American Health Care Association

Statement
of

Steve Biondi, RN, LNHA

On behalf of the

American Health Care Association
for the
U.S. Senate Special Committee on Aging
Hearing on
"Nursing Home Transparency, Enforcement & Quality Improvement"

November 15, 2007

Thank you Chairman Kohl, Ranking Member Smith, and members of the Committee. I appreciate the opportunity to be here today representing the American Health Care Association (AHCA) and our profession's perspective on how to increase transparency, accountability, and meaningful information that can help consumers evaluate long term care quality as well as how we can continue to work together and toward our mutual objective of always providing optimal patient care.

My name is Steve Biondi, and I am Vice President for Clinical Services with Extendicare Health Services, based in Milwaukee, Wisconsin. I oversee regulatory compliance, which includes ensuring that Extendicare's 200 long term care facilities across North America achieve and maintain regulatory compliance. Extendicare employs 34,000 people and the capacity to care for nearly 27,000 patients and residents.

I am a registered nurse (RN), a licensed nursing home administrator (LNHA), and have worked as an ombudsman. I am certified as a surveyor by the Centers for Medicare & Medicaid Services (CMS) and have conducted national satellite education programs for surveyors on adult abuse prevention and survey, certification, and enforcement for CMS' precursor, the Health Care Financing Administration. Early on, I worked for the State of Florida's Department of Health and Rehabilitation Services and was appointed by then Governor Graham to oversee licensure and certification of nursing homes in South Florida, Medicaid approval and payment, pre-admission assessment, adult abuse investigation, and other programs where I was involved with revoking and decertifying three facilities due to inadequate quality outcomes.

As a member of the American Health Care Association (AHCA), I co-chair the Association's Survey/Regulatory Committee, which focuses on quality, federal survey, certification, enforcement, and

American Health Care Association
1201 L Street, NW • Washington, DC • 20005
www.ahca.org

regulatory issues related to quality. I serve concurrently on the Quality Improvement Committee, which seeks to advance the use of evidenced-based practices, and to build leadership competencies for AHCA membership.

I am proud to represent my fellow long term care providers and a profession that has embraced quality. We know that you, Mr. Chairman, and the members of this committee understand the myriad issues surrounding the long term care of some of our nation's most vulnerable citizens. We acknowledge your salutary commitment to ensuring our seniors receive the quality care they need and deserve – as evidenced by your leadership with this committee and introduction of legislation such as the *Patient Safety and Abuse Prevention Act of 2007 (S. 1577),* which AHCA supports.

I also wish to commend Senators Gordon Smith, Blanche Lincoln, and Susan Collins, who have put forward some of the most important regulatory reform concepts of the past twenty years – systematic reforms to the survey and certification process, and other critical changes that can help to build mutually beneficial partnerships, and undo an era of unproductive confrontation. The Smith-Lincoln-Collins *Long Term Care Quality and Modernization Act of 2007 (S. 1980)* represents an important step toward establishing more broadly such a culture of partnership – one we enthusiastically embrace and endorse.

Mr. Chairman, as today's hearing focuses on federal, state, and industry initiatives to improve nursing home transparency and survey and enforcement, along with the quality of services in the country's 16,000 nursing homes, I submit that part of the challenge before us is to work together – collaboratively – to promote transparency across the board.

By this, I mean expanding the concept of transparency beyond just facilities to include the survey and enforcement process itself. Doing so would enhance facilities' efforts to improve patient care, and would mirror our profession's own quality improvement initiatives. We believe that working together and creating a "culture of cooperation" is imperative—it is how we can continue to improve the quality of care and quality of life for the millions of patients (patients is used to refer to both long term care patients and residents) and families who rely on us everyday for the long term care and services they need.

Commitment to Quality

We have made tremendous strides in the twenty years since Congress enacted the *Omnibus Budget Reconciliation Act of 1987 (OBRA '87)*, which included the *Nursing Home Reform Act.* Earlier this year, as this Committee explored *OBRA's* history, its intent, and why it was a milestone piece of legislation, one factor that was undeniable twenty years ago, is undeniable today, and that will be undeniable twenty years from now is the unbreakable link between stable funding and quality.

