A147987

IN THE COURT OF APPEAL
OF THE STATE OF CALIFORNIA
FIRST APPELLATE DISTRICT, DIVISION FOUR

CALIFORNIA ADVOCATES FOR
NURSING HOME REFORM, *et al.*,

Plaintiffs and Appellants,

v.

KAREN SMITH, MD., MPH,
as Director of the California
Department of Public Health,

Defendants and Appellants.

On Appeal from the Superior Court for the County of Alameda,
The Honorable Evilio M. Grillo
Case No. RG13700100

APPLICATION OF CALIFORNIA LONG TERM CARE OMBUDSMAN ASSOCIATION TO FILE *AMICUS CURIAE* BRIEF IN SUPPORT OF PLAINTIFFS AND APPELLANTS

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CERTIFICATE OF INTERESTED ENTITIES OR PARTIES

Pursuant to rules 8.208 and 8.488 of the California Rules of Court, proposed *amicus curiae* California Long Term Care Ombudsman Association, to the best of its knowledge, is unaware of any entities or persons who have a financial or other interest in the outcome of this proceeding that would be relevant to the question of disqualification under Canon 3E of the Code of Judicial Ethics.

Dated: September 29, 2017 BRAUNHAGEY & BORDEN LLP

/s/ Matthew Borden
Matthew Borden
Attorneys for Amicus Curiae California Long Term Care Ombudsman Association

Pursuant to Rules 8.200(c) and 8.520(f) of the California Rules of Court, California Long Term Care Ombudsman Association respectfully requests leave to file the attached *amicus curiae* brief in support of Plaintiffs and Appellants California Advocates for Nursing Home Reform ("CANHR"), Anthony Chicotel and Gloria A.

IDENTITY AND INTEREST OF THE *AMICUS CURIAE*

Amicus curiae California Long Term Care Ombudsman Association ("CLTCOA") is a public interest organization dedicated to improving the accessibility and quality of long-term care ombudsman services for elders and vulnerable adults living in nursing homes and other long-term care facilities across California. CLTCOA has a substantial interest in this appeal because its statutory obligations expressly include the duty to advocate on behalf of residents "with limited or no decisionmaking capacity and who have no known legal representative." 42 U.S.C. § 3058g(a)(3)(A)(i). CLTCOA believes that it has information that will aid this Court because its members have extensive first-hand knowledge of the competency-assessment process, IDT procedures and how unrepresented residents are treated.

CLTCOA is a membership organization made up of local Long-Term Care Ombudsman Programs, their staff, certified volunteers and program supporters. Since 1979, it has been the mission of CLTCOA to provide a unified voice in advocacy and assistance to the Local Long-Term Care Ombudsman Programs in California to enable the local programs to provide Ombudsman services to the residents of long term care facilities.

The Local Ombudsman Programs comprising CLTCOA were created pursuant to 42 U.SC. § 3058, which allots federal money "to pay for the cost of carrying out vulnerable elder rights protection activities." Local Ombudsman's statutory duties include an obligation to "identify, investigate, and resolve complaints that are made by, or on behalf of,

residents, including residents with limited or no decisionmaking capacity and who have no known legal representative." 42 U.S.C. § 3058g(a)(3)(A)(i).

Local Ombudsman receive, investigate and resolve complaints made by or on behalf of long-term care residents. In 2016, Local Ombudsman received, investigated and resolved 41,788 complaints made by or on behalf of the nearly 300,000 residents. Local Ombudsman staff and volunteers maintain a regular presence in the 8,638 long-term care facilities throughout California, visiting many facilities monthly or even weekly. During these visits, they gain valuable insight into the daily operations of these facilities.

As part of its mission, Local Ombudsman educate and inform residents of their rights. In 2016, the local Ombudsman programs provided over 52,400 consultations to individuals. One of the main topics of these consultations was advanced health care directives – an issue that is obviously critical to the lives of nursing facility residents, whom CLTCOA's members have a duty to protect.

Local Ombudsman also help advocate for residents, including individuals who have been deemed incompetent and have nobody to act as their power of attorney to make legal and medical decisions. Advocacy for such residents is especially critical because skilled nursing facilities often use § 1418.8 to further their own interests to the detriment of this population.

Because CLTCOA's members are present in virtually every facility in the State, CLTCOA has a unique and critical understanding of how the competency assessments and the IDT process actually work in the real world and how unrepresented residents are actually treated. As the attached proposed *amicus curiae* brief explains, the current processes in place do not effectively protect residents.

