



**Statement of  
Mary Ousley**

*On behalf of the*  
**American Health Care Association**  
*for the*  
**U.S. Senate Special Committee on Aging**

**“The Nursing Home Reform Act Turns Twenty:  
What Has Been Accomplished, and  
What Challenges Remain?”**

**May 2, 2007**

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Thank you Chairman Kohl, Ranking Member Smith, and members of the Committee. I am grateful for the opportunity to be with you here today – and to offer our profession’s perspective on both the successes and remaining challenges we face in ensuring ready access to quality nursing home care for the frail, elderly, and disabled Americans we serve.

My name is Mary Ousley and I speak today as past Chair of the American Health Care Association (AHCA), which represents some 11,000 providers of long term care that employ more than 1.5 million compassionate, well trained caregivers.

Having been in the care giving profession for three decades—as a registered nurse, a licensed nursing home administrator and a senior executive of a multi-facility corporation – I am intimately familiar with the challenges front line caregivers face. I also have worked formally and informally with the Centers for Medicare & Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration (HCFA), over several decades, in various capacities, and on many issues. My experiences have made me acutely aware that providing quality care for seniors and people with disabilities depends on having a collaborative relationship among providers, government, consumers, and the other long term care stakeholders.

I want to note from the outset that CMS and HCFA have worked long and hard to implement the *Omnibus Budget Reconciliation Act in 1987 (OBRA ‘87)* which sought to improve patient care in our nation’s nursing homes. As well, I am impressed with their willingness to meet with us and listen to our profession’s concerns. I truly believe that working together and creating a culture of

cooperation is imperative to improve the quality of care and quality of life for those patients relying on us for their long term care.

Our profession, Mr. Chairman, has made tremendous strides over the past twenty years. However challenges remain and we must be aggressive in addressing them. As we move forward, we must ensure that we are prepared to meet the growing complex care needs of baby-boom retirees, and to do so, our profession requires financial stability which is critical to our continuing progress with quality improvement. That link between stable funding and quality has been noted time and again—by former Secretary of Health & Human Services Tommy Thompson, by former Administrator of CMS Dr. Mark McClellan, and most recently by CMS Acting Administrator Leslie Norwalk whose article for this month's edition of *Provider* magazine states,

*Nursing home providers have been on the leading edge of this quality movement. 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 launched last September... builds on the 2001 Quality First campaign and stresses the essential connection between quality, adequate payment for services and financial stability.*

Ms. Norwalk goes on to say,

*Quality measurement has worked in nursing homes.... Collaborating to measure quality of long-term care, report it, support it, and improve it – that's the best path to a high-quality, patient-centered, provider-friendly system that everyone can afford. At CMS, we look forward to working with you to achieve it."*

Again, we thank you, Mr. Chairman, and this Committee, for providing the long term care community such a timely and valuable opportunity to discuss our ongoing commitment to providing quality long term care and services, and your efforts to foster an environment in which we can continue to work together successfully.

I also wish to commend Senators Gordon Smith and Blanche Lincoln, members of this committee for many years, for putting forward some of the most important regulatory reform concepts of the past twenty years – reforms to the survey and certification process, and other critical reforms that can help to build mutually beneficial partnerships, and undo an era of unproductive confrontation.

The *Long Term Care Quality and Modernization Act of 2006 (S. 3815)* represents an important step toward such a culture of partnership, one that we enthusiastically embrace and endorse, and that I will discuss in more detail later in my testimony.

Twenty years ago, passage of the *Omnibus Budget Reconciliation Act in 1987 (OBRA '87)* ushered in an era of change in our approach to patient care. Congress made the care mandate very clear: all certified facilities must “attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.”

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 resident-centered, outcome-oriented, consistent system of oversight that was originally intended bears little resemblance to the reality we have today.

What we 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*.

We must be mindful here today of the important lessons we have learned since 1987, and be open to the new ideas that will help improve care quality through 2027, and make it better, still, by 2047.

Today, we know far more about promoting quality, and we have better 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 to such a system.

### **Comments on the United States Government Accountability Office (GAO) Nursing Homes Report (March 2007)**

Mr. Chairman, we take very seriously the newly-released Government Accountability Office (GAO) report being discussed here today – and acknowledge the fact we still have many challenges ahead of us in terms of addressing and improving the nation’s most troubled facilities – one patient harmed is one too many and every patient deserves only the best care possible.

Instances of poor care, while rare, are always to be taken seriously and quickly addressed. That is why we are committed to working constructively with Congress, CMS, state survey agencies, and all long term care stakeholders in improving care quality that our seniors and persons with disabilities deserve.

There are mechanisms in place to deal with poor performing providers, and we support transparent processes that ensure improvement in these facilities in the most expeditious manner. AHCA and its members have been in regular dialogue with CMS regarding this issue, and we continue to aggressively pursue avenues where we can work in concert with the federal government to ensure care quality is maximized.

