity to choose their

rooms.

The impact of these visits is hard to assess. Contrary to the original plan, the group was kept together during these visits and patients had little opportunity for individual exploration. One staff member thought the visits provided an effective mechanical orientation, but did not do much to socialize the patients. In a post-move interview, patients who made the three visits divided about equally between positive and negative judgments about them.

Each of the three visits lasted an hour or more. Each visit increased in amount. Sub-groups met to discuss the visit within 24 hours. The discussion sessions were intended to reduce apprehension and anxiety and to refresh the patients' memories.

Group II did not see the convalescent center again until moving day. Instead, they remained at the county home and participated in a preparation program which included slides and other visual materials. In the first session, each sub-group viewed color slides of the new facility. The slides were arranged to give the impression of approaching and entering the building. Also pictured were areas within the building, specific objects such as furniture and physical therapy equipment, and members of

the staff. The sub-group leader gave a running commentary and conducted discussion while the slides were being shown.

The second session consisted of looking at color and black and white reproductions of the slides. Patients were able to pass the photos around and look at them as long as they wanted. This was thought to be particularly important for mentally confused patients.

The third session was a visit from the administrator of the new facility who discussed such day-to-day policies as money, laundry, and visiting hours.

The slide and photograph sessions prompted questions about the facility and seemed to reinforce memories of the visit the patients had made. The photo session lasted longer than the slide show and seemed more interesting. There was some indication that the slide screen was too small for many patients

Other types of help were provided to patients in each group. Each patient had the opportunity to express preference for bed position in the new room and for roommates. Patients were given calendars to hang in their rooms with their moving day circled. A certain amount of informal counseling was provided

by staff to any patient who asked for it. Most of this counseling was designed to smooth out disruptive individual problems pertaining to the move.

Discussion Groups

The discussion groups for both Groups I and II were generally similar in content and structure. The research team analyzed the discussions from cassette tape recordings. One discussion leader said the discussion became more lively when the tape recorder was turned off, so there is some indication that the content analysis may not reflect the whole range of patient reactions.

Most of the patients' questions were about furnishings within the new facility, particularly about matters which might affect their mobility and independence. Examples are questions about whether wheelchairs could fit in the dining room, whether the height of the beds could be changed, the amount of carpeting in the facility, etc. Next in frequency were questions about policy and procedural questions such as visitors, meals, and laundry. Patients asked few questions about the nursing staff and medical treatments.

Group leaders were able to uncover patients' emotional feelings about the move only by intensive

questioning and probing. Some patients consistently denied the reality of the move throughout the preparation program. It is unclear whether a longer program would have gotten through to them.

3. Phase III. of the preparation was the move itself. County facility staff escorted all patients to the new facility on moving day. They helped patients according to their expressed or perceived needs. Assistance ranged from escorting patients to the front door to feeding the patient his first meal. The patients were moved in groups of five or six per day.

Help From Relatives

A general meeting of patients' legal next-of-kin or key family member was held at the county home. The purpose of the meeting was to encourage the relatives to give the patients emotional support during the difficult period before and after the move. Approximately 25 relatives attended the meeting, which was conducted by the administrator of the home and by members of the research team. Patients were not included in the meeting because the staff wanted to directly urge relatives to help them and because the meeting was also an opportunity for relatives to express their anger, problems and fears. The home's

social worker reported that the meeting was successful in eliciting response from relatives and in clarifying and answering their questions.

III

RESULTS OF THE PROGRAM

Patients

The multi-visit preparation program had a dramatic effect on the patient mortality rate. Within one year of the move, more than half of Group II (single visit) had died (52 percent). The rate for the patients who had made four visits was 27 percent. The groups were closely matched on age, sex, degree of illness, physical limitation, mental status, and level of behavior. Consequently, the differences in their mortality rates are not attributable to these factors.

Previously, we had shown that length of hospitalization was a factor that affected mortality rates following relocation (see Relocation Report #2). Therefore, we attempted to determine whether longer and shorter hospitalized patients were affected differently by the two programs. Over three-fourths of the patients in our study had been hospitalized

more than one year. For these patients, the differences in the effect of the two programs were obvious and dramatic. In Group II 53% of the longer hospitalized patients died whereas in Group I the mortality rate of longer hospitalized patients was reduced to 18%. A similar statement cannot be made about the short hospitalized patients, i.e., those hospitalized less than one year because the number of patients falling into this category was too small to permit valid comparisons. Our conclusion is that preparation involving multiple site visits has a marked effect on reducing mortality rates among relatively long hospitalized patients. We are uncertain about whether it has a similar effect on short hospitalized patients.

These mortality rates support the benefits of familiarization and multiple task assignments in a new environment in order to prepare elderly patients for relocation. Future research should study the optimal number of visits and the best way to expose such people to a new environment.

Staff

The research team felt the involvement of the staff in the preparation program was crucial to its success. Not only were staff supportive of the patients, but the need to help prepare the patients

for the move gave the staff a concrete goal to achieve at a time which was also difficult for them. The main deficiency in this aspect of the program was a feeling that various time and organizational problems prevented the staff from being more helpful.

The particular circumstances of the medical facility's closing prevented most staff from becoming completely familiar with the new facility. There simply wasn't enough time for all staff members to free themselves from their regular responsibilities to travel to the new facility for a full orientation. Consequently, leaders of the sub-group discussions frequently were forced to refer patients to the social worker or the assistant head nurse for full answers to their questions. Often, this prolonged rather than relieved patients' anxiety.

Another weakness was confusion about the staff escort's responsibility when taking the patient to the new setting on moving day. The point where the former staff person's responsibilities ended and the new staff took over should have been defined more clearly. It was also felt that some provision should have been made for the former staff to remain in touch with the patient for at least a few days after he moved into the new setting. Questions about treatment procedures, financial arrangements, family

issues, rules in the new facility, and other problems could have been smoothed over with the former staff acting as a communications liaison.

The research team felt that a major accomplishment of the program was its success in eliciting response from the patients. Patients' reactions were varied. Some felt the preparation program was very helpful; others termed it deceptive. Some consistently denied the reality of the move. Only a small group was apathetic and neutral. It was felt that this emotional response — even negative response — was healthy for people caught up in a difficult situation.

CONCLUSIONS, RECOMMENDATIONS

SUMMARY OF IMPRESSIONS

A. A preparation program including site visits with a program of environmental familiarization and multiple task assignments was dramatically successful in reducing the mortality rate of elderly patients following relocation

B. Portions of the preparation program which seemed to be effective:

1. Total involvement of the staff gave staff cohesiveness and contributed to patient support.
2. Involvement of all levels of staff
3. Inclusion of all patients who are physically able to participate.
4. Group meetings to discuss the field visits.
5. Individual follow-up for patients with special problems or concerns.

C. Portions of the preparation program which might be more effective if changed:

1. Planning time for the program should be longer
2. Involvement of the new facility staff should be increased
3. Actual moving time should be extended so patients have the time and attention to get settled and staff have an easier time absorbing the new patient load.
4. Greater effort to involve relatives and volunteers in assisting with the visits and move.

5. Increase direct communication between former and new staff
6. Continue patient group meetings with new staff to solve post-move problems
7. Keep field visits flexible to the expressed needs of the patients.
8. Consider the decreased ability for vision and hearing during the visits and discussion groups.

D. Suggestions for consideration while planning a preparation program:

1. Flexible deadlines and sufficient time for preparation (planning and program) should be negotiated.
2. Make arrangements to cover liability in case of accident during the preparation and the move.
3. Perhaps involve patients in the direct planning of visits.
4. Give relatives/volunteers a written set of instructions for packing, unpacking etc. and involve them in helping get patients settled.
5. Be sensitive to patient preferences for preparation, as it might be appropriate to move some patients earlier.

EXHIBIT 4

A Tentative Draft

MODEL RECOMMENDATIONS:

INTERMEDIATE SANCTIONS FOR ENFORCEMENT OF QUALITY OF CARE IN NURSING HOMES

American Bar Association

Commission on Legal Problems of the Elderly

Funded by the Retirement Research Foundation

July 1981

This discussion paper has not been approved by the House of Delegates or the Board of Governors and, until approved, does not constitute the policy of the American Bar Association.

tions without establishing *mens rea*, because it is appropriate to impose criminal liability to protect the public health even where prohibited acts are committed without criminal intent or criminal negligence.[151]

SECTION 9
STATE INITIATED RELOCATION OF RESIDENTS

It is necessary that the regulatory agency have the authority to order the transfers of residents and the ability to protect the health and safety of the residents and the security of the property during those transfers.

Recommendations:

9.1 The Act should require the enforcement agency to promulgate reasonable rules and regulations and establish appropriate criteria for the transfer of residents when the regulatory agency has determined that such transfer is necessary to close or reclassify a facility, or when an emergency exists threatening the health, safety, or security of the residents. In determining to remove a resident from a facility, the regulatory agency should balance the likelihood of serious harm to the resident which may result from the removal against the likelihood of serious harm which may result if the resident remains in the home.

9.2 The regulatory agency should offer relocation assistance to the resident, including the placement of a relocation team in the facility, assessment of the resident's need for supportive services, provision of information on alternative placements, and assistance in moving the resident and his property. The resident should throughout be involved in planning his or her removal and should be permitted to choose among available alternative placements, except when an emergency makes a temporary placement necessary.

9.3 The agency should attempt throughout relocation to mitigate any effects of transfer trauma on the health, safety, and welfare of the residents. Where possible, the enforcing agency should design transfer trauma mitigation care plans for individual residents and implement such care in advance of removal.

9.4 The enforcing agency should provide notice to the resident, resident's guardian, resident's representative, and/or resident's family prior to the transfer of a resident from a facility.

Commentary:

A necessary concomitant of the power to close a facility is the authority to transfer the residents from that facility to other facilities. Transfer may also be needed if a facility is reclassified or ordered to reduce its capacity.

Transfer of an elderly, physically and mentally disabled nursing home resident can cause grave injury to the resident. All possible steps should be taken to mitigate this transfer trauma whenever a state agency initiates the transfer of a resident. Moreover, even residents who are not seriously at risk of transfer trauma may need assistance from the state agency during the transfer to move themselves and their possessions and to find a place in which to relocate. In response to these concerns, several states have legislation describing obligations of the state enforcement agency for state-initiated resident transfers.[152]

Illinois and Wisconsin provide by far the most detailed provisions for relocation.[153] Their statutes contain very specific provisions for transfer preparation, relocation assistance, and review of the transfer decision. Other states' statutes address the same concerns in more cursory fashion.[154] Finally, several statutes provide for authority for the regulatory agency to transfer residents when facilities close[155] or for receivers to initiate transfers.[156]

SECTION 10
PRIVATE ENFORCEMENT PROVISIONS

Private Rights of action should be available against negligent long-term care institutions.

Recommendations:

10.1 Enforcement legislation ought to provide that the owners and licensees of nursing homes are liable to a resident for injuries caused by acts or omissions of a facility or of its agents or employees which deprive the resident of any right or benefit created or established by state or federal statute or rule by the terms of any contract.

10.2 The resident should be permitted to maintain an action for damages and for any other form of relief, including injunctive and declaratory relief.

10.3 A resident, resident's guardian, or guardian *ad litem* acting on behalf of a resident should be permitted to recover three times the actual damages or $500, whichever is greater, plus costs and attorneys' fees for any violation by the facility, its agents, or its employees of a resident's rights as established by statute.

10.4 The first $2,500 in damages recovered by a resident in an action brought against a facility should be excluded from consideration in determining eligibility for, or the amount of aid under the state's medical assistance program.

10.5 Any waiver by a resident, or by a resident's legal representative, of the right to commence an action against a nursing home should be void.

Commentary:

Common law tort suits
through which quality o
Negligence actions have a
such cases have not app
general level of care in nur
face a number of barrie
damages for injuries t
ing in economic producti
and whose medical bills n
respondeat superior liabil
if the employee's actions
ficult if the resident i
Establishing the standar
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have, understandably, be
ing home litigation.[159]

The general difficultie
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number of states have pa
human rights of nursin
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difficult to ascribe a mo
Even the question of th
litigation, absent specifi
from doubt. Therefore,
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To respond to all of t
tion recognizing a priva
rights.[161] Such legislatio
punitive damages where
Most statutes also allo
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and generally excuse p
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an action for civil dama

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of residents' rights. The
three times the actual da
Missouri statute recogn
five times the actual d
York statutes allow for
of the daily reimbursen

The Illinois, New
damages recovered sha
the Medicaid program.
have little incentive to b

EXHIBIT 5

COMMONWEALTH of PENNSYLVANIA
DEPARTMENT of PUBLIC WELFARE

Nursing Home Relocation Program

RELOCATION PLAN

Milton J. Shapp,
Governor

Frank S. Beal
Secretary of Public Welfare

I. Introduction:

A large number of Pennsylvania's nursing homes have deficiencies which if not corrected will preclude their continued licensing. The deficiencies are primarily in relation to the Life Safety Code. Homes which do not meet these Life Safety Codes will have to close unless they are able to submit an acceptable plan of correction for those deficiencies that given a reasonable amount of time could be corrected to meet Life Safety Codes.

There are, however, a significant number of facilities in which the deficiencies are so gross that an acceptable plan of correction would cost far in excess of their justification. For example, a particular home may have to be razed and a new building constructed for that facility to meet licensing requirements. It would then be necessary for patients in such homes to be relocated into facilities which do meet Life Safety Codes.

There is a genuine hazard in the relocation of infirm aging persons from one site to another. Dramatic increases in mortality far in excess of what would normally be expected have been documented. In order to minimize the risk of increasing death rates, there must be a program of patient preparation before relocating to another facility. Given suitable advance preparation and great care in the handling of the actual transfer, the hazards of relocation can be significantly diminished.

A program to prepare nursing home patients for relocation has been developed in consultation with Dr. Leon Pastalan of the Institute of Gerontology at the University of Michigan. Dr. Pastalan and his colleagues originated the relocation plan upon which the present program is based. This plan, which involved a specific program for relocating nursing home patients from one facility to another, was carried out several years ago and has been formally evaluated and the findings published. They were able to demonstrate that subjecting elderly nursing home patients to a specific program prior to their transfer significantly decreased their rate of mortality when compared to groups who received no advance preparation. In addition it was discovered that certain procedures for preparation were more successful than others.

The Pennsylvania program has utilized consultation with several other independent authorities with experience in nursing home care and the problems of relocation. An advisory panel of experts from within, as well as outside the Department, has been established to provide the management team in charge of directing the relocation program with suggestions and guidance. Representation on this panel is from both the public and private sectors of the nursing home industry, the Medical and Social work profession as well as professionals with expertise in the field of Gerontology.

The plan calls for a Relocation Team of four Relocation Specialists to be assigned to a nursing home after the home's administrator is notified that his facility will have to close and he agrees to participate in the Relocation Program. The teams will sensitize the staffs of both the closing and receiving homes, as well as other concerned individuals within the community, to the full implications of the Relocation Program. The teams will provide extensive counseling with the patients and their families and conduct a series of site visits to the new facility.