That link has been recognized repeatedly by the Centers for Medicare & Medicaid Services, including in its recommendation that skilled nursing facilities receive a 3.3 percent Medicare market basket update for FY 2008 that states, "These new payment rates reflect our commitment to improving the quality of care in the long-term care setting while maintaining predictability and stability in payments for the nursing home industry…."

In an article written by then-Acting Administrator of CMS Leslie Norwalk for the May 2007 issue of *Provider* magazine, Ms. Norwalk observed:

> *Long before hospitals, doctors, home health providers, pharmacies, dialysis facilities and others came to the table, the nursing home industry was out front with Quality First – a*

volunteer effort to elevate quality and accountability…. Advancing Excellence in America's Nursing Homes… *builds on the 2001 Quality First campaign and stresses the essential connection between quality, adequate payment for services and financial stability.*

Just as stable funding fosters quality, quality improvement centers on greater disclosure, transparency and accountability – all of which must be continued and expanded.

These central tenets of quality improvement initiatives represent the core of *Advancing Excellence in America's Nursing Homes*. *Advancing Excellence* is a coalition effort, co-founded by AHCA and comprised of providers, caregivers, researchers, government agencies, workers and consumers. The campaign builds on previous initiatives and focuses on specific, measurable quality improvement goals supported by evidence-based information and a national infrastructure. The campaign is designed to cultivate greater partnership both nationally and at the state level, which is ameliorating the sometimes adversarial atmosphere among these groups as they work together to ensure that patients in their communities receive the highest quality long term care.

Nearly 6,200 facilities – about 39 percent of nursing homes nationwide – are participating in the voluntary *Advancing Excellence* campaign, which AHCA continues to promote among our membership.

Nursing homes participating in the *Advancing Excellence* campaign select both clinical quality goals and organizational improvement goals to achieve consistent delivery of better quality care by enhancing staff performance. One of the hallmarks of the campaign is the evidence-based resources provided to nursing homes as well as access to support from the Quality Improvement Organizations (QIOs). The campaign culled best practices and other materials that give nursing home staff the information and tools needed to improve on clinical quality goals such as minimizing high and low risk pressure ulcers, ensuring patients remain independent to the best of their ability, minimizing pain experienced by longer-term patients and those patients admitted to nursing homes from hospital settings.

Measuring Quality Improvement

We are making progress and reporting on that progress. In fact, the clinical quality goals align with data tracked by CMS through the Online Survey, Certification and Reporting (OSCAR) system and publicly reported and posted to its *Nursing Home Compare* website.

OSCAR data clearly points to improvements in patient outcomes, increases in overall direct care staffing levels, and significant decreases in quality of care survey deficiencies. At the same time, an independent analysis confirms consistently high patient and family satisfaction with the care and services provided.

Specifically, the data shows:

- There is a positive trend in the quality measures posted on *Nursing Home Compare* with improvements in key areas for short-term and long stay patients in pain, restraints, and pressure ulcers.
- Pain for long term stay patients was vastly improved from a rate of 10.7 percent in 2002 to 4.6 percent in 2007.
- Pain in short-term patients was reduced from 25.4 percent in 2002 to 20.7 percent in 2007.
- Use of physical restraints for long stay patients dropped from 9.7 percent in 2002 to 5.6 percent in 2007.

- For short-term patients, the pressure ulcer measure also improved – from 20.4 percent in 2002 to 17.5 percent in 2007.

Assessing Patient & Family Satisfaction

In addition to improving clinical quality, we are evaluating consumer satisfaction and staffing as it relates to quality. A 2006 benchmark study, which included approximately 2,500 AHCA member facilities, indicated that a vast majority – more than four out of five – of nursing facilities have very high customer satisfaction ratings. In these 83 percent of facilities, patients and family members stated that they would recommend their facility – a clear indication of quality.