No party or counsel in this case has authored the attached *Amicus Curiae* Brief or paid any money for the preparation or submission of the brief. No person or entity has made a monetary contribution intended to fund the preparation or submission of the brief, other than the *amicus curiae*, its members, or its counsel.

CONCLUSION

For these reasons, CLTCOA's Application to File the attached *Amicus Curiae* Brief should be granted.

Dated: September 29, 2017

BRAUNHAGEY & BORDEN LLP

/s/ Matthew Borden
Matthew Borden
Attorneys for Amicus Curiae California Long Term Care Ombudsman Association

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[PROPOSED] BRIEF OF AMICUS CURIAE CALIFORNIA LONG TERM CARE OMBUDSMAN ASSOCIATION IN SUPPORT OF PLAINTIFFS AND APPELLANTS

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INTEREST OF THE *AMICUS CURIAE*

Amicus curiae California Long Term Care Ombudsman Association ("CLTCOA") is a public interest organization dedicated to improving the accessibility and quality of long-term care ombudsman services for elders and vulnerable adults living in nursing homes and other long-term care facilities across California.

CLTCOA is a membership organization made up of 34 local Long-Term Care Ombudsman Programs, their staff, certified volunteers and program supporters. Since 1979, it has been the mission of CLTCOA to provide a unified voice in advocacy and assistance to the Local Long-Term Care Ombudsman Programs in California to enable the local programs to provide Ombudsman services to the residents of long term care facilities.

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California, visiting many facilities monthly or even weekly. During these visits, they gain valuable insight into the daily operations of these facilities.

As part of its mission, Local Ombudsman educate and inform residents of their rights. In 2016, the local Ombudsman programs provided over 52,400 consultations to individuals. One of the main topics of these consultations was advanced health care directives – an issue that is obviously critical to the lives of nursing facility residents, whom CLTCOA's members have a duty to protect.

Local Ombudsman also help advocate for residents, including individuals who have been deemed incompetent and have nobody to act as their power of attorney to make legal and medical decisions. Advocacy for such residents is especially critical because skilled nursing facilities often use § 1418.8 to further their own interests to the detriment of this population. One common occurrence is that in lieu of increasing staffing, facilities use the IDT process to subject residents to dangerous and unnecessary psychotropic drugs in contravention of the black box warnings required by the FDA, which state that these drugs are not an approved treatment for dementia and that their off label use almost doubles the risk of dying.

Local Ombudsman have no ability to intervene in, or stop such decisions. Ombudsman are often not notified of IDT meetings before they occur, and have no ability to alter the course of such proceedings even if they did. Further, contrary to the representations by the nursing facilities and the State, in practice, doctors have virtually no input into the competency determination and IDT process.

No party or counsel in this case has authored the attached *Amicus Curiae* Brief or paid any money for the preparation or submission of the brief. No person or entity has made a monetary contribution intended to

fund the preparation or submission of the brief, other than the *amicus curiae*, its members, or its counsel.

For the reasons discussed below, the IDT process does not protect residents. Because CLTCOA's members have boots on the ground in virtually every facility in the State, CLTCOA has a unique and critical understanding of how the IDT process actually works in the real world and how unrepresented residents are actually treated. As such, its perspective and experiences will aid this Court.

ARGUMENT

The process now being used for declaring a resident incompetent and making decisions for the resident does not protect the resident's rights. Despite its cataclysmic effect on every aspect of a resident's life, residents have no notice or opportunity to be heard, much less any ability to appeal, when their competence is conclusively determined. Doctors make competency determinations with little or no examination and have little involvement in the IDT process (several Local Ombudsman have reported having never seen a physician at an IDT meeting). Facilities' efforts to locate family members, friends, or advance directives are scant. Local Ombudsman are often told about IDT meetings after the fact, and have no legal or practical ability to alter their course in any event. As a result, nursing facilities are unilaterally making life-and-death decisions for residents without any meaningful safeguards.

The inherent problems with this process have routinely resulted in unconscionable errors regarding the most fundamental human rights. Strong financial incentives to misuse the process also exist. To maximize profit margins, and for the convenience of staff, residents are being drugged with psychotropic substances that impair their ability to communicate their needs, *i.e.*, being in pain, often causing them to act out aggressively when the drugs begin to wear off. All of this is occurring without notice or

opportunity to be heard, and without any meaningful protections for the victims.

For these reasons, CLTCOA supports the positions taken by Plaintiffs/Appellants. Residents must be given notice and an opportunity to be heard before they are declared incompetent, and § 1418.8 cannot be used to impose health care directives and decisions about psychotropic drugs on residents.

