

Fact, Fiction and 2011 Wisconsin Act 2: Tort Reform and Wisconsin's Nursing Homes

There were numerous statements made during the debate on January 2011 Special Session Senate/Assembly 1, the tort reform legislation which ultimately was signed into law as 2011 Wisconsin Act 2, which are in need of either clarification or refutation as they apply to nursing homes. This is an attempt by WAHSA's not-for-profit long-term care providers to set the record straight.

Statement #1: “For our most vulnerable citizens in nursing homes, Act 2 protects the people who hurt or kill them by their own negligence by shielding vital information from juries' eyes.”

Response #1: The tort reform debate was replete with references to “incident and accident reports” and their value in determining whether facility staff had acted negligently. In order to understand the significance of those terms, it should be noted that DHS 132.46, Wis. Adm. Code, requires nursing homes to maintain a quality assessment and assurance (QAA) committee for the purpose of identifying and addressing quality of care issues. The QAA committee, which must be comprised of at least the facility's director of nursing, medical director, and three other members of the staff, must meet at least quarterly to identify quality of care issues with respect to which QAA activities are necessary and is required to identify, develop and implement appropriate plans of action to correct identified quality deficiencies. There is a similar QAA committee requirement for nursing homes in federal law under 42 CFR 483.75(o).

The activities of the QAA committee often are referred to as “peer review.” The written or oral statements provided to the QAA committee “for the purpose of identifying and addressing quality of care issues” sometimes are referred to as “incident reports.” Some facilities call them their peer review documents; others refer to them as risk management tools. What should be noted, however, is **there is no statutory or code requirement for nursing homes to maintain incident reports as part of their QAA process.** And if such records are maintained, DHS 132.46(3) prohibits the Division of Quality Assurance (DQA), the division of the Department of Health Services (DHS) with nursing home survey and quality assurance responsibilities, from requiring the disclosure of QAA committee records. Act 2 did not modify that provision.

Act 2 also left intact the current law provision that a person who participates in QAA committee activities may not disclose information acquired in connection with the health care services review unless agreed upon by the health care provider. Act 2 expanded the current law health care records confidentiality provision to prohibit the use of an incident or accident report under the s. 146.38 health care services review statute in any civil or criminal action against a health care provider.

It should be noted that a nursing facility cannot “hide” documents by labeling them as a QAA product. The documents that are protected under Act 2 are those that are generated for the purpose of a QAA committee review or that are generated at the request of the QAA committee. No other records or reports can be shielded. Indeed, shielding documents is a two-way street; some documents might be needed later to defend the actions of the provider.

The purpose of these Act 2 changes under s. 146.38 is to permit nursing homes and other health care providers to study and improve practices and accelerate collaborative efforts aimed at improving resident outcomes without fear of those findings being used against them in a court of law.



While Act 2 prohibits the use of QAA committee records or incident reports in any civil or criminal proceedings against the facility which produced those documents, it is quite a stretch to say the new law “shields vital information from juries' eyes.” The following documentation remains accessible to nursing home residents, their family members, and their legal representatives as allowed by and in accordance with the Wisconsin Open Records law, the federal Freedom of Information Act, Chapter 146, Wis. Stats., and federal and state discovery laws:

- Nursing home surveys and findings
- Nursing home plans of correction
- Resident medical records, including all incidents or accidents which include the time, place, details of the incident/accident, action taken, and follow-up care
- Prompt notification of the resident's physician, guardian, if any, and any other responsible person designated in writing by the resident, of any significant accident, injury, or adverse change in the resident's condition.

Statement #2: In cases involving allegations of physical or mental abuse in nursing homes, Act 2 explicitly prohibits prosecutors, residents, families, guardians or advocates from using either an incident report created by staff of the facility contemporaneous with the incident, as required by federal and/or state law, or investigative reports generated by the DHS in any criminal or civil legal proceeding.