Critical to the relocation program are the site visits which are designed to familiarize the patient with the new facility to which he will be transferred as well as the new staff who will be caring for him. The program aims to reduce the anxiety of facing the unknown and to provide a network of supports to soften the strain of the transition. The site visits may be considered to constitute the core of the relocation program. Pastalan's studies have indicated that the site visits are the key element in reducing mortality rates during relocation.

A major prerequisite for the success of the relocation program is time--sufficient time at each facility which is closing to permit the Relocation team to carry out the bundle of closely inter-related activities and still find time to treat each elderly person as an individual and to contribute to preserving his dignity and maximizing his chances for survival.

Making this time available becomes a major goal of the Nursing Home Relocation Program. Two time related preconditions for adequate preparation for a relocation period include; a. programming the pace of closings so as to facilitate scheduling of the Relocation teams, and b. making arrangements for each closing nursing home to remain open long enough for the relocation period to run its course.

II. Target Groups

There are four primary target groups in the Relocation Program:

1. The patients to be relocated.
2. The families of such patients.
3. The staff of the facility being closed.
4. The staff at the facility to which the patients are being moved.

In addition there are a number of secondary target groups which have particular relevance in relation to involvement in the Relocation Program. Included are such persons and groups as:

- County Board of Assistance personnel
- Volunteer organizations
- Red Cross affiliated organizations
- Church groups
- Service organizations
- Communications media personnel
- Doctors, dentists, health service agencies
- Private citizens

III. Objectives and Goals

The three primary objectives of the Relocation Program are:

a. to preserve lives of nursing home residents being relocated;
b. minimize the trauma and discomfort of all patients in uncertifiable nursing homes during their relocation;
c. to avoid the extra hazard and suffering resulting from repeated moves, by maximal approximation of final placement at the time of the first move.

The Relocation Program designed to achieve these objectives is aimed at three goals:

a. a reduction in the anxiety which arises from confronting the unknown;
b. a familiarization of patients with the make-up of the physical building of the new facility, its staff members, patients, social and medical procedures and programs;
c. a network of supports to ease the burden of psychological, social, and environmental adjustment.

The Relocation Program is designed to achieve these objectives and goals through:

- site visits by patients to their new setting;
- involvement of patients in relocation decisions and activities;
- counseling with patients and encouragement of their maximum feasible participation in the placement decision;
- a training program aimed at the closing home and the receiving home and other concerned individuals;
- a communication effort to inform and orient the community to both the scope of the nursing home crisis and the role that the community can play in response;
- small group meetings for discussion and ventilation of feelings;
- involvement of the families of patients in relocation activities and placement decisions.

IV. Staff

Full operation of the relocation program utilizes six levels of participants:

A. Relocation Management Committee (Harrisburg)
B. Regional Relocation Management Committee
C. Regional Relocation Chairmen
D. Regional Relocation Teams
E. Relocation Consultants
F. Nursing Home Staffs and support groups

A. Relocation Management Committee

Statewide direction of the relocation effort is the responsibility of the Headquarters Relocation Management Committee. Represented on this committee are the Office of the Executive Deputy Secretary for Operations, the Office of Medical Programs, Licensure Office and the Bureau for the Aging. The functions of the Headquarters Relocation Management Committee include:

- statewide coordination of the relocation effort through the Regional Offices,
- maintaining liaison with other relevant state and local agencies, the Department of Labor and Industry and the Relocation Advisory Panel, and interested others.

B. Regional Relocation Management Committee

The Regional Management Committee serves in an advisory capacity to the Relocation Chairman. Represented on the committee are regional Medical Programs, Licensing, Aging, and Operations staff who are available to offer consultation to the Relocation Chairman as problems occur in their areas of expertise.

C. Relocation Chairmen

The Chairman has primary responsibility for the Relocation Program in the region. Functions of the Chairman include:

- Direct supervision of the Relocation Teams.
- Negotiating with nursing home operators for Termination Agreements, the reserving of beds, and acceptance of the Relocation Program.
- Relating to the Relocation Committee in Harrisburg.

D. Relocation Teams

At the core of the Relocation Program is the four member Relocation Team. Team members include representatives from both the social work and nursing profession. Relocation teams are a combination of contract personnel and existing staffs from County Boards of Assistance on a temporary assignment basis.

The primary function of the Relocation team is the field implementation of all phases of the relocation program under the direction of the Regional Relocation Chairman.

E. Relocation Consultants

An expert (with staff assistants) in the field of Gerontology with experience in relocation serves on a per diem basis, as needed. Their functions include:

- Consultative activities relating to development, implementation and operation by the Relocation Program.
- Training of and ongoing guidance to Relocation Teams.
- Ongoing monitoring of Relocation Program.

F. Nursing Home Staffs and Support Groups

Critical to the relocation process, although not formally attached to the Relocation team, are the staffs of the closing and receiving nursing homes along with any support groups who may become involved with the relocation program. Support groups would include the Red Cross, Fire Department or other voluntary organizations.

The Relocation team will provide training and guidance to this group and will make every effort to utilize them in the preparation of patients for relocation and in the actual transfer.

V. Training

Of primary importance to the entire Relocation Effort is training. The training aspect of the relocation program can be considered as being twofold, 1. the training of the relocation teams by the consultants and 2. the training that the Relocation Team itself provides to nursing home staffs, patients, families, and other concerned individuals and groups.

1. Training of Relocation Teams

Early in the relocation program is the initial training of the Relocation Teams by the relocation consultants. Training is given in two day sessions and includes workshops in the areas of sensitivity to the problems of the elderly, role playing, background information on relocation, and suggestions and practical guidelines for working with patients, their families, nursing home staffs, and volunteers.

2. Training Done by Relocation Teams

One of the main functions of the Relocation Team is to provide training for patients to be relocated, their families, and nursing home staffs through a program of group meetings and private counseling sessions. The goal of this training is to provide as full and complete an understanding of, and sensitivity towards the Relocation effort as possible, in order to elicit maximum cooperation by those most directly concerned with care and welfare of the patients to be relocated.

VI. The Relocation Process

The following represents a summary of the mechanical steps involved in the relocation process itself. See Outline of Relocation Process (Attachment A).

1. Notification of Closure

Upon completion and review of the licensure survey of all nursing homes in the State, the Department of Labor and Industry will send an official notification to each facility that does not comply with the Life Safety Code. The Department of Public Welfare takes the appropriate licensure action by closing all admissions to the facility and negotiates a Termination Agreement (Attachment B) which includes an Interim Protection Plan (Attachment C) to minimize the hazards during the Relocation period.

Caution should be exercised so that patients in the closing facility receive notification that their facility is closing through proper channels. Rumors and newspaper reports have been found to create additional and unnecessary anxiety and trauma.

2. Location of Available Beds

All subsequent relocation efforts are contingent upon the availability of beds in licensed and MA certified facilities into which patients from the closing nursing home can be transferred. The identification of such beds must

be an ongoing function of the Regional Medical Commissioner, Regional Relocation Chairman, and Relocation Specialists. A list of available beds should be maintained.

In determining the availability of beds, attention should be directed to:

a. The type of bed, ie. skilled, intermediate, or custodial care.
b. Distance from the Old Nursing Home. Focus should be on the same county or contiguous counties.
c. Matching, where relevant and possible, the new home's general setting. Size, ethnic or sub-cultural should match the old.

To facilitate the timely availability of the appropriate bed, a bed reservation mechanism has been developed. This mechanism provides qualified facilities which have available beds with an interim payment to reserve a specific number of beds until the residents to be relocated can be moved into these beds. This agreement also provides that the facility will be cooperative to the Relocation program and agreeable to the necessary site visits inherent in it. See Attachment D, Letter of Agreement.

3. Medical Review

The Medical Review of patients is typically an ongoing procedure carried out by the Department of Public Welfare, Bureau of Medical Assistance. The final Medical Review will classify residents of closing facilities according to appropriate level of care (skilled nursing, intermediate, or custodial.) It is essential that this procedure be completed prior to the initiation of relocation preparation activities in order to accurately determine the appropriate type of placement facility.

4. Schedule Relocation Team Date of Arrival

A follow-up telephone contact to the closing home is necessary to either confirm the date of arrival previously scheduled or to reschedule the time at which relocation activities in the closing facility can be initiated.

5. Initial Visit to Old Nursing Home

Full understanding of the goals and cooperation with the strategy of the Relocation Program by those most directly concerned with care of residents are vital to the success of the program. It is for this purpose that special attention be devoted to the orientation of the nursing home operator and staff to the relocation effort. In addition to the orientation of operation and staff certain basic items of information should be obtained if possible at this time including:

1. Lists of patients both MA and private.
2. Attending physicians.
3. Legal guardians.
4. Any pertinent patient data such as medical and social histories.

Also at this time, should be a determination of whether substitute staff for the closing home will be necessary. The nearest state hospital or VNA are potential sources for temporary substitute staff.

6. Patient Counseling

Personal counseling will be initiated immediately. The other necessary activities which are occurring at this point include obtaining the necessary consents from the patient or guardian, physician's order to transfer, and arrangements for the transfer of Medical Assistance payments to the receiving home. If the receiving home is located within the same county as the old home, the CBA will have to be notified of the address change. If the new home is located in a different county from that of the old home, the CBA's in both counties will have to be notified.

7. Site Visits to Receiving Facility

Site visits constitute the core of the preparation program for the resident. It is essential that prior to the actual transfer, patients be exposed to and become familiarized with the layout of the building; the social and medical procedures and other supportive services offered at the new facility; the staff members and the residents of the new home. The following step-by-step procedures will be necessary for carrying out site visits:

1. prior orientation to staff at receiving home;
2. arrangements for transporting patients by contacting patient families, volunteer organizations, etc.;
3. arrangements with present nursing staff for obtaining patient release forms, for administering medication on day of site visit, etc;
4. individual and/or group follow-up counseling.

In order to provide transportation and related transport services necessary to residents during their preparatory site visits to the new location and/or on actual day of move, a Transportation Authorization mechanism has been developed (See Attachment E). This mechanism is to be used only when State or volunteer vehicles are not available.

8. Transfer of Patient to Receiving Home

Day of Transfer - At new N. H.

Relocation Specialists assure that the beds needed in this transfer are available and desirable as pre-planned and have a list of patients being moved and bed classification. The Relocation Specialist should check to see where resident's belongings are to be placed in the new home in order to be of assistance when they arrive there.

Day of Transfer - At Old N. H.

The Relocation Specialists should prepare patients, assemble clothing and belongings and mark with patient's name and home to which being transferred and assure that any money or valuables in the safe have been recovered. The Specialists should ensure that any pertinent records to be transferred are transferred. The Relocation Program's Medical and Evaluation Forms, PW 46C and 46D (see attachments F & G) are completed on each resident transferred and copies retained in Regional and Headquarters Offices. The evaluation form is compiled in Headquarters on a routine basis to keep all informed of the progress of the Program.

Valuables should be in the patients' possession or the relative, friend or volunteer accompanying the patient. Some residents may have their own furniture and a determination of disposition would have to be reached before day of transfer. Ensure that each person accompanying a patient is briefed about the patient especially if the patient is subject to any type of medical reaction and has the necessary knowledge and/or medication if it should be needed in transit.

9. Follow-up Counseling

The Relocation team should conduct one follow-up counseling session with the transferred patient within six weeks after transfer to see if the patient is secure in his new surroundings, to evaluate the placement and to address any problems of adjustment. Evaluation materials should be completed after six weeks.

Prepared by:

Office for the Aging and the
Headquarters Relocation Management Committee

With Consultation by:

Dr. Leon Pastalan
University of Michigan

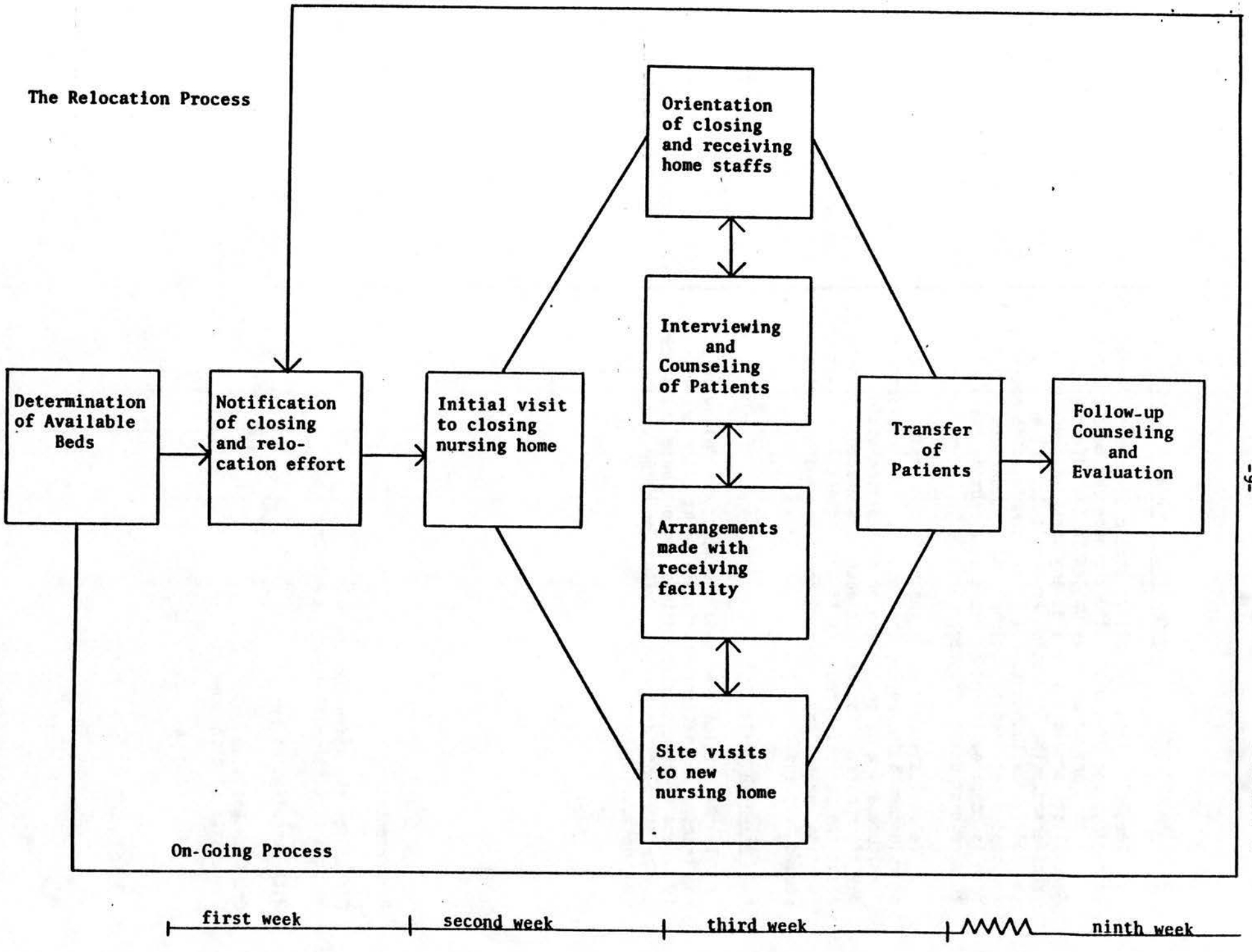
The Relocation Process
Determination of Available Beds
Notification of closing and relocation effort
Initial visit to closing nursing home
Orientation of closing and receiving home staffs
Interviewing and Counseling of Patients
Arrangements made with receiving facility
Site visits to new nursing home
Transfer of Patients
Follow-up Counseling and Evaluation
On-Going Process
first week
second week
third week
ninth week

Exhibit 5

Outline of Relocation Process

--Relocation Training

--Determination of Available Beds (ongoing)

--Notification of Closure

--Medical Review of Patients (Medical Programs) to determine appropriate level of care.