The GAO report also takes note of the critical role CMS plays in overseeing the care provided to frail, elderly, and disabled Americans each day. While the GAO criticizes CMS for not effectively utilizing available sanctions when dealing with persistently poor performing facilities, the report also shows that nationally the percentage of nursing homes being cited for actual harm or immediate jeopardy in recent years has drastically reduced.

From an historical, comparative and frankly, instructive standpoint, let us briefly look at a 2003 GAO report which found an almost 30 percent reduction in actual harm deficiencies over an 18 month period that ended in 2002. It is unclear whether this was due to an understatement of deficiencies as the GAO concluded, or as we would argue an indication of real quality improvement. This dichotomy points to the central problem in understanding today's oversight process, and underscores the inability to distinguish between the failure to identify deficiencies and real quality improvement.

Yet, in assessing the effectiveness of the joint federal-provider *Nursing Home Quality Initiative* (NHQI), our profession's *Quality First Initiative*, and other quality improvement programs now underway for several years, we say proudly and unequivocally they are proving effective. In fact, NHQI data illustrates improvement in key quality measures.

These efforts help place us on the course necessary to ensure care quality continues to improve, and evolves in a manner that best serves patient needs throughout the long term care continuum.

The survey system is designed to assess compliance with Requirements of Participation and to measure quality. However, in practice, it is focused more on process compliance rather than actual patient care outcomes. Our focus needs to return to the patients, their satisfaction, their care outcomes and the degree to which the facility meets their clinical and quality of life needs.

## **GAO Recommendations for Executive Action**

The GAO makes several recommendations in their report – some with which we agree and others we feel will not be in the best interest of patients or the individuals who deliver their care:

- *GAO Recommendation:* Expand CMS' Nursing Home Compare Web site to include implemented sanctions and homes subjected to immediate sanctions.
- *AHCA Position:* We see CMS' web site *Nursing Home Compare* as a valuable resource but more needs to be done to ensure that the data is validated, current, accurate, and displayed in a manner that enhances consumers' understanding and effective use. This

recommendation seems contrary to GAO's own concern related to the accuracy of CMS data systems.

- *GAO Recommendation:* CMS should expand its Special Focus Facility program with its enhanced enforcement requirements to include all homes that meet a threshold, established by CMS, to qualify as poorly performing homes.
- *AHCA Position:* We are supportive of CMS terminating consistently poor performing facilities. However, we believe that CMS' process for determining a Special Focus Facility (SFF) is not transparent, which makes it extremely difficult to ascertain the level of clear standards, established thresholds and the presence of due process. We are supportive of CMS' effort to better define and identify poor performers. We encourage greater cooperation between the Quality Improvement Organizations (QIOs) and problem facilities – it has been demonstrated that such cooperation is effective improving quality patient care.
- *GAO Recommendation:* The CMS Administrator should develop an administrative process for collecting civil money penalties (CMPs) more expeditiously (prior to the exhaustion of appeals) and seek legislation to implement this process effectively.
- *AHCA Position:* We have always advocated for due process in the administrative review. Given significant concerns about the validity of deficiencies, and inconsistency between states in the Informal Dispute Resolution process, we believe skilled nursing facilities should not pay a CMP until determination of fault is finalized. Therefore, we cannot support this recommendation.
- *GAO Recommendation:* Ensure the consistency of CMPs by issuing guidance such as the standardized grid piloted by CMS in 2006.
- *AHCA Position:* We believe that circumstances surrounding noncompliance must be evaluated on an individual basis before remedies can be imposed – a standardized CMP grid does not take into account the specific circumstances around noncompliance.

## Summary

In total, the increased focus on resident-centered care, actual care outcomes, increased transparency and public disclosure, enhanced stakeholder collaboration and the dissemination of best practices models of care delivery is paying off. Here are some of the facts:

- Key quality indicators tracked by the Nursing Home Quality Initiative have improved since it was launched by CMS five years ago, including:
  - improved pain management,
  - reduced use of restraints,
  - decreased number of patients with depression, and

- improvements in physical conditions such as incidents of pressure ulcers.
- Satisfaction of patients and family members is a critical measure of quality. An independent survey of nursing home patients and their families, conducted by *My InnerView*, indicates that a vast majority (83%) of consumers nationwide are very satisfied with the care provided at our nation's nursing homes and would rate the care as either good or excellent. A soon-to-be-released update to this report will illustrate increased consumer satisfaction.

We face four situations which impede ongoing quality improvements:

First, surveyors simply do not have a clear understanding of the challenges faced daily by the staff of a nursing facility caring for these frail, elderly and disabled patients.

No, this is not a surveyor's job – but a better understanding of a day in the life of a nursing home patient and their caregivers can only benefit the patients for whom survey process is intended to protect.