Response #2: As noted above, there is neither federal nor state law which requires nursing facilities to maintain incident reports as part of their QAA committee activities under the s. 146.38 health care services review provisions in Act 2. We assume, therefore, that the above statement refers to Section 32 of Act 2, which creates s. 904.16 Health Care Reports. Under s. 904.16(2)(a), “reports that a regulatory agency requires a health care provider to give or disclose to that regulatory agency . . . may not be used as evidence in a civil or criminal action.” For purposes of this discussion, “health care provider” refers to nursing homes and “regulatory agency” refers to the DHS Division of Quality Assurance.

Both federal law (42 CFR 483.13(c)(2)-(4)) and State law (s. 146.40(4r) and DHS 13.05(3)-(6)) require nursing homes to immediately report to the DHS all incidents where allegations have been made of caregiver abuse, neglect, misappropriation of resident property, and injuries of an unknown source and to conduct investigations of those allegations. The results of the facility’s internal investigation must be documented in the **Caregiver Misconduct Incident Report**. Incidents of caregiver misconduct must be reported to the DQA if the nursing home “has reasonable cause to believe it has sufficient evidence or another regulatory authority could obtain the evidence to show the alleged incident occurred **and** has reasonable cause to believe the incident meets or could meet the definition of abuse, neglect, or misappropriation.” If the facility investigation determines that the allegation is required to be reported, that complaint of caregiver misconduct is forwarded to the DHS Office of Caregiver Quality (OCQ), which conducts its own investigation. If the OCQ substantiates the allegation of misconduct, the name of the caregiver whose alleged misconduct has been substantiated will be placed on the Wisconsin Caregiver Misconduct Registry. Federal law permanently bars nurse aides with a finding of caregiver misconduct from working in any capacity in Medicaid/Medicare-certified nursing homes. State law in some instances enables the caregiver to go through a rehabilitation review process.

The DQA requires nursing homes to use the **Caregiver Misconduct Incident Report** to report allegations of abuse, neglect, misappropriation of resident property and injuries of an unknown source. This 8-page report contains the following information: (1) Summary of the incident, which would identify when the incident occurred, a brief description of the incident, the effect of the incident on the affected resident or the person’s reaction to the incident, what the facility did to protect the resident once it learned of the incident, and the

specific location of where the incident occurred; (2) Detailed information related to both the affected resident and the accused caregiver; (3) A law enforcement incident report, if any; (4) Identification of any persons with specific knowledge of the incident; (5) A description or an attached copy of the facility's investigative records concerning the incident; and (6) Any written statements provided by the affected resident, accused caregiver, or any other persons with information about the incident.

Act 2 would prohibit the Caregiver Misconduct Incident Report and its attachments from being admissible as evidence in a civil or criminal action against the nursing home which conducted the caregiver misconduct investigation because the mandated report is self-incriminatory against the provider. *But all the information listed above that is contained in the Caregiver Misconduct Incident Report is accessible to prosecutors, residents, the resident's family members and legal representatives, guardians and advocates. A resident's attorney may have to conduct his/her own investigation in any civil or criminal action against that nursing home but the groundwork to do so is clearly laid out in the accessible information contained in the Caregiver Misconduct Incident Report.*

Statement #3: “Nursing home providers want to block access to important evidence of what happened, who was present when it happened, who was supposed to be present, and whether the injury or death was preventable. This is the type of information that is only contained in incident or accident reports. Why should the resident and family be denied access to an explanation of what happened and why?”

Response #3: As noted above, residents, their families and their attorneys DO have access to the information they are seeking through the information contained in the Caregiver Misconduct Incident Report.

Statement #4: “When state investigators find that nursing homes are breaking the law, they create a public report available to all taxpayers and required to be available to all residents. Yet, the nursing homes want to exclude this public information paid by public tax dollars from judges and juries who are looking for the truth – was the resident neglected or abused?”

Response #4: The public report issued by the OCQ/DQA following its investigation into an allegation of caregiver misconduct is both accessible to the public and admissible as evidence if the allegation of caregiver misconduct is substantiated; unsubstantiated allegations remain confidential. Under Act 2, s. 904.16(2)(a) only prohibits reports “that a regulatory agency requires a health care provider to give or disclose to that regulatory agency” from being used as evidence in a civil or criminal action.