--Schedule relocation team visit to closing facility.

--Initial Visit to Old Nursing Home

*orientation of relocation program to operator.
*orientation of relocation program to staff.
*provisions for substitute staff where necessary.
*obtain lists of patients M.A. and private.
*obtain patient data.
*obtain attending physicians.
*identification of legal guardianship.
*secure available medical and social histories.

--Initiate interviewing and counseling of individual patients.

*present relocation program.
*identification of alternatives to patient.
*contact of families or legal guardians.
*arrive at decision with patient and family.
*obtain consents of patient and/or legal guardians.
*arrange for payment to reserve bed, if necessary.
*submit patient names and dates of transfer to receiving home.
*secure attending physician's order to transfer and complete necessary forms.
*arrange for transfer of Medical Assistance payments to receiving home.

--Site Visit to receiving home

*arrange transportation-family, volunteers etc.
*make arrangements with old Nursing home staff medication, release forms, etc.
*make arrangements with appropriate staff at receiving home.
*counseling of receiving home staff.
*conduct site visit.
*Individual and group follow-up counseling.

--Transfer of patient to Receiving Home

*arrange for continuation of physician's care
*arrange for transportation to receiving home (family, volunteers, etc.).

*arrange for transfer of medical records.
*arrange for transfer of patients' personal belongings.
*final orientation of receiving home.

--Follow-up counseling

*collection of patient data for evaluation.

DEPARTMENT OF PUBLIC WELFARE

NURSING HOME RELOCATION PROGRAM
TERMINATION AGREEMENT

This AGREEMENT is made _____ between the
(Date)
Department of Public Welfare, hereinafter referred to as the Department, and _____ _____ _____, hereinafter referred to as Home.

WHEREAS, the Home is licensed/approved to operate a nursing home pending an orderly phaseout, and

WHEREAS, the patients, including persons eligible for Medical Assistance, must be transferred to other facilities as soon as possible, and

WHEREAS, the Home must continue to operate and provide care pending the transfer of the patients to alternate facilities, and

WHEREAS, the Department is obligated to reimburse providers for nursing care for eligible Medical Assistance recipients.

Now, THEREFORE, both parties agree as follows:

1. The Home will list all patients in the Home at the time of execution of this Agreement and identify them as MA or non-MA patients.

2. Admissions to the Home are closed upon execution of this Agreement, by the Home.

3. The Home will implement special safety features as defined by the Department of Labor and Industry, included with this Agreement and listed on Attachment A of this Agreement.

4. The Home will continue to operate and to provide the appropriate level of care (skilled nursing or intermediate care) to patients pending transfer.

5. The Home will reduce operating expenses in accordance with good management standards as the patient census declines.

6. The Department will reimburse the Medical Assistance share of the Home's costs of operation. The cost of special safety features required by Attachment A is a cost of operation. The monthly Medical Assistance share is based upon the ratio of M.A. patient days to all patient days during the month. In no event, however, shall the MA per diem rate exceed the maximum amount of $50.

   (a) In determining the formula for ascertaining the monthly Medical Assistance reimbursement, the following definitions shall apply:

      (1) Special safety features cost means the cost of safety features required by Attachment A.

      (2) Monthly total cost (MTC) is the total operating expenses including costs of the special safety features.

      (3) Payments under the provisions of paragraph 6 of this Agreement will commence as of the first day of the month in which the patient census is reduced to 80% or less of the bed complement for the Home authorized by the Department; provided that the costs of the special safety features shall be reimbursable as of the effective date of this Agreement.

   (b) The formula for determining the monthly Medical Assistance reimbursement (MAR) is

$$MAR = \frac{\text{Medical Assistance Patient Days}}{\text{Total Patient Days}} \times MTC$$

7. The Home will invoice the Department monthly providing the following information:

   (a) most recent operating cost statement attached to the first invoice,
   (b) total patient days,
   (c) number of Medical Assistance patient days,
   (d) monthly total cost of operation,
   (e) Medical Assistance reimbursement due for month, and
   (f) status of current census, indicating by patient name the reason for change (relocation, death or other).

8. The maximum estimated cost of Medical Assistance payments under the Agreement is $_____ per month; subject to written amendment, duly signed and attached to the original of this Agreement.

9. The Home agrees to provide full cooperation to the Department of Public Welfare Relocation Team, as assigned, to assure the orderly transfer of patients.

The term of this Agreement is from _____ to _____ or the day the last patient is relocated, whichever may occur first.

Home agrees upon expiration of this Agreement it will no longer be entitled to operate a skilled nursing facility, intermediate care facility, or any other facility required by the Department of Health, Education, and Welfare, to conform to the chapter on institutional occupancies of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) in the facility at the location described in the introductory paragraph of this Agreement without first having received written certification from the Department of Labor and Industry that the facility described in the introductory paragraph to this Agreement fully complies in every respect to said chapter on institutional occupancy.

Home also agrees to waive all rights and/or privileges it may have pursuant to the Public Welfare Code, the Fire and Panic Act, or any other statute or decision which may require notice to or hearing for a licensee or operation of a facility prior to a denial of a license/approval or right to operate a facility.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their officials thereunto duly authorized.

COMMONWEALTH OF PENNSYLVANIA
Department of Public Welfare

_____
Secretary

_____
Nursing Facility

Approved as to Form and
Manner of Execution:

_____
Regional Commissioner
of Medical Programs

_____
Asst. Attorney General

_____
Comptroller

Attachment C

Exhibit 5

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF OCCUPATIONAL AND INDUSTRIAL SAFETY
HARRISBURG, PA. 17120

INTERIM PROTECTION PLAN

According to our records the _____ has not been certified under the Life Safety Code as meeting the Federal-State requirements for safety in a nursing home.

It will be necessary, therefore, under our joint plan of inspections of these homes that the plan for termination be put into effect immediately.

During this phase-out period, in order to provide at least a minimum degree of safety for the patients, I strongly urge the following preventive steps be taken:

1. No new admissions. Patients moved to lower floors as space becomes available.
2. No smoking.
3. Eliminate all unneeded storage.
4. No clothes dryer permitted.
5. Monthly visits by local fire authority.
6. Fire guards employed on a 24-hour basis.
7. Reinspection of the home on a regular basis by the Department of Labor and Industry to monitor progress of phase-out; the initial inspection will be 30 days after the date of this agreement.
8. No deep fryer in kitchen.
9. Proper stair enclosure must be provided to protect against the spread of fire or smoke.
10. Fire exit signs will be installed at proper locations.
11. Fire drills will be held on a weekly basis with maintainer of record.
12. Additional fire extinguishers provided.
13. This IPP is effective for a maximum of 6 months from the date of this agreement.

J. F. Dwyer
Director

Exhibit 5

Attachment D

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HARRISBURG

LETTER OF AGREEMENT

Frank S. Beal
SECRETARY

TELEPHONE NUMBER
787 2600, 787 3600
AREA CODE 717

The Commonwealth of Pennsylvania has Long Term Care Facilities, both Skilled Nursing Homes and Intermediate Care Facilities, which do not meet the standards for program or for Fire and Safety or for Health and Sanitation. When it is determined that the facility cannot or will not provide an acceptable plan of correction, the Department of Public Welfare will assist the residents of these facilities to relocate.

The planned relocation of Long Term Care residents required the assurance of available bed capacity at the receiving facility when the preparation for the residents' move is complete.

The purpose of this agreement is to provide the qualified facilities which have available beds with an interim payment to reserve a specific number of beds until the residents to be relocated can be moved into those beds. It is agreed, further, that the proposed patients shall have an opportunity at a time mutually agreed upon, for visits to this facility prior to date of movement to become familiar with the staff and the facility. If such visits take place during a normal mealtime, a meal will be served to the visiting residents.

Service Purchase Contract Number has been approved to cover this relocation allowance. When this agreement is appropriately completed, signed, dated, and returned to Harrisburg, it will become part of the contract and signify your acceptance of the terms and conditions set forth.

The Comptroller of the Department of Public Welfare can not process your invoice for this service without a copy of this signed agreement.

The beds, the days and dollars indicated are the maximum allowable under this agreement. Billing and payment will be for only the period actually reserved.

Sincerely yours,

Frank S. Beal

_____ DATE

\# _____ CONTROL

$ _____ MAXIMUM $ OF AGREEMENT

_____
NAME OF FACILITY

_____
ADDRESS

This agreement provides for the reservation of _____ beds for a period of up to ____ days beginning on the above date at the rate of $_____ per bed per day vacant for an amount not to exceed total dollars of $_____.

_____
SIGNATURE OF ADMINISTRATOR

_____
LICENSE NUMBER

Exhibit 5

Attachment E

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HARRISBURG

Frank S. Beal
SECRETARY

Transportation Authorization

The Commonwealth of Pennsylvania has Long Term Facilities, both Skilled Nursing Homes and Intermediate Care Facilities, which do not meet the standards for program or for Fire and Safety or for Health and Sanitation. When it is determined that the facility cannot or will not provide an acceptable plan of correction, the Department of Public Welfare will assist the residents of these facilities to relocate.

A Relocation Program is necessary to minimize the trauma associated with Relocation of the aged, medically fragile residents involved. Several site visits are required for this program. The purpose of this authorization is to provide transportation and other related services necessary to residents being relocated during their preparatory site visits to the new location and/or on actual day of move. The vendor will be responsible for providing adequate insurance coverage during the time the service is being rendered.

Service Purchase Contract Number . . has been approved to cover this relocation allowance. When this authorization is appropriately completed, signed, dated, and returned to Harrisburg, it will become part of the contract and signify your acceptance of the terms and conditions set forth.

The Comptroller of the Department of Public Welfare cannot process your invoice for this service without a copy of this signed authorization.

The transportation cost per trip plus any excess mileage indicated are the maximum allowable under this authorization. Invoicing and payment will only be for services rendered.

Sincerely yours,

Frank S. Beal

_____ DATE

_____ CONTROL

$_____ MAXIMUM $ OF AUTHORIZATION

_____ VENDOR'S NAME

_____ VENDOR'S ADDRESS

This authorization provides for transportation cost(s) of $_____ for _____ number of trips and (if applicable) excess mileage cost(s) of _____ miles at $_____ per mile. The total amount of this authorization is $_____.

_____ SIGNATURE OF VENDOR

_____ SIGNATURE OF REGIONAL RELOCATION CHAIRMAN

Attachment F

Exhibit 5

RELOCATION PROGRAM

PATIENT REFERRAL AND TRANSFER (MEDICAL)

(The purpose of this form is to insure continuity of care in transfer between Nursing Homes)

INSTRUCTIONS: Complete in triplicate, send original with patient; copy to Regional Manager, copy to Headquarters Management Committee (Room 328, Health & Welfare Building, Harrisburg.)

PATIENT'S NAME	SEX	BIRTHDATE	MA OR SS NUMBER

PATIENT'S HOME ADDRESS	C.A.O. NUMBER

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	RELIGION

NAME AND ADDRESS OF RELATIVE OR GUARDIAN	PHONE

PHYSICIAN IN CHARGE AT TIME OF TRANSFER	PHYSICIAN TO WHOM TRANSFERRED

TRANSFERRED FROM Facility Address	TRANSFER TO Facility Address

ADMISSION DATE	TELEPHONE NUMBER	TRANSFER DATE	TELEPHONE NUMBER

CLINICAL INFORMATION

Diagnosis - Primary:

Secondary:

Does patient know diagnosis? ☐ yes ☐ no

Rehabilitation Potential (Prognosis)

Medication at time of Transfer	Treatment at time of Transfer

OPERATION (IF ANY)	DATE

COMPLICATIONS AND/OR DISABILITIES - IF ANY

MENTAL STATUS ☐ ALERT ☐ AGGRESSIVE ☐ CONFUSED ☐ PASSIVE	MENTAL STATUS ASSESSED BY ☐ MD ☐ RN ☐ LPN ☐ AIDE ☐ RELOCATION SPECIALIST

ALLERGIES - IF ANY

Significant Laboratory, X-Ray and Consultation Findings

AMBULATION: ☐ INDEPENDENT ☐ WHEELCHAIR ☐ CANE OR WALKER ☐ WITH HUMAN ASSISTANCE ☐ BED OR CHAIR BOUND	SIDE RAILS ☐ YES ☐ NO

DIET	APPETITE

CONTINENCE - BLADDER ☐ CONTINENT ☐ OCCASIONAL MISTAKE ☐ INCONTINENT	CONTINENCE - BOWEL ☐ CONTINENT ☐ OCCASIONAL MISTAKE ☐ INCONTINEN

Remarks concerning patient nursing care suggestions

Use Reverse for Additional Information

SIGNATURE OF PHYSICIAN OR NURSE

DATE

Attachment G

Exhibit 5

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

RELOCATION DATA
(Evaluation)

INSTRUCTIONS: Complete in duplicate - send original to Evaluation Project Director (Room 322, Health & Welfare Building, Harrisburg) and copy to Headquarters Management Committee. (Same address)

SOURCE OF INFORMATION

Records ☐ Staff ☐ Patient ☐ Family ☐

NAME OF PATIENT	SEX Male ☐ Female ☐	BIRTHDATE	RELIGION

RACE

DIAGNOSIS Primary ☐ Secondary ☐

MARITAL STATUS

Single ☐ Divorced ☐ Widowed ☐ Married ☐

LENGTH OF TIME IN NURSING HOME (date of last admission)

ADMITTED FROM (name of old facility)	ADMITTED TO (name of new facility)	PHONE

MENTAL STATUS (most of time)

Alert ☐ Confused ☐ Agressive ☐ Passive ☐

ASSESSED BY

MD ☐ RN ☐ LPN ☐ Aide ☐ Reloc. Specialist ☐

MOVEMENT DURING PREVIOUS YEAR

Once ☐ Twice ☐ Other (specify) ☐

PHYSICAL MOBILITY

Ambulatory ☐ Wheelchair ☐

Cane or walker ☐ With human assistance ☐ Chair/bed fast ☐

INDEPENDENCE OF PATIENT (most of time)

Independent ☐ Requires some human assistance ☐ Requires much human assistance ☐

CONTINENCE (most of time)