I. SECTION 1418.8 DOES NOT PROTECT RESIDENTS

Section 1418.8 is not protective of resident rights. The State argues that it contains "procedural safeguards." (State OB at 13.) Whatever safeguards exist are insufficient. Competency determinations and IDT decisions are made without doctor participation, without notice to the resident, without input from any representative of the resident and without any ability for the resident to challenge the determination.

A. Residents Are Found to Be Incompetent without Any Meaningful Safeguards

The first step in the process contemplated by § 1418.8 is assessing whether the resident lacks capacity to make his or her own decisions. There are no meaningful protections for residents in this process.

1. Residents Are Not Informed about Their Own Competency Determinations

Local Ombudsman are unaware of any instance where a resident has received notice that his or her competency is being evaluated or that he or she has been declared incompetent. In fact, once a resident has been found incompetent, the resident is not even informed of his or her own care plan. As detailed below, the process for determining whether a resident is competent does not involve a searching inquiry and is frequently erroneous.

At the same time, a determination of incompetency carries catastrophic consequences for a resident. It takes away all his or her autonomy. Further, as detailed in Section B below, facilities use such a

determination to impose life-or-death decisions and force unnecessary drugs on residents – also without any meaningful process. Despite the importance of a determination about competency, there is no significant safeguard for protecting residents in the frequent event such a determination is incorrect.

2. Physicians Spent Little to No Time Assessing Competency

The competency decision is supposed to be made by a physician after a thorough examination of the resident. In reality, this determination is made by checking a single box on the medical chart. Local Ombudsman have observed that the box is routinely checked without any assessment whatsoever. It is sometimes done right after the resident has had a stroke or urinary tract infection or some other condition that can temporarily affect cognition. Local Ombudsman have reported many instances where the determination was made without the physician seeing or speaking to the resident at all. It is impossible to know why a resident has been declared incompetent because there are never any backup records that one would expect to find if a thorough examination had been made.

CLTCOA is aware of instances in which a resident was declared incompetent, where the resident did not speak English, and the facility had no Spanish interpreter. Similarly, we have seen cases in which deaf residents were deemed incompetent, where the physician was not aware that the client could not hear, and the facility had nobody who knew sign language or otherwise had the ability to effectively communicate with the resident. Such circumstances prevent any meaningful determination and make it virtually impossible to locate family members and friends.

3. Determinations of Incompetency Are Frequently Erroneous

Through talking to residents, Local Ombudsman have seen many instances where a physician has erroneously checked the box stating that a

resident lacks competence. This occurs for the reasons given above, *viz*., because the physician never performed any examination of the resident, the examination was done in circumstances that predetermined the result, it was done without seeing the resident, or it was done too quickly to be reliable, without any record-keeping requirement to function as a check.

Even physicians skilled in assessing competency exhibit significant disagreement. In one study, the authors conducted an experiment where five physicians with extensive clinical experience in assessing dementia and capacity were asked to render capacity determinations for 29 patients with mild Alzheimer's disease. (Marson, Daniel C. *et. al*., *Consistency of Physician Judgments of Capacity to Consent in Mild Alzheimer's Disease*, Journal of the American Geriatric Society, Vol. 45 (April 1997), pp. 453-457.) The physicians had only 56% agreement regarding the capacity of the patients to make their own medical decisions. *Id*. The study's authors deemed the results "alarming," substantiating "a long-standing clinical concern, namely, that physician competency assessment is a subjective, inconsistent, and arguably idiosyncratic process." *Id*. at 455-456.[1]

Because residents have no voice in this process, and no other safeguards are in place, the cases Local Ombudsman are able to identify are likely a mere fraction of the erroneous competency determinations that have been made. This is especially true given that once a resident has been found to be incompetent, there is little to prevent a facility from drugging the resident into an incoherent state (*see* Sections I, B and II, below).

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[1] A subsequent study by many of the same authors found that the use of a specific definition of capacity improved physician agreement to 76%. Marson, Daniel C., *et. al*., *Consistency of Physicians' Legal Standard and Personal Judgments of Competency in Patients with Alzheimer's Disease*, Journal of the American Geriatric Society, Vol. 48 (August 2000), pp. 911-918. Even under these conditions, which do not exist in the skilled nursing context, such an error rate is much too large to go unchecked given the consequences to residents.

4. Residents Have Nobody to Help Them in the Process

The competency determination process is also subject to a high rate of error because residents have no one to advocate for them in during this process. Facilities make little effort to find friends and family members who could assist, and there is no legal requirement that facilities include an Ombudsman in the competency determination process. As a result, Local Ombudsman, who communicate with residents far more than physicians, are almost always left out and have no ability to advocate for the resident or to try to find friends or family members, who could provide valuable insight.