The Quality Indicator Survey (QIS) pilot now in place is meant, in part, to provide more objective results in application of interpretations. While we are encouraged by the program, increased transparency regarding details of QIS is necessary to assist facilities in understanding and fully supporting this new system. The pilot is currently underway in six states, and its use for all facilities is still several years away. In the interim, improvements in consistency can be addressed through a program that trains both surveyors and providers simultaneously, as well as trains new surveyors within a facility for a period of time so they can experience firsthand the day-to-day operations of a nursing home.

Second, provisions of The Nurse Aide Training and Competency Evaluation Program specify when a facility is prohibited from providing nurse aide training. Criteria automatically triggering such a two-year nurse aide training prohibition include imposing civil monetary penalties in excess of \$5,000, imposing the denial of payment remedy, or conducting an extended or partial extended survey – which is required if surveyors find substandard quality of care (SQC).

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. In these instances the loss of training is particularly onerous and unfair – especially to residents themselves. If we don't have the ability to train new nurse aides, we are limited in the ability to recruit these potential caregivers, and as we are all aware, quality care is provided by those individuals at the bedside.

Furthermore, as I mentioned, the two-year prohibition is instituted regardless of when the problem is corrected, even if the problem is corrected within a day.

Here's an example: noncompliance with the environmental aspects of quality of life rules – that have little or no impact on patient safety or quality care – could trigger SQC, and therefore a two-year nurse aide training prohibition. This negatively impacts quality far more than it helps.

Third, barriers that currently exist for individuals purchasing problem facilities must be eliminated. In some circumstances facilities have closed or are in imminent danger of closure; one might assume that in certain cases, sadly, the situation might not improve. In those rare cases, Congress and CMS should consider the suspension of certain fines and penalties when a facility is being purchased. This of course assumes that it would be an arms length transaction by an individual or group who have no connection to the previous owner. This will help in two ways: 1) assuming the facility is not yet closed, it may negate the need to transfer patients, which can have serious psychological and medical consequences; and 2) it will encourage individuals and groups to purchase a problem facility in order to improve it by removing insurmountable obstacles at the outset which might otherwise discourage them from making the purchase.

Fourth, we also urge Congress to consider the major problem of workforce in 2007, not only in terms of its reauthorization of the Nurse Reinvestment Act but also in terms of comprehensive immigration reform and developing training programs which establish an adequate, appropriate and well trained domestic nurse aide workforce. 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 from the United States to fulfill our capacity. And when it comes to recruiting CNAs, we find ourselves competing with other industries altogether.

So we ask that Congress think carefully about targeted relief to recruit nurses, not only domestically but internationally as well.

Each of these four areas, Mr. Chairman, needs to be reformed with one goal in mind, improving patient care.

We pledge to work with you, Mr. Chairman, and the entire Congress to encourage an environment which continuously improves the long term care services delivered daily to nursing home patients. To this end, we applaud the legislation which Senators Smith and Lincoln introduced in the 109<sup>th</sup> Congress and hope that such a bill that encourages a culture of partnership is again introduced. This bill would encourage investment in capital improvements and health information technology, foster the creation of a stable and well-trained workforce, address pressing access and financing concerns, ensure essential rehabilitation services are available to those who need it most, and facilitate our ability to sustain continued quality improvements by removing some of the illogical, counterproductive barriers I just outlined.

From a regulatory reform standpoint, Senators Smith and Lincoln's bill would, in summary:

- Require joint training and education of surveyors and providers, and implement facility-based training for new surveyors; and
- Direct CMS to modify the definition of SQC so that factors not affecting quality of care or the training of nurse aides are eliminated, and amend current law to allow nursing facilities to resume their nurse aide training program when deficiencies that resulted in the prohibition of the training have been corrected and compliance has been demonstrated.

On the front lines of care, Mr. Chairman, these proposals are significant, and they merit strong support.

In addition to ensuring the nearly \$15 billion, five year Medicare and Medicaid funding cuts are not included in the federal budget, passage of this landmark legislation is our most important legislative priority for 2007.

We have discussed special focus facilities with CMS on numerous occasions. As we have been transparent about our industry, we have urged CMS to be similarly transparent. What do we mean?

There need to be very clear standards that are promptly conveyed to nursing homes across the country. What are the criteria which CMS utilizes to place nursing homes on the list of special focus facilities? When and how have owners and operators been informed? What are the specific steps which a facility must undertake in order to graduate off the list? These are not only issues of due process for the facility, but they also serve as a “roadmap” to get facilities back on the right track.

Each of us here today seeks precisely the same objective, which is to work to improve the quality of long term care – and to do so in a manner that helps us best measure both progress as well as shortcomings.

As I have noted, improving care quality is a continuous, dynamic, ongoing enterprise. While we are enormously proud and pleased by our care quality successes, we concur with all here today there is far more to accomplish.

I can say from all my years in long term care, Mr. Chairman, that there has never been a broader recognition of the importance of quality, or a broader commitment to ensure it keeps improving. Let us all commit today to ensure the systems and methods used twenty years ago to help assess and measure care quality are improved upon and supplemented by new, evolving systems and methods we are just now beginning to explore and assess.

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