Bladder: Continent ☐ Occasional mistakes ☐ Incontinent ☐

Bowel: Continent ☐ Occasional mistakes ☐ Incontinent ☐

VISITORS

Number of visits per week_____ per month _____

By spouse ☐ family ☐ other ☐

RN/LPN PROGNOSIS

PATIENT'S SPECIAL INTERESTS AND/OR SKILLS

Exhibit 5

NUMBER OF SITE VISITS

OVER WHAT PERIOD OF TIME

ACTIVITY DURING SITE VISITS

Met staff ☐ Met patients ☐ Ate meal ☐

Selected new room ☐ Saw new room ☐ Participated in activity ☐

NUMBER OF GROUP DISCUSSIONS

NUMBER OF PERSONAL COUNSELING SESSIONS

COUNSELING SESSION INVOLVEMENT

Old facility staff:	heavy ☐	some ☐	little ☐	none ☐
New facility staff:	heavy ☐	some ☐	little ☐	none ☐
Family:	heavy ☐	some ☐	little ☐	none ☐

SITE VISIT INVOLVEMENT

Old facility staff:	heavy ☐	some ☐	little ☐	none ☐
New facility staff:	heavy ☐	some ☐	little ☐	none ☐
Family:	heavy ☐	some ☐	little ☐	none ☐

FINAL PATIENT TRANSFER

Old facility staff:	heavy ☐	some ☐	little ☐	none ☐
New facility staff:	heavy ☐	some ☐	little ☐	none ☐
Family:	heavy ☐	some ☐	little ☐	none ☐

ATTITUDE TOWARD RELOCATION

Old facility staff:	positive ☐	negative ☐	indifferent ☐
New facility staff:	positive ☐	negative ☐	indifferent ☐
Family:	positive ☐	negative ☐	indifferent ☐

NUMBER OF TRAINING SESSIONS

Old facility staff: 1 ☐ 2 ☐ 3 ☐ other (specify) ☐

Staff involved: administrators ☐ RNs ☐ LPNs ☐ aides ☐ other (specify) ☐

NUMBER OF TRAINING SESSIONS

New facility staff: 1 ☐ 2 ☐ 3 ☐ other (specify) ☐

Staff involved: administrators ☐ RNs ☐ LPNs ☐ aides ☐ other (specify) ☐

PATIENT'S EXPRESSED ATTITUDE TOWARD RELOCATION (before move)

accepts ☐ angry ☐ neutral ☐ passive ☐ agressive ☐ rejects ☐ denies ☐ docile ☐

PATIENT'S EXPRESSED ATTITUDE TOWARD RELOCATION (after move)

accepts ☐ angry ☐ neutral ☐ passive ☐ agressive ☐ rejects ☐ denies ☐ docile ☐

ROOM AT OLD FACILITY

single ☐ double ☐ other (specify) ☐

ROOM AT NEW FACILITY

single ☐ double ☐ other (specify) ☐

SIZE OF NEW FACILITY

same as old ☐ smaller ☐ larger ☐

TRANSPORTATION TO NEW FACILITY

ambulance ☐ car ☐ taxi ☐ family ☐ other (explain) ☐

WAS PATIENT MOVED IN A GROUP

no ☐ yes ☐ size of group _____

DISTANCE BETWEEN OLD AND NEW FACILITY

PW 46D - 4-74

Department of Public Welfare
Nursing Home Relocation Program

Organization of Relocation Effort

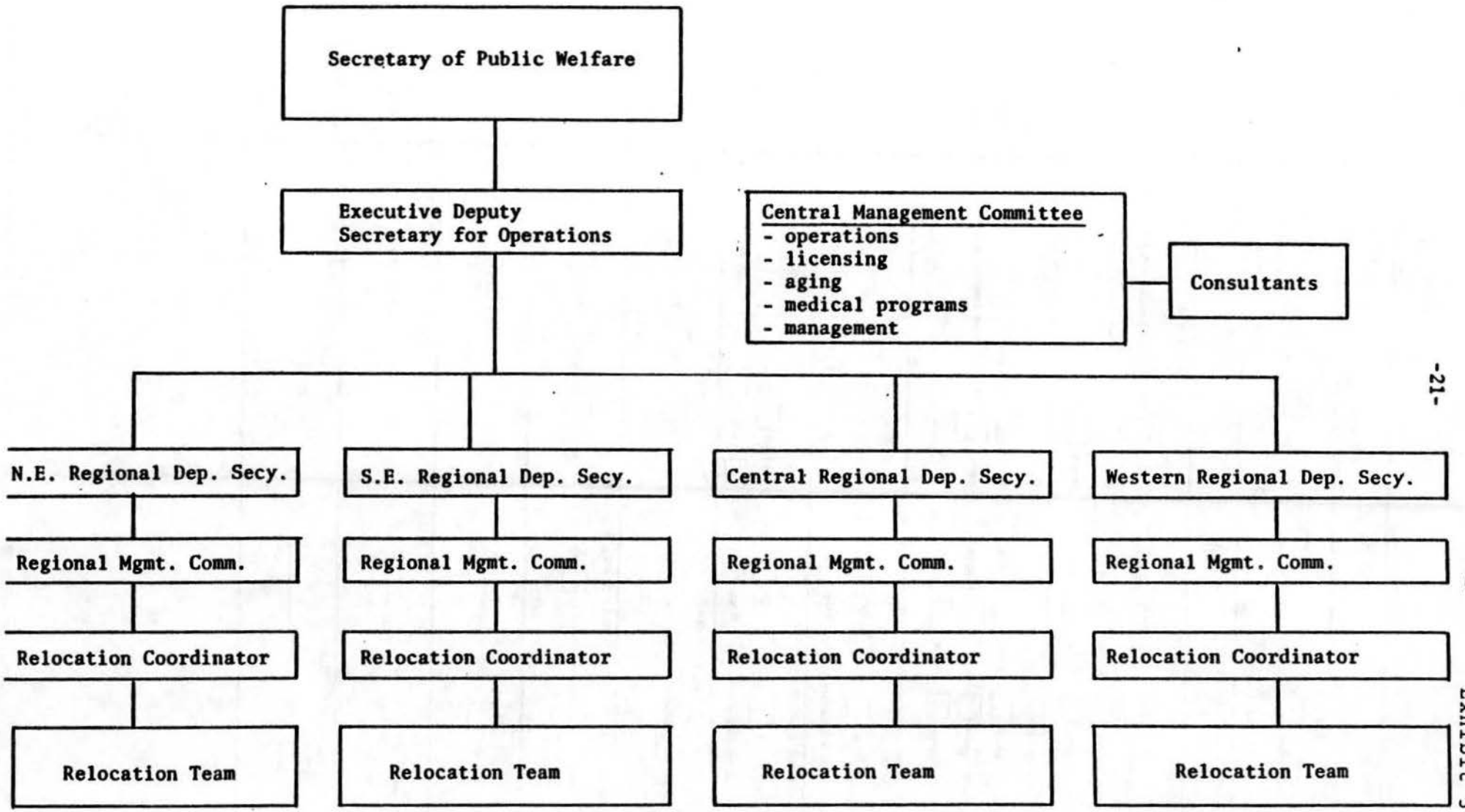

Exhibit 5

The Elderly

A Change of Scene Can Be Fatal

Moving from familiar surroundings to strange ones is not only unsettling for elderly nursing-home patients; it can be fatal.

Leon Pastalan and Norman Bourestom of the University of Michigan's Institute of Gerontology found that the mortality rate increased sharply among elderly persons forced to transfer from one institution to another. Part of the research project, which began in 1971, compared two groups of elderly nursing-home patients, matched in age, sex, and physical and mental health. One group was moved after four preparatory visits to their new home; the other was moved after only one visit. Within one year, 52 percent of the latter group died, compared to only 27 percent of the better-oriented old people.

Stricter federal enforcement of safety and medical regulations in nursing homes, particularly of the fire code, have forced many elderly persons to relocate. Pennsylvania, for instance, had to close

Carlos Llerena

150 nursing homes and relocate 2,000 to 6,000 people. Pastalan and Bourestom note the effect such a move could have: "A transfer of 2,000 persons could increase the normal death rate for this population by 250 to 450 people. By contrast, only 16 institutionalized elderly were known to have died in nursing-home fires in Pennsylvania in 1972."

In 1974, Pastalan and other researchers started a program in Pennsylvania to prepare the elderly patients for their move. Nurses, social workers, and other professionals familiarize patients with their new environments before they move, through counseling sessions, group discussions, and visits to the new homes. A recent study of 400 relocated nursing-home patients who participated in the preparatory program showed a 22 percent annual mortality rate. This was lower than both the national rate of 28 percent and the Pennsylvania rate of 27 percent for patients who did not move.

The researchers also noted that the people who moved more than 45 miles had a higher mortality rate than those who moved a shorter distance. And those who either definitely accepted or rejected the move died at a lower rate than those who didn't seem to care, though this may "...be a reflection of the very old, sick, and confused persons' inability to express a clear reaction to an anticipated event."

As a result of these studies, public-interest lawsuits requiring a state to conduct preparatory programs before relocation of patients have been won in Rhode Island, New Jersey, and New York; one is pending in Florida. The federal Administration on Aging has also urged states to adopt preparation programs for elderly persons. —Sherida Bush

Leon Pastalan is at the Institute of Gerontology, University of Michigan, Ann Arbor, Michigan 48109.

This paper compares and contrasts the effects of a radical involuntary relocation of elderly patients vs. the effects of a more moderate involuntary relocation that involved only a change in the physical environment. Effects are described in terms of mortality rates, self-perceived changes in health, relationships with others, and activity patterns as well as changes in level of behavioral complexity. On all measures the radical-change group fared more poorly than did the moderate-change group, which suggests that a weighty source of the variance in relocation effects is the degree of environmental change involved.

Alterations in Life Patterns Following Nursing Home Relocation[1]

Norman Bourestom, PhD,[2] and Sandra Tars, PhD[3]

In recent years a number of studies have appeared concerning the effects of relocation on the aged and disabled. While many of these studies have reported deleterious effects, usually in terms of higher than expected mortality rates (Aldrich & Mendkoff, 1963; Aleksandrowicz, 1961; Jasnau, 1967; Killian, 1970; Markus, Blenkner, Bloom, & Downs, 1971; Shahinian, Goldfarb, & Turner, 1968), other research has failed to substantiate these findings (Lawton & Yaffee, 1970; Miller & Lieberman, 1965; Ogren & Linn, 1971; Watson, 1973). In attempting to account for these variations Blenkner (1967), Lawton & Nahemow (1973), and others have called attention to methodological shortcomings and differences among the various studies, noting particularly differences in characteristics of the populations under study and the conditions under which the relocation was carried out, e.g., whether the move was voluntary or involuntary, and the degree of environmental change involved.

In addition to ambiguity concerning potential sources of variation in relocation effects, little attention has been paid to the survivors of relo-

1. This work was supported by NIMH Grant 5 R02 MH 20746-02, Norman C. Bourestom, PhD, Project Director. Tabular data may be obtained from the senior author.

2. Psychology Service, Veterans Administration Hospital, St. Cloud, MN 56301.

3. Hutchings Psychiatric Center, Syracuse, NY.

Photographs from Philadelphia Geriatric Center illustrate the continuum of activities in a multi-service agency.

Facilities are provided for residents to engage in many creative activities.

cation experiences. If involuntary relocation is conceptualized as an externally imposed stress-inducing situation, its effects may be manifested among survivors in such well-known stress reactions as impaired physical health and various behavioral and interpersonal anomalies.

The data to be presented are partial findings from a 2-year study in progress that bear on these issues. The study concerns a longitudinal assessment of elderly patients in two county medical care facilities in Michigan who were being involuntarily relocated. A third facility in Ohio provided a matched nonrelocated control group.

In one of the Michigan facilities, patients were to undergo a radical environmental change from the county facility to a new and much larger proprietary nursing home in a nearby community. For these patients the change was total, and adjustments had to be made to a new staff, a new program, a new physical environment, and a new patient population. By contrast, patients in the other Michigan facility had many fewer adjustments to make. Although the move was also involuntary, these patients experienced a moderate change in their physical environment only, namely a move to a new building several hundred yards away. Staff and patient groups remained intact as did the nature and structure of their program. In the Ohio facility no environmental change was to occur.

These situations afforded an excellent opportunity to study relocation effects in terms of the degree of environmental change involved, while holding constant one of the important conditions of relocation, i.e., the involuntariness of the moves.

The Study Populations and Measures

A total of 98 patients in the two relocated groups were matched for age, sex, length of hospitalization, and primary diagnosis with a like number in the control facility. Although perfect pairings were not always possible, each experimental group was highly similar to its control on these variables. In addition, ratings of each patient's physical condition, based upon evaluation of medical records by a consulting physician, indicated that the experimental and control groups were highly comparable, particularly along the dimensions of prognosis and vulnerability to death. In the radical change group patients had a median age of 76 and two-thirds of them were women. Almost half of the patients in this group had been hospitalized over 3 years and all of them had some form of cardiovascular, neurological, or musculoskeletal pathology that required long-term care. On the other hand, patients in the moderate change group were older (median age 82), and there was a somewhat higher proportion of women in this group. In terms of pathology and length of hospitalization, however, the moderate-change group was nearly identical to the radical-change group.

Data were collected 1 mo. prior to relocation and at intervals of 1, 4, 8, and 12 mo. following relocation. On these occasions each patient was interviewed extensively and time-sampled observations of his behavior were made, using a measure developed by Ciarlo and Gottesman (1966). The interview probed for changes in the patient's evaluation of his health, perceived changes in relationships with staff members and other patients, and for self-reported changes in activity patterns. Observations of patient behavior were classified in terms of level of complexity, ranging from low-level behaviors such as sitting and staring, to purposeful behavior such as actively working on a task, performing a chore, or interacting with others. On the basis of these classifications, a single score was derived which represented level of behavioral complexity for each patient in the study. All measures were intercorrelated, and a subset of items which proved to be relatively independent of each other was selected from the larger set for the initial analysis.

Although data were collected for a 1-year period following relocation, we will report here, with the exception of death rates, only those changes which occurred between the pre-move assessment and the 1-mo. follow-up. The reason

for this is mainly methodological in that mortality caused the sample size to decrease beyond the point of meaningful statistical analysis in the later stages of the research.

Differential Outcomes

Perhaps the most dramatic finding was a strikingly higher mortality rate for the relocated groups than for their nonrelocated counterparts. This effect, however, was notably greater for the radical-change group than for the moderate-change group. Of the radical-change group, 43% died in the 6 mo. preceding and the year following relocation compared with a rate of 21% among their controls, a difference which was statistically significant. By contrast, the moderate-change group experienced a 37% death rate compared with a 26% rate among their controls, a difference which could have occurred by chance. In terms of mortality experience, therefore, it appears that the degree of environmental change involved in relocation is a potent factor influencing mortality rates.

Of interest also is the fact that death rates for the radical-change group were highest in the 3 mo. preceding and 3 mo. following relocation. The findings are consistent with those reported by Aldrich & Mendkoff (1963) and confirm their suggestion that anticipation of relocation has effects which are nearly as lethal as the relocation itself. On the other hand, the moderate-change group showed a different pattern. While death rates for this group were relatively high during the 3 mo. preceding relocation, the peak in death rates occurred during the 7- to 9-mo. period following relocation, much later than was the case in the radical-change group.

