Law and the Public's Health

THE CASE OF LAGUNA HONDA

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This installment of *Law and the Public's Health* reviews the August 2004 Letter of Findings issued by the U.S. Department of Justice (DOJ) in the case of Laguna Honda Hospital and Rehabilitation Center in San Francisco. The findings are notable for their depth and breadth, as well as for the remedies ordered by the DOJ to halt the unjustifiable and unnecessary segregation of persons with disabilities. The sweep of the investigation—as well as its implications for monitoring the quality and performance of publicly supported nursing home programs nationally—makes the *Laguna Honda* decision essential reading for public health officials.

BACKGROUND AND OVERVIEW

Title II of the Americans with Disabilities Act (ADA) prohibits discrimination by publicly supported programs against qualified individuals with disabilities. Specifically, the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be subjected to discrimination by any such entity."[1] Regulations implementing the ADA require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[2] The preamble to the rules defines the term "most integrated setting" to mean a setting that "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[3] Persons with disabilities who qualify for publicly assisted programs are considered "qualified persons with disabilities" under Title II.[4] The ADA's protections apply to persons of all ages.

In 1999, the U.S. Supreme Court issued its landmark decision in *Olmstead v L.C.*[5] In *Olmstead,* the Court held that the medically unnecessary institutional segregation of persons with disabilities violates Title II of the ADA, and further, that public agencies are required to provide community-based treatment services when three conditions are met: *(1)* an individual meets the essential eligibility requirements for a community program based upon reasonable professional assessment; *(2)* the individual does not oppose community treatment; and *(3)* a community placement can be "reasonably accommodated" taking into account the resources available in the jurisdiction and the needs of similar persons.

Under *Olmstead,* the obligations of public programs are not "boundless," and programs can place limits on resources, but fundamentally, they may not administer their programs and services so that persons who do not need institutional care and who desire and can benefit from community services have institutions as their only treatment recourse. Waiting lists are not unlawful under the ADA (although Medicaid requirements may impose separate "reasonable promptness" requirements on Medicaid-supported services).[6] What *is* unlawful is medically unnecessary institutionalization of qualified persons with disabilities and without any reasonable alternatives.

THE LAGUNA HONDA INVESTIGATION

The Laguna Honda Hospital and Rehabilitation Center, located in San Francisco, is one of the nation's largest publicly operated nursing facilities, providing about one-third of all skilled nursing facility beds in the city.[7] The facility has 1,200 beds and employs some 1,500 full-time-equivalent employees.[7] Residents range in age from young adulthood to over 100, but as DOJ notes, an "unusually high number"—22%—are under age 55, and this segment of the population has grown rapidly over the past decade.[7] A "substantial number" have multiple mental and physical disabilities. The average daily cost of the facility is $236 per resident, bringing the facility's total annual operating cost to more than $90 million in federal, state, and local funds.[7]

The DOJ inquiry began with an investigation of the City of San Francisco in 1998 and resulted in findings that the city had violated numerous federal laws including the ADA and the Civil Rights of Institutionalized Persons Act (CRIPA).[8,9] This investigation identified legal violations related to conditions of care and treatment of the institution's residents and included examination of reported failure to ensure reasonable safety and failure to provide adequate health care and living environment. The initial investigation also focused on the facility's admissions and discharge practices. The DOJ found extensive evidence of legal violation: residents who were institutionalized despite having been assessed as having no skilled nursing or medical needs that required assistance in activities of daily living; the admission of individuals simply because their caregivers wanted services; the failure to identify persons with mental illness and who did not receive Preadmission Screening and Resident Review (PASRR) evaluation; the absence of discharge plans; and the absence of community services, in particular housing. Numerous residents regularly traveled into the community for work and other interaction, returning to Laguna Honda each night "simply because they have not been provided with appropriate community supports."[7] Investigators found that by allowing residents to languish under deeply inappropriate and isolated conditions, the Laguna Honda situation created problems that were "systemic, a gross departure from generally accepted practices and legal standards, and were likely to continue in the future absent implementation of remedial measures."[7] Because the facility operated with state funds (chiefly Medicaid), investigators concluded that the state health agency might also be contributing to the unlawful isolation of residents "through its administration of Medicaid programs and waivers, as well as other long-term care and services."[7]

Because DOJ concluded that there was credible evidence to find complicity at the state level, officials broadened the investigation to include several state agencies, including the state's Health and Human Services Agency and staff members from the departments of Health Services, Mental Health, Developmental Services, Social Services, and Aging.[7]