In May 2007, My InnerView, Inc. (MIV), which offers Web-based quality management systems, released its independent second annual report on patient and family satisfaction for the care and services provided in nursing facilities. For two consecutive years, more than four out of five of the more than 92,000 individuals indicated high overall satisfaction. The latest report indicates that 82 percent of the respondents would assess their overall satisfaction as good or excellent. Further, 88 percent of respondents rated the nursing care as either good or excellent.

Long Term Care Workforce

An essential element to providing quality care is having well-trained, qualified staff—that is why two of the organizational improvement goals for *Advancing Excellence* relate to staffing.

We already suffer from a nursing shortage, which is exacerbated by a nurse educator shortage. Nationally, more than 15 percent of registered nurse (RN), 13 percent of licensed practical nurse (LPN), and 8 percent of certified nursing aide (CNA) positions – nearly 100,000 vacancies overall – have been identified and the current long term caregiver shortage is only projected to get progressively worse over the next decade. So, attracting, training, and retaining quality long term care staff remains a particular challenge for long term care providers. AHCA has been working with the U.S. Department of Labor to address some of the critical issues regarding workforce, but clearly Congress has a critical role to play in ameliorating some of the workforce issues.

It is important to note one particular research study of the current Survey & Certification process and its impact on the long term care workforce. Long term care researcher, Vivian Tellis-Nayak, PhD, recently highlighted the fact that nursing home administrators are often discouraged by a survey process that seeks to identify faults, rather than to encourage quality. Tellis-Nayak notes that the state survey "is confrontational and leaves no room for collaboration. It is uncaring and punitive, not educational." This view of the survey system is shared by many of the staff in nursing facilities nationwide. In order to address these shortfalls of the current system, we must move toward a "culture of cooperation" where stakeholders work in tandem to promote enhanced outcomes, rather than sensationalize shortcomings. *OBRA '87* took the first step in promoting care quality and standards of excellence for long term care – passage of the *Long Term Care Quality and Modernization Act of 2007* today can take us the next step.

Special Focus Facilities

AHCA has been working proactively with CMS for more than a year to address concerns with its Special Focus Facility Initiative. Recent revisions from the agency allow for notification of the State Medicaid Agency and the State Ombudsman Office when a facility is designated as a "Special Focus Facility."

While AHCA is pleased that CMS accepted our recommendation to require that a facility's administrator, owners, and governing bodies also be notified should a facility be designated for "special focus," we are concerned about CMS' plan to make that designation public by adding a hyperlink to the *Nursing Home Compare* website. Adding such a notation on this public website is more likely to alarm patients, families, and health care consumers who have little background or understanding with respect to what it means to be a Special Focus Facility.

CMS has been slow to adopt any transparency around its Special Focus Facility Initiative. We remain concerned that CMS has not been forthcoming with details about the formula used to identify special focus facilities and the specific criteria a facility must meet to remove the special focus designation.

Expanding the Role of the Quality Improvement Organizations

The Quality Improvement Organizations (QIOs) play a vital role in long term care. The Agency for Healthcare Research and Quality's (AHRQ's) second annual *State Snapshots* based on the *National Healthcare Quality Report* highlights how – through an ongoing partnership and cooperation between the QIOs and individual nursing homes in every state – the QIOs are helping to improve quality in our nation's nursing homes.

All nursing homes in every state can access basic improvement assistance from their state QIO, and a subset of nursing homes in each state receive more intensive QIO assistance. Recent CMS data on nursing home performance strongly suggests that when QIOs partner with individual nursing homes, patient outcomes improve. Data collected between the fourth quarter of 2004 and the fourth quarter of 2006 shows that all nursing facilities across the country averaged a 9 percent relative improvement in the incidence of pressure ulcers and a 21 percent relative reduction in the use of physical restraints. But the facilities receiving intensive QIO assistance achieved a laudable 16 percent relative improvement in pressure ulcers and a 32 percent relative improvement in pain management.

Looking ahead, Mr. Chairman, we believe Medicare should fund an expanded role for QIOs in improving quality outcomes in all nursing homes and most importantly, those considered poor performers. According to a recent study from The Commonwealth Fund entitled, "Medicare's Quality Improvement Organization Program Value in Nursing Homes" published in the Spring 2007 *Health Care Financing Review*, which specifically looked at QIOs' work with nursing homes, suggests that "based on measurable improvements in residents' quality of life, the QIO program is a sound investment of health care dollars."