As noted, the experiences of the survivors of both relocations as well as their control counterparts were assessed in terms of self-perceived changes in health status, changes in relationships with staff members and other patients, changes in activity patterns, and observed changes in levels of behavioral complexity. Of the 13 items which made up these content areas, patients in the radical-change group showed significant decline on 4 items and trends toward significant decline on 4 other items, whereas patients in the moderate-change group showed significant decline on only 1 item. Likewise, as would be expected, the nonrelocated controls showed little change, declining significantly on only 1 item following the move.

In the radical-change group the most marked shifts occurred in the way patients viewed their health and in their levels of psychosocial activity. Following relocation, these patients became more pessimistic about the state of their health. Before the move 37% of the surviving sample felt that their health would be better in the future, whereas only 21% were this optimistic following the move. Likewise, the percentage of patients who evaluated their current health condition in positive terms dropped from 65% pre-move to 28% post-move. In the moderate-change group, the only shift toward increasing pessimism was in the patient's self-perceived ability to care for himself in the future.

Following the move, patients in the radical change group also showed a marked decline in the number of psychosocial activities engaged in such as occupational therapy and recreational therapy, whereas patients in the moderate-change group showed little or no change in participation in these activities. Paralleling this decline in psychosocial activity was a corresponding increase in observed low level behavior in the radical-change group as reflected in the observation weighted score.

Although the pre- and post-move differences did not reach statistical significance, there was a trend for patients in the radical-change group to be less intimate with staff and fellow patients following relocation, a trend which was not evident in the moderate-change group. Following relocation, radical-change patients were less likely to report that staff members were interested in them and were less likely to find other patients they trusted to talk over personal problems.

In contrast to the many-faceted decline in

Community Housing for the Elderly is located across the street from PGC main buildings.

integrating the person in his new environment so as to prevent the development of disabling life patterns such as we have noted in this study.

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the radical-change group, nonrelocated patients, like the moderate-change group, experienced little change. Only one pre-post difference was statistically significant for these patients, and that was in terms of a reduced likelihood to report that there were staff whom they trusted to discuss personal problems.

Interpretations and Implications of Results

The findings are consistent with the hypothesis that a weighty factor influencing the outcomes of involuntary relocation among elderly patients is the degree of environmental change involved in the transfer. When environmental change is total, involving changes in established routines, in the persons who provide care and service, and in the physical environment, higher than expected mortality rates can be anticipated as well as decrements in health outlook and behavioral functioning of survivors in the months immediately following the move. On the other hand when the environmental change is partial, involving a change in the physical environment only, the destructive effects are minimal in these areas and no greater than would be expected among elderly patients whose environments remain stable.

It is interesting to note the way in which the stress of relocation exacted its toll on the survivors in the radical-change group. Following relocation, patients in this group grew increasingly pessimistic regarding the state of their health, withdrew from activities in which they had formerly engaged, exhibited lower levels of behavior, and were somewhat less inclined to perceive interest or trust on the part of those with whom they came into contact. Coleman (1973), reviewing studies of stress, has pointed out that the sequela of stress may be manifested in such forms as hyperirritability, sleep disturbances, disturbed interpersonal relationships, and ego-defense oriented reactions including emotional insulation and detachment. For example, Bowlby's (1960) study of children's reactions to separation experiences involving hospitalization revealed that most children show an initial response of acute distress and crying followed by a phase of misery and apathy and, finally, a stage when the child loses interest and appears detached.

York Houses, pioneering high-rise apartment residences, provide variety of services, including two main meals daily.

Similar reactions have been observed in newly blinded persons (Cholden, 1954), in reaction to both amputation and bereavement (Parkes, 1972), and in persons with terminal illness (Kubler-Ross, 1969). In many respects, the patterns of behavior adopted by the survivors in our radical change group resemble those seen in these other studies. The increased insulation and detachment from the world and activities of the institution which these survivors showed may have represented an ego-defense reaction against the possibility of future disruption and stress.

Our findings are also consistent with Rahe's (1969) studies on the relationship between extent of life crises and subsequent changes in health. Rahe has shown that frequency and severity of illness increases in proportion to the extent of life change among Navy personnel on extended cruises. Paralleling these findings, our results show that more radical environmental changes are associated both with higher mortality rates and with more negative changes in life patterns. It would appear then that the sheer *amount* of forced change overloads the *organism* to such an extent that negative consequences can be anticipated.

The poorer adjustment of the survivors of the radical relocation in this study indicate that the destructive effects of environmental change are not limited to higher mortality rates. Effects which are more insidious in nature results in disabling life patterns for those who survive such moves. In a previous paper (Bourestom, Pastalan, & Tars, 1973) we described the results of two different programs of preparation for relocation. Those results indicated that proper planning and preparation were helpful in reducing fatalities and in facilitating adjustment. It is our contention that preparation programs should become mandatory policy in all situations which contemplate radical and involuntary relocation of elderly individuals.

Furthermore, follow-up programs after relocation should be implemented to further assist

DISTRICT OF COLUMBIA AND ATTORNEYS FOR RESIDENTS WORK OUT RELOCATION FOR CLOSING OF NURSING HOME

District of Columbia Long-Term Care Coordinator, Karyn Barquin, and the District's Legal Services Developer, Michael R. Schuster, recently met with District of Columbia officials and staff of the National Senior Citizens Law Center to discuss how to deal with the persistent health care problems in a local nursing home, Mar-Salle Convalescent Center. (As a result of these persistent health care deficiencies, HEW discontinued all Medicare and Medicaid payments in November 1979, to eligible residents of Mar-Salle). Subsequently, the District of Columbia filed a lawsuit against Mar-Salle seeking receivership, and in the alternative, an injunction. A Temporary Restraining Order was issued enjoining the nursing home from permitting certain health care deficiencies to persist, including insufficient nursing staff, improper preparation and administration of medications and inattention to "stop orders" on medications. After the Temporary Restraining Order was issued, attorneys from the National Senior Citizens Law Center, Legal Counsel for the Elderly, and the George Washington University Institute on Law and Aging applied for leave to intervene on behalf of several residents of the nursing home; the application was granted. Intervenors' attorneys were especially concerned that relocations may not be done in a manner to minimize the effects of "transfer trauma."

After the District filed its complaint and the Temporary Restraining Order was issued, Mar-Salle informed the District of Columbia that it intended to cease operating as a nursing home. On April 10, 1980, the parties agreed to the entry of a preliminary injunction which would be effective for six months and which would require the nursing home to remain open during the duration of the preliminary injunction. This time period is necessary to ensure the "reasonably expeditious, safe and orderly transfer" of all residents of the home to other appropriate health care facilities, "given the extreme shortage of nursing home beds in the District of Columbia."

The preliminary injunction contains, among other things, the following provisions:

1) The defendant nursing home shall immediately bring the home into compliance with the DC Health Care Facilities Regulation, 74-15;

2) In particular, it shall assure that adequate, competent nursing staff, assistants and aides will be on duty at all times;

3) The District and intervenors intend to jointly develop a relocation plan in consultation with the defendants, dealing with the involuntary transfer of residents. The parties intend to address site visits, pre - and post - transfer counseling and intra - and inter - facility transfers;

4) The defendants shall not transfer ownership of the nursing home (or its premises) except to a buyer who shall provide uninterrupted nursing home services, until all current residents have transferred in accordance with paragraph 4 of the Order, which states:

> "Patients shall not be involuntarily transferred within the Center or from the Center except:
>
> a. Pursuant to the unopposed transfer plan of the District of Columbia or, if the District of Columbia transfer plan is opposed, pursuant to the final transfer plan approved by the Court; or
>
> b. if necessary for emergency hospitalization and medical care, or to respond to other emergency situations; or
>
> c. as otherwise agreed by all the parties in writing. Defendants shall continue to maintain a daily census report which shall be made available to all parties upon request."

A Relocation Task Force has been created consisting of Intervenors' attorneys, District officials, and representatives from both Mar-Salle Convalescent Center and other long-term care facilities. This Task Force has developed the Relocation Plan and is

completing the guidelines for the counseling sessions. Members of the Task Force have met with residents, and it has scheduled additional meetings with both residents and either their legal guardians or relatives, to discuss the Relocation Plan in detail. The District government has identified available beds for all District Medicaid residents, and it will assist private-pay residents in identifying alternative placements.

Any one interested in more information regarding this case may contact the District's Legal Services Developer, Michael R. Schuster, at Legal Counsel for the Elderly, 1016 16th Street, N.W., 6th Floor, Washington, DC 20036. Telephone: (202) 234-0970.

NURSING HOME OMBUDSMAN NEWS

The Kansas Department on Aging reports that a bill establishing the Office of Long-Term Care Ombudsman and granting access to facilities and records, at any time, was signed in Kansas on April 16, 1980

On May 14, the Illinois created a commission adults 60 years

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Other reports from Florida concern passage by the House Committee of a bill authorizing appointment of a receiver if a nursing home is closing or cannot meet its financial obligations. Another bill would make it mandatory for nursing homes to honor their declared intent to serve a certain number of Medicaid patients as a condition of receiving a Certificate of Need.

POSITIONS AVAILABLE

The Urban Elderly Coalition is seeking an Executive Director for its office in Washington, DC to oversee chief administrative responsible to

Applications

NSCLC Washington Weekly

National Senior Citizens Law Center

1424 16th Street, N.W., Suite 300
Washington, D.C. 20036
202/232-6570

NSCLC Main Office:
1636 West 8th Street, Suite 201
Los Angeles, California 90017
213/388-1381

Serving the Older Americans Advocacy Assistance System

Vol. IV., No. 21

May 23, 1980

NATIONAL CHANNELING DEMONSTRATION PROGRAM

The Department of Health and Human Services (HHS) is seeking applications from states in support of the National Channeling Demonstration Program. The announcement was made in the Federal Register on May 21, 1980 (pages 34250 -51).

According to John Palmer, Assistant Secretary for Planning and Evaluation, the purpose of the funds is to assist states to more effectively plan for and provide institutional and community-based long-term services. The authority for the grants will be awarded under Act Amendments of Section 421.

Grant applications are available from the Division of Grants and Contracts Management, Office of Human Development Services, Hubert H. Humphrey Building, Room 345F, 200 Independence Avenue, S.W., Washington, DC 20201, Attn: National Channeling Demonstration Program: Long-Term Care System Development Projects.

The deadline for submitting applications is July 11, 1980. For more information contact Brina B. Melamed at 245-7363.

HOUSE COMMITTEE PROPOSES $10 MILLION TO FIGHT CRIME IN PUBLIC HOUSING

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EASING THE STRESS OF MOVING DAY

by LOUIS J. NOVICK

At this home for aged chronically disabled patients, the executives had read all the literature, and it was dismal indeed. When old people are relocated the mortality rate rises sharply. The author tells of the months spent in preparing the old people of Montreal's Maimonides Hospital for the new home they helped plan. The move was made, and the mortality rate actually fell, the author reports.

RELOCATING 125 aged patients into a new structure in a totally different area of the island of Montreal took place in late November 1964. None of these patients of Maimonides Hospital for the Aged were less than 70 years old and their age as a group averaged 81.7 years.

During the course of planning this move, much anxiety was aroused by reports of studies made elsewhere[1] which indicated that relocation of sick aged people had resulted in a high rate of mortality. Indeed, the incidence of mortality among the patients of one large home for the chronically disabled had been 38 per cent at the termination of the first year following relocation, with the preponderance of deaths occurring during the first three months of the year.

The move of Maimonides Hospital was dictated by the fact that the land on which its old building was located was insufficient in size to permit an expansion of physical facilities from 132 to 247 beds. Maimonides Hospital, an institution offering long-term care to aged chronically disabled patients, is recognized by the Province of Quebec as a public hospital. As

(Please turn to page 69)

(ABOVE) PATIENTS receive a word of encouragement from the executive housekeeper as they wait to be transported to the new facilities of the Maimonides Hospital and Home for the Aged, Montreal. Many of the patients brought shopping bags containing their most prized personal possessions. (BELOW) Three busloads of patients lined up in front of the old building are ready to depart to the new Maimonides Hospital. Each bus bears patients for a specific floor of the new building, with patients having similar nursing needs assigned to the same floor

Louis J. Novick is executive director, Maimonides Hospital and Home for the Aged, Montreal, Quebec, Canada.

(ABOVE) A PATIENT entering the new hospital building is surrounded by staff members extending a warm welcome and ready to assist her to her new room. Each patient wears an identification tag showing his name, floor number, and room number. Staff members also wear tags. (BELOW) Escorted by staff members, two patients enter the new building. The stronger, more able patients were the last to be taken off the bus because they were better able to stand the strain of waiting while the weaker patients were taken to their rooms.

require additional adjustments at a time of life when they possessed the smallest reserves of strength required for such adjustments.

Patients asked many questions reflecting their anxiety. Would they be permitted to retain their old belongings? Would the present staff accompany them to the new building? Would they continue to live in bedrooms that must be shared with others?

As the issues that provoked anxiety were defined and the patients' questions answered, anxiety was visibly reduced. Of enormous help was the patient's knowledge that they were playing an active and direct role in the process of decision making on important problems. The entire club membership met with the new building committee of the board of directors to express a desire for single bedrooms in the new building. The patients' expression of feeling was decisive in helping the board recognize that single bedrooms were important.

Furthermore, we were able to give substance to the new experience for the patients far in advance of the actual relocation by taking them on frequent bus trips to the new site and by constructing in one area of the old building a full-size model of a single bedroom of the new building. This room was completely equipped with the very furniture that would later be used.

How meaningful the visits to the site were to the patients was reflected by the insistence of individuals whose ability to walk was poor and who suffered from circulatory difficulties that they be permitted to traverse the length of the rutted and muddy temporary road leading to the growing structure. The feeling generally expressed by patients was that watching the building grow was like watching their children grow.

By asking patients to experiment with various fixtures of the model bedroom, we were able to determine with accuracy what particular type of fixture in each case was best suited to serve them. Thus we found that patients preferred a window that opened on a horizontal rather than on a vertical plane. They preferred a conventional door to a folding door. They preferred the bar type of water faucet to the circular one ordinarily used.

When wheelchair patients sat in their chairs next to the sink in the model toilet room, the physical therapist was able to establish a sink height that permitted the patients' knees to slide beneath it. When patients with little strength in their legs sat on the toilet bowl, the physical therapist found that if the bowl unit were placed on a four-inch base, the patients could use it with comfort and ease.

When all the experimentation was completed, not only was the unknown made known to a large extent, but the patients believed with good reason that the known and the established were in part the product of their creative activity.

FAMILIAR RELATIONSHIPS PRESERVED

Great efforts were taken to ensure that familiar relationships in the old building would be carried over into the new building. Retaining old staff members was considered crucially important. Every attempt was made to see that salary scales were equal to the best that existed in other hospitals in Montreal. New workers who had to be added to the staff in order to serve the increased population in the new building were engaged well in advance of the actual relocation in order that they could become thoroughly familiar with the residents in the old building.

The social service staff spoke to all patients individually, in order to determine whom each one preferred to have as his immediate neighbor in the new building. The children of the patients were contacted individually, too, in order

(Continued from page 64)

such, it receives full remuneration for the per diem cost of each of its resident patients.