Statement #5: “Without the threat of punitive damages, care providers have no financial incentive to have quality staff. Act 2 will allow nursing homes to slash staff and cut corners.”

Response #5: This statement simply ignores the fact that nursing homes are one of the most highly regulated sectors of our economy. Licensed Wisconsin nursing homes are regulated under Chapter 50, Wis. Stats., and DHS 132, Wis. Adm. Code. In addition, nursing homes certified under the Medicaid and/or Medicare programs (which virtually all are) are also regulated under 42 CFR 483 and 488. A serious violation of state nursing home regulations could subject a nursing home to a state forfeiture of up to \$10,000 for each violation. Under federal code, the same serious violation could subject the facility to a civil money penalty (CMP) of up to \$10,000 per day that the violation remains uncorrected. These are penalties paid by the facilities, not by their liability insurers. To say there are no financial incentives for nursing homes to properly staff simply ignores the regulatory environment in which facilities operate. It also impugns the dedication, motives and mission of the vast majority of Wisconsin's nursing home providers.

It should be noted that in addition to monetary penalties, nursing homes are also subject to sanctions ranging from suspension/revocation of license, suspension of admissions, conditional licenses, state monitors, appointment of receivers, temporary management, denial of payment for new admissions, denial of payment

for all Medicaid and Medicare residents, directed plans of correction, and directed in-service training to termination from the Medicaid and/or Medicare program.

Curiously, there was no discussion of the nursing home survey and enforcement system during the Act 2 debate. Nursing homes are surveyed by the DQA for compliance with federal and state standards every 9-15 months. Violations of any of these standards could subject facilities to the sanctions listed above. There were numerous horror stories told during the Act 2 debate of negligent care provided to nursing home residents that needlessly cost those residents their lives. If true, there simply is no justification for such poor care and those facilities should be subject to the most stringent legal and regulatory sanctions available.

But during the Act 2 debate, not once did anyone ask in response to these horror stories whether the DQA investigated these allegations of shoddy care. Not once did anyone ask if the DQA investigations corroborated these allegations of negligent care. And not once did anyone ask if and how the DQA punished the facility for providing poor care.

Finally, nursing homes bore the brunt of much of the anti-Act 2 rhetoric. But if inadequate staffing in nursing homes is a concern, there must be a shared responsibility to address that concern. Please keep in mind the following:

- (1) According to the DHS, 41% of the State's nursing homes are operating at a net loss;
- (2) A recent analysis of the nation's Medicaid nursing home payment systems ranked Wisconsin's reimbursement system **the worst in the nation**;
- (3) The average Wisconsin nursing home loses \$37.71 per day for each Medicaid resident it serves, with an average annual loss of just under \$782,000. In the aggregate, the State's MA nursing home deficit is \$260.8 million;
- (4) Two-thirds of the State's 30,500 nursing home residents are either Medicaid recipients or Family Care enrollees;
- (5) According to the most recent figures, Wisconsin nursing homes on average provide each of their residents 3.57 hours per day of RN, LPN and nurse aide care; the state of Wisconsin reimburses those facilities for only 2.83 hours of that daily nursing care; and
- (6) Since 1999, 65 of the State's 399 licensed nursing homes have closed, primarily because of insufficient Medicaid funding.

Statement #6: Act 2 “would deprive attorneys of key evidence, which they would have to try to find by conducting their own investigations.”

Response #6: We disagree with the first part of the statement. As for the second part, isn't that their job?

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of not-for-profit corporations principally serving seniors and persons with a disability. Membership is comprised of 188 religious, fraternal, private, and governmental organizations which own, operate and/or sponsor 195 nursing homes, 14 facilities for the developmentally disabled, 87 residential care apartment complexes (RCAC), 95 community-based residential facilities (CBRF), 114 senior apartment complexes, and more than 300 community service agencies which provide programs such as Alzheimer's support, adult day care, child day care, home health, hospice, home care, and Meals on Wheels. Together, WAHSA serves 505 not-for-profit nursing home, assisted living, senior housing, and other community-based providers principally serving elderly persons and individuals with a disability. WAHSA members employ over 38,000 people who provide compassionate care and service to over 48,000 individuals each day.

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