Accelerating efforts to strengthen and broaden the system of quality measurement in nursing homes, just as Medicare is doing in hospitals and physician office practices, will also lead to even greater improvement.

Stakeholder Collaboration to Address Poor Performing Facilities

In June, Mr. Chairman, AHCA and American Association of Homes and Services for the Aging (AAHSA) reached out to AARP, which convened a group of stakeholders, including the Long Term Care Ombudsman, National Citizens' Coalition for Nursing Home Reform (NCCNHR), and CMS to discuss "poor performing facilities," and to identify how we could intervene and help a facility improve, before being designated as a Special Focus Facility.

Subsequently, a subgroup tackled this issue and developed several recommendations that will be evaluated by the larger group of stakeholders and that we would be pleased to share with this committee

sometime in 2008. Again, we are proud to be working collaboratively and cooperatively with other long term care stakeholders in addressing a problem requiring aggressive action.

Consumer-Friendly Resources

Clearly, family and ombudsmen involvement within facilities are key components to improving quality. AHCA has long encouraged family members to stay involved when a loved one is receiving care in a long term care facility. This year, AHCA acknowledged the extraordinary involvement of one such family member—Benjamin Thacker—who we recognized as "AHCA's Young Adult Volunteer of the Year." The 18-year old high school senior spoke eloquently to our membership last month and described how many of the patients living in the local Virginia nursing home are like family to this third-generation volunteer.

AHCA also promotes family involvement in facility-based family councils and offers advice for families in our consumer information materials. Our consumer materials can be accessed online at www.longtermcareliving.com and cover topics including:

- *Having the Conversation About Long Term Care*
- *Making the Transition*
- *Living in a Nursing Facility: the Myths and Realities*
- *Paying for Long Term Care*

Furthermore, we recognize consumer satisfaction is integral to quality facility care, which is one reason why we encourage facilities to conduct satisfaction surveys of patients, family members and staff. MIV reports that more than 4 out of 5 consumers would rate their facility as good or excellent. The survey also drills down into areas including environment, meals, staff, and solicits input as to which areas in which facilities need improvement efforts.

Transparency, Empowering Consumers & Nursing Home Compare

Long term care providers have led the healthcare sector in transparency and publicly reporting on quality. While providers continue to support transparency and public reporting of data, CMS has not successfully translated regulatory jargon, clinical descriptions, and data, into useful, accessible, and easily understandable information that consumers can use to inform their health care choices. This failing undermines the current value of *Nursing Home Compare*.

CMS' *Nursing Home Compare* website posts data collected from nursing home surveys and also lists compliance with certification requirements, progress on quality measures and indicators, and staffing data. In addition to the shortcomings as a consumer information tool, the lag time in correcting errors that are reported by providers, if a correction happens at all, is excessive. *Nursing Home Compare* also reports a facility's general staffing and patient characteristics as well as deficiencies identified in a facility's last survey. The data posted to the site does not reflect a facility's most recent survey, yet there is no explanation of that fact offered to the *Nursing Home Compare* user. While *Nursing Home Compare* has the potential to become a valuable resource, its present iteration does not empower consumers to make informed decisions about long term care options or other users of this resource.

AHCA Reform Recommendations

Mr. Chairman, the *OBRA '87* mandate was intended to move care in new directions, and it did. The law required a comprehensive assessment of each patient using a uniform Minimum Data Set (MDS) – this was groundbreaking. It was equally important that each facility needed to create and use an ongoing quality assessment and assurance committee.

This offered a platform from which each facility could evaluate the daily processes and procedures that generate positive patient outcomes. We took that direction and ran with it like no other health care sector. Even so, in the final analysis, the patient-centered, outcome-oriented, consistent system of oversight that was originally intended bears little resemblance to the reality we have today.