The program in the old building included medical, nursing, x-ray, laboratory, pharmaceutical, social casework, social group work, occupational therapy, physical therapy, and sheltered workshop services of high caliber. The medical program was enhanced by an excellent cooperative relationship with a local general hospital. Relationships between resident patients and staff and among staff members themselves, both interdepartmentally and intradepartmentally, were marked by warmth and mutual respect.

Of major concern, however, were inadequacies in the allocation of space in the old building, which made it exceedingly difficult to meet some important emotional needs of the patients. By allocation of space is meant the setting aside of specific floor areas for the purpose of serving specific needs. What these inadequacies were will be discussed later.

EFFECTS OF MOVE STUDIED

Long before the patients of Maimonides Hospital were relocated in their new setting, it was assumed that the following negative and positive factors in the relocation situation might have a bearing on mortality rate: (1) fear of the unknown, (2) preservation of satisfying relationships, (3) retention of emotionally meaningful belongings, and (4) arrangement of space in the building with due regard for the emotional needs of patients. With respect to each of these factors, specific action was instituted to ensure that anxiety among the patients would be reduced to a minimum.

Of the 125 resident patients who were relocated, 78 were mentally alert, though physically disabled, while 47 were classified as mentally confused or senile. We shall first discuss the action taken in relation to the 78 mentally alert resident patients.

For a period of four years prior to relocation, there had existed at Maimonides Hospital an organization called the Patients' Club. Membership in the club was open to all patients willing and able to participate in its activities. One of the chief aims of the club was for patients to participate, together with members of the staff, in the process of evaluating existing services and in planning improvements in program.

The club elected an executive committee, which met with the administrator and members of his staff on a regular basis. All recommendations of the executive committee had to be submitted to the total membership for consideration and approval at monthly meetings of the club.

The club and its executive committee offered excellent channels of communication between staff and patients for a thorough and continuous discussion of the latter's reactions, needs, and aspirations with respect to the new building and the prospect of relocation. Initially patients expressed a fear of moving into an unknown situation. The building in which they lived, while it contained defects, was at least known to them. Moving to a new location would

unusual importance attached to regular visits with their parents in the new building, particularly during the first few months following relocation. Similar interpretation was given to the staff of volunteer workers.

Belongings hold unusual meaning for old people. Their personal possessions may be associated with a significant social role the person played during an earlier period of his life. They may be associated with a loved one who is no longer living or with living members of the family. Familiar belongings are like a bridge helping a person to move from one location to another. Therefore, the executive housekeeper or her staff met with each resident individually to ascertain which belongings he or she wished to take along.

Each patient was encouraged to participate actively in the physical work of packing his belongings. As these were placed in specially provided cartons, the cartons were sealed in the patient's presence, and the latter's name and room number in the new building were written on them. Because long-term patients often complain that their belongings are lost when they have been removed from their rooms, the sealed cartons were left in the rooms until two days preceding the move.

Among the criteria we used to determine how space in the new building should be arranged, the following are listed: (1) the importance of privacy to an old person, (2) the importance of small groups in encouraging intimate and warm relationships, (3) the importance to old people of participating in social activity, and (4) the importance of providing separate living areas for individuals whose physical and mental needs differ so markedly that living in a common area is mutually destructive.

When an old person enters a long-term care facility, he is compelled to give up one of his last remaining important social roles—that of maintaining his own household in which he alone decides what time he shall retire at night and rise in the morning; whether a window shall remain open or be closed; whether his radio shall

Occupying a room with a stran person limits severely the range of independent action within the room and emphasizes sharply for the patient how small a role he plays in life. A private room therefore helps an aged person to feel a greater sense of self-respect.

In the old building, only four of the 125 patients lived in single rooms. Most of the rooms contained two beds. Altercations between room partners occupied a major portion of the caseworkers' time.

In the new structure of Maimonides Hospital, 163 of its 247 beds are located in single rooms, each room containing its own toilet. Of the 78 mentally alert patients among the 125 who were relocated, only two chose to share a room in the new building. Were it not for limitations of money, an even greater proportion of the beds would have been located in single rooms.

LIVING-AREA GROUPS KEPT SMALL

Experience in social group work indicates that when a group is small, interaction among its members tends to be more intimate, warm and meaningful. Accordingly, no corridor section of bedrooms in the new building contains more than 16 beds. Each floor on which patients live is shaped like the letter H, with the two perpendicular bars bent at their centers. Thus each floor consists of five sections containing 16, 15 or 8 beds.

In all, there are 70 beds per floor divided into two 35-bed nursing sections, each section being provided with an identical complex of nurses' stations and other nurses' work rooms for nurses. At the two ends of each perpendicular bar and at the center of the perpendicular bars, where they bend, is a living room. Thus each floor contains six living rooms. Since each living room has space for approximately 16 patients, groups that gather in them are always small. Individuals living in different sections have the opportunity of mingling in the centrally located living rooms. In the old building, each floor consisted of one undifferentiated corridor on which as many as 40 patients lived. There

gather.

Each floor also contains a dining room and a group activities room, each large enough to seat all 70 patients at once. These rooms enable patients to participate in social activities involving larger numbers of people. In the old building, these rooms were not provided on each floor but were centrally located. Therefore, patients who were too feeble to move from one floor to another had to eat in their own rooms and could not visit the group activities room.

PATIENTS CLASSIFIED

Because the new building contains 18 individual bedroom sections in the various floors of residence, it is possible to separate, by section, patients whose medical conditions would make their living in close proximity inimical to their benefit. Before we relocated them, all patients were carefully classified according to their physical and mental conditions. As explained, if patients fell within the same classification, they were placed near one another if they so preferred. Thus, the fifth or topmost floor contains mentally alert patients in need of moderate nursing care. The fourth floor contains mentally alert patients in need of maximum nursing care. The third floor contains mentally confused patients who require a great deal of nursing care. Because of the existence of five sections on this floor, it was possible to separate those who were maximally confused from those who were moderately confused.

The second floor, which contains only 37 beds, has been set aside for mentally alert patients, most of whom are unable to get out of a bed or a chair without the help of a nurse. Of the 37 beds, 10 have been set aside for use on a temporary basis by patients from the upper floors when they become acutely ill. These arrangements are much superior to those in the old building.

With respect to the 47 mentally confused patients, while they were not sufficiently in contact with reality to understand advance explanations of the move, it was assumed that they were sufficiently aware of familiar positive

charged environmental cues to become disturbed when they were no longer at hand, and that they were also sufficiently aware of familiar but negatively charged environmental cues to become more relaxed when these cues were no longer at hand.

Among the negative cues, the following may be listed: (1) a room partner whose behavior is upsetting (confused room partners in the old building were constantly upsetting each other); (2) a nearby neighbor whose behavior is upsetting. In the old building, the mentally alert patients who lived on the same floor expressed continuous hostility toward the mentally confused patients. The same was true of moderately confused patients, who expressed annoyance with those more confused than they. In turn, the latter exerted a negative influence on the former.

Among the positive cues, the following may be listed: (1) a positive relationship with members of the staff, both paid and volunteer; (2) a positive relationship with family members; (3) activities which follow one another in a specific pattern on a daily basis and which are pleasant. Such a stable pattern gives a great feeling of safety to the confused patient.

CONFUSED PATIENTS PREPARED

In preparing the confused patients for relocation, the following actions were taken: With the exception of two maximally confused patients who expressed a deep affection for each other, all others among the total of 47 confused patients were assigned to single rooms. Furthermore, the maximally and moderately confused were placed in geographically distinct bedroom sections on the same floor, where contact was minimal. The few mentally alert patients who used to share the same floor with them were assigned to a totally different floor in the new building.

No effort was spared to have staff members who had cared for the confused patients in the old building continue to care for them in the new structure. This effort was directed particularly toward the nurse aides and orderlies who helped patients with their activities of daily living, such as toilet care, grooming, bathing, feeding, walking and being helped into and out of bed. Members of their families, too, were urged to make frequent visits, particularly during the period immediately following the relocation.

In the old building, a unique program of activities that included simple games, music, simple arts and crafts, and even simple conversation had been established for the confused patients.[2] This program, when added to the daily routines of nursing care, provided them not only with a stable pattern of activities that met their need for safety and protection, but also met their need for enjoyable recreation. In the new building, the members of the social group work, social casework, nursing, occupational therapy, and physical therapy staffs and the volunteer workers assigned to help them bent every effort to ensure the successful continuation of this program.

On the day when the relocation actually took place, every patient wore a tag bearing his name, floor number and room number in the new building. Staff members also wore identification tags so that patients would not feel different. Buses, each one identified by a number corresponding to a specific floor in the new building, stood ready to receive the patients. On each floor, staff members thoroughly familiar with the patients led them via elevator to the buses.

The strongest and ablest patients were brought down first because they would be better able to bear whatever strain might be involved in waiting in the bus until the last patient had left the old building and the trip to the new building could begin. Patients' belongings, marked by name and room number, had been placed in the appropriate rooms of the new building two days earlier. They were left there completely sealed, to be opened by the patients themselves, who would thus be assured that nothing had been lost or stolen.

Awaiting the patients at the new building were additional members of the staff, also thoroughly familiar with them. As the buses arrived, the feeblest patients were the first to be taken to their rooms, where they were helped to unpack and make themselves comfortable. The entire operation of moving was carried out in an atmosphere of efficiency and calm.

At the end of a year after the move, the mortality statistics among the 125 patients who had been relocated were startling. Only 19, or 15.2 per cent, of the group had died. Not only was this 22.8 per cent below the mortality rate of 38 per cent experienced elsewhere[1] during the first year following relocation, but it was also 9.8 per cent below the normal annual mortality rate of 25 per cent which had been experienced by Maimonides Hospital in its old building. Furthermore, during the crucial first three months following relocation only one patient died.

EMOTIONAL SHOCK LESSENED

It would seem that removal of fear of the unknown, the preservation of satisfying relationships, and the retention of emotionally meaningful belongings, all of which were involved in the process of relocating the patients of Maimonides, lessened the emotional shock of relocation and thus prevented this shock from increasing their rate of mortality. These factors, however, did not explain the unusual decrease in the rate of mortality among patients after their relocation.

The only new element of significance that can be detected in the environment of the new building is arrangement of space with due regard to the emotional needs of the patients. It would seem, therefore, that this new arrangement of space that provides privacy, makes possible small group experiences, offers a variety of larger group experiences to all patients, and enables the separation of patients whose medical conditions render their living together mutually destructive constitutes the factor that actually decreased the rate of mortality.

REFERENCES

1. Aldrich, C. K. Personality factors in the relocation of the aged. *Geriatrics* 4:32 June 1964.
2. Novick, L. J. Programming for the brain-damaged aged in a long-term care facility. *Hospitals, J.A.H.A.* May 1, 1965.

New York
State Plan

EXHIBIT 9

DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

PROCEDURE FOR INVOLUNTARY TRANSFER OF PATIENTS

The Division of Medical Assistance and Health Services will implement, effective upon adoption on March 1, 1977, the following procedural guidelines which affect the involuntary transfer of Medicaid patients from a long term care facility.

100. Purpose

A. The Division of Medical Assistance and Health Services recognizes that there may be problems in relocating infirm aged persons from a long term care facility. The purpose of these regulations is to specify the circumstances in which the involuntary transfer of a Medicaid patient in a long term care facility is authorized and to establish conditions and procedures designed to minimize the risks, trauma and discomfort which may accompany the involuntary transfer of a Medicaid patient from a long term care facility.

B. These regulations shall be interpreted consistent with the Federal requirement that care and services under the Medicaid program be provided in a manner consistent with the best interests of the patient.

200. Applicability

A. These regulations shall apply to the involuntary transfer of a Medicaid patient at the request of a long term care facility and not as part of the Division's utilization review process, except as indicated in Section 300.

B. Definitions:

→ 1. An involuntary transfer is any transfer of a Medicaid patient which was not consented to or requested by the patient or by the patient's family or authorized representative.

2. Medicaid patient includes (a) a Medicaid patient residing in a long term care facility which has a Medicaid provider agreement in effect, including patients over the minimum number stipulated in the agreement, and (b) a patient who

had entered the facility as a non-Medicaid patient and becomes a Medicaid patient or is awaiting resolution of Medicaid eligibility, except for a patient who enters the facility under a signed admission agreement for private payment and then converts to Medicaid within six months from the date of admission.

3. Division means the Division of Medical Assistance and Health Services.

C. Internal Relocation. These regulations shall not apply to the internal relocation of a Medicaid patient within a facility.

300. Grounds for Involuntary Transfer

A. A Medicaid patient may be transferred involuntarily only for the following reasons:

1. The transfer is required by medical necessity.

2. The transfer is necessary to protect the physical welfare or safety of the patient or other patients.

3. The transfer is required because of non-payment for the patient's stay in the facility, or

4. The transfer is required by the State Department of Health pursuant to licensure action or if the facility is suspended or terminated as a Medicaid provider by the Division.

B. A Medicaid patient shall only be involuntarily transferred when adequate alternative facilities acceptable to the Division are available.

400. Criteria for Determination

A. In any determination as to whether a transfer is authorized by these regulations, the burden of proof by a preponderance of the evidence shall rest with the party requesting the transfer, who shall be required to appear at a hearing if one is requested and scheduled.

B. Where a transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

1. The effect of relocation trauma on the patient.

2. The proximity of the proposed facility to the present facility and to the family and friends of the patient.

3. The availability of necessary medical and social services at the proposed facility.

4. Compliance by the proposed facility with all Federal and State regulations.

500. Procedure for Involuntary Transfer

A. The facility shall submit to the Division a written notice with documentation of its intention to and reason for the involuntary transfer of a Medicaid patient from the facility.

B. If the Division's Medical Evaluation Team determines that an involuntary transfer is warranted, the patient and/or the patient's authorized representative, shall be given 30-days prior written notice by the Division that a transfer is proposed by the facility and will take effect upon completion of the relocation program specified in Section 600, unless the patient requests a hearing within 30 days of the date of the written notice, in which case the transfer is stayed pending the decision following the hearing, except in instances where the Division determines that an acute situation or emergency exists.

C. The written notice to the patient and/or authorized representative will advise of the right to a hearing which shall include a simple form prepared by the Division for requesting a hearing.

D. The Division will endeavor to comply with the hearing time requirements in State and Federal regulations, unless an adjournment is requested by the appellant.

E. The hearings will be conducted at a time and place convenient to the patient. Notification shall be sent to all parties concerned.

F. All hearings shall be conducted in accordance with the Fair Hearing procedures adopted by the Division.

600. Relocation Procedure

A. In the event the relocation of a patient is a final Division determination, the Division shall afford relocation counselling for all prospective transferees in order to reduce as much as possible the impact of transfer trauma.

B. The staff of the transferring and receiving long term care facilities shall assist in the transfer process, although responsibility and authority for the coordination and transfer rests with the Division and shall include:

1. Medical evaluation review by Division medical, nursing and social service staff.

2. Initial patient, family or authorized representative counselling.

3. Involvement of the patient, family or authorized representative in the placement process with recognition of a patient's right to freedom of choice.

