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Good Afternoon.

My name is David Zimmerman. I am a Professor of Health Systems Engineering in the Department of Industrial and Systems Engineering at the University of Wisconsin-Madison, and I am the Director of the Center for Health Systems Research and Analysis at UW-Madison. I am also the President of the Long Term Care Institute, a non-profit organization created to assist in the monitoring of quality of nursing home care in organizations with Corporate Integrity Agreements with the DHHS Office of the Inspector General.

I have been conducting research in nursing home quality of care and performance measurement for 25 years. Researchers at our center have been involved in CMS-funded efforts to improve the quality assurance process for more than a decade. We also developed the original set of quality indicators based on the Minimum Data Set, as well as the software to make the data on these indicators available to all 17,000 nursing homes and all 50 state survey agencies. More recently, as part of our work on corporate integrity agreements with the DHHS OIG, we at the Long Term Care Institute have been involved in 13 monitoring engagements with national and regional corporations under OIG corporate integrity agreements, covering more than 1000 nursing homes and 100,000 nursing home residents.

In the combination of these activities, our clinicians and systems analysts have conducted visits to more than 900 nursing homes in the past six years. We have observed or participated in more than 100 quality improvement meetings, including more than 30 such sessions at the corporate level of organizations. I have spoken to at least 15 corporate boards or board committees and met with individual board members about quality of care issues.

These activities have given us important insights into the world of quality assurance and quality improvement in nursing homes and the corporations that own some of them. They also

provide the basis for some observations and suggestions for ways that the federal government can truly protect the health and safety of nursing home residents, perhaps the most vulnerable population in our society. Below I have set forth some suggested legislative solutions to improve nursing home quality of care.

There has been increasing attention focused on the quality of nursing home care, most recently because of the rise in the number of ownership transactions between regional and large nursing home corporations, and the tendency for these transactions to involve a transfer of ownership from a public corporation to entities commonly referred to as private equity firms. At the heart of this debate and scrutiny is a corollary issue that should, in fact, be the center of our attention, and that I fear is being lost in the scuffles over private equity ownership. That issue is **transparency**.

Solution 1: There should be complete transparency on full ownership of every nursing home.

It should be undeniable that the purchaser and recipient of nursing home care have the right to know who is providing that care. When that purchaser is the federal government, which spends billions of dollars on nursing home care every year, the case for complete transparency is compelling. Simply put, the federal government should have the right to know, with complete transparency, the complete ownership structure of every nursing home participating in the Medicare and Medicaid program. This should be true no matter which or what type of entity owns them. There are several corollary principles that follow from the right to ownership transparency:

1. The complete ownership structure of all entities involved in the provision and administration of resident care should be fully reported to CMS.
2. The ownership reporting requirement should be the responsibility of the provider organization. The provider organization should set forth, in understandable detail, the complete ownership of all parties involved in the provision and administration of resident care.
3. The principle of transparency should apply no matter what level of complexity in the labyrinth of organizational structures exists. In fact, the more complex the web, the greater the need for more detailed transparency. And, the greater the complexity, the

more reasonable it is that the originator of that complexity ought to have the responsibility for explaining it to the purchaser of care.

Solution 2: Staffing information for every nursing home should be reported in a standardized format.

In addition to ownership transparency, there should be transparency on the staffing in nursing homes. In the world of health systems, we often describe the nature of the work along two dimensions: "tech"(nology) and "touch." In an industry as "high-touch" as nursing home care, it is reasonable for the purchaser of care to know the labor resources that are being devoted to that task. Nursing homes should report the staff resources, on a resident-time basis, that are devoted to resident care. This information should be based on payroll data, which exist in accessible form for virtually every nursing home in the country. The technological means exist to submit and receive staffing data, in a standardized format, for the entire nursing home industry. Reasonable people representing all stakeholders can make sound decisions about how to structure the definitions into a common taxonomy. Acuity-based staffing in this industry is far more crowed about than practiced, but these adjustments can be taken into account if necessary.

Solution 3: There needs to be greater ability to expand the scope of observation and analysis from individual facilities to nursing home corporations and networks.

Currently, virtually all regulatory activity is focused on the individual nursing home. To a large extent this is because of the concept that the "licensee" is the operator of record and accountability. Yet in many survey situations, it is the corporate entity that will be integrally involved in the process from the provider side. Related and equally important, it is often the corporation's policies and procedures that govern the system of care in the facility. In some cases these corporate policies and procedures are inadequate to provide proper governance to the delivery of care. Yet in many other cases, the problem at the facility and resident levels is that reasonable policies and procedures are not being executed consistently across facilities in the network. A stronger focus on this level of management would be a much more efficient way to improve care systematically across an organization, as opposed to one facility at a time.