What we now have is a system that defines "success" and quality in a regulatory context that is often measured by the level of fines levied and the violations tallied – not by the quality of care, or quality of life, as was the original goal of *OBRA '87.*

Today, we know far more about promoting quality, and we have more tools with which to measure it than we did twenty years ago. We need to intelligently change the regulatory process to allow and encourage us to use what we have learned – to place quality over process, care over procedure, and most importantly, put patients at the forefront.

Now is the time, Mr. Chairman, to move toward such a system – a system that keeps existing oversight authority in place, and improves the universe of data used to make important decisions related to patient care. Below we identify several impediments to ongoing quality improvements and proposed solutions for consideration by this committee.

Encourage Joint Training of Surveyors & Providers

Joint training of surveyors and providers on regulations and changes to guidelines, and operational policies helps to ensure that those most directly responsible for protecting patients and providing quality care receive the same information, at the same time, and from the same source. Joint training also provides surveyors with a clearer understanding of the challenges faced daily by the staff of a nursing facility caring for these frail, elderly and disabled patients.

Greater Transparency in the QIS Pilot

The Quality Indicator Survey (QIS) pilot is currently underway in six states including, California, Connecticut, Florida, Kansas, Louisiana, and Ohio. Minnesota will be added to the pilot in early 2008, and possible use of the QIS for all facilities is still several years away. The QIS pilot is meant, in part, to provide more objective results in application of federal requirements. While we are cautiously optimistic that the QIS represents an improvement to the survey process, increased transparency regarding details of QIS from CMS is necessary for AHCA to fully support the continuation and expansion of this new system.

Eliminate the Loss of Critical Nurse Aide Training

Provisions of The Nurse Aide Training and Competency Evaluation Program prohibit a facility from offering nurse aide training as an added penalty in certain instances. Civil monetary penalties in excess of $5,000, denial of payment on new admissions, or the need for an extended or partial extended survey – which is required if surveyors find substandard quality of care (SQC) – automatically trigger a two-year

suspension of a facility's nurse aide training program.

Although SQC may indicate a serious problem in a facility's care delivery system, there are times when SQC does not indicate a problem that is directly related to the care or safety of patients. The loss of a training program for two years is particularly onerous in rural areas where access to other training is extremely limited or non-existent. The loss of training is equally unfair for those receiving care in a facility. A 2004 study entitled, "Nursing Home Characteristics and Potentially Preventable Hospitalizations of Long-Stay Residents" that was published in the *Journal of the American Geriatrics Society* (Volume 52, Issue 10, pages 1730-1736), found that facilities that operate a nurses' aide training program were associated with fewer hospitalizations. Additionally, restricting training for new nurse aides, compounds the challenges long term care providers already face in recruiting and retaining high-quality caregivers—and as we are all aware, quality care is provided by those individuals at the bedside.

Furthermore, the two-year prohibition is instituted regardless of when the problem is corrected, even if the problem is corrected within a day. For example, noncompliance with the environmental aspects of regulations that have little or no impact on patient safety or quality care can trigger SQC, and therefore a two-year nurse aide training prohibition. This negatively impacts quality far more than it helps.

Remove Barriers That Threaten A Patient's Long Term Care Residence

Currently, barriers exist that prevent quality providers from stepping in and turning around a facility that is in imminent danger of closure. In these rare cases, Congress and CMS should consider the suspension of certain fines, penalties, and other enforcement actions when a facility is in "turnaround mode."

Removing such barriers would negate the need to transfer patients, who could otherwise suffer serious psychological and medical trauma from such a move, and would encourage quality providers to take over these troubled facilities.

When new leadership has stepped in to resolve a facility's chronic regulatory non-compliance, the new operator must be given a clean slate to allow time to address the root cause of the systemic non-compliance.

Alleviating the Workforce Shortage

We also urge Congress to consider the major problem of workforce in 2008 in terms of comprehensive immigration reform and developing training programs, which establish an adequate, appropriate, and well-trained domestic nurse aide workforce. We need to continue to support the *Nurse Reinvestment Act* and other federal programs that address domestic nurse supply and nursing education.