4. Patient preparation and site visit for all patients able to do so within the capability of the transferring agent.

5. Unless the patient otherwise requests, the patient shall be accompanied on the transfer day by a family member, authorized representative or attendant.

6. Follow-up counselling at the new location.

C. There shall be no administrative hearing on a claim of failure to implement the requirements of this section for relocation counselling.

700. No owner, administrator or employee of a long term care facility shall attempt to have patients seek relocation by harrassment or threats. Such action on behalf of the facility may be cause for the curtailment of future admission of Medicaid patients to the facility or for termination of the Medicaid provider agreement with the facility.

800. Any complaints regarding the handling of patients relative to their transfer shall be referred to the Division for investigation and corrective action.

EXHIBIT 10

Interpersonal networks of 56 residents in a home for the aged were studied before and after relocation. Close primary relationships were associated with successful adjustment to relocation as measured by changes in life satisfaction, in degree of physical infirmity, in psychological deterioration and agitation. Further study is needed to focus on the differential quality and nature of intimate ties in the friendship, kinship, and caregiving sectors of the network and to determine how helpful interactions can be fostered.

Interpersonal Networks and Post-Relocation Adjustment of the Institutionalized Elderly[1]

Lilian Wells, MSW[2] and Grant Macdonald, MSW[3]

Involuntary relocation creates major disruptions in the lives of elderly people. For many in this particularly vulnerable group, relocation constitutes a threatening event which may manifest itself in undesirable physical, emotional and social consequences. Much of the literature on relocation reflects the seriousness of the problem. A number of researchers have reported that extensive environmental change can lead to behavioural, psychological and physical deterioration in elderly people (Aldrich & Mendkoff, 1963; Bourestom & Tars, 1974; Kasteler, 1968; Killian, 1970; Markus et al., 1972; Miller & Lieberman, 1965; Pablo, 1977). On the other hand, there is evidence to suggest that a stimulating new environment may increase life satisfaction and functioning for those people who are able to cope with the change (Gutman & Herbert, 1976; Novick, 1967; Zweig & Csank, 1975).

Since relocation of the elderly is often unavoidable, it is essential to explicate factors which might reduce undesirable effects. Social supports have been shown in a number of areas other than gerontology to be critical to the function and adaptation of the individual in times of stress (e.g., Boswell, 1969; Caplan, 1973; Coelho et al., 1974). The availability of social resources has proven to be particularly important to successful adaptation in a wide range of stress-evoking transitional situations, such as the loss of a spouse (Silverman, 1972; Walker et al., 1977), severe illness (Croog et al., 1972; Finlayson, 1976) on return to the community from a mental health setting (Caplan, 1974). Surprisingly little research has been conducted on the relationship between interpersonal networks and response to crises in elderly populations. There is copious literature on the importance of family and personal relationships to regular daily life, happiness and a sense of well-being in the elderly (e.g., Moriwaki, 1973; Spark & Brody, 1970; Troll, 1971; York & Caslyn, 1977), but to date, there have been relatively few studies of the relationship of these social factors to successful adaptation to relocation (Brand & Smith, 1974; Kasl, 1972).

This study attempts to help fill the gap. Its objective is to explore the extent of disruption in close interpersonal networks created by inter-institutional relocation and to determine if there is a link between close relationships prior to the move and successful physical and psychological adjustment following it.

Context of the Study

The relocation which forms the basis of this study was brought about by the closure of Hilltop Acres which, having been constructed in 1902, no longer met safety standards. The building was one of eight Homes for the Aged, owned and operated by the Municipality of Metropolitan Toronto's Dept. of Social Services.

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The home accommodated a maximum of 180 residents and provided two levels of service. "Residential care" was primarily supervisory with some assistance with activities of daily living. "Extended care" provided up to 90 min per day of additional, skilled nursing and personal care. Forty percent of the residents received this level of service.

Residents opposed the closure and petitioned Metro Council to undertake renovations instead. However, this was not feasible.

Studies of relocation indicate that the impact is related to the choice, nature of preparation, degree of environmental change and the health of those involved (Kasl, 1972; Schultz & Brenner, 1977; Yawney & Slover, 1973; Zweig & Csank, 1975). While the closure of the home meant that the relocation was involuntary, the residents did have a range of alternative choices of where to move. A special program, described elsewhere (Wells, 1979), was developed to prepare and help them through the relocation. The goals of this program were to provide support and information, deal with emotional distress and enhance autonomy and self esteem. The home was phased out over 4 months with transfers of residents and staff occurring throughout this period. Usually, two to four residents were moved at a time with most residents deciding to move to another of the seven homes within the system. These other homes were larger with more modern facilities but with fewer private rooms; however, the policies, programs, services and staffing patterns were similar.

Sample

We provided some control to assure uniformity of the health and environmental variables. The study sample was restricted to those residents requiring "extended care" and those who chose to move to other homes within the system. There were 74 residents who met these criteria, but 3 refused to participate, 8 were unable to complete the structured interview, 2 did not speak English and 5 moved before we could interview them.

The socio-demographic characteristics of these 56 residents are presented in Table 1. As indicated, 47 were females and 9 were males. All subjects were Caucasian except one and their ages ranged from 65 to 100 years (mean age was 85 years). The majority (71%) of the subjects had been residents at Hilltop Acres for 4 years or more. Most (73%) were ambulatory.

Instrumentation

Network information. — Residents were asked to identify other residents, staff, family and friends outside the home with whom they felt "close." It has been assumed for this study that the notion of "closeness" is an acceptable translation of the sociological concept of a primary relationship, or a personal tie involving support and affectional concern. This method of determining primary relationships has been used by Wellman et al. (1971), Hagarty (1975) and others. Unlike Wellman et al. (1971), this study did not limit the number of persons the subject could name as being close. Using this method, the total range of primary relationships was obtained for the three network categories: (1) close residents; (2) close staff; (3) close family and friends.

Life satisfaction. — The Life Satisfaction Index Z (LSI-Z), a 13-item questionnaire (Wood et al., 1969), was used as a measure of general life satisfaction or morale.

This index, a shortened version of Neugarten et al. (1961) 18-item index, has been used extensively in research with elderly populations (Bloom, 1975). The subject may respond with an agreement, uncertain or disagreement response to each statement about the respondent's perception of his or her well-being. Wood et al. (1969) recommendation that a trichotomous

Table 1. Socio-Demographic Characteristics.

	Number	Percent
SEX		
Males	9	16.1
Females	47	83.9
Total	56	100.0
MARITAL STATUS		
Single	7	12.5
Widowed	48	85.7
Divorced	1	1.8
Total	56	100.0
AGE*		
65-70 years	4	7.1
71-80	8	14.2
81-90	30	53.7
91-100	14	25.0
Total	56	100.0

*Mean = 85 years

scoring system be adopted has been taken for this study. Responses indicating high life satisfaction are allocated two points, while responses reflecting low satisfaction are allocated zero points. Uncertain or intermediate responses are given one point. Consequently, the theoretical range of scores is 0 to 26. Wood et al. (1969) have found the shortened version to have acceptable reliability and validity.

Physical and mental deterioration. — The widely used (Bloom, 1975) PAMIE Scale (Physical and Mental Impairment-of-Function Evaluation) was employed as a measure of physical and psychological deterioration. Developed by Gurel et al. (1972), the scale consists of 76 items designed to assess impairment in elderly populations. Assessments were made by a nursing staff member who had the best knowledge of the subject's overall health.

Examples of several items are: "When left alone, sits and does nothing"; "Walks flight of stairs without help"; "Looks worried or sad." A "yes/no" response format is used with scores of 1 given to responses reflecting impairment. Thus, higher scores reflect greater impairment. An overall measure of physical and mental impairment consists of the sum of all items (reverse scored where necessary). In addition, three PAMIE factors developed and described by Gurel et al. (1972) are also used to explore different dimensions of impairment.

(1) *Physical Infirmity* was composed of four sub-scales: ambulatory; sensorimotor impaired; self-care dependent and bedfast/moribund. (2) *Psychological Deterioration* was composed of five subscales: mentally disorganized/confused; withdrawn/apathetic; behaviorally deteiorated; self-care dependent and bedfast/moribund. (3) *Psychological Agitation* was reflected in the scores of items composing three subscales: paranoid/suspicious; belligerent/irritable and anxious/depressed.

Complete baseline information on the 56 subjects' network of primary relationships and life satisfaction prior to relocation was obtained during the course of a structured interview with each subject. Some additional socio-demographic information was obtained from the files. All interviews were conducted by social work students who had both research interviewing skills and experience working with the institutionalized elderly. In addition, the nursing staff was asked to complete the PAMIE ratings soon after the pre-move interview was completed.

The subjects were followed-up 8 to 12 weeks after they were relocated. A PAMIE was completed at that time. Life satisfaction and network information was again obtained by interview. Where possible, the same interviewer was used to conduct the follow-up interview.

For the PAMIE and LSI-Z variables, change scores were computed by subtracting scores prior to the move from scores after the move. These scores reflected changes in the functioning or life satisfaction which occurred between the first and second interview.

Results

Sample attrition. — At the time of follow-up, 5 subjects (9% of the sample) had died, 3 refused to be interviewed and 9 were disoriented and unable to participate. Complete follow-up data were obtained for 45 (80%) of the subjects for the PAMIE ratings, 39 (69%) for the network information and 35 (62%) subjects for the life satisfaction ratings. Analysis of PAMIE and LSI-Z scores comparing residents who were reinterviewed and those lost to follow-up, revealed no significant differences although the latter group tended to have somewhat higher impairment scores and lower life satisfaction scores.

Primary-relationship network prior to relocation.— Prior to the move, all 56 subjects were asked to signify residents, staff, family and friends to whom they felt close. On the average they named less than one (0.8) resident per subject. A total of 52% did not name any residents as close. The total sample named an average of less than one (0.7) staff member per resident, with 68% not naming any staff. It is interesting to note that one particular staff member was named by 10 residents. Finally, the results indicated that most residents (82%) had at least contact with one family member or friend outside the home. As a group, they averaged about two close relationships outside the home per person.

Disruption of primary relationship networks. — The results indicate that relocation substantially disrupts the primary relationship networks of many of the residents. The 39 subjects, for which there was network information available before and after the move, showed a significant loss in terms of their range of close ties. As a group, these 39 subjects identified, prior to the move, a total of 165 persons whom they de-

Table 2. Comparison of the Mean Number of Primary Relationships in Different Network Categories Before and After Relocation (N = 39).

Network Categories	Before Relocation Mean	Before Relocation S.D.	After Relocation Mean	After Relocation S.D.	t-value[a]	Significance
Number of Close Residents	1.00	1.17	0.31	0.47	3.69	$p < 0.001$
Number of Close Staff	0.90	1.47	0.26	0.71	2.48	$p < 0.05$
Number of Close Family & Friends	2.33	1.78	2.36	1.58	−0.14	N.S.S.[b]
Total Number of Close Relationships	4.23	3.07	2.92	1.98	3.45	$p < 0.001$

[a]t-test between variables for paired samples.
[b]Not statistically significant.

Table 3. Comparison of Means of Life Satisfaction Index Scores (N = 35) and PAMIE Scores (N = 45) Before and After Relocation.

Measures of Functioning	Before Relocation Mean	Before Relocation S.D.	After Relocation Mean	After Relocation S.D.	t-value[a]	Significance
Life Satisfaction Index	15.6	6.3	14.1	6.0	1.98	$p < 0.10$[b]
Physical Infirmity Factor Scores	12.6	4.4	12.9	4.7	−0.55	N.S.S.[c]
Psychological Deterioration Factor Scores	11.7	5.3	13.6	7.4	−2.09	$p < 0.05$
Psychological Agitation Factor Scores	2.5	3.3	3.1	3.9	−0.80	N.S.S.[c]
Total PAMIE Scores	20.6	7.4	23.0	9.9	−1.66	$p < 0.10$[b]

[a]t-test between variables for paired samples.
[b]Although $p < 0.10$ is not statistically significant at the traditional 0.05 level, it has been noted here since it indicates a trend toward significant change in the means.
[c]Not statistically significant.

scribed as close. Following relocation, these same subjects named only 114 persons as close, a reduction in the total number of primary relationships of 31%. The mean number of relationships for this group prior to the move was 4.2 compared with 2.9 after, a loss which was statistically significant (t-value = 3.45, d.f. = 38, $p < 0.001$). This reduction in range was largely attributable to the loss of close relationships with residents and staff from the former home which were not replaced after relocation. The number of family and friends outside the home remained constant over the period of the move (Table 2). One might speculate that the 31% reduction in the total range of primary relationships will eventually disappear as residents find new friends amongst the residents and staff of their new homes. However, the figure clearly reflects the extent of the disruption in their close social interactions created by relocation.

Change in life satisfaction and functioning. — Complete before and after scores on the LSI-Z were obtained for 35 of the subjects. Although a few subjects' scores increased, indicating greater life satisfaction, there was a general trend (t-value = 1.98, d.f. = 34, $p < 0.10$) towards a reduction in life satisfaction for most subjects. Similarly, there was a trend towards increased impairment of functioning as indicated by increases in the overall PAMIE scores. Although there was no statistically significant change in scores for the Physical Infirmity and Psychological Agitation factors, there was significantly greater impairment after relocation in terms of the Psychological Deterioration factor (t-value = −2.09, d.f. = 44, $p < 0.05$).

The results, in Table 3, make it apparent that the relocation contributed to mental disorganization, confusion, apathy and behavioural deterioration of the residents. Again, it is uncertain

Table 4. Correlations[a] Between Ranges or Primary Relationships Prior to Relocation and Change in Life Satisfaction Scores (N = 35) and PAMIE Scores (N = 45).

Network Categories	Change[b] in LSI-Z Scores	Change[c] in Physical Infirmity Scores	Change[c] in Psychological Deterioration Scores	Change[c] in Psychological Agitation Scores	Change[c] in Total PAMIE
Number of Close Residents	.01	−0.05	−0.07	−0.03	−0.04
Number of Close Staff	.24	−0.39**	−0.36**	−0.12	−0.31*
Number of Close Family/Friends	.30*	−0.23	−0.28*	−0.26*	−0.30*
Total Number of Close Relationships	.30*	−0.33*	−0.35*	−0.21	−0.33*

[a]One-tailed Pearson correlation coefficients (*$p < 0.05$; **$p < 0.01$).

[b]Change scores were computed by subtracting the Life Satisfaction Scores prior to the move from scores after move. Positive change therefore reflects improvement in Life Satisfaction.

[c]Change scores were computed by subtracting PAMIE scores prior to move from scores after move. Therefore, negative change reflects improvement in functioning.

whether or not, with a longer period of adjustment, residents' scores would return to pre-move levels.

Primary relationships and post-relocation adjustment. — We expected that residents who, prior to the move, had fewer close supportive relationships would be more likely to adjust poorly to the move. In order to test this hypothesis, Pearson correlations were computed between the number of primary ties in the various network categories and the LSI-Z and PAMIE change scores.