The August 2004 Letter of Findings details the numerous ways in which, according to DOJ, state officials had actively contributed to the conditions at Laguna Honda. In essence, DOJ found that the state had tolerated—and indeed, through their failure to address them—had tacitly enabled known and flagrant abuses of legal standards governing the institutionalization of persons with disabilities. In effect, state officials had abetted the violations by failing to exercise the type of oversight of institutional admission required under Medicaid specifically and public programs more generally as a result of the ADA. Specifically, DOJ found that state officials had:

- "Regularly" failed to review resident assessments "to ensure that" residents were served in the most integrated setting and failed to require nursing facilities to submit the type of information that would ensure a proper authorization by the state for the expenditure of nursing home funds. (Federal Medicaid law requires authorization prior to institutionalization.) Specifically, state officials failed to insist on ". . . detailed information on appropriate alternative placements to the nursing home, the person's previous status in the community, or possible resources that might be available to facilitate community placement in the future."[7]
- Failed to exercise ongoing oversight of resident progress and status, routinely authorizing two-year extension of stays and failing to exercise oversight of the appropriateness of placement. The state demanded no information and essentially tolerated the facility's total control over information flow: "The state's inadequate review process allows an institutional provider . . . to play a nearly exclusive role in determining whether or not an individual has meaningful access to home and community based services."[7]
- Failed ever to develop an adequate clinical assessment tool or review process, going so far as to return unspent a $600,000 grant under the Department of Health and Human Services' Real Choice Systems Change program, a special initiative to help states create community alternatives to institutional care.[10]
- Tolerated extensive evidence of specific cases of substandard care, resident abuses, and the provision of inappropriate care to persons who did not need to be institutionalized and who wanted to leave the facility.[7]
- Failed to screen residents for mental illness and disability in accordance with heightened federal requirements aimed at protecting persons with mental illness from inappropriate institutional placements.[7]
- Failed to meaningfully oversee the PASRR admissions and oversight process by tolerating assessments that were so inadequate as to be virtually non-existent. Officials essentially had no information on the continuing status of admitted residents or whether residents were experiencing significant changes in status so that adjustments in care could be made.[7]
- Failed to enable informed decision-making by residents with regard to community options. Residents were given no information about feasible alternatives in the community, nor were they assisted in making decisions. Instead the state used a "passive information" system, providing information only when requested of a state agency by an institutionalized person.[7]
- Did relatively little to develop community alternatives in relation to need, and equally importantly, exercised little stewardship over the resources that were available to ensure their best possible use.[7]

The DOJ remedial instructions included several basic components. First, officials were ordered to develop "meaningful" review of treatment and authorization requests to ensure a thorough and proper assessment of the needs of individuals both at the time of admission and throughout their stay. The DOJ ordered changes to ensure that individuals are assessed for services in the "most integrated community setting," a change that essentially shifts the presumption away from institutional placement and toward community residence. DOJ also ordered more investment in transition and discharge planning services, far stronger and more competent PASRR evaluations for persons with mental illness and mental retardation, the development of strategies for broadening community services, and the development of procedures to ensure appropriate information and assistance with informed decision-making. The DOJ also identified the development of more home- and community-based care resources through expanded waivers as key activities.

IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

Its sheer size makes Laguna Honda a particularly egregious example of the practice of virtually warehousing persons with disabilities (who can live and interact in the community)—and at enormous public expense. The funds spent to maintain this nursing home behemoth amount to almost $100 million in annual expenditures, much of it medically unnecessary according to the federal government's own assessment. Hundreds, if not thousands, of good-quality community integrated placements could have been secured with these funds, much of it qualifying for federal Medicaid contributions.

There is little explanation for Laguna Honda, other than systemic failure at all levels of government that permitted the city to operate and maintain a totally inappropriate health care institution whose greatest contribution appears to be the creation of extensive public employment opportunities (which could exist in connection with community programs as well). Precisely these types of practices lay at the heart of the *Olmstead* decision, and as the U.S. Supreme Court made clear in that decision, such practices fly in the face of federal civil rights law.

Public health agencies in all states play a central role in the ongoing assurance of health care quality under federally assisted programs. The failure to exercise such oversight in this case not only subjected thousands of residents to years

of poor quality care, but furthermore, has potentially exposed the state and city to liability for repayment to the federal government of hundreds of millions of dollars in federal Medicaid funds expended on inappropriate and unnecessary care. The Laguna Honda investigation should serve as a wake-up call to health administrators and public health officials alike that the Bush Administration is serious about its emphasis on the expenditure of public funds in a manner that advances—rather than impedes—the provision of health care in the most integrated community settings.

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