Put simply, nursing homes face major obstacles not only in terms of recruitment but also retention of nurses and certified nursing assistants (CNAs). Providing for incentives to create more nurse faculty positions will help colleges create more nursing programs, many of which are already filled to capacity. In terms of immigration, removing the caps for the recruitment of nurses from beyond our borders is an absolute necessity. We need the ability to attract sufficient nurses to the United States to fulfill our capacity. And when it comes to recruiting CNAs, we find ourselves competing with other industries altogether.

Improving Nursing Home Compare

We would suggest that CMS take several steps regarding *Nursing Home Compare*, including: developing specific processes for correcting erroneous data and for indicating when data is not up-to-date; conduct a focus group analysis to assess consumers' understanding of terms and data presented on *Nursing Home Compare* and how to make the site more user-friendly for consumers and other users.

Transparency In Reporting – Protecting the Process

The long term care profession is committed to continuously improving quality of care and informing consumers about the level of care and services delivered through disclosure of quality and patient safety data. Health & Human Services (HHS) Secretary, Mike Leavitt, acknowledged that long term care has led this effort in remarks he made to the National Governors Association in August 2006. Secretary Leavitt stated,

> *"a wonderful thing is happening in the nursing home industry – they started posting their quality measures and their prices… and [because of] public disclosure of them they immediately began to improve and the price got lower and the care got better because the providers themselves said we don't want to be in a place where we are compared negatively because it will affect our market. Health care competition does work… once people have information they make good choices."*

One way to achieve quality improvement is for providers to feel confident in their ability to collect, analyze, and publish information that will lead to additional patient safety and quality assurance.

Certain patient information utilized by providers to analyze quality and safety concerns and ultimately improve clinical practice and care outcomes should be afforded more privilege and confidentiality. The information used for quality improvement purposes and the safety information should be protected from use against those providers who are committed to improving patient safety. Nursing home providers are transparent in the disclosure of quality data, but there are those who take the information and use it against us. For example, the form used by the government to document the deficiencies found during a survey—the "2567" form—is the same form where a facility records its "Plan of Correction." Submitting a Plan of Correction—required by the regulatory process—can be construed as an admission of deficient practice. Furthermore, either the state agency or CMS has given the facility a list of specifics that must be included in a Plan of Correction. The "2567" form is often used against a provide in a court case, which can seriously stymie any desire for transparency.

Voluntary and mandatory provider reporting systems that are designed to detect and disseminate patient safety and quality information should come with some hold harmless provisions as an incentive for providers willing and able to increase self-analysis and disclosure for the purposes of improving care and assuring the public of its commitment to that process.

Mr. Chairman, we ask you to help us incentivize more providers to join those who have been acknowledged by CMS and consumers for making significant advances in care and customer satisfaction. AHCA and the profession want to seize this opportunity to work with you and CMS to continue to lead the way in helping our members strive to do even more to improve care, customer satisfaction and the public trust.

Conclusion

Each of the areas cited above, Mr. Chairman, needs to be reformed with one goal in mind: improving patient care. We will always respect the prerogative of Congress to hold our profession accountable, yet we simply seek to implement and live by the benefits of our accumulated knowledge and proven dedication to always improving.

We pledge to work with you, Mr. Chairman, this Committee, and the entire Congress to foster an environment which continuously improves the long term care services delivered daily to nursing home patients. To this end, each of us here today seeks precisely the same objective, which is to work to improve the quality of care and quality of life for patients in America's nursing homes – and to do so in a manner that helps us best measure both progress and shortcomings.

Finally, while we are enormously proud and pleased by our quality of care and quality of life successes, we concur with all here today that there is far more to accomplish. But we must do so together.

As we can also all agree, we can best achieve the results we seek by building bridges and forging better, stronger working relationships – collaborative, open-minded relationships that look ahead to meeting the demographic challenges that await us in the near future. We owe that to every American today and in the years ahead – from every walk of life, and from every corner of our great nation. We want to accomplish this with you.

Thank you.

American Health Care Association
1201 L Street, NW • Washington, DC • 20005
www.ahca.org