The results are presented in Table 4. Interestingly, the number of close resident friends are not predictive of adjustment, whereas the number of close relationships with staff at Hilltop and family and friends outside the home, are significantly correlated with most of the change scores. The number of close staff correlates to the change in physical infirmity scores ($r_{xy} = -0.36$) and change in psychological deterioration scores ($r_{xy} = -0.39$). The number of close relationships outside the home is significantly correlated with the change in life satisfaction scores ($r_{xy} = 0.30$) and changes in the psychological deterioration ($r_{xy} = -0.28$) and agitation ($r_{xy} = -0.26$) scores.

The connection between primary relationships and changes in physical and mental functioning is illustrated in Table 5. A significant association ($\chi^2 = 6.25$, d.f. = 1, $p < 0.01$) was found between changes in overall PAMIE scores (before and after the move) and the existence of a close staff member prior to relocation. As indicated, 76.7% of the residents who reported no close staff relationships "deteriorated" in terms of their total PAMIE scores, compared with only 33.3% of the residents who felt close to one or more staff members.

Table 5. Number of Close Staff Prior to Relocation by Change in Total PAMIE.

Change in Total PAMIE	Number of Close Staff Prior to Relocation	
	None	One or More
No Change/Improved	23.3%	66.7%
Deteriorated	76.7%	33.3%
Total %	100.0%	100.0%
(Total N)	(30)	(15)

$\chi^2 = 6.25$ d.f. = 1 $p \leq 0.01$

Thus, it appears that the existence of close primary relationships with staff and ties outside the home were associated with successful adjustment to relocation in terms of life satisfaction and physical and mental functioning.

Conclusions and Implications

This inter-institutional relocation created a major disruption in the lives of those affected. The study, while limited by the small sample, demonstrated some of the changes that occur in terms of life satisfaction, functioning and primary relationship networks. Although there was no control group to determine whether or not relocation itself was the main contributor

to deterioration in these areas, the magnitude of the change in such a short period of time suggested that the changes were due to more than just the aging process. Attrition is always a problem in longitudinal studies of elderly people with health problems and in this case five subjects died and nine deteriorated in their physical and/or mental functioning so that they were not able to provide data in the post-move phase of the study. Since life satisfaction and quality of relationships may be adversely affected by failing health, this attrition could have masked the level of significance of the findings (Johnson & Bursk, 1977; Palmore & Kivett, 1977).

Nonetheless, the results indicate that interpersonal networks are a salient dimension to consider in relocation. The number and stability of close relationships with family and with friends outside the institution is of particular importance in minimizing undesirable effects of relocating elderly people. The findings once again, point to the importance of maintaining and strengthening the linkages between the elderly person in an institution and family and friends in the community. For those without family, it is necessary to discover whether it is possible to provide substitutes for this vital portion of a social network.

While only 22% of the sample identified a member of staff as part of their intimate network, it is interesting that residents who felt they had such a close personal relationship with a staff member prior to relocation had good post-relocation adjustments despite the fact that these relationships were usually disrupted by the move.

It appears that close relationships with staff and family provide a sense of security, belonging and esteem which may facilitate coping with stress and adaptation to a new situation.

It could be assumed that the presence of these relationships is based on characteristics or skills which certain residents possess. The fact that there was a particular staff member identified by many residents, however, suggests that characteristics and functions of staff are also important. There is clearly a need to clarify those special characteristics in the relationship with staff that prove helpful and consideration of the roles staff can fulfill. While institutions expect staff to treat residents with kindness and concern, the idea of personal relationships is usually not considered and, in fact, objectivity and detachment are more often expected. There is recognition that the nature of relationships differs in acute-care and long-term care facilities but little attention has been given to what the crucial elements are.

There are indications that the kinship, friendship and care-giving sectors of the residents' intimate network had differential impact on adjustment. That is, the number of close resident friends, while associated with pre-move life satisfaction was not associated with any of the post-move adjustment measures. Ties with family and friends in the community were associated with change in life satisfaction ($p < 0.05$) and negatively associated with psychological deterioration and agitation ($p < 0.05$). Ties with staff before the move were associated with maintenance of physical and emotional health as measured by change in physical infirmity and psychological agitation scores ($p < 0.01$). The meaning and content of friendship anchored in these different sectors needs further exploration.

The impact and importance of these relationships may be different in periods of stability and in periods of crisis. Moriwaki (1973), for example, suggests that with high degrees of role loss, the individual is much more role dependent on the affective rather than the instrumental context of the relationship which, in these situations, is not as predictable. It would have been interesting if it had been possible to obtain baseline data before the intent to close the home was made public since the pre-move phase was not a stable period and undoubtedly had an impact.

The present study was limited to consideration of the number of primary relationships in different network categories. Further research is required to focus on the qualitative components of the interaction between the elderly person and the members of his social network. This should lead to identification of ways to enhance the establishment and functioning of the supportive components of social networks and the development of policies, services and strategies that foster adaptive capacity and improve the quality of life of institutionalized, old people.

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EXHIBIT 11

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Reprinted from : National Citizens' Coalition for Nursing Homes Reform, Second Annual Training for Vista Volunteers, Marriottsville, Maryland, January 20-25, 1980. Questions should be addressed to NCCNHR, 1924 16th St., N.W., Suite 204, Washington, D.C. 20036. (202) 797-8227

ADDENDUM 2

Rule as Proposed
and
Notice Of Intent to Adopt a Rule

Rules as Proposed (all new material)

RELOCATION OF RESIDENTS FROM NURSING HOMES AND CERTIFIED BOARDING CARE HOMES

4655.6810 DEFINITIONS.

Subpart 1. Scope. The terms used in parts 4655.6810 to 4655.6830 have the meanings given them in this part.

Subp. 2. Certified boarding care home. "Certified boarding care home" means a facility licensed pursuant to Minnesota Statutes, sections 144.50 to 144.56, and certified as an intermediate care facility as defined in United States Code, title 42, section 1396d, as amended through December 31, 1982.

Subp. 3. Facility. "Facility" means a nursing home or certified boarding care home.

Subp. 4. Nursing home. "Nursing home" means a facility licensed pursuant to Minnesota Statutes, section 144A.01, subdivision 5.

Subp. 5. Relocation. "Relocation" means a situation when residents are to be discharged from a nursing home or certified boarding care home as the result of the closing of the facility or the curtailment, reduction, or change of operations or services offered there.

Subp. 6. Service offered in the facility. "Service offered in the facility" includes participation in the Medicare and Medicaid programs, or both programs, pursuant to United States Code, title 42, sections 1395 et seq., and 1396 et seq., as amended through December 31, 1982.

Subp. 7. Social service agency. "Social service agency" means the county or multicounty agency authorized under Minnesota Statutes, sections 393.01, subdivision 7 and 393.07, subdivision 2, for the county in which the facility is located.

4655.6820 NOTICE TO DEPARTMENT OF HEALTH.

Subpart 1. Notice required. The licensee of the facility shall notify the Department of Health, in writing, at least 90 days prior to the cessation or the curtailment, reduction, or change of operations or services which would result in the

relocation of residents.

Subp. 2. Notice information. The written notice shall include the following:

A. the date of the closing, curtailment, reduction, or change of operations or services;

B. the number of residents to be relocated; and

C. the names and telephone numbers of the persons in the nursing home responsible for coordinating the relocation of residents.

4655.6830 FACILITY RESPONSIBILITIES.

Subpart 1. Cooperation. The licensee of the facility and facility staff shall cooperate with representatives from the Department of Health and from the social service agency in planning for the relocation of residents.

Subp. 2. Interdisciplinary team. The administrator of a facility shall establish an interdisciplinary team which shall be responsible for coordinating and planning the steps necessary to relocate the residents. The interdisciplinary team shall consist of members involved in providing direct care services to residents.

Subp. 3. Advance notice. The facility shall send the written notices in items A to C at least 60 days in advance of the date by which the relocation of residents is to be completed.

A. Notice shall be sent to the resident who will be relocated and to the individual responsible for the resident's care. This notice must include the name, address, and telephone number of: the individual in the facility to be contacted for assistance and further information; the social service agency; and the area long-term care ombudsman, provided under section 307(a)(12) of the Older Americans Act, United States Code, title 42, section 3027, as amended through December 31, 1982.

B. Notice shall be sent to the attention of the commissioner of human services and to the social service agency. This notice must include the name of each resident to be relocated and the name, address, and telephone number of the individual responsible for the resident's care and the

individual in the facility to be contacted for further information.

C. Notice shall be sent to the attending physician of the resident to be relocated. The resident's attending physician shall be requested to furnish any medical information needed to update the resident's medical records and to prepare transfer forms and discharge summaries. This written notice must include the name and telephone number of the individual in the facility to be contacted for further information.

Subp. 4. Bed list. A list of available beds to which the resident can be relocated must be prepared. This list must contain the name, address, and telephone number of the facility, the certification level of the available beds, the type of services available, and the number of beds that are available. This list must be made available to the resident, the individual responsible for the resident's care, the area long-term care ombudsman, and the social service agency.

Subp. 5. Informational meetings. The facility shall conduct small group meetings for the residents and the individuals responsible for the care of the residents, to notify them of the steps being taken in arranging for the transfer. Individual residents shall be assisted as necessary.

Subp. 6. Resident inventory. The inventory of the resident's personal possessions must be updated and a copy of the final inventory provided to the resident, the individual responsible for the resident's care, or both. A final accounting of personal funds held in the facility must be completed in accordance with part 4655.4170. Arrangements must be made for the transfer of the resident's possessions and personal funds.

Subp. 7. Site visits. Unless it is medically inadvisable, as documented by the attending physician in the resident's care record, the resident shall be assisted in making site visits to facilities to which they may be transferred.

Subp. 8. Administrative duties. All administrative duties must be completed prior to the actual relocation of the resident.

Personnel in the facility to which the resident will be moved shall be provided with the information necessary to provide care and services to the resident, in accordance with part 4655.3500.

Subp. 9. Final notice. Unless otherwise agreed to by the resident or the individual responsible for the resident's care, at least a 14-day notice shall be provided to a resident prior to the actual relocation.

Subp. 10. Transportation. The resident shall be assisted in making arrangements for transportation to the new facility.

Subp. 11. Ease in transition. There must not be a disruption in the provision of meals, medications, or treatments of the resident during the relocation process.

Subp. 12. Notice to physician. If not previously notified, the resident's attending physician shall be informed of the new location of the resident within 24 hours after the actual relocation.

Subp. 13. Status reports. Commencing the week following the relocation notice to the Department of Health required in part 4655.6820, subpart 1, the facility shall provide weekly written status reports to the Department of Health as to the progress being made in arranging for the relocation. The initial status report must include the relocation plan developed by the facility, the identity of the interdisciplinary team members, and a schedule for the completion of the various elements of the plan. Subsequent status reports must note the progress being made, any modifications to the relocation plan, any change of interdisciplinary team members, and must include the names of residents who have been relocated during the time period covered by the report. Once relocation has been completed, a listing of the residents who have been relocated and the identity of the facilities or other locations to which the residents were moved must be provided to the Department of Health.

APPROVED IN THE
REVISOR OF STATUTES
OFFICE BY:

Department of Health

Health Resources Division

In the Matter of the Proposed Adoption of Rules of the State Department of Health Governing the Relocation of Residents from Nursing Homes and Boarding Care Homes

Notice of Intent to Adopt a Rule Without a Public Hearing

Notice is hereby given that the State Department of Health proposes to adopt the above-entitled rules without a public hearing. The Commissioner has determined that the proposed adoption of these rules will be noncontroversial in nature and has elected to follow the procedures set forth in Minnesota Statutes sections 14.22 to .28.

Persons interested in this rule shall have 30 days to submit comments. Persons interested in this rule are encouraged to submit written comments identifying the portion of the rule addressed, the reason for the comment, and any change proposed. The proposed rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in substantial change in the rule as proposed.

Unless twenty-five or more persons submit written requests for a public hearing on this rule within the thirty day comment period, a public hearing will not be held. Any person requesting a hearing should state their name and address and should identify: the portion of the rule addressed, the reason for requesting a hearing, and any change proposed. The comment period will close on May 15, 1985. In the event that a public hearing is required, the agency will proceed according to the provisions of Minnesota Statutes sections 14.131 to .20.

Persons who wish to submit comments or a written request for a public hearing should submit such requests to: Robert Eelkema, Minnesota Department of Health, P.O. Box 9441, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440.

Authority for the adoption of these rules is found in Minn. Stat. §§ 144.56, 144A.02 to .08, 144A.16, and 144A.31, Subd. 4. A Statement of Need and Reasonableness has been prepared for this rule. The Statement of Need and Reasonableness is available for review at the Minnesota Department of Health Building, 717 Delaware Street S.E., Room 228, Minneapolis, Minnesota, or may be obtained at a minimal charge by calling (612) 623-5473. A copy of this Notice and of this proposed rule, may be obtained by calling (612) 623-5473 or by writing to Mr. Eelkema at the address noted above.

This rule will not result in any increased expenditure to local public bodies. Nor will it result in a fiscal impact in excess of $100,000 annually. See Minn. Stat. §14.11, Subdivision 1 and

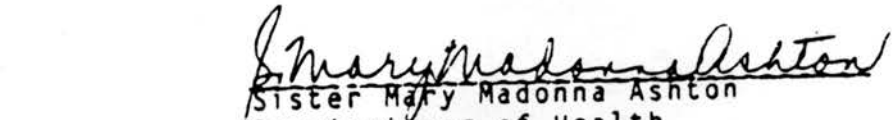
§15.065. Promulgation of rules by the Department of Health is exempt from Minn. Stat. §14.115, Small Business Considerations in Rulemaking, by virtue of subd. 7(c) of that law.

The following information is being provided to comply with the provisions of Minn. Stat. §144A.29, subd. 4 which requires that each rule promulgated by the Department contain a short statement of the costs and benefits to be derived from the rule. Development of this rule is required by a mandate given to the Interagency Board for Quality Assurance to develop a relocation plan. See Minn. Stat. §144A.31. Promulgation of this rule will assure compliance with that mandate as well as with other relevant provisions of Minnesota Statutes applicable to Nursing Homes and Boarding Care Homes. A major benefit of this rule is that specific relocation policies and procedures will be developed. This rule establishes the procedures to be followed by a nursing home or boarding care home in the event that relocation of some or all of the residents becomes necessary. The rule provisions are designed to ensure that proper and sufficient notice is given to residents and other affected parties and to require that the necessary assistance is provided to properly prepare for the relocation. The costs associated with this rule will be minimal as many of this rule's requirements are a compilation of existing requirements of Minnesota Statutes and Minnesota Rules. The Department believes that placement of the relocation procedure into one rule will help assure that the necessary steps are taken to safeguard the health, safety, and well-being of residents during the relocation process.

Upon adoption of the final rule without a public hearing, the proposed rule, this Notice, the Statement of Need and Reasonableness, all written comments received, and the final Rule as Adopted will be submitted to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised ~~of~~ the submission of this material to the Attorney General, or who wish to receive a copy of the final rule as proposed for adoption, should submit a written statement of such request to Mr. Eelkema.

The text of the proposed rule follows this Notice. Additional copies may be obtained by calling (612) 623-5473.

State of Minnesota



Sister Mary Madonna Ashton
Commissioner of Health