Yet, currently there is virtually no way that a state regulatory agency can expand its scope across state lines. CMS does have greater authority to expand the scope to a more systematic examination of multi-facility networks, even across state lines, but much more could be done to utilize the available information in an aggregated fashion to focus on regional and even national nursing home networks. Our Center produces monthly reports on survey deficiencies comparing the largest national corporations and provides them to the OIG and to each specific corporation that is covered by a Corporate Integrity Agreement. (I have provided de-identified examples of these types of reports with this testimony.) And we provide similar information on the MDS quality indicator/quality measures to the same parties, on a quarterly basis. This information can and should be provided on all national and regional corporations on a routine basis.

In addition to the information vehicle described above, CMS should have the authority to take corrective action with respect to corporate entities if there are problems at individual facilities. More often than not, the problems found at a network's facilities display a common set of patterns and issues; it is much more efficient to deal with these issues and corrective responses on a broader basis than just individual facility actions.

Solution 4: There should be more use of intermediate corrective measures.

There have long been calls for broader and more innovative ways to incentivize, exhort, and pressure providers into taking better and more systematic corrective actions to improve care and sustain that higher care level. These appeals have continued unabated, and have actually become more urgent in recent years, because of the confluence of three very troubling trends: the demographic graying of America, the increasing complexity of the nursing home population as it accepts more post-acute patients, and the stagnant or decreasing skill sets of provider staff. Care problems need to be identified earlier and addressed—in meaningful ways—more promptly and with more ingenuity and commitment. The current arsenal of intermediate sanction weapons—including admissions freezes, civil monetary penalties, and suspension of CNA training programs—have been used to varying degree and imposed inconsistently. There needs to be more stable use of these vehicles for correction and improvement. But there also needs to be increased scrutiny on providers—at both the facility and network levels—who have not demonstrated the ability to adequately self-identify a problem and fix it; and then keep it fixed.

One measure that has demonstrated success in both process and outcomes is the use of monitors to provide additional scrutiny on the care provided in problematic facilities, as well as the systems put in place to correct identified problems and sustain the fix. Our previously mentioned work with several national corporations has provided a number of insights into the barriers to and facilitators of quality improvement efforts. In particular, the focus of attention on the corporate district level—the level of the corporation just above the individual facility level—has proven extremely valuable, improving the consistency of the quality assurance protocols and activities as they are rolled out from this level to facilities. Similarly, our focus on the ***systems*** of care delivery and quality assurance has shown both model practices and complete breakdowns in how care is provided, and how quality improvement efforts have been effective or not. Providers sometimes focus inordinate attention on finding "leaders," then expecting them to work miracles without giving them the support they need to be successful, and then holding them solely responsible if this impossible task is not accomplished. I call this the "awesome goat" phenomenon, and we have seen it in action scores of times. Monitoring can correctly place the focus on the systems of care that need to be implemented consistently across every facility, every shift, and at every bedside.

The monitoring process can promote and expand the concept of transparency described earlier. Facilities and organizations that have demonstrated problems in providing and assuring quality care will be the focus of additional attention and scrutiny, with the transparency that monitors can provide to determine the capability of the provider to improve their systems and oversight.

Solution 5: Increase the focus on the landlord as well as the licensed operator.

Currently, the entity owning the actual physical asset of the nursing home (the "bricks and mortar" as it is called) has virtually no responsibility or accountability for the adequacy of the care provided at the facility. Yet we have seen cases in which the actions (or inactions) of the landlord have had deleterious, and sometimes direct, effects on the quality of care in the facility. For example, there are sometimes restrictive clauses in the lease agreements that effectively prohibit the licensed operator from making needed upgrades or renovations consistent with evidence-based care practices. Other restrictive lease practices might make the implementation

of physical or structural changes so onerous financially that it becomes prohibitive for the licensed operator to even consider such changes. It is certainly conceivable that a licensed operator might find itself in the "Catch 22" situation of being in violation of federal certification or state licensure regulations that cannot be fixed without taking steps that are legally or financially prohibitive in the lease it has with a landlord.

I realize that this problem, in particular, might be very difficult to solve. Holding the landlord to the same certification and licensing requirements of the operator may not be feasible. But consideration should be given to (a) making sure that the lease provisions are transparent, along with other aspects of ownership, and (b) finding a way to ensure that if lease agreements stand in the way of corrective actions necessary to bring about compliance with conditions of participation, there is a way to deal with these situations.

Conclusion:

All the solutions I propose above have to do, in some way, with increasing the transparency of information about who provides care, and who owns whatever entity or entities responsible for the decisions pertaining to that care. Transparency is essential to the continued delivery of nursing home care through existing private and public markets. There is an elegant simplicity to transparency solutions. With full transparency of ownership, so we know who is and should be accountable, and transparency on staffing so we know who is providing care, we can examine the outcomes as they are produced through the survey process and examination of resident-level outcomes. Facilities and organizations demonstrating their ability to deliver adequate (and hopefully excellent) care can continue on with this critical task, and with our appreciation. Facilities and organizations that have demonstrated an inability to deliver adequate care can expect to see additional scrutiny and even greater transparency requirements, including outside monitors to assure that they can earn our trust to provide care and protect the health and safety of our most vulnerable population.