5. No Other Meaningful Checks on the Process Exist

Despite the problems above, there is no meaningful check on the process for assessing competence or ability for a resident to legally contest such a determination. The overwhelming majority of residents in this situation do not have the ability to retain an attorney to challenge such a finding in court – to the extent this can be done. If a facility is using incompetency as a means to obtain "consent" to the use of psychotropic drugs, which is often the case, there is no way of knowing how many individuals have been wrongfully found to be incompetent because the drugs severely suppress an individual's ability to communicate.

In sum, despite the magnitude of the determination, the assessment of a resident's competency is done perfunctorily, without notice or opportunity to be heard by the resident, and without any safeguards or ability to appeal. Because this determination has immense consequences on a resident's autonomy, life and death, basic due process protections must attach to this practice.

B. IDT Decision-Making Is Almost Exclusively Done by Nursing Facilities

Both the State and CAHF portray the IDT process as a mixture of different perspectives and opinions about how to do what is best for the resident. In actuality, however, physicians do not participate in the IDT process, there are no representatives to advocate for the resident, and the decision-making is done almost exclusively by the skilled nursing facility.

1. Physicians Do Not Participate in the IDT Process

In addition to spending little to no time on competency decisions, physicians also spend very little time fulfilling their role on an IDT. This occurs because medical care in the skilled nursing context is a volume business, where brief telephonic "examinations" – often with facility staff, rather than the resident – and telephonic diagnoses (and drug prescriptions) are the norm.

In skilled nursing facilities, physicians are rarely present and almost never see the residents. Local Ombudsman indicate that many residents report having gone years without ever seeing a doctor in person or knowing who their doctor is. Even talking to physicians by phone is difficult for Local Ombudsman, who indicate that many physicians do not return calls, are not present at the facilities, and are otherwise inaccessible.

Many Local Ombudsman recount that whenever they have been able to attend IDT meetings, they have never seen a doctor in attendance. The absence of any physician, along with the lack of any representative for the resident (discussed in Section 2 below), means that IDT decision-making resides exclusively with employees of the skilled nursing facility.

2. Little Effort Is Made to Find Family Members, Friends or Advance Directives

Facilities make little or no effort to locate family members, friends or advance directives that could help determine a resident's wishes about end-of-life decisions and medical treatment. This is harmful to residents at

the point where an assessment of competence is made and thereafter because the nursing facility often ends up being the only participant in the IDT process.

There is no legal standard for the amount of inquiry a facility must do to try to locate family members before it decides the resident is unrepresented, and it is free to take over the decision-making through the IDT process.[2] Local Ombudsman indicate that facilities generally have no protocols for finding family members, friends, or advance directives, and make very little effort to do so. In situations where Local Ombudsman have been able to participate, they have often been successful in finding family and friends to represent individuals whom facilities previously found were unrepresented.

3. IDT Decisions Are Routinely Made by Nursing Facilities without Any Checks

Because physicians do not participate and there are rarely any friends or family involved, IDT decisions are almost always made unilaterally by the facility, without anyone to advocate for the resident.

Local Ombudsman are often not notified of IDT meetings if they occur, and have no statutory right to participate in them or to alter the course of such decision-making even if they are able to attend, and even if they understand the position that the resident wants them to advocate. Because there is no law stating that Local Ombudsman must be included in IDT meetings, individual facilities set their own policies. As a result, many of CLTCOA's constituents indicate that they are routinely told about IDT meetings after the fact.

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[2] In one case, *Davis v. AG Seal Beach, et al.*, No. BC 468346 (Los Angeles Superior Court), the complaint alleges that the facility found the resident to be mentally incompetent and friendless, declared itself the payee for her Social Security, and repeatedly gave her psychotropic drugs, when in fact she was later proved competent once a friend was able to find her and made the facility stop drugging her.

In light of the foregoing, Local Ombudsman cannot effectively advocate for residents in the IDT process. In fact, we are aware of situations where facilities have decided that a patient is incompetent and made decisions against the patient's wishes as stated by an ombudsman. CLTCOA has received numerous reports from its constituents that unrepresented clients' health care directives do not match their actual wishes – including one instance where a resident was denied wound care. Yet if the IDT process is employed, a resident has no ability to dispute or change such decisions.

In *Rains v. Belshe*, 32 Cal. App. 4th 157, 182 (1995), the court appeared to rely on the IDT process including a patient representative, and cited the legal broad standard as support for its conclusion that: "It appears almost impossible to conceive of a patient who could not have a patient representative, under this standard." In the experience of CLTCOA's membership, this statement has proven inaccurate. Most IDT meetings do not involve doctors, much less resident representatives. Local Ombudsman are not patient representatives and have no right to attend IDT proceedings. To the extent ombudsman are able to attend these meetings, their positions carry no weight. Residents, themselves, do not participate in these meetings. As such, IDT decision-making is mainly performed by skilled nursing facilities. As detailed below, the consequence of this structure is that residents have end-of-life-care terminated because of subjective, undefined notions of quality of life and are subjected to dangerous, unnecessary drugs because of facilities' incentive to increase profits.

II. FACILITIES HAVE ECONOMIC INCENTIVES TO MISUSE THE IDT PROCESS

In its Amicus brief, CAHF argues that if § 1418.8 is found to be unconstitutional, residents would be denied insulin, dialysis, antibiotics,

and other life preserving medical interventions. (CAHF Br. at 9.) This argument is a straw man.

Section 1418.8 only applies to non-emergency medical decisions. Absent a clear instruction from the resident to refuse medical treatment, giving insulin to a diabetic or dialysis to someone with kidney failure is necessary to protect against imminent harm.

Decisions that benefit facilities are another matter. For example, if a facility wants to increase its margins by substituting psychotropic drugs for staff, there is no emergency. Because that decision will have a profound impact on the resident's wellbeing, it should not be considered a routine medical issue decided through the IDT process.

In an overwhelming number of instances, a patient is prescribed psychotropic drugs at the request of facility staff who are trying to suppress behavior that they lack staffing and training to address properly. The staff report the behavior to the physician by phone, and the physician prescribes the drugs without seeing or assessing the resident. When the facility has the ability to both request and consent to the drugs on the resident's behalf, it can easily substitute drugs (paid for with federal tax money) for staff and training, increasing its profit margins.

While increasing drug use to make residents compliant allows for fewer staff members on the floor, a short-sighted way to boost profitability for nursing facilities, most of the time there is no medical reason for using them. There are no drugs specifically approved by the U.S. Food and Drug Administration ("FDA") to treat behavioral and psychiatric dementia symptoms. Using antipsychotics to "treat" dementia is an off-label use, and the Black Box warning required by the FDA states that such drugs are "not approved for the treatment of patients with dementia-related psychosis." The Black Box warning further states that using such drugs on elderly

residents with dementia almost doubles the risk of mortality.[3] The 2011 OIG Study on this issue found that "Eighty-three percent of Medicare claims for atypical antipsychotic drugs for elderly nursing home residents were associated with off-label conditions." (Daniel R. Levinson, U.S. Dep't of Health and Human Services, Office of Inspector General, OEI-07-08-00150, *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, at ii (2011).)

There is no harm, and every reason, for a resident to have the protection of a disinterested third-party decision maker before being subject to such drugs. Section 1418.8 was not intended to facilitate the mass drugging of the State's most vulnerable population, and none of the parties of *amici* have cited anything contrary in their briefing.

CONCLUSION

For the reasons above, CLTCOA respectfully supports the positions of Plaintiffs/Appellants.

Dated: September 29, 2017 BRAUNHAGEY & BORDEN LLP

/s/ Matthew Borden
Matthew Borden
Attorneys for Amicus Curiae California Long Term Care Ombudsman Association

[3] The warning states: "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10 week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group."

CERTIFICATE OF WORD COUNT

I certify that the text of this brief consists of 3,484 words as counted by the Microsoft Word word-processing program used to generate the brief.

Dated: September 29, 2017

BRAUNHAGEY & BORDEN LLP

/s/ Matthew Borden
Matthew Borden
Attorneys for Amicus Curiae California Long Term Care Ombudsman Association

PROOF OF SERVICE (Court of Appeal) ☑ Mail ☐ Personal Service	FOR COURT USE ONLY
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3. I mailed or personally delivered a copy of the following document as indicated below *(fill in the name of the document you mailed or delivered and complete either a or b):* Application of California Long Term Care Ombudsman Association to File Amicus Curiae Brief in Support of Plaintiffs & Appellants & Proposed Brief

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            (ii) Address:
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            1225 Fallon Street, Oakland, California 94612

         (b) Person served:
            (i) Name:
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STATE OF CALIFORNIA
Court of Appeal, First Appellate District

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Court of Appeal Case Number: **A147987**
Superior Court Case Number: **RG13700100**

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information, knowledge, and belief.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

09-29-2017

Date

/s/Matthew Borden

Signature

Borden, Matthew (214323)

Last Name, First Name (